Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Unscheduled Care Task Group: DHSSPS and HSCB

14 January 2015

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Paula Bradley (Deputy Chairperson)
Mr Mickey Brady
Mrs Pam Cameron
Mrs Jo-Anne Dobson
Mr Paul Givan
Mr Kieran McCarthy
Ms Rosaleen McCorley
Mr Michael McGimpsey
Mr Fearghal McKinney
Mr George Robinson

Witnesses:

Mr Jackie Johnston	Department of Health, Social Services and Public Safety
Ms Charlotte McArdle	Department of Health, Social Services and Public Safety
Dr Michael McBride	Department of Health, Social Services and Public Safety
Mr Michael Bloomfield	Health and Social Care Board

The Deputy Chairperson (Ms P Bradley): I welcome Charlotte McArdle, Dr Michael McBride, Jackie Johnston and Michael Bloomfield. I advise members that Dr McBride is here in his capacity as Chief Medical Officer and not as the chief executive of the Belfast Trust. Michael, for your benefit, if you feel that we are straying into anything to do with the trust that you feel is not relevant, please feel free to say so. I will also comment should I feel that that is the case. I invite you to make your opening presentation, please.

Ms Charlotte McArdle (Department of Health, Social Services and Public Safety): Good afternoon, Chair and Committee members. On behalf of my colleagues, I would like to express our thanks and appreciation for the invitation to come and speak to you this afternoon on the work that we are taking forward through the unscheduled care task group. I apologise again for the difficulty that we had in getting this session arranged and appreciate your offer to accommodate us this afternoon instead of next week.

I hope that you have had the opportunity to read and consider the briefing paper that we submitted to you, which sets out in broad terms the strategic approach that we have taken and that there will be a real and meaningful improvement in the experience of patients accessing unscheduled care services.

The briefing also builds on the Minister's statement of 19 November by setting out in some detail many of the innovative pieces of work that we have developed and continue to implement, which will strengthen and improve our urgent and emergency care services. They include improvements in

direct access for patients — helping them to bypass the emergency department; work with Marie Curie to introduce the extension of a seven-day service for out-of-hours rapid response palliative care services; and the trusts working with the Ambulance Service and other transport providers at local level to improve non-urgent transport for patients.

Other examples are that, through the unscheduled care task group, we have set standards for the care of older people, particularly the transferring out of hospital after 8.00 pm, and made improvements to the bureaucratic processes involved in many of the discharge plans in order to speed up discharge, make it easier for the staff and make sure that it is done safely for patients and their families. Also, we plan to train and develop more roles for advanced nurse practitioners so that they can support the team in the emergency department.

Work is also ongoing to develop a statement on values and principles for urgent and emergency care to guide strategic work later in the year on how we will deliver urgent and emergency care services in Northern Ireland. That is in response to one of the Regulation and Quality Improvement Authority (RQIA) recommendations.

As the Minister's statement also set out, some significant challenges remain, and it is important that we continue to address those over the coming weeks and months. In our most recent briefing paper, we gave a very high-level overview of performance in October and November. With the Committee's permission, and I think that you already have that paper, we would like to bring that up to date with a short presentation on the most recent numbers of patients accessing the emergency departments over January and the holiday period into the new year. That will be particularly important given the recent decisions taken by all trusts on, for example, elective procedures. Michael Bloomfield from the Health and Social Care Board has kindly agreed to do that and has prepared a short presentation. You should all have a copy. If not, there are copies here for anyone who does not have one.

I will take the opportunity to hand over now to Dr McBride to say a few words before Michael begins his presentation.

Dr Michael McBride (Department of Health, Social Services and Public Safety): Thanks, Charlotte. First, I echo Charlotte's thanks to the Committee for the opportunity to give evidence this afternoon. Obviously, some time has passed since Edwin Poots, the then Minister, made a statement to the Assembly on the findings of the RQIA review of unscheduled care and announced the establishment of the unscheduled care task group.

I am also grateful for the opportunity to come here today to update the Committee on the work that was done and is ongoing so that we were better prepared for the winter and to strengthen and improve our unscheduled care services regionally and into the future. I offer my sincere apologies to the Committee that we did not get to update you sooner on this work. I wish to assure the Committee that we have learnt lessons on improving our mechanisms and processes in the Department to ensure that that does not happen again.

Chair, I would like to take the opportunity publicly to record our thanks to the very many staff from right across the Health and Social Care (HSC) organisations and professions who have dedicated their time — often their personal time — to the work of the task group in developing the new pathways and models, which Charlotte referred to, with the ultimate aim of doing better for the patients and clients who use our services.

When the task group was established, it was set clear aims for improving waiting times for patients in hospitals over the course of this winter, but, importantly, it was also tasked with ensuring that the people of Northern Ireland, particularly our frail, elderly population, receive safe, effective and dignified care. I do not need to remind members of some of the evidence sessions that we had last winter on the challenges and impacts that it had, particularly on frail, elderly people using our Health and Social Care services. I hope that we will have the opportunity to brief you on the progress that we have already made and will continue to make throughout the remainder of the winter and into next year.

Members will be aware that HSC achieved a 44% reduction in the number of people waiting over 12 hours during the past year. That progress has continued into 2014-15, with the lowest number of people waiting over 12 hours in our emergency departments in the past five years. That is despite a 5·5% increase in ED attendances over 2014-15. Michael, subject to your agreement, will give you a short update on that. I caution, however, that these are unvalidated figures, but today is an opportunity to provide you with an update on pressures over the past couple of weeks. It would be

remiss of us not to seek to provide members with a sense of how the service responded, the pressures in the system and what impact that has had on those using our service.

It is important to set all of what we have been doing in the context of a system that, despite the significant financial and demographic pressures, which we have discussed and I know that members are very aware of, continues to improve. I hope that the figures and information that we will be able to share with you this afternoon will give you some confidence in that.

There is a great deal to discuss this afternoon. Whether it is the work that we are doing on values and principles, which Charlotte mentioned, the strategy and policy on scheduled and emergency care, finance or operational service development, we are happy to take questions on any of those issues.

With your agreement, Chair, I wish to hand over to Michael to take you through a resume of the unvalidated figures on how the service has performed over the past number of weeks.

The Deputy Chairperson (Ms P Bradley): Yes, OK.

Mr Michael Bloomfield (Health and Social Care Board): Good afternoon. I thank the Committee for this opportunity to join departmental colleagues to update it on the pressures experienced in a number of emergency departments over past weeks and the actions taken to address them. As Charlotte said, you have a copy, I hope, of my short presentation containing a number of slides. I will be brief.

Pressures in lengthening waiting times in emergency departments manifested themselves in particular at the start of last week, on Monday 5 January, which was the first full normal working day following the holiday period. That followed a two-week period of significantly higher attendance in emergency departments. There was a 7·5% increase on the same two-week period last year. That translated into an increase of 3% in admissions from emergency departments compared with the same period last year. So, there was quite a significant increase in demand over the two-week period preceding 5 January.

As well as an increase in the number of patients attending and being admitted from emergency departments, there was an increase in their acuity. A number of indicators provide a proxy for acuity, but one of those is the triage category of patients attending emergency departments. During the two-week period to 5 January, there was a significant 14% increase in category 2 patients — those who are very ill — compared with the same time last year. There was also a 7% increase in category 3 patients. During December, there was also a 12% increase in the number of patients admitted with fractures. All worked together to place considerably increased pressures on hospitals at the same time.

The increase in activity was not experienced only in hospitals. During the same two-week period, there was an 18% increase in GP out-of-hours calls. Within that 18% increase, there was a 34% increase in urgent calls. As I said, the result of that increase in activity and acuity was a particularly busy period in our hospitals, and, regrettably, that meant that a number of patients experienced delays in emergency departments, particularly on Monday 5 January and Tuesday 6 January, when, unfortunately, a substantial number of patients waited longer than 12 hours.

The slides show the position at 9.00 am each day from 1 January up to and including yesterday. I am pleased to be able to say that, this morning at 9.00 am, there were no patients waiting longer than 12 hours. However, as you can see, around 5 January and 6 January, there were large numbers doing so. Delays of that length are unacceptable, and we apologise to patients who experienced such long waits. However, trusts prioritise the most urgent patients, and, therefore, some patients had to wait longer while sicker patients were admitted ahead of them. That was in the context of what I said about the increased number of admissions and the increased sickness levels therein. Those are the 9.00 am snapshot figures. They are not the total number of patients who waited over 12 hours in a given day, but, typically, 9.00 am is the most difficult time for waiting times. I believe that the figures show the steps that trusts took over that period and that the plans that they already had in place leading up to it meant that the position improved very quickly during the week: from 40 on Monday to 29 on Tuesday, one on Wednesday and none for the rest of that week. At the start of this week, regrettably, three patients on Monday and two on Tuesday waited for over 12 hours.

This improvement is consistent with the longer-term trend that Dr McBride referred to and which is shown on the next slide, where you can see that, in 2011-12, over 10,000 patients waited longer than 12 hours in our emergency departments. That had almost halved in 2012-13 to 5,500 and was just over 3,000 last year. To date, to the end of December, there has been a 32% reduction this year

compared with the same nine months last year. So we are on track to have fewer than the 3,100 such waits in 2013-14, which, as Dr McBride said, was the lowest in five years. December, for example, was a busy time and part of the period in which the significant increase in attendances took place. It was also the period when there was an increase in fracture admissions. In December, 92 patients waited longer than 12 hours; in the previous December, the number was 163. So the direction of travel for patients waiting over 12 hours is the right one. That said, we are certainly not complacent and certainly do not celebrate that 3,000 patients wait over 12 hours. That is much too high a number. The position should be that none wait that long, but, hopefully, it reassures the Committee that progress is being made.

Twelve hours is, of course, only one indicator. There is a wide range of indicators, particularly quality indicators. Twelve hours is only one of the time indicators, and that improvement is to be welcomed. However, where we need to be is that the vast majority of patients are seen, treated and discharged or admitted to a ward within four hours. It is fair to say that, regionally, the position has been broadly unchanged for the past number of years and that further improvement is required. I fully recognise that 12 hours and four hours are the ministerial standards, but a number of our large emergency departments are at around 90% for six hours, which gives some sense of how long the majority of patients wait if not treated within four.

I will conclude by saying something about how the position in the emergency departments was improved during last week in the face of the increase in activity that I outlined. All trusts had reviewed and tested their escalation plans before the start of the winter. That was one of the areas of work taken forward under the unscheduled care task group chaired by the Chief Medical Officer and the Chief Nursing Officer. Those escalation plans have a range of measures to be taken depending on the circumstances at any time. They include some of the things that we have listed, such as opening additional beds, increasing staffing levels, extending services such as social work, pharmacy, occupational therapy and physiotherapy into the evenings and at weekends and having a particular focus on discharge by carrying out additional ward rounds.One of the measures in the escalation plans that has attracted some attention in the last week is the postponement of non-urgent elective procedures. The impact that that has on individual patients who have their procedure postponed, many having waited a considerable time and made plans around it, is very much recognised, so the decision to postpone such procedures is certainly not taken lightly. However, it is an appropriate part of trusts' normal escalation plans to ensure that the sickest patients are prioritised by freeing up bed capacity and medical and nursing staff to care for emergency patients. From 1 to 9 January, it was necessary to postpone the procedures of 179 patients. This week, from 11 January to Friday 16 January, 13 patients will have had their procedures postponed. It is regrettable that this measure was necessary, and again we apologise to the patients affected. I assure the Committee and those patients that trusts are taking steps to ensure that they have their procedures rescheduled as quickly as possible.

In conclusion, Chair, I believe that the trusts' escalation plans worked effectively over the last two weeks to quickly improve a very challenging position. Our hospitals remain very busy. There will, however, be a regional debrief to identify what learning there is from the experience over the last couple of weeks, and, no doubt, that will identify areas where further improvements can be made.

The Deputy Chairperson (Ms P Bradley): Thank you. Just before I ask a question and bring members in, may I remind the four of you to use as little jargon as possible?

Dr McBride: We are conscious of that, Chair.

The Deputy Chairperson (Ms P Bradley): Some people will understand it fully; others might not. I was glad that you explained what categories 2 and 3 are.

Mr Bloomfield: I apologise, Chair.

