SAVE THE MID, SUBMISSION TO THE COMMMITTE OF HEALTH SOCIAL SERVICES & PUBLIC SAFTEY. IMPROVING WAITING TIMES IN NORTHERN IRELAND'S A&E'S

6/12/2012

Mid Ulster Hospital Run Down To Shut Down

Introduction:

At the request of the health committee Save the Mid have responded with evidence and recommendations to reduce waiting times at A&E's in Northern Ireland.

For Further information and background reading, Save The Mid's submission to the Compton review can be found here:

- Acute care response - link
- Inpatient Care response - link
- Patient Survey responses - link

The subject area for these services is quite large; it is the aim of this document is to breakdown as much vital information as possible to bit size informational points.

Attached with this document are the responses of an on-line survey carried out by Save The Mid, some of these experiences are quite shocking and only reaffirm the reports carried out by Rutter & Hinds, in this case however these experiences we already submitted to government in Nov 2011

Thank you for taking the time to read this document.

Yours

Hugh McCloy

Chairman – Save the Mid

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Since the reduction of A&E services at the Mid Ulster Hospital site, there has been a damaging but pre-warned detrimental effect on the ability of network hospitals to cope the demand that would be placed upon them. Namely in regards to Mid Ulster Hospital the network hospitals are:

- Antrim Area
- Craigavon
- Causeway
- Altnagelvin
- Royal Victoria Hospital Group

In 2005 it was cited in a medical risk assessment that the most high risk move was to fully downgrade Mid Ulster Hospital According to the Developing Better Services plan unless several extensions were made elsewhere

Table 9.2 Detailed Risk Scoring – Mid Ulster Hospital

Risks	Option 1 Do Nothing	Option 2 Withdraw Maternity	Option 3 Restricted A&E	Option 4 Maternity and A&E	Option 5 Local Hospital	Impact Score
Maternity Service						
Inability to sustain 24/7staff rota						
A. Midwife rota	1	0	1	0	0	5
B. SHO rota	2	0	2	0	0	5
C. Consultant rota	4	0	4	0	0	5
Inability to provide paediatric support to maternity service	3	0	3	0	0	4
Inability to provide haematology	1	0	1	0	0	4
Inability of other network hospitals to manage additional activity	1	5	1	5	5	2
A&E						
Inability to provide backup services (e.g. labs, ICU, radiology, paediatrics)	5	5	3	3	0	3
Inability to sustain staff rotas and 24/7 medical presence	2	2	1	1	0	5
Inability to secure timely ambulance transfer	4	4	2	2	0	4
Inability of other network hospitals to manage additional activity	0	2	4	4	5	4
Anaesthetics						
Inability to provide anaesthetic support: staffing	2	2	1	1	0	5
Inability to provide anaesthetic support: during transfers	3	3	1	1	0	4
Inability to provide anaesthetic support: dual requirements	2	1	1	1	0	4
General Medicine						
Inability to maintain medical rotas						
A. SHO rota	1	1	1	1	0	5
B. Consultant rota	1	1	1	1	0	5
Inability of other network hospitals to manage additional activity	0	0	3	3	5	4
General Surgery/Trauma						
Inability to provide backup services (e.g. blood, labs, ICU, radiology)	4	4	2	2	0	4
Inability to maintain surgical rota						
A. SHO rota	2	2	1	1	0	5
B. Consultant rota	2	2	2	2	0	5
Inability of other network hospitals to manage additional activity	0	0	3	3	5	4

Source: UHT staff at Risk Workshop, 5th July 2005

Likelihood scores range from 0 (impossible) to 5 (the event is certain to occur). Impact scores range from 0 (no impact) to 5 (service closure)

Figure 1.1 Reference: Save The Mid Compton Submission, page 17 - Link

In all areas of the above risk assessment the services are classed as acute and emergency, as can be noted from Option 5, where we find ourselves in 2012, network hospitals are not be able to cope with the downgrading of Mid Ulster Hospital. A move that must be reversed.

