

Statement by Garrett Martin to the Clostridium Difficile Public Inquiry Team

I was the Assistant Director for Medicine and Unscheduled Care in the Northern Health & Social Care Trust from July 2007 through to the end of September 2009.

Prior to taking up post in the Northern HSC Trust, I had been a Nurse Consultant in the Emergency Care in the Western Health and Social Care Trust. I took up post just four months after the re-organisation that merged the three legacy organisations of Home first Community, United Hospitals and Causeway Trusts. I had no previous experience of employment in any of these organisations and I knew very few of the staff in the organisation. I joined the organisation when Directors were putting in place their organisational and management structures at level three, four and five.

My post was a level 3 post, reporting directly to the Director of Emergency, Primary Care and Older People. I was the last of 4 assistant directors appointed in this directorate as the internal appointment processes during RPA had failed to appoint a suitable internal candidate. My remit was all the in-patient medical services across six hospital sites (Causeway, Antrim, Whiteabbey, Mid Ulster, Braid Valley and the Inver Hospital). My managerial remit included the four A&E departments in the Trust. In total there were 33 wards and departments covered.

The significant organisation change at this time certainly influenced priorities. My initial priority was to put in place my management structure. As mentioned above, I was an external appointment to the organisation, I was a couple of months later in putting my level 4 and 5 structures in place.

When I was developing my structures I took advice from colleagues, and from the Director of Emergency, Primary Care and Older People, and the Director of Nursing, Miss Bronagh Scott. At the time I did believe that the scope of the job and the major operational challenges faced would require a robust infra-structure of support however I was restrained within the funding envelope available to me as a result of the RPA efficiency savings.

Within the funding available I had available to me initially, I consulted on and implemented a structure with 4 level 4 management posts (8B General or Service Managers) and also 4 professional nursing posts (Lead Nurse Band 8A). A number of months later extra funding was identified to support this and I was able to appoint a fifth General Manager (Patient Flow) and another level 5 post (head of hospital social work at Band 8A) to help deliver on the challenging agenda of managing the services areas previously described and a budget over £50m and 1,200 professional staff.

I moved on appointing the above staff as quickly as possible. However it took approximately seven weeks from my appointment to consult relevant staff, develop a structure, agree job descriptions, advertise, interview and appoint. For the most part, the successful candidates were able to take up posts within a couple of weeks of being offered the job.

Other priorities for me within the first few months following appointment were really getting to know the organisation, get my own structures in place, and start setting

priorities in terms of key areas which needed to be addressed. Key relationships for me included my clinical directors at the time, Dr Olivia Doran (A&E Consultant), and Dr Charles Jack (Physician and Cardiologist), my assistant director colleagues within the directorate and across the Surgical and Elective Services Directorate, Miss Audrey Douglas. Building relationships with these key people and trying to understand some aspects of the organisational culture was a key priority in my first 3-6 months of the job.

In addition to the issues above, the scope of the job was further impacted on in terms of the geography, the number of facilities, and the different cultures and relationships within the facilities. Meetings were held across the Trust with the HQ in Ballymena. This resulted in significant travel, which added considerable time to the already busy working day for many staff.

My initial impressions of the organisation, and the previous legacy organisations, was that the staff were very committed, hard working and with considerable experience in the system. My initial impression of the former "United" legacy organisation was that there were considerable issues around the acute hospital profile. I had concerns about the amount of patient movement between the facilities. I was aware that these concerns had been identified in a previous governance review that led to a reduction in the opening times of A&E in WAH and MUH. However, there remained concerns and this remained an item on the Trusts corporate risk register at that time.

It was evident that there was significant pressure in Antrim Area Hospital in particular. It was evident that there was a lot of patient movement, particularly out-of-hours where patients were having to be moved from A&E in Antrim Area Hospital to a suitable and appropriate acute hospital bed in one of the smaller hospitals (either Whiteabbey or MUH). The historical decision to limit the opening hours of both these A&E department was surprising to me. My previous significant experience had been that A&E departments opened 24 hours a day and if hours were reduced the status of the department would be reduced e.g. to a minor injuries unit. It certainly appeared to me that the closure of both these departments was having a significant impact on pressures within Antrim Area Hospital out-of-hours that resulted in a build up of patients at night waiting for emergency admission.

