Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Regional Neurology Service: Evidence Session with the Belfast Health and Social Care Trust

14 October 2010

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Regional Neurology Service: Evidence Session with the Belfast Health and Social Care Trust

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Tommy Gallagher
Mr Sam Gardiner
Mr John McCallister

Witnesses:

Mr Gerry Atkinson	)	
Mr Stephen Cooke	)	
Ms Patricia Donnelly	)	Belfast Health and Social Care Trust
Dr Jim Morrow	)	
Ms Bernie Owens	)	

The Chairperson (Mr Wells):

I welcome the representatives from the Belfast Health and Social Care Trust. I have to pop out briefly after I have introduced the witnesses. Normally, we ask Alex, in his role as the number 12 of the Committee, to take the Chair. Are members content that Alex takes the Chair for five minutes?

Members indicated assent.

I welcome Patricia Donnelly, who is the director of acute services. There are a lot of Patricia Donnellys out there.

Ms Patricia Donnelly (Belfast Health and Social Care Trust):
Unfortunately, there are.

The Chairperson:
You are probably the most senior one.

I welcome Bernie Owens, who is the co-director of acute, critical care, trauma services; Stephen Cooke, who is a consultant neurosurgeon and the clinical director of neurosciences and rehabilitation; Dr Jim Morrow, who is a consultant neurologist; and Gerry Atkinson, who is the service manager in neurosurgery. We seem to have all the people who are involved in this issue. Is there much going on back on the ward with all of you missing? We appreciate such a high-powered delegation coming to the Committee.

You will be aware of the concern that has been raised about the regional neurology service. Tommy Gallagher was the first member to raise the matter, followed by Dr Deeny. A few members have received material on the issue from concerned individuals in our constituencies, because you provide a service for the entire Province.

(The Acting Chairperson [Mr Easton] in the Chair)

The Acting Chairperson:
Thank you for attending. Please give us a 10-minute presentation, after which members will ask questions.

Ms Donnelly:
We welcome the opportunity to set out our plans for the service and some recent developments.

Committee members will know that the Belfast Trust consulted widely in 2007-08 on a strategic document, 'The Belfast Way'. In that document, we set out everything that we wanted

to achieve, including, at the top of the list, patient safety, modernisation and good resource management. It was with those particular objectives in mind that we came forward later in 2008 with a document, 'New Directions', that went out to wide public consultation. In that, we set out some of the strategic aims for our big services and for all our hospitals in Belfast. Within that, we committed to come forward with specific service improvements in cases where there had been a large strategic change in the service.

We are currently in consultation about acute services reorganisation. The consultation commenced in July and closes on 31 October. However, the neurology service and the neurosciences service were not part of that strategic change as there was no real movement between hospital sites or movement of staff across the trust. In 'The Belfast Way', as I said, we made a commitment to modernise, and we have at least 25 to 30 individual work groups on any specialty that you can think of — cardiology, vascular, and so forth. In those groups, we work with clinicians to consider how to improve patient pathways, because some of the ways that we have been working in the trust have existed for many years. We know from evidence elsewhere and from good practice that there are better ways to improve patient pathways.

I will pass over to Bernie Owens, who will set out some of the context of the neurosciences service.

Ms Bernie Owens (Belfast Health and Social Care Trust):

The neurosciences service in the Belfast Trust is largely contained within neurosurgery, neurology and neurophysiology. Neurosurgery is based at the Royal site and deals with brain tumours, spinal cords, head injuries, brain haemorrhages, and so forth. The neurology service, which we are specifically here to talk about today, has inpatient and outpatient services based at the Royal and an outpatient-only service at Belfast City Hospital; it deals with conditions such as epilepsy, multiple sclerosis, Parkinson's disease, Huntington's disease, motor neuron disease and some strokes. Neurophysiology, which obviously complements those services, is based at the Royal Victoria, Belfast City and Mater hospitals. They largely deal with the specialist neurodiagnostic service, and carry out the inter-operative monitoring for spinal surgery.

Referrals to the neurology service come from GPs, inter-hospital transfers, through A&E at the Royal site and from consultants inside and outside the trust. Neurology operates on a network basis, with the hub in Belfast. However, there are also two consultant neurologists at

Altnagelvin, one at Antrim, two at Craigavon and two at the Ulster Hospital. They work in collaboration across the region.

Neurology in the Belfast Trust is largely an outpatient or day-case-based service, with new outpatient attendances of 5,500 a year, and review outpatients of approximately 10,500, giving a total of 16,000 attendances at outpatients. There are 650 day-case treatments or diagnostic interventions.

Inpatients, which is based solely on the Royal site, gets approximately 350 patients through the elective care pathway and 350 through the non-elective, emergency pathway. The neurologists based in the Belfast Trust also provide outreach services to other trusts in the region: Altnagelvin, Antrim, the Erne in Enniskillen and Omagh to name a few. There are 8·5 whole-time equivalent neurologists in Belfast, supported by two neurophysiologists.