A summary of A&E performance was carried out by Save The Mid in submission to the Compton Review, Transforming Your Care, link ,the network hospitals examined in this submission show that since the removal of 9am-11pm A&E services at the Mid Ulster Hospital A&E waiting times have greatly increased.

- Antrim
- Craigavon
- Mater
- Belfast City
- Mater
- South Tyrone
- Causeway
- Royal Group Hospitals

Month	Increase In Test Period –Patients Waiting 4 to 12 Hours may-August 2009/10	Increase Between May-August 2009/11 – Patients Waiting 4-12 hours	Increase In Test Period – Patietns waiting 12 hours or More 2009/11	Increase Between May-August 2009/11 – Patients Waiting 12 hours or more
May	+1,042	+1,153	+586	+747
June	+1,385	+2,338	+184	+746
July	+666	+1,290	+108	+249
August	+1,816	+2,429	+126	+177

Figure 1.2 Reference: Save The Mid Compton Submission, page 10 - Link

In April 2011 Deloitte were commissioned by the HSCB to carry out a study that identified the attendances at the aforementioned network hospitals from Mid Ulster patients. This report showed attendances 100 day after the removal of acute services, to note these attendances were taken during the summer period when all A&E departments are least busy;

Out Of Hours A&E Attenders From Mid Ulster

	24 May-31 Aug 2009			24 May-31 Aug 2010			Difference in 2009 / 2010		
	Minor Injury	Acute	All	Minor Injury	Acute	All	Minor Injury	Acute	All
Antrim	361	720	1,081	806	1,347	2,153	445	627	1,072
Causeway	152	46	198	363	87	450	211	41	252
Craigavon	126	96	222	286	137	423	160	41	201
South Tyrone	219	40	259	341	44	385	122	4	126
Total	**858**	**902**	**1,760**	**1,796**	**1,615**	**3,411**	**938**	**713**	**1,651**

Figure 1.3 Reference: Deloitte; review of Minor Injury Provision at the Mid Ulster & Whiteabbey Hospital, April 2011

An increase of 1,651 patients from Mid Ulster travelled out of hours (5pm-9am) to network hospitals, as shown in Figure 1.2 this same time period shows the effect of patients waiting for treatment in A&E.

- Out of hours minor injury attendances rose 109% in test period
- Out of hours acute attendance rose 79% in test period
- All attendances rose 94% in the test period
- More research is needed to define actual hourly attendance times for more accurate decision making, this HSCB commissioned report lacks depth and detail, but serves as an indicator to a need for a service in Mid Ulster.

Emergency Department Attendances in Antrim & Causeway A&E with BT45, BT46 & BT80 Postcodes								
	Antrim				Causeway			
Month	BT45	BT46	BT80	Total	BT45	BT46	BT80	Total
Jan-12	515	76	200	791	72	121	6	199
Feb-12	504	75	226	805	103	118	7	228
Mar-12	532	79	231	842	78	157	8	243
Apr-12	538	88	201	827	97	119	17	233
Total	2089	318	858	3265	350	515	38	903

Figure 1.4, Reference Freedom of Information Request HMCC110512, see appendix

Emergency Department Attendances in Antrim & Causeway A&E with BT45, BT46 & BT80 Postcodes Out Of Hours 5pm-9am								
	Antrim				Causeway			
Month	BT45	BT46	BT80	Total	BT45	BT46	BT80	Total
Jan-12	263	37	100	400	35	62	1	98
Feb-12	257	34	118	409	52	45	2	99
Mar-12	287	41	110	438	30	77	2	109
Apr-12	265	43	102	410	49	55	2	106
Total	1072	155	430	1657	166	239	7	412

