Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Antrim Area Hospital: Accident and Emergency Reports

30 May 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Kieran McCarthy

Witnesses:

Dr Andrew McCormick	Department of Health, Social Services and Public Safety
Mr John Compton	Health and Social Care Board
Ms Mary Hinds	Health and Social Care Board
Mr Sean Donaghy	Northern Health and Social Care Trust

The Chairperson: OK. Apologies for keeping you. Mr Donaghy was here, and he never stops talking. I tried to push him on.

Members, we are going to have an evidence session on the A&E reports on Antrim Area Hospital. I refer members to the reports from Dr Ian Rutter and Dr — I nearly elevated you, Mary — Ms Mary Hinds. I advise officials that I was briefed on the reports by the board and the Department last Wednesday. Members will know that the reports were leaked to the media early last week, before they were made public by the Northern Trust last Thursday. Given the public concern about the A&E and the stuff that was leaked to the media, it was decided that the Committee needed to have an urgent session on this. That is why the officials have been asked to come here today. I want to thank them for facilitating that. Members were e-mailed a copy of the report last week. I will hand straight over to you, Andrew, to lead off the presentation, and then we will open it up for questions or comments. For the record, thanks very much for last week's briefing and for coming here today.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety): Thanks, Chair. As always, we want to make sure that we help the Committee in every way we can in the context of the difficult and challenging work at present. What I want to do, in setting the scene, is to give a little bit of context around the nature of the work that was going on and then to let the questioning draw out your concerns arising from what has been reported.

I think the starting point has to be the fact that we are seeking to secure significant improvement in emergency department performance, so that patients have the best possible service, high-quality care and a good experience. All those things are fundamental, and we have been working on them for some years. It has had its ups and downs, to be honest, and I have told the Committee before that we

are not satisfied and have not been satisfied with the standards for quite some time in many ways, but the question is how to make sustainable, lasting improving in a challenging context. It is very important that we move on in a way that secures the full engagement and leadership of all the teams in the service to secure as positive a way forward as possible.

That will happen when people feel that there is a recognition that they are trying to do the right things. It is not always easy, and there are lots of complications in all these things. The two pieces of work, as I am sure was explained last week, were commissioned with the Department's knowledge and awareness. Fundamentally, we were seeing from about last autumn that there were concerns arising about performance issues.

The Health Care Services Board (HSCB) has a statutory responsibility for performance management as well as commissioning. Performance management is, in some sense, part of the commissioning function. Commissioning is about ensuring that the public get the services they need. So, it is planning, procuring and securing those services and always ensuring that they are of the highest possible quality and that standards are being met.

The Minister and Department set the targets and standards that need to be achieved. It is then for the board to lead in the relationship with the provider side. So, it was a perfectly normal and orthodox part of the board's role, when it identified a concern, to ask what could be done and what the underlying issues were. There is an element there of understanding what underlies a concern. It is important never to rush to reaction or to judge too quickly what to do. I think the board did exactly the right thing in securing expert input and advice to help it to judge, as the commissioner, what should happen.

So, it drew on expertise from Ian Rutter, as a GP, given that there was a manifestation of an issue between the GPs and the trust about the point of entry and the access of patients to hospital services through A&E. A concern was identified, the board wanted to understand more fully what was going on, and Ian was the ideal expert to come in and help with that piece of work in order to understand better how to move forward.

Similarly, when the wider issues arose in January about the difficulties facing Antrim Area Hospital A&E, Mary Hinds was commissioned to see how to secure service improvement. We have always taken the view that improvement is secured by the application of good practice. In a complex world of health and social care, that requires understanding of how different parts of the service work together. The issues in and around emergency departments are by no means solely related to the staff who work there. These are whole-system issues, and one reason we have integrated trusts is because that should allow us to work in a way that is seamless, is patient-centred and allows the whole system to function effectively and secure timely and effective high-quality care.

Given that there was an issue through January, the board, again with my knowledge and the Minister's knowledge, commissioned further work to investigate, understand and then secure the dissemination and application of good practice. That is absolutely part of the board's job. It was doing that conscientiously and effectively because we are all trying to secure improvement in a way that is reinforcing of good practice. In a context where there are difficulties, and there have been difficulties in a number of contexts, as we are all well aware, it is very important that we have the right learning environment.

If the environment is too reactionary and punitive, that will not produce right outcomes or serve the public interest. We need to find the right balance. As I said before to the Committee, there has to be accountability. In the end, I am personally accountable. The buck stops with me, and that is the way it stands. We have a system whereby the board and the trusts have clear functions and I am accountable to the Minister for overseeing all that. Ensuring that we work mainly by reinforcing good behaviour and practice, and ensuring that that is known and understood, is the best way forward. I am against a culture that is too punitive. I am also against what is described as a no-blame culture. My phrase is that you have to have a culture of fair accountability, where, based on evidence and on knowing what is really going on, there can be the right judgements as to how to move forward. That does involve holding to account, but it also involves reinforcing and sustaining good practice. Finding the balance is not easy, and that is something that we are asking the system to do all the time — to balance a lot of complex risks and manage those risks. That is what this work has been all about.

