Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Accident and Emergency Services: Royal College of Nursing

26 March 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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

Witnesses:

Ms Fiona Devlin	Royal College of Nursing
Mr Garrett Martin	Royal College of Nursing
Ms Linsey Sheerin	Royal College of Nursing
Ms Janice Smyth	Royal College of Nursing

The Chairperson: Folks, you are very welcome. We have Janice Smyth, the director of RCN NI; Mr Garrett Martin, deputy director of RCN; Ms Fiona Devlin, chair of the RCN board and lead in the RCN NI community nursing network; and Ms Linsey Sheerin, lead in the RCN emergency care network. I understand that this is the first time that you have been in front of the Committee; at least, my information leads me to believe that. The procedure here is that we ask you to make a presentation of around 10 minutes, and we will then open it up for questions from members.

Ms Janice Smyth (Royal College of Nursing): Chair, thank you very much for your introductions. We are very pleased to be with you. Thank you for the invitation to meet you. We in the Royal College of Nursing in Northern Ireland take very seriously our obligations in pursuit of our mission statement, and we will work in partnership with any person or, indeed, any organisation in that regard.

It is our view that the health and social care (HSC) system in Northern Ireland is seriously challenged. For two years, the college has been on record as expressing its concern that the health and social care system is not fit for purpose and that nurses are being left to face the public and to apologise. That remains our position today. The totally unacceptable situation that is being played out in the majority of our emergency departments is as a result of an inability to address problems across the health and social care system. The review of public administration was intended to deliver a more streamlined and accountable health and social care system and to maximise resources. In addition, public health and well-being were to be placed at the centre, with a greater focus on prevention and support for vulnerable people to live independently in the community for as long as possible.

The Department of Health, Social Services and Public Safety framework document describes the roles and functions of the Health and Social Care bodies. It clearly states that the Health and Social Care Board (HSCB), Public Health Agency (PHA) and trusts are ultimately accountable to the Department and that the Department, through the Minister, is accountable to the Assembly. The framework document sets out the functions of the Health and Social Care bodies. The Health and Social Care Board is responsible and accountable for commissioning, performance management and for service improvement in resource management. The Public Health Agency is responsible for improvement in health and well-being, health protection and service development, and it provides professional leadership to the Health and Social Care Board. Trusts were established as service providers, and the framework outlines their statutory obligations for monitoring and improving the quality of health and social care that they provide to individuals and for the environment of care that they provide it in. The Regulation and Quality Improvement Authority (RQIA) is an independent, although accountable to the Department, health and social care regulatory body. It was established to keep the Department informed about the provision, availability and quality of health and social care services, to promote quality improvement and to review and report on clinical and social care governance in the health and social care system.

In all of this today, we ask this question: where is the patient or client in all of it? What is the patient or client experience, and what do we know about the quality of care and the patient or client experience? What lessons are we learning from the valuable collection of patient stories that are gathered by the Public Health Agency?

The RCN is seriously concerned that targets have become more important than people, that financial break-even takes precedence over the statutory duty of improving quality of care, that care is not being organised or commissioned around the patient and that, in that context, it is neither effective nor efficient. There is a sense that the focus is on going through the motions of sustaining the bureaucratic and administrative processes and not on the patient, and that messages are presented in a positive manner even when the information raises significant issues that require to be addressed. We are measuring the wrong things. We are measuring compliance with processes as opposed to patient outcomes.

There is a fear that the abnormal has become the normal, and there exists desensitisation to poor standards of care. Many front line staff perceive a disconnect between those in management and leadership roles, and nurses' concerns, when expressed, are not being heard and are being referred to as soft information. Corrective action is not being taken to address concerns brought to the attention of managers. This is borne out in the HSC staff survey published in October 2012. Nurses are overwhelmed by the demands put upon them. They feel demoralised, disempowered and stressed. Staffing levels in many clinical areas are wholly inadequate. HR policies, slowing recruitment and freezing and removing vacant posts as cost-saving measures have resulted in nursing teams becoming depleted and in an over-reliance on the use of bank staff. The college has been unsuccessful in its attempts to highlight that these cost-saving measures, which are neither effective nor efficient on costs, pose a significant risk to the quality of care, patient safety and patient experience.

Work led by the director of nursing at the Public Health Agency and our Chief Nursing Officer has resulted in an agreement in the first instance a normative staffing range for general medical and surgical wards in our hospitals. The Minister, who has been very supportive, has announced in the Assembly the implementation of these agreed staffing arrangements. The college is concerned that, despite this ministerial announcement, there is a reported reluctance in the system to accept professional opinion and policy direction for nurse staffing, and we will watch with interest progress on the implementation of the policy.

We want to take the opportunity to make reference to Transforming Your Care (TYC). The Royal College of Nursing was initially supportive of the policy direction outlined in Transforming Your Care. We are concerned that, despite the appointment of a director, project managers and support staff to lead this work, we see a vision without action.

Community services have not been developed as anticipated. As our briefing paper indicates, district nursing, health visiting and school nursing services have all been impacted on by a reduction in their workforce to meet cost savings and, as a consequence, there is an inability on the part of those nurses to deliver the most basic of services.

The college wrote to the director of Transforming Your Care in December 2013 and, again, on 24 February 2014 raising our concerns about the lack of investment in nursing initiatives to support

Transforming Your Care implementation, and has yet to receive a response. Information forwarded to the trade unions by the director of TYC in February 2014 outlining the TYC investment proposal gives further cause for concern. It lacks any rationale for investment and confirms that £5·5 million of the £6·7 million available was allocated to infrastructure costs to support implementation, including external management consultancy.

