WRITTEN MINISTERIAL STATEMENT

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Health, Social Services and Public Safety

NORTHERN HEALTH AND SOCIAL CARE TRUST: IMPLEMENTATION OF IMPROVEMENT PROGRAMME

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Mr Poots (The Minister of Health, Social Services and Public Safety): The purpose of this Statement is to inform the Assembly of progress on the implementation of the Improvement Programme at the Northern Health and Social Care Trust; emerging issues as a result of that work; and the next steps in taking this work forward.

This is an important matter and it is worth recapping on the background. Members will recall that I previously made two Statements to the Assembly regarding the work of the Turnaround and Support Team at the Northern Trust. In a written Statement to the Assembly on 10 December 2012, I announced the appointment of a Turnaround and Support Team to the Trust in light of concerns about sustained poor performance in relation to waiting times in the Trust's emergency departments, and a request from the then Chief Executive of the Trust for further support in addressing these issues. The overall remit of the Turnaround and Support team was to work alongside the support already being provided by the Health and Social Care Board and the Public Health Agency, to provide an assessment of the changes required to improve performance and to support the management of the Trust in the delivery of services.

Under its Terms of Reference, the team was asked to take forward the work in two phases with Phase 1 focusing on the analysis of the challenges facing the Trust and its ability to deliver on services commissioned; and Phase 2 focusing on turnaround and support in light of the findings of Phase 1.

In light of the findings of the Turnaround and Support Team in Phase 1, I announced the appointment of two Senior Directors on a temporary secondment to the Trust in May 2013. Mary Hinds was appointed as senior Director of Turnaround to lead the improvement Programme at Antrim and Causeway hospitals and the related community services and Paul Cummings was appointed as Senior Director of Corporate Management to oversee the remaining service Directorates and the corporate management functions. These appointments were made as part of a programme of intensive support to the Trust to ensure the necessary turnaround was achieved.

I made a further Statement to the Assembly on 11 June 2013, following receipt of the Team's Report containing the detailed findings of Phase 1 of that work. The report identified a wide range of issues that needed to be addressed in order to deliver improvement at the Trust and made five distinct recommendations. These were to:

(i) enhance the leadership capacity at the Trust and empower clinicians to lead change;

(ii) ensure support to deliver an Improvement Plan in three phases;

(iii) gain assurance that Governance and Quality systems are robust;

(iv) gain assurance that mortality data is robust; and

(v) put in place a performance framework that would ensure delivery of the Improvement Plan and would contain clear consequences for non-delivery, alongside incentives for delivery.

Overall, however, the analysis identified that the Northern Health and Social Care Trust was in a poor position and required intensive support to improve. But the important conclusion was that the Trust could be turned around.

With the continued support of the external Turnaround and Support Team, the Trust, led by these two Senior Directors, began the process of implementation of Phase 1 of the Improvement Plan, covering operational delivery of services at Antrim Hospital; operational delivery of services at Causeway Hospital; and maximising Primary and Community Care and Older People's Services.

Progress with the delivery of the implementation plan has been monitored on an ongoing basis under the aegis of an Improvement Oversight Programme Board chaired by the Permanent Secretary of my Department and I note the progress to date that has been made, though many challenges remain.

Operational plans for both Antrim and Causeway hospitals which identified new ways of working to improve performance, particularly in unscheduled care were completed in June 2013. Particular concerns had included overcrowding at Antrim Hospital, poor patient flow, poor patient experience and poor staff experience. On foot of reviewed operational plans, work has focussed on: management of demand and capacity; new admission pathways; direct access by GPs; new escalation procedures; introduction of some 7 days services; use of electronic real time reporting on patients in emergency departments; and use of electronic whiteboards to track patient movements.

As I said in my Statement on 11 June last year, I recognise that turnaround will not happen overnight. Change takes time and must be carefully planned and implemented. I am very grateful for the way in which the whole organisation, and especially the clinical staff, who previously had not been sufficiently supported and engaged, have responded to the challenges and opportunities and have begun a path of progress to make the Trust a real success. There has been some very clear evidence of improvement at the Trust – for example latest available figures indicate that in January 2014 the number of 12 hour breaches of the Emergency Department waiting time target had reduced by almost 73% when compared to the same time last year i.e. from 353 in January 2013 to 96 in January 2014. I know that no-one is under any illusion that there is still very much to be done and that work is continuing to address the issues highlighted in the report and take forward the implementation of the Improvement Plan in a sustainable way.

The turnaround process has now entered the second phase of implementation, with a concentrated focus on driving forward improvement. That work has included ensuring a culture of openness and transparency and sharing of information to foster effective learning not just within the Trust but more widely across the entire HSC system, and this is being secured through new and improving relationships within the Trust and with key stakeholders such as the GPs in the Northern Area. In its report to me last June the Turnaround team had questioned the culture of reporting in the Trust. The team also questioned how learning from incident reporting was shared. It noted that although the quality and frequency of reporting had improved, more work needed to be done to address variable performance across the Trust in terms of learning from adverse incidents in order to ensure and improve patient safety. This is an important issue and one which is crucial to enable shared learning.

