SUMMARY BRIEF & RECONMENDATION'S FOR TRANSFORMING YOUR CARE REVIEW 2013

Save The Mid

PRESS EMBARGOED UNTIL 20/01/2013

NHSCT Demographics (page 9 briefing paper)

Points of Interest

Total Population

- Despite much being said across the population plans about the rise in population within the SHSCT, The NHSCT area has the largest population within Northern Ireland, largest geographical area that is spread mainly over rural areas.
- The Population of the NHSCT has risen by 34,878 people between 2000 and 2011, a rise of 7.6%
- The NHSCT accounts for a quarter of all residents in Northern Ireland, in context there are 5 health trust areas to base this on and of the 5 different areas a quarter live in the NHSCT

Children aged 0-4 Years of age:

- 31,061 children aged 0-4 years of age live within the NHSCT, a rise of 6% since 2000
- This is the largest population sample of this size when compared to other health trust
- The highest amount of live births are accounted for by NHSCT resident mothers
- 24% of all live births where to mothers who reside within the NHSCT in 2011, these births are spread against 5 health trusts

Persons ages 60 years +

- The NHSCT has the largest amount of residents aged 60 years or more, 96,051 residents live within the NHSCT area accounting for 27% of the total 60+ population of Northern Ireland

Deaths by Health & Social Care Trust

- The NHSCT sees the high number of deaths across all categories when compared to other health trust areas, this will be partly because of it being the largest health trust areas in Northern Ireland
- there were 3,622 deaths within the NHSCT in 2011 accounting for 26% of all deaths in Northern Ireland

Deaths 2012

- The NHSCT has seen 25% (2,742) of deaths in the first 3 quarters in Northern Ireland in 2012
- The NHSCT has seen 25% (20) of all still birth deaths in the first 3 quarter of 2012 in Northern Ireland
- What is known as the Mid Ulster area has accounted for 40% (8) of the 20 still births deaths in this period, Magherafelt 5 and Cookstown 8 within the Northern Health 7 Social Care Trust

Mid Ulster Demographics (page16 briefing document),

Using NNIS NISRA interactive map, these figures while different to the previous are using a different population estimate; however all is referenced in the document.

Usual residents:

- 18% of the total population of NHSCT resides in what is known as the Mid Ulster area (Cookstown & Magherafelt)
- What is known as the Mid Ulster areas is resident to 20 %of all children aged 0-4 years of age within the NHSCT

Potential Years of Life lost 2006 – 2008; "Potential years of life lost (YLL) provide a summary measure of premature mortality. Potential years of life lost may be defined as the years of potential life lost due to premature deaths. Years of life lost (YLL) take into account the age at which deaths occur, giving greater weight to deaths at a younger age and lower weight to deaths at older age. The indicator measures the YLL due to a cause as a proportion of the total YLL lost in the population due to premature mortality. YLL is used in public health planning to compare the relative importance of different causes of premature deaths within a given population, to set priorities for prevention, and to compare the premature mortality experience between populations" [1]

"Standardized mortality rate tells how many persons, per thousand of the population, will die in a given year and what the causes of death will be."[2]

While not one age group is on or above the YLL lost when compared to Northern Ireland on a more localised area where the population plans do not go into enough depth show several issues.

The Cookstown area sees higher than the Northern Ireland rate in YLL. In line with current death rates seen in the recent 2012 quarterly bulletins this gap will remain the same:

- The male population is a full 1 point higher than the Northern Ireland
- Children aged 0-14 years the rate is 1.6 higher than the Northern Ireland
- In those aged 25-64 years of age is 0.3 higher than the Northern Ireland average
- The standardised mortality rate is 2.8 points higher than the Northern Ireland figure and 7.9 points higher than the NHSCT rate

Hospital admissions:

- The NHSCT sees an admission rate to hospital that is 1.6 above the NI rate in all areas bar Emergency admission. This would give rise to the notion that more admission are elective. Also in perspective due to the fact that internal capacity within the Trust is not sufficient to admit all patients immediately there is a demand for services.

Cookstown:

- All hospital admission 4.4 above NI rate and 2.8 above NHSCT rate
- Elective care admission 2.2 points above NI rate
- Emergency admissions 5.9 points above NI rate and 9.8 points above NHSCT rate
- Respiratory disease admissions 11.8 above NI rate and 9.1 points above NHSCT rate
- Circulatory disease admissions 10.6 points above NI rate and 4.3 points above NHSCT

Magherafelt:

- All hospital admission 6.8 above NI rate and 5.2 above NHSCT rate
- Elective care admission 10.8 points above NI rate
- Emergency admissions 2.8 points above NI rate and 6.7 points above NHSCT rate
- Respiratory disease admissions 14.4 above NI rate and 11.7 points above NHSCT rate
- Circulatory disease admissions 9.9 points above NI rate and 3.6 points above NHSCT

[1] http://www.healthknowledge.org.uk/public-health-textbook/research-methods/1a-epidemiology/years-lost-life

[2] http://en.wikipedia.org/wiki/Standardised_mortality_rate

Over view of Emergency Care (page 19 briefing paper):

Antrim:

- Average attendance per day at Antrim has risen from 178.5 in 2009 to 194 in 2012,
- this accounts for a rise of less than 1 patient per hour
- The increase came post the closure of Mid Ulster and Whiteabbey A&E and shows how fragile the emergency system is in Antrim when an increase of less than 1 patient an hour on average has led to the issues and problems we see now.