Northern Ireland has some excellent health and social care professionals and, arguably, some of the best nurses in the world. The problem is that we do not have management structures and a health and social care system that supports, encourages and empowers them to deliver safe and effective quality care to patients and clients. It is a system that is neither open nor transparent. So, we say, "Enough is enough". This is a time for strong, professional and clinical leadership, staff engagement and empowerment, because that is fundamental to the delivery of safe and effective care for our patients. That will require a review of the trust executive nurse director's role to ensure that the professional and regulatory obligations of that role are clearly understood at board level, and that, in the interests of patients and clients, those obligations are given the priority currently afforded to financial balance. Reporting arrangements for nursing staff from the bedside, wherever that bedside may be, to the executive director of nursing must be clearly demonstrated in uncomplicated management structures.

Robert Francis QC, in his first report into Mid Staffordshire NHS Foundation Trust, said:

> *"If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented."*

It gives me no pleasure to come before you today with that message. However, as our briefing paper makes clear, the Royal College of Nursing does not believe that we can move forward unless and until we all admit that we have a significant problem, and unless and until we start asking the right questions.

Thank you. We are happy to answer any questions that you may have for us.

The Chairperson: Thank you, Janice, for that very frank submission. To begin with, I express our admiration as a Committee for the incredible and valuable work that nurses carry out on a daily basis. I have always made that point about front line staff and the need to support that. During our visit to the Royal on Monday, we could see at first hand how people are under extreme pressure regarding this system.

I want to pick up on a few things. You said that you had written to, I think, the director of the implementation group on Transforming Your Care in December 2013 and had not received a response.

Ms Smyth: That is right.

The Chairperson: That is completely unacceptable, and it is something that we as a Committee will certainly take up. It is unacceptable that an organisation such as your organisation, or any organisation with valuable insight and potential solutions to the issue, are ignored, but we can come back to that.

I think that it is very important that your paper and, indeed, you, have indicated that we have moved into a place where targets are more important than people. Increasingly, we are getting that message very loudly and clearly. I think that you said that there has been a reported reluctance in the system to take professional advice. Again, that is a very challenging obstacle that needs to be flushed out and moved to the one side.

I have a very direct question, because you mentioned Mid Staffordshire. Are we on the same track with regard to the processes around Mid Staffordshire?

Ms Smyth: We do not know that, and that is part of the problem. My colleagues will speak for themselves — two of them in practice — and take in the views of members. With regard to the lack of openness and transparency, we never saw the College of Emergency Medicine's report on the Belfast Trust until it was given to us by the media, yet we allegedly are in partnership working with

organisations. So, I am not sure that anybody has the full picture and, if they do, we are not aware of what the full picture is.

My colleagues and I and many of our members were absolutely shocked to hear the things being said in the media about patients coming to harm and, indeed, patients dying as a result of difficulties that we have in our services. That was news to us, and we heard it as you heard it.

I am sorry that I cannot answer your question, but I have concerns that targets, particularly financial targets, which we are not meeting anyway — that is the irony of it all — are coming before the professional advice and the delivery of care to patients.

The Chairperson: That is very straight.

I know that you stated in your paper about asking the right questions, and that is important advice for us all. One of the issues is that, if we are serious about Transforming Your Care and shifting left, we have to look at the community infrastructure. I know that you picked up on the number of district nurses who are now in post. Is there enough community infrastructure?

Ms Smyth: I will invite the chair of the board, who is a community nurse, to answer some of those questions. I can pick up on the others if Fiona wants me to address them.

Ms Fiona Devlin (Royal College of Nursing): From the evidence that we have, we feel that the number of district nurses in Northern Ireland has fallen by 12% since 2008, with the workforce again beset by an ageing profile. Throughout Northern Ireland, our members indicate that there are not enough staff on the ground; in effect, staff have been withdrawn and there is no backfill. As a result, more pressure is put on existing staff, which causes them to have low morale and leaves them unable to meet the service that is required. The pressures are extreme.

Mr Garrett Martin (Royal College of Nursing): If I may come in on that, Chair. Last night, I spoke to a community nurse from one of our trusts who described what it is like. She said that every evening it is well past 6.00 pm by the time she finishes work and quite often she does not get her breaks during the day. She has a caseload of maybe 13 or 14 patients in a day and the complexity of care of those patients is ever increasing. She said that the demands on the staff and the lack of staffing to provide the care means that she cannot spend time with patients. She gave examples of end-of-life patients and of having to rush in and rush out of their house when families are obviously grieving and need time to speak. The nurses are finding that it is increasingly difficult to do that. She feels that it is a risk, and that is not something that I have heard from just one community nurse. There is also the overuse of bank and agency nurses in the community which, once again, regarding continuity of care for patients, is saying, basically, that any nurse will do. With regard to patient experience, that is not quality care.

The Chairperson: To clarify: the paper stated that 9% of nursing staff currently provide care in the community.

Ms Smyth: That is correct.

The Chairperson: That is quite a stark figure.

Mr Beggs: You mentioned a 12% reduction in district nurses, and you mentioned the age profile. Has no attempt been made to replace them or retrain alternatives? Why is there not a process to ensure that numbers are maintained?

Ms Smyth: District nurses are trained on an 18-month programme at the University of Ulster. There is a process for looking at the training needs and ascertaining how many we need. The commissioning process for pre- and post-registration nursing in Northern Ireland is amongst the best in Europe. The problem is that the resource is not always there and the staff are not there to backfill to let nurses out to have that level of training. Therefore, the trusts do not commission the places to train the nurses, and nobody is keeping an eye on the overall picture.

The other thing that has happened in recent years is that the money available for post-registration nursing programmes, of which district nursing is one, has been reduced significantly in the cost-saving economic climate that we are in.

Mr Beggs: Do you have numbers to illustrate that?

Ms Smyth: The budget was £12 million, which is not a lot for a workforce of 16,000. In three years, it has gone down, I think, to £7 million.