The bed complement in neurosciences is largely contained in wards 4E and 4F on the Royal Victoria Hospital site. Neurosurgery has a bed stock of 40, and neurology has six in ward 4E. Those beds are used flexibly, because they are adjacent to each other. Although we say that there are 40 neurosurgery beds, 29 are in ward 4F and 11 in ward 4E, where the remaining neurology beds are situated.

With regard to the environmental aspects, ward 4E has two six-bedded bays and four single rooms for neurology service use, and the remainder for neurosurgery, although, as I said, those beds are used flexibly. Infection control monitoring is ongoing, and there are no issues of environmental standards in that area.

The drivers for change, as Patricia highlighted, are to provide safe, high-quality, effective care in a faster, more flexible way, as were set out in the 'New Directions' consultation document. To that end, we have been involved in a benchmarking exercise with peer comparable services on other sites in the UK with a view to how we can improve the service in neurology to decrease our length of stay. We are doing ongoing work with a clinical expert from the NHS Institute for Innovation and Improvement, who is particularly challenging us by looking right across our services and not at just neurology.

We embarked on a neurology modernisation programme earlier this year, considering how we

can do things differently, improve patient pathways and make efficient use of all our resources. We agreed to look to some peer institutes across the United Kingdom that are comparable to the Royal site to see how we can learn from them.

We want to agree pathways of care for patients who access the service through either the elective or the emergency pathway. Regardless of the route by which patients access the service, they will know the journey that they will be involved in. We are working on senior clinical decision-making in a timely and regular manner so that we keep the care plan as the focus of all that we do. We want to ensure: timely and appropriate diagnostics and interventions as part of the patient care pathway; effective and timely discharge; everyone is operating in the patients' best interests; the length of stay is optimum; and all the appropriate diagnostics, interventions and treatments are commenced when they are supposed to.

The opening statement outlined the network of neurologists. At present, an informal approach is taken. We want to make that more formal as part of the modernisation programme so that there is engagement. As part of the modernisation programme, we have engaged with neurologists from areas outside the Belfast Trust.

Ms Donnelly:

From that presentation, you can see that we are very ambitious about what we are doing. It is not the only area in which we are trying to improve patients' experience. It is all about dealing with increased demand. All that we know is that patients should be kept out of hospital as much as possible because, by and large, hospitals are not healthy places when people remain unnecessarily. We have different ways of doing things at outpatient and day-case level. We are looking at a more innovative approach to dealing with some investigations and interventions that is common practice in the rest of the UK — for example, a programme assessment unit that crosses a number of specialties.

This is challenging for every single one of us who is involved. It is challenging for the managers who have to deliver it and for the clinicians, because it is a different way of practice. However, we are all committed to working together to do this. We would have wanted to make the improvements even if we had not had a comprehensive spending review that took 11% out of our budget over the past three years. However, we also have an obligation to be as efficient as we can with all the resources that we get from the taxpayer. We are very happy to take any questions

that you have; I am sure that there will be many.

The Acting Chairperson:

The Deputy Chairperson gave me a question to read out to you. Have any detailed discussions taken place between the trust and allied health professionals regarding the proposed changes? Can you outline the impact on the provision of services, such as neurophysiotherapy for patients with MS?

Ms Donnelly:

I have managed and led thousands of allied health professionals over many years. It is challenging for allied health professionals to look at how they will modernise. We have an allied health professionals modernisation group, which has been involved in its own modernisation streams across physiotherapy, occupational therapy, speech and language therapy, dietetics and podiatry. Clearly, for some MS patients, it is much more likely to be physiotherapy and occupational therapy and perhaps only occasional use of some of the others. Bernie led that modernisation group, and Stephen and others were involved with it. Am I correct that there was engagement with allied health professionals?

Mr Stephen Cooke (Belfast Health and Social Care Trust):

Physiotherapists, occupational therapists and speech therapists are all involved.

Ms Donnelly:

I am not saying that other professions do not put the patient at the centre, but those professions play a strong advocacy role for patients. They let us know very quickly if they have strong views about what we are doing; they are fully committed to improvement.

The Acting Chairperson:

The closure of those beds obviously means that you are saving money, but how much are you saving? Is that money staying in your department? Did management direct you to make those changes or did you decide in-house, as it were, to make them?

Ms Donnelly:

If you do not mind, I will start with the last bit first. We have an obligation to modernise. Medicine and social care have changed enormously over the past 20 years, and the speed of

change over the past five years has been much greater. We are looking at best practice from elsewhere and are seeing different ways of doing things. I come from a clinical background, and I know that patients need to stay at the centre of their care and to be in control of it. One of the lessons that we have learned about keeping people well is that they must be at the centre and in control of that care and responsibility. We have always wanted to ensure that that happens.