Causeway

- Average attendance per day at Causeway has not increased when compared to that of that in Antrim post the closure of Mid Ulster and Whiteabbey A&E
- There was a rise in patient‟s between Jan – May 2010, this can only be concluded that the Causeway was heavily utilised during the rundown of Mid Ulster hospital. Figures show that 12 hour breaches with Antrim where already out of control before the closure of the Mid Ulster unit.
- Average attendance in 2009 per hour was 4.7, the current average is 4.9

Mid Ulster

- While operation the Mid Ulster seen an attended rate of 48.5 patients a day / 3.5 patients per hour during 2009. The A&E was open 365 days a year from 9am to 11pm. Ambulance bypass protocols were in place to stop patients going to the Mid Ulster hospital for trauma, children and maternity patients.
- The attendance now for the Minor Injury unit sees the same hourly average as when it was an A&E of 3.5 patients per hour, Minor Injury Unit is only open weekdays, excluding bank holidays from 9am to 5pm.

In comparison to all A&E attendances in 2009 there were 143,610 attendances at A&E‟s of all types within the NHSCT, for the year 2011 it stood at 129,138 attendances. Despite a drop of 10% (14,472) patients a year the NHSCT has seen some of the worst waiting times in record across A&E departments in the UK.

Waiting times:

- Since the closure of Mid Ulster hospital A&E in May 2010 6,044 patients have waited over 12 hours for treatment, admission or discharge from Antrim Area Hospital A&E (May 2010-Nov2012)
- In terms of hours using 12 hours as the multiple a total of 72,528 hours were spent waiting by patients inside the A&E in that period, this equates to 3,022 days spent waiting or 8.3 years.
- The Causeway Hospital has fared better in its performance yet is still under performing, since the closure of Mid Ulster A&E. 1,707 patient‟s waited over 12 hours for treatment, discharge or admission between May 2009 – Nov 2012. This equates to a minimum of 20,484 hours waiting inside A&E or 2.3 years.

What is noticeable from the DHSSPS figures for waiting times is that periods of high instances of 12 hour breaches come in months where the A&E has fewer for below average attendance. May& June 2011 can be explained by the removal of inpatients in wards 2 & 3 at the Mid Ulster hospital site; this shows a direct relation between inpatient capacity in the trust and A&E waiting times.

Month & Year	Over 12 Hours	Total (new & Unplanned Review)	Average Monthly attendance
May 2010	240	6,052	5,947
June 2010	0	6,228	5,947
July 2010	24	6,185	5,947
August 2010	12	6,167	5,947
September 2010	56	6,104	5,947
October 2010	92	6,160	5,947
November 2010	100	5,596	5,947
December 2010	164	5,541	5,947
January 2011	561	5,873	5,947
February 2011	547	5,273	5,947
March 2011	343	6,169	5,947
April 2011	209	6,114	5,947
May 2011	448	6,286	5,947
June 2011	539	6,098	5,947
July 2011	94	6,063	5,947
August 2011	108	6,059	5,947
September 2011	97	5,972	5,947
October 2011	252	5,925	5,947
November 2011	164	5,636	5,947
December 2011	394	5,621	5,947
January 2012	446	5,541	5,947
February 2012	181	5,682	5,947
March 2012	109	6,178	5,947
April 2012	78	5,892	5,947
May 2012	198	6,225	5,947
June 2012	93	5,902	5,947
July 2012	66	5,748	5,947
August 2012	58	6,224	5,947
September 2012	66	5,952	5,947
October 2012	122	6,106	5,947
November 2012	183	5,776	5,947

Cumulative period activity:

- The Mid Ulster Minor Injury Unit is the only unit showing an increase in activity when compared to other emergency departments within the Trust
- There is a 9% increase of patients who attend the Minor Injury Unit at Mid Ulster hospital, this figure could be more as it does not take into account Dec 2012 when compare to the full year of 2011.
- Between Jan 2011 and 28th Nov 2012 1,237 patients have attended the Minor Injury Unit at Mid Ulster only to have to be sent to another A&E as their injury could not be treated. 168 of these were children under the age of 5.

Postcode analysis, figures are based on Jan – Feb 2012s, these figures do not include patients who attended other network hospitals e.g. Craigavon, Royal group in Belfast etc.:

- A total of 6,240 patients attended Antrim & Causeway Emergency departments during Jan12 – Apr 2012
- In the time period 79% (3,965) of all attendances from mid Ulster postcodes attended Antrim area hospital.
- 2,072 or 33% of patients from Mid Ulster post codes attended Causeway and Antrim A&E‟s during out of hours (5pm-9am)
- There were 121 days in the time period, in relation to Mid Ulster patients this equates to on average 52 patients a day attending Causeway and Antrim A&E‟s alone.

NHSCT are not just failing to attract doctors into their hospitals but management within the NHSCT are also failing to hire in properly trained doctors (page 83 briefing document).