The Chairperson: This is the final one from me, although there may be other issues that I will come in on. Your paper, which comes from lessons learned from your valuable experience, looks at not only recruitment in its broadest sense but at the types of nurses we require. There is also an acceptance in the paper that nursing alone will not solve the problem and that a whole-system approach is required. Specifically, you talk about the role of the emergency nurse practitioner. Could you expand on that? I think that there are very limited numbers of these individuals employed.

Ms Smyth: I defer to my learned colleague, who is that person. She will talk to you about that role and how many colleagues are trained at that level.

Ms Linsey Sheerin (Royal College of Nursing): Emergency nurse practitioners are nurses who have been trained and are skilled in assessing, treating and diagnosing patients who present to the emergency department or minor injury units with a range of minor injuries and some minor illnesses. They are an invaluable resource to our emergency departments, because this releases our medical staff so that they can assess patients who present with more serious conditions.

Our members definitely feel that nurses can give more. In the UK, we have seen the rise of advanced nurse practitioners, who are nurses who can also assess, see, treat and discharge patients who present with more complex medical conditions. It is important that emergency nurse practitioners are seen as separate from our nursing workforce. When we look at the nursing establishment within our departments, our emergency nurse practitioners are often counted in with the nursing numbers. They are a valuable resource that we need within our departments as well as nurses.

The Chairperson: The Minister, in his statement last week, talked about advanced nurse practitioners and the appointment of two of them. I just want to clarify that you are indicating that the emergency nurse practitioner is different.

Ms Sheerin: Yes. The emergency nurse practitioner role and the advanced nurse practitioner role are two valuable but quite different roles. The advanced nurse practitioner will assess patients with more complex conditions that, traditionally, the doctors would see within the department. Examples are patients presenting with chest pain or respiratory illnesses. It is not that we do not have suitable courses in Northern Ireland. However, the training and education for the role of advanced nurse practitioner is at masters level and, unfortunately, we do not commission for masters level training courses in Northern Ireland.

Ms Smyth: Those two nurses are training in England. They have been on that programme for about a year.

Ms Sheerin: Eighteen months.

Ms Smyth: Eighteen months.

The Chairperson: It is stark to hear that that training is not even commissioned here.

In your paper, you talk about ratios in nursing care and say that, in hospitals where one nurse cares for six patients and over 60% of nurses have degrees, the risk of hospital deaths is 30% lower.

Ms Smyth: That is from research that has just been published. I may be getting older, but we live in a world where professional opinion in itself is perhaps not enough and people are asking where the evidence for it is. Thankfully, there is now emerging evidence, and lots of it, of the effects of nursing staffing levels and the outcomes for patients, which are the most important thing. The research that you are looking to was recently published in 'The Lancet'. It has been able to demonstrate quite clearly across several countries that, once you start to educate nurses to degree level — as you are aware, there has been a lot of controversy about that — the mortality rates of the patients who they care for drop. So, basically, what they are saying is that the more robust the academic preparation and practical preparation of nursing programmes, the better the outcomes for patients.

Mr Beggs: In your paper, you state that, at one accident and emergency unit, 21,000 patients of a total of 70,000 were treated by an emergency nurse practitioner, which is a quarter of the patients. Yet, there is a shortage of consultants, who are critical actors. Has there ever been a shortage of nurses willing to do this course and applying to take on the role? We are told that there is a shortage of consultants, yet a quarter of the patients can be treated by emergency nurse practitioners.

Ms Sheerin: I do not think that there are a lot of emergency nurses who aspire to be emergency nurse practitioners, but, again, it comes back to the commissioning of the courses. It is my belief that there is one health trust in Northern Ireland that is not commissioning the course this year. Much of the reason for that is that there is not the resource to allow the nurse to go out to train to be an emergency nurse practitioner. There is not that backfill to allow the nurses to go out to develop. There are lots of emergency nurses who are very capable and willing to take on these roles, but the availability of the course is being reduced.

Mr Beggs: Has there been a turnover of those who have been trained? We have been told that many emergency doctors have moved on elsewhere. What has been the experience of emergency nurse practitioners? Have they remained in Northern Ireland and treated patients here?

Mr Martin: They pretty much have stayed. The nursing workforce is much more stable and sustainable. The evidence that we presented in the paper demonstrates the potential and that, when they are given the opportunity and supported and where there is backfill, nursing staff will provide an absolutely excellent service that is worth investing in.

Mr McCarthy: Thanks very much for your presentation. What you have said to the Committee is horrendous, but it had to be said. We think we know what has been going on, and, Janice, in your presentation, you made no attempt to hide what is going on. We are very grateful to you for that. As the Chair said, everyone in this room has the utmost admiration for nurses. We see the work that nurses are asked to do and are doing. In some instances, they are burned out. If people are not listening to you, the representatives of nurses, I do not know where we are going to go from here. I do not know why you have not been invited here before now, but you are here and you have said your piece. Those listening have a duty to act on what you have said.

You talked about sending a letter to the executive director of nursing outlining the problems and not having a reply after three months. That is horrendous and unacceptable.

Ms Smyth: Yes. It was a letter to the director of Transforming Your Care. We are trying to give patients care closer to home, which we believe is the right thing to do when appropriate, but we need to have a workforce that is able to do that. Instead of seeing that workforce increase, we were watching it decrease. Our question was this: under Transforming Your Care, what resource will go in to support nursing to deliver care closer to a patient's home? We wanted an answer to that question but, as I said, we did not get an answer.

Mr McCarthy: You have not got an answer; that is absolutely shameful. We have been told over and over again, from day 1, that Transforming Your Care is not about saving money. John Compton told the Committee on more than one occasion that it is not about saving money. However, we are two years into the outworking of Transforming Your Care, and it seems to be getting worse and worse and worse. Would you support the slowing down of Transforming Your Care before it gets too far through and there is a crisis on top of a crisis?