I think that it is misnomer to say that that money is "savings". We do not have a bank into which we put money when we close a bed, redesign something or save money in some way. The trust has had to find 11% efficiencies in a staged process over three years under the comprehensive spending review. There is an obligation on all public services, including the Health Service and the Belfast Trust, to do what they can to maintain the service that they deliver to the best and safest standards and in the most efficient way. The Health Service is often criticised for not being efficient, and it is very easy to criticise the Belfast Trust for not being as efficient as other trusts because of its size. However, there has been less money available in each of the past three years. There is an obligation on us to look at what people are doing elsewhere and at how we could do things differently and to ensure that we are practising in the best possible way. We have not, therefore, collected a nice big sum of money that we can use for other things. In the past, it may have been the case that there was an opportunity to modernise, reinvest and do something differently. However, that is not the case now, and it is certainly not the case with this specialty.

I should say that the seven beds that were closed were not in the main neurology ward but in ward 7C and that two of those beds were re-designated as stroke beds and are managed by the medical service with some neurology support for thrombolysis. There is a new pathway for more acute and rapid intervention for stroke patients, and those two beds were included in that set-up and have become part of that service,

I do not know the exact detail, but I can give you a rough idea of the kinds of money involved. A level 1 medical bed with nursing staff will vary in cost from £25,000 to £35,000 or £40,000 a year depending on the level of a patient's dependency. If we were to close a bed in October, which we have just done, we would not get a full-year effect from that; we would get only a part of that saving. Therefore, the maximum amount that we may get from the closure of those beds this year is less than £100,000.

Ms Owens:

The full-year effect would be £210,000.

Ms Donnelly:

That money is a deficit for the Belfast Trust. I am not saying that we have saved up that money for something else. The Belfast Trust's budget has been reduced by £112 million over the three-year comprehensive spending review period. I should say that no part of our service is untouchable. We work with commissioners to decide on the standards and priorities of our provision, and they take into consideration the fact that we have an ethical as well as a professional obligation to be as efficient as at least any service elsewhere in the UK. We have not yet had the opportunity to modernise some of our services in the way that we want. We are at the beginning of that journey for this service. However, we are well down the road in the journey towards modernising the neurosurgical service. Mr Cooke, our neurosurgeon, will say how much that has improved the patient experience.

Mr Cooke:

We had a painful enough start to the modernisation project in neurosurgery in 2005-06. We had colleagues over from Manchester and had management and departmental support, with the same number of beds that we have now. We have been able to increase our throughput by about 36% for this year compared with 2005-06. That is what can be achieved by doing things differently.

Some of the things that we have done are also applicable to neurology, such as increased rates of day-case admission. It is about scheduling patients' appointments so that they do not come in and sit around hospital for two days before they get their operation or their principal diagnostic procedure; rather they come in and have everything done as quickly and efficiently as possible, and then they are discharged home or back to their local hospital as soon as their acute episode is over. By doing things differently, there is great potential to benefit more people. We have been able to demonstrate that in neurosurgery, and there is probably more to develop in neurosurgery.

The heart of the issue is changing how consultants work. That is a difficult process, and there are anxieties among clinical staff about that, but, as Patricia said, we are obligated to be efficient — to put the patients at the centre of our care but also to give the Health Service value for money. If you want to look at it in relation to productivity and throughput, we could look at it that way, but it is essentially about giving patients a better, slicker service, better accessibility and shorter

time in hospital, while trying to maintain good outcomes, however those are determined in the different specialties.

The Acting Chairperson:

Thank you for your rather detailed and long answers, but I am looking for a couple of short answers if possible. It does not seem as if the money from the reduction in beds has gone back into the Department but that it has gone to pay for the deficit in the trust. Is that right? Yes or no?

Ms Donnelly:

The money was not available at the beginning of the year, so there has been no money. That contributes in a very small way to the reduction in funding for the trust.

The Acting Chairperson:

I want another quick answer. Were you instructed to do it? I know that you were going to do it anyway — you explained that — but were you instructed by management?

Ms Donnelly:

I am the director of acute services; I am management. I lead those teams, and I can tell you as convincingly as you are prepared to accept that I put patients first. I am only interested in improving the service for patients, and this is the right thing to do.

The Acting Chairperson:

Therefore, it was your decision.

Ms Donnelly:

I do not make every single decision. It is a large service, and I do not make every decision that is made within the service, but I lead a team that understands exactly what we are trying to achieve, and I fully support that team. I play my part in launching the modernisation groups and chairing many of them. I do not chair this particular group, but I was certainly there at the start of it, and I am fully supportive of it. It is one of a large number of things that we are doing, and I am fully supportive of it. It is the right thing to do. I also take full responsibility for it.

Mr Gallagher:

I would like you to respond to a number of issues. Quite frankly, Patricia, you have contradicted yourself several times already. You are telling us about some kind of care for the feelings of patients, but you have already told us that you are going to do this anyway, and you have done it. You collectively, or whoever has taken the decision, has handled the whole thing very badly. One of your colleagues spoke about putting patients in control of their own care. That does not sit alongside any sentiments that you expressed about caring for patients.