The above configuration of the hospital system as a whole was outside my control however the operational pressures in Antrim Hospital was one of the other main priorities for me initially. Along with the Clinical Director (Dr Dornan) we looked at the processes within Antrim Hospital to see if improvements could be made. The A&E department was built a number of years previously for 35,000 patient attendances, and at this stage the attendances were in excess of 60,000 patients per year. The admission process for emergency and unscheduled care admissions appeared to me to be frantic, and at times chaotic. It was also evident that the so-called medical assessment unit at the time, did not function or was not staffed as a modern medical assessment unit should be. The unscheduled admission process was therefore sub-optimal.

The Clinical Director for Acute Medicine shared my view that there was a risk to patients by being admitted to any available bed. It meant increasing workload for

consultants, and junior doctors. My first meeting with the consultants group in Antrim Hospital was a very challenging one, where they expressed great dissatisfaction and concerns regarding the pressures and regarding the process that patients were finding themselves in. Other concerns obviously were that patients were moving around considerably within the hospital. If their initial base- ward was not the most appropriate ward, they quite often moved on a number of occasions before finally getting to the most appropriate ward .

Obviously this was a concern around patient movement from a patient experience perspective and continuity of care and was far from acceptable. We were also aware at this time that the more a patient moves the greater the increase and likelihood of contracting a healthcare acquired infection. It was not exclusively for infection control reasons, however, it was a component part of our rationale when we decided to make changes to the process in late October 2007

Therefore, one of my main pieces of work within the autumn period of 2007, was to work with my Clinical Director to improve the process for unscheduled and medical admissions. We met with consultants and other key stakeholders through a group to reconfigure the system, which included plans for

1. Re-designating ENT surgical beds to medicine,
2. Re-engineering the medical assessment unit.
3. Creating and redesignating specialist medical wards
4. Enhancing and improving patient flow processes and infrastructure

Considerable work took place from October through to early December to bring people on board and to get agreement. The Clinical Director and I presented to the Trust Senior Management team and to the Commissioners in early December. Agreement was reached re-designate the beds, acquire some additional resources for medical staffing and to re-engineer the pathway for medical emergency admissions.

During this period I was aware that we had some incidents of patients with C-Difficile. At that time I was aware that my team were involved in managing these incidents, and that these patients were in some of the wards under my management. I understood they were being managed through the normal processes at that time - local meetings to manage local 'clusters' involving local clinical staff and laboratory staff. I was kept informed by members of my team but at the time I believed that these were isolated and individualised cases. I was unaware that these cases at this stage may have been linked, and suffice to say I was unaware that we were in an outbreak situation.

During this initial period, the autumn of 2007, it is important to say that within the context of the overall organisation and overall HPSS culture, that there was a very strongly enforced performance management ethos. Many senior staff in the trust, including myself, felt that the process of holding to account, by the then Service Delivery Unit, was very aggressive in nature. Two of the key priorities were the A&E four and twelve hour targets and the delayed discharge standards. These were primarily seen as being within my operational patch. Despite the above aggressive approach at a regional level, I believe the performance management approach adopted by the Trust was much more reasonable and measured. I have always stated when

leading and driving operational standards that there should be in patients best interests and that targets were a means to an end and not an end in themselves. Breaches of targets were defended when a decision in was based on the individual patients best interests.

At the time we were made to believe by the region that the Targets were more than achievable and that we were not performing to the level they we should have. We were made to feel that we were one of the poorer performing Trusts in relation to both the A&E four-hour target, and in relation to the late discharge target.

We made good progress on our discharge targets and within six months and certainly within the period of February 2008, the late discharge picture had improved significantly. When we did put many of the changes in place regarding the medical admissions process and re-engineering of our medical assessment unit, our A&E target performance improved significantly also. Patient movement across the wards in Antrim significantly reduced also. This was during the worst period of the outbreak.

