31/05/2022

Dear members of the committee,

The Church and Society Commission (CASC) of the Church of Ireland has prepared the attached submission to the Department of Health NI consultation on Review of Urgent and Emergency Care Services in Northern Ireland.

CASC is an advisory group, serving the Standing Committee of the General Synod, and engages with legislatures and governments on a variety of issues, including legislation. The mission of CASC is to provide oversight and direction for the Church of Ireland’s work, in respect to social theology in action. CASC’s views only become representative of the Church of Ireland after being approved by its General Synod.

Yours Sincerely,

Rev Dr Rory Corbett

Most Rev Michael Jackson, the Archbishop of Dublin (Acting Chair)

Church and Society Commission

Church of Ireland

**Submission from the Church of Ireland Church and Society Commission
to the Review of Urgent and Emergency Care Services in Northern Ireland**

Acute and Emergency 2022

The Church and Society Commission of the Church of Ireland thanks the Department of Health for the opportunity to respond to this consultation process. We feel that the Church is in a particular position to comment, as it regularly hears from its members of their experiences, good and bad, and in addition the Church has many members, or family members, working in the HSC system, constantly feeding back on the situations they find themselves in. In addition, one of our members has been part of a small group drawn from the four Anglican Churches in the United Kingdom and Ireland, looking at issues regarding End of Life, in particular those that seem to prevent the development of a coherent whole integrated service, which seem entirely relevant to the present exercise.

We are all too well aware of the situation regarding the provision of Health and Social Care (HSC) in Northern Ireland, which has been under a lot of pressure for some years, with major exacerbations as fallout from the recent pandemic, especially as it has affected the Acute and Emergency Services. We feel that the recent events of the past few years, though the pandemic is essentially over, the virus remains present, has had profound effects on society in terms of isolation, inability to lead normal lives and activities, fear and anxieties and will have a significant influence on the assessment and response to any proposed changes. And whatever are the effects on society, these can only be magnified for those actually working directly with patients in health care or those similarly in Social Care, who are also aware, in addition, of all the problems as a result of decisions made or statements issued from central government regarding items such as PPE, which did not seem to match experiences in places of contact. A recent survey by the British Medical Association continues to show the despair and feeling of let down by doctors regarding failures in supply of PPE, even now.

The Church, however, would like to place on record its appreciation of the commitment of staff both in Health Care and Social Care settings during the Covid 19 pandemic for their altruism that was well above the call of duty and did lead to many deaths, amongst various work groups. They also showed a willingness in flexibility to change work practices, to rearrange teams, to work in areas which were uncomfortable, physically, and mentally. As observers much of this change appeared to be made at the ground level, by consent and understanding need, and not from above and we hope this will continue to be the situation as these proposed changes are considered, and not felt to be an imposition from the Department of Health downwards.

The documents provided show a commitment to changes, which would lead to improvement of the services provided, as a result, but we cannot fail to be aware of the numbers of papers and consultations over the years that there have been, to improve the delivery of HSC in Northern Ireland, but that are lying on shelves.

We do not wish to comment on the minutiae of the proposals, but rather make some more general ones that go across different sections, and include Communication, Workforce and Capacity.

1. **Communication.** We will use your terms of “providers” and “users”, even if the latter seems very impersonal. We entirely agree with your stress on inter-provider communication. When end-of-life and palliative care is looked at the biggest complaint by patients, families, and carers, as well as by the providers, was poor or even total lack of communication; primary care to secondary, secondary care to primary, from both to nursing services, physiotherapy, occupational and social services, and pharmacies. Changes might be made in care, sometimes minor but often more important, such as drug or dosage changes, but the complaint often was that it was poorly communicated. This seemed to be a particular difficulty for those providing home care to try and get information, or new drug prescriptions, especially at night or weekends. These workers were the ones left embarrassed in front of patients and families. Even if the situation was understood by the user or carers, it was not solving an immediate need.