(The Chairperson [Mr Wells] in the Chair)

All over Europe and beyond, as far as I know, the patient is coming more and more to the centre of healthcare, which is a good thing. We should be past the days when some people on high decided that they knew what was best for everyone. It seems that that is the way that the Belfast Trust feels about this decision. There was no consultation about it, and, furthermore, it is not a Belfast Trust service; it is a regional service. It is the only 24-hour regional service in Northern Ireland. I have had correspondence and communication from a range of people: health professionals; the agencies that represent people with neurological difficulties; and the general public.

The message that I want to convey to you clearly is that you should go back and look at this matter again. People will be very angry if it comes out from this session, which the Committee asked for, that the trust came here and told us that it is a fait accompli and that it knows better than everyone else. I ask you to reflect very carefully on that.

There are some points that I would like you to give me some information on. First, tell me about the demand for beds for urgent-care patients and for those coming in for diagnosis and treatment. I understand that some of those patients had been waiting for two and three months, but you have cut the number of available beds. That seems to be a very odd thing to do. However, you have the figures. You represent the Belfast Trust, which keeps figures on patient beds across all areas of care. Let us have the figures on the neurology beds that you have decided to cut.

Secondly, I want you to talk about bed provision. As I understand it, there were single-bed en suite rooms for patients from across Northern Ireland, some of whom were my constituents. I

understand that some of those rooms will no longer be available, and those patients will be expected to share washing facilities and toilets. If you call that an improvement or some kind of slick operation, no one outside will accept that. Please provide me with information about the facilities that existed before you embarked on this course of action and what is going to be available now. Do not forget about the provision of and demand for beds.

Ms Donnelly:

I will answer part of this question, and I will ask colleagues to provide the details to satisfy some of the specifics that you are asking us to address.

Putting the patient at the centre does not improve patient care. It will bring patients into hospital to wait for things to happen. The improvement is about making those things happen more effectively and in the right place at the right time. That is where we have to have an absolute obligation. There is no contradiction in what I am saying. That is absolutely the way that it has to be approached. There are lessons from every single specialty. When we look at this — it was reflected at the beginning by Bernie Owens —we have 350 elective patients who come in every year and 350 unscheduled care patients. A proportion of the elective patients are urgent patients. We are not aware of any patients whose treatment has been delayed more than would be reasonable. At times, plans will be made to do various things for elective patients. Gerry Atkinson, who manages the service, will give you details on that.

Mr Gerry Atkinson (Belfast Health and Social Care Trust):

The waiting time for outpatients is currently 13 weeks, which is the current target for outpatients. We achieved that target with new neurology outpatients. The target waiting time for inpatients is 13 weeks. We also achieved that target for all admissions in neurology, with the exception of video EEG, which is a neurophysiology test that requires the patient to be admitted to the ward for five days. We have a capacity problem, which is one of the work streams that we are working through as part of our modernisation programme. We are looking at different ways of providing that service.

Mr Gallagher:

To clarify: you said that it is currently 13 weeks.

Mr Atkinson:

Yes.

Mr Gallagher:

Is that based on the 23 beds that you had? You have cut that by more than 30%. That is helpful. There is a 13-week waiting period for 23 beds, which you have cut to 15, and you think that that will be a better service.

Mr Atkinson:

Yes.

Ms Donnelly:

Our trust admitted people to hospital for conditions that other trusts did not. Even in Northern Ireland, our practices for dealing with unscheduled patients — that is, patients who are admitted more urgently — are slightly different to those elsewhere. We are trying to look at best practice so that we and other people operate efficiently.

Demand for beds is not exactly the same every day of the week or every week of the year. It varies according to demand, and demand varies. Our plan had been to flex in and out of the neurosciences beds because there are times when neurosurgical beds are not needed. Again, they flex up and down. Some of the beds in the neurology ward have neurosurgical patients in them because they are part of the 40 neurosurgery beds. In fact, that is the case as we speak. Some patients are in those beds in that same place. We keep the situation under constant review.

The beds that we believe that we need for patients are those that we have left in the system. We keep it under constant review. Should that change and should we believe that there is a different way of doing things, we will do that. I ask members to be mindful of what I said earlier: we have to be completely convinced that that is the most efficient way to deliver the service. If it is not, some other part of the service, such as cardiac, vascular, intensive care or A&E, will have to take a disproportionate part of the savings because of the reduced budget and funding that we have for that service. I have an obligation to all patients to make sure that we are being as efficient as possible.

Mr Gallagher:

What about the facilities?

Ms Owens:

Previously, there were 15 beds in ward 4E, which is the main hub of the neurology and neurosciences service, and eight beds in ward 7C, which was the older people's service. It is where the designated work for the stroke complement of beds is commencing. Neurology patients had access to more of the single rooms than they had on ward 4E. We will have lost access to the share of the single rooms that are available in ward 7C that we had previously. We still have four single rooms in ward 4E. Those will be prioritised on the basis of patient need. Infection control issues mean that people need to be cared for in, and get priority to, a single room. Observational beds will also be needed, and patients will be cared for in a side room.