Yes, there are issues of concern. I think that everyone in the board, the agency, and the trust is well aware of the concerns and is committed to securing better outcomes, and good progress is being made. There are significant long-term issues that need to be addressed and resolved, but the Minister has undertaken to secure sustained and sustainable improvement in emergency department

performance across the whole of Northern Ireland. The stated objective is to secure no 12-hour breaches by the end of June. That is a challenging target, but it is one that the system is working very hard to rise to. It requires consistent application of good practice, and that is what we are all trying to do. This work shows that there are particular difficulties, and it is important that the action plan that is being developed is pursued. That is all normal, orthodox business. It is part of the fundamental roles of the board as the commissioning organisation and the trust as the providing organisation. Drawing on the expertise from Ian Rutter and Mary has been essential to move that forward.

That is the context that we have been working in. I believe that there is a positive way forward here, and we need to engage on it. The organisations were set up to fulfil those responsibilities. There was a clear, open process. Those reports were heading for public board meetings at the trust last week and the board this week. Again, congratulations to Seanin on having them. Well done to her as a journalist, but we have to fulfil our responsibilities and make sure that we do the job as well as we can. At times, complex organisations like our service need time and space to work. Certain things cannot go public immediately. Any organisation needs some time and space to think through the issues and work those things through. That is just the way it is. What we are clear on is that there is public accountability in everything that we do, so nothing is being hidden. There is no surprise in that sense. I do not think it was necessarily helpful to have a prior disclosure, but we know that it happens, and our job is then to give an account to you. We are very clear on our willingness to do that and to work with the Minister on securing improvement, which is what it is really all about. That is all that I wanted to say by way of scene-setting. I hope that it was of some help.

The Chairperson: OK, Andrew, thank you. Unfortunately, every time there is a health story in the media, it is a bad health story.

Dr McCormick: We do our best.

The Chairperson: I appreciate that there is a balance there. There is an issue out there with trying to convince people that our health service is second to none, and it is a daily job to do that, which everybody needs to take responsibility for. Specifically on the report, I know that other members have questions, because I was able to tease out some of the issues last week. The reports were finalised in March, and there were a number of recommendations in both reports. You are talking about settling down, getting space and moving on. There were problems there, and we need to do it. I assume, as you were talking about the internal workings of organisations, that the signing off of the report in March 2012 was not the first time that you had an idea of what was in it, so there was space there in the organisation to try to implement some of the recommendations. Are we going to be looking at those recommendations not being implemented? Give us a timeline of where we are sitting on the recommendations.

Mr John Compton (Health and Social Care Board): First of all, it was a shared piece of work between the trust and us as the commissioning organisation. Throughout the development of the report, we shared the information as it came. We got the reports and finalised them, and they went to our respective boards confidentially, which is the normal course, in April, and they will be in the public arena in May. That is the normal view. Alongside that, there will be an action plan, and it is fair to say that there has been progress on the action plan. It is not a sequential thing where you are just waiting all the time to do things.

We have now received an action plan from the trust that we are content with, and we will continue to work with the trust on that. Action is currently being taken, and we will review that as part of the normal business between ourselves as a performance organisation and the trust as a providing organisation and say something in the public arena probably within three months or so on the achievement of where that action plan is. That is the normal process by which that would be handled. Therefore, it was not as if we did something and waited until the very end, and there was a big surprise. This was running through. For example, when Mary was there for the seven-week period, she had regular and recurrent meetings with Sean and his colleagues. She shared with them her views and the work that she was finding when she was there.

The Chairperson: It might be useful if we can get sight of the action plan or a regular update on it.

Mr Wells: As you know, the reason that the Committee was aware of Rutter and Hinds was that a member of staff from the Northern Trust approached me three weeks ago. That was the first time that the Committee had ever heard of either report. I thought to myself that Rutter was such an unusual name that I would have remembered it if I had heard it mentioned. We wrote to the Department, and

the response came back to say that the reason why the Committee was not informed was an administrative matter between the board and the trust and that, therefore, we would not be required.

Having seen Mary's report and the Rutter report, it is quite clear that this is way beyond what could be perceived as merely being an administrative thing between the two organisations. Surely, the Committee should have been aware of both reports at a very early stage, given the import of what they both produced.

Dr McCormick: I emphasise that part of the work was knowing that there was an issue and getting below the first presentation of that issue to understand what is going on. Therefore, there was an investigative phase to both pieces of work. Until that was advanced, nobody knew exactly what the scale of the issues would be, what was right to surface and what was right to deal with. That is part of any complex organisation working with another organisation. That, to me, is totally understandable.

Maybe there was a point when we could have said to the Committee that something was going on, and I acknowledge that that was a possible judgement that we could have formed. With hindsight, that is clearer, but this was part of the board's performance management function in seeking to secure service improvement and doing what is an ordinary organisational job. I do not disagree that the content and nature of what has emerged in the reports is challenging, but that is the nature of the services that we are dealing with. I just want to make those points in response to what you have said. John may want to add to that.

Mr Compton: The first thing is that there was no intent not to be completely open about the whole thing. Normally what happens with the board is that we deal with each of the organisations on a performance management arrangement on a regular and recurrent basis across a whole range of issues. From time to time, we have particular and special arrangements with organisations over a whole range of matters. That, sometimes, leads us to asking people who have some expertise to assist us in understanding what the issue is. We normally share that information prudently and sensibly with colleagues in the Department, but it is primarily the ordinariness of the business between the board and the trust. As that emerges and evolves, sometimes, as Andrew has said, you can say with hindsight that we should have said something a little ahead of time, but we were talking about it at board level, and it was due to come to our public board meeting. There was never any issue about it not coming to the public board meeting. At any point in time, we are dealing with organisations, not quite in the same way as this report suggests, but on a range of issues around performance. Those issues can go to a variety of places. Sometimes, it is only at the end of the process that you realise that something needs wider circulation. At no point was there any desire to do anything other than have this in the public arena in a proper and orderly way, which is what we had planned to do.