Figure 1.5, Reference Freedom of Information Request HMCC110512, see appendix

- Within the NHSCT 4,215 Mid Ulster patients attended Antrim & causeway A&E's between Jan-April 2012
- Within the NHSCT 2,069 Mid Ulster Patients attended Antrim & Causeway A&E's out of hours 5pm-9am between Jan-Apl 2012
-

	Jan-12	Feb-12	Mar-12	Apr-12	Total
Antrim A&E	791	805	842	827	3265
Coleraine A&E	199	228	243	233	903
Mid Ulster *Minor Injury Unit*	455	518	601	501	2075
Total	1445	1551	1686	1561	6243
Potential Attendances per day	46.6129	53.48276	54.3871	52.03333	51.59504

Figure 1.6, Shows Mid Ulster Patients Attending Antrim A&E, Causeway A&E and Mid Ulster Minor Injury Unit, reference: DHSSPS Link , Freedom of Information Request HMCC110512, see appendix
*Mid Ulster Minor Injury Unit operation 9am-5pm, weekdays, excluding public bank holidays

With the Introduction of A&E services at the Mid Ulster site 9am-11am and Minor Injury potentially there could be on average 51 patients a day. Consideration does have to be taken into account that this does not include acute attendances during 11pm-9am, nor do the figures above include attendances to other network hospitals, but services an indicator as it would be expected the loss of attendances in acute would be replaced by minor injury patients from the BT80 area.

Ambulance response times in mid Ulster Hospital catchment areas, 2011 (reference – link):

BT46
Number of category A calls: 282
Calls with response of 8 mins or less: 12
Percentage of calls responded to within 8 mins: 4%
Longest wait for ambulance or RRV: 00:54:43

BT45
Number of category A calls: 1235
Calls with response of 8 mins or less: 812
Percentage of calls responded to within 8 mins: 66%
Longest wait for ambulance or RRV: 01:01:20

BT80
Number of category A calls: 847
Calls with response of 8 mins or less: 465
Percentage of calls responded to within 8 mins: 55%
Longest wait for ambulance or RRV: 01:29:28

Northern Ireland Patients have waited the equivalent of 2,006 days In Northern Ireland A&E Jan-Mar 2012

According to the most recent data released by the Department of Heath Safety & Social Services at total of 4,011 patients had to wait over 12 hours in an A&E before being treated, admitted, transferred or discharged home.

As the DHSSPS do not provide the statistical information for waiting times above 12 hours, using the 12 hour base line of patients waiting 12 hours or more a total of 48,132 hours were spent waiting in A&E's, this is equivalent to a minimum of 2006 days.This shocking figure is also equivalent to 5.5 years. And does not contain waiting times for patients waiting 4-8 hours or under 4 hours.For table click here: http://savethemid.weebly.com/uploads/7/4/7/7/7477841/ae_waiting_2012.pdf

Recommendation 1

The immediate reintroduction of A&E services at The Mid Ulster Hospital site between the hours of 9am to 11pm

- **Ambulance bypass protocols from 2006 to be reintroduced to support patients of serious trauma, maternity and young children to be taken specialised acute services elsewhere.**
- **This will also alleviate ambulance waiting times for hand over at A&E and provide a more rapid response to rural areas.**
- **Also see recommendation 3 -**

Reconmednation2

The immediate introduction of out of hours Minor Injury Services at the Mid Ulster Hospital site between the hours of 11pm to 9am

- **will take the pressure of the larger acute facilities at network hospitals**
- **provide for human dignity**

For the implementation of services at the Mid Ulster hospital it is recognised that the Mid Ulster hospital must also have the relevant back up services.

The relocation of Dr On Call to the site will provide medical cover of a doctor grade at the site, this service can be developed or work in conjunction with Northern Health & Social Care Trust. If steps are taken to reintroduce the first 2 recommendation's this will render Mid Ulster as it was in 2006. In 2008 the NHSCT published its Modernisation Plan and cited several reasons for shutting Mid Ulster, these reasons were later found to be fabricated in a response form a 20 year veteran worker at Mid Ulster to Dr Peter Flanagan.