The issue of reporting can be difficult to address, as it is a feature of organisational culture which can only be improved by sustained encouragement and reinforcement of the fact that an open learning culture is essential to securing the best interests of patients, as, if mistakes are hidden they can be repeated but if they are disclosed without fear of unfair blame, lessons can be learned and shared. This ethos is absolutely vital in any sector where safety is an issue. It is worth noting that the level of reporting of Serious Adverse Incidents by the Northern Trust has increased significantly in the last year. Figures indicate that 131 SAIs were reported by the Northern Trust in 2013 compared to 63

SAIs reported in 2012 – an increase of more than 100% in cases reported – though as explained below, some of these incidents related to earlier years. This is a welcome change towards a more open and transparent culture within the Trust which facilitates the opportunity for learning and improving delivery of services across all of health and social care for the benefit of all of the patients and clients who rely on those services. I believe it reflects the positive commitment with which the clinical and care staff at the Northern Trust have responded in respect of the challenges of the Turnaround process.

A further significant component of the second phase of implementation, and the focus on driving improvements, has involved the Trust reviewing the operation and quality of services. This has involved the Trust looking at a range of evidence including examining and building on existing good practice within the Trust and has also involved looking back at previous incidents in order to inform the improvements which can be made.

In the course of this work the Trust has identified a number of cases where it believes that the quality of care it provided, and/or its previous response to cases where things went wrong, fell below the standard that I, the Trust itself, and most importantly, the population served by the Northern Trust, would and should expect. Earlier this week the Trust provided my department with a summary of a number of cases which it has looked at covering the period from 2008 to 2013. A small number of these cases had already been notified to the Department previously. I was briefed on Tuesday about these cases and felt it important to share, as far as is possible, the details of these cases and the actions that have been taken or are ongoing with the Assembly.

In a number of instances these cases highlight shortcomings in the reporting, investigation and learning from serious adverse incidents which date back a number of years. These shortcomings were reflected within the Turnaround team's report published last June. This latest information from the Trust has brought some key issues to light and it is important to me that these are explained publicly in a clear and appropriate context.

I want to assure the Assembly that, in light of these findings, the Trust has now taken prompt and appropriate action such as initiating fuller investigations and making sure all affected patients and families are given the appropriate information and support. I have asked the Trust to confirm to my Department as soon as possible that all such action has been completed to ensure that these individual cases have all been reported appropriately, properly investigated and that learning from those instances is effected within the Trust and more widely within the HSC as necessary.

Members will appreciate that it would not be appropriate for me to give details of individual cases but equally it is important that I share with you, in the spirit of openness and transparency, the substance of those findings and the actions that have been or will be taken on foot of those findings.

The Trust has identified 20 separate incidents in which the response by the Trust was below standard. These instances were across a number of areas within the Trust including: in obstetrics and gynaecology; imaging; and the Trust's emergency departments. These incidents involved deaths in 11 cases of which 5 were perinatal deaths.

I would stress that it is not clear that these were avoidable deaths but it is clear that the Trusts response should have been better.

In 8 of these incidents there were delays in them being reported as SAIs - the majority of these were identified as a result of the Trust reviewing complaints and clinical negligence claims against the Trust. The investigation of some of these cases are still on-going.

I understand that the imaging follow up cases that have been identified in this process related to incidents where there may have been a failure to follow up on x-ray reports and that in some instances these were not classified as SAIs, thus missing an opportunity for learning and avoiding

future occurrences. Those that were raised as SAIs had resulted in a learning letter issued across the HSC in November 2012. However in light of the information in relation to all of these cases the Trust has completed a review of some 35,000 x-ray reports at Causeway Hospital covering all of 2011 and 2012. Of these, 9 cases were identified which require further investigation which is continuing. As a further and additional precautionary measure the Trust extended the review to cover the remaining sites across the Trust in January this year to determine whether there has been appropriate follow up in chest x-rays taken in 2013 where this was recommended. This involves checking whether the x-ray report contained a recommendation for further follow up and whether this was appropriately dealt with by the referring clinician. So far more than 19, 000 reports have been reviewed and a further 28,000 are in the process of being reviewed. Of those reviewed to date 2 cases have been identified which will require further investigation. This review is ongoing. The Trust has assured my Department that there is no concern as to the accuracy of any x-ray reporting and I would again emphasise that this review is precautionary and patients who have had an x-ray in the Northern Trust should be aware that it has only been necessary to investigate further in a tiny number of cases. I would not wish patients to be unduly alarmed and if anyone has any concern, the Trust has a helpline in place to answer any questions.

