Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session with Departmental Officials on Acute Services in Northern Ireland

27 May 2010

NORTHERN IRELAND ASSEMBLY

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

Witnesses:
Mr David Galloway) Department of Health, Social Services and Public Safety
Dr Miriam McCarthy)

The Chairperson (Mr Wells):

I would like to introduce the witnesses who will give evidence at today's meeting. A regular attendee Dr Miriam McCarthy was here last week, and Mr David Galloway, who has also been here many times. I see that Dr Paddy Woods will not give evidence.

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

He is unable to join us today.

The Chairperson:

I hope that you will be able to field any questions that he would have answered. You have been through the routine many times. I ask you to make a presentation of 10 minutes, if possible. I assure you that there will be a lively question-and-answer session afterwards. You will probably be able to guess the sort of issue that members will raise.

Dr Miriam McCarthy (Department of Health, Social Services and Public Safety):

To set the scene, we will take a couple of minutes to go over some facts and figures and provide some background to the configuration of acute hospital services. We are happy to take any specific questions afterwards.

We expect the current population of approximately 1·8 million to increase significantly in coming years. It is anticipated that the population of Northern Ireland, between now and 2020, will rise by 142,000, a significant proportion of whom will be older people. The number of people who are over 75 years of age will increase by 40% compared with the figure in 2008, and there will be a significant increase in the number of elderly people who are over 85 years of age. That will have a major impact on the utilisation of hospital services. On any typical day, for example, 800 beds are occupied by people who are over 70 years of age, because, needless to say, older people tend to be sick more often. As many as two thirds of hospital beds are occupied by people who are over 65 years of age. The likely impact of that demographic change towards an ageing population is a 17% increase in hospital admissions by 2020.

That gives you a flavour of the anticipated increase in acute services activity. Hospital services are already extremely busy responding to the needs of people in Northern Ireland. In 2008-09, there were 1·369 million — almost 1·4 million — outpatient attendances.

The total A&E attendance is also interesting: in 2008-09, there were 732,000 attendances, which is a significant level of activity. The total number of admissions was 583,000. Half of those were elective, planned admissions, usually for surgical procedures, and the balance was made up of emergency and other admissions.

In 2008-09, the number of hospital births, which we talked about last week in the context of maternity care, was almost 26,000. We now make more appropriate use of our space by carrying

out much more surgery, almost 70%, on a day-case basis, rather than admitting people to hospital. That is much improved from previous years and represents a significant change. The average length of stay in hospital is about 2·5 days. Those statistics provide you with a flavour of the demand for the hospital service, how it is managed and the sheer number of people who use it.

The strategic direction for the configuration of services was mapped out in the 'Developing Better Services' (DBS) document, which was published for consultation in 2002 and followed by a ministerial announcement early in 2003. That document, which the Committee has discussed previously, sets out key criteria, one of which is access to services. The vast majority of people live within 45 minutes of a hospital that provides a 24-hour A&E service and a consultant-led maternity service. Everyone in Northern Ireland lives within an hour of an acute hospital that provides both services.

'Developing Better Services' also stated that hospitals should work on a networked basis. Some local hospitals should primarily deal with outpatient activities, such as outpatient appointments, day-case surgery, diagnostics and minor injuries. They should also provide some beds for palliative care and rehabilitation. Acute hospitals should provide all those services and more: coronary care, inpatient medicine and the more complex surgery that requires an inpatient stay.

We recognise that some hospitals should provide regional services. Realistically, given the population base in Northern Ireland, certain services can and should be provided in a single location. Typical examples are cardiac surgery and neurosurgery, both of which require highly specialised services, and they tend to be concentrated in Belfast. They are based in the Royal Victoria Hospital and cater for the entire region. 'Developing Better Services' set out the different types of hospital but emphasised that, to ensure safety, quality and sustainability, they would have to work together in a network, rather than in isolation. That is largely the pattern of service that exists today.

In recent years, the responsiveness of services has significantly improved. Most emergency calls are now answered and responded to within the eight-minute target time. In most areas of Northern Ireland, about 70% of calls are responded to within that time, which is an improvement on the position some years ago.

The current targets are nine weeks for outpatient appointments, nine weeks for access to diagnostics and thirteen weeks for elective inpatient work. Four or five years ago, when people waited for significant periods, we could hardly have dreamed of achieving that degree of responsiveness. The enormous improvements have been recognised across Northern Ireland, and people have accepted and come to expect that improved level of service.

No one wants to stay in hospital for longer than necessary. We have improved the speed at which people are discharged when medically fit to go home, and, for the vast majority of people, that happens within a matter of hours. The target is to discharge those with uncomplicated cases within six hours of their being declared medically fit. In some cases, complex care packages must be put in place to enable people to go home. In those circumstances, we aim to have most people discharged within 48 hours, and all patients within seven days, bearing in mind that a little time is needed for those whose care requires complex planning. Against a backdrop of an inexorable rise in the demand for acute hospital services, there has been a significant improvement in their responsiveness.

That was a brief profile of some aspects of acute services. It is not complete by any means, but we are happy to respond to any specific issues that members want to raise.

The Chairperson:
Thank you, Dr McCarthy. You may be aware that several West Tyrone MLAs are here, so I will allow them to raise their concerns about acute services.

As it is topical and relevant to what you have said, I will voice the general dissatisfaction about how the situations at the Mid-Ulster Hospital and Whiteabbey Hospital were handled. The fact that accident and emergency services would eventually be removed from both hospitals had been flagged up. Suddenly, however, out of nowhere, the residents of both areas were given two weeks' notice that those services were being removed, and they have now gone.