Mr Wells: At this stage, you brought in over 1,000 people who waited 12 hours. No matter what way you interpreted those statistics, it was highly unlikely that Mary's report and Dr Rutter's report were going to come back with a glowing, ringing endorsement of the Northern Trust. Clearly, you had identified it and quite rightly brought in two experts to deal with the situation.

I am getting rather fed up with Seanin Graham driving the agenda of healthcare in Northern Ireland. Indeed, the only week when there is not a leak is the week she is on holiday. The 'Irish News' cannot be allowed to drive what happens with health service provision in Northern Ireland. Had I not had that one contact, I and the entire Committee would have been totally unaware of the existence of either report until Ms Graham splashed it across the front page of the 'Irish News', which she was perfectly entitled to do.

Indeed, at one stage, the breaches of the 12-hour rule were running at 14·6%. That must have set alarm bells ringing. What subsequently happened was the right thing, so I am not making a big deal out of it. However, I have to ask, and I hate doing so, whether there are any other experts investigating similar situations in other hospitals in Northern Ireland. If so, should we know about them?

Mr Compton: Not at this time, no.

Dr McCormick: As John said, there will always be a periodic need to have external reviews of one sort or another. The normal process of open disclosure about that will take its course. That is part of how we have to work.

On the scale of the problem, of course there is regular reporting of the numbers in the performance measures. So, the number of 12-hour breaches and the performance against the four-hour target have been regularly reported on and the results are always in the public domain. That was not a new issue. There is a regular pattern of accountability meetings that allow performance to be discussed between Department and board at the top level, between the Department and the trusts and between the board and the trusts.

The question really is: was there sufficient action being taken to get to the heart of those issues across Northern Ireland and secure improvement? That is where the Minister's intervention in his Mossley Mill speech has set us a new strength of commitment which unifies political will, managerial will and clinical leadership to secure that improvement. That is the new commitment, and we are all marching to that very strong drumbeat. It is important that we are doing that and securing improvement, but the fact of there being a significant number of breaches was well known and not hidden at any stage.

Mr Wells: To compare two hospitals with almost identical throughput in Northern Ireland, Antrim Area Hospital in 2011-12 had 71,175 patients and Craigavon Area Hospital had 71,667. During a five-month period, Antrim had a cumulative 1,346 patients who waited over 12 hours. In contrast, Craigavon had a maximum of nine: I am saying "nine" because that is split between Daisy Hill and Craigavon, so it may be less than nine. So, you had two almost identical hospitals, one of which had few, if any, patients waiting more than 12 hours, and another in which, by the time the investigations were mounted, the situation was rapidly running out of control. Why is there such a distinction between the two hospitals? Can the Northern Trust learn anything from a hospital of a similar size that seems to have got its act together on the issue?

Ms Mary Hinds (Health and Social Care Board): This is a very complex issue. People look at patients who are delayed in the emergency department and sometimes say that it is an emergency department issue. It is not: it is a whole systems issue. Those trusts that have been more successful than others, including the Northern Trust, have managed to combine the efforts of appropriate prevention of attendance at A&E, appropriate management of the A&E department and getting their patients through their hospital with no delay. Every day in a hospital you require a prescription of acute care, and if you do not require acute care you are somewhere else. They manage their discharges very well. Hospital and community are completely integrated and work hand in hand. That has been the challenge, in part, for the Northern Trust. There are areas of absolute excellence in the hospital and the community side. One of the key challenges for the trust is to bring the two together.

Mr Wells: There are 25 miles of road between Antrim Area Hospital and Craigavon Area Hospital. Is it beyond the realms of possibility that staff in Antrim could drive down to Craigavon to see and learn from best practice? Is that too revolutionary?

Mr Sean Donaghy (Northern Health and Social Care Trust): We have driven down the road to colleagues in the Southern Trust and spent time working with the teams who are responsible for the management of the admission process, the management of patients flowing through the hospital and the management of the discharge process into the community, and we have learned some lessons from there that we are using in Antrim hospital. We are also speaking with colleagues in the Western Trust who have had considerable success. The picture for Northern Ireland is that the Southern and Western Trusts are distinguished. It is clear that we have much improvement to manage elsewhere. We are committed to managing that improvement, and we are very, very disappointed when patients experience what happened, particularly in those first two weeks in January that you highlighted. I assure the Committee that we are very open to hearing of practice that works better elsewhere and to ensuring that we apply that in the Northern Trust, and have been doing so over the past four or five months. That, in part, has led us to secure improvement. We are not where we wish to be yet. We need to get to the point where — as the Minister made very clear — no one has to suffer the indignity of waiting in an accident and emergency department for an extended period of time for admission. However, it is a very different picture now to the one that this report chronicles.

Mr Wells: There is also a view that Antrim Area Hospital is having trouble attracting staff and that there may be some requirement for locum cover. That is a bit worrying, given the fact that Antrim is well within the greater Belfast area for attracting staff. You would expect that to happen somewhere out west, rather than in the greater Belfast area. Is that still the case?