In relation to obstetrics and gynaecology, we know that the majority of patients receive a very high quality and safe level of service, however, the incidents identified raised concerns about aspects of governance including the management of incidents. Informed by these concerns and as part of an overarching review of Trust governance arrangements the Trust has carried out a review of Obstetrics and Gynaecology Governance. Among other things the review was aimed at assessing the culture within Obstetrics and Gynaecology with respect to learning from Serious Adverse Incidents (SAI's), Incident Report Forms (IRF) and litigation cases: assessing how such learning is shared; establishing if there are areas of practice that may cause concern; and to make recommendations for improvement where concern has been raised. The Trust is currently developing an action plan to implement agreed recommendations emanating from this review.

While the identification of an incident as an SAI does not in itself have any impact on the outcome for the individual patient at the time the incident occurs it is, as I have already highlighted, crucial that it results in a prompt and timely investigation so that any learning can be shared to ensure processes and procedures or other corrective action can be applied.

In continuing the drive for higher quality services we need to learn from past experience and share that learning across the system for the benefit of patients and of the staff who serve those patients on a daily basis. In my Statement to the Assembly on 11 June I was clear that learning from the turnaround work at the Northern Trust would be shared across Northern Ireland.

I want to consider the findings of the Northern Trust team in more detail, in terms of the issues they highlight, the implications, the challenges and how these can and should be addressed across the system.

More generally I want to consider the broader issues of the quality of care, openness, transparency, learning, and how the HSC responds when things do go wrong.

There are many factors that impact on the safety of care:

- Organisational leadership;
- Systems, policies & processes;
- The work environment, team communication, task complexity;
- Patient characteristics; and
- Staff knowledge, skills and motivation.

Given the multiplicity of factors, most unintended harm and unnecessary deaths are due to a combination of circumstances within a system rather than the failings of an individual. The vast majority of patients experience care that is of a very high quality. In Northern Ireland:

- Each year there are in excess of 15 million key interactions between HSC staff and healthcare patients and social care clients (patients and clients) in the form of appointments, admissions and other interventions.

- There are over 78,000 people employed in commissioning and delivering the full range of health and social care services to Northern Ireland's population of 1.8 million.

- Attendances at hospitals each year include over 1.5 million outpatient attendances, over 700,000 treatments at Accident and Emergency departments and around 500,000 inpatient or day case admissions.

- In addition to those who receive services at a hospital, approximately 105,000 patients/clients receive a range of health and social care provision on a typical day.

- Almost 6,000 complaints per annum are raised against Trusts by those who have accessed HSC services.

We have an SAI process in place which is a key driver to openness and learning. The fact is that in such a highly complex and stressful environment, no matter how committed or dedicated staff are, things on occasions, can and will go wrong for many varied reasons. While this only applies in a tiny proportion of cases, to deliver a high quality health and social care service, it is vital that learning is achieved from all such events and applied consistently so as to minimise, and to prevent in as far as possible the risk of reoccurrence. There can never be room for complacency. Safety will always be the component of quality that needs to be guarded and continually improved and consistent and timely reporting is fundamental to that. The price of quality is eternally vigilance.

No-one wants things to go wrong in our health and social care services, but when something does go wrong we need to know about it and act upon it to ensure that as far as possible it does not happen again. In that respect I want to acknowledge the fact that the Northern Trust team has brought this information to my attention and has acted immediately and correctly to address the issues in these cases as they were identified. I believe that what we are seeing is the outworking of the Turnaround in the Northern Trust and that the necessary transformation of organisational values and behaviour is well underway within the Trust. We are now seeing a culture of openness, transparency and sharing of information to foster effective learning being embedded within the organisation.

Changing the culture of an organisation requires resolute commitment and determination from the Trust Board to the Ward. I wish to acknowledge all the staff and managers in the Trust for their commitment in bringing about that change. That work is not yet finished, phase two of the Improvement Programme is well underway and it is essential that the positive developments at the Trust are built upon and sustained into the future. It needs to be embedded into everyday practice at the Trust. As the Trust continues with the programme of improvement stable and effective leadership will be critical and for that reason I welcome the fact that the Trust has moved this week to seek to fill the Chief Executive post on a permanent basis through open competition.

Mary Hinds, Senior Executive of Turnaround at the Trust will end her period of secondment to the Trust at the end of this week. I want to extend my sincere thanks to Mary for the work that she has done and the strong leadership she has demonstrated, together with Paul Cummings, in taking the turnaround process to this stage.

I have decided in light of these findings and having previously informed Members of poor practice in procurement in the Trust together with other issues that have been the subject of consideration,

concern and debate for the Assembly; that I will commission further work to examine the HSC in its entirety in respect of its:

1. Openness and Transparency;

2. Appetite for enquiry and Learning; and

3. Approach to redress & making amends.

I will update the Assembly when I have finalised details of this work.

My overriding objective for the entire health and social care system is to protect and improve the quality of services we deliver. The Health and Social Care service must be safe, effective and totally focussed on the patients and clients it serves. They are at the heart of everything we do. That is what the public expects and that is what I require.

I want to conclude this statement by expressing my appreciation to the nurses and doctors, all of the front line staff at the Trust, and to the management team who carry corporate responsibility for the governance of the Trust's services, for their professionalism and dedication and unrelenting commitment in the services they deliver to their patients and clients.