Ms Smyth: If we knew what it was, what it meant and what it looked like, we would answer that question. Our problem is that we do not know what it is. We do not know what the model looks like or what direction it is being taken in.

What we do know is that we see things being presented as being innovative things that are happening in accordance with Transforming Your Care. We do not believe that. We believe that some of those things would have happened anyway. We see nurses and other health and social care professionals who are very creative, who are working closely with people and who know how to make the system and the service better. They innovate, they do it, and there is no doubt that that is transforming patients' care.

My concern is how we do the bigger-picture stuff with an ageing and larger population, more demand and, let us face it, less money. We live in the real world and, unless we cut the cake differently, there is no doubt that we are financially challenged. If that is the case, where is the bigger picture in the

model that is actually going to deliver that? If we do not know that, how have we costed it, and how do we know how much it will cost? Those are our concerns about Transforming Your Care. Nobody can tell us that.

Mr McCarthy: Finally, you used the words "seriously challenged".

Ms Smyth: I did.

Mr McCarthy: I think that you are being a bit modest. I think that you are at your wits' end. On almost a daily basis we see the care that patients are not getting. They should be getting that care, and would be getting it if you or your organisation had the means and the resources to provide it. That is what we are all about and what we all want.

Finally, I do not like the term "whistle-blowing", but in recent times good things have happened as the result of people going to their line manager. Are you happy and content? The Minister has always supported whistle-blowing, but so often we see people who want to do the right thing being penalised, punished and losing their jobs etc. Are you fully supportive of people coming forward and saying what is wrong in order to get it fixed?

Ms Smyth: We absolutely are. About three or four years ago, we issued guidance to every one of our members in Northern Ireland to help them to raise their concerns appropriately. We have a team of staff in Belfast who will speak to any of our members — indeed, I will do it myself, if they contact the college, to support them to speak up and do the right thing. The thing that we really need to remember is that registered nurses are obligated to do that. It is not optional for them; they are absolutely obligated to do it. So, we do that. Nationally, we have a whistle-blowing helpline as well. We absolutely agree that people should speak up.

However, I would say this to the Committee about raising concerns: consider the context in which health and social care professionals, including nurses, are working, and the caseloads in the community that are utterly impossible, and that they are raising their concerns every day. Many of those nurses do not have a mobile phone or access to a computer, and there are maybe 16 of them coming into an office to access information.

In all those wards in the hospitals where they have put in extra beds for patients, there are no privacy screens or call bells, the beds are blocking fire exits and there are not enough staff to look after the patients. We are also doing multiple transfers of patients during hospital admissions. Many of those patients are older and vulnerable people and, on some occasions, they are transferred from one hospital to another late at night, in the dark and in a cold ambulance. If those are not concerns, what are concerns? What message does that give to staff? Does it tell them that it is OK to do that? It is absolutely not OK to do that.

That is what nurses are concerned about. They say that the abnormal is becoming the normal and that people are getting desensitized to what is totally unacceptable. There are men in beds beside women on our wards.

Mr McCarthy: And in corridors —

Ms Smyth: Yes, and that is totally unacceptable.

Mr McCarthy: — for a week at a time. It is shocking.

Finally, where did the 40 nurses that the Minister promised us come from so quickly?

Ms Smyth: I am meeting the director of nursing in the Belfast Trust tomorrow about that. I am not sure that it is new money and it is 40 extra nurses; I am really not sure about that. What I do know is that those nursing teams in those clinical areas have been under pressure for a long time.

Whoever advised the Minister that it was a spike — I have had this conversation with the Department, and I do not know who did that — was wrong. It was not a spike. It was an increase in pressure, it was building and the nurses knew that from October last year. Some of those teams are staffed to about 50% to 60% if you are lucky, and the other 40% of the staff comes from the bank — anybody and everybody, daily, weekly or whatever. That is because, when somebody left, posts were frozen to

save money, and they are trying to fill them from the bank. I will check tomorrow, but I believe that what they may have done after the RQIA inspection — we were raising those things since last October, at least, with no success — is realised that they need to staff those teams properly and convert the money, because it was not saving money, that they were using on temporarily filling in these posts into a proper nursing team. That is what should have been done in the first place. However, I need to clarify that.

Mr McCarthy: Thank you very much.

Mr Martin: If you do not mind, I would like to add to that. As Janice said, there are still a lot of questions to be answered, but it shows that there has been a reaction to a crisis. It also shows how there have been failures in planning. We could ask whether that money would have been better invested in 40 community nurses to prevent patients coming to the emergency departments in the first place and to support patients when they come home from hospital.

On all those other things in terms of planning, and going back to the previous point as well, around commissioning, what we see is a failure in terms of planning. Unscheduled care is at least 80% predictable in terms of the times of day, the days of the week and the months of the year. If planning was what it should be, surely we should be able to match the workforce to meet the needs of the patients and the service in a way that prevents the emergence of the crisis that we have seen played out in recent months.

Ms Sheerin: I also want to come in on that. We need to note that every major emergency department in Northern Ireland is under pressure with regard to staffing. The members are definitely concerned about the lack of effective workforce planning.

Mr McKinney: Thank you very much. The Chair and other members have reflected on the fact that you were frank. I could describe it as blunt and direct, and I also thank you for that. We have a £4 billion-a-year life-and-death health service. Unless those at the front line are direct with the Committee, the Department and the Minister, I do not think that we will have change.

On the basis of some of your questions, I was going to ask whether you are being listened to. In your submission, you asked 22 questions and concluded with "Who is accountable?". Would I be right in describing that, in its totality, as an indictment of the present situation?