We naturally are concerned that if there are communication problems in a relatively small area of clinical practice, how will this translate to whole population needs and services. It does seem that the “silo” issue of jealously guarding information, under the guise of patient confidentiality, needs specific attention, so that, at least, an essential summary is available of important and up to date information, either in paper or electronic format.

1. **Workforce.** The Church is like many others fully aware of the publicity surrounding shortages of personnel in primary, secondary, domiciliary, and social care settings, as well as from families and carers of users. In addition, many church members have family or friends working in the HSC, and can hear and see the effects that these shortages are having on morale and general well-being.

 The consultation papers do talk about these issues and about the need for increases, indeed giving figures for medical personnel. However, given the time it takes for someone to be trained up in a specialism, whatever their profession, to then be available for an appointment, we are disappointed not to see much more emphasis on the need to retain personnel, both in the Health and in the Social Care settings. Anecdotally we keep hearing of depression, disillusionment, inability to carry out a good, rewarding and satisfying job, lack of support, resultant sick leave, and further pressures on those remaining, and early retirement of those least expendable because of experience. We do worry about what seems to be a failure of a “Caring Organisation” to care for its own, particularly those in high stress placements such as ED. But this does apply to all parts of the HSC if there is to be a smooth flow through the system and achieve what the Department is trying to. You could double the funding tomorrow but would have no immediate increase in numbers of doctors, and you could double the numbers of doctors tomorrow but would have no effect on the system if there are no carers for domiciliary or care homes.

1. **Capacity.** The document discusses in detail bed numbers available, and their reduction, including comparisons with other countries. These maybe available elsewhere, but these comparators do not help, in the absence of details of the care systems available both pre-and post- hospital admission. We welcome the emphasis on reducing occupancy rates, with an aim to remain below 90%. We cannot determine if that figure is an aspiration for the highest demand period or lowest of the year. We also worry that a midnight time for bed occupancy tally could deflate figures to an acceptable level especially surgical wards, if daycare beds are included in the total count. We would stress that we would wish to see that the 90% figure applies to the time of most demand, so as to allow appropriate time for all necessary cleaning of beds and furniture etc, as appropriate, and to reduce risks of infection transmission, as one example. The repeated reports of patient numbers waiting for a bed in ED’s throughout Northern Ireland, would suggest that the figures are much higher, and that occupancy of nominal numbers of beds is actually over 100%, and in EDs must be greater when we see the numbers of patients waiting on trolleys or in chairs, with the attendant risks this poses to patients and to staff alike. The comments we receive are not those of failures by staff but of a system where pressures are such that safe and proper care are compromised.

The plans proposed in these documents seem positive and should produce the desired effects on improving the situation in Emergency Departments and Acute Care, but at the same time it is important that it is fully recognised that these departments are not stand alone, and that any improvement is totally dependent on reducing the numbers arriving in these departments and smoothing the passage back to home or the community. If these changes are to be achieved then the present problems with communication need to be fixed to achieve effective vertical and horizontal transmission; workforce personnel need to be retained, while awaiting new appointments, after training, and employment in domiciliary and social care needs to be made much more attractive and rewarding; capacity in all aspects of the Health and Social Care services needs to have a spare reserve, as it cannot continue to run at 100% of its various capacities, any more than an engine can without breaking down, sometimes minor and easily fixed and sometimes catastrophic. We do appreciate that all this has significant funding implications, but if these changes cannot be achieved, then your other proposals are redundant and acute and emergency care will continue to fail those who need it and those who work there.

Finally, we would wish to acknowledge that we are aware that there are examples where the out of hospital services are excellent, as a result of good communications between all the providers, commitment of all those providing the various services, no delays and the right people providing and managing the systems. This does keep people out of hospital and reduces demand from the pre-hospital route, and we would hope that these examples are made use of in planning. We do feel that these proposals have the ability to produce a system that is equitable throughout the province, safe and patient/user focused, and also safe and rewarding for all those providing care, wherever and whoever they are in the system.

We would be willing to follow up this submission with a meeting face to face to talk through any issues it raises- either now or in the future.