The Deputy Chairperson (Ms P Bradley): My first question was going to be to ask you to explain what they are, so, if you would try to be careful about using jargon, that would be good.

You spoke about the postponement of non-urgent elective procedures. Have you any time frame for clawing those back? How will you manage that?

Mr Bloomfield: Yes. The board has sought assurances from all the trusts about the patients who have had their surgery postponed. The numbers vary quite considerably across the trusts, but all five

have assured us that they expect those patients to have had their procedures within the next three to six weeks.

The Deputy Chairperson (Ms P Bradley): So, they imagine that within three to six weeks they will be back on track with their original timelines.

Mr Bloomfield: The trusts expect to treat patients who would otherwise have been treated last week or this week within the next three to six weeks.

The Deputy Chairperson (Ms P Bradley): That is good to hear, but will that then put back the next tranche of elective surgery? Will we catch up at some stage and be back exactly where we would have been had that decision not been taken?

Mr Bloomfield: That is certainly the board's expectation. We have contract volumes with each trust for each specialty, whether for outpatients, day cases or inpatients. The events of the last two weeks do not change that. We still expect those volumes of activity to be carried out over the year. That is not without challenge, but we expect it to be done. We will put in place arrangements to carry out those procedures. It is a relatively small number. On average, about 4,800 procedures are carried out each week in Northern Ireland. That will have been planned to have been lower in the last week or two because of the expected increase in unscheduled care pressures at this time of year, but I think that that figure gives a sense of scale: it was necessary to postpone about 190 procedures, so catching up on that scale of activity does not present a significant challenge.

Dr McBride: May I add to that, Chair, from the Department's perspective? On behalf of the system, we wish to apologise to patients who have had their procedures postponed to be rescheduled. None of us would wish for patients already waiting too long for a procedure to have it postponed, even by another three to six weeks, often, in the circumstances in which we have found ourselves over the past number of weeks, at very short notice. From the Department's perspective, it has a clear expectation that trusts will deliver, as Michael has indicated on behalf of the board, the volume of procedures in line with the agreements established between the respective trusts and the Health and Social Care Board. Indeed, the Department will seek assurances that that is the case. No comfort will be sought or given on that. Our targets for some of the electives remain. We had a system that was dealing with a significant period of unprecedented pressures. Unfortunately, these steps needed to be taken in line with the escalation plans that had been developed by the trusts to respond to such eventualities. However, it is deeply regrettable. Again, on behalf of the Department, I apologise to the patients and, indeed, their families, who have been affected in this way.

The Deputy Chairperson (Ms P Bradley): Thank you. I am sure that some members will pick up on that as we go through.

Mr McCarthy: Thank you very much for your presentation. First, I welcome that apology from Dr McBride. Every member will know the disaster that we have been through this past two or three weeks. I have a copy of the membership of the task group: 15 of the most senior health people in Northern Ireland. I do not think that Mr Bloomfield and Jackie Johnston are on it, so they can relax for a moment or two. Surely, Michael, as chair, and Charlotte, as deputy chair, you must be hugely embarrassed by what has happened. I have been on the Health Committee for a number of years. Individuals, maybe not you, come back regularly with the same problem. On behalf of the Committee, I want to know whether you, as the task group, know what the main cause is. We have heard what Michael has said up until now. Do you know the main causes of what we went through in the past while? There has been poor performance in the emergency department. Is it a money problem? Is it a problem with how hospitals are internally organised? Is the public's inappropriate use of emergency departments the problem? We must bear in mind that, as I understand it, Northern Ireland is the worst area in the UK for this happening, despite the fact that we spend more per head on our population. The previous Health Minister set up the task group in July, I think, last year, so you had six months to prepare. We have not even had the winter yet — well, the north and west of Northern Ireland are having it, and it will probably spread to the rest of us — so how will you cope if the situation gets worse?

Dr McBride: I will start and maybe defer to Charlotte to take you through some of the detail of the work and achievements of the unscheduled care task group to date. As the paper that you have before you makes clear, the extant accountability arrangements in the system remain. So, individual trusts are accountable for their performance across the spectrum of care that they provide, whether

that is elective activity or urgent and emergency care. Indeed, they are held to account for the performance management of that and how well they are doing in processes that the Health and Social Care Board has responsibility for.

The unscheduled care task group is, perhaps, a unique arrangement. As you rightly said, Kieran, we brought together the senior professional and executive leadership in the entire health service around one table to ensure that we were taking forward clinically led, managerially supported and strategically coordinated activity to improve some of the pressures in our Health and Social Care system. I think it fair to say that the pressures, as reflected in the facts and numbers that Michael gave, point to a period of unprecedented pressure, not only here in Northern Ireland but across the United Kingdom and, indeed, in the Republic of Ireland. The question that you, rightly, asked was this: what was the cause? At this point, it would be speculation on my part to seek to understand what contributed to it. Many commentators have pointed out that we were not particularly far into the flu season and did not have a particularly bad period of severe weather. They then ask the same question: what actually contributed to it? At this time, I am not in a position to respond to that, but we can say that it was not a pattern of pressure that was peculiar to Northern Ireland.

You asked whether I was embarrassed by how we responded.

Mr McCarthy: Not only you; the entire team.

Dr McBride: We had anticipated that this would be a period of significant pressure. The entire Health and Social Care system in Northern Ireland learnt from the experiences of last year and the failings — let us be clear that there were failings — of last winter. The fact is that we had significant problems last winter. As a result of the RQIA review, the recommendations in it and the progress that we have taken forward through those recommendations, which has been overseen by the unscheduled care task group, we are in a very different situation. One of the key recommendations in the RQIA review was that Northern Ireland develop trust and regional escalation plans to deal with this sort of eventuality. Those plans were developed and tested by trusts in the run-up to the winter. Assurances were sought by the Health and Social Care Board from each and every trust that those plans were in place and had been tested, and that assurance was provided to the Department, which was asking for that assurance so that this sort of situation did not happen as it had happened elsewhere. We planned and prepared for this. We responded to it, and it worked, but it certainly inconvenienced people waiting for the non-urgent elective procedures that we had to postpone. However, let us bear in mind that we did not have signs outside our EDs, as in some parts of England, saying, "Major incident". None of our trusts in Northern Ireland declared a major incident; we had planned step-by-step escalation and response across all the trusts in Northern Ireland to the pressures that we saw.

I have no doubt that members and the public may be confused by some of the mixed messages reported in the media: on the one hand, we have "crisis" and "chaos"; on the other hand, we have "what crisis?" and "what chaos?" Our system was tested because of the significant numbers of patients seen, including many who were very sick, and it responded well. All the staff in Health and Social Care, in both the community and the acute sectors, responded very well to those pressures. Charlotte and I had the opportunity to go out and talk to staff. They felt under significant pressure, but the system coped and managed. It did not fall over.

The achievements of the unscheduled care task group have been significant. Charlotte, maybe you could highlight some of them.

Ms McArdle: Kieran, I do not feel remotely embarrassed by what has happened. I —

Mr McCarthy: I have had constituents coming to me about their appointment. I was at a planning appeal this morning, and the lady had to adjourn it simply because her surgery had been cancelled over and again. That is reflected and impacts throughout the community.

Dr McBride: I accept that.

Ms McArdle: Again, I apologise most sincerely to any patient affected. I picked up in the media some of the personal stories of those people. They are significant: they rearranged their lives to have a procedure done and, at the last minute, it was cancelled. That is very regrettable, but I hope that I will demonstrate, by sharing with you some of the successes of the task group, that we can see that, if we were not having this success, we could have been in a much worse position. One of the big successes has been the escalation group, which Michael Bloomfield chaired. It worked between

September and November in supporting trusts to look at their escalation plans, beef them up and test them. That all happened before Christmas. We, as an unscheduled care task group, met just before Christmas. We checked with everybody that their plans were in place, that they had tested them and that they were working. The fact that the system was able to respond as quickly as it did over the holiday period is testament to the work that went on in the escalation group.

Mr McCarthy: I am looking at the escalation plan. The first step is additional beds being opened. Surely that must be a contradiction to Transforming Your Care, in which you propose to close over 160 beds. Here we are turning Transforming Your Care on its head. We welcome the additional beds to sort the problem out, but is Transforming Your Care going in the wrong direction?

Ms McArdle: We experienced a surge in demand. Michael has already shared the increase in hospital admissions of 2·5%, and the 7% increase in attendances at ED. In an escalation, our response has to be beefed up. It is all hands to the pump, and we must open as many beds as we can to make sure that the patients are cared for safely. That is our priority and concern.

Mr McCarthy: Will that continue?

Ms McArdle: Absolutely.

Mr McCarthy: So the Transforming Your Care reduction in beds is gone — out the window.

Ms McArdle: While we are in this escalation phase with increased pressure on our system over this particular period. Those beds will be turned down again and we will be back to normal functioning once we get over this surge of activity.

The Deputy Chairperson (Ms P Bradley): Let me just come in and go back to the original question that Kieran asked. You have told us about the things that you did in the run-up, before we had this problem with A&E departments. Going back to that, lots of things were put in place and you were on your way towards something that was going to be successful and you are going to be able to deliver it. Then why did we end up in the position that we were in? That was Kieran's original question. Was it due to money, the internal organisation or people misusing A&E, which we know happens? Michael, you said that, at this stage, it is purely speculative. So, if we had all these plans in place, why did it happen? Can you give an opinion on that?

Ms McArdle: As Michael has already said, we do not have the detail on it. We have not had the opportunity to analyse the information to that level. We can say that this was an unprecedented surge, over and above what we put in place.

The Deputy Chairperson (Ms P Bradley): When do you think that we will have that information?

Dr McBride: I will defer to Michael in a second. We have some of that information now. For instance, we know the raw numbers, though they are not validated in terms of the actual numbers of people who were attending our emergency departments. The category 2 patients are people who need to be seen within 10 minutes of arrival, so these are sick people. They do not need to be seen immediately but they need to be seen within 10 minutes, and that number was up 14%. The number of patients that need to be seen within 20 minutes, the category 3 patients, was up 7%. So these were sick patients. We have had the opportunity to talk to the medical and nursing staff on the ground in the emergency departments and those on the medical units. Anecdotally, they indicate that they saw increased numbers of frail, elderly patients who were sick. Obviously, we cannot discharge people before they are medically fit to be discharged. However, if you have frail, elderly people coming into hospital in increased numbers — which we most certainly did; we had a 2·9% increase in admissions — it takes a while for those patients to get the appropriate medical and nursing care to be ready and fit for discharge. I do not have the age profile of those patients at this point; we will have to look at that. However, from talking to those working in the front line, that is their impression. Why did that happen? Again, I can speculate.

Another thing, from talking to the doctors and nurses, is that they say that we had a large percentage of people with exacerbations of respiratory conditions. We normally see that at this time of the year anyway. We had large numbers of people with fractures. There was a 10% increase in those cases. As others have commented, it was not particularly severe weather. We had a period of mild weather and, if you remember, we had two icy mornings. I do not know whether that sharp change in weather

was a factor that contributed to the increase in fractures. We also had a poor-air quality alert from the Department of the Environment during that period because there was increased air pollution. We know that there are links between that and exacerbations of asthma and chronic respiratory disease. That may have been a factor. These are all speculative at the moment. However, you are absolutely correct, Kieran: we need to understand what happened. It happened not just here in Northern Ireland but throughout the UK and in the Republic of Ireland. There was something unusual about the circumstances that contributed to the pressure.

I have some confidence in saying that, unlike other parts of the UK and the Republic of Ireland, the health and social care system in Northern Ireland stood up to that period of sustained pressure. We did not stand up last year; but this year, because of the planning, the preparation and the work of the unscheduled care task group, we were in a much different and better place. The work of the trusts, the assurances sought by the board and the work of the unscheduled care task group and some of the other things that we have been taking forward as part and parcel of that work contributed. I do not know whether you want to get into the detail of that —

The Deputy Chairperson (Ms P Bradley): I just want to make the point that we are not here just specifically to talk about what happened in that period —

Dr McBride: Sure. I appreciate that.

The Deputy Chairperson (Ms P Bradley): We are looking right back to the autumn and we know that there were a lot of 12-hour breaches then as well. It is not just this one-week period. I do not want everybody just to get fixated on that week. We need to look at the job that you are doing and the job that you have done since it was set up, and tease that out a bit more, rather than just concentrate on that one week.