I understand that a meeting took place last Friday between local MLAs in the mid-Ulster area and Colm Donaghy, the chief executive of the Northern Trust. Mr Donaghy admitted that it would have been perfectly feasible to continue providing accident and emergency cover at the Mid-Ulster Hospital through locums. That could have happened for at least another year. For one or two weekends, cover might not have been provided because of the unavailability of

consultants, but the community could have lived with that. What people cannot understand is the blind panic that arose when Antrim Area Hospital was told that accident and emergency services would be removed from those hospitals in two weeks' time. It has also been said that the Antrim Area Hospital was, at times, bursting at the seams. Why was that situation allowed to develop, and could that happen to other hospitals in Northern Ireland?

Mr Galloway:

You will be aware from the Minister's comments on the issue that he met with Colm Donaghy and Dr Dornan, the clinical director of unscheduled care in the Northern Trust, on 26 April 2010. At that meeting, the clear advice from the trust to the Minister was that, because of staff reductions at Whiteabbey, it could not guarantee that it could sustain the A&E services on either site. Two members of the medical team in the A&E department at Whiteabbey left in May 2010. The Mid-Ulster Hospital had locum doctors but no permanent staff in post, and the trust envisaged trying to sustain acute services at the Mid-Ulster Hospital, Antrim Area Hospital and Whiteabbey Hospital in that scenario. The trust's clear advice to the Department was that it could not live with that situation because of the potential risks to patients.

The Chairperson:

Up to that stage, the trust had been using locums quite happily.

Mr Galloway:

For the past six months, the trust had been using locums almost exclusively. However, its judgement was that locum cover itself was not a satisfactory solution. The absence of permanent staff led to a situation in which locum contracts were continually being renewed, and, at times, that might not work. If anything had happened to services at Whiteabbey Hospital and there had been difficulty providing locum cover in the Mid-Ulster Hospital, the trust would not have been able to spread resources across the three sites.

The Chairperson:

I am sure that that issue will be raised again by the representatives from the area. As far as A&E services in Northern Ireland are concerned, who has ultimate control over where a consultant works? Does the Department have the authority to say that a consultant must go to a certain hospital? Alternatively, does the Department ask a consultant nicely to go to a particular hospital, but he or she has the right to refuse?

Mr Galloway:

Consultants are under contracts of employment with a specific trust, not the Department. The contract specifies where a consultant is expected to work on entering his or her contractual commitment. There are problems with trying to change the terms of individual contracts to get consultants to work across different hospital sites, but those are matters for the trusts.

The Chairperson:

Surely the trusts should move towards contracts that require a consultant to go where he or she is needed. The current contracts seem to allow a consultant to decide where he or she would prefer to work and, in doing so, leave A&E departments, particularly in rural areas, bereft of cover.

Dr M McCarthy:

The trusts will always try to match the staffing resource of consultants, nursing staff and others to the service needs. There is, therefore, a need to set out what the service needs of a trust and match that with the right level of staffing. That is often tricky for a trust that has several sites, and the consultants' jobs may be altered to help to accommodate that. However, the trust holds discussions with staff on where the need exists and how that need can best be met on all its sites.

The Chairperson:

Is it a discussion rather than an instruction?

Dr M McCarthy:

My understanding is that, as David said, consultants are employed by the trusts. When consultants join a trust, they receive a job plan that sets out their role. It details a consultant's specific duties, such as outpatients or surgical lists, and it outlines the required administration and professional development elements of their posts. Each year, the job plan is reviewed and, perhaps, amended. From the trust's perspective, that review must take account of the service requirement and acknowledge the professional element that the consultant must bear in mind.

Mrs O'Neill:

David, you are well aware of my arguments about the Mid-Ulster Hospital.

Mr Galloway:

Indeed I am.

Mrs O'Neill:

The feeling in the mid-Ulster area is that Antrim Area Hospital cannot cope with the overspill and, as mooted in the 'Developing Better Services' document, a newbuild is required to enable it to cope with the capacity. What is happening with that?

Mr Galloway:

The business case for the newbuild and its additional 24 beds is with the Department. The decision brought with it other increases in capacity at Antrim, in the A&E department and additional beds throughout the hospital. In preparation for the change that took place on Monday, the trust opened a new area in the A&E department to use for the triage of minor injury patients, and it created a clinical decision unit of 10 beds associated with the A&E department. Both measures were designed to help the hospital to cope with the expected increase in demand. A further 11 beds were created in wards throughout the hospital. The trust did not embark on that change without having made provision for the anticipated increase in workload from the Mid-Ulster Hospital and Whiteabbey Hospital. The trust had to put steps in place to ensure sure that the hospital was properly equipped.

Mrs O'Neill:

The 'Developing Better Services' document, which planned services across the North, was published in 2002. We are now eight years down the line. Given the increasing demand on the Health Service, will that document be reviewed? Most health professionals agree that Antrim Area Hospital is badly located to service the population that it is supposed to serve. I have spoken to many health professionals who work in the area, and they share that view. When will you re-examine the period ahead?

Dr M McCarthy:

Strategic documents never last forever. It is the role of the Department, with the Minister's direction, to review, within appropriate timescales, every strategic document. We have no firm plans to reconsider the 'Developing Better Services' document, many elements of which have not yet been delivered. We are always conscious of ensuring that changing needs within the population are reflected in the documentation and that the implemented plans address those

needs.