Ms Smyth: We believe that we know who is accountable. That was the purpose of outlining that in my verbal submission at the outset of this evidence session. If I am truthful, I am not sure that we hold people to account as we should do. I do not understand how we got to a position where the voices of professionals are not being heard, and support services have become the control mechanism for how we staff professional teams and deliver care to patients.

As a nurse, I am very clear about what I am responsible and accountable for. I am also very clear as the director of the organisation that I work for. That is why I had to come today to give that message. I believe that it is for others to look at their responsibilities and accountabilities and ask themselves who is accountable for getting us to where we are. I believe that the people who work in my organisation and the members that we work in partnership with, including our board, have done their bit to try to say to people, "This is not the way to do this. We need to take stock and do things differently around here", but, unfortunately, we have not had much success.

Mr McKinney: I will draw a straight line from your accountability questions to your concluding remarks, which were that whoever is responsible should now start to admit that there is a problem. In your view, at the highest strategic level, what is that problem?

Ms Smyth: I have had this conversation with many people. If I could have come here today with my colleagues and all the expertise that we have in our college, and that is a lot, and given you on two sides of an A4 paper how to fix this, I would have done that long ago. I feel duty bound to say that the Minister, the Chief Nursing Officer at the Department and, indeed, even the permanent secretary understand the problem, and there is an absolute will to support nurses and others to provide a quality standard of care to our patients. However, I said in the paper that nursing is not the solution on its own. We need to look at the executive director of nursing role, and we need to understand their professional obligations for standards of care and their regulatory obligations and duty of care to patients. That needs to be given the same weighting and credibility at a trust board as the requirement for financial break-even. The boards of all our organisations have obligations and

responsibilities, and I think that people need to review what those are. However, I think that it is for other people to do that; it is not the job of the college to hold people to account.

Mr McKinney: I assume that you have thought long and hard about this in your direct submission: two and a half years into a TYC process, you describe TYC as "a vision without action", and you do not know what it is, what it is meant to be and what direction it is going in. Specifically, as front line operators and you, as a union, monitoring this, are you witnessing any systems in place that measure any progressions in TYC?

Ms Smyth: I am not aware of them. We have taken lots of hospital beds out for older people. That, perhaps, was the right policy. It is not the best place to care for older people, and we accept that. Our problem is that we do not know what alternatives were put in place and what models of care are in the community to care for those people. In our opinion, that has resulted in those people getting care that is wholly inappropriate. In all the deliberations that we have had, it is our view that there should have been a model, and it should have been a strategically, regionally led model of what we were trying to achieve with Transforming Your Care, and the resources to deliver it should have been invested in that. Doing it the way that we are doing it with these little bits and pieces, I do not know what the money is being used for, and I said in the submission that £5·5 million of £6·7 million appears to be going to infrastructure costs to take people out of their jobs to develop implementation plans. What is all this about, and what difference is it making to the people?

Mr Martin: Just to come in on that, we see structures and groups who meet, but when you speak to front line staff, you may see some examples of small pilots or small pieces of work where, once again, there seems to be an idea that, on paper, might work, and there is a small bit of investment in it, but in terms of any outputs in relation to patients, we are hearing from our front line staff that they do not see anything actually happening on the ground.

Mr McKinney: Finally, if this was a widget factory, we might be able to sustain some of that, but, as I said at the outset, this is a life-and-death service, and when there are no measurements or systems in place, we have to ask questions.

The Chairperson: Absolutely.

Mr Dunne: Thanks very much for coming in today. We appreciate it. Can you clarify, first of all, Janice, how many staff you represent in Northern Ireland?

Ms Smyth: We have about 14,000 nurses in membership with the Royal College of Nursing in Northern Ireland.

Mr Dunne: Is that all grades of nurses?

Ms Smyth: Yes, all grades of registered nurses, and we have a small number of healthcare nursing support staff.

Mr Dunne: Is it true to say that we have had a significant increase in the total number of nurses across all grades in the last three years?

Ms Smyth: When you say "a significant increase", there has been a decrease in the number of nurses that we have trained over the last three years. We have decreased those numbers. If you look at the statistics —

Mr Dunne: Overall, though, in the grades, is it true to say that there have been 500 extra nursing places in the last three years?

Ms Smyth: I am not honestly sure that that is quite right. The only official statistics we have is the workforce census that the Department publishes, which is accurate. I am not calling into question in any way that it is not right, but I do not know that we have had an extra 500 nurses in three years. That may well be the case, but if it is the case, those are nurses who are being employed via the banks in our trusts and not nurses who are being employed on permanent contracts in nursing teams to create —

Mr Dunne: Is there not a spread, though, throughout the organisation of those nurses?

Ms Smyth: No. I would say that if you ask the trusts to produce for us the advertisements that they have placed in the past three years for registered nurses, you will find that each trust has probably placed one, if not two, advertisements in a year — but no more, I would suggest — for band 5 nurses, which is the lowest band of a registered nurse. The advertisement will say, "Permanent, temporary, full-time, part-time, all clinical areas, nurse bank". They set up these panels over days and interview all those people. They come in, and then most of them get a letter to say, "We do not have a permanent position for you but if you would like to work in our bank, we can give you a contract for the bank".

So, you have thousands of nurses registered —

Mr Dunne: So, a lot of these posts we are talking about could well be within the bank.

Ms Smyth: Yes.

Mr Martin: It depends on the point where you start measuring. There was a peak in 2009. From memory, there was a reduction of almost 3% in the overall workforce from 2009 to 2011. That rose again to figures that are basically the same as they were in 2009. So, yes, there may have been an increase from 2011, but there was a decrease between 2009 and 2011. It would be worth checking out those figures.

Mr Dunne: OK, thanks very much. One issue of great concern is lack of communication from people like yourselves and your staff through to senior management. How, as an organisation, do you communicate with senior management, and do you do that on a regular basis?