Dr McBride: I am very conscious of that, Chair. We are conscious that this was a postponed meeting, and we apologise for that. We would have wished and preferred to have given you an earlier update in terms of the work of the unscheduled care task group, but it would be quite wrong for us not to reflect and give you an update on the current situation and, indeed, the situation over the weeks immediately —

Mr McCarthy: Finally, everyone around this table has huge admiration for the work that is being done in our hospitals and by GPs, but I have asked whether it is a problem with money and you have not answered that. I am very concerned about the elderly, which you mentioned. We need to look after the elderly. Some of the trusts, my own included, have reduced the domiciliary packages from three to two, I think. That means that those people will run the risk of breaking a leg and being back in the hospital. Can you get over that?

Dr McBride: As Chief Medical Officer, it is not for me to advise on financial matters, but let me refer to the concerns that the then Minister briefed the Committee on when I was last here. I had raised my concerns with the Minister in terms of the impact of some of the trusts' contingency plans and, indeed, the deficit that we face in our budget, and, thankfully, due to the decisions made by the Executive, that gap was closed. However, we still have, as the permanent secretary indicated when he last presented evidence here, a gap of some £80 million. There is no doubt that that will have an impact. We will have to make some difficult decisions in terms of health and social care, and we will have to make some short-term decisions in terms of where those savings can be made. Strategically, we may not have wished to make those decisions.

Mr McCarthy: They are detrimental to elderly people.

Dr McBride: We have indicated that this is a priority area. The Minister has been very clear about the priority that he affords to unscheduled care. The then Minister was and the current Minister has been very clear about the priority that he affords this. We were grateful to the Executive for the additional £80 million that we secured in June and October monitoring, £31 million of which went to unscheduled emergency care and flows, and £5 million of which went to winter pressures in planning and preparation for this winter. We have used those moneys well in actually responding.
It is important, Kieran, to put this in the wider context that, over the period of the comprehensive spending review, as the Minister, the permanent secretary and Julie Thompson previously provided in evidence to you, the HSC and the Department have delivered savings of some £490 million. We have committed to delivering £170 million next year. That will be some £660 million in savings over the

period of the comprehensive spending review, which is in line with what was indicated to McKinsey in terms of efficiency savings that could be made across the Department. We have delivered those savings at a time when, as Michael said earlier — it is only one measure of the health service and, in many respects, a very crude measure — we are seeing year-on-year improvement in the number of people waiting more than 12 hours. It is not acceptable that anybody waits more than 12 hours, but we are seeing improvement there. At this point, we are not seeing the sort of improvement that we need to see in the number of people waiting four hours, and we are using fewer hospital beds than we were using in 2012-13. So, I think that we are making steady progress in terms of using the resources and the taxpayers' money that we have more efficiently and more effectively. But, again, that matter is really outwith my competence to brief the Committee on.

The Deputy Chairperson (Ms P Bradley): We recognise that there have been improvements, but the question as to why our emergency departments have that poor performance will not go away. We are not just talking about the week at the beginning of January because there was poor performance back in October/November as well.

Dr McBride: There certainly was, Chair.

The Deputy Chairperson (Ms P Bradley): The question will not go away. It will be asked, and, as a Committee, we would appreciate even an answer on why there was the major spike last week that caused the problem. We would be very keen to get that evidence and your findings back as soon as possible, because we will continue to ask the question.

Dr McBride: We are very happy to provide that information, either in written format or to come and brief you again when we have carried out that analysis. We are very happy to do so if that would be helpful to members.

The Deputy Chairperson (Ms P Bradley): As I say, we are here to discuss the task force, what is up to date, what has been done, and whether those are successes or not. It is like everything: sometimes there are successes and sometimes there are not, but we need to be open and honest.

Mr McKinney: Given that you put these graphs on the table, I feel the need to interrogate them briefly. Obviously, you have agreed that 12 hours is the ceiling here. One graph reflects a drop in the numbers waiting more than12 hours, while another clearly reflects insufficient movement on the four-hour period, so there is a gap between four hours and 12 hours. If we were to see the figures for 11, 10, nine, eight, seven or six hours, that would probably give a much more accurate picture. Can we see those?

Mr Bloomfield: That information is available. The reason why four and 12 hours are specified in the presentation is that those are the ministerial standards and are recognised throughout the UK. Four and 12 hours are the two measures, but we monitor six hours. A number of our large ED sites are at or around 90% within six hours, and some slightly over 90%, but that information is available up to 10 hours.

Mr McKinney: It is just that, sometimes, with figures like these, if it was 11 hours and 59 minutes, we would not know.

Dr McBride: Yes, the point is well made.

Mr McKinney: Without being pejorative, it would be a statistical lie.

Dr McBride: No, the point is well made and accepted, Fearghal.

Mr McKinney: You acknowledged that you put in extra staff to deal with the percentage increase in ED.

Ms McArdle: Yes, well —

Mr McKinney: So, in your plans, that should have dealt with that.

Ms McArdle: No. What we put in for the escalation plan was what we thought we needed, based on the experience of winter last year.

Mr McKinney: Including the major incident.

Ms McArdle: Including all that happened last winter.

Mr McKinney: So you should have had enough cover.

Ms McArdle: But we could not have predicted that we were going to have another seven-odd percentage surge in a very short time frame. That was —

Dr McBride: On top of —

Ms McArdle: The issue was that, over a very short time, for some reason — and we do not know the reason for it —

Mr McKinney: This was an escalation plan.

Ms McArdle: Yes, so we escalated —

Mr McKinney: With provision.

Ms McArdle: Yes, and we managed it very well. We put in all the extra resources that we could muster because it was the holiday period. Staff came in from annual leave. We explored bank and agency staff. We had locum medical cover in. We had a number of staff who were on sick leave. We used every additional capacity. We turned down some services in order to free up capacity to support the staff on the front line.

Mr McKinney: Yes, but was that not a failure in a public sense —

Dr McBride: Not at all.

Ms McArdle: No.

Mr McKinney: — because you cancelled, at short notice, nearly 200 elective care procedures? You were building up capacity to deal with an emergency.

Ms McArdle: Yes.

Mr McKinney: And then you had to eat into the ordinary stuff to sort it out.

Ms McArdle: No, because we could not cope with the additional increase in a very short time frame, over and above the increase that we expected and had planned for. The reason that we turned down elective activity was mainly to give us some bed and staff capacity to manage and maintain safety because safety is our priority in all these cases.

Mr McKinney: But you as a task force did not foresee that, or did you foresee that as an option in your task force planning? You did or you didn't.

Mr Bloomfield: We certainly did in terms of the escalation plan. One of the work streams within the unscheduled care task group was to look at escalation. What the service cannot do is provide, on an ongoing daily basis, the level of staffing in place to deal with a possibility of a particular spike.

Mr McKinney: I did not see that in your plan.

Mr Bloomfield: In the escalation plan. There is a regional escalation plan, which was issued to the service in September. All trusts were required to review and revise their local escalation plans, consistent with the regional escalation plan.

Mr McKinney: Were the public generally alerted to that?

Mr Bloomfield: The trusts were required to test it and the board sought assurance and provided that assurance to the Department that the trusts had tested it. The board also sought assurances from all trusts that they had sufficient staffing in place throughout the holiday period to maintain patient flow. What happened — what Charlotte was referring to — was the extent of additional activity over that period at 7·5%, compared with not an average over last winter but with those same two weeks last winter. That was beyond what would have been expected. That is when an escalation plan is required.There is a range of measures. The trust's first move was not to cancel elective procedures. Opening additional beds and bringing in additional staff is —

Mr McKinney: I am conscious that we are dealing with a specific period, but it is in the context of how your organisation deployed its plans. You put in place the extra staff needed. What perceived percentage was that to deal with, given the major incident last year?

Mr Bloomfield: Escalation plans have a whole series of measures within them. It is for trusts at an operational level, depending on the extent of pressures being experienced, to put in place an escalating series of measures. Had the increase in activity been 10% instead of 7·5%, they would have done more and gone further to be able to respond. That is the purpose of the escalation plan, rather than planning and putting in additional staff, at additional cost, for something that may not happen. The plans are in place to deal with what is expected over that period. The escalation plan is subsequently activated, very quickly, to respond to what is happening. As has already been said — I think that the figures bear it out — there were two very difficult and very challenging days at the start of last week. EDs remained busy throughout the rest of that week, but the escalation plans that the trusts put in place brought them back to what might be considered more normal.

Mr McKinney: On the other side, what extra staffing did you put into the GP out-of-hours service to deal with that spike?

Mr Bloomfield: There was additional funding provided to the GP out-of-hours service.

Mr McKinney: Was it able to cope?

Dr McBride: Michael can give you the exact figure, but £800,000 was put into in-hours GP services from November through to March, allowing for 3,500 additional GP surgeries. An additional £600,000 was put in place for out-of-hours GP services, which allows, for that same period, an additional 12,500 hours. That was planned for, put in place and will be in place until March. Additional nurse capacity, additional cover for patient visits and an additional car were all put in place for the GP out-of-hours service. Therefore, a huge amount of additional resources was put into GP out-of-hours services. A further decision was taken by the Health and Social Care Board when the pressures increased in the system over that period, 22 December to 5 January, to put an additional 10%, over and above that, into GP out-of-hours.

Mr McKinney: Did it cope?

Dr McBride: To support GP out-of-hours, in terms of —

Mr McKinney: Has it coped?

Dr McBride: Well, I think that looking at the response times is the best way of looking at that. Overall, the number of GP out-of-hours calls increased by 18%, and the number of urgent calls increased by some 34%. Michael, you may want to give the figures.

Mr Bloomfield: During that period of an 18% increase in out-of-hours activity, 90% of urgent calls received a call back within 20 minutes, which is the standard, and 84% of routine calls received a call back within one hour, which is the standard. We want to do better than that, but —

Mr Jackie Johnston (Department of Health, Social Services and Public Safety): When the Department contrasts this year with last year, it is satisfied that the escalation plans worked. Last year, we had to bring in the RQIA, as you know, to carry out an inspection in the Belfast Trust. There was then a regional review on the basis of what was happening in Belfast. We had no concerns at all

about that this year. The situation was well managed and properly managed. Escalation plans were put in place and they kicked in.

Mr McKinney: How many of those who did not get a proper response from the GP out-of-hours service turn up at A&E?

Mr Bloomfield: That information is not currently available.

Mr McKinney: Do you analyse that information?

Mr Bloomfield: We look at the source of referral.

Mr McKinney: Is it not possible that the under-provision of GP out-of-hours services was a contributor to increased attendance at A&E?

Mr Bloomfield: I do not accept that there was an under-provision. As Dr McBride already said, £600,000 of planned, additional resource was put into out-of-hours, and £800,000 into in-hours. Once the position of the additional activity over that two-week period was evident, an arrangement was put in place to expand out-of-hours by a further 10%.

Mr McKinney: It is a big figure, but was it the right figure?

Mr Bloomfield: I believe that the overall increase of 18% in calls to the GP out-of-hours service, within which there was a 34% increase in urgent calls, could not have been anticipated. The 90% response within 20 minutes —

Dr McBride: Your question is absolutely the right one: was the right tolerance built in for every eventuality? The difficulty is that, as Michael said, if we plan for the worst-case scenario, rather than having a responsive system that can step up depending on the pressures on it, we would spend a lot of money, and a lot of people would be sitting, not doing very much. I think that you are getting to the question of whether sufficient additionality was put into both in-hours and out-of-hours GP services. If you put it into the context of an increase of 18% in demand and the fact that the response time to the urgent calls was still 90% within 20 minutes, that was the case. Nobody could have predicted the level of demand.

Mr McKinney: The point is that you took decisions through the task force about the A&E side etc. You may or may not, depending on how you look at it, have achieved some success, but it is presented in the public mind as failure because you had to take extreme measures and cancel elective operations. Could more have been done on the GP side, consistent with TYC, as a strategic focus to ensure that, whatever the spikes are, they get ironed out at that end, rather than at the expensive A&E side?