One of the other areas that influenced the patient admission process for emergency and unscheduled care was the bed management team (patient flow as it is now). It was evident that this function plays a significant part in helping manage these operational pressures. Initially there was quite a poor infrastructure in Antrim Area Hospital, but there was also a lack of accountably and clarity around where patient-flow/bed management staff 'sat' within the organisational structure. Following some discussion between the acute and elective directorate and our own directorate i.e. Miss Bronagh Scott and Catherine Hinton, the decision was made that the team would operationally be managed within my team.

Certainly during the autumn and winter of 2007- 2008, I worked to improve the infrastructure for patient-flow, knowing it was a considerably challenging job with competing priorities, and one which in the circumstances provided extremely high levels of stress for the individuals involved.

Regarding some of the processes for decision-making, procedures were in place for the use of side rooms and risk assessing patients with infections. I was not familiar with the details of these, however, I was aware that there were systems and processes in place.

I initially became aware of the scale of the C-Diff problem following a meeting with the Medical Director, in late December 2007. Very quickly following this meeting an outbreak control team was set up. I was a member of the OCT, which met on a weekly basis and was chaired by the Chief Executive. Comprehensive notes are available for all these meetings.

My attendance at the meetings was almost unbroken for the complete time that the outbreak ensued, right through until August. Certainly the seriousness of the situation was apparent from early January, so much so that it certainly became my number one priority. One of my main tasks within that group initially was to get the isolation ward up and running as quickly as possible. I set up a small operational team on the Antrim site to manage and monitor the setting up the isolation ward in Ward A1. The ward was set up and up and running within 24 hours of the initial instructions. The

effect on staff was significant and it took a lot of managing medical, nursing and support staff through the process. I can honestly say the staff responded in a very professional and committed way.

The period January to April within the outbreak was incredibly challenging for everybody involved. The feeling that patients were being harmed as a result of having to come into the system was incredibly difficult for everybody, but there was a very deep sense of commitment to getting the problems sorted. Our initial actions and action plan appeared to be focusing on the right thing, only to continually see that it wasn't making the impact that we wanted it to make.

One of the biggest challenges I felt was the scale of the outbreak, it wasn't contained in one to two particular areas, it was spread out over 3,4 even 5 sites. This from a purely operational perspective was incredible challenging.

My own communications within my own directorate were very much through combinations of regular emails and telephone calls. I had a weekly meeting with my general management team. It was very much a standing item, if not the main item on the agenda. Notes and communications from the outbreak control team were circulated among my team, but the sheer scope of the problem left it that it was difficult to have assurances that all of the information was getting to the places that it needed to get to.

I attempted to have a physical presence on the Antrim Hospital site as often as I could and that was certainly at least on a weekly basis. However, with the other sites it was practically and logistically impossible for myself to have a presence, but to counteract that I attempted to strategically place my teams with responsibility for covering specific areas depending on their base, rather than their operational management remit, so that communication and following up on actions would effectively take place.

During the period from January to April the workload certainly was immense. It was immense for everybody at senior management level, and also obviously on the operational teams. During that period I frequently worked 60-70 hours per week, and "on call" for patient flow on a regular basis.

I think the OCT worked quite well together, they were obviously committed and focused and wanted to address the issue as quickly as possible. Contact was made with other organisations to get information to see if there were things we were not doing and to clarify if we were doing the right things by a number of people in the outbreak control team.

Operationally in my area the outbreak was very difficult to manage despite endeavouring to do what I could within my own areas, insofar as I could within the infrastructure available to me. My area was operationally and managerially very large but also limited to those areas I had that responsibility for.

In relation to inter and intra hospital transfers, there were some policies in place but some ad hoc arrangements. During the outbreak itself there were a number of

protocols that were developed which very much tightened up the processes from a governance and accountability perspective. I think these provided the opportunity also for staff to have greater clarity and more robust risk assessments to inform their decision-making.