Over the past 2 years 4 doctors have been struck off while working within the NHSCT:

- 2009, Dr Katya [3]; Applied to the then Causeway Trust for the post of SHO Paediatrics in 2006, it was found that Dr Kataya was not honest on previous experience and posts and forged a letter of recommendation, which led to his erasure from the GMC in January 2010, 28 days after closure of the case in December 2009
- 2010, Dr Hussain [4]; Investigated for instances in Bucknall Hospital, Staffordshire between 6 Oct 2008 - 6 Jan 2009 and Antrim Area Hospital between 12 Jan 2009 – 23 Jan 2009, at Antrim Hospital Dr Hussain failed to diagnose or inform junior doctors properly on the result s of CT scan which led the patient not being “urgently transferred to neurosurgery.
- 2010, Dr Krishnamurthy [5]; Employed as second year SHO in Anaesthetics at Antrim Area Hospital between 2 Jan 2007 – 4 Apl 2007, for one patient did not formally admit a patient to Intensive Care and administers medication properly. Another patient in the same year was not monitored properly and left to the care of nursing staff.
- Dr Abdool Majid Vahdani [6]; Between 24 August 2009 and 1 October 2009 you were employed as a locum SHO at the Causeway Hospital, Coleraine, Northern Ireland (the „Causeway‟), as a “Staff Grade Obs & Gynae. Found to have unacceptable performance in; providing care or arranging treatment, good clinical care and relationship with patients. After failing this was found guilty of prescribing a private prescription. Dishonest on CV submitted to Locum agency Surgi-Call, therefore made a false representation to gain work. Needed supervision while working.

Child Vetting Failing, GMC Strike Doctors Off, Over £2 Million Unaccounted For, Rising Management Costs. Attachments: Annual notes to accounts NHSCT 2010-11 / GMC minutes of hearings

Although the published Annual Accounts recently published by the Northern Health & Social Trust paints a pretty picture, in June a BSO Audit highlights concerns and weaknesses in the Northern Health & Social Care Trust‟s performance.

Major weaknesses included (pages 7 & 8)[7];

- · Areas of high graded incidents not being investigated.
- · Delays in completion of investigations and appropriate documentation not being completed and returned to the complaints/service user office
- · Arrangements relating to the trust acting as appointee for a client, reconciliation of bank statements, and safekeeping of a small number of donations
- · Weakness in the areas of evidence of Access NI (child vetting) checks, delay in confirmation of GMC registration, confirmation of entitlements to work in the country.

[3] http://savethemid.weebly.com/uploads/7/4/7/7/7477841/kataya_minutes.pdf
[4] http://savethemid.weebly.com/uploads/7/4/7/7/7477841/hussain.pdf
[5] http://savethemid.weebly.com/uploads/7/4/7/7/7477841/krishnamurthy2.pdf
[6] http://savethemid.weebly.com/uploads/7/4/7/7/7477841/vahdani.pdf
[7] NHSCT ANNUAL Report http://savethemid.weebly.com/uploads/7/4/7/7/7477841/annual_accounts_2010_2011.pdf

Ambulance Service (page31 briefing paper)

The Northern Health Trust Area for 3 years in a row has had the lowest response to live saving calls in less than 8 minutes.

The average response time in the Northern area was 64.3%; the largely rural area has seen local areas perform far worse. The Cookstown and Magherafelt areas have suffered some of the worst response times in Northern Ireland, as previously reported; these areas are 20% below the average in the Northern Area and 28% below the Northern Ireland average.

These types of performance times must be rectified more, it is not acceptable to strip areas like Mid Ulster of acute services and leave residents stranded for ambulance cover. An ambulance cannot fill the gap made by removing the A&E, the current consultation on Transforming Your Care must recognize the demand in Mid Ulster for acute services and deliver them before more lives are lost.

During the time period in the report Mar 12 – Jul 12:

- only 44% of life saving calls were responded to in under 8 minutes within the Mid Ulster area

According to the ambulance services all ambulances are fitted with trackers that ensure that the closest vehicle available responds to an incident, regardless of where the vehicle is based.

Example:

- A 999 stroke call is received from Cookstown at 8pm.
- Ambulance is dispatched from Magherafelt base.
- 8:03pm a 999 stroke call is received from Moneymore
- The ambulance that is on route to Cookstown will pick the Moneymore patient up first and another ambulance will be dispatched from base of wherever it is at.

This shows a major flaw as when ambulances receive patient in the Mid Ulster area they will deliver the patient to Antrim in the majority of cases

To follow on from this,

- The ambulance that was based in Magherafelt that picked up the Moneymore patient will then deliver the patient to Antrim.
- Antrim being 17 miles of Belfast and a densely populated area there is the risk that instead of the ambulance returning the base it will be caught up in the urban areas.
- When this happens and no ambulances left in the base, no other enters into the Mid Ulster area to provide cover.
- The only cover is a rapid response vehicle, which use is limited and while yes it can administer first aid the primary objective of these is to beat target times.

A snapshot of how this affects Mid Ulster patients can be found on page 36 of the report, as the report shows Craigavon Hospital as being the destination we can assume that this applies to patient‟s in the Cookstown District area. The longest time for a response was 5 hours and 40 minutes. If this ambulance was stationed in Magherafelt or Cookstown that is nearly 6 hours cover was absent from the area for other patients.