Mr Donaghy: It is important to place that in context as well. There is a UK national shortage of senior middle grade staff in particular, that is those who support the consultant rota in accident and

emergency, and that is a UK-wide difficulty. I am not sure why fewer doctors across the UK are choosing to work in emergency departments, although one might begin to conjecture why that would be so.

Mr Wells: I have a fair idea.

Mr Donaghy: Yes, there are shortages at Antrim, and Antrim is not alone in that regard. There are very few emergency departments across Northern Ireland with a full complement of those staff. Certainly in Antrim, and even more particularly in the Causeway, we have had to rely on other than the usual training-grade staff rotating routinely through the hospital, because Northern Ireland, like the rest of the UK, has shortages of such staff.

Mr Wells: I inquired about that on a recent visit to Daisy Hill Hospital. It had three jobs for consultants in the paper, and it had absolutely no difficulty filling them with people from Northern Ireland or the Republic. It seems that, even though Daisy Hill Hospital is much more out of the way, as it were, compared to Antrim — the hospital does not see it that way, but I think consultants do — it has found it relatively easy to get staff.

Indeed, I was in Craigavon on a visit about a month ago and, equally, it was quite happy with the responses and the quality of what it was getting. I am going to ask questions later about the whole issue of whistle-blowing and people feeling free to speak out. Is there something about the culture in Antrim that is discouraging quality staff from applying for positions? You would think that it would apply equally to hospitals in more extreme areas of the Province.

Mr Donaghy: The comments that I just made were in relation to emergency department staff. Antrim has been recruiting staff — medical, nursing and a wide range of other staff — and we are very happy with the calibre and capacity of the individuals that have been appointed. Most recently, that has included 40 additional permanent nurses and several consultant medical staff. However, there are enduring problems with emergency department staff across Northern Ireland. We have seen instances of staff moving from one location to another where, perhaps, it was closer to home or they were at the start of their career. However, we do not have enough of those trained staff to fill all the positions in Northern Ireland. That is a clear fact just now, and I was commenting on that in particular. I am happy to give the Committee separate details of the success in Antrim and Causeway, with the recruitment of medical, nursing and allied health professionals in a wide range of areas.

Mr Wells: Perhaps one of the most worrying aspects of the reports was the issue of the culture in A&E in that people felt extremely reluctant to come forward. I found out about the situation because someone approached me. He or she was terrorised and felt unable to come forward and alert senior management to issues that he or she felt were very much below standard. There should be stats on this, because, presumably, if people have invoked the whistle-blowing policies, records will be kept of who raised what. Is there any evidence that staff in the Northern Trust are much less willing to use the formal whistle-blowing processes than staff in other trusts?

Mr Donaghy: Not that I am aware of. Particularly in light of what was reported recently, we looked carefully at staff having recourse to whistle-blowing. We are confident that staff do use the whistle-blowing process and are comfortable with, and confident in, that. It is a small number of staff in all trusts across Northern Ireland who tend to use those kinds of processes, but they use them in the Northern area and do not point any particular finger at our whole unscheduled care process. I want to emphasise that this is about the whole of unscheduled care. Building on Mary Hinds's points, I should say that it is not about the emergency department per se, and it would be wrong to characterise it as such. We all owe our emergency departments a tribute for carrying the burden that they do, but they do so on behalf of our health and social care system. If people fail to go out the back door, there are queues at the front door. That is the core point.

Having covered this subject previously, members will know that we have well-developed channels through which staff can express concerns. Our staff side colleagues are very accessible to us. I consulted them on whether there was anything that we should be aware of, any clusters that we should be identifying, anything that they were a bit worried about and whether people were afraid to come forward. Nothing recorded in our whistle-blowing incidences shows any systematic and clear trends that point us to any given area. We have carefully reviewed all of those channels. Very recently, in a personal letter to all staff, I reminded them of those channels. I told them that, if they cannot use any of those channels and are genuinely worried, they can ring me personally. I will talk to anyone who feels that he or she is facing the sort of treatment you described because it is absolutely intolerable and will not be accepted.

Having said that, I point out that Mary Hinds's report referred to a sense of disempowerment in some people with whom she had contact when she was with us for several weeks. There was also reference to some frustration. In the Northern Trust, there had been concerns for many years about whether we had enough nurses working in Antrim Area Hospital. In the past two to three years, we have been able to increase the level of nurse staffing available at ward level. Initially, that was done through bank staff, agency staff, and so on. More recently, it has been through permanent staff coming into post progressively from February. I mentioned the 40 additional nurses employed.

At times, there will be a sense of frustration if your daily job feels as though it challenges you heavily. It does for many staff in health and social care, and that was particularly the case at Antrim. I hope that the investments that we are making, with the support of colleagues in the board, are beginning to tell and will address that. I acknowledge that, at times, there is a sense of disempowerment and frustration, particularly given the legacy. I hope that, over time, we will be able to demonstrate a lessening of that sense. None of the reports mention bullying and harassment, and I can find no evidence to support the notion of a broader, more threatening atmosphere. We will keep our minds open to that and do not suggest that it does not exist. We are highly vigilant, and we will talk again with staff side colleagues. We have begun to do that to see whether anything gives us a thread of suspicion that there is a hotspot, a difficult area or an unreasonable manager. Thus far, we see no evidence of it, but we will keep our minds open to it.

