Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Acute Services at Mid-Ulster Hospital and Whiteabbey Hospital

1 July 2010

NORTHERN IRELAND ASSEMBLY

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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr John McCallister
Mrs Claire McGill

Witnesses:

Mr Michael Bloomfield	)	Health and Social Care Board
Mr David Galloway	)	Department of Health, Social Services and Public Safety
Dr Olivia Dornan	)	
Dr Peter Flanagan	)	Northern Health and Social Care Trust
Ms Valerie Jackson	)	
Mr Brian McNeill	)	Northern Ireland Ambulance Service

The Deputy Chairperson (Mrs O'Neill):

I welcome Mr David Galloway from the Department, who is no stranger to the Committee; Mr Brian McNeill from the Northern Ireland Ambulance Service; Mr Michael Bloomfield, from the

Health and Social Care Board; Dr Peter Flanagan, the medical director of the Northern Health and Social Care Trust; Ms Valerie Jackson, the Northern Trust's director of acute services; and Dr Olivia Dornan, the trust's clinical director of medicine and emergency medicine. I invite you to make a 10-minute presentation, after which members will have an opportunity to ask questions.

Mr David Galloway (Department of Health, Social Services and Public Safety):

To start the session, Valerie will take the Committee through the paper from the Northern Trust.

Ms Valerie Jackson (Northern Health and Social Care Trust):

I will begin by setting the scene in relation to the documents that support the changes in the Northern Trust area. The Committee will recall that the document 'Developing Better Services' (DBS), which was issued in 2002, signalled changes to service delivery at the Whiteabbey and Mid-Ulster sites. During 2003 and 2004, concerns were raised about the profile of services at those sites, which were, at that time, part of the United Hospitals Trust.

As a result of the concerns that were raised, the trust commissioned Deloitte and Touche to carry out a risk assessment in 2005. That assessment identified a number of risks in sustaining services. At that time, changes were made to maternity services at the Mid-Ulster Hospital and to A&E services at the Mid-Ulster and Whiteabbey sites. Bypass protocols were put in place for major trauma cases for those sites, ill children were diverted to other sites and the opening hours of the A&E departments were changed. From that point, the service was already operating in a limited way.

In early 2009, in response to the comprehensive spending review (CSR), the Northern Trust released a document called 'The Reconfiguration of Acute Hospital Services'. That document was subject to a full equality impact assessment and to consultation over the three-month period from January to March 2009.

The trust made recommendations, which were forwarded to the Minister in March 2009 and approved in September 2009. Those recommendations stated that, within the comprehensive spending review period, the trust should make changes to acute, inpatient and A&E services at Whiteabbey. At that stage, it was felt that the full anticipated changes to the Mid-Ulster Hospital could not be completed in advance of the completion of the new ward block at the Antrim Area Hospital site. In the interim, the trusts were to make significant efforts to sustain services at both sites. However, until the additional capacity was in place at Antrim, those services were subject to any clinical risk or patient-safety issues that emerged during the intervening period.

In summer 2009, serious concerns emerged about the maintenance of acute surgical services because of problems with maintaining junior doctor rotas and with the recruitment of consultants on those sites. That resulted in changes to surgical services at Whiteabbey in October 2009 and at Mid-Ulster in November 2009. Following those changes, clinical staff raised further concerns in December 2009 about the safety of services provided at the local A&E departments as a result of the changes to the surgery service in the autumn. Additionally, concerns emerged about cardiology as a result of changes in practice in relation to the treatment and care of patients with acute myocardial infarction.

In response to those concerns, the trust discussed the issues with the Health and Social Care Board, and, with its support, put in place immediate contingency arrangements to support the delivery of a safe service on those sites. However, at the same time, the trust considered enhanced contingency arrangements that may have proved necessary. During January, February, March and April 2010, the situation was closely monitored, and, by early April, the trust realised that the position was unsustainable for a number of reasons. At that time, further discussions took place between the trust, the Health and Social Care Board and the Department. The trust advised that the only viable solution was to accelerate the changes that had been proposed in the original CSR proposals.

On 26 April 2010, the chief executive of the Northern Trust, Mr Colm Donaghy, the chief executive of the Health and Social Care Board, John Compton, and Dr Olivia Dornan met the

Minister to present the concerns, explain the difficulties in sustaining the current level of acute services and outline the immediate changes that were required in A&E departments on both sites. They emphasised that decisions and action were urgently required. An announcement about the changes was made on 12 May 2010, and, during the following week, a number of staff, media and public announcements took place, and information was provided to a range of stakeholders.

In response to the trust's situation, we made a number of changes at the Antrim Area Hospital site to find and create additional capacity. We redesigned our treatment areas at the Antrim Area Hospital site and created a 10-bedded clinical decision unit in the A&E department at the site. We opened 11 additional medical inpatient beds at the site, and, to manage that additional capacity, we redeployed 44 staff from both of the affected sites. As a result, the trust has noticed significant improvements in performance, particularly of the A&E service at the Antrim Area Hospital against the four-hour and 12-hour targets that the Department has set.

As for the future, the remaining acute medical beds from Whiteabbey and the high-dependency beds from the Mid-Ulster site will transfer by the end of July 2010. Following that, the remaining medical beds from the Mid-Ulster site will move during 2011.

On behalf of the trust, I want to say that the Northern Trust is committed to providing vibrant local services from the Mid-Ulster and Whiteabbey sites. We will continue to provide services such as day surgery, diagnostics, inpatient and outpatient rehabilitation services, and day-case services. As members know, the Whiteabbey site has recently obtained accreditation for bowel cancer screening. That will bring a significant volume of work to that site. We are in negotiations with the board to bring a cataract service to the Mid-Ulster site, along with providing a renal fistula service from that site.

In summary, the trust considered the changes carefully as they emerged, and it has, at all times, taken account of patient safety and the quality of service that we provide for our local population. Over the past number of years, that has been the overriding concern of the trust

throughout the changes. We want to work closely with local communities, and we want to ensure that we use the facilities that we have at the Mid-Ulster Hospital and Whiteabbey Hospital to full effect and efficiency.

The Deputy Chairperson:

Thank you for your presentation. As a Mid-Ulster representative, I have met many of you on a number of occasions. You know my views on the withdrawal of services from the Mid-Ulster Hospital and that I believe that the people in Mid-Ulster have been left devoid of acute services. They have to travel long distances, taking well over the hour in some cases. People who live in Pomeroy are not within the golden hour of access to acute hospital services. We feel hard done by — that is the honest way of putting it. We feel stripped of services, and we feel that there is a massive equality issue: equality of access to acute services.

An equality impact assessment (EQIA) was carried out on the comprehensive spending review proposals that set out the withdrawal of accident and emergency services from the Mid-Ulster Hospital. Was an EQIA carried out on the decision, taken at short notice, to close the acute services at the Mid-Ulster Hospital?

Mr Galloway:

The EQIA process is embedded in section 75 of the Northern Ireland Act. As Committee members know, that places a responsibility on public authorities to take due regard of the need to promote equality of opportunity between the various groups in section 75. That process was completed in 2002, with consultation on the 'Developing Better Services' document, and the decision taken at that point was that the Mid-Ulster Hospital and other smaller hospitals in Northern Ireland would be developed as local hospitals without acute services. After that decision was made, an EQIA assessment was carried out.