Dr McBride: There are two answers to that. The point that you make in terms of strategy is accepted. Is there more we need to do in terms of primary care and community services to provide more alternatives to attending emergency departments? Is there more that we need to do to ensure that primary and community-based services are perceived by the public as being as responsive as emergency department services? Is there more that we need to do to raise awareness, despite all the work we did in November and December in terms of raising public awareness around the self-management week, which was launched by the Minister in November, and the whole campaign around Choose Well etc? Is there more that we need to do? Of course there is.

The strategic point you are making is valid. Is there more we need to do in terms of investing in primary care services? Yes. Is there ongoing work on looking at workforce planning in primary care? Yes, there is. Obviously, factored into all that is the resources that are available. The board put in place investment for the increase in anticipated demand over that period, and the out-of-hours GP service responded. If you look at the pressures on the GP out-of-hours service, you see that it has soaked up an 18% increase in demand. Our emergency departments soaked up a 7·5% increase in demand. The service responded well in the context.

Going back to Jackie's point, we, as a Department, have no concerns in relation to how the system responded to an unprecedented and unpredicted surge in activity.

Mr McKinney: It would be important to see that information. If a patient makes first contact with a GP and does not get face time with the service, where do they go? That is very important. You have marked yourself down —

Dr McBride: Have I?

Mr McKinney: Yes, significantly.

Dr McBride: Oh dear. What have I done now?

Mr McKinney: Just in your last —

The Deputy Chairperson (Ms P Bradley): Fearghal, can I come in there? Are you going to move on to a different line of questioning, or are you on the same line?

Mr McKinney: It is consistent with what we discussed.

The Deputy Chairperson (Ms P Bradley): It is just that Mickey has a supplementary question. Is that OK?

Mr McKinney: Yes. Sorry, I did not see you.

Mr Brady: It is just an issue about the out-of-hours service. I am interested to hear about the money that has been spent on soaking up the surplus. The difficulty that we have in Newry in my constituency is that the GP out-of-hours service has not really been functioning. There are supposed to be two doctors, but it is either one or none. I will give you one example about the emergency response time of 20 minutes: there was a case this week where a lady was having a chronic asthma attack. She rang the out-of-hours service, which is based at Daisy Hill, so there is obviously a correlation with the emergency department. She waited for approximately four hours to get a phone call back. When the doctor phoned her back, he told her that, if her condition worsened, she should go to the emergency department. She cannot drive, and neither can her husband. He said that he would ring Daisy Hill to get some steroids for her. She got a family member to go to the hospital, but they did not have the tablets, so that family member had to drive at 2.00 am to Craigavon to get two tablets, presumably prednisone or something like that. How does soaking up solve things? You can soak it up only if you are there. If you are not there, there is an issue. What happened to the money that should have gone to providing the GP out-of-hours service in Newry?

Dr McBride: I do not know the specifics of that at all, Mickey.

Mr Brady: I am just giving it to you as an example because it is maybe indicative of what is happening in other places.

Dr McBride: I will not sit here and say there is not more that we can do to improve services and responsiveness; absolutely not. The point that I was trying to make was that there had been anticipation of pressure. There had been investment, certainly in primary care, in hours and out of hours, to allow for that increase in pressure. Despite the unprecedented level of pressure over and above what was anticipated, the service performed well.

I cannot comment on specifics because I do not know the specifics. Apologies, but I honestly do not know the specifics of the services in Newry.

Mr Brady: I am just making a general point that if all that money was put into the out-of-hours GP service, in our area something obviously went wrong.

Dr McBride: Sure. The details of the case would suggest that the GP made a decision that it was not urgent. If he or she felt that it was urgent, they would certainly have dealt with it very differently than —

Mr Brady: With respect, how did he know whether it was urgent or not if it took four hours to call back?

Dr McBride: I think that is the point. When a call goes in, there is a set time for triage. I do not have all those details, and there are others better placed within the Health and Social Care Board who commission those services to advise on that. I really do not know the specifics of the response times in that area. If it would be helpful, we can provide that to you.

Mr Brady: Obviously, we have been in touch with the trust and they will get back to us.

Dr McBride: OK.

Mr McKinney: Mickey, where did she go?

Mr Brady: The nearest out-of-hours service that people in Newry are being referred to is in Dungannon, which is a fair distance away.

Dr McBride: It is indeed.

Mr Brady: The family member had to go to a pharmacy in Craigavon to access that particular drug.

Dr McBride: There will be many cases when things did not work as well as they should. I do not think any of us would sit here and say that the circumstances that you describe were defensible or should have happened. Those are, rightly, cases that we need to learn from to ensure that sort of scenario does not arise again. But, for every one of those, there are very many more that we do not hear about because there is an excellent service provided by our colleagues in general practice, supported by nursing colleagues in general practice, in turn supported by all those who take the calls. I had the opportunity to see that in action over the holiday period. We do have an excellent service.

Mr Brady: I accept, in general terms, that the out-of-hours GP service provides a very good service in Newry, but we only hear about the nightmare scenarios.

Dr McBride: Of course and we need to learn from that.

Mr Brady: And we have to hear about that —

Dr McBride: Of course you do.

Mr Brady: — because it has to be addressed.

Dr McBride: And that has to be fed back. We need to understand how that happened and we need to make sure that we are using that to improve the service.

The Deputy Chairperson (Ms P Bradley): Thank you, Mickey. Back to Fearghal.

Mr McKinney: I will be brief because I want to let colleagues in, of course. As I was saying —

Dr McBride: I was ahead for a time, Fearghal, was I?

Mr McKinney: You were marking yourself down. Out of 10, how would you rate your performance as a task group?

Dr McBride: I was hoping for the opportunity to provide you with an update on the achievements of the task group. I was hoping, as the Chair said, for an opportunity to outline what was delivered. The performance of the health and social care system remains a matter for trusts and, indeed, the board, in that they are holding organisations to deliver against departmental targets. There is a separation between the two roles, and the briefing paper makes that very clear. The accountability in the system for performance against elective targets or how trusts are doing in relation to urgent care is the responsibility, primarily, of trusts, with the Health and Social Care Board holding them to account.

As a task group, I think we have made significant progress, Fearghal. If time permits, we will happily take you through that today. We started this work in July. I think we were in a very different place this winter than last. Out of 10, I would certainly give ourselves — what would you say?

Mr McCarthy: Two? *[Laughter.]*

Dr McBride: I was going to say six or seven.

Ms McArdle: If you look at the number of patients who have been delayed for more than 12 hours, you see the marked decrease, year on year. That is a testament to the work of the task group. Our first priority, as set by the Minister, was to tackle the problem of 12-hour delays, and that is where we have focused our energy and where we see the improvement. There are lots of work streams. Some will deliver over the next few months, and some will require a longer lead-in time. Others require the commissioning process at the board to take them on and manage them. In a way, it is too early to make a complete assessment but, on our number one priority, which was the reduction in 12-hour delays, I think we have done pretty well.

Dr McBride: Chair, there is a vital point to make. You are absolutely right, Fearghal, that, last winter, public confidence in our emergency departments and the health and social care service was severely challenged as a result of what happened, as well as the RQIA review and its findings.We were all diminished by that report and its findings and by some patient experiences. The then Minister rightly expressed his indignation at some of the findings. It galvanised the system to make sure that those circumstances did not occur again.

One of the primary objectives set by the then Minister and reaffirmed by the current Minister was to eliminate the number of people having to wait for more than 12 hours in our emergency departments, because we know that, when people are waiting for excessive periods, they come to harm. We know that it is a poor patient experience and a very difficult environment for staff — in particular, for experienced nursing staff — in which to continue to provide high standards of care. As Michael said, despite the sustained pressure in December 2014, with an increase in attendance of 7·5%, we delivered a 32% reduction in the number of people waiting over 12 hours compared with the previous December. There is no arguing with the facts. The facts are the facts, and I hope that, in our response, irrespective of how it gets played out, reported and commented on, the facts speak for themselves about how the health and social care system responded this winter.

I commend all staff in the community, the social workers, the primary care teams, the out-of-hours teams and, as Fearghal said, hospital staff for responding in the way that they did. Charlotte and I have met them. I also thank all the patients and their families, who understood that, unfortunately, as Michael said, some people had to wait longer on that Monday and Tuesday than we would have liked, because we needed to get sicker patients into hospital beds to stop them coming to harm. I apologise to those individuals whose procedures we had to postpone and reschedule and thank them for their understanding, because we fully accept that we would rather not have taken that step, but, as Charlotte said, it is about balancing risk. It is about making sure that we prioritise the treatment of the sickest, keep hospitals safe and do not get into situations like we did last year.

Mr McKinney: Nobody is denying that success must be recognised when it happens. As I said, I want to see a fuller picture of the other issues and to look ahead. There is mixed success, and there was failure in that you had to reach for an extra level of escalation, which impacted very negatively on a range of ill people. What powers will you have in the future to make sure that the trusts comply with the direction set?

Dr McBride: The Minister will determine the priorities and standards. Those will be set by the Department, and the board will then ensure that those standards are implemented in how we commission services and that organisations are performing against those standards. Michael, I do not know whether you want to expand on that.

Mr Bloomfield: There is a range of accountability arrangements in the system. Trusts are obviously accountable to their trust boards and are directly accountable to the Department. For operational performance, they are accountable to the board. The board seeks assurance from trusts on the actions that are taken. We need to be balanced in that assessment. As we come out of a period of a 7·5% increase in attendances, is it reasonable to expect a certain level of performance and to understand that there will be some difficulties? The board carries out audits in trusts to ensure good practice in the management of patients. When that is not the case, we seek plans from trusts on how to address that. A whole range of assurance mechanisms are in place to ensure that trusts are taking the appropriate steps to continue to deliver improvements, whether in unscheduled care, elective care, cancer care or other areas.

Ms McArdle: Two things are foremost in our minds: the experience of people who use our services and the safety and quality of the care that is provided. Through the unscheduled care task group, we have set up a number of indicators. To be fair to the trusts, they have already developed many of the quality metrics on emergency care. There are now indicators on safety, particularly with the treatment of sepsis. There are quality indicators about care and treatment, how quickly patients are seen, triage times and whether people leave without being seen, and patient experience indicators, listening to the voice of the patients and their experience. Those measures are being reported back to the Department through the board's accountability processes.

Dr McBride: That is hugely important. A measure of the number of people waiting more than 12 hours is important, because it should not happen. We are making progress, and you are absolutely right that we need to make improvements on four hours. Measuring turnaround times for ambulances and all the rest of it is very important, but, at the end of the day, over and above all that, we need to make absolutely certain that, when patients present to emergency departments, they get the right treatment, care and outcomes, as Charlotte said, against those range of measures. Are we identifying sepsis quickly when people present to an emergency department? Are we taking the right steps to make sure that we are managing that effectively? Is the patient experience at the right level? Is there more that we can do? We have worked very closely with clinical teams, the RCN and the standards that it has developed, and the College of Emergency Medicine and the basket of indicators that it has developed for measuring the quality and not just the process. Process measures are very important, but, in the middle of all this, there are patients who need urgent and emergency care, and, as Charlotte said, we need to make sure that we are measuring the things that matter and their experience of that.

Ms McArdle: We have also set important standards, one being the movement of older people, which goes back to Kieran's point. I want to reassure members about our responsibility and our focus on older people, because, increasingly, the majority of the people who use our services are in that category. We have set standards that people should not have more than two moves through the hospital system and should not be discharged later than 8.00 pm. We got that information and feedback directly from patients, their advocates, the Commissioner for Older People and so on. We have also designed an audit tool to support nursing staff, particularly in EDs, to make sure that issues that were raised through the RQIA inspection and review on dignity, respect and pain relief are picked up. That is being tested and will be implemented across the five organisations.

The Deputy Chairperson (Ms P Bradley): I will bunk Pam up the queue, because I know that she has to leave for a meeting.

Mrs Cameron: Thank you, Chair; it is much appreciated. I will be brief, and I would appreciate it if you could be brief in your answers to me. I want to ask about the four- and 12-hour targets. Who came up with the policy of having four- and 12-hour targets? What are the strengths and weaknesses of targets?