Mr Gallagher:

Will more patients be in mixed-sex settings? Will there be more sharing of washing and toilet facilities? Those are two very important aspects.

Mr Cooke:

The same number of patients will be in ward 4E as there are today and for the past number of years. The same washing and toilet facilities are there. There is no reduction in those.

Mr Gallagher:

Will they all have separate washing facilities?

Mr Cooke:

No. There is no change to bed numbers in ward 4E.

Mr Gallagher:

That is at the heart of my question. How many of them will have to share wash basins, toilets and showers? Do you have those numbers? Will there be more patients in mixed-sex units than was the case previously?

Mr Cooke:

The numbers will be the same.

Mr Gallagher:

Will you tell me the numbers?

Ms Donnelly:

The 16 remaining neurology beds in ward 4E, the main neurology ward, are configured into four individual rooms.

Mr Gallagher:

You said earlier that there were 15 beds.

Ms Donnelly:

There are now 16. Bernie said that we originally had 15 beds and that we took one bed from ward 7C. Therefore, the number of beds is 16 plus the neurosurgical beds. However, they are outside our discussion. There are 16 designated core neurology beds. However, they can flex into other beds. Of those 16 beds, four are in individual rooms. The reason that some patients go into individual rooms — apart from the fact that they are preferential — is because there is a risk of infection. We put them there when we know that we do not need to observe them as closely as those who are so ill that they need to be near a nursing station.

In critical care, patients are placed where they can be seen rather than in a room where they cannot be seen, and someone must be with them 24 hours a day, seven days a week. The level of nursing in any neurology ward is never one-to-one nursing. The health budget cannot afford it, and we cannot afford it. Therefore, there will always be a number of patients in bays. It is not the same as the big Nightingale ward that we used to have, in which patients faced each other down a long corridor. We now have two bays, each of which holds six patients. They share some washing facilities, but a number of — not just one — individual showers and bathrooms are available. It is our intention now, as it always has been, to have one male bay and one female bay. However, in any one day, someone might be so ill that they need to be put into the different bay.

We have agreed to track that as part of our own performance monitoring. We want to know when and where that happens and whether it was absolutely unavoidable or whether we could have done something about it. It is very challenging for patients and staff, and we do everything

that we can to avoid it. However, I can honestly say that, on occasions, individual patients will be in a different bay area. However, that is not our intention, and we minimise that. We have organised them as separate bays.

Mr Gallagher:

Is that satisfactory?

Ms Donnelly:

Given the physical space in the Royal Victoria Hospital, that is our only option on that main ward.

Mr Cooke:

The building for neurosurgery and neurology was constructed in the mid-1970s and was designed with six-bedded bays, which were the standard at the time. Standards have changed in the 30 years since that building was opened. Four-bedded bays would be preferable but would lead to a reduction in our capacity, and, as Patricia said, some patients are suitable for single bays.

Mr Gallagher:

You reduced the capacity yourselves. It was you who reduced the number of beds from 25 to 16.

Ms Donnelly:

The number of beds was reduced from 23 to 16, and two beds went to stroke services. Therefore, it was, in effect, a reduction of five.

Dr Deeny

You are welcome, ladies and gentlemen. As you know, our job as the Health Committee is to scrutinise the Department and the Minister. This is a talking point among the public and in the medical and nursing professions. I would like to pick up on a couple of things. Please remind me how many whole-time equivalent neurologists there are in Northern Ireland.

Mr Cooke:

We have 8·5 whole-time equivalents, all of whom are employed.

Dr Jim Morrow (Belfast Health and Social Care Trust):

No, we have 16. There are 15·5 for the whole of Northern Ireland.

Dr Deeny:

My other question is for you, Bernie. I am a GP. Jim, we know from networking that we have had very good service from one of your colleagues, Victor Patterson, who is now retired. He used to provide wonderful tele-neurology from the Royal, and the fact that has gone is a step backwards. Let me clarify for other members of the Committee that those consultants also network and work in clinics outside hospitals, but there are no neurology beds in those clinics.

Ms Donnelly:

The only place that has inpatient beds is the Royal.

Dr Deeny:

It is important to know that, in case members think that all those services have a consultant neurologist.

I want to mention a couple of things. Stephen, I know one of your neurosurgical colleagues, John Gray, very well. I worked with him many years ago. Comparing surgery with the medical part of neurology is not comparing like with like. We know that surgeons right across the board, including you good neurosurgeons, do things more quickly now, and patients, therefore, leave hospital much more quickly. That is an important point to bear in mind.

I must ask you about the article that was published during the week and in which you are quoted. Is it correct? It appeared in Tuesday's edition of 'The Irish News'. I have been phoned by a few GPs since it appeared. The article, written under a headline that refers to "cuts" states:

"Consultant neurologists working at the unit have written to trust management outlining serious concerns about the impact of the bed closures on the already overstretched facility."