As Valerie explained, in 2009, our CSR proposals for acute reforms in the Northern Trust were also subject to public consultation, and an EQIA was performed at that time. The

characteristics of the population have not changed, as the Deputy Chairperson would accept. Between 2002 and 2010, the characteristics of people living in Northern Ireland or in the Northern Trust area have not changed significantly. Perhaps your concern is about what mitigating factors the trust put in place. You will hear from Dr Dornan and Dr Flanagan that the change was necessary. However, sufficient mitigating factors were in place to ensure that the change was implemented safely and that patients continued to receive the best possible care available.

The Deputy Chairperson:

I am well rehearsed on the reasons why the decision was taken at short notice, and Dr Dornan has talked about that at length. However, I am still frustrated because I think that consultants are leading the change and closing down hospitals through their refusal to work there. I accept that people need to keep up their skills, but they should be asked to work on a rota basis across all hospitals in a trust area. In doing so, they could maintain their skills and good services would still be available on the Mid-Ulster site.

I want to pick up on an issue about risk assessment. I assume that the risk associated with an additional influx of patients to Antrim Area Hospital, as a result of closing the A&E department at the Mid-Ulster Hospital, has been examined. Will you reassure the Committee that such a risk assessment was carried out and that the lower risk option is the location of A&E services at Antrim? Will you also reassure us that the reconfiguration of the three A&E services will not exacerbate pressures on the services already located at Antrim? Members have seen the Monday morning statistics showing the many trolley waits in Antrim Area Hospital, and we feel that its A&E service is already under pressure. How will it cope with the additional patients?

Dr Olivia Dornan (Northern Health and Social Care Trust):

You asked many important questions, Deputy Chairperson. I will go back to your first concern, which is that consultants are leading the change. You might say that, in a way, consultants are leading the change. However, in most ways, we are not. Our responsibility is to flag up concerns. Ultimately, the doctors who treat a patient or stand over a service must make their

views known. Individual doctors and teams of doctors take that professional responsibility incredibly seriously. I refute any suggestion that the issue has anything to do with lifestyle or a choice of where people live or work.

There is a genuine responsibility to debate the infrastructure needed to provide care provision and where that care can best be provided. We must provide a consistent 24/7 service, and we hear a great deal about that now as medical technology improves. We can do more now, and more senior staff are required to deliver those improvements. Consultants bring feedback to me as a clinical director, and I provide feedback to the trust and further afield about what we believe is best and safest for patients.

Dr Dornan:

In response to your second question, the risk assessment focused on monitoring the impact of the surgical change. As we described, the surgical change was driven by changes to junior doctors' working patterns. It must be said that junior doctors have always been the workhorses of around-the-clock medicine. I, for example, worked and trained in casualty and surgery in South Tyrone Hospital, for example. I went into work on a Friday morning and was quite happy to stay until the Monday evening. That is no longer possible, but it was crucial to being able to maintain services at a certain level.

When surgical services were removed from those sites — we addressed why that had to happen — the physicians, medical consultants and emergency medical teams had to weigh up the risks of trying to continue without the backup of onsite surgery and associated infrastructure. On balance, we wanted to try to continue to provide what we call a stand-alone medical service and the existing emergency medical profile. However, we knew that we would have to monitor that carefully. We had an in-depth debate about that, and, on balance, we thought that we should try. We recognised that the trust had made a commitment to maintain services, and we thought that we should try that approach.

When the change was made, the monitoring took place through incident monitoring and through my speaking regularly to medical and nursing colleagues in person to gain a sense of their state of comfort and concern. We do not want to wait until there is an incident; we would rather not have any. To monitor and assess risk, we have to listen to people. I asked people how things were going and whether they had any concerns. That was the kind of level at which I often worked. From that, I got the sense that the system was not as safe as it should be.

You referred to the pressures in Antrim Area Hospital and its not being as safe as it had been. Antrim was receiving more cases and sicker patients, but its medical resources were being diluted and spread across more sites. We could not recruit more doctors, although we made extensive efforts to do so. Therefore, Antrim was becoming more risky. The clinicians, initially in Whiteabbey Hospital, expressed concern that the service was not as safe as it should be. After all, when there is an accident and emergency sign above the door, people expect to be able to walk in at any time and receive the same safe service that they would receive at any other hospital, regardless of the diversion protocols for ambulances.

Although clinicians initially raised safety concerns in Whiteabbey, those concerns applied equally to the Mid-Ulster Hospital. That was the main concern that drove me to write to Ms Jackson, the director of acute hospital services, and Dr Peter Flanagan to outline our worries about an escalating pattern of risk and of increasing stress among clinicians.

I should also mention the issue of medical staffing in both those hospitals. We tried extensively to recruit a team of doctors. My colleagues and I did a great deal of work to try to build up a medical establishment of permanent doctors who could work in the Mid-Ulster Hospital. We built up the idea, to which you referred, of a network of staff across the Causeway Hospital and Mid-Ulster Hospital. Such a network would have enabled staff to spend some time in each hospital and, in doing so, maintain their skills.

Repeatedly, we had no applicants for those positions, and we submitted some of that

information to the Committee. Therefore, we were unable to recruit doctors. Meanwhile, key staff were leaving Whiteabbey Hospital. There had been no permanent staff in Magherafelt for some time, and we were working on a day-to-day basis. As members will recall, at 4.45 pm one Friday, we discovered that we had no doctor. That reflected poorly on all our systems. Therefore, we were working from day to day in Mid-Ulster, and, in Whiteabbey, we suddenly lost key personnel whom we could not replace. The situation was one of escalating safety concerns against a background of difficulties with recruiting and retaining staff, despite an attempt to develop clinical networks.

The Deputy Chairperson:

As you are aware, the statistics on waiting times were published this week. Antrim Area Hospital was the worst performing hospital: 61·9% of people spent four hours or less in A&E, and 241 people spent more than 12 hours in A&E. It appears that its A&E department cannot cope.

Dr Dornan:

Doctors and nurses always cope. We do not want patients to have to wait for medical care, especially in the wrong environment. However, the patients receive care, including when they wait on trolleys. We have an elaborate system in place to ensure that that happens. However, it is not of the standard that we want.

Since the change, there has been a dramatic improvement. In the week beginning 19 June, for example, 85% of patients were seen within four hours at Antrim. Throughout June, there were no 12-hour breaches in trolley waits. Although the changes were driven by safety concerns on the other sites, the impact on Antrim, where we provide the 24/7 all-singing, all-dancing service, has been extremely positive. I hope that, in time, we will start to hear from people who have accessed that service from the wider locality that we now cover. As a working doctor, I have received extremely positive feedback. I am open about the fact that we want to improve in many areas. We always work to improve, but our performance has improved dramatically since the change.

The Deputy Chairperson:

The high dependency unit (HDU) is due to be closed this week or next week. As part of the CSR proposal, it was to close in July 2010. Members of staff at the Mid-Ulster say that they have not been consulted about that. I can relay to you only what staff say to me and to other representatives. Will that closure go ahead? If so, will you outline the reasons for that and the impact that it will have on the other services at the Mid-Ulster?