Ms Smyth: The Royal College of Nursing has a nurse leaders network. Every executive director of nursing in a trust is a member of that network, and we have very good working relationships with them. They are constructive, and sometimes we have quite healthy debates, but we have very good working relationships with them. The Chief Nursing Officer also attends that network. They recognise that there is a problem raising concerns. The network has asked that we lead a piece of work, which is being developed, to go out and engage with front line staff.

The Chief Nursing Officer herself met nurses from Northern Ireland at congress last year, just after she was appointed. She has met the emergency care network nurses on one or two occasions since, so it is not a matter of those people not engaging with us and engaging with nurses. The problem is the management structure that exists in our organisations, which was in my speaking notes, and how nurses can communicate from the bedside, wherever it is, whether in the community or in a hospital, right up to the executive director of nursing in a trust. That is far too convoluted and complex, and that is part of the communication problem.

If you are firefighting every day, there ain't much time to take time out to look at what you are doing and discuss whether there are alternative ways to do it. That is part of the problem as well. The system is under so much pressure that there is only time to look after patients and try to prevent harm from coming to them. There is not much time for anything else.

Mr Dunne: Have you as a union put forward ideas on improved communications?

Ms Smyth: Absolutely.

Mr Dunne: You have a lot of full-time people there who should be engaging.

Ms Smyth: We have four full-time employment relations officers in the Royal College of Nursing. Those four people are in our trusts and our independent sector facilities, and the employers also fund some of our full-time stewards to carry out a trade union role. They are all working flat out.

Mr Dunne: This thing that we hear about in the media, that senior management does not listen to the front line staff — is that true?

Ms Smyth: I believe absolutely that it is true. That is what our members tell us. I can only say to you that we have recently raised concerns and that it is on record. People can see that at will. I have to

ask the question of whether they are listening to us, and if they do not listen to us, what hope has the front line staff got?

Mr Dunne: OK. Thank you very much.

Mr Brady: Thank you for the presentation. You have rightly articulated a very bleak scenario. You have summed up Transforming Your Care very well — "vision without action". There were 99 recommendations made, which probably seemed like a good idea at the time. However, they are aspirational. You cannot develop those recommendations. You have mentioned that community services are not developed, so you do not have the infrastructure to take over from the acute end. You have talked about a disconnect with management; and how there is no openness or transparency.

You have also talked about the trust boards abdicating responsibility and accountability in that sense. Do you feel that that is endemic to all the trusts? You mentioned the emergency services departments right across the North. I am familiar with Daisy Hill, and I know that it is under tremendous pressure. We saw in the Royal on Monday that it just seems to be a continuous problem. However, I do not understand how you can have a health system that absolutely ignores front line staff and professionals who are working flat out to try to maintain a service that is really crumbling around them. I do not want to be too prescriptive, but that seems to be the case that you rightly present.

Ms Smyth: I do not think that we are in a position today to give a report, trust by trust, of how we think that they are doing. I do not think that that is what you are asking us to do. What I will say is that we know that there are areas of good practice in every trust. Some appear to be managing better than others, but what we fail to do is look at areas of practice, in whatever trust, that appear to work and, as a commissioner, look at those closely and see whether they can be replicated across Northern Ireland. If it works in one place, why do we not apply it to somewhere else? Whilst the presentation today might have been bleak, let me say that there are areas of excellent practice in Northern Ireland, and some trusts deliver excellent services to patients. It is not all bad. However, I cannot absolve myself of the responsibility of portraying to you how concerned nurses are about the system that they are trying to operate in.

Mr Brady: I think that there is an acceptance that we have excellent professionals. You said that the Minister is supportive. I put a question mark after that, because where does the buck ultimately stop? You can be supportive, but you are trying to implement an aspirational system. We fell at the first hurdle with residentials, and since that it has degenerated, for want of a better word. Ultimately, people are suffering. One of the other things you said is that it should be people before numbers, but it seems that numbers and targets — and the Chair mentioned targets earlier — are paramount, without the patient being the priority and at the forefront of everything that you do, which I know they are, but you are being let down. It seems to me that you are not getting support and recognition. If there is a disconnect between you and the management, it is a serious problem because obviously you are not being listened to. That needs to be addressed. It is a responsibility for us here as a Health Committee to try to do something to rectify that situation. It is incumbent upon us to do that, otherwise we should not be here. It is as simple as that. Thank you very much. It is not all depressing, I am sure.

Ms Smyth: No.

Mr Brady: We live in hope.

The Chairperson: Are you finished, Mickey?

Mr Brady: Yes.

The Chairperson: Sam.

Mr Gardiner: Thank you, Madam Chair; at last.

The Chairperson: Apologies.

Mr Gardiner: Thank you very much for your presentation, but I wish that you had not had to make it to us, to be honest.

Ms Smyth: So do we.

Mr Gardiner: I feel gutted that you have had to come through this. I hope that this Committee, as the Health Committee, has the common sense to write to the Minister to express its concerns about what is going on and to ask for a full investigation. It is not good, and it is not healthy. We want the best for our community. I appreciate you coming and being so frank with us. It is welcoming. It is not good news, but it is up to us to see that it is sorted out. Thank you very much indeed. I hope that that is followed through.

The Chairperson: Thank you for that, Sam.

Mr Wells: In his statement, the Minister said that there were significantly more nurses practising in Northern Ireland now than when he came to his post in May 2011. He did not differentiate between bank nurses and full-time, long-term contract nurses. Do you accept that it is the case that there are significantly more nurses now than there were in May 2011?

Ms Smyth: If the Minister said that, I do accept it, because I have never known the Minister to say something that was not truthful. However, Jim, the issue for us is that the front line does not feel it, because of the way in which they are being employed and deployed. That is probably the issue.