Dr McBride: I suppose that the answer to that is that the Department sets the standards, and, as Michael said — I will maybe defer to him on the evidential basis for those — they were nationally agreed targets. When I say "nationally", I mean across the rest of the United Kingdom, certainly in England and Wales. Scotland has those targets, but it also has another measure. From memory, the Republic of Ireland uses a six-hour target. Undoubtedly, the rationale, particularly for the 12 hours, is that research evidence demonstrates that, when people wait longer than 12 hours in ED, particularly if they are unwell, the risk of their coming to harm increases. So sick patients should not be waiting for excessive periods in emergency departments. You will have heard the College of Emergency Medicine and, indeed, nurses working in emergency departments talking about "exit block". That is at the nub of the discussion. It is not about bed capacity but about the flow of patients through the hospital system. It is the flow of patients in. Fearghal made the point about alternatives to keep people out — that is, diversion.

Mr McKinney: TYC.

Dr McBride: I am sure that you will come on to that. It is about ensuring the smooth flow of patients, once they are in an ED, through to wards and prioritised on the basis of how many of them are sick. There is then, as Charlotte said, our work on discharges and on coordinating and streamlining the discharge process back out into the community. So it is about the flows. The four- and 12-hour

targets are specifically there as a crude measure of flows through the system and how we are performing as organisations and systems.

Mr Bloomfield: As Dr McBride rightly said, the Minister sets the targets, the trusts are responsible for delivering them, and the board is responsible for holding trusts to account, supporting them to do it and ensuring that they are appropriately resourced to deliver them. The only point to add is that the four-hour target was in place UK-wide. When it was introduced in Northern Ireland in about 2007-08, a group of ED clinicians informed and provided advice and recommendations to the Department and the Minister. The target in England and, I think, in Wales was 98% of patients within four hours. A group of local ED consultants recommended to the Department and the Minister that the appropriate target for Northern Ireland would be 95%, not because we could not do as well, but because 5% of patients, for clinical reasons, should not and would not go through ED within that time. So targets were introduced in Northern Ireland, taking account of clinical advice. As Charlotte said, while those are the two targets that attract most attention, a whole suite of indicators are routinely monitored, and performance is discussed with the trusts. They include re-admission rates into emergency departments, the time taken from arrival to triage, the time taken to be seen by a doctor and the number of patients who leave the department without having been seen. Arrangements have also been put in place to monitor the additional standards that the task group has identified for elderly patients not being discharged late in the evening and so on. There is a suite of them, but the four hours in Northern Ireland was clinically set.

Mrs Cameron: Michael, you described it as a crude measure. Are you happy with those targets? Have you given any consideration to altering the targets?

Dr McBride: I think that those are important measures; they are established measures in the mind of the public. There is absolutely no doubt that people who are sick and wait for more than 12 hours come to harm. There needs to be a relentless drive and a continued focus on further reducing those numbers. We are making steady and sustained progress. Charlotte and I have made it very clear that it is unacceptable that any patient in Northern Ireland waits longer than 12 hours in an emergency department. It is not what any of us would want for any of our relatives. Unfortunately, at present, the circumstances are such that sicker patients take priority. The Minister has been very clear that he regards that as being unacceptable, and he has set a clear direction to the health and social care system in Northern Ireland to eliminate all waits over 12 hours. I think that the measures are an important benchmark of how we are performing. They ask the question: "What do we need to do to improve 12 hours?" It goes back to Fearghal's point. Incrementally, we are not hitting the four hours; we have not seen an improvement in four-hour performance. That is not to say that things are not happening to people during those four hours. They are in; they have seen a nurse; triage is happening; diagnostic tests have been started; and a decision is being worked on as to whether to admit or discharge. There has been active engagement with the nursing team and a range of other professionals. However, it is important that we understand why we are not comparing favourably in the four-hour performance compared with some other parts of the United Kingdom, and we need to understand what we need to do to improve our performance. I would argue that a lot of the work that we are doing on unscheduled care will drive that.

Ms McArdle: I think that targets are important, and there is an evidence base for patient outcomes. However, they have to be taken in the context of a range of other indicators, because it makes them more meaningful and real for the people who are using the services as well as for the staff. The targets support them and ensure that the care that they are providing is at the standard that we would want for our families. As the work of the unscheduled care task group continues, we will develop more standards for specific specialties and how they are managed in the system.

Mr Johnston: I will give you an indication of the underpinning indicators. In addition to triage times, there is the length of time that patients wait in emergency care, broken down by two-hour time bands; patient and ambulance turnaround times; the percentage of unplanned re-attendance of patients to an emergency department within seven days of their original attendance; the total length of time patients spend in the department; the number of patients who leave before treatment has been completed; and the time from arrival to triage and from triage to treatment. There is a range of underpinning indicators.

Mrs Cameron: So the answer is that you are not looking at altering the targets.

Dr McBride: We are going to expand them, because, as Charlotte rightly said, the length of time that people wait, particularly if they wait for too long, is ultimately a measure of quality and the experience

of care. However, there is a range of other important metrics, and, through the unscheduled care task group, we want to make absolutely certain that the care that is being provided to patients to get the right outcomes is as it should be and that the experience of that care is excellent.

The Deputy Chairperson (Ms P Bradley): I remind members and officials to keep to the point and to make their answers as succinct as possible.

George, did you want to come in, because Rosie is next.

Mr G Robinson: My question is on the A&E situation, but I will wait, Chair.

Ms McCorley: Go raibh maith agat, a Chathaoirligh. Thank you very much for the presentation. I acknowledge the good work of the health service and the service that it provides. My question follows on from Pamela's point about the four- and 12-hour waiting times. The October/November figures showed little improvement, particularly in Belfast, and that is a concern. You talked about that, but I wonder whether you can be very specific about the reasons for that failure to make significant improvements. If you do not identify it, you will just keep on doing the same thing.

Ms McArdle: Through the work of the unscheduled care task group, we have set up a number of subgroups, which are, in the main, clinically led, and they certainly have senior Health and Social Care leaders as chairs and co-chairs. From the ground up, they are generating the problems that the staff are experiencing. Everybody's focus, no matter what their role is in Health and Social Care or at the Department, is on the care and treatment of patients and making that the best that it can be. The staff on the ground are now telling us what would help them with some of the issues that they are dealing with. We have taken that alongside the RQIA recommendations, and we have put together a series of work streams. Those work streams will generate some of the solutions that we need to the problems that we are experiencing. As Michael said, it is not complex, but it is complicated. Every little change or any chink to the system has a knock-on effect elsewhere, and we need to be mindful of all that. I referred, for example, to the standards work that we have done, and the view is that a number of older people should not have to go through the emergency department, full stop. However, there is a group of people, regardless of age, who will require treatment in an emergency department, but, for many, it is about chronic disease management and long-term condition care. You mentioned some of the issues with the Belfast Trust. As a result of recognising those difficulties and looking for solutions, the Belfast Trust set up BCH Direct, which is a service on the Belfast City Hospital site where older people can go directly for assessment and treatment and, if possible, return home; if they require admission, they will be admitted through that route and will not have to go through the emergency department. That work is being shared through the unscheduled care task group with the other trusts, which are all looking at similar but different models of managing older people to ensure that they have a better experience of care. That is just one example.

The Deputy Chairperson (Ms P Bradley): May I just come in on that. With the Belfast Trust initiative, how is the referral made? Are people referred by a GP?

Ms McArdle: Yes. The feedback from staff is that patients have a much better experience, and the staff have been monitoring that. Patients are describing a much better experience and quality of care, and they are much happier with the care and treatment that they are getting with that model. We really need to sell that as a successful pilot project and scale it up with the other trusts.

The Marie Curie initiative is about providing more palliative care out of hours, co-located with GPs to support people to stay at home, particularly in the last days of life when we know that the situation can be very difficult to manage for the individual and the family. It can become a crisis issue, and, unfortunately, in the last few days of life, the person ends up going into hospital, often through the emergency care route. So specialist nurses with advanced skills in palliative care will be there out of hours to support the community team — district nurses and out-of-hours GPs — to help to keep that person at home with appropriate care and treatment. On a quality level, that is a really important initiative that we have put in place. Those extra posts will be in place from the end of this month.

Those are just two examples of some of the issues that we are dealing with to make sure that there are alternatives out of hospital, particularly for the older population and those with long-term conditions, to prevent them having to use our emergency departments.

Dr McBride: You also asked specifically about the performance of the Belfast Trust. Michael, do you want to comment?

Mr Bloomfield: I will try to be brief and will add to what Charlotte said. As was said, it is complicated. If it was not complicated or difficult, I assure you that it would have been done by now. As Charlotte outlined, one of the issues that needs to be addressed is the provision of more suitable and appropriate alternatives for people rather than coming to emergency departments, but there are still more things that can be done for patients who come to emergency departments. It is fair to say that, when the difficulties show themselves in the four- and 12-hour performance, they are not generally issues or difficulties in the emergency department; it is in the flow of patients. The particular difficulties and challenges are about patient discharge. It is then simply a blockage in the system. More things can be done in our hospitals with more effective and early planning for discharge. Work is ongoing in that regard.

A significant issue is the extent of seven-day services. People get sick seven days a week, they get better seven days a week, and there is a challenge to respond to those who get better on two days a week more than the other five days. One of the outworkings of the unscheduled care task group has been a patient flow paper, with a series of recommendations. The Health and Social Care Board is now working with the trusts to take forward the specific recommendations from that on putting in place radiology services seven days a week where that is not currently the case and supporting twice-daily consultant decision-making. If consultants do not see patients twice daily, too much time is being spent on keeping things moving. There are also recommendations that look at embedding allied health professionals, such as physio, OT, social work and pharmacy, across seven days more than is currently the case. It is there to some extent across seven days, but it is not nine-to-five and seven-to-seven. There is a range of things to enhance the real seven-day working that needs to be put in place, as well as improving the planning for discharge. Every patient, from when they are admitted to hospital, should have a plan for discharge within 24 hours and be actively working towards that. There are still more things that can be done to improve that as well as investing in seven-day services.

The Belfast Trust saw a very significant reduction in 12-hour breaches. The chart in the presentation shows a reduction from 10,000 a year to 5,000 a year. The Belfast Trust accounted for a significant proportion of those at that time. It is fair to say that it has experienced difficulties since then. It has, by quite some way, the largest number of patients waiting for over 12 hours in the year to date. However, it has very significant plans in place through a programme called IMPACT. Improvements are being seen from that. The board works very closely with the trust in supporting to improve and through the performance management and accountability arrangements, given what performance has been like over the last number of months. There are certainly improvements. I do not like using the word "only" when it is in relation to patients waiting for more than 12 hours, because, for that one patient, it does not matter how many others there were, but my understanding is that only one patient waited for longer than 12 hours in the Belfast Trust in the last week. That is a very different place from this time last year.

Ms McArdle: Part of the Belfast work stream was to implement the recommendations of the RQIA report. There was a follow-up inspection in December. While we do not yet have the report, we understand that the RQIA is content that there has been a significant improvement across the areas it initially found in January and in its review.

Ms McCorley: Do you have any details about those findings?

Ms McArdle: We are awaiting the RQIA report. We should have it in the next week or two.

Ms McCorley: I have one more question. In general terms, whether it is to do with the emergency department issue last week or waiting times in general, how would you respond to claims that you are not listening to the voice of everybody who has a view and might be relevant to the discussion? I am referring to groups that were not included in the subgroups coming out of the task force and the comments of Patricia McKeown. The suggestion was that they had ideas but that nobody was listening. Are you confident that you are listening to everybody and thinking outside the box?

Ms McArdle: I am confident that we have been very mindful of that. It is not just about the people who are in the groups. We have set up an expert group across the other three UK countries and Northern Ireland, which informs Michael and me, as co-chairs, of ideas and proposals that are coming through from the workforce. Some of those have been tested elsewhere. It is reassuring to note that much of the work that we are doing is similar to the work that is being done in England. In fact —

Ms McCorley: Excuse me. To say that you are doing what England is doing is not a vote of confidence, because there are worse examples there of similar things happening in emergency departments. Claiming that you are doing what England is doing is not good.

Ms McArdle: I apologise if I used the wrong words: I wanted to say that we have a deliberate engagement strategy. Through the unscheduled care task group, we have met a range of interested parties. For example, the Patient and Client Council, which is the voice of patients, is represented on the task group by its chief executive. We have engagement with a range of stakeholders and professional bodies, and we are very happy to speak to anyone who wants to give us information or ideas that we might have overlooked.