Dr Dornan:

The rationale is a medical one and, as the Committee knows, all the issues are linked. The first question was about the level of care that patients in a HDU require. There are national guidelines on the levels of critical care that are required for various conditions and, typically, an HDU provides level 2 or level 3 care. Patients who currently use the HDU in Mid-Ulster require level 1 care, which may be defined as enhanced nursing skills, an increased number of nurses and more monitoring equipment. That type of service should now be provided in a medical receiving ward.

The first task was to define the needs of the population in the HDU. The question was how to use that unit, given that we had reduced the severity of cases that we accepted in medicine in Mid-Ulster as a result of the change to accident and emergency services. We introduced additional diversion protocols, and we can accept patients who are referred for medical admission to Mid-Ulster. However, we advised GPs that many patients who become unwell suddenly should go to the nearest 24/7 facility. Therefore, we considered that we could not use the HDU properly and that we had to provide level 1 care in the ward that receives patients. Essentially, the rationale was, again, clinical.

The Deputy Chairperson:

Will that not have a negative impact on the newly refurbished medical wards 1 and 2? Will some people in those wards have to go to the HDU?

Dr Dornan:

That is exactly the issue. Most clinical guidance now recommends that patients who go into a

receiving ward should receive level 1 care. In Magherafelt, that mainly refers to ward 2, which is the most recently refurbished facility. It should be able to provide enhanced care for sicker patients whom the clinicians, doctors and consultants want to monitor closely, especially during the night when there are fewer doctors in the hospital. Those patients should be co-located with the doctors who work on new admissions. At night, if a HDU is one place, even if it is a level 1 facility, and the doctors who work in medical admissions are in another place, that requires doctors to divide their time between locations. It is safer to provide the care in the ward in which it is needed, so that doctors are immediately available to provide that care.

Ms Jackson will discuss the consultation. We have been working closely with the consultant physicians at Magherafelt, because they required reassurance, and they must be confident that their patients will be treated safely.

Ms Jackson:

We have had ongoing discussions with staff. Over the past number of weeks, there have been meetings with senior clinical medical and nursing staff to tease out the issues that we must deal with in advance of the transfer at the end of July 2010. We established a series of working groups with senior staff to consider how we will manage a range of clinical issues. The HR discussions with staff began last month. Two weeks ago, we met staff organisations with a view to starting the process of supporting staff on those sites through the change.

Mr Gardiner:

I share the concerns of the members of the public who are present today. I come from the Craigavon area, representing Lurgan, Portadown and Banbridge. We had to go through what the mid-Ulster area faces now. The maternity unit in Carlton House in Portadown has closed. The hospital in Banbridge has closed because it could not carry out X-rays or surgery. There is no surgery in Lurgan at all; it does X-rays and caters for people who are recovering, having been discharged from the hospital in Craigavon. Those three towns suffered what is being discussed today, and people were rightly angry.

The hospital in Craigavon is now a state-of-the-art facility, and we draw consultants to that location because the work and equipment are on site. Previously, it was not possible to spread the work over three or four hospitals. Hand on heart, I am disappointed that I could not get the Committee's support when I asked recently for the health budget to be ring-fenced. I made that proposal and it was seconded, but no one else supported ring-fencing the funding for hospitals and the Health Service. I am angry about that, and they all jolly well know it.

Although we will listen to you today, the funding is not available for the professionals, the hospitals and the services that we require. The Health Minister is being asked to cut his budget again. I understand why some smaller hospitals are facing cuts. I share your concerns, but the money is not here, and we cannot provide it for you to ensure the safety of your friends or the general public. I could cry with you, because I know what you want. I know what we would like to deliver, but it costs money, and we are not getting the top consultants to deliver that.

Mr Easton:

On a point of order, Deputy Chairperson. Today's discussion is about two hospitals losing their A&E departments because they could not get cover; it is not about budgets. The member's question had nothing to do with what we are discussing.

The Deputy Chairperson:

I was just going to make that point. However, the member has a right to put across his views.

Mr Gardiner:

Yes, and you were one of those who voted against it.

Mr Easton:

No; you voted against making health a priority in the Budget. .

The Deputy Chairperson:

Members, please make your remarks through the Chair. I was about to point out that we were repeatedly told that the decision to remove A&E services from the Mid-Ulster Hospital was not based on money; it was a patient safety issue. I am sure that the panel will want to pick up on that. Does anyone wish to respond to Mr Gardiner? His contribution was more by way of comment than asking a question.

Mr Galloway:

If the trust set out in detail what services the Mid-Ulster Hospital provides and will provide in future, it might be helpful to the Committee and to the people in the Public Gallery.

It is important that the local community receive some assurance about the services that will be available there in the future.

Mr Gallagher:

We all have a fair idea of the problem, and I share many of the concerns. I speak as a representative of a rural constituency, although not the constituency in question. The situation is completely different from that in Craigavon, Lurgan and Banbridge. I take David's point, but now that the presentations have been given, all members who wish to seek to make points about what we have heard so far should do so now. That that would be the fairest approach.

The Deputy Chairperson:

OK. We will take questions first and talk about that afterwards.

Dr Deeny:

David, I have heard all this before. The people and patients whom I represent, and, indeed, the medical profession, do not refer to the strategy as Developing Better Services, but as "Developing Poorer Services" or "DPS. As there is not a full complement of MLAs here today, perhaps we

will be able to ask a few more questions than is normally the case, because it is an extremely important issue to the people of mid-Ulster.

Who made the decision to remove A&E services from the Mid-Ulster Hospital and Whiteabbey Hospital? I presume that Olivia, Valerie and Peter may all have been involved, but was the Department also involved? I do not want you to give me your exact addresses, but, out of interest, where do you all live? I am aware of such decisions being taken before by people who do not live in the area.

As a group of six, do you think it fair that there are five acute hospitals within 10 miles and seven within 20 miles of the centre of Belfast, but none in mid-Ulster? In fact, there is not one A&E department west of the Bann until one reaches the west coast. Is that fair to the people of Northern Ireland?

Mr Galloway:

OK. The decision was made by the Northern Trust, after it had taken into account the views of the Health and Social Care Board and advised the Minister of the action that it needed to take. In answer to your question about where we live, I am from Carrickfergus.

Dr Deeny:

Do any of you live near Magherafelt or Cookstown?

Ms Valerie Jackson:

I live near Ahoghill.

Dr Deeny:

I will tell you why I asked. Never mind the fact that I am a doctor — Valerie, this is a serious

issue — my family lives more than an hour away from an A&E department. Never mind the fact that I am a clinician, I am not happy that I do not have an A&E department within an hour of where I live. Your decision has added to the list of people for whom that is true. The Deputy Chairperson referred to the fact that many people who live west of Cookstown, for example, including some of my patients in Dunamore, Killeenan and Kildress, are now more than an hour away from an A&E department.