Dr McCormick: I reinforce that. The Minister wrote a letter about whistle-blowing, the first part of which made clear that the organisational style that he wants to promote, and which is shared by the entire HSC leadership team, is one that allows openness, disclosure, open communication and openness to challenge at every level. Any member of staff can challenge any other member, however high and mighty they may be, to say that the right thing should be done. The letter, which was distributed to all staff, then reinforced the right and power to whistle-blow. In other words, the culture should promote correction without recourse to whistle-blowing but everyone should feel that whistle-blowing is facilitated and supported if the culture is not working on those terms. That was a clear personal message from the Minister for all staff to see. I am well aware that everyone at this end of the table and the other chief executives are highly supportive of that approach.

The Chairperson: Unfortunately, there is now a perception in the media that bullying is going on at Antrim Area Hospital. We need to deal with that as well.

Mr McCarthy: This is the most uncomfortable meeting that I have attended. The reports are horrendous, and I have to say that it is not acceptable. The reports from Mary, Dr Rutter and, of course, the press are totally intolerable. Jim Wells criticised the press but I will not, because, without them, we might not be sitting here talking about this issue, and other patients and staff may still be affected — they probably still are affected. I hear what Andrew says but, as a member of the Committee, I say that somebody has to be responsible for what happened. You said that you were responsible.

Dr McCormick: Yes.

Mr McCarthy: The public want to know what is happening not only in Antrim Area Hospital but in other hospitals. This situation is, however, the worst that I have ever come across.

Somebody mentioned bullying and harassment, and I will ask Mary a straight question about that. I read somewhere, maybe in the report, that bullying and harassment had been mentioned but that you refused to publish that information, or something along those lines. You have the opportunity to clarify: were bullying and harassment mentioned? Is it the case that you heard about it but, for whatever reason, did not want to publish that information?

Ms Hinds: I am absolutely clear. I was invited in and given free access to any member of staff. I could talk to anyone at any time and spoke to a wide range of staff. Some sought me out, others I found, and I heard a wide range of views.

A number of staff did describe a culture of bullying —

Mr McCarthy: There we go.

Ms Hinds: May I finish? Others described exhaustion and frustration. All those descriptions were individual reflections. The individuals who spoke to me wanted the situation to be better. I thought long and hard about how I described a total picture of the trust, not individuals. Individuals trusted me, and I would never breach their confidence. The words I chose, I chose with care to try to reflect what I felt was present in the organisation. However, the emphasis of my report is to make it better. The recommendations are, clearly, a challenge to the trust to do just what you said: to make it better for staff and patients. I was not gagged, and I was not asked to change words. It is my report, and I stand over it.

Mr McCarthy: Thank you very much for that answer.

Dr McCormick: You said that had it not been for the press, the matter may not have come to the Committee, but that is not the case. In fact, the reports were about to come into the public domain through the proper process of accountability, the trust board and the Health and Social Care Board meetings that were to be held in public within days.
Again, I commend Seanin for good journalism. I do not object to that. However, it is not true to say that the reports would not have come to the Committee but for the press. They were heading for the public domain anyway. The Assembly passed legislation that set up these organisations, the nature of the governance and their structure. All that is done under statute, and that is the nature of how, in its wisdom, the Assembly decided that health and social care should be governed. We want to fulfil those responsibilities conscientiously and fully. It is complex and challenging, and the risks are significant. We deal with individual patients at their most vulnerable and with staff under severe pressure and demands. Everyone is trying to do the right thing, and we need to make space for and recognise that.

Yes, there must be corrective action when things are not working. So I share and accept the concern that standards are not as they should be. My personal goal and responsibility is to do all that I can to help with that. That is why the board, the local commissioning groups and the trusts are all seeking to do the right thing — it is difficult.

Mr McCarthy: Chair, I am trying to keep calm, but it gets worse. I pay tribute to the front line staff, not only in Antrim Area Hospital but in other hospitals, who are under horrendous pressure. We see that when we go to any hospital. Why? They are being hounded from above by you people to do more in less time, and this is the result. Everyone is working in unsafe conditions, and it is totally unacceptable. We spent last week in the Chamber talking about unsafe conditions for patients and staff, and here we are again. Why was this not caught on much earlier? Why was it allowed to drift on to the horrendous state that it has reached now — horrendous for patients, staff and everyone else? You say that you hope to make it better? It should never have been like this in the first place.

Mr Compton: I will make a couple of observations. First, I must refute the assertion that the people at the top of Health and Social Care have no interest in —

Mr McCarthy: I did not say that, John; I said that they put too much pressure on front line staff.

Mr Compton: It is the way it comes across. It is a perception that senior staff are interested only in clipboards, numbers, and so on. All those I know who work throughout the system do it for only one reason: to make the patient experience better. That is their primary motive, so I simply cannot accept your assertion.

Why did it happen? It happened because we have a system that, I contend, was working. Let us go back to the autumn, when the problem began to emerge. We, as the performance management organisation, were in touch with the trust. We signalled our concern and said that there had to be a significant improvement. We talked to the trust about a number of issues, and there was improvement in a number of them.

Two matters emerged: the first was referred to us by general practitioners, and the second was the post-Christmas period in the accident and emergency department, which was, without question, extensively and publicly known. At the point that I recall, the problem was publicly presented in all sorts of media and throughout the system. The actions that we took, in partnership with the organisation, were to install Mary for a seven-week period to begin to understand what was going on and to invite Dr Ian Rutter to come across to speak to general practitioners and get a perception of how they saw the situation.