Mr Wells: You also seem to indicate that you feel a bank nurse is of less value than a full-time permanent nurse, but most of the bank nurses, at one stage, were, or maybe still are, permanently employed. A lot of bank nurses are people who work in hospitals and then put themselves down for bank nursing to supplement their income. Most of the bank nurses would be well known to you; indeed, many of them are your members.

Ms Smyth: Two thirds of the nurses employed in banks in our trusts are actually the trusts' own employees. The reason why they are employed in the bank, predominantly, is that when Agenda for Change was implemented, nurses, for the first time, were entitled to be paid overtime. They were not entitled to that before. So, if a nurse works 37·5 hours, which is full time, they are entitled to overtime once they work over those hours. If a nurse wants to do an extra shift in our trusts, they have to do it through the bank, and they get paid a flat rate and not overtime.

Mr Wells: Yes, but therefore this is Nurse Jones who is working at hospital X, Monday to Friday, and then puts her name down — or his, although they are mostly her, of course — down for a Saturday shift. That is a very experienced and capable nurse simply doing extra hours. So, they are not inferior staff.

Ms Smyth: If they are working in their own team, that is absolutely no problem, although I do not see why sisters should have to go through a bureaucratic process to get Janice to work an extra hour on Saturday, just because they have to do it through a nurse bank, and all of that nonsense that goes on. The problem with that is that people assume that a registered nurse is an all-singing, all-dancing registered nurse. A registered nurse who works in theatres has very different skills and attributes from someone who works in a care-for-the-elderly setting or in an emergency department. The problem is that when you go to the bank to look for a nurse, you get a registered nurse, and the emergency nurses, in particular, complain that many of the nurses who come to fill the gaps are people who have never been in an emergency department before, let alone nurses who have the skills and attributes to function properly as an emergency care nurse.

Finally, the RQIA inspection report is not published yet, but my understanding is that it will allude to nurses working in an emergency department above their competency level. That is very concerning. It is not a safe way to staff clinical areas, unless you can assure yourself that you are getting a nurse with the experience, skills and attributes to work in the medical ward, the psychiatric unit or the theatres.

Mr Wells: Surely, the simple solution to that is that, when the request goes in, you say "We want a nurse with that experience".

Ms Smyth: They are not there. Remember, you are not obligated to do your shift in the bank. When you get a phone call to ask you to come to work, you have no obligation whatsoever to come. They struggle to fill those shifts, and many go unfilled.

Mr Wells: I have been on this Committee for five years — for my sins, I think. I was here at the very start and the whole way through the TYC process. I have to say that, in the early stages, I detected a much more positive approach to TYC from you.

Ms Smyth: Absolutely.

Mr Wells: You and I have spent many hours together at various meetings. You have never been shy or retiring about putting your views forward. That is about the one thing on which we could all agree. Three or four years later, you seem to have had a shift of emphasis on TYC.

Ms Smyth: Absolutely. That is because I saw the vision. We, the members, considered everything carefully and wrote a robust response to the consultation. We were supportive of that policy. However, we do not see the outworkings; we do not see the services in the community for our people. We see our emergency departments backed up with people who, frankly, should not be there and who should have services elsewhere and be able to access services via another route. We do not see any transformation taking place.

Mr Wells: Do you accept that it is inevitable that when you have such a sea change in health and social care provision, and you move from the old model to the new one, the interim period is bound to have technical and teething difficulties? Do you accept that it is such a major shift that problems are bound to occur?

Ms Smyth: Absolutely. We would not dispute that. However, we do not believe that that is what we are seeing. We believe that we are seeing a policy and a vision, but we do not see the action to support them, for whatever reason. We believe that it is because there is no strategic direction or the model was never properly agreed. How do you deliver something when you do not really know what it looks, smells and feels like?

Mr Wells: Do you also accept that within days of your making those views public, the Minister faced your members at quite a heated meeting?

Ms Smyth: As I said earlier, and it is something that the college is very careful about, it is a matter of record that Edwin Poots has been absolutely supportive of the Royal College of Nursing and its members. He has been accessible more than anyone else. That is not an issue for the college. It is not a reflection of his relationship with or commitment to do the right thing for nurses and patients.

Mr Wells: I appreciate your putting that on the record. I have spoken to him since that meeting. Like today, he did not walk out trying to catch the nuances of what you were trying to say. It was a difficult meeting for him.

Ms Smyth: It was.

Mr Wells: He heard a lot of articulate and forceful people give their point of view.

Ms Smyth: Absolutely.

Mr Wells: Since that meeting, have you had any contact to find out what he is doing to take account of your views and to try to improve things?

Ms Smyth: Yes. We noted his recent statement to the Assembly. People will be aware that a summit is being facilitated and chaired by the College of Emergency Medicine —

Mr Wells: I am attending it.

Ms Smyth: On 9 April. We will be there as well. I believe that the Minister is monitoring progress to ensure that that work is taken forward. I should say that the Chief Nursing Officer has worked with the emergency care network. It will lead work on her behalf with the Northern Ireland Practice and Education Council for Nursing and Midwifery to look at a framework for nursing in the emergency services. So, as I said earlier, there are people who are truly trying to do the right thing. However, it will take strong leadership and a steady hand, first of all, to say that we have a problem — I think that

people have done that now — and what actions we will take and with whom we need to engage to put it right.

Mr Beggs: One issue that you have raised on a number of occasions is that management has not been listening to front line staff. You also said that you have raised your concerns in writing. What has been the response to the issues that you put in writing to management?