Dr Peter Flanagan (Northern Health and Social Care Trust):

As Olivia pointed out, the key driver is the need to provide high quality services to care for acutely ill patients. I am sure that you, as a doctor, will understand that. The decision was driven by the need to ensure that, when dealing with acutely ill patients, we have all the facilities and services that are required. The ease of access to the hospitals concerned is an issue. More importantly, however, is the issue of whether a patient who arrives at a hospital can receive the right standard of care.

Dr Deeny:

Peter, I am shocked that you, as a doctor, do not judge the standards of healthcare based on how quickly a person can be transported to a hospital. Is that not part of the equation? Have you ever worked in the community?

Dr Dornan:

I have worked in the community. I live near Glenarm, and many of my relatives live in the Moy. Northern Ireland is a small place, and many of us have either lived in, or are connected to, west of the Bann, even though we do not live there now.

Emergency medicine is my specialty, and I would like to say something about the concept of the golden hour. I have been involved in working with the Ambulance Service, and so forth. The golden hour references work that was done in the United States many years ago.

That work studied the hour in which the body compensates after injury. During that period, one uses one's physical reserves to keep going. Evidence shows that that can be sustained for about an hour, but, after that, the body stops compensating and the patient becomes ill very quickly. In the golden hour, the patient requires oxygen, fluid resuscitation and haemorrhage control. Therefore, the golden hour is not about getting knife to skin, although there are some conditions, such as coronary interventions, in which it is more effective for the patient to receive such care within the hour. Nevertheless, the golden hour is about getting support for the body: oxygen, fluids and haemorrhage and airway control.

Dr Deeny:

I am sorry to interrupt, but you are giving the Committee a medical lecture. Let me pull you up on a few things that happened in my area. What about mothers who deliver children who cannot breathe and need ventilation? What about babies with flat head syndrome or children who have seizures? In many cases, such as road traffic accidents and head injuries, expertise is needed on the spot. Are you telling me that it does not matter as long as those people get to hospital within an hour?

Dr Dornan:

I am talking about the golden hour. All the cases that you cited require what doctors often refer to as ABC, which stands for airways, breathing and circulation. I wish to respect the lay person who wishes to know more, so that he or she can challenge what doctors say, and that is why I am giving some medical background. We talk about airway, breathing and circulation, and those can be sustained by trained paramedics as well as by doctors. The hospital must deliver definitive care. Therefore, when the patient arrives at hospital, our job is to be able to deliver that definitive care — the CT scan, the X-ray or intensive care. We are not typically part of the golden hour, although if a patient reaches us within the golden hour, of course, we carry out the ABC checks.

Dr Deeny:

Nobody is disputing the fact that we want top quality standards in our hospitals. Nevertheless, as an experienced doctor who has been living in the area for 25 years, having moved from the east

coast, the whole area has become unsafe. That is because we have the worst terrain and the worst roads, and people cannot get to the hospital in time for you to perform your good work on them. That is my point, but nobody listens to it.

Have you spoken to the local GPs about the situation? Were they consulted? GPs were not consulted about the closure of the hospitals in Dungannon and Omagh, and I presume that the same thing happened in this case. How do you view the statement of the new Secretary of State for Health, Mr Lansley, who said that it seemed that a policy of decentralisation was being adopted, but that local hospitals in England would no longer be closed against the views of the local clinicians? That was good to hear.

You have not answered the question, but maybe you will answer this one. Is it fair that there are five hospitals within 10 miles and seven hospitals within 20 miles of Belfast, but no hospitals within 40 miles for my patients?

Dr Flanagan:

With respect, that question is not for the trust, but for the Health and Social care Board.

Dr Deeny:

What are your personal views?

Dr Flanagan:

It is fair to say that, if one were starting with a blank sheet of paper, the hospitals in Northern Ireland would not be located where they are at present, and I think that everyone would agree with that.

Mr Galloway:

That question takes us back to the 'Developing Better Services' document. Dr Deeny expressed his view on the validity of the Developing Better Services strategy. However, that strategy sets out a clear pattern of hospital services for Northern Ireland that ensures that everyone is within one hour of an acute service.

Dr Deeny:

That is not the case, David. Come to my home, and I will prove it to you.

Mr Galloway:

I will accept that invitation. There is a much modelling done —

Dr Deeny:

[Interruption.]

The Deputy Chairperson:

Dr Deeny, let the panel answer your question.

Dr Deeny:

I am sorry, Deputy Chairperson. I have one last point. I am sorry, but I feel deeply about the issue. I live in an area that I consider unsafe. I have a question about the equality impact assessment, especially the part relating to mothers and children. Will the Northern Trust send its report to me, please? I want to see how you determined that mothers and children throughout mid-Ulster are treated equally when it comes to healthcare, particularly emergency healthcare.

I have heard the same argument being rehashed and regurgitated for years. David will tell us

about the services that are provided, but they are not the life-saving services that my community needs. It is that simple. Have you assessed the impact, which, I believe, is highly detrimental, on mothers and children? I know of two mothers who left my area to live in Belfast so that they could deliver their babies safely. Are you saying that that is the way we should go? What impact has the equality impact assessment had? As a trust, are you telling me that mothers and children in mid-Ulster and in the city of Belfast are treated equally?

Mr Galloway:

The trust's equality impact assessment is in the public domain and addresses each section 75 group, including people with and without dependants. It considered the equality impact on and between those groups of the decision to develop the Mid-Ulster Hospital and the Whiteabbey Hospital as local hospitals.

Dr Deeny:

The closures in three different trust areas highlighted the lack of communication between trusts. Do you take cognisance, for example, of the opinions of people in the Western Trust or the Southern Trust? Do you even talk to them? That appears never to have happened. You decided to reduce services in the hospital at Magherafelt, the Southern Trust decided to reduce services at the hospital in Dungannon, and the Western Trust decided to do the same in Omagh. Does no one talk to the people who will be affected? Did you not consider the situation to the west of Magherafelt before taking that decision?

Mr Galloway:

I bring the Committee back to the Developing Better Services strategy, which is the road map for acute hospital provision throughout Northern Ireland. In 2002, DBS set out the future of South Tyrone, Mid-Ulster, Omagh, Whiteabbey and other local hospitals. That was consulted on, and an equality impact assessment was conducted at the time. As members know, the published document became the Department's strategy.

The purpose of DBS is to ensure that, as we go forward, we are able to deliver high quality emergency care. Olivia is better placed to talk about that than I am, because I am not a doctor. However, the key consideration is how to sustain those intense acute services and the elements that must sit behind an A&E department, such as an ICU department, acute surgery facilities, paediatrics and anaesthetics. Those services must be available to enable us to provide accident and emergency services safely.

Dr Deeny:

David, you are saying that, rather than consult and talk to people in the Western Trust area, you simply proceeded on the basis of DBS. Can you not reconsider DBS? Will the trust not highlight the fact that the closures will expose a huge population to the west of Magherafelt and Cookstown?

Mr Galloway:

At the time, DBS took into account the needs of the entire population of Northern Ireland. Therefore, the implementation of DBS is designed to ensure that, in the future, we have an appropriate model of hospital services. It should be a mix of acute centres that provide the intensive high quality care that Olivia described. Furthermore, those services should work as part of a network with local hospitals to provide the necessary services, on a regular basis, to the people whom Kieran serves as a GP.