Is that the case, Patricia? Did the neurologists write to you raising that concern?

Ms Donnelly:

Yes. They wrote to us raising those concerns, and they have raised their concerns with us before.

Dr Deeny:

Did you take those concerns on board?

Ms Donnelly:

We are in the middle of a process. We do not do any of these things lightly. We have been involved in a process since much earlier this year. We commenced the planning around April and formally launched some of the thinking on modernisation in June.

I will not understate the anxieties that surround the change. However, let me be clear: the neurologists and the management team are fully committed to working together to make those improvements. You cited an example of a good service, the tele-link, which has changed. We want to look at everything that is of value before we act. To a degree, people are so focused on the pressures of dealing with patients that they do not look at how best we can do this. That makes it much harder for an individual consultant to cope with some of those pressures, but there are simpler and more straightforward ways of doing things. That is what we are doing in our work with the consultants.

Dr Deeny:

Are you saying that this is still a consultation exercise or that the decision has been taken?

Ms Donnelly:

We are not taking a decision on modernising the service or how to do so. We are still developing some of the detail. However, since May or June of this year, we have been organising and putting in place other aspects, such as a programme assessment unit that would be an alternative to admission for many patients. We should have been able to open that a few weeks ago, and we are in the process of preparing it. I hope that, later this month or at least within four weeks, it will be open to patients.

Part of the job that I and the management team that is here today have to do is to steady the nerves of those who are anxious about this. No harm will come to any patient. As we speak, no one is in a hazardous position through any of the changes that have been put into place to date. We are confident that that will not be the case. We will be careful, but we have an imperative to move forward and not to wait for six months or a year until everything is lined up, because my experience of change is that it does not happen that way. You have to be ambitious and keep the pace and impetus going. I understand the anxieties of some of the staff, but we are in active discussion with them, and they are still committed and engaged.

Dr J Morrow:

The article in 'The Irish News' is a bit overstated. I think that it came from a letter, which we wrote as a group of consultants to our clinical and medical directors, to stress our concerns. It was one of a series of letters that we have written over time to express our concerns. Those concerns came from general frustration because none of the letters have been acknowledged or responded to. Therefore, there are difficulties.

There is a modernisation group, and we actively look at better ways of updating our practice. We do not accept that we are inefficient in providing these beds by any means; I can quote statistics if the Committee wants them. However, it was clear at the outset of the sitting of the modernisation committee that the decision to close the beds had been made in advance of any discussions with clinicians.

Dr Deeny:

That was going to be my next question. Patricia mentioned that the Belfast Trust has been given a hard time. Believe me, that is not the case. I have criticised the Western Trust countless times since I was elected some years ago. My major concern has been that decisions that affect patients in the community are taken without consulting GPs. That consultation is imperative; not only in your trust. What we are hearing today is that there was no consultation with the neurologists before the decision was taken: yes or no?

Ms Donnelly:

I think that that would be a misrepresentation.

Dr Deeny:

I am asking you a "yes or no" question.

Ms Donnelly:

If there is a —

Dr Deeny:

Did you consult the neurologists? It shocks me that the people right at the top, who carry the can for the clinical care of patients and are responsible if something goes wrong, are not consulted,

whether they be GPs or consultant neurologists. I have criticised the Western Trust in the past for not consulting its most senior doctors, and I now hear that the Belfast Trust did not consult the consultant neurologists prior to making the decision.

Ms Donnelly:

If I can make it very clear, the consultant neurologists were in the room in June when we —

Dr Deeny:

Are you saying that you did consult them?

Ms Donnelly:

Let me take this in two stages: they were in the room when we set out the objectives of the modernisation group. Parallel to that, we have been having reports on a very regular basis from benchmarking organisations that look at our length of stay and practice elsewhere. Data was already available, external to the trust, which stated that the length of stay for the patients there was too long and equated to x number of beds. In this case, it equated to five beds, two of which should go to thrombolysis and stroke services.

We already knew the information, and I was present at that very first meeting with all the neurologists when our information department presented all that clear data. No decision was taken on that day; it would have been subsequently. Certainly, it was very clear what we were trying to achieve: we were trying to achieve an objective that would give us the same standard of efficiency and modernisation that exists elsewhere in the UK. That was our objective. That is what we were trying to achieve at that first meeting.

Dr Deeny:

We are not going to argue, Patricia, we are simply getting the facts. What you are saying is that you went on the data and did not consult your consultant neurologists.

Ms Donnelly:

We used the data in our meeting with the consultant neurologists to say what we were going to try to achieve. The decision to close —

Dr Deeny:

Did you use the data to tell the consultant neurologists what you were going to do?

Ms Donnelly:

We told them what we were going to try to do and what the objectives were over the subsequent months. That meeting was some months ago, in June this year.

Dr Deeny:

That has made it clear to me. Thank you.

There are two other points that I want to argue. 'The Irish News' article states:

"One doctor, who wished to remain anonymous, said it will lead to further delays in diagnosis".