We have an engagement strategy in place, which is as broad as we thought we could make it at the time. We are happy to reflect on that. The Minister has asked us to take forward work on values and principles. We are working that up, and it will be going out for consultation, probably in the next month or so.

Dr McBride: I will add to Charlotte's comment. We had a very active programme of engagement with professional bodies and organisations. As you are aware, we had two events in April and June last year with the College of Emergency Medicine, and we had an event with the Royal College of Nursing and the emergency department nurses' forum to inform that work. We also had a workshop at which a range of parties were present, including the unions, which gave a presentation on their ideas and solutions.

Given the pace at which we have been progressing this work and the real need to have some of it in place for this winter, we would have benefited from more time for preparation and more involvement from a range of other key stakeholders who — I agree with you — have a very valuable contribution to make. As I said, we started on this work only in July, and we have a communication strategy and a very active ongoing programme of engagement. We will follow up on that, and we take that point on board.

Ms McCorley: If any of the groups that made those comments comes and speaks to you, they will feel happy that you will take their views on board.

Ms McArdle: Absolutely. We have been out in all five organisations to speak to the front-line staff on a number of occasions, both in the early days of the unscheduled care task group and, more recently, over the holiday period. I have also met each of the senior nurses in the five trust emergency departments, and we have had a number of engagements with the RCN through the emergency department nurses' forum on particular nursing issues that they raised. I have a plan in train for the issues that they raised about advanced nurse practitioners, career development for nurses, workforce planning for EDs and all sorts of issues. Effectively, they have open-door access to me, as Chief Nursing Officer, to listen to their concerns.

Dr McBride: Those working on the front line have the answers.

Mr Brady: You mentioned the Minister, and Kieran welcomed him back into the public domain yesterday. Unusually for him, he has been quiet over this past while. I wanted to make that point.

I met GPs and GP representatives recently, and, in the context of the task force, they feel fairly excluded, because they are on the front line. We talk about preventative measures so that people do not have to go to emergency departments or out-of-hours services, and GPs normally deal with those people. In Daisy Hill, for instance, there was a policy of direct admission with GPs, so that people did not necessarily have to go through the emergency department. I would not say that they have been ignored, but they feel excluded. We have had meetings with the unions, and they have a similar view.

Dr McBride: Mickey, I accept the perception. The three things that you do in any major change programme are communicate, communicate and communicate. Given the speed and pace with which we have been trying to make progress, we will certainly improve communication in some areas. I have met the Royal College of General Practitioners and the chair of the general practice committee of the BMA.We have had engagement. They expressed those views to me as well that they feel that they have not been as involved as they would like. I am happy that we continue in that engagement. We have individual general practitioners involved in many of the work streams. I am happy to continue to improve that level of engagement.

It has been the pressure of time to make sure that we are making progress. It has certainly not been a deliberate attempt by the Department through the work of the unscheduled care task group to exclude anyone. If people have contributions to make, solutions or ideas, we would be grateful to hear them to see how we could take them forward.

Mr Brady: The point is that there are no GPs in the task force. If you look at the composition of the task force, you might look at it on a bureaucratic level. That is only a perception. GPs are on the front line of primary care on a daily basis; they should have a much bigger input.

Dr McBride: Sloan Harper, who is responsible for primary-care services in the Health and Social Care Board, has been working closely with us on this issue. He is responsible for the commissioning of services, and a number of GPs have been involved in inputting into many of the work streams.

It is a system of care; it is not a disconnected and disjointed system. We will never get this right by concentrating on the acute sector and what happens in hospitals. It is about the front end, what happens in primary and community care, what happens in the hospital system, and then what happens in the community. It is about the flow through the system.

Have we had the time to have the level of engagement and communication that we would have liked? No. Can we improve on that? I think that we can, and I will certainly take those comments on board. Our doors are open, and we are happy to have ideas and solutions from anyone.

Mrs Dobson: I have been listening carefully and noted, Michael, how many times you talked about the system, and the system being tested. Let us not forget about the human aspect and not just the system.

Dr McBride: I accept that.

Mrs Dobson: I was glad to hear Charlotte refer to the patient more. Patients have been grossly inconvenienced and many put at risk; some of us have shared the personal stories of people who have been affected. Your answer is, effectively, that it could have been worse. For many caught up in this matter, whether by not having their surgery or in A&E, that is staggering and is an understatement of response. I am quite incredulous to hear it.

You will be aware, Michael, that I wrote to you recently about the A&E at the children's hospital. I know exactly what it is like to sit and wait in that queue when you have an ill child, and the worry and fear is exacerbated. Having a young child who is in pain and who cannot tell you their feelings is every parent's worst nightmare.

I commend the staff, who are just outstanding, but many of them are exasperated and at breaking point as well. Episodes such as we saw recently only put them, and the lives of children, under more pressure. No child should be expected to wait those lengths of time and no parent expected to endure watching their child in pain.

Perhaps, Michael, you could update us on what action you have taken since.

Dr McBride: In relation to what, specifically?

Mrs Dobson: The extent of A&E waiting times that I wrote to you about.

Dr McBride: Jo-Anne, you wrote to me in my capacity as chief executive of the Belfast Trust, which is really not the purpose of today's meeting.

The Deputy Chairperson (Ms P Bradley): What about the answer?

Dr McBride: I think that I responded to your email within an hour, and I have indicated that I will be responding to you in writing in due course. I really do not want to get into the detail of that.

The Deputy Chairperson (Ms P Bradley): I suppose that we could ask, because it is a good point, —

Dr McBride: I could comment generally.

The Deputy Chairperson (Ms P Bradley): — for a comment generally about A&E at the children's hospital rather than the specifics.

Dr McBride: The thing that we tend to forget is that, apart from adult emergency departments, there is a regional children's hospital in Northern Ireland and an emergency department there, which is consistently high performing. Michael will have the details.

It is unheard of for someone to wait 12 hours in the emergency department; that just does not happen. If you look at the four-hour performance —

Mr Bloomfield: It is in the mid- to high 90%. I do not, unfortunately, have the figure to hand.

Dr McBride: As a general comment, it would also be important to put it in the context of a particular period of pressure that all children's services also experience in this period. Those of you who followed the media over the period will have seen that there was severe pressure on paediatric intensive care over the holiday in the run-up to Christmas and the new year. Whilst we are not sure exactly what that might have been be due to, we know that there is an increase in circulating flu and viruses at this time of year. One of the problems that we see at this time of the year is the respiratory syncytial virus, which can cause quite a nasty and severe respiratory illness in children, and we are beginning to see an increase in that in the recent Public Health Agency report of 8 December. Unfortunately at this time of year, just like every other year, we have had a range of infectious conditions that put significant pressure on children's hospitals and particularly specialist facilities in them, and that has been the case right across the UK. I think that the performance of the children's hospital in Northern Ireland is high.

To go back to your earlier comment —

Mrs Dobson: I would be the first to commend the work of the children's hospital, as I have used it with my son. I thank the Chair for making you answer this question: with regard to the task group, are you gathering the views of the parents, patients and staff in the children's A&E? Will that be part and parcel of —

Dr McBride: It is not, no. At this point, we are, fortunately, in a very different place.

Mrs Dobson: Do you intend to? Has there been periodically those views —

Dr McBride: As you will see from the paper before you, the task set us by the Minister was specifically to ensure a system-wide response to the 17 recommendations of the RQIA review — seven that were specific to the Belfast Trust and 10 regional — and the tasks that the Minister set Charlotte and me, as Chief Nursing Officer and Chief Medical Officer, to ensure that the system responded to those and the work stream that Charlotte mentioned that flowed out of that. There are no plans at this point to include the children's hospital or the ED service there.

The service has been under significant pressure, as have other services right across the UK. A committed, dedicated staff is working extremely hard, as you said, but, at this time, it is not a service in whose responsiveness the board or the Department has any lack of confidence. However, I acknowledge that the service, and the doctors, nurses and other health-care workers working in it, has been under significant pressure.

Mrs Dobson: I heard you use "system" again. It is very worrying that that has not been looked at and that lessons are not being learned from the past, particularly if the children's is not contained.

Dr McBride: What specific problem would you like to flag up that you feel we should consider?

Mrs Dobson: Well, extended times. Patients have been in touch with me, and, as you know, they are waiting longer in A&E with an ill child. We have heard how things keep happening year after year. Surely, if that is not flagged up or addressed, it will continue to happen.

Dr McBride: I will defer to Michael on performance. However, there will be periods where, as with the adult service, sicker children will take priority. Unfortunately, we know that, right across the UK, we have had some very sick children.

Mrs Dobson: As I said at the start, it was a young child.

Dr McBride: I accept that. Please do not infer from any comments that I made on what we need to do as a system to improve things that I am in any way, shape or form trying to depersonalise this. I know from first-hand experience from talking to patients who have been in emergency departments and waited longer than we would have liked, and from talking to staff; so there is no sense from me, as Chief Medical Officer, to seek to take the people and the personal experience out of this. I have already apologised for those delays.

Mrs Dobson: Surely there should be flexibility in the task force. If you stick rigidly to the 17 recommendations, there is no flexibility and no reaction to other measures; it is rigidly to what —

Dr McBride: Jo-Anne, if the Minister felt there was a particular issue with improvement in the performance, or in the experience of patients or parents with the services provided in any ED, whether in children's or elsewhere, we would take that forward. In terms of performance —

Mr Bloomfield: I will try to reassure you: one of the functions that the Department established and required the board to do is performance monitoring and management, appropriate escalation and support etc across a range of areas. The children's hospital and all emergency departments, whether they are type 1, 2 or 3, which are the different levels, come within the monitoring of performance. If there are any issues or concerns, they are dealt with. I have to be honest: the efforts in relation to unscheduled care are focused largely on the six sites with the most significant challenges.

Mrs Dobson: Is listening to parents not part of monitoring performance?

Mr Bloomfield: That is in relation to some of the other ways of getting feedback that Charlotte mentioned earlier, such as Patient Voices.

Ms McArdle: The Public Health Agency leads on a project called Ten Thousand Voices, which has already gathered more than 5,000 stories. It has programmes of work, so it has looked specifically at ED and mental health. There is a rolling programme. I am not sure exactly where —

Mrs Dobson: I am very well aware —

Ms McArdle: — children's services sit in its work programme. All trusts undertake patient-experience surveys and feedback from the policy of the Department on the five standards of care. The Belfast Trust will have undertaken that on behalf of the children's hospital. I do not have the detail here, Jo-Anne, but I am happy to follow it up.

Mrs Dobson: I am concerned. You have such high hopes coming from the unscheduled care task group, yet it is so focused and generic. Surely things, particularly with health, need to be reactionary. Kieran started the ball rolling earlier this afternoon about drawing lessons from previous winters. You have to be reactionary, surely, as well, rather than being so generic.

Can I move on, Chair?

The Deputy Chairperson (Ms P Bradley): Just on that, have we had problems, and have they been highlighted, in our children's ED? Have major problems been highlighted?

Mr Bloomfield: No.

The Deputy Chairperson (Ms P Bradley): So, it would not be part of the task force —

Mrs Dobson: Michael, you gave me a holding email within 20 minutes —

Dr McBride: That was in another capacity. There were two specific experiences, so —

The Deputy Chairperson (Ms P Bradley): Generally, on the whole, has there been? I have taken children to A&E, and they are seen straightaway. Even when I walk into an adult A&E, it is straightaway.

Mr Bloomfield: From a performance point of view, there are — we have talked at length, so I will not repeat it — many measures more than four and 12 hours, but, in terms of timeliness, it is four and 12 hours. I am not aware of any 12-hour issues at the sick children's hospital. Four-hour performance is consistently strong, as it is in a number of the smaller sites, which is why most of the focus and efforts to identify ways of improving performance are targeted at the areas where the most significant challenges are. The sick children's hospital is not seen as being in that position.

Mrs Dobson: I only hope that it does not become an issue and that it is an isolated incident.

Mr Johnston: In terms of children's services, a number of initiatives have been taken over the last couple of years. In the middle of last year, the Department completed a major review of community- and hospital-based paediatric services and palliative end-of-life services. It involved intensive consultation with parents and children's groups on the improvements that they would like to see in scheduled and unscheduled care in children's health services. Those reviews have been completed. The policies are now ready to go to the Minister to consider and approve. We expect to have them published shortly. They will set a whole range of new and improved standards of service right across the whole raft of children's services. We have been active on that side of things. Also —

Mrs Dobson: I hope that no one else contacts me and that this is not going to continue with instances in the children's hospital. You are all fairly confident that it will not happen, so I hope that you are correct in that assessment.