Trust Statement	Response to Dr Peter Flanagan
"Neither Whiteabbey nor Mid Ulster hospitals have training status so cannot employ Junior Doctors in training" **The trust later contradicted themselves in the same document** **"Both Whiteabbey and Mid Ulster have restricted medical training status and as such cannot employ Junior Doctors in the same way that other acute hospitals"**	This is not correct – we have as you know training posts for F1, F2, ST1, ST2, and ST3 doctors at Mid Ulster and have had consistently good reports from training and inspection/surveys in recent years.
"Junior Doctors employed at Antrim and causeway Hospitals cannot be a part of rotas to staff Whiteabbey and Mid Ulster Hospital"	Is not correct, this already happens
"Senior Doctors who are working permanently in the smaller hospitals cannot participate in a Medical Staff rota across larger acute sites since they will not have had exposure/experience in the range of cases that would present in a larger acute site, eg heat attack cases"	This is obviously untrue
"no out of hours anaesthetic cover at Mid Ulster"	Is not correct
"lack of specialist radiology services at Mid Ulster"	Is not correct

Figure 1.7: Letter from senior consultant to NHSCT Dr Flanagan, see appendix, reference FOI Hugh McCloy

The senior Consultant went on to state,

> 'The high level of dependency on Locum cover is history fulfilling itself. The pressure on the A&E department at Mid Ulster is history fulfilling itself – this department was never staffed as a department with Juniors/Seniors hence the current reliance on Trust Grades and Staff Grades'
>
> 'After the transfer of acute services from the Mid Ulster site it is proposed to leave 30 or so inpatients of a non-acute nature. This is foolish – how will such a small isolated unit be medically staffed? Certainly it would not be recognised for training of junior staff. The local General Practitioners have not been approached to ask if they are willing or interested but I can predict they will not be interested or willing to cover such a unit. A nurse led unit seems unworkable and would be no more than a nursing home'

He concludes his letter to Dr Peter Flanagan:

> 'Also I feel the inaccuracies in the papers produced by the trust for public consumption are unacceptable'

The Unit that the Consultant speaks off is Ward 6, Thompson House, and is the only remaining inpatients at the Mid Ulster hospital site.

2. **The average occupancy rate of Thompson House (ward 6) Mid Ulster Hospital between September 2011 - December 2011 , each month shown separately.**