Mrs O'Neill:

Will you consider opening the minor injuries unit at the Mid-Ulster Hospital seven days a week and extending its opening hours to 9.00 am to 11.00 pm or 9.00 am to 9.00 pm? Opening hours of 9.00 am to 5.00 pm from Monday to Friday are no good to anyone. A development of the system along the lines of the south Tyrone model would be far more beneficial to the people in the mid-Ulster area, and it could assist in building confidence in the Health Service.

Mr Galloway:

I can confirm that the Minister has asked the Northern Trust and the Health and Social Care Board to consider an extension of opening hours at the Mid-Ulster Hospital and at Whiteabbey Hospital.

Mrs O'Neill:

I welcome that. You talked about ambulances and how they are a critical part of the acute care process. Has there been any study of how effective the rapid response vehicles have been since their introduction?

Mr Galloway

I remember the many discussions about rapid response vehicles that we and the Committee have had in recent years. Rapid response vehicles have been in service since 2006. The number of vehicles has increased, which has been valuable to the Ambulance Service and helped it to achieve better standards of performance against the eight-minute target. There has been no specific evaluation of their role since the comprehensive spending review (CSR) decisions of the past year.

Mr McCallister:

I want to take you back to some of the questions that the Chairperson raised about the idea of sharing staff. Miriam mentioned networking: how can we build and improve networking in the Health Service? Those of us who attended today's lunchtime briefing heard about the problems with sharing the expertise of consultants and middle-grade doctors among the Tyrone County Hospital, Altnagelvin Area Hospital and the Erne Hospital. The Chairperson and I are familiar with that problem, because the Downe Hospital and the Ulster Hospital have had difficulty

sharing staff. How do we put the sharing of staff into practice?

David Galloway said that staff have employment contracts with the trusts. How do we lift our game to share that expertise on sites where the patients are located, as opposed to bringing the patients to the doctors? It seems that we are going about things the wrong way round.

Mr Galloway:

The DBS document envisages a network model that includes acute hospitals and local hospitals. A network of local hospitals would continue to do the majority of the work needed by their local communities, including diagnostic procedures, day procedures and other non-acute activities. Therefore, people in mid-Ulster would still use the hospital in Magherafelt for the vast majority of problems that require them to go to hospital.

You are right, John, about the need to work together, and that goes back to the Chairperson's point about contracts. The trusts must step up to the mark and ensure that the services that they deliver are coherent across their area. To gain the best from the facilities and optimise the ability of local hospitals to deliver outpatients' services, diagnostics and day procedures, they must make the best use of the local hospital network within their organisation. That is important, because the future demand on the acute sector will rise as the population ages and people with more acute illnesses come forward. We must, therefore, ensure that the acute hospitals do not become swamped by people who could receive their care elsewhere.

The onus is on the trusts to put networking into practice. One of the issues for trusts is that DBS has not yet been realised to its full extent. We are in the process of trying to achieve that full realisation, which may explain why certain elements are not working as well as we hope that they will work in future.

Dr M McCarthy:

I will give a little more detail on how the network is made to work. As David said, the concept is one of aiming to provide as much as possible, as locally as possible. The ideal is to provide services locally, because that is far easier for patients than having to travel excessive distances. People who have to be admitted to hospital for major and complex treatment are usually content to travel, because doing so enables them to access the best care and attention.

The network often requires medical, nursing and other staff to work across several sites. In recent years, the move to fewer trusts has helped to make that possible. Consultants who may have been employed previously by a single facility or hospital are now employed by a trust that manages two, three or four hospitals. That creates more flexibility across the boundaries, as opposed to consultants feeling that they are attached to a single institution.

More and more consultants work across sites. A surgeon, for example, might carry out complex inpatient operations on breast cancer at Antrim Area Hospital. However, he or she would perform hernia and more straightforward operations, for which patients can be admitted in the morning and discharged in the evening, at the Mid-Ulster Hospital. The provision of services across two sites creates the beginning of a network.

Networks of trusts also work well, but we have more work to do to develop those. In urology services, for example, a clear alignment has recently been mapped out between patients in north Antrim and Altnagelvin. That will benefit people in the area and require consultants to work across trusts. Consultants will meet the needs of a particular part of Northern Ireland, rather than thinking on an institutional basis.

Furthermore, for regional services such as paediatric cardiology, which can be provided only in Belfast because of its specialised functions, consultants who are out at clinics in other parts of Northern Ireland have telemedicine facilities. The link enables a consultant to see a child at Altnagelvin on video, watch the child's heart tracing and provide an expert opinion to the general paediatricians in Altnagelvin. That happens in real time, negates the need for the baby or child to travel and provides access to the best service.

We will continue to expand the concept to ensure genuine networking across boundaries. As far as patients are concerned, the boundaries are artificial. Patients are interested in accessing the care, professional help and expertise that they need, when they need it.

Mr McCallister:

I agree with that. I live on a boundary, and I was not always sure in which trust area I was living. You told the Committee that progress is being made, but where have the blockages been? Is there some reluctance at professional level, or, if networking can be expedited, is everyone willing to move forward with that?