Dr Deeny:

I have one final comment. You mentioned the DBS statements about the services that have closed at the three adjacent hospitals in the middle of Ulster. Olivia must provide some clarity. In the press, blamed was attached to doctors and nurses for not applying for posts in Mid-Ulster, Dungannon and Omagh. Once it is announced that a hospital is to have no acute services, doctors or nurses will not apply. I would not have applied, because to do so would not have allowed me to complete my GP training. The public should know about that. You cannot turn round and say that hospitals are unsafe because of the lack of doctors. Doctor or nurses who want to further their careers will not apply to those hospitals after such announcements. The medical and nursing

profession knows that, and it is time for you to be upfront and tell the public that that is the case. If you were to continue to provide acute services in the middle of Ulster, as you should, doctors and nurses would apply for those jobs.

The Deputy Chairperson:

That was more of a comment than a question.

Mr Wells:

I now recognise what a privilege it is to be the Chairperson, because, in that role, I am able to ask all the best questions early in the session. *[Laughter.]* It is instructive to listen to other members asking the best questions one by one. Am I right in thinking that the equality impact assessment was predicated on the fact that there would be a newbuild unit in Antrim? In other words, the promise was given to the people of mid-Ulster that a new unit would be built to take the extra throughput. Subsequently, somewhere along the line, you decided that that would not happen, and you rearranged the deckchairs in the Antrim Area Hospital. I have a direct involvement in that, because, although I do not live in mid-Ulster, my wife did, and I am getting it in the ear from her. The people of Tobermore are up in arms, as, I am sure, is everyone in the mid-Ulster area. That being the case, surely it invalidates the equality impact assessment, which means that you should start again and carry out a new one.

Mr Galloway:

The equality impact assessment dealt with the expansion of service capacity at Antrim Area Hospital. That was one of the mitigating factors that the trust intended to put in place to ensure the safe transfer of services. However, the situation that Dr Dornan described was such that the trust concluded that it had to take immediate steps to bring forward its decision. The clinical need, which Dr Dornan also described, meant that action had to be taken to ensure that patient safety was not diminished or compromised in any way through trying to maintain a service that clinicians felt was not safe.

The trust planned to put in place sufficient mitigating arrangements to ensure that the transition could be made safely and that patient safety would be sustained throughout the trust area. We advised the Committee previously, and it was mentioned again today, that a 10-bed clinical decision unit was created in the A&E department in Antrim Area Hospital. Additional space has been made available in that department, as well as an extra 11 medical beds, to ensure that the transfer of service can happen safely.

Mr Wells:

Nevertheless, you must carry out a new EQIA, because the original one was based on a totally false premise.

Mr Galloway:

The EQIA examines the policy decision, which was that the Whiteabbey and Mid-Ulster sites should be developed as local hospitals. That policy decision will lead to the change of service from A&E, albeit on a limited hours' basis, to a minor injuries unit. The decision has been addressed in the EQIA vis-à-vis its impact on the section 75 groups. There is no obligation on the trust to revisit that. The trust has put mitigating arrangements in place to deal with the transfer of service, and the impact on the population has not changed in any way.

Mr Wells:

I would love to know how the EQIA passes the test for services to rural dwellers. I will not dwell on that.

We are not here to talk about money. We are here because you could not attract the senior clinicians that you needed to keep open the service in the Mid-Ulster Hospital. You had the money to pay them, but you could not recruit them. If those individuals, who are highly experienced and valued members of staff, are needed to work in a certain hospital to maintain an essential service for a rural community, you should not have to go on bended knee to plead with them to do it.

This morning, I used the police to illustrate my point. If I served in Newry, and the Chief Constable told me that my services were needed in Strabane, I could not say that, because there is a better class of criminal and a wider range of criminal activity in Newry, I could develop my skills better there and ensure that I would be more likely to be promoted. A policeman is told to go to a certain location to provide an essential service. Is it unreasonable to say to consultants who are based in BT9 or BT4 that, for a five-year period, they should travel from Belfast to Magherafelt to provide an essential service?

Some consultants say that that is totally unreasonable. The fact that thousands of civil servants make the reverse journey every day for significantly less pay strikes me as totally unfair. Why does it seem that the consultant tail wags the trust dog? I am being as kind as I can, because I have great respect for those gentlemen and ladies. Why were they not told to go to the Mid-Ulster Hospital?

Mr Galloway:

I will ask Dr Flanagan to respond to that.

Dr Flanagan:

We covered this issue to some extent before you came in, Mr Wells. I will recap on what Dr Dornan said, particularly about the input of the medical staff. The misunderstanding is that medical staff are, in some way, being blamed for some of the changes that are taking place. As Olivia said earlier, there is a professional input into assessing the quality of services that we provide in each hospital. What drives us is that we must ensure that we meet the highest professional standards when dealing with acutely ill patients, who must, as David mentioned, be treated in a facility that provides all the necessary services. It is not true to say that services in those hospitals are changing because medical staff refuse to work there.

At present, there is a major shortage of doctors. The bulk of 24/7 cover in those hospitals is provided by doctors who are in training. Currently, there are approximately 100 vacancies for

such doctors in Northern Ireland. Therefore, if we were to start moving doctors from one place to the other, we would be robbing Peter to pay Paul and destabilising services across Northern Ireland. The only sensible and reasonable approach is to concentrate our scarce resources in fewer locations.

We moved staff when we were able to do so. However, in practice, all our staff are hard-pressed and hard-working. We simply cannot take a member of staff out of one service and tell him or her to work elsewhere, because doing so would destabilise that service.

Mr Wells:

Why did Colm Donaghy tell Ian McCrea MLA that it was perfectly possible for the Mid-Ulster Hospital to continue to provide A&E services for another 18 months using locum consultants and senior doctors? Why, after saying that to Mr McCrea, did Mr Donaghy pull the plug two weeks later?

Ms Jackson:

I cannot comment on what the chief executive said.

Dr Flanagan:

We covered some of the issues that we were facing before you arrived, Mr Wells. We also outlined the timeline that we set out for the changes that had to take place and the reasons for those changes. For the past six to nine months, we worked constantly with locum staff and tried to recruit additional staff. The decision had to be made, because, towards the end of April 2010, we reached the point at which we felt that we could no longer provide the service. There is a shortage of locums, and they do not necessarily provide a high quality of care. The nature of locums is that they come and go, and their standard of training varies. Thus, many issues are connected to the quality of care that can be provided solely by locums. However, the bottom line is the major shortage of locums.

Mr Wells:

Mr Donaghy did not think so.

Dr Flanagan:

I was not present when he made that comment. I would need to study carefully what was said at the time, but I would be surprised if he made such a direct statement.

Mr Wells:

We made Mr Donaghy's comments public, and he did not deny having made them.