The NHS Confederation, as body that covers the UK stated[8]:

> "Handing over a patient from an ambulance to an ED is expected to take no more than 15 minutes. But as the National Audit Office highlighted in its review of ambulance services in June 2011, only around 80 per cent of handovers meet this expectation.
>
> Each failure to meet this standard means a delay and poor experience for the patient waiting to be received. It also means a delay in an ambulance crew being available to dispatch to a new emergency call – posing a potential safety risk to the next patient waiting for an ambulance in the community." [9]

Key performance indicators: A London example

Key performance indicators (KPIs) are the agreed contractual measures of performance, and have been developed in a number of areas. In London, for example, these are set as follows and are incorporated in each acute contract:

KPI 1: Patient handover should be achieved within 15 minutes from arrival 85 per cent of the time.
KPI 2: Patient handover should be achieved within 30 minutes from arrival 95 per cent of the time.
KPI 3: Any patient handover that takes 60 minutes or more must be reported and investigated by the acute trust as a serious incident (SI), with contractual penalties applied.
KPI 4: All acute trusts should ensure patient handover times are recorded via the patient handover button on the hospital-based alert and (web-based) handover system for 90 per cent of all hospital turnarounds.
KPI 5: The difference in performance reported through the ambulance service system and the acute trust‟s system shall not exceed 10 per cent for KPI 1.
KPIs 1 and 2 are reciprocated in the London ambulance service contract. The ambulance contract also includes associated KPIs regarding 60-minute handover to „Green Available" delays and data compliance.

Within the documentation supplied by the NHS Confederation the capacity of hospitals both of the A&E and inpatients has a bearing on the ability of ambulances to quickly handover patients and return to serve the community. Unnecessary hold ups in transferring a patient to Accident & Emergency can prevent an ambulance responding promptly to its next life-threatening callout; with ever shirking acute care cover areas like Mid Ulster should be the focus of the provision of ambulance care.

This sentiment is also echoed by Deputy NHS CEO David Flory in a letter to health trusts in England regarding ambulance hand overs[10]:

> "It is timely to remind organisations that there is a "Duty of Cooperation" to ensure effective working at the interface of health care organisations. This is also reflected in the Terms of Authorisation with which Foundation Trusts and aspirant Foundation Trusts are required to comply. Where local handover delays continue to be problematic, both Monitor and the Care Quality Commission have the responsibility to assure compliance with this duty and I have encouraged them to take appropriate action where organisations fail to do so."

Page 36 of the briefing paper also shows ambulance response times for pregnant mothers in Mid Ulster and shows another reason why the ambulance service must be improved in the Mid Ulster area.

[8] NHS Confederation Zero Tolerance on Ambulance Handovers http://www.nhsconfed.org/Publications/reports/Pages/Zero-tolerance.aspx / http://www.nhsconfed.org/Publications/Documents/Zero_tolerance061212.pdf

[10] Letter David Flory http://www.dh.gov.uk/health/files/2012/06/Ambulance-handover-delays-19062012-gw-17718.pdf

Hospital Inpatient, Outpatient and Day Case activity NHSCT (page36 briefing paper)

Although A&E attendances have fallen since the reconfiguration of A&E"s within the NSHCT, the amount of patient"s admitted via A&E within the NHSCT has increased since Jan 2010. There has been a 10% increase in admission via A&E since Jan 20120 and Nov 2012, with Nov and Oct 2012 seeing the largest actual number of patient"s admitted of any previous months.

This is very significant, health Minister Edwin Poots, CEO NHSCT Sean Donaghy and Head of TYC review John Compton are all o record that part of the problem with delays in A&E is due to unnecessary attendances. The NHSCT post Rutter and Hinds have put in place an action plan that stops unnecessary admissions via A&E, so even with falling A&E attendances at Antrim Area Hospital, coupled with the action plan of Rutter and Hinds, more patient s are being admitted than ever before, this would lead to the conclusion that unnecessary attendances is not the issue at Antrim A&E IT IS PURLY A CAPACITY ISSUE of the A&E and inpatient wards

Available inpatient beds (page 40 briefing paper)

There has been a 17% decrease in the number of available Acute Inpatients beds in the NHSCT since April 2009/10, in total since 2007/08 the NHSCT has seen a 23% reduction in available beds across all programmes of care, and these losses have mainly been sustained at the Mid Ulster hospital.

Hospital	Available beds 2001/02	Available beds 2011/12	Change / %
Antrim	399	473	+74 / 19% increase
Causeway	220	246	+26 / 12% increase
Mid Ulster	177	37	- 140 / 79% decrease
Whiteabbey	160	46	- 114 / 71% decrease
NHSCT Hospitals with A&E units	956	802	- 154 / 16% decrease

On the 27th November 2012, at a publically recorded meeting hosted in the Sandal Centre, Coleraine, John Compton CEO of the Health & Social Care Board and Sean Donaghy CEO of the Northern Health and Social Care Trust both stated that Northern Ireland has too many inpatient beds in its hospitals. While in the same instance they are so short for beds that they now have to pay private health companies to hire out their beds.

Brooklands Private Health Centre was been awarded £430,155 to provide 15 intermediate health care beds, not unlike the type of beds that have recently been removed from the Mid Ulster Hospital. In addition to this Dalriada Urgent Care was awarded £86,418 to provide backup services. The question is, are our Hospitals too big or too small? Evidence would suggest to small and getting smaller every month. The most affected people here will be elderly people living in Mid Ulster and their families.