Dr M McCarthy:

Sometimes, logistical issues, rather than causing blockages, cause a small delay. We developed, for example, a networked arrangement for consultants to travel from Altnagelvin to Omagh to perform gastroscopies. It is not simply a matter of moving one doctor, because he or she requires nursing expertise and other support. The doctor must know that the necessary facilities and equipment are at the hospital. He or she also requires a facility to decontaminate and to ensure that the facilities are sterile, clean and ready for the next patient. That cannot necessarily happen overnight. The planning for, and recruitment of, support staff is required, and a small administrative element may also be needed. The direction of travel is established, but it takes some time to get everything in place to make it happen.

The Chairperson:

I wish you well with that. The Downe Hospital has been bedevilled by the reluctance of consultants, junior doctors and senior midwives to travel the 24 miles from Belfast to Downpatrick and back — hardly a horrendous journey. They simply were not prepared to make that journey. If we cannot get doctors and senior clinicians to go down the road to Downpatrick, what chance does a new hospital in Omagh have of recruiting such staff? The fact that 10,000 civil servants journey daily from south Down to Belfast seems to be perfectly acceptable. Perhaps that is not perceived as being as long a journey? The Downe Hospital has had a real battle to get people to provide that essential cover. I hope that you will be more successful, because clinicians are extremely reluctant to travel.

Dr M McCarthy:

As we discussed last week, we have been able to mark some real improvements in the Downe Hospital, one of which is the successful recruitment of more midwives for the community midwifery unit. Recruitment for that unit is ongoing, but it looks as though we will gain the required numbers of staff.

As we mentioned previously, the fact that a service at the Downe Hospital stopped and restarted created an additional problem. However, all such issues require time, and I hope that the Committee will see improvements in the future.

The Chairperson:

I really should not have lapsed into parochialism.

Mr Easton:

Is there a shortage of consultants in the Northern Trust?

Mr Galloway:

I do not have a precise figure for the number of consultants in that trust.

Mr Easton:

It is an easy question: yes or no?

Mr Galloway:

I do not believe that there is a shortage of consultants in the Northern Trust.

Mr Easton:

Yet there seems to be a shortage of consultants in the A&E departments of the Whiteabbey Hospital and the Mid-Ulster Hospital. If there is no trust-wide shortage, why did the consultants not come together to work out a rota to cover those A&E departments and keep them open? It strikes me that consultants were able to dictate where, when and how they worked, but the trust should have been doing that. From what you said, there was no reason why those A&E departments closed, because there were enough consultants to cover the Northern Trust.

Mr Galloway:

Sorry, if I could just clarify —

Mr Easton:

I have not finished. That was my first question.

The Chairperson:

Will we let the witnesses answer that question? It is an interesting and fundamental one.

Mr Easton:

OK.

Mr Galloway:

You asked a specific question. The doctors in the Whiteabbey and Mid-Ulster hospitals were not consultant-grade doctors. The difficulty was in sustaining a rota for a lower grade of medical cover.

Mr Easton:

There is no reason why the consultants could not have got together and provided cover until the situation was resolved. They are meant to lead by example, and it is quite clear that they did not do so in that case.

Dr M McCarthy:

I do not have the exact staffing numbers for the Northern Trust across all the specialities. There may not be a shortage of consultants in the Northern Trust, but the trust has four acute sites, and staffing services across that number of acute sites is extremely difficult. The number of consultants may be sufficient, but they are dispersed across the sites. In some areas, that means that the cover may be thinner than the Department would like it to be for the provision of a quality service.

The redistribution of staff to provide more even cover may appear to be a reasonable way forward. However, the difficulty is that the majority of ill patients who require emergency attention are more likely to go to the Antrim Area Hospital or the Causeway Hospital. It is essential to provide the right level or care and ensure that the level of consultant presence is greatest in those hospitals. The consultants are not, therefore, evenly distributed. The trust has considered the matter seriously for some time and endeavoured to provide the appropriate level of cover at the Mid-Ulster Hospital and Whiteabbey Hospital. However, as David mentioned earlier, the situation reached the point at which it was no longer safe enough. It is a matter of having the necessary resources — not only consultants, but doctors, training, nursing support and allied health professionals (AHP) support — where they are most needed by the population attending the hospital.

Mr Easton:

I do not accept that Whiteabbey and mid-Ulster are areas in which there is less need for consultants. I do not accept your argument that staff could not have banded together for a short

period and compiled a rota to cover the A&E services until replacements had been put in place. As Mr Galloway said, there is no shortage of consultants in the Northern Trust.

You did not have a problem getting locums to cover those two sites. However, the fact that they were not permanent staff led to those A&E units being deemed unsafe. If you were able to afford locums, which cost more to provide for the period that they worked, why did you not simply make them permanent? Had you done so, you would have had sufficient cover.

Mr Galloway:

The trust tried to recruit to those permanent positions on three occasions, but was unsuccessful in attracting candidates. The trust told me that the locum doctors who are working in the Mid-Ulster Hospital did not apply for the permanent positions. That situation has been ongoing for some months, and it reflects the difficulty that the trust has experienced in filling those posts permanently.

Mr Easton:

It is strange that locums want to work there temporarily but not in permanent positions. I would have thought most people would want have a permanent job, particularly during a recession. When I worked for the trusts, all my contracts contained clauses stating that the employer had the right to change my hours or move me between Ards, Bangor and the Ulster Hospital. Why can such clauses not be included in consultants' contracts? Will the Department ensure that such flexibility can be built into future contracts, so that cover can be provided when needed?