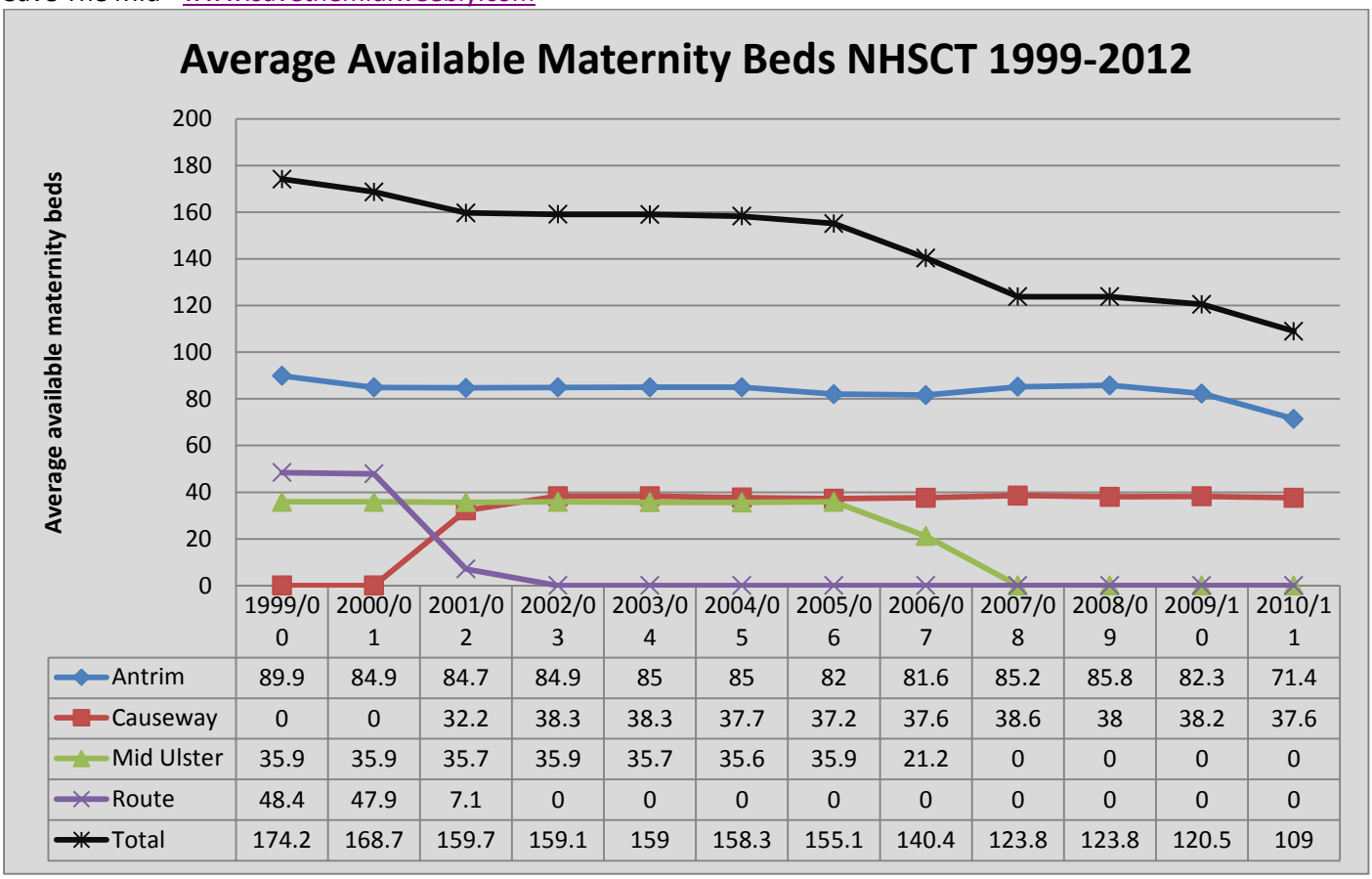
Month	Year	Percentage Occupancy
Sept	2011	97.2%
Oct	2011	94.5%
Nov	2011	89.8%
Dec	2011	91.5%

Figure 1.8, % occupancy rate Thompson House, Ward 6 Mid Ulster, reference: FOI Hugh McCloy

Activity trends by HSC Trust 2006/07 - 2010/11					**All Programmes Of Care**		
	Activity Indicator	2006/07	2007/08	2008/09	2009/10	2010/11	**Change 06/07**
Northern HSCT	Average available beds	1422.8	1373	1320.4	1252.7	1158.2	**-264.6**
	% Occupancy rate	84.30%	84%	83.30%	81.30%	84.10%	
Antrim	Average available beds	450.3	462.7	455.1	453.8	475.4	**25.1**
Causeway	Average available beds	257.6	260.3	256.9	253.5	244.6	**-13**
Mid Ulster	Average available beds	155.4	119.9	104.3	94.7	75.5	**-79.9**
Total	**Average available beds**	**863.3**	**842.9**	**816.3**	**802**	**795.5**	**-67.8**

Figure 1.9, Average available beds NHSCT, References:

- http://www.dhsspsni.gov.uk/inpatient_hospital_statistics_2010-11.pdf
- http://www.dhsspsni.gov.uk/hospital_statistics_inpatient_activty_2009-10.pdf
- http://www.dhsspsni.gov.uk/volume_1_programme_of_care2pdf.pdf
- http://www.dhsspsni.gov.uk/volume_1_programme_of_care-2.pdf
- http://www.dhsspsni.gov.uk/volume_1_programme_of_care.pdf