The logic of what you said is that the increasing specialisation and concentration on core areas means that we are heading towards virtually all acute medical cover in Northern Ireland being centred on two or three sites. If you are correct that there is a need for a scale to specialise skills and that it is necessary to have the full teams to which you referred on site, you can be talking only about Belfast City Hospital, the Royal Victoria Hospital and Altnagelvin Area Hospital. I see what is happening in Downpatrick and what happened in Tyrone, Omagh, Mid-Ulster and Whiteabbey, and the same thing will happen at the Mater Infirmorum Hospital. If that is where we are going, the public need to know that the changes at Mid-Ulster and Whiteabbey represent the start of a process, whereby most rural hospitals will become cottage or local hospitals.

Dr Flanagan:

That is a question for the Department and the Health and Social Care Board, because the Northern Trust does not set the agenda.

Mr Michael Bloomfield (Health and Social Care Board):

Where we are going, as David said, is back to the full implementation of DBS, which sets out the road map for future services. The Health and Social Care Board's draft commissioning plan signalled the need to move towards the implementation of DBS. The reasons for doing so have

been outlined: the inability to retain and attract sufficient staff at all sites; and the fact that the reliance on locum staff was becoming unsustainable. Therefore, we are back to the implementation of DBS as our direction of travel.

Mr Wells:

DBS should be subject to democratic input. The fundamental problem with DBS is that it would not have survived scrutiny by the Assembly or the Committee, because it leaves a huge part of Northern Ireland — I reckon about 40% of the land mass — without acute cover. From an equality perspective, that is simply unacceptable. That is my view, and, wearing my South Down hat and Claire's hat, I am sticking to it.

Dr Flanagan:

You are right that there is a major issue. There must be a major public debate about what model we will have and whether it is feasible for every small town in Northern Ireland to have a fully functioning acute hospital with all the associated facilities that are required. Resources are limited and will probably become more limited in future. Professional standards and new treatments require specialist facilities. Therefore, we must think carefully about how best to provide services. However, it is hard to envisage every small town in Northern Ireland having a fully functioning acute hospital.

Mr Wells:

It is not difficult to envisage the transferral of some acute services to a specialist unit west of the Bann and those being concentrated in Omagh or Mid-Ulster. That could be done instead of bringing all the acute services to two conurbations. There is no reason why everything has to be located on those two sites.

Mr Gallagher:

That was developing into an interesting discussion. Dr Flanagan referred to issues that are foremost in the public's mind, such as whether everything should be concentrated at two or three hospitals. Apparently, decisions are being taken by the Royal Colleges, and there is no doubt that

they tilt their decisions against people in rural communities. There is no understanding of the fear that exists among rural communities everywhere in Northern Ireland. They fear that health provision has been undermined and been made even more difficult for them to access. Today's discussion highlights one such case, and I could cite several other examples.

The situation has been compounded. Olivia talked about easing the pressure on accident and emergency services and about people using their local out-of-hours services, but that is not working. People in rural areas are so fearful about the implications of time and distance that the opposite is true. They put the patient in the car and go straight to accident and emergency, where he or she will be treated. That happens despite the fact that out-of-hours services cost the Health Service almost £25 million each year.

You outlined the concerns that consultants flag up, which is fair enough, but they see only their side of the picture. Their perspective is important, but it does not represent the full picture. The concerns of rural communities are being ignored again and again. Important facilities are undermined and then closed down, with the result that people are asked to travel huge distances. It is a pity that the matter was handled so poorly, because there was an understanding that the accident and emergency service at Antrim Area Hospital would be extended. A new wing with approximately 30 beds was to be built at the hospital before all the changes came into play.

However, what happened is that a small, select group of clinicians somewhere decided to do it the other way round. You tell me that the system works well, and I suppose that that is encouraging. However, how can an A&E service that needs to be extended and requires improved facilities be working satisfactorily for the benefit of all patients? I am concerned that, at the moment, there is a big drive simply to cope with the pressure. I am concerned that you do not have the facilities and that, over time, the quality of service will decline. People are extremely worried about that, and that is part of the wider picture that must be discussed.

What is your view on the recruitment of doctors? We are led to believe that, when the

changes have been made, the recruitment problems will begin to disappear. Although there was a major outcry about the changes in Omagh and Enniskillen, the recruitment problems there remain. Are you examining the problem at all, or do the people who take the decisions fail to consider the wider problem? In other words, are you missing something as far as the recruitment of doctors is concerned. Dr Flanagan said that there were not enough doctors. We must consider that.

I gather that the lack of availability of junior doctors played a part in the decision. Whose fault is that? I ask that because, after all the services were shifted to Enniskillen, we were suddenly told that those services were to be shifted out of Enniskillen again because of problems with the recruitment of junior doctors. However, when the problem was examined, it emerged that the health authorities were experiencing problems in the recruitment process that led to a hold-up in the appointment of junior doctors. Does that same problem exist in your trust area?

Dr Flanagan:

Medical staffing levels are crucial. As I said earlier, there is a shortage of doctors in training in Northern Ireland and across the UK, and it is they who provide the foundation for many acute services. There are probably three main reasons for that. One major reason is the change to the immigration rules that took place a couple of years ago. Perhaps members have heard about that. A major restriction has been placed on doctors from outside the European Union, as with any people from outside the European Union. As the Committee knows, for many years, the Health Service in Northern Ireland was supported by and relied on doctors from, in particular, countries in the Indian subcontinent, such as Pakistan, India and Sri Lanka. Those doctors simply do not come here anymore or, if they do, in extremely small numbers.

Mr Gallagher referred to the delays in recruitment. Even when we identify the people whom we want to appoint, it takes a huge amount of time to get through the paperwork. Recently, the Northern Ireland Medical and Dental Training Agency conducted a recruitment exercise in India to try to recruit some additional doctors. However, it is likely to be at least six months before any of them start to work here.

The second reason for the shortage is the change to doctors' practices, particularly those that resulted from the European working time directive. In the past, a rota of four or five doctors could provide a day-to-day 24-hour service, but now that requires at least eight doctors. Therefore, more doctors are needed to cover the same rotas.

The third reason is the change to the training and selection of junior doctors.

On the positive side, recruitment to medical schools has increased at, for example, Queen's University. However, as the Committee will understand, it takes quite a few years for those students to work through the system, but there will be some improvement in years to come. The medical workforce is highly mobile, and staff travel to all parts of the world to work. Some may take time out to do research. A new feature is that over 50% of graduates are now females, and many of them take time out for family reasons. Therefore, a combination of factors contributes to the shortage.

Mr McCallister:

You mentioned that the workforce is mobile and travels across the world. Are we doing everything that we can to maximise our pool of clinicians and professionals? That issue might have been touched on earlier; I apologise if that is the case.

That is a recurring theme. We are not getting the doctors when we need them. Are we managing recruitment to maximise the pool across Northern Ireland?

Dr Flanagan:

Unfortunately, when we have vacancies, it is hard to move people from one place to another. As I said earlier, to do so means robbing Peter to pay Paul, because it destabilises services elsewhere. There is a choice: should there be unstable and unsatisfactory services across a range of hospitals, or should the resources be concentrated in a smaller number of hospitals and have the appropriate

services? I think that the latter is the right approach. I also said that we have moved doctors in our trust, and we will continue to do so, but that cannot be done if there are not enough doctors at the outset.