Mr Johnston: On the values and principles, subject to the Minister approving them, there will be a full public consultation and engagement, covering information and choice and what information and choice in services patients want. What kind of access? What kind of partnership with the health service? What kind of compassion and respect do the public expect from the health service? What about openness and transparency? A whole consultation exercise will take place; that came out of the unscheduled care task group. We are really only six months into the work.

Mrs Dobson: Mickey highlighted that GPs were not involved in it. I am concerned that it is so rigid and generic that it is closed. Rosie highlighted it as well. So many are not included, yet it cannot be reactionary, and it cannot move or change. It is very rigid and set in stone, and it is going to tell you exactly what you want to hear about the outcome. That is my concern.

Finally, you talk about the work of the task force. In your briefing, you talked about the trust having implementation plans to eliminate available breaches. Can you highlight more of what is in the task force group to do that, because I believe that it is very important to learn lessons from previous years. This is not the first winter that we have had. How will that be fed in and acted on in the task group?

Ms McArdle: As Michael said earlier, we have had engagements with front-line staff, trusts, professional bodies, people who wanted to tell us a story, and those who have ideas about how we could make changes, and we have learned from that experience. The recommendations of the RQIA review are also a primary driver in how we have set up the unscheduled care group. We have taken learning from that. We have taken its recommendations, and we have fed them, along with the College of Emergency Medicine, into how we have structured the task group and the work that we have prioritised.

Mrs Dobson: We had breaches last week. The Chair spoke about October/November. The task force is up from July. When will these breaches be eliminated? When do you see the work of the task force coming into play? Will we be sitting here next year talking about —

Ms McArdle: I do not think that I can give you a definite date, although we are making very good progress; the earlier presentation demonstrates that. We have more work to do, some of which is longer term requiring changes at speciality and at hospital level. Those things will take time.

Mrs Dobson: Do you have the confidence that, with the work of the task force, we will not be sitting here next year talking about breaches and eliminating —

Dr McBride: At this time, we should not be using the term "12-hour breaches". Going back to your earlier point, these are people waiting in ED for longer than we would wish them to be. That is the point that you made earlier, and that is the point that I make now.

Mrs Dobson: I am very, very aware —

Dr McBride: We do not use the term, and the unscheduled care task group does not talk of, "breaches"; we talk about patients waiting —

Mrs Dobson: And systems.

Dr McBride: — for longer than 12 hours. We need to be consistent in that, because, going back to your point, it is not about depersonalising. These are people who are —

Mrs Dobson: I am referring to the work of the task force. If you have such confidence in it —

Dr McBride: We are making sustained progress; the numbers and facts back that up. We are absolutely committed and determined. The Minister has been very clear about his expectations and what he requires of us, and we will be working to deliver that.

Mr McGimpsey: It has been a long session, so I will try to be as brief as I can. I can understand how you can get to evidence overload and weariness. When I went into the Department in April 2007, it was, roughly, when the four-hour targets came in. I understood then that the four-hour targets were the key targets — the critical targets. Yes, there was a 12-hour target — a long stop — but the absolutely important, crucial target was the four-hour target, which was 95% in four hours. That is what I look at. Yes, you have made good progress on the 12 hours, and I congratulate you on that — that is good work — but it seems that there is a long way to go for the four hours.

Michael, your graph shows the numbers for over 12 hours, but you jump to percentages for four-hour waits, and we cannot see like for like. If, for 2013-14, you were hitting 78% in four hours, you were hitting 22% over the four hours. How many patients are we talking about there? For April to December, you were hitting 79%. How many patients were missing their four hours? It is important. My focus is and always has been the four hours.

Briefly, Jo-Anne made a point about the children's hospital. I have been there with my grandchildren. I could not speak more highly of the staff there; the clinicians and the nurses are first class. Your four-hour waits there are almost on target; they were at 93·5% in November. That is very good, but 184 children were waiting for more than four hours. You have very good staff, but you need more people. When you look at four-hour waits and where the issues are, issues that go back over 2012, 2013 and 2014, the four-hour breaches — you will know all this — are primarily or mainly hitting the Royal, the Mater and Antrim hospitals. Those are the three areas.

Craigavon, which is a major acute hospital, is hitting 86%, which is very good; Daisy Hill, a minor acute hospital, is at 88%, and the Royal is at 68%. The Mater is at 69%, Antrim at 67%. You would know better than me, but that is where you have to concentrate. That is where you have to get the investment. You need more people. You have a brand-new A&E in Antrim, and you have to populate it properly. If you are hitting that sort of number, it is not the facility; it is the number of people going through. We are all getting the same story about people sitting waiting, and we know that the four-hour wait is there for a very good reason. I think that prominent doctors in the Department explained to me at the time why the four-hour wait was key.

Dr McBride: I think that I remember those comments as well.

Mr McGimpsey: Yes. So that is where you need to concentrate. You need more investment. The Royal is sitting at 2,500, missing the four hours; the Ulster is trembling on the brink at about 75%, and Altnagelvin is at 75%. I agree: you have a very good health service here. It has been working and delivering superbly over many years, but it is not getting the support from all of us in here, by voting it the resources that it needs to provide the supply. I keep talking about supply and demand. If demand is there, supply has to match; if demand goes up, supply has to go up. It seems to me that supply is not reaching demand. How are you going to square that circle? You have a task force. Cleverer working will help; it will take you some way, but we have been doing this for years. There is no getting away from the fact that you will need extra doctors, nurses and ambulance crews. You need extra

people. Have you any sense of where you need to be so that we know what we should be voting for, because we are in a very serious financial situation?

There are certain key things that government has to do: upholding the rule of law or protecting life and property is the number-one priority; the second is health and social care. All of us have a duty, but we can fulfil that duty only if you tell us what you need. You have to invest, be efficient and engage the population. Those are the things that we always talk about, but how are we measuring against what we need to do? We hear what you need to do, and we will tell you what you have to do and where we are not happy and all the rest of it. You, however, have a duty to tell us where you think we need to be and what you think we need to do. I set up the board, and one of the key things that the board is doing, other than being an exemplar of efficiency and so on, is giving support to the trusts. Can you take this back to Valerie and Ian? There has been precious little support coming publicly from the board for the trusts. Belfast is a big fish in a small pond; it attracts most of the criticism, and it needs more public support. I know that you wheel out John Compton occasionally —

Dr McBride: I think that he wheels himself out; he does not need any encouragement.

Mr McGimpsey: Well, he has grown a beard, so we do not always recognise him. The board needs to do more to support the trusts, and, if they need more money or more support, you have to find it for them.

Mr Bloomfield: The board continues to work closely with the trusts, and it has done considerable work providing media statements and interviews on this issue.

Mr McGimpsey: Your chief executive has been absent —

Mr Bloomfield: For the last couple of weeks —

Mr McGimpsey: Another big issue for me is that you have lost the chief executive of the Belfast Trust, who was a first-class operator. Now, you have got a very good one in, I am quite sure, on a temporary basis, but I could not believe that Colm Donaghy was allowed to go. I do not want to personalise, but you are in the same boat in the Southern Trust. How are you going to manage this? If the board is supposed to be there to support the trust, you cannot keep dropping the ball.

Mr Bloomfield: The chief executives of the trusts are not a matter for the board.

Mr McGimpsey: No, but you have a duty to support them.

Mr Bloomfield: I believe that the board fulfils that duty; it works very closely with all the trusts. You started by asking what things needed to be done, and we touched on some of them during the session. Considerable work still needs to be done to put in place the alternatives, and that requires funding. There are still things that need to be done to make the system better and more efficient, and the board is working with the trusts on them. Other measures were identified through the task group, such as broader seven-day working across services, which I touched on earlier. The board is working with each of the trusts through the local commissioning groups to bring forward detailed proposals as to how we put those broader seven-day services on the ground over the next year. However, that will be subject to funding.

Dr McBride: May I pick up the workforce issue? I refer to Fearghal's earlier point on policy direction. Someone wiser than I once said that every system is perfectly designed to get the results that it gets. It is about how we transform the model of health and social care in Northern Ireland and make strategic policy direction as outlined in Transforming Your Care, to which you quite rightly referred earlier. As I said when I last gave evidence to the Committee, large-scale system reform takes time. We are three years in. Could we be further down the track? I think, yes, we are all —

Mr McGimpsey: That is what we used to call shift left.

Dr McBride: We are all frustrated by the pace of change under the new model. It is radically different, Michael, as you know, from the model that we currently have for dealing with the demographic pressures of an ageing population, finance and resource pressures, and providing the same quality and experience of care at lower cost. It is a model that requires much more investment in primary and community care, another point that Fearghal made earlier, and it is a model that shifts the focus away

from the acute sector. However, that strategic direction will be affected by our ability to invest in new models while building public and, indeed, political confidence in those new models during transition. It will also be constrained by the resources available to the health service in the years ahead.

We have seen it have an impact already on the changes that we wish to implement. The Minister made that point when talking about what he sees as the dominant issue for health and social care this year. Again, you had umpteen opportunities to talk to officials, receive evidence and question officials on that, and I have read the Hansard transcripts showing your frustration at the pace of change. The next period will be very challenging as we seek to implement the new model in a very financially constrained environment. Would you like to say something about the workforce, Charlotte?

Ms McArdle: In order to predict what you are asking, we need to have robust workforce plans in place. There was a gap in our workforce planning at the Department, but it has been rectified. The Department set up a regional workforce planning group to take forward workforce planning in a multidisciplinary way, something that has not been done before by programmes of care. The first one that we will look at is primary care. In advance, we have done uni-professional workforce plans; the nursing workforce plan has just been completed. Over the past few years, there has been a reduction in the number of nursing places at Queen's. The recommendation is that we do not reduce it any further and that we target particular groups of the workforce to support the change that needs to happen through TYC.

We look specifically at how we can promote new roles and extra staff in the community. The district nursing teams are working hard with complex cases. There is much more difficult and complex care in the community now than there was even five years ago when the sorts of care being provided in the community would have been provided in a hospital. We need to recognise that in how we skill up our workforce. The workforce review is in its final stages and will go out for engagement through consultation, subject to the Minister's approval. I am not as close to the medical workforce review, but I know there has been cross-cover between it and the nursing review in the areas of sharing roles, taking on different roles and supporting one another, particularly where we have had difficulties traditionally, for example, in emergency departments and emergency care.It is a team approach, and we need to utilise the best skills in the team regardless of the professional background of the person.

We have developed a programme around advanced nurse practitioners to support our colleagues in emergency care. That model could be used in primary care to support GPs in practice. I do not see any reason why nurses with advanced nursing skills could not be seeing, treating, prescribing and discharging patients on behalf of the GP, if we find a way to make that work.

Urology is another example where we have difficulties with consultant-led care and where nurses can support consultants to do the most complicated work. The nurses could take on a higher level of skill in a contained way using protocols that would support the consultants to work on the urgent and complicated cases.

We are looking at all those things and, no doubt, that will have to be factored into what is a difficult financial situation. We can use only the money that we have in our budget. Trying to meet these needs in that difficult environment is difficult.

Dr McBride: The same applies to the medical workforce. We touched on this earlier in relation to primary care. We know the shortfall that we have in GPs per head of the population in Northern Ireland, so there is a work stream looking at what we will need in primary care. You have taken evidence from the Royal College of General Practitioners in the past on its concerns about the resourcing and numbers in general practice. There are areas around the workforce where we need to invest.

We talked about diagnostics earlier. We are doing a major imaging review, and there are major workforce implications there for consultant radiologists but also for other skilled members of that team and other roles that they could be taking on. There are major workforce issues.

Mr McGimpsey: There is so much to be done. You need to invest in people, equipment and buildings. The work is going through at the Ulster Hospital and we will get a new A&E out of that as well as award block and all the rest of it for £190 million. Guess who signed that originally.

The other one that I signed for was the £150 million critical care building at the Royal Victoria. That was expected to be ready about a year ago. I know you have had construction problems there.