	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Antrim	89.9	84.9	84.7	84.9	85	85	82	81.6	85.2	85.8	82.3	71.4
Causeway	0	0	32.2	38.3	38.3	37.7	37.2	37.6	38.6	38	38.2	37.6
Mid Ulster	35.9	35.9	35.7	35.9	35.7	35.6	35.9	21.2	0	0	0	0
Route	48.4	47.9	7.1	0	0	0	0	0	0	0	0	0
Total	174.2	168.7	159.7	159.1	159	158.3	155.1	140.4	123.8	123.8	120.5	109

Figure 2.0, Average available Maternity Beds NHSCT, Reference http://www.dhsspsni.gov.uk/index/stats_research/hospital-stats/inpatients.htm

Developing Better Services

To Highlight the material evidence we must revert to the Developing Better Services / Hayes report, it cited several service's for Mid Ulster when it was downgraded and several specific warning and preconditions that were not followed. These services can only be retained with the implementation of recommendations within this document.

Developing Better Service 2001, specifically stated what a local hospital was to have, Mid Ulster was defined as a local Hospital in this document and states:

- Acute Medical beds for patients not requiring 24 hour consultant oversight
- Step down and convalescence beds for those patients requiring post-operative care following discharge for Acute facility
- Respite care beds for patients requiring respite for a number of weeks per year
- Palliative care beds for patients requiring this support
- Rehabilitation beds including those for patients requiring rehabilitation following stroke, accident or fracture who are suffering from debilitation of from age and chronic rheumatoid conditions

Recommendation 3

The relocation of Dalriada Doctor on Call to the Mid Ulster site:

- **provides resident Dr support onsite for staffing rotas**

Recommendation 4

The reopening of Ward 2 at the Mid Ulster Hospital Site:

- **Valarie Jackson – Head of acute services in the NHSCT stated on the 24th May at Fern House, Antrim Hospital that 90% of patients waiting in regards to the Rutter & Hinds report were waiting as there were no available beds**
- **This will make the Mid ulster Hospital fully compliant with the DHSSPS & NHSCT legal duty to meet the standards as laid out in previous Equality Impact Assessments**
- **Will introduce the inpatient beds as cited by developing Better Services**

Recommendation 5

The reopening of Ward 3 at the Mid Ulster Hospital site to house those patients that will be moved from ward 6 of the Mid Ulster Hospital by Jan 2013:

- **This is for clinical reasons in where these patients will not need ambulance transport to get x-rays in the main building, will increase capacity of Northern Ireland Ambulance Service**
- **To preserver human dignity of patients**
- **Valarie Jackson – Head of acute services in the NHSCT stated on the 24th May at Fern House, Antrim Hospital that 90% of patients waiting in regards to the Rutter & Hinds report were waiting as there were no available beds.**

Recommendation 6

Reintroduction of High dependency unit to provide back up for previous recommendations

Recommendation 7

Reintroduction of inpatient general Surgery to provide back up for previous recommendation's

Recommendation 8

Time spent waiting for treatment, discharge or transfer in Antrim's:

1. **Short Stay ward**
2. **Clinical decision ward**
3. **New Corridor ward that has curtains blocking part of the A&E entry where patients are wheeled into**

Added into the Emergency care waiting times

- **This will give the public and government an accurate description of the actual waiting times within the emergency care pathway**

Recommendation 8

All plans to reconfigure services within the Northern Health & Social Care Trust be postponed until such times service's within the trust are stabilised and made clinically safe.

Conclusion:

It can be quoted that the current Health Minister, Edwin Poots, has stated the closing of the Mid Ulster Hospital was a mistake, a mistake that can be rectified and must be rectified until sufficient confidence and capacity has been made elsewhere to ensure a clinically safe transfer of services.