"Within the Northern Trust for the year 2011/12 a total of 97 beds was lost, 38% of which were in the Mid Ulster hospital. Since the Northern Trust came into effect a total of 362 beds have been lost. Although the Trust intends to open a new 24 bedded ward at the Antrim there will still be a net loss of beds, bed shortages are one of the most clinical dangers within the Trust, one which they compound by their own actions." [11] [12]
For more information the dangers of Bed Shortages read Rutter and Hinds report, as according to Valerie Jackson, former Director of Acute Services NHSCT, and 90% of all patients left waiting in A&E was due to the fact there were no beds [13]

[11] BED LOSS NHSCT http://savethemid.weebly.com/1/post/2012/10/northern-health-social-care-trust-cut-beds-life-saving-operations.html

[12] Save The Mid Media http://savethemid.weebly.com/1/post/2012/11/mid-ulster-hospital-cut-as-nhsct-go-private-for-inpatients-brooklands-awarded-400k-contract.html

[13] Rutter & Hinds Report http://savethemid.weebly.com/rutter--hinds-report-antrim-ae.html

Inpatient, Day case & Outpatient Performance (page 44 briefing paper)

Assuming form the previous chapter on A&E performance we can see that inpatient capacity has a material bearing on the performance of the hospital in terms of getting patients admitted via A&E. A&E is not the only route into hospitals and Transforming Your Care tries to assure us that „Pathways" will solve part of the problem we are currently seeing. What Transforming Your Care does not take into account that inpatient capacity has severely dropped year on year and has caused huge back logs.

Operations cancelled in the NHSCT Jan – Nov 2012 (excluding Jun 2012) these account for cancellations on the day or later of the intended session:

- 423 operations were cancelled on the day or later of the intended session during the time frame.
- 92 were cancelled due to no ward beds being available.
- 118 were cancelled due to no surgeons being available.

Outpatient Activity, page 48:

Outpatient performance via DHSSPS 2011/12

- The NHSCT, which is the largest residential trust, account for 13% of all outpatients appointments made in Northern Ireland, The view would be that several NHSCT are sent out of the Trust for appointments each year.
- 3,810 patient"s Did Not Attend their appointment, this account for 11% of the Northern Ireland total
- 10,265 patients Could Not Attend their outpatient"s appointments
- Hospital cancellations accounted in total for 28,351 cancelled appoints, which was 16% of all cancellations of this type in Northern Ireland

Hospital cancellation Reason	Definition [14]
Did not attend	This is the number of patients who did not attend, and failed to give advance warning to the hospital,
Could not attend	This is the number of patients who could not attend, and gave advance warning to the hospital, for an outpatient appointment before the day of the scheduled appointment. These should not be confused with those who either did not attend without prior warning or those who could not attend and informed the hospital on the day on which the appointment was scheduled. This does not include appointments cancelled as a result of the hospital being notified of the patient"s death. Depending on the timing of the cancellation, these appointments may be rescheduled for attendance by another patient
Hospital cancellation	This is the number of appointments cancelled by hospitals Hospital Cancellations may occur for the following reasons: - Consultant unavailable - Medical staff / Nurse unavailable - Patient treated elsewhere - Consultant cancelled appointment - Appointment rescheduled (brought forward) - Appointment rescheduled (put back) - Cancelled following validation / audit - Administrative error by hospital - Hospital transport not available - Cancelled by hospital in order to rebook as alternative booking method

When compared to 2009/10 the following observations can be made:

- The amount of outpatients seen in the year has dropped 8% (5,281) between the time periods.
- There was a drop of 7% (8,650) in the amount of review appoints seen in the Trust

There are fewer outpoints being carried out within the NHSCT, this will be talked about later.

[14] DHSSPS, page 105 http://www.dhsspsni.gov.uk/ni_hospital_statistics_-_outpatient_activity_2011_12.pdf

Further to the previous the DHSSPS created a detailed breakdown of 56,793 appointments that were cancelled by the Trust or patient (page 46 briefing paper):

- 17,113 appointments were cancelled within the NHSCT because the Consultant cancelled them; a further 5,976 were cancelled as no consultant was available.
- The figure of 17,113 appoints cancelled directly buy the consultant accounts for 61% of cancellation of this type when compared to other health trusts.
- 2,606 were cancelled within the NHSCT due to administrative error.

The consultant issue has been there for some time and according to the result from 2009/12 17,598 appoints were cancelled by consultants, account for 62% of this type when compared to other health trusts.

Current Outpatient waiting times in NHSCT (page49 briefing paper):

- As at Nov 2012 2,224 patient‟s resident in the NHSCT are waiting over 9 weeks for their first outpatient appointment

This figure is lower than it has been in previous years, however that is due to the increased reliance of sending patient‟s to private health care facilitates.

- 3,933 patient‟s resident in the NHSCT have been sent to private health care providers for outpatients between Apr-Nov 2012
- 10,874 patient‟s resident in the NHSCT have been sent to private health care provider‟s for inpatients and day case surgery between Apr-Nov 2012
- In total 14,807 patient‟s resident in the NHSCT have been sent to private health care provider‟s

This is a large amount of patients; this is directly due to the NHSCT cutting services within the Trusts despite increased demand. Transforming Your Care will only increase the reliance of private health care provider‟s with the proposal to downgrade Mid Ulster hospital into a community hub.

Private health care spending costs not just millions of pounds but hundreds of millions (page 78 briefing report), the annual accounts produced by health trust and submitted to the NI Assembly show that for the year 2011/12 totalled £415,855,000 (excludes SEHSCT due to figures not being available). During 2010/11 the SHSCT spent over £83 million purchasing non health and social care board care, it is estimated the total amount between the 5 health Trust amount to £500 million for 2011/12. This money was directly paid out of the budget the Trusts were given by the Health & Social Care Board, the same budget that funds hospitals, residential homes, care homes etc...