Dr McBride: Yes.

Mr McGimpsey: Can we see that being resolved? If that building, with all the gear that is going into it, was in place, although it would not solve the problem, it would ease some of the burden of the staff at the Royal A&E.

Dr McBride: I think you are right. Look around our EDs. The ED at Altnagelvin is a very constrained environment for committed, dedicated staff who are working for patients to be looked after. If we look at the ED at the Ulster Hospital, yes the new build there will be a huge asset. Similarly, if you look to the ED at the RVH, again it is temporary accommodation. The new building and the new emergency department will be a huge boost to staff morale but also to improving patient flows and the patient experience, which is hugely important.

As Chief Medical Officer, I am not aware of the details of those discussions. You are right that there have been difficulties. I understand there has been work going through to resolution. I understand that those will hopefully be resolved in the next number of months.

Mr G Robinson: I thank the team for their presentation. It was absolutely excellent. As well as that, I thank all the health workers throughout Northern Ireland for the magnificent job that they do. I have been in hospital several times, and I just could not fault them. The care that I have been given has been absolutely excellent. Thanks to yourselves for making that happen.

My question is around the City Hospital. You said that there has been a 32% reduction in the A&E service between December 2013 and last month. Could the City Hospital's A&E department not be opened on even a temporary basis during the peak winter months — from December through to February, roughly? Are there still staffing problems there?

Dr McBride: We need to remember that the decision made by the Minister at the time in relation to the emergency department at Belfast City Hospital was in relation to concerns around the safety of that service. What it enabled was a concentration of services on the other sites. It is fair to say that one of the important findings of the RQIA review, on pages 21 and 22, was that the closure on a temporary basis of the Belfast City Hospital A&E department did not precipitate the problems in relation to the RVH ED last winter. Indeed, if you look at the figures — I think Michael will be closer to the detail of this — you can see that the problems last winter were not related to a huge spike in emergency attendance. It was quite the opposite.

Quite frankly, with those issues and concerns in relation to the safety and the ability to staff the Belfast City Hospital site at an appropriate level, to take the sort of approach that you have suggested as a consideration would only have compounded some of the difficulties that the Royal Victoria Hospital emergency department, or, indeed, the Mater emergency department, would have faced over that period. It would not have been of assistance. It actually would have diluted the number of very expert nurses and doctors available to provide an appropriately resourced and functioning service. Charlotte, do you want to add to that?

Ms McArdle: I just think that we need to maximise the resource that we have. We have a group of very skilled ED practitioners, and we need to ensure that they are working at the top end of their game in the most difficult circumstances, supporting each other both through the urgent emergency and the minor injury unit. I think it would be difficult to staff that up again. It would take a long time. It would not be possible to do it in the foreseeable future.

Dr McBride: Certainly in the short term.

Ms McArdle: That is not to say that it is impossible — I do not mean that — but it would take so long to staff it up and get it ready for the time period that you are talking about. There is too much of a lead-in time, and it would dilute the resources at the other ED sites. Therefore, the rest of the EDs could not treat the same volume of patients.

Mr G Robinson: As I mentioned, it was just on a temporary basis. Last winter and this winter have been fairly mild, and we are only into January. I am sure that there are going to be future pressures on our A&E departments. I am just thinking about that. Even if the task force could look at it for next year —

Dr McBride: As you know, the board has completed a piece of work in relation to the pattern of emergency services. That was one of the recommendations in Transforming Your Care. No decision has been made by the Minister in relation to the future of emergency departments in the greater Belfast area, but one of the lessons that we have learned from other jurisdictions internationally is that it is about ensuring that we have the right degree of local services supporting patients with long-term conditions, but that when you have really specialist services requiring emergency department care, it is crucially important that you concentrate that expertise to get the best outcome for patients and, at the same time, make sure that the transfer time and travel time for anyone is not so excessive that it actually compromises their care.

Whilst the suggestion, like all suggestions, is not something that should be rejected, I honestly think, looking back to that period, that we would certainly not have had the capacity, quite simply, or the time to take that step. To be perfectly honest, in my view, based on the work of the unscheduled care task group, I think, as Charlotte said, it would have compounded the problem rather than eased the problem.

Mr Bloomfield: As we have said a number of times this afternoon, one of the areas where there is still a need for action and progress is the move to much more seven-day working and extended-day working. That is more difficult the more sites you spread that across. If we need our physicians to review every patient who is in a bed twice daily, seven days a week, it is easier to do that when those resources and skills are concentrated in an area.
I want to pick up on something Dr McBride said. On the day, last year, of the major incident in the Royal and on the preceding days, it was not about the number of attendances coming through the front door of the Royal; it was about the number of consecutive days before that when there was a particularly low number of discharges. It reached the point where that caused those pressures. The number of patients presenting at the Royal on those days was within the expected levels and modelling, following the temporary closure of the City Hospital, on the basis of how many patients would move from the City to the Royal as opposed to the Mater, the Ulster or, indeed, some other areas. It was planned for on that basis, and the numbers presenting were in line with that.

Mr McKinney: You made the point about the spike, surge or whatever it was last year, when you shut the City Hospital. The City shut three years earlier, and, as a result, there was an increase in the Royal Victoria Hospital. It may have been by virtue of the increase that was generated.

Dr McBride: It was not the conclusion that the RQIA reached.

Mr McKinney: May I touch on one other thing? It is linked to these things in terms of community provision. Has everybody else asked their questions?

The Deputy Chairperson (Ms P Bradley): No, I have still to come in, but you go ahead.

Mr McKinney: Just one, as CMO and not CEO. How is the sudden announcement of the closure of nursing provision at Orchard House in east Belfast consistent with the need for nursing provision in the community?

Dr McBride: Again, that is maybe something that Charlotte will be better able to respond to. I am not familiar with all of the detail of that decision or of what informed that decision, but I think that a range of factors impact on such decisions. One factor is often around the type of service. Speaking generically, it may well follow reviews with the RQIA on the appropriateness of the service or the appropriateness of the environment providing that service. As we have said before here at the Health Committee, and, indeed, as the Minister has previously indicated, some decisions are made in relation to contingencies that the service has had to make. It has to live within the allocations. As Chief Medical Officer, I do not know the specifics of that case, Fearghal, so I am not in a position to provide any greater detail. I do not know if Charlotte is.

Ms McArdle: I do not have any detail on it, Fearghal.

Mr McKinney: Rather than have you scan around for an answer, we will communicate about it separately.

The Deputy Chairperson (Ms P Bradley): I want to finish off by looking, again, at A&E services and various issues around the problems that we have in A&E. I do not know whether I agree with it; I am on a five-year career break and could end up back at Antrim Area Hospital in a year and a half. Looking at seven-day working, I know that I will be voting to be doing that myself, if that is the case. Before I left, in 2011, it had already started in the social work department, and it was happening in occupational therapy, physiotherapy and other things. Did you say you were looking at radiography as well?

Dr McBride: Yes, radiography and radiology. As Michael, I think, said, patients get sick seven days 365. To go back to the point that Michael made, to be able to respond to that, we need the service configuration, the service model and the workforce to actually —

The Deputy Chairperson (Ms P Bradley): We know that it is not just A&E, because we know that to discharge a patient from hospital, which will free the bed for the A&E patient, we need community services in place for weekends. It is a bigger piece of work that needs to be undertaken.

We can look at some of the problems surrounding A&E and look at some of the users of it. We know that our A&E is free to everybody. It is open 24 hours a day, anybody can come in and we do not stop anybody coming in. I will be really controversial now: has anybody ever looked at that? I am talking about people who are abusive or under the influence of alcohol or drugs. Do we have any specific procedures around that? We have to protect staff, and we have to protect patients.

Dr McBride: I have two comments, briefly, and Charlotte will talk to the detail of the work that we are looking at in relation to alternative models for patients who have consumed too much alcohol and may have some minor injuries. That is very disruptive, not just for staff but for other patients in the emergency department.There is zero tolerance of verbal or physical violence to staff in all our hospitals. That is the Department's policy. All trusts have policies in relation to the enforcement of that. We will pursue prosecution where there is a case in relation to anyone who —

The Deputy Chairperson (Ms P Bradley): What would happen, Michael, if there was a prosecution or —

Dr McBride: Well, there have been.

The Deputy Chairperson (Ms P Bradley): Is an order then put out that that person cannot attend? Can we do that?

Dr McBride: There is zero tolerance. We have regular rounds by security teams in emergency departments. There is zero tolerance of any behaviour where there is abuse, verbal or otherwise, of staff. Trusts will seek to press charges to the full rigour of the law where practically possible.

In relation to people's use of ED, that is something that we are looking at. I talked earlier about the diversion away from ED. We know that we have more to do in terms of the point I mentioned earlier in relation to Fearghal's question, which was about educating people about alternatives, providing viable alternatives in community and primary care, and informing their choice. I did a lot of work in the run-up to Christmas with the self-care week, which was launched by the Minister on 19 November, and the Choose Well campaign. There is more that we need to do there. There are undoubtedly a significant number of patients who still use our emergency departments for a condition that they already have attended their general practitioner for. They may be receiving ongoing treatment, care and advice from their GP. At the moment, those patients will still attend ED and will still be seen by doctors and nurses. We need to have a conversation about better educating the public and making some decisions around how we inform patients that they may have attended an emergency department but that it is not the most appropriate place for them to access care. In that discussion, there have been all sorts of proposals around charging. Ultimately, those decisions are matters for a Minister. Personally, as Chief Medical Officer, I would not support such an approach. I do not want any situation where anyone feels that, because of their inability to pay, they are discouraged or dissuaded from any contact with the health service.

In relation to the specific issue around alcohol, there is work we are doing.

Ms McArdle: Yes, the out-of-hospital group of the unscheduled care task group has been asked specifically to look at putting forward proposals. A model has been developed that works with the

voluntary sector and the police to look at developing the work in Shaftesbury Square around the bus that looks after people who are intoxicated, particularly at the weekends. We would like to try to extend that to provide some minor injury cover to it and to pilot that and see what difference it makes to both that group of clients and the emergency department. That can be done in a fairly low-cost way.

In support of what Michael said around the number of people, I have been talking to the nurses who are often the first person the patient meets when they come into the department in that triage role about how they begin to use protocols to redirect people to the most appropriate service. That requires us to have alternatives to the ED in place for that to happen, but there is work in other countries; I point to Scotland in particular. We are looking closely at that in the unscheduled care task group.

Mr Bloomfield: The board is finalising a specification for that pilot service, with the aim of having a pilot service in place by March. That will focus on diverting patients who otherwise would have presented at the Royal or Mater emergency departments, offering minor injury and sobering services for patients under the influence of alcohol. Obviously, it is essential that such a service has robust governance arrangements around it, so work is going on with the Ambulance Service and others in relation to that. Our aim is to have a pilot service in place by March.

Dr McBride: We have been tasked by the Minister specifically. It is something that he has heard during his visits to the emergency departments in the run-up to Christmas. As you know, he has been out around all the emergency departments. It is something that he heard from staff; he has certainly heard it from those using the service, and he has tasked us with looking at options. We are looking at models that are available in Wales, for instance, where there are similar services.

It is important to be clear that we will not compromise the safety of patients. You will know that sometimes those who present to our emergency departments under the influence of alcohol can also have significant health issues. They may have fallen or injured themselves. They may not be terribly coherent in terms of their ability to give a history. Their safety is of paramount importance as well. The alcohol can often disguise some serious health issues that need to be addressed. We will not compromise the safety of those individuals in any shape or form.

Mr Brady: On the point about the sort of filter system, there are people who present with quite serious mental health problems.

Dr McBride: There are.

Mr Brady: They may be alcohol- or drug-related. It is maybe about trying to work out some kind of filter system. If they genuinely need help *[Inaudible.]* or otherwise.

Ms McArdle: Quite a lot of work in relation to mental health has been done in emergency care.

The Deputy Chairperson (Ms P Bradley): A&E is not the best place for those people, anyway.

Dr McBride: It is the wrong place.

Ms McArdle: It is the wrong place. There is a pathway. There is psychiatric liaison support, and alcohol liaison nurses work with those groups. There is also the Card Before you Leave scheme. Initiatives have been put in place to support that group of people.

The Deputy Chairperson (Ms P Bradley): Thank you.