I reinforce the point that general practitioners raised concerns about the front door of the hospital. There is no question about that. Simultaneously, they expressed complete confidence in large elements of the hospital and how it operated, such as breast surgery, the haematology unit and the cardiology unit. So this is complicated, and there is no one simple issue or fit. Our system is predicated on our having the honesty to hold up a mirror, look at ourselves, acknowledge when something goes wrong and do something about it. We have an action plan, and we are following it through. There is evidence of improvement, and that will be continually monitored. Quite rightly, the Minister has required from us a fresh energy on accident and emergency units, and Mary and her team are working right across those units. We are seeing signs of improvement, particularly on the 12-hour breaches. So one must have confidence that the system that is set up can understand that it has a problem, address it and work with it. That is how, in the long term, we can sustain change, improvement and a better patient experience. Violent, knee-jerk reactions to particular problems do not, in my view and experience, produce long-term solutions that result in higher quality and better outcomes for patients.

Mr McCarthy: Finally, Chairperson, I hear what everyone is saying, but patients are the priority. John, you mentioned the concerns that GPs expressed about Antrim Area Hospital. That should never happen, so something is wrong. I would expect accountability and openness, and someone, somewhere must be accountable for the mess that the hospital is in.

If the same thing was happening in the Ulster Hospital, I would be shouting from high heaven, because it is my local hospital. I cannot understand how this situation was allowed to continue for such a long time. You talked about action plans and moving forward, but the hospital should never have been allowed to get to that position in the first place. Someone has to carry the can.

Mr Compton: First, I think it positive that general practitioners felt that they had a way of talking to the system to raise concerns and get solutions, rather than not raising them. Secondly, I remind you of my earlier point: the general practitioners who were concerned about the experiences of their patients at the front door of the hospital also complimented strongly and positively other component parts of the same hospital. There was a particular problem about which they were concerned when they came to speak to me individually at Christmas time past. It is important that we have a system in which people feel able to make that sort of contact and complaint, and feel that something will happen if they do so.

Mr McCarthy: You know as well as I do that the staff at Antrim, and probably in all hospitals, are afraid to put their head above the parapet to bring problems to the attention of their bosses because of the consequences. That is true despite what Mary says. I think that her report was generous.

Mr Compton: I have heard the assertion being made a number of times about people being afraid, but evidence is the important thing. I am not aware of any individuals who worked in health and social care and lost their job because they raised a genuine concern or issue.

Mr McCarthy: It has happened across the water.

Mr Compton: I cannot comment on that. I can simply comment on where we are. I believe that we have staff who are confident about raising concerns and making complaints. In fact, it is not a matter of choice, because staff have contractual and professional obligations that make it imperative that they do so.

Dr McCormick: I want to reinforce and support everything that John said but also to acknowledge that these things should not have happened. As is our responsibility, everyone at this end of the table and others in leadership roles sought to react as soon as we became aware of these issues. We sought to find the right and proportionate response.

I join you in commending the front line staff, because they do carry immense burdens. I also commend the leadership teams, clinical leaders and managerial staff, because they are conscientious in dealing with the issues. Have we done as well as we should have done? No, and I accept that, but we are now working under the Minister's direction to move forward.

The Minister drew out the fact that a major transformation programme was required and that the long-standing issues affecting services in Northern Ireland had to be addressed and resolved. That is why he commissioned John and the team to produce the 'Transforming Your Care' report and why getting on with that process is so important. We would love to fix it more quickly, but that is not the real world.

We have to work conscientiously and diligently to secure improvement. I accept your point that it should not have arisen in the first place.

Ms Brown: I welcome the panel and thank you for coming and giving your time to discuss this issue.

There has been much talk about media reports, and so forth. From experience, I know that the media tend to lean very much towards the negative. In fact, people in general tend to remember only the negative and not the positive stories. It is positive that you are here today and that the Committee has Mary's report. We welcome the report, its content and the ongoing improvements. Obviously, we hope for more improvement in the future. We all want to be in another place, and we have to work with what we have. This is the situation that was left after previous decisions that affected Antrim Area Hospital in particular.

I want to ask specifically about the step-down and re-ablement beds available to the Northern Trust. In comparison with the other trusts, are the numbers in the Northern Trust similar, or do other trusts look better on paper? Does the difference in the availability of such beds affect the discharge rate?

Mr Donaghy: There is no clear-cut comparison across all trusts in Northern Ireland. However, the Northern Trust acted to increase the number of those beds in the meantime to ensure that we did not have a large number, particularly of older people, whose complex needs can make their discharge from hospital more difficult to manage. We are managing the rehabilitation process for more older people in such beds, which can be in a variety of places from elderly people's homes to nursing homes. As we look to the future, we will take stock of how much of our investment is in those kinds of beds, as compared with what we invest in the balance of services for older people, including domiciliary care services and a wide range of others. The best intelligence that we have is that the Northern Trust probably invests more of its resources in intermediate care than some other organisations. Nonetheless, in the short term, we felt it important to ensure that no older people, in particular, had to stay in hospital when they could be looked after in a more suitable environment that brought them closer to home, and we have taken that step.

Mr Compton: The direct answer is that the Northern Trust is not disadvantaged in its access to intermediate, or step down or step up, beds. Perhaps an area of some concern was the interplay with primary care and the nature of medical cover for those beds. We worked with the trust to change the nature of that medical cover to make it more available and, therefore, more efficient. That enabled the trust to put people through hospital appropriately and correctly and on to a different location in a timely and sensible manner. One of the issues for us to pick up on was how that interface worked and whether we could make it work better.