Ms Smyth: As I said earlier, I think that you are referring to the department in Belfast in particular; it is a matter of record that we said that. I am not sure that we got that right. We started to raise concerns at the end of October. For whatever reason, we did not succeed in conveying the seriousness of the situation. We had the major incident called in January, I think. So, tomorrow, the director of nursing and I will sit down to look at it and reflect on why, when the Royal College of Nursing raised those concerns, we were not able to achieve the additional staffing for our members to support them to deliver care to patients. Why did it take an RQIA inspection to do that? I want to have that conversation with her, and she has agreed. We will have discussions tomorrow. I would not like to make assumptions about why, when we raised those concerns, we believe that our voice was not heard or that it was heard and ignored.

Mr Beggs: I will leave that. You seem to be content with the method by which you intend to take it forward.

In paragraph 17 of your paper you mention the current generic recruitment of band-5 nurses to the pathway in emergency care nursing. What alternative mechanisms may be used elsewhere? Why is that a problem?

Ms Smyth: You are referring to the current generic recruitment of band-5 nurses to career pathways in emergency care nursing. That goes back to the discussion that we had when I responded to Jim. At present, when they advertise for nurses, they just advertise for nurses. As I have said before, some nurses have the personality, skills and attributes to care for older people or to work in very fast-moving theatres, where, most of the time, patients are not awake, or to work in outpatient departments and deliver services there, or to work in emergency departments or general wards. However, nurses have aspirations for their careers. The way in which they are recruited denies them the opportunity to see where they believe they could best contribute.

There are nurses who would like to work in emergency departments. Nurses are deployed in emergency departments on temporary contracts through the bank; then a permanent contract comes up and they are on a waiting list. Would you like to say where the last permanent post came up, Linsey?

Ms Sheerin: It was in surgery.

Ms Smyth: It was in the surgical ward. The next thing we know is that the nurse who has been in the emergency department for two years, is trained up and has skills and attributes, gets a permanent post. Who would turn it down? So they are off to the surgical ward. The next thing is that somebody else is pulled from the bank into the emergency department and we start all over again. Meanwhile, there are people in the emergency department who want permanent posts somewhere else but cannot get them and are stuck there. It is all about numbers — as it is with patients. It is not about people; it is not about their career aspirations.

Please do not misunderstand us: the Royal College of Nursing is very aware that the health service is not here to give people careers or to meet their aspirations. However, I believe that you can do both. There is now very good research from the King's Fund Point of Care Foundation that shows why staff matter. If you look after and value staff, patient care is better. There is research to prove that.

Mr Beggs: You say in your paper that there is emerging evidence of difficulty in filling posts in some of the medical admission units and emergency departments.

Ms Smyth: There is. That is quite correct.

Mr Beggs: How big is that difficulty?

Ms Smyth: If you were a young nurse or doctor today, would you rush to work in those clinical areas under that pressure? We need to be very careful when we do that to nurses and other health visitors and care professionals that we do not make environments totally unappealing and, indeed, so stressful that they say, "Do you know what? I do not want to go there." That is what is happening with some of the bank nurses. When they get a phone call and are told that there is a bank shift for them, they ask where it is and say, "Do you know what? I do not think I will take it."

Mr Beggs: You say that in emergency units, 50% to 60% of nurses may be full time and the rest bank nurses.

Ms Smyth: Yes. In some teams they range from 60% or 70% of capacity, and the other 30% is made up of temporary staff from banks or agencies.

Mr Beggs: Your paper also says that the system should try to avoid staff burn-out. Are you receiving evidence of staff burn-out from your members who work in emergency departments?

Ms Smyth: Garret will answer that because he does our employment-relations work, although there is certainly evidence of it.

Mr Martin: We have had members come to us in a distressed state and others who have gone off on work-related stress. It is reported that sickness absence levels are increasing as a result of pressure. Janice mentioned the King's Fund and Jocelyn Cornwell from the Point of Care Foundation and her research about investing in staff, staff engagement and how that transfers to compassionate care being delivered, and we are seeing that as well.

The Chairperson: The summit has been announced, and we recognise that a whole-system approach is needed. From my point of view — I think that it is shared with Committee members — it is clear that part of the failing in Transforming Your Care is that there is absolutely no outcome framework attached to it, and you mentioned that yourself. There is nothing that gives any of us confidence that the shift left will have x, y and z outcomes. That is a challenge. However, if, as a result of the summit, you could request specifics, what would they be?

Ms Smyth: The emergency care nurses here will speak for themselves and perhaps even the community nurse. However, following the emergency care summit, there needs to be recognition that just looking at emergency care and putting extra doctors and nurses in is not the answer. We need to stop moving to solutions before we have done proper diagnostics about what the problems are. That is the reason for the 22 questions; I did not realise that there were 22 questions in that paper. I hope that, as a result of the summit, there will be collaboration and that the Royal College of Nursing will be included in it. We could get round the table and look at what we know about the people who are coming to our emergency departments, and, if that is what we know about them, what are the other services that we could put in place that would care for them without their having to come there, and to return emergency departments to the purposes for which they are meant: to care for people in emergencies.

The Chairperson: It is a regional review of what exists, where the gaps are, where the gaps can be plugged, the infrastructure needs and then, I suppose, the type of nurses — bearing in mind that it is not only nurses — that are required.

Ms Smyth: You cannot plan a workforce until you know the services that you want to deliver with it. Since her appointment, the Chief Nursing Officer, under the instruction of the Minister, has set up proper workforce planning groups for nursing. Those are moving at quite a pace, and we are involved in all of that. We had no workforce planning for three to four years for any profession, not just nursing. The Minister has that under way now. However, we need to know the models that we want to deliver and, if those are the models, what kind of healthcare professionals we need to deliver them.

Mr McKinney: This is not a question but just something to be left hanging. Does that, in our minds, amount to a review of Transforming Your Care? I do not need an answer.

The Chairperson: We will need to reflect on that. Thank you all very much. It has been very useful. Unfortunately, it is maybe not something that is new to us, but we appreciate your honesty and frankness. We will take on board and reflect on the information that you have provided.