Mr McCallister:

The problem of not enough doctors is a recurring theme. As Jim knows, the Downe Hospital in the South Eastern Trust has experienced that problem. Can nothing more be done to maximise the use of the doctors that we do have?

Mr Easton:

I have a question about the timeline. When you made your decision, I take it that you had to go to the Health and Social Care Board, then to the Department and finally to the Minister to seek their approval to close the A&E departments.

Ms Jackson:

The trust had been monitoring the situation closely from early January until March and April. At that stage, we were becoming increasingly concerned. An early meeting with the board provided us with support to put in contingency arrangement to provide support to keep the service afloat for a continued period. By the end of early April 2010, we were clear that the service would be unsustainable. At that stage, we had further discussions with the board and the Department. A meeting was scheduled for the end of April between the Minister, the chief executive of our trust, the chief executive of the board and Dr Dornan to advise the Minister on the way forward. Subsequently, we had to seek the approval of our trust's board to take that decision forward.

Mr Easton:

Initially, did the Minister approve what you were doing?

Ms Jackson:

The Minister was aware of the current issues on the sites and knew that we planned to present our

advice to the board of the Northern Trust.

Mr Easton:

Did he agree with you?

Mr Galloway:

He did, and his agreement is on record in the Assembly and elsewhere.

Mr Easton:

A couple of weeks ago, the Committee had a discussion with departmental officials, who said that there were enough consultants in the Northern Trust. I said that, if there were enough consultants, why were some of them not asked to split the work in the A&E departments on a shift rota until permanent cover could be found. The officials also said that the money that was saved from the closure of A&E departments would go back into the minor injuries units and the A&E department at the Antrim Area Hospital. However, considerable savings on top of that were not returned. If the extra savings were not ploughed back into the A&E departments and the minor injuries units, where did they go?

Ms Jackson:

I will answer your point on savings, and I will ask —

Mr Galloway:

I was the official who answered your question at the previous session.

Mr Easton:

Was it you?

Mr Galloway:

At that session, I said that I was not aware of any consultant vacancies in the Northern Trust area. However, I will ask Peter to come in on that question. He will explain that, as far as accident and emergency is concerned, trying to manage the Mid-Ulster Hospital from the Antrim Area Hospital by using the consultant staff in Antrim would not have been a successful approach, because it would have destabilised Antrim.

Dr Flanagan:

We are talking about A&E services, but, as you have heard and understand, A&E is only the entrance to a hospital. All kinds of services are needed behind A&E to look after acutely ill people. Therefore, the issue concerns not only A&E consultants but the other consultants who support them. Junior medical staff are key to the provision of 24/7 cover, and that is where the major problem lies at the moment. Olivia may want to talk about medical staffing in A&E.

Dr Dornan:

The fact is that we are not entirely the same as police officers, and there are fewer of us. There are approximately 30 A&E consultants in Northern Ireland, and it takes years to train us. It is no secret that we all work flat out to maintain services at the current level. Although our numbers have increased over the past number of years, the need has been overtaken by the unexpected impact on junior doctors, who used to deliver much of the service. Therefore, I am afraid that the trained A&E specialist body has no capacity to cover any extra hospitals.

Mr Easton:

What about the funding issue?

Ms Jackson:

There will be savings in addition to some of the changes that have been made. A large chunk of the money that will be released from those savings will go towards supporting the business cases that we have submitted for additional beds and for a newly refurbished A&E department on the

Antrim site.

We must also take account of any workflows that go to other trusts, because not all the work from the Mid-Ulster and Whiteabbey sites comes to Antrim. Nor does all of the work north of the Bann come to the Causeway Hospital. Some work goes to Craigavon and Belfast. Therefore, we have had to factor in resources based on that. We have also had to factor in a resource for the Ambulance Service, because it will have to undertake an increased number of journeys. Any money that is left over will go back to the board as part our CSR response, and the board will redirect it in whatever way it sees fit.

Mr Wells:

I am sorry that I was late. I have a minor point that I do not think has been raised. What about children under the age of five who attend the minor injuries unit? Am I right in thinking that they are taken right past the front door of the Mid-Ulster and straight to Antrim? Surely that is a major issue for parents. My late brother-in-law passed away in Antrim Area Hospital, so I know about travelling and parking there; it was a nightmare. Are we telling the people of mid-Ulster that they have to make a long journey to see their relatives but that, if they have a child under the age of five, they will not even be given the option of going to the Mid-Ulster Hospital? Why was that decision made?

Dr Dornan:

Yes, that is right. The common practice in most nursing-led minor injuries units is that we do not ask nurse practitioners to take sole responsibility for treating children. Most of us would be able to grin and bear minor injuries through anaesthetic, stitching or another intervention. Often, however, pre-school children cannot co-operate, and they become exceptionally restless and require sedation or an alternative procedure. We cannot guarantee to deliver their requirements in our minor injuries units. That is a core reason for that decision, and it centres on the management of children who might need additional interventions even for minor injuries. The legislation on nurses' requesting X-rays for pre-school children is also a factor.

I fully appreciate what you said, Mr Wells, about small children who may simply have received a bump on the head. However, children under the age of five are a special group when it comes to assessment, treatment, X-rays, prescribing, and so forth. We do not deliver care to them without having a doctor who is trained in paediatric emergency medicine or in paediatrics on site.

Mr Wells:

How would parents living in Knock react at being told that they had to go to Antrim with a child with a minor injury? That is equivalent to someone from Cookstown having to travel to Antrim.

Dr Dornan:

Our first duty is to be safe. In answering you, I will refer to Mr Gallagher's comments about the provision of out-of-hours services and minor injuries. Many conditions that I see as a doctor working in Antrim, often in the evenings but also throughout the day, could be served by primary care. That provision includes care for smaller children. My primary care colleagues are particularly skilled at assessing small children. That may not apply to certain minor injuries that require procedures, but I have spoken about those. Nevertheless, we must have a debate about, and reach an understanding of, the services that people can access locally. Primary care is a key element of much of that. The minor injuries service that we provide in the Mid-Ulster Hospital, though not for those under the age of five, is crucial. We are keen to gain public confidence in that service. We have been quite pleased with the response from the public who have used it to date, but we would like there to be an even greater response. The issue, as far as children are concerned, is safety, although I fully appreciate the member's point.

Mrs McGill:

As most of the key questions have been asked and answered, I will make a few comments as a West Tyrone MLA and as a member, alongside Kieran Deeny, of the campaign group for the rural west. During the campaign group's meetings, the subject of what would happen to the Mid-Ulster Hospital came up regularly. Even at that early stage, the fear was that the Mid-Ulster Hospital would eventually lose key services, which is the position now.

Contrary to the impression that Mr Gallagher gave, Enniskillen got its big acute hospital. However, no matter how hard we tried, Omagh did not. Kieran stood on a ticket of obtaining and retaining acute services in Omagh. I am being parochial, but we are extremely concerned about the future in Omagh. On occasions, we look for reassurance from the Minister that Omagh will provide services, whether they are enhanced or at local hospital level. We hope that Omagh will be protected.