I bring that up because some of my GP colleagues phoned me about it, and I met a few more GPs at a meeting yesterday. GPs share that concern. I have been a doctor for 30 years, 25 of them as a GP. GPs know that, often, in certain cases, we need to get patients admitted for investigation in order to get proper diagnoses. That is why we are concerned about the prospect of delays for someone who, for example, has to be admitted as an inpatient to be tested for different types of epilepsy in order for a diagnosis to be made. I am going to back Tommy up on this issue. This week, someone asked me how it can be an improvement when patients must wait so long to get into neurology in Belfast for diagnosis.

I want to make a final point about a comment that you made, Stephen, which appeared in the article in 'The Irish News', and I think that you repeated it today. You said, and I agree, that it is not right that patients should take up hospital beds if they are being held there due to a delay in getting their investigation or scans done. However, surely a deficiency in a department, whether it be in MRI scanning or CT scanning, is not a reason to close beds. That is the department's problem. When someone is admitted, their investigation should be done on the same day. You say that beds are being closed because patients are being kept in too long, and that is because they are not being scanned on time. That is someone else's problem.

Mr Cooke:

It is about working together. There is a great deal of interdependency in the hospital. If you look at reasons why patients are admitted to neurosciences, it is for specialist diagnostics that they need as inpatients, such as MRI scans or neurophysiology. We know that, if a consultant brings a

patient in tomorrow without having scheduled or arranged those tests to be done, that patient will wait in hospital for three or four days — perhaps, longer — for those tests. While that patient is in a hospital bed, and may not need to be, another patient is prevented from being admitted. That is what I mean by doing things differently.

The surgical model is different. There are different conditions. However, the same principles apply with regard to planning, scheduling and trying to have a more orderly management plan for patients. To a large extent, it has worked for us in neurosurgery. Without having to increase the number of beds, we can put more patients through for treatment. That is what it is about.

Dr J Morrow:

That is all very well in theory, except that we cannot get patients admitted for investigations. They have to have outpatient investigations because there is an insufficient number of beds in Northern Ireland for those tests to be done. The Royal College of Physicians and the Association of British Neurologists recommend that there should be 15 neurology beds per 100,000 of the population. That is around 250 neurology beds. We started with 23. We are now down to 16. When statistics are quoted for people staying longer in hospital, it is easy to explain why that is the case just by looking at the hospital that we are being compared with and the number of beds that it has per head of population. We have far fewer beds per head of population. We serve an entire country, whereas that hospital serves an area that has another neurology unit down the way.

When the number of beds is small, the only patients who get into those beds are the sickest patients with the most complicated problems. Is it surprising that they stay a couple of days longer? I do not find that surprising.

Ms Donnelly:

Recently, we had a diagnostic visit from a clinical expert who is an experienced doctor in the UK and has supported 50 hospitals in making improvements. He works with the Institute for Innovation and Improvement in the UK. He was not impressed with how we manage our unscheduled care and non-surgical care. He said that there were instances of good practice. However, he said that we were less organised and that there was much about our clinical practice that we had opportunities to improve. That was exactly what we found when we commenced the improvement group. We intend to bring him back to work with us within the coming weeks and months.

Dr Deeny:

I am glad that Jim is here, so that we can hear the view of a consultant neurologist. That is extremely important.

How many paediatric inpatient neurology beds are there in Northern Ireland?

Ms Donnelly:

I am sorry; I cannot answer that. They are not in the adult service. Children have to be kept separate.

Dr J Morrow:

However, we take over kids at 13 years of age in Northern Ireland, which is unusual. In the rest of the UK, neurologists will not take over children until they are between 16 and 18 years old. Our concern has always been how to house a 13-year-old in an adult neurology ward. There are two six-bedded bays. We have got side rooms. However, two of them are video EEG rooms. One is a day-case room. Therefore, we have one available side room. It is a little difficult to manage that situation.

Dr Deeny:

I have two final quick questions. Will the situation be monitored as it goes ahead to see whether, as I fear, it provides a lesser neurological service for patients throughout Northern Ireland? If so, will that be rectified?

My second question is for Jim. As a doctor, I believe that we have to offer our young GPs and consultants the best facilities and services so that they will stay here. As neurology is very much a front-line service, my primary concern is to do with patient care. However, I am also concerned that we must hold on to our future, through our newly and highly qualified neurologists who will want to work to the very high standards to which they have been trained and provide the very high-quality healthcare that those standards allow them to provide. My concern is that, if we do not have those services, which would, I imagine, include sufficient beds, our future consultant neurologists may decide to work elsewhere and we would, therefore, lose them from Northern Ireland. That is a long-term concern if, as is our suspicion, a neurology service across Northern Ireland provides a lower standard of service for patients.

Ms Donnelly:

I understand the anxiety that you express, those who have spoken to you have expressed and Jim is expressing here today. Of course, we keep it monitored. We would not be responsible if we did not. However, we still want to improve the service so that patients get the best that they can, and that includes getting their care in the right place at the right time.