There is an identified need for services based centrally in Northern Ireland, while huge investment will be needed to build a new facility; the Mid Ulster Hospital is still centrally located to serve a 700 square mile radius. Thus giving a vital lifesaving service to mid Ulster residents while easing the burden on network hospitals, which were only built to serve the immediate areas that they stand in. the NHSCT in the largest and most dispersed residential Trust within Northern Ireland, to conceive that the current locations of the Acute A&E's is viable to serve that population is folly.

It should be concluded and recognised that the Northern health & Social Care Trust is not capable of undergoing another reconfiguration of service's and the Committee should fully recognise the need to postpone any changes in services until the existing services are stabilised.

Headlines like these from Doctors must not be allowed to be repeated:

Dr Brian Patterson, British Medical Association's Northern Ireland GP committee, May 2011, "**I worked at the Mater Hospital A&E during the Troubles and nothing I witnessed there is worse than the situation at Antrim Area Hospital.**
Identity hidden due to fear of reprisal form trust, in a board room meeting, GP, Nov 2011 **"you could wait that long in Antrim A&E you could pick up a Hospital Acquired Infection"**
Dr Josef Kuriacose, GP, Jan 2012 "**If you are ill in this area, it's just horrible. If I became ill I'd have to go to Antrim A&E and I don't want to go there."**
Dr Sandy Inglis, A&E Consultant, Feb 2012 after working 5 days in Antrim A&E **"chaotic"** & **"the congestion and space limitation make our ED's (emergency Departments) feel like airport hangers"**

Appendix

Northern Health & Social Care Trust

Freedom of Information Requestion HMCC110512

Time Period Jan 2012 to April 2012

Emergency Department Attendances in Antrim and Causeway ED with BT45, BT46 & BT80 PostCodes

	Antrim ED			ANT Total	Causeway ED			CAU Total
Month	BT45	BT46	BT80		BT45	BT46	BT80	
Jan-12	515	76	200	791	72	121	6	199
Feb-12	504	75	226	805	103	118	7	228
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Grand Total	2089	318	858	3265	350	515	38	903

Emergency Department Attendances in Antrim and Causeway ED with BT45, BT46 & BT80 PostCodes Who Arrived between 5pm and 9 am

	Antrim ED			ANT Total	Causeway ED			CAU Total
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Grand Total	1072	155	430	1657	166	239	10	415

Download as at 17/05/2012
Source Symphony/BOXI

Save The Mid 2011: ref stm/00/1002

[redacted]

05 FEB 2009

26 January 2009

Dr Flanigen
Medical Director
Northern Health and Social Care Trust
The Cottage
5 Greenmount Ave
Ballymena,
BT43 6DA

Cc Mrs N Evans, Chief Executive, Northern Health and Social Care Trust, The Cottage, 5 Greenmount Ave, Ballymena, BT43 6DA
Cc Dr Clivia Doman, Clinical Director Acute Emergency Medicine, C/o Medical Directorate Office, Antrim Area Hospital, Antrim

Dear Dr Flanigan

In response to your invitation to local meeting in Cookstown, Tuesday 10 February I will be [redacted] out of Northern Ireland on the night concerned but even if I were in Northern Ireland I would not be willing to attend a local public meeting on reconfiguration of acute services.

I recognise the clinical drivers and have worked through too many clinical cases not to realise that while the majority of cases we receive in the Mid Ulster can be managed here a significant number find themselves in the wrong hospital.

I accept specialisation of services have led to Mid Ulster's demise as an acute hospital.

However, I feel some continuing loyalty to the area, partly through working here for 24 years and partly as I am a home grown native of the Mid Ulster area. I have loyalty to the people I work with, namely nursing, paramedical, secretarial, clerical and portering staff none of whom wish to lose their jobs or move – a move in a lot of cases would amount to the same thing as a job loss as far as a lot of employees are concerned.

Also I do not feel that I can go to a public meeting and support closure of acute services at Mid Ulster for the following reasons.