Mr Dunne: Thank you very much for your presentation. We have a lot of evidence about issues of concern and risk areas. In a few lines, will you tell us how you will address the issues? We very much look forward to the outworking of the Compton report. I take it that this is an example of a necessary exercise under that. What can be done to make a difference within the next year?

Mr Donaghy: I will start off, and colleagues may want to comment. Even prior to the appearance of these two important reports, the trust had plans in place to continue to ensure that we reduced the number of people facing queues through our system. I emphasise once more that we are talking about queues throughout the system, as a queue to leave through the back door has an impact on a queue at the front door.

Mr Dunne: Patient flow is one of many issues. The problem of too many people turning up at the front door needs to be addressed. Too many people going through the buildings creates bottlenecks, and how patients are discharged is also a big issue. Issues with staffing, IT systems, and so on, have all been clearly identified. There is clear evidence that the problems need to be addressed and that there must be an action plan.

Sorry, go ahead. You were assuring me that you are already working on that.

Mr Donaghy: All those items are in our action plan. One of the reasons for a steady improvement from January through to now has been a particular emphasis on good discharge management. Jim Wells asked whether we had got into our cars and driven down to the Southern Trust area. We learned from colleagues in the Southern Trust about the need to bring staff together more effectively to help them to support good discharge planning. We start planning for an individual's discharge on admission, as opposed to when he or she is ready to go home. Thinking ahead, the ability to restart

packages of care and looking at nursing home places are all important. We guide families through the very difficult process of choosing a nursing home early to prevent delay when a person could be cared for elsewhere. We particularly want older people to leave hospital as quickly as possible because that is best for them in the long term and best for their independence. So that is one area about which we picked up some useful processes from colleagues in the Southern Trust, which has supported us. We looked at, for example, our transport arrangements. It was found, for example, that a delay in discharges from 10.00 am until 4.00 pm or 5.00 pm increased waiting times in the emergency department at very busy periods. We have brought online a trust vehicle that can cope with most kinds of discharges, which allowed us to ensure that many more people go home in the early, rather than the late, part of the day. That eases the pressure on our total hospital system during the day. To enable us to plan early, we have employed more occupational therapists to conduct the assessments that are so important in understanding people's — mostly older people — complex needs on discharge. The same is true of pharmacy. I could go through a long list of what is being done to address the areas that you mentioned. Clearly, we need to make sure that we pursue those actions and that they produce the improvement that we all know is required. That process is managed through the board.

Dr McCormick: John and Mary are leading on an action plan across Northern Ireland that is founded on evidence-based good practice. For years, we have known which elements of change are most significant in securing an improvement in how the emergency department system works. As was said earlier, that means looking at aspects of practice and how the system is managed from the front door, through the whole hospital system and into community services. Sean gave good and commendable examples of that. The trust is aware of the right things to do. The board, which is leading the performance management improvement process, is well aware of the elements of good practice. No one has a monopoly on them or on total success. The application of each technique and tool depends on the context in which it is applied. However, we are committed to working systematically and effectively to apply evidence-based good practice across all emergency departments. We know from other jurisdictions in which progress has been made that that is the way to go. There are also challenges. Our significant problems of demand include a 10% increase, within a short time, in the number of people requiring emergency department services. We have to manage demand problems, which requires looking at integrated care as part of the way forward. That, again, is a strong element of Transforming Your Care. This is complex and systematic, which is why we need strong leadership, effective management and support in moving forward. Sean gave some good examples of how that is being done.

Mr Compton: Where the actions needed are clear, we, along with Mary and her team, are working on them across Northern Ireland. We are also planning a learning event for the whole of Northern Ireland. We have not finalised dates yet, but that is likely to take place in June this year. The event will share learning across Northern Ireland, and we will invite people from other jurisdictions who have been grappling with similar problems and perhaps made more progress in some areas than we have. They have things to learn from us, as we have from them. It is a case of seriously and methodically addressing the issue and, as Andrew said, adopting an evidence-based arrangement. It is not a case of trying something that we think might work, finding that it does not work and trying something else. We are much more logical and rigorous about where we are going. The early signs of the work that we are doing suggest that the number of 12-hour breaches is dropping. The issue of breaches is not off the table yet, but recent figures are markedly different from those six, nine or 12 months ago.

Ms P Bradley: Thank you for your presentation. Listening to the discussion, I have been getting angrier and angrier. Antrim Area Hospital is a wonderful place, and I miss it terribly. I worked there for five years, as everybody knows —

Mr Dunne: Yes

Ms P Bradley: I was part of one of the hospital's most highly pressured social work teams and dealt with discharging people. I never once felt that I could not complain or speak to management if I felt under pressure. We were listened to, and if we asked for meetings at director level, we got them. I know that there were many faults in Antrim Area Hospital but, on the whole, it was a wonderful place to work and the teams were wonderful to work with.

The reason for my getting so angry is that the hospital is filled with many dedicated professionals doing a job over and above any other. I have never in my life worked in a job that involved such dedication. We never left at the time that we were supposed to leave; we worked on for the sake of

our patients because we cared about what we were doing. It just makes me so angry that the hospital is being painted in this light.