Dr Deeny:

Does that include talking to GP representatives about their patients being admitted to hospital? That is all that it takes.

Ms Donnelly:

If you look at the statistics, you will see that 16,000 patients are seen as outpatients. Therefore, it is largely an outpatient service.

Dr Deeny:

I am not talking about outpatients. I am talking about the beds that we need.

Ms Donnelly:

The inpatient service is diagnostic and some intervention, and there are some sick patients in there. We will look, as Bernie mentioned in her presentation, at how we work as a network within the profession, within the trusts and across the total service and journey. It is a process. We are not at the end of the process, and this is only one part of that.

Dr Deeny:

We are hearing from Jim that only the sickest neurological patents will be admitted. It seems to me that those patients who go to outpatient services and are told that they need to be brought in for a period to get to the bottom of the problem will wait for longer.

Ms Donnelly:

Jim can, obviously, speak to his individual practice. However, it is the view of others who have looked at our service that we also bring patients in for unnecessary stays and for unnecessary lengths of time.

Dr J Morrow:

I would like that to be independently re-examined, Patricia. I also want the views of the other trusts to be taken on board. They have had no say in this whatsoever. It was the Belfast Trust that looked at that one figure and decided: "That's it. You're inefficient, your patients stay too long, and you have to reduce the number of beds." I do not accept that, and none of my colleagues accept that, nor will we until it has been looked at in a proper and independent fashion.

Dr Deeny:

On the point of future neurologists, Jim, do you think that, if the service is not up to the gold standard that it has been — although I am sure that you would like to see improvements, as would all of us in the Health Service — you would have a concern?

Dr J Morrow:

I would be very much concerned. A few years ago, a consultant neurologist resigned from the Belfast Trust because of the way that it treated him. Therefore, I have real concerns about being able to attract people. We, in Belfast, in neurology, have a very good reputation, as you will be aware, in the epilepsy world, and so on. However, if we are dealing with what is basically one bed per consultant in the whole of Northern Ireland, how could that service be managed?

The Chairperson:

I was going to ask, Mr Cooke, why there was an initial reluctance to bring a consultant with you today.

Mr Cooke:

I am a consultant.

The Chairperson:

Yes, but a real-life consultant who is involved in neurology at the coalface on the wards. However, that question has been answered to some extent. Initially, my understanding was that Mr Morrow was not going to be here.

Mr Cooke:

I was asked to be here, and that is why I am here.

The Chairperson:

Yes, but you are an enthusiastic supporter of what has happened.

Mr Cooke:

I believe that we can improve patient care through the regional neurology service. There are things that we can do to make the service deliver better for patients.

The Chairperson:

Yet there was a resistance to bringing a consultant neurologist —

Ms Donnelly:

Mr Wells, you asked us to come and talk to you about the issue. We brought the clinical director for the service, as we would do on any other occasion. However, it became clear that you wanted more than that. I would not say that Mr Cooke is an enthusiast for the service; he is an early adopter for change. We have plenty of those in the trust, and it is just as well. We would have no modernisation of our cardiac services, nor would we have 1,000 cardiac surgeries taking place, if we did not have the enthusiast support of the cardiac surgeons and cardiologists. That is part of the journey that we are all on.

The Chairperson:

If anything in 'The Irish News' article is true, you have not been able to take the people on the ground with you on that decision.

Ms Donnelly:

I am more optimistic, perhaps, than you might feel today, and I still believe that our consultants are committed to doing the right thing to improve the service. We have had many discussions with Jim about this, and he certainly has restated his commitment to looking at how we can improve this, and we will go forward on that basis. It is not over.

Dr J Morrow:

Patricia, to portray us as not embracing change is disingenuous; we have very much embraced change. We are the only unit in Northern Ireland to provide out-of-hours thrombolysis, and we have done so for the past two years. That was, apparently, a funded service, but we never had any funding for it, and it has been possible only because we have been able to get people into our

beds. We can no longer provide that service, and we heard that they are going to open two thrombolysis beds. We are happy to pass that over, but we will still obviously be responsible for providing the service, but in those other beds. The problem is that our beds shut two weeks ago, and the Royal has not provided two beds. It has provided one bed for thrombolysis on Monday to Friday from 9.00 am to 5.00pm, and, in our experience, most strokes occur at the weekend. So Mr Wells, if all of this gets to you, and you have a stroke at the weekend, I am sorry, but you are on your own.

The Chairperson:

There are no other questions from members. I thank you for providing that information. We have all, as individual MLAs, and apart from being on the Committee, been approached by constituents and groups. The decision was taken on 1 October, and it was the burning issue for everyone present at a recent epilepsy conference, as was the manner and speed in which the decision was taken. Therefore, it is not just the Committee that is concerned. We reflect the view in the Assembly after many individual MLAs were approached about the issue. I thank you for your time. The Committee will, no doubt, want to deliberate further on the issue.