Over the past 2 financial years the NHSCT have spent £228,900,000 a figure that is increasing, private care costs more than in-house care. While the Trust have not stated how much these private care companies are getting paid, when referring to a previous FOI answered by the DHSSPS [15] where in some cases the cost of going private cost twice as much as the cost of doing services in house. Surly any future health service should be built on the notion that capacity should meet demand in-house, not by centralising services to acute facilities that will end up blocking beds and result in poor performance across all areas of care. The table on page 51 if the main report will show the contracts awarded.

What is more worrying within the accounts is the amount of money being paid out In clinical negligence, if these changes are to support a better safer health care then why year on year are we seeing increase clinical negligence liabilities and compensation pay outs. All money that is paid out in fines via clinical negligence comes from the health budget as hospitals are not insured against their mistakes.

Poor clinical governance is not just costing lives, it is costing millions of pounds within the NSHCT, the highly paid board executives who make these decisions must be brought under control by the health minister, their salaries, pension and CETV pension funds can be found on page 87 of the briefing paper.

[15] FOI cost of private care http://www.dhsspsni.gov.uk/private_healthcare_operations_26kb_-2.pdf

Why are we seeing these problems?

Dellotte Touché Risk Assessment [16] (page 52 briefing paper)

The problems that we are seeing today are nothing new and nothing that the NSHCT and successive Health ministers should not have been prepared for. Sean Donaghy CEO of the NHSCT stated in a public meeting in Magherafelt Council buildings that Developing Better Services 2001, is no longer part of the future configuration plans of health in Northern Ireland, a little too late for Mid Ulster as it was the Equality Impact Assessment form Developing Better Services that prevented a Judicial review of the removal of the Type 2 A&E. Page 6 of the risk assessment specifically states the implementing developing better services or downgrading the mid Ulster to a local hospital had risk to network rating of 5 and 4 respectively.

Risk ratings:

likelihood Scores-	Impact Score –
0- impossible	0- no impact on service
1- rare	1- little impact on service
2- unlikely	2- minor impact on service
3- moderate	3- disruption to service
4- likely	4- major disruption to service
5- near certain	5- closure of service

In a detailed risk scoring the likelihood score “Inability of Network Hospitals to manage additional activity” was scored as 5,

In the scoring staffing was a major issue for shutting down services, but as already was prove by Save The Mid to the Health Committee and First & Deputy Frist Ministers is that the NSHCVT did not try and recruit staff for the rotas, the NSHCT furthered this by not maintaining staffing rotas on purpose. This is proven by the CSR 2008.

For Maternity Services, A&E, General Medicine and general Surgery/Trauma the risk of the likelihood of network hospitals to manage additional activity was scored 5, Near Certain, unless significant developments were made across the trust. This risk was a clinical risk yet from 2006 to 2011 the NHSCT continued to downgrade Mid Ulster Hospital to a local one and the performances as seen earlier have suffered. The cost to both the patients and to finance should in effect see the removal of all managers involved in this decision making.

Acute Inpatient bed capacity:

- Between 2006 & 2012 the Mid Ulster hospital has seen an 83% (12,256) decrease in available acute inpatients bed days.
- In the same period despite the NSHCT being required to increase its provision it has also see a decrease of 2,096 (5%) decrease in available bed days.

This is a worrying figure and as already proven the relationship between inpatient availability and performance we can clearly see that the closure to shut the Mid Ulster hospital was clinically unsafe for patients.

[16] Rask Assessment
http://savethemid.weebly.com/uploads/7/4/7/7/7477841/20100805_hmcc210610f_responseattachment_deloitteriskassessmentreport2006.pdf

This clinical failure has been seen before,

A case Study (page 57 briefing paper) was presented in the form of Maternity services within the NHSCT; maternity services were reconfigured in 2006 following a risk assessment carried out by Deloitte Touché. Within this risk assessment it was stated that 5 being the highest risk, the score given to the inability of network hospitals to cope with the extra work load score 5.

From the population stats provided it shows that the highest number of live births come from mothers resident in the NHSCT, account for 24% of all live births. Considering that this is compared to 5 health trusts this is a very high figure, however what would happen if all NHSCT resident mothers chose to have their child within the NHSCT.

Despite 6, 048 live births being recorded and year on year since 2001 having the highest actual births based on residential status, available maternity beds have decrease 41% within the NHSCT since 2001/12 despite the NHSCT having the demand of the largest amount of births to NHSCT resident mothers.

When comparing still birth rates as the accounting years for NISRA and the NSHCT do not mirror each other I will use the figures that show full permeate years as produced by NISRA:

- Since maternity services were reconfigured and removed from the Mid Ulster hospital in 2006 there have been 156 still births to NHSCT resident mothers

Such is the duty of care shown by the board of the NHSCT in regards to these services that it passed at board level the building of a new children ward that is by the trusts own admission too small by standards as laid down by RQIA [17].

> "The ward was initially twice the size, incorporating the A1 paediatric surgical ward and A2 paediatric medical ward. However A1 was later converted over to breast screening after the amalgamation of the paediatric surgical ward and medical ward into one children‟s ward."

The above proves that instead of developing these services post the removal of them at id Ulster the NSHCT have actual contracted maternity and children‟s services despite being warned in the Deloitte risk assessment of Antrim‟s inability to meet the demand that will be placed on it

> "The outcome of this exercise evidenced that from the 2006/07/08/09 fiscal years there has been an increase of 11.6% traffic through A2. During 2009/10 ward attenders were redirected to the ambulatory unit in the MUH in a deliberate attempt to help decrease the patient flow through A2."