There are problems, but we all know that they are not all with A&E. We need to look at the big picture. The problem is with the community, GPs, consultants, everybody. I am really encouraged that the number of breaches has dropped significantly. That is positive. I know from working as a member of staff there that the most demoralising thing in the world is when negative stories and bad news about the hospital come out. As a member of staff, you feel that it is partly your fault. We have even heard about people throwing punches in reaction to what is happening there. The staff need big, broad shoulders to take that pressure and acknowledge that there is a problem when something goes wrong. They need to address it head on and deal with it. In my opinion, Antrim Area Hospital was never designed for the number of people who flow through it. There have been difficult times and there will be again, but staff take the pressure and deal with it.

Looking at the action plan, I can say that it includes sensible suggestions for how to make a difference. I am encouraged by what you will do and put in place for the road ahead. I stress that the staff there do such a good job. Kieran wound me up a bit about whistle-blowing, so I want to put on record that I never felt that I could not say that I was under immense pressure, which we were. Everybody there is under immense pressure, and everybody goes home at night feeling totally exhausted. However, we went home feeling that we had made a difference to someone's life. We were doing a job that we loved, surrounded by people who worked as part of a team. It is important to remember that. There is a big team up there, and there are procedures in place should staff want to speak to someone because they feel that they are not part of the team or are under pressure. I want to flip the discussion a wee bit and say that I look forward to the breaches coming down even further. We can produce what is in your report, John, and we can build a better service for our clients in the Northern Trust.

Mr Compton: Thank you for your honest and straightforward comments, many of which I endorse and support. Dr Rutter spent a brief time at the hospital because he was looking at a specific issue, whereas Mary had a rather elongated period of seven weeks. Had those two been unable to access individuals or have conversations with staff, they would have come to my office to tell me so — I want to reinforce that at no point did that happen. I believe that staff felt that they could say what they wanted openly and honestly throughout the period. As you know, reports such as theirs are exchanged to check factual accuracy and all the associated normal procedure. As part of that, on one occasion, Dr Rutter and I met Sean and a number of his senior clinical colleagues, and there was an informative, straightforward and honest exchange of views. There was not the slightest sense that people could not comment. We start from the point of view that it is disappointing that anyone has a very difficult experience, because we are genuinely concerned about that. However, it should be a reasonable matter of fact that we will get to a better place, and that is what the effort is about. We want to support Antrim Area Hospital in what it does.

Mr Donaghy: I, too, thank the member for her comments. I remind the Committee that Antrim Area Hospital will have a brand new emergency department by May 2013. Of course, ideally, we would have liked to have had that some time ago, but we very much look forward to having that and the additional modern capacity that will be available at the turn of the year. Both will help to make the hospital more resilient and more able to cope with the sorts of pressures that we know will come to all our hospitals.

The Chairperson: It is useful to end on that note. At no time has anyone on the Committee said that the problem was a reflection on staff. I have also talked to the media about A&Es in general. It is important to say that staff face a multitude of problems coming through the door and are very professional. In my view, the system failed the staff, partly because of difficulties in A&E or other parts of the hospital.

You are off the hook, Sean, as my next question is for John and Andrew. It would be remiss of me not to mention what emerged yesterday about A&Es in general. Will the closure of Belfast City A&E be permanent? We have seen the impact of its temporary closure — I am being flippant by saying "temporary" — on the Royal and other A&Es. Is the board or the Department looking at a strategy for A&Es across the North, rather than looking at A&Es in the Northern Trust, the Western Trust, the Southern Trust or the Belfast Trust? We need a holistic approach to A&Es in general.

Mr Compton: Absolutely. That is the whole point of Transforming Your Care and the plans being developed by each population area. All of that is being developed by the total local health economy,

which is the local commissioning group in partnership with the local providing organisation and primary care. For the first time, Transforming Your Care brings together that triangulation of people to examine what is the best way to respond to provide an emergency department service. We need to be clear that that service has a number of constituent parts: the trauma centre; blue-light ambulances, which are what everyone understands by an emergency service; urgent care; minor injuries; and an out-of-hours general practitioner service. As we have not properly examined the service for a long period, we ended up with a whole lot of people in the one place, which has compounded the difficulty. Transforming Your Care is very much targeted at getting a Province-wide solution that is locally sensitive to the desired outcome for individuals so that no one in Northern Ireland feels disadvantaged when accessing an emergency service. It is not about creating that sort of difficulty.

Dr McCormick: John described how the change process will go forward with the population plans. The temporary change at Belfast City Hospital happened before the report. The next step is a formal public consultation on the options for the long term and the right permanent configuration of emergency departments in Belfast. The board and the Belfast Trust will lead that work, there will be public consultation work, and it will be for the Minister to make the final decision. That work will examine openly and genuinely what are the options. They must be viable options that meet the criteria of sustainability and safety and provide an effective service for the population. That consultation process will happen relatively as part of the move towards the right outcome. It will be led by the board and the trust on behalf of the Minister.

The Chairperson: I take the opportunity to thank Mary and Dr Rutter for their work. There have been crises in A&Es, and I think that their reports have lanced the boil and allowed us to see what is going on. I am keen that we receive regular action plans — maybe through you, John — showing how the situation will change.

Kieran is right, and he, like all of us, is passionate about this. We are the ones who have to face our constituents. At least if we know about the journey, how things will change and the impact that that will have, we can sell this and give people as much information as possible. So use us as much as we use you. Thanks very much, and, again, apologies for the late start.