1. The closure of acute services at South Tyrone Hospital, Dungannon and Tyrone County Hospital, Omagh and the proposed closure of acute services at Mid Ulster Hospital would lead to the centre of Northern Ireland being left with essentially no acute hospital at an acceptable travelling distance and time for the people of Cookstown, Moneymore, Draperstown, Plumbridge and Gortin etc.

Recent studies have shown that the mortality rate of patients increases the further patients are from acute care especially with respect to acute respiratory conditions.

I know we cannot turn the clock back and the almost defunct Area Boards all decided to concentrate their acute services away from the centre of Northern Ireland and propose to leave this unacceptable hole in services. To say that the Northern Ireland Ambulance Service will be able to compensate by increasing their efficiency is laughable when we consider travelling times in Northern Ireland at 8 am or 4 pm during the working day and the scant resources in terms of manpower/vehicles that NIAS works with. If paramedics are so capable why is our local cardiac ambulance called out so frequently to assist paramedics at resuscitation of patients? I have bitter experience of NIAS when it comes to transferring patients from Mid Ulster to other hospitals or even from Ward 6, Mid Ulster to High Dependency Unit, Mid Ulster. Delays are unacceptable.

2. The document modernising Health and Social Care Services has of course a lot of meritorious proposals on disability, mental health and estate issues. However, I feel the acute hospital services proposals should have been a separate document and consultation process, otherwise tacit approval for the document as a whole leads to acute services being removed in a fog of other issues.

3. The briefing paper – Modernising Acute Hospital Services, July 2008 as well as the document 'Modernising Health and Social Care' contains a lot of inaccuracy, eg I quote from the July 2008 document 'Neither Whiteabbey nor Mid Ulster Hospitals have training status so cannot employ Junior Doctors in training'. This is translated in the later document to 'Both Whiteabbey and Mid Ulster Hospital have restricted medical training status and as such cannot employ Junior Doctors in the same way that other acute hospitals do' – this is not correct – we have as you know training posts for F1, F2, ST1, ST2 and ST3 doctors at Mid Ulster and have had consistently good reports from training inspections/surveys in recent years.

   The statement – 'Junior Doctors employed at Antrim and Causeway Hospitals cannot be part of rotas to staff Whiteabbey and Mid Ulster Hospital' is not correct. This already happens.

   The statement in the paper Modernising Acute Hospital Services, I quote 'Senior Doctors who are working permanently in the smaller hospitals cannot participate in a Medical Staff rota across larger acute sites since they will not have had exposure/experience in the range of cases that would present in a larger acute site, eg heart attack cases' is obviously incorrect.

   To say that there is '—no out of hours anaesthetic cover at Mid Ulster' is not correct.

Save The Mid 2011: ref stm/00/1002

To say that there is '—lack of specialist radiology services at Mid Ulster' is not correct.

The high level of dependency on Locum cover is history fulfilling itself. The pressure on the A&E Department at Mid Ulster Hospital is history fulfilling itself – this Department was never staffed as a Department with Juniors/Seniors hence the current reliance on Trust Grades and Staff Grades.

4. After the transfer of acute services from the Mid Ulster site it is proposed to leave 30 or so inpatients of a non acute nature. This is foolish – how will such a small isolated unit be medically staffed? Certainly it would not be recognised for training of Junior staff. The local General Practitioners have not been approached to ask if they are willing or interested but I can predict they will not be interested or willing to cover such a unit. A nurse led unit seems unworkable and would be no more than a Nursing Home.

In conclusion I recognise that change is necessary but now that we are about to lose the Area Boards should the Department of Health, Minister of Health and the Trusts not sit back and look at the map of Northern Ireland and consider the distribution of acute hospital services across the country to allow everyone fair and equal access? Also I feel the inaccuracies in the papers produced by the Trust for public consumption are unacceptable.

Yours sincerely

[redacted]