Dr M McCarthy:

I am not in a position to comment on the exact wording of consultants' contracts, but some flexibility is built into the system. All consultants must revise their job plans annually in conjunction with a senior colleague, who will set out their job plan for the following year. That job plan must reflect whether a consultant is required to perform more or less surgery and see more or fewer outpatients. That depends on the requirements of the trust and the particular hospital. The yearly review and inbuilt flexibility ensure that the system is sufficiently responsive and that needs are met.

The Chairperson:

That is a crucial point. Are consultants told that cover is needed in the hospital in Whiteabbey,

mid-Ulster or Coleraine and that they are needed there for two, four or six months? Alternatively, do consultants decide that they want to work for a week in one place, a couple of weeks in another, and the boss says that that is fine? Does that involve a cosy chat about where the consultant would like to go?

Dr M McCarthy:

My understanding is that it is a rigorous process, rather than a cosy chat. First, the consultants must satisfy a number of required elements to maintain their skills and expertise. Cardiac surgeons, for example, might need to perform about 200 cardiac procedures each year to avoid the risk of non-accreditation. Consultants and the trust, therefore, want the job plan to reflect sufficient cardiac sessions to allow the former to perform the appropriate number of operations. That is better for consultants and for patients, who receive care from a skilled expert.

If a consultant fancied carrying out a new procedure, but only five times a year, that would not necessarily be encouraged. Such occasional procedures do not provide an explicit proof of skills or of a consultant's ability to maintain his or her level of expertise. Therefore, a consultant will be required to carry out certain duties to meet the appropriate level of expertise. On the other hand, the trust knows the referral rate, the amount of activity coming into the trust and what is needed to respond to that activity. Therefore, the drawing up of the job plan involves a rigorous conversation and does not merely appeal to someone's wishes or likes and dislikes. It focuses on how a particular consultant, bearing in mind his or her area of expertise, is best placed to meet the needs of the service.

Mr Easton:

Does the Northern Trust save money through the closure of the two A&E departments, or does it have increased expenditure at Antrim Area Hospital to cover those closures?

Mr Galloway:

I understand that savings will be made as a result of a change in the pattern of service from A&E departments to minor injuries units at the hospitals in mid-Ulster and Whiteabbey.

Mr Easton:

How much will be saved?

Mr Galloway:

I do not want to misquote the figure, but I think that it is in the region of £3 million. We can confirm that for you.

Mr Easton:

OK. Were the closures aimed at saving money or improving patients' health?

Mr Galloway:

The decision was taken solely on the basis of patient safety.

Mr Easton:

Into what will the savings of £3 million be ploughed?

Mr Galloway:

Some of the money will be used to increase the capacity of the service at Antrim Area Hospital and to ensure that a stronger medical and nursing team is there to cope with the change.

Mr Easton:

You said "some".

Mr Galloway:

People will transfer from the Newtownabbey area to Belfast hospitals, so there will be increased activity there, and some people from the southern part of the western side of Lough Neagh will divert to Craigavon. Therefore, the Southern Trust will also receive additional patients. Money will be diverted out of that pool of savings to meet those additional needs.

Mr Easton:

Not the full amount.

Mr Galloway:

I do not know the full spending plans. I cannot detail that for you.

Mr Easton:

I will let someone else provide that.

The Chairperson:

We can ask for that information.

We move slightly west with the next question.

Mr Buchanan:

In your opening remarks, Miriam, you said much about using the Developing Better Services programme to create better access to services. You must agree, however, that the programme has failed the people of Omagh. You said that it stipulated a maximum 45-minute journey to an A&E and maternity services. It takes 45 minutes to travel from Tyrone County Hospital to the hospital in Enniskillen. It takes most people about 20 to 25 minutes to travel to Omagh in the first instance. The total travelling time is well outside that target of 45 minutes and well outside the golden hour target for acute services.

When we look at a map showing all the acute hospitals, there is a black hole in mid-Ulster, particularly in County Tyrone, which is the only county in Northern Ireland that does not have an acute service. You will agree that the future configuration of acute hospitals in Northern Ireland does not make sense. That is plain for everyone to see. At this Committee today, you must agree that, based on the map, the Developing Better Services programme has failed the people of County Tyrone.

Country Antrim has a population of 566,000 and four acute hospitals. County Down has 416,000 people and three acute hospitals. County Londonderry has 213,000 people and two acute hospitals. County Armagh has a population of 141,000 and one acute hospital. County Fermanagh has a population of 57,527 and one acute hospital. Lo and behold, County Tyrone has a population of 166,516. How many acute hospitals does it have? None. That is a grave failing by the Department. The driving forward of Developing Better Services has stripped County Tyrone of acute hospital services, which, as I think that you will all agree, is an issue of grave concern.

Earlier, you spoke about the need to network services across the trust. However, I am fed up and sick to the back teeth of listening to all the talk about networking, because it is not working in the west of the Province. I want the trust to examine that problem.

The Chairperson:

Tom, will you come to a question?

Mr Buchanan:

I will. You spoke about telemedicine. Omagh had a great telemedicine system that was taken away. Why was it taken away and never restored?

Given that the Chairperson is pushing me, I shall come to my final question. We hear that the new hospital is being built in Omagh, but the Minister tells us that he does not have the money for it. Where is the money that was supposed to have been secured in the CSR, and will the hospital in Omagh be included in the next three-year investment strategy?

The Chairperson:

Had that question not been asked, I would have been dumbfounded, so I am sure that the witnesses are ready to answer it.