The point was made about the number of acute hospitals that are located in, for example, Belfast, and another such facility is being built in Enniskillen. However, there is, as was discussed during the campaign group's meetings in Omagh, a massive area in the centre of this place, of the North, of the Six Counties of Northern Ireland, with no acute services, and that is an issue.

I want to ask about the Ambulance Service. I asked this question of Mr McNeill at a previous evidence session. There is an eight-minute target for the Ambulance Service: is it 70% —

Mr Brian McNeill (Northern Ireland Ambulance Service):
This year, the target is 72·5%.

Mrs McGill:
The target is that, 72·5% of the time, an ambulance should arrive at a call-out within eight minutes. My point has always been that the remaining percentage of ambulance requests — I will round it up to 30% — could all be made from a rural area. Recently, I spoke to some members of the Ambulance Service, and, if that were to be the case, that eight-minute target will never be achieved in a rural area. The figures for the Northern Trust, which are detailed in the papers that I have in front of me, are not particularly impressive. Given what Dr Dornan said about the golden hour — she had a different take on the issue than the campaign group for the rural west in Omagh — do those target times matter in a rural area? I would have thought that they did. In your submission, you state that you hit the target 57·47% of the time, which is the

lowest performance by any trust area in the North. Does that concern you? If a patient receives treatment en route to the hospital, does that matter?

The Deputy Chairperson:

You nearly got away lightly, Mr McNeill. *[Laughter.]*

Mr McNeill:

I thought that I had.

Mrs McGill:

Mr Gallagher talked about the situation in rural areas. I understand that even the capitation formula takes some account of the difficulties faced by those living in rural areas. We spoke earlier about how that capitation formula is rolled out to take account of those unique circumstances. We will come back to that. There is an issue in rural areas, and we must determine and declare whether an ambulance arriving within the eight-minute target matters.

Mr McNeill:

In context, the eight-minute response time applies to life-threatening conditions, which account for about 34% of our 999 calls. I will follow up on what Olivia said: the objective of the Northern Ireland Ambulance Service is to reach as many people in the life-threatening condition category as possible within eight minutes. Although the target is currently 72·5%, we endeavour to get to every call that we answer within eight minutes.

It is true that, at face value, the Northern Trust's performance may not look impressive compared with those of other regions. However, since we started engaging in performance improvement with the Department, we have improved from a category A response of 49·4% in 2007-08. In 2008-09, we brought the figure up to 56·8%, last year it increased to 62·7% last year; and the figure, as of this morning, is 66·7%. Given the terrain that we cover, that improvement

was difficult to make. The present debate has identified that an extremely rural area is one in which it is difficult for the Ambulance Service to deliver an A&E response.

Nevertheless, to put today's discussions into context, rather than front-loading to achieve 72·5% or more in some areas in an effort to improve our regional position, there is an inbuilt lower limit for the Northern Trust area of 67% this year. Last year, that figure was 65%. Therefore, our objective is to try to ensure that the minimum target is achieved in all areas, with a view to improving it to the level of the priorities for action (PFA) target. In fact, in some areas we exceed the PFA target. Therefore, for us, every response is critical, and we endeavour to do our best with the resources that we have.

Mr Bloomfield:

In addition and by way of clarification, Brian McNeill mentioned the performance in the Northern Trust area. The question was whether, to achieve 70% response within eight minutes, there was a risk that all the remaining 30% of calls would be made from rural areas. That is definitely not the case. The minimum target requirement, which is to achieve 62·5%, increasing to 65% in any local area, has exactly the same status as the regional target of 70%. There is, therefore, no question of sacrificing any area to achieve a regional target.

Mrs McGill:

I disagree. Is there any analysis of the figures?

Mr Bloomfield:

Yes.

Mrs McGill:

Is there mapping to show that, in the extremely rural area to which you referred, the eight-minute response target for life-threatening conditions is being met?

Mr Bloomfield:

Yes.

Mrs McGill:

It would be valuable to see that. Therefore, in extremely rural parts of, for example, mid-Ulster and my area of west Tyrone, is that eight-minute target close to being met?

Mr Bloomfield:

The eight-minute target is met in the area covered by the Western Local Commissioning Group and, in this case, the area covered by the Northern Local Commissioning Group. In fact, the Ambulance Service achieved the 62·5% requirement in the Northern Trust area throughout 2010, and those figures are available.

Mrs McGill:

However, the fact remains that approximately 30% of calls are not reached in anything like the eight-minute target. Brian, you mentioned the resource, which is another argument: how many ambulances are there?

The Deputy Chairperson:

I will let Kieran come in with a quick question.

Dr Deeny:

Thank you, Madam Vice-Chairperson. That is a nice title. I will call you that from now on.

I will not hold you up. I just want to clarify something that Peter said. Peter, I hope that you are not sending out the wrong message. Those of us who believe that rural communities must be

provided with life-saving services do not suggest that every area should have a spanking new hospital, such as the Royal. No one has ever said that.

My question is directed to the Department. I visited Scotland to see what happens there. In Scotland, six hospitals provide the ABC services, which Dr Dornan mentioned, to stabilise people before they are moved to bigger centres. The problem is that we do not have any of those. I visited Oban and Fort William. Such a service also exists in Wick, and it looks after a population that is much more remote than that of the west.

Staff in large, acute hospitals will tell you that they want a patient who arrives at the Royal with a head injury, or at the Ulster Hospital with a burn, to have been well stabilised, rather than being almost deceased. Having worked in a hospital, I agree with them, because that is to everyone's benefit. In Scotland, six hospitals provide for rural and remote areas. Has the Department ever studied what happens in Scotland?

I agree with the Chairman, Mr Wells, that for the Department to persist with Developing Better Services would be to fail Northern Ireland's rural people. That is for sure. Were that strategy on the table now, it would not be passed, because far too many of us represent rural areas. By the way, Northern Ireland is a mainly rural part of the world. Should the Department not examine how Scotland provides for its rural communities?

Mr Galloway:

We could study other models of service, but the Department's strategy is based on Developing Better Services, which does not exist in isolation, but sits alongside, for example, the Ambulance Service. Often, we debated with the Committee rapid response and the use of paramedics to carry out ABC work to ensure that people are stabilised for their transfer to hospital. The information that I gleaned from clinicians is that, although they want patients to arrive at hospital having been stabilised, they do not want them to be taken to local hospitals as a stopgap.

Dr Deeny:

That happens in Scotland, where the Royal Colleges have accepted the practice.

Mr Galloway:

The distances involved are markedly different. In Northern Ireland, we want to get patients to the right place as soon as possible. The right place is an acute emergency department that has the backup of intensive care, acute surgery, anaesthetics and the range of acute services that are vital to ensuring that someone who is seriously ill and whose life is at risk has the best possible chance of a good outcome. That is what the Department's strategy aims to deliver.

The Deputy Chairperson:

OK. I thank all of you for your attendance and for taking our questions. We have not asked all of the questions that we wanted to ask. If we were to forward you some questions, perhaps you would respond to us in writing. Furthermore, we did not get to discuss David's point about how you envisage the future of the Mid-Ulster Hospital. Perhaps, the Committee could receive a briefing on how the Northern Trust envisages the hospital's development in the future. Thank you, again, for your presentation.