The above will feed directly into the recommendations for children‟s care at Mid ulster Hospital.

[17] http://www.northerntrust.hscni.net/pdf/Business_Cases_Childrens_Services_Antrim_Area_Hospital.pdf

"Through the Right for Our Children Project, which is steering the Reform and Modernisation of paediatrics within the Northern Health and Social Care Trust"s (NHSCT), the multi-professional team within the NNU had been exploring plans for an expanded NICU. Capital allocation of £230,000 had been secured from the Directorate budget to enable works to be carried out within the restrictions of finite financial resources and a physically „landlocked unit". However, these minor improvement plans would only result in the potential to achieve no more than approximately 7.3m2 cot space; still well below current HBN21 recommendations of 15m2, and would have made little impact on meeting infection prevention and control challenges as well as not improving parent and family experience to any great extent.

Statement of Need

The RQIA Independent Review of Incidents of Pseudomonas aeruginosa Infection in Neonatal Units in Northern Ireland, Interim Report, and 31 March 2012 recommends that the intensive care accommodation in the NNU in AAH should be expanded to allow more circulation space around cots. Representatives from Health Facility Planning and HEIG met with Trust clinical and managerial staff in the NNU to discuss this recommendation and to explore the feasibility of delivering on the Trust"s proposals for expansion of the cot space within the NICU without adversely impacting on existing clinical and support spaces and without compromising safety, functionality or the quality of service provided.

The current unit design layout, workflows and functionality of the clinical areas and support spaces were reviewed against the current floor plan:

- The 6 cot space NICU is 32m2 which equates to approximately 5.3m2 per cot resulting in the cots being extremely closely located.
- The mobile supplies base in the centre of the room further reduces this to 5m2 per cot.
- Most of the equipment is stored on available corridor spaces due to storage areas being too small for their purpose.
- The utility room is used for other functions including baby clothes laundry and blood gas analysis. shortfall or capital for this more extensive

This proposal sets out to address the spatial shortfall by increasing the current cot space allocation in the NICU to 13m2 along with increased storage space for essential equipment thereby resulting in:

- More effectively managing infection, prevention and control challenges.
- Improving flow throughout the unit.
- An improved family and child experience"

The above from the business case factually shows that the new unit will be too small by the standards required this was passed by the board, this is serious gross misconduct. A likewise business case was passed for a new mental health ward where the Trust passaged the business case for a new ward that was going to be too small for the projected patients it will be required to handle [18]

[18] http://www.northerntrust.hscni.net/pdf/Reprovision_of_Mental_Health_Inpatient_Services.pdf

Router & Hinds (page 71 briefing paper)

In Jan 2011 due to a critical underperformance of services within the NHSCT Health Minister Edwin Poots announced that a review will take place, this review was carried out by 2 Transforming Your care review member.

Ultimately this review failed, its recommendations have failed, and the implications of this are extreme. These 2 people will be part of reshaping the future health configuration of Northern Ireland and in their first attempt they have failed.

In Dec 2012 Health Minister Edwin Poots has commissioned another review team, headed by Sue Page CEO of the Cumbria NHS, a health trust that is also suffering. In context the Cumbria has poor performances in response to this Sue Page introduced several programmes to put more care in the community. More Care in the community is the ethos of the NHS Bill currently in Westminster and also transforming Your Care. The difference being that the NHS Bill is being openly debated unlike Transforming Your Care.

In regards to care in the community in Cumbria[19]:

- "The management challenge of the trust just got bigger and bigger," he adds. "It had to deliver more and more financial efficiency, it had to help deliver Closer to Home, and it was clearly struggling to create a sustainable hospital based service across two sites 40 miles apart."
- "Dr Walker says the community interventions in Closer to Home did have an impact, bringing down North Cumbria admissions at a time when they were steadily rising across the NHS."

We are already starting to see likewise problem"s, but will likewise solution"s work for the NHSCT, Dr Walker as cited in that report would question the care in the community aspect

- "The efforts to keep some people at home have had an impact," he says, "but what I think"s happened now is we"re suffering the consequences of that. They"re coming back into our hospital sicker." The report states that, along with admissions, lengths of stay for non-elective patients are also rising, indicating an increasing proportion with complex conditions. Some in the hospital, Dr Walker adds, now "want to have a discussion about whether that"s as a consequence of keeping them at home too long".
- He argues that while an increasingly complex hospital case mix is "what you would expect" from the Closer to Home strategy, "what you shouldn"t do when you implement Closer to Home is cut the [hospital] services, because down the track you"re going to need them".

Closer to Home on the Mainland UK is akin to Transforming Your Care in Northern Ireland, evidence is now suggesting that closer to home is not working as acute hospitals that provide the backup are being cut simply for cost cutting exercises.

The other risk with trying to put more care into the community is that it will need substantial finance to crate, for acute care services will lower the amount of money health trusts are commissioned each year and with 5 years of cumulative savings to be made with Transforming Your Care every effort must be made to ensure that acute care is commissioned based on need that is currently active rather than the needs of untested projects. We cannot predict the future and if we create an environment like Dr Walker has explained we will eventually and habitually require acute care every bit as much as we do in the future as we do now.