Dr M McCarthy:

Before answering Mr Buchanan's final question, I shall make a couple of other points. There is no acute hospital in County Tyrone, but we do not — and, at the time of DBS, we did not — look at Northern Ireland by county. At that time, to ensure that people would have access to an acute facility within an hour, a rigorous piece of work was carried out on travel times, and that work still holds. Several road improvements will, it is hoped, improve travel times in parts of the Province. Nevertheless, access to acute services was not defined by county boundaries, but by travel time.

You are absolutely right, Mr Buchanan, that networking could and will be a real asset for people in the Omagh area. Some aspects of networking have already helped to deliver better services. Cardiac assessment in Omagh is one area in which we acknowledge the benefits of working with consultants in Altnagelvin. Dr Albert McNeill, a cardiologist from Altnagelvin, led a significant piece of work to ensure that a facility was put in place for people with cardiac problems to be suitably assessed and, if requiring admission, as, inevitably, some will, to be admitted to Altnagelvin. In those circumstances, a natural linkage exists. A great deal of effort and work went into putting that facility in place. My understanding is that it works extremely

well, benefits the local population, and local GPs and clinicians are highly appreciative of it. That is one example of successful networking, although more can be done.

Ophthalmology is another area in which the potential in Omagh has been explored. In addition, we expect to see an increase in day-case procedures and further diagnostics. I acknowledge that there is scope to do more, and we must do so. As I said, that will not happen overnight, but the direction of travel has been established. That must be exploited fully so that people in the Omagh have access to all those services that can be provided locally. An enormous amount of healthcare could be provided locally, and we expect that 70%, if not a little more, will be. That will mean that people will need to go to an acute hospital only in serious circumstances in which they might need access to an intensive care bed or to a specialist opinion. It is important to get that balance right, and networking is a valid and important issue to address in trying to achieve that.

I understand that the Committee met the Minister yesterday and that he assured you that he is still committed to the new hospital. I am sure that my colleagues who were here last week emphasised that the capital budget is under considerable pressure. There are competing priorities for that capital money. For many years, there was an underinvestment in the buildings and infrastructure of hospitals. In recent years, the development of much more modern treatments requires more sophisticated technology and equipment, which are expensive to provide. Therefore, even greater pressure is being placed on an ever tightening capital budget. That has required the Minister carefully to consider his priorities. There is much that he wants to do, but sometimes the money available does not match the long list of capital expenditure.

The Chairperson:

If the notional £190 million that was set aside in the budget for a new hospital in Omagh were reduced to £60 million and a hospital similar to the Downe Hospital was built instead, would the Department's view change, particularly given that the community has said that it would be happy to accept that? It just so happens that the Committee was at the Downe Hospital last week. If the cost reduced to £60 million, which is not as big a chunk, would the new hospital become more realisable?

Mr Galloway:

I hope that it was explained to the Omagh liaison group at yesterday's meeting that the Health

Department and the Department of Finance and Personnel must settle the capital budget that will be available. Undoubtedly, there is benefit in delivering a capital build for less cost. However, at the moment, we are not clear about what capital funds will be available to us in the time frame in which we want to take forward that project. I think that the Minister tried to explain that to the liaison group yesterday, Mr Buchanan. We cannot draw on money that we have in a bank somewhere. DFP allocates money to the Department annually. The capital resources available to us have been cut for 2010-11, and revenue cuts have already taken place. The Department's capital profile over future years remains a matter for discussion with DFP.

Mr Buchanan:

Where does the new capital build project for Omagh sit on the Minister's list of priorities?

Mr Galloway:

I heard the Minister tell you yesterday that the Omagh project sits highly on his list of priorities, because it is central to establishing a network of hospitals for the western area that will work in conjunction with the new hospitals in the south-west.

Mr Buchanan:

With all due respect, you are using a broad brush. Your saying that the project is reasonably high or very high on the Minister's list does not give a true indication of its position. It is my understanding that the project is twenty-seventh on the priority list. Will you clarify whether that is correct, or is it higher? Is it one of the Minister's most prioritised areas?

Mr Galloway:

We have a wide range of priority areas across the acute sector, of which Omagh is definitely one. However, I cannot rank its priority.

Mr Buchanan:

We are not getting an answer.

The Chairperson:

I understand your position, Mr Galloway.

Dr M McCarthy:

It is not as simple as ranking the priorities in linear order, because there are sequencing issues for some of the capital work. We cannot, for example, work on one part of Royal site until we decant from another part. Certain complexities mean that we cannot take the number one project off the list, then number two, and so forth. However, as David said, the Omagh project is certainly one of the Minister's priorities, and, as you know, it has been for some time. He is committed to that.

Mrs McGill:

You are welcome. I wish to follow on from Mr Buchanan's contribution on the Omagh hospital. I am also an MLA for West Tyrone. The Minister met the liaison group yesterday, and members of the Committee have just come from a meeting with Kate Law, Mr McKee and Fr Kevin Mullan, who are members of a long-standing steering group that campaigns for acute hospital provision in the rural west. It is now accepted that there will not be an acute hospital. I will raise some of the points — particularly those that Kate Law made — from that meeting, which took place at lunchtime.

Kate Law raised the issue of the Ambulance Service, which Dr McCarthy mentioned earlier today. We spoke about the networking between Altnagelvin Area Hospital and the hospitals in Enniskillen and Omagh. Omagh and the rural areas that comprise its hinterland are part of my constituency. Kate Law said that trolley waits are often preceded by ambulance waits. There is a wait of between 10 minutes and half an hour for a trolley to offload a patient. It strikes me that the hospitals in Enniskillen, Altnaglevin and, perhaps, Craigavon, are not in a position to cope in the way in which the Department and others have described.