From early on in my role I believed that the previous legacy United Trusts staffing levels were not to the degree that they should have been. My own clinical background and expertise lay in emergency care, but obviously having some knowledge and expertise in overall nursing levels, I felt there were areas requiring improvement. I was aware that there had been a number of bids made to the commissioners to resource nursing better but they had for the most part been turned down. There were a number of additional posts that I put in place on some of my wards to improve the staffing levels.

The nature of the wards and departments in Antrim particularly, in terms of the intensity of work, the movement of patients, the level of admissions led to a very busy and demanding clinical context. This requires an appropriate resource, which unfortunately, I don't believe was in place. The resource was spread too thinly across the system.

It is my belief that the system as a whole in terms of the amount of acute hospitals and the profile of particularly the smaller hospitals led to the intensity of work being focused at in Antrim. There was an element of busyness and intensity within both Mid Ulster and Whiteabbey, but not to the same degree and there was capacity on these sites. Patients were being moved because that was where capacity was, but as an emergency care system as a whole, that is not effective or the safest.

Unfortunately from the trust senior management perspective it was something that, in terms of changing or doing something about, was outside their control. Changes to this system require ministerial approval. Therefore, I believe that system of emergency care it created was chaotic for managing unscheduled care activity and that it contributed to the problem of patients initially finding themselves in a hospital with no capacity (Antrim) and subsequently requiring transfer to a hospital with capacity (MUH or WAH).

One of the other factors, which contributed to workload and pressures, and potentially to some of the issues within the C-Difficile outbreak, was medical staffing level. Antrim Hospital had significant difficulties and vacancies at different levels. The challenge of maintaining acute hospital rotas for medical staff in training, middle grade staff and consultant grades across all the sites was incredibly challenging. Also from a financial perspective the cost was hard to justify, as there was a high usage of locums. Locums are quite often not familiar with clinical areas and their procedures.

From my own perspective it was a very challenging time, almost traumatic on a personal level, it is fair to say it took over my life to a large degree and in terms of support, I felt unsupported from management, albeit at times I felt it wasn't as apparent as it could have been. I understood however that everyone was under significant pressure at this time and it was incredibly challenging for directors, my team and the front line staff. I would describe the stress levels as being the highest I have experienced in my professional career to date.

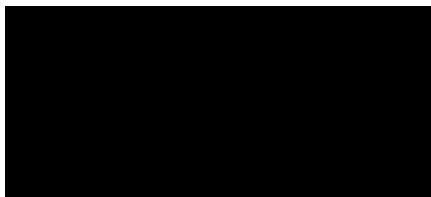
The personal stress was related to the fact that patients were being harmed by the system. Providing a high quality service for patients and to providing compassionate care for people was what motivated me to apply for the job in the first place, but during this period it was impossible to derive any job satisfaction knowing that we were actually (and the evidence was there from the figures) harming patients.

I would like to think that my own team felt supported throughout. I know that it was very difficult as a manager to provide staff with support and leadership to keep morale at a level that was going to keep them going and keep them committed. So from that perspective I was very aware my own leadership role in supporting my team, and supporting everybody within my directorate at ward level. The people delivering the care needed support and particularly the staff in the isolation ward. I certainly attempted to be there as often as I could and have a physical presence to visibly be supportive.

I wasn't directly involved with any media communication in relation to the C-Difficile outbreak, however, I felt the trust did as well as it probably could have in relation to managing a very, very difficult situation. I think that the local public view was one that undermined confidence in the service, and had a dramatic impact on staff confidence and staff morale and in turn increased the pressure they experienced. The reputation of the hospital and the trust was being scrutinised at a very public level. I think that the strategy by the Trust to put clinical staff (medical director) in the media's eye was probably the best under the circumstances.

I have experienced the service in a lot of difference settings in Northern Ireland, and I didn't believe that the standards were any less than the standards in a lot of the other areas where I have worked.

I confirm that the contents of this statement are true and correct to the best of my knowledge and belief.



Mr. Garrett Martin

5th May 2010