Kate Law also said that when the services in Omagh were reconfigured, reduced and removed, extra ambulance cover was provided. However, she said that an ambulance and crew that had been promised were withdrawn. Although there are three rapid response vehicles, only one has a crew. That is important, and I remember only too well from my time as a member of the campaign group that the provision of rapid response vehicles was supposed to act as a substitute for the acute services that were being removed.

You referred to the target of providing 70% of responses within eight minutes. That applies in urban and rural areas. In calculating performance against that target, an average figure is taken.

Has a survey ever been conducted on response times in rural areas? I imagine that the response in rural areas is slower and that the figures even out when urban and rural response times are combined to produce an average.

I have another question, and I will be brief —

The Chairperson:
I will let the witnesses answer those three difficult questions before they answer a fourth.

Dr M McCarthy:
I will answer a couple of those and ask David Galloway to comment on the detail, particularly on the last question.

You are right, Mrs McGill to raise the issue of ambulance cover. I am not aware that an ambulance has been withdrawn from that area, and I will check on that. In 2008, when we considered the proposed changes to services, a proposal was made to increase the level of ambulance cover in the south-west. A significant investment was targeted at ensuring that people in that area had speedy access to the hospital care that they require.

At that time, we carefully considered call times, distances and ambulance stations. In the past couple of years, the Ambulance Service has improved considerably in many ways. That is partly because of the GPS technology through which it can track its vehicles and partly because it has flexible deployment points. That flexibility means that vehicles can be positioned closer to the areas from which the service anticipates that the calls will come, rather than sitting in a station. That greatly increases their ability to respond quickly and attend an emergency call within eight minutes, if not less. If a patient's heart has stopped following a heart attack, for example, the first few minutes are vital, and resuscitation must occur within three minutes.

I want to make one point about acute services in the rural west. In 2012, we will be in a position to open the acute hospital in the south-west, which is currently under construction. It will be a state-of-the-art modern facility and provide real advantages to people in the wider south-west area. When it opens, there will be a major improvement in hospital facilities and in the ability to access services in a timely manner. Such a state-of-the-art facility will be much appreciated in the area.

Mrs McGill:

Perhaps I did not make myself entirely clear. My area, Omagh, is in the west. However, it is now being identified as somewhere that will be served by the hospital in Enniskillen, which is in the south-west. To be clear, I am talking about West Tyrone and areas such as Gortin, Greencastle and Plumbridge.

Dr M McCarthy:

I understand that. However, I am dealing with the population in its widest sense.

Mrs McGill:

Mr Buchanan made a good point earlier. He quoted the stark figures that detail hospital provision by county. We received those figures from Kate Law, and they —

The Chairperson:

We are running over time, and, unfortunately, I have to move the meeting on. If members have any further questions, we will write to departmental officials.

Mrs McGill:

I will finish on one final point. I welcome the Minister's statement, but only if it will deliver. However, Kate Law made the point that services, as opposed to buildings, are the priority for Omagh at this stage. Perhaps you could consider that.

Finally, you referred to the work of Dr Albert McNeill and that of other clinicians and medics. Others, outside the field of medicine, also commend the extremely good work that he does.

The Chairperson:

To speed things up, I will ask Dr Deeny and Tommy Gallagher to combine their questions. We are well over the hour that was allocated for this session, and the next session is on a crucial issue that we simply must address.

Dr Deeny:

I will be as brief as I can. Apart from the Minister, most senior people from the Department are present, and perhaps they can answer my question. Why are there three MLAs from West Tyrone

on the Committee? If patients in the area were happy with their lot, would that still be the case? There are 18 constituencies and only 11 Committee members, but three are from West Tyrone. That speaks for itself. Surely the Department recognises that something is wrong. I also speak on behalf of health professionals, and I am glad to have the support of my two colleagues on the Committee. The issue will not go away, and we will not let it go. I am glad to see that people from a professional background are here today, because they know that the issue will not go away until it is resolved.

The Minister talks about the inequality of healthcare. Does the Department think that the map depicting hospital provision reflects an equality of healthcare? There are four hospitals in the greater Belfast area, six hospitals within 20 miles of Belfast and seven hospitals within 25 miles of Belfast.

I have something important to put on record in response to Miriam's comments. I live over an hour away from a hospital. I do not know how the research on travel times was carried out, but it is incorrect. The bottom line is that my patients live over an hour away from a hospital. I live some 40 miles, on one of the worst roads in Northern Ireland, from the nearest acute hospital. I cannot get there within an hour, unless I do so at 4.00 am, when there is no traffic. Once and for all, let us bury the myth that everyone in Northern Ireland lives within an hour of a hospital. I hate hearing that — it infuriates me. Time and again, we are told that that is the case, but it is not. Talk of equality of healthcare is nonsense, because it does not exist. Three hospitals in my area have gone. Does that represent equality of healthcare? There is geographical discrimination in the provision of healthcare in Northern Ireland — full stop.

My last question is about safety, about which I should know something. When I am contacted, safety and responsibility begins at that point of contact. Your Department continues to talk about safety in buildings, but where does the responsibility for safety begin? As a practising clinician, safety begins at the point of contact. As clinicians on the front line, it is our job to ensure a patient's health and care from the moment that he or she makes contact. I read all of the Department's statements about safety in hospitals. Of course, we want our hospitals to be safe. I am from the east coast, but I now live in Tyrone and have done so proudly for the past 24 years. That area is now unsafe. As a Department, do you not have a responsibility for people from the moment that they lift the phone to talk to their GP, rather than confining safety to the time at which they arrive in a building? You must answer that question.

You talk continually about safety, but a third hospital has closed in my area. The other night, Gerry Robinson talked about how three hospitals in Belfast are located within two miles of one another, and yet three in mid-Ulster have closed. We hear about safety, but there have been closures in Omagh and Dungannon and now at the Mid-Ulster Hospital. Why are we not talking about the safety of the areas in which people live and work? My view, and that of my fellow clinicians and the public, is that the area of mid-Ulster, thanks to your Department, has become an unsafe area in which to live and work.

The Chairperson:

Tommy, will you combine your questions with those of Dr Deeny?

Mr Gallagher:

Yes. Earlier, you talked about improved clinical networks, which I welcome. That objective was contained in the 'Developing Better Services' document. To realise that objective, you have a great deal of work to do in pushing the trusts' management and consultants. You said that almost 500,000 people used A&E services in 2008-09. Is that number on the increase? If so, have you analysed the figures to ascertain why that number is increasing, given that some out-of-hours operations state that they are not particularly busy at night and have had to make adjustments accordingly?

You stated that a patient waits for about nine weeks for a diagnosis and for so many weeks after that for treatment. As all members know, particularly from hearing in our constituency offices about people who are on the receiving end, that is a problem. In view of the new financial arrangements and pressures that we will face during this financial year, will those times be maintained?

The Chairperson:

Can you take on board all those points? You may have detected a certain level of uneasiness about the provision in Tyrone. There is a great deal of concern about the lack of provision there.

Dr M McCarthy:

I will try to keep my response brief. A&E activity has increased. Between 2006-07 and 2008-09, for example, the number of attendances increased by some 40,000, which was significant.

Referrals to outpatients have also increased by about 10% each year. We are examining that pattern in an effort to understand why the increases are happening so quickly and how best to deal with them. The trend may be partly explained by an ageing population and the fact that older people tend to have more illnesses, but we want to drill deeper to find out what other explanations there may be and how best to address the situation.

In general, activity in the acute hospital sector has increased. Mr Gallagher's point that there are fewer out-of-hours surgeries in the middle of the night is probably correct. However, some years ago, a report stated that operating in the middle of the night did not provided the same good outcomes for patients as daytime surgery. It identified risks associated with operating at 3.00 am or 4.00 am, although, if the situation is life-threatening and there is no choice, the operations go ahead. If patients can be stabilised and are able to wait until the early morning, medical staff prefer to operate then, because the outcomes for patients are better. For patient safety reasons, we have deliberately reduced the amount of operations that are carried out in the middle of the night.

I agree that patient safety starts not when a person enters a hospital, but at the first point of contact. Dr Deeny, Ambulance Service staff are acutely conscious, as are GPs, that the first objective is to do no harm and then to provide as much treatment as is necessary to stabilise a patient and prevent further complications.

In those areas in which there have been changes to the hospital services, we have ensured that safety is sustained by increasing ambulance cover in those areas, without compromising the ability to respond quickly.

We have responded to the issue of travel time to hospitals. I am aware of Dr Deeny's comments today, and previously, on potentially lengthy travel times. I can only reinforce the point that the work carried out on travel time indicates that people live within an hour of an acute facility, and —

Dr Deeny:

They are not. That is not the case.

Dr M McCarthy:

I am aware of your comments on that, Dr Deeny. I made only brief responses, because I am

aware of the time.

Mr Gallagher:

What about waiting times?

The Chairperson:

The issue was raised of having to wait in the ambulance and then on a trolley.

Mr Galloway:

The typical turnaround time for an ambulance driver at an A&E department is about 20 minutes. The ambulance staff must perform certain tasks to hand the patient over safely to the care of hospital staff. Without knowing the detail of what was explained to the Committee at the lunchtime meeting earlier today, I suggest that it may be connected to that issue.

Mrs McGill:

If I may interrupt, Chairperson, it was a former consultant Kate Law who made that point, and I assume that she knew what she was talking about. Sorry, but I had to make that point.

Dr M McCarthy:

In response to the general issue of waiting times, the many improvements in the past couple of years did not happen without a great deal of work and genuine commitment from hospital staff across a broad range of specialities. Often, it is challenging to meet the nine-week, nine-week and 13-week waiting times that were outlined earlier. Undoubtedly, as we look forward to facing further financial constraints, that will increasingly be the case. Colleagues who are due to give evidence to the Committee later this afternoon will be in a position to say more about what that may entail.

Dr Deeny:

Why do you think that three West Tyrone MLAs sit on the Committee that scrutinises your Department?

Dr M McCarthy:

What can I say? I know that you all have an interest in health and in your population base in rural areas, and I think —

Dr Deeny:

Do you not think that it has something to do with our constituents and patients?

Dr M McCarthy:

I think it is —

The Chairperson:

I thank Dr McCarthy and Mr Galloway for answering a varied range of questions on an issue about which all MLAs, never mind the Committee, care deeply. I am sure that we will return to the subject in the future. Thank you for your time. The Committee will move on to another difficult and pressing issue in which I know that you also have an interest.