[19] http://savethemid.weebly.com/uploads/7/4/7/7/7477841/hsj-local-briefing---cumbria-may-2012.pdf

Deloitte Minor Injury review (page 75 briefing paper)

This review was commission past the removal of A&E services at the Mid Ulster hospital site; it determined that Mid Ulster Hospital did not have enough demand to create longer opening hours. This report while useful in its observations was flawed from the aspect that it did not take into account the state of the network hospitals, the report should have both looked at where Mid Ulster patients were going and what effect this was having on waiting times and performance of network hospital. As show previously the performance in the main network hospital was hitting an all-time low. Patients did not know what to do when they were ill as a promised post drop to inform patients of the changes never took place; indeed it took a long period of time for the signage to change to let people know the A&E in Mid Ulster was not operational.

The second flaw of this report was that it was carried out during the summer months, these months are most notable for being quiet compared to other seasons.

Points of interest, all figures relate to out of hours services 5pm – 9am during the 100 day test period:

- When Mid Ulster was operation as a 9am-11pm A&E, out hours (after 5pm) mostly seen patient"s requiring minor injury treatment account for 83% of all attendances. When compared to Whiteabbey which had 93% of patients who needed minor injury treatment out of hours it can be seen from an early glance that Mid Ulster was a critical services due to its rural locality
- Antrim Hospital bore the weight of the removal of services, during the test period 1,081 patient"s travelled out of hours to Antrim Hospital from Mid Ulster, this increased to 2,153, doubling from the previous year. Antrim hospital had to absorb and extra 445 minor injury patient"s and 627 major injury patient"s in the test period.

•	24th may - 31st August 2009			25th may - 31st August 2010				
	All attendances	Minor Injury	% Minor Injury	All attendances	Minor Injury	% Minor Injury	Actual Change	Actual change %
Mid Ulster Total - Antrim	1,081	361	33%	2,153	806	37%	445	123%
Mid Ulster Total - Causeway	198	152	77%	450	363	81%	211	139%
Mid Ulster Total - Craigavon	222	126	57%	423	286	68%	160	127%
Mid Ulster Total - South Tyrone	259	219	85%	385	341	89%	122	56%
MID ULSTER TOTAL	1,760	858	49%	3,411	1,796	53%	938	109%

Table to show total Mid Ulster Residents who attended network A&E"s, for minor injuries, out of hour"s pre and post the closure of Mid Ulster A&E

	24th may - 31st August 2009			25th may - 31st August 2010				
	All attendances	Major Injury	%	All attendances	Major Injury	%	Actual Change	Actual change %
Mid Ulster Total - Antrim	1,081	720	67%	2,153	1,347	63%	627	87%
Mid Ulster Total - Causeway	198	46	23%	450	87	19%	41	89%
Mid Ulster Total - Craigavon	222	96	43%	423	137	32%	41	43%
Mid Ulster Total - South Tyrone	259	40	15%	385	44	11%	4	10%
MID ULSTER TOTAL	1,760	902	51%	3,411	1,615	47%	713	79%

Table to show total Mid Ulster Residents who attended network A&E"s, for major injuries, out of hour"s pre and post the closure of Mid Ulster A&E

Summary

The decision to shut the Mid Ulster Hospital was proved long ago that it was a clinically dangerous move in terms of the ability of network hospital to handle the extra provision; such is the fragility of Antrim A&E being that less than 1 patient extra on average per hour has collapsed the system

From January 2012 Antrim Area Hospital has adopted the use of show beds in wards to try and improve performance, day case beds were removed from their wars and placed in the admission wards, Also the practice of show beds in the wards has now become common practice. A show bed is a bed that has no:

- a secure cabinet for medicines
- oxygen points
- space to bed is limited in the event of a crash call

This has led to wards being over crowed, and the risk of the spread of hospital acquired infection has risen, also the blocking of fire doors is also common practice just to find the need to place a bed in the ward (see picture on next page.

When we take cost cutting exercises like the non-recurrent savings of closing wards 2&3 at Mid Ulster creating a full year equivalent saving of £1,100,000 in 2011, only then to be followed by the expenditure of £946,728 to hire out 15 intermediate care beds and medical cover for 15 beds in a private hospital. Wards 2&3 at the Mid Ulster would have been far cheaper to run and also have a greater capacity.

Health Minister Edwin Poots is on record on Hansard stating it was a mistake to shut the Mid Ulster Hospital, now recognising the mistake we must find a way to rectify it. This will only be done by re-introducing services to the Mid Ulster Hospital site.

The future of acute care in the NHSCT must be built on solid foundations; we cannot simply allow any future plan for acute care to devoid the Mid Ulster area of any.

There have been many headlines over Antrim Hospital since Mid Ulster A&E:

- "Patient waits 50 hours for bed" [20]
- „I thought I was going to die" [21]
- "Doctor would not be treated in Antrim Hospital" [22]

One of the major talking points in the build-up of Transforming Your Care was Admission via A&E from alcohol related illnesses, there were 945 Admissions Via A&E to Antrim Hospital for Period 01/01/11 to 31/12/11 Where Diagnosis was Alcohol Related [23] Although it is an issue, this figure accounts for 1% of all attendances at Antrim A&E in that time period for there are far more worrying issues within the hospital than blaming alcohol and obese people for blocking beds and A&E"s,

There are far bigger reasons than saying that people turn up to A&E for no reason for the poor performance in the NHSCT, very few people within Mid Ulster are making such a long trip knowing that they could face long waiting times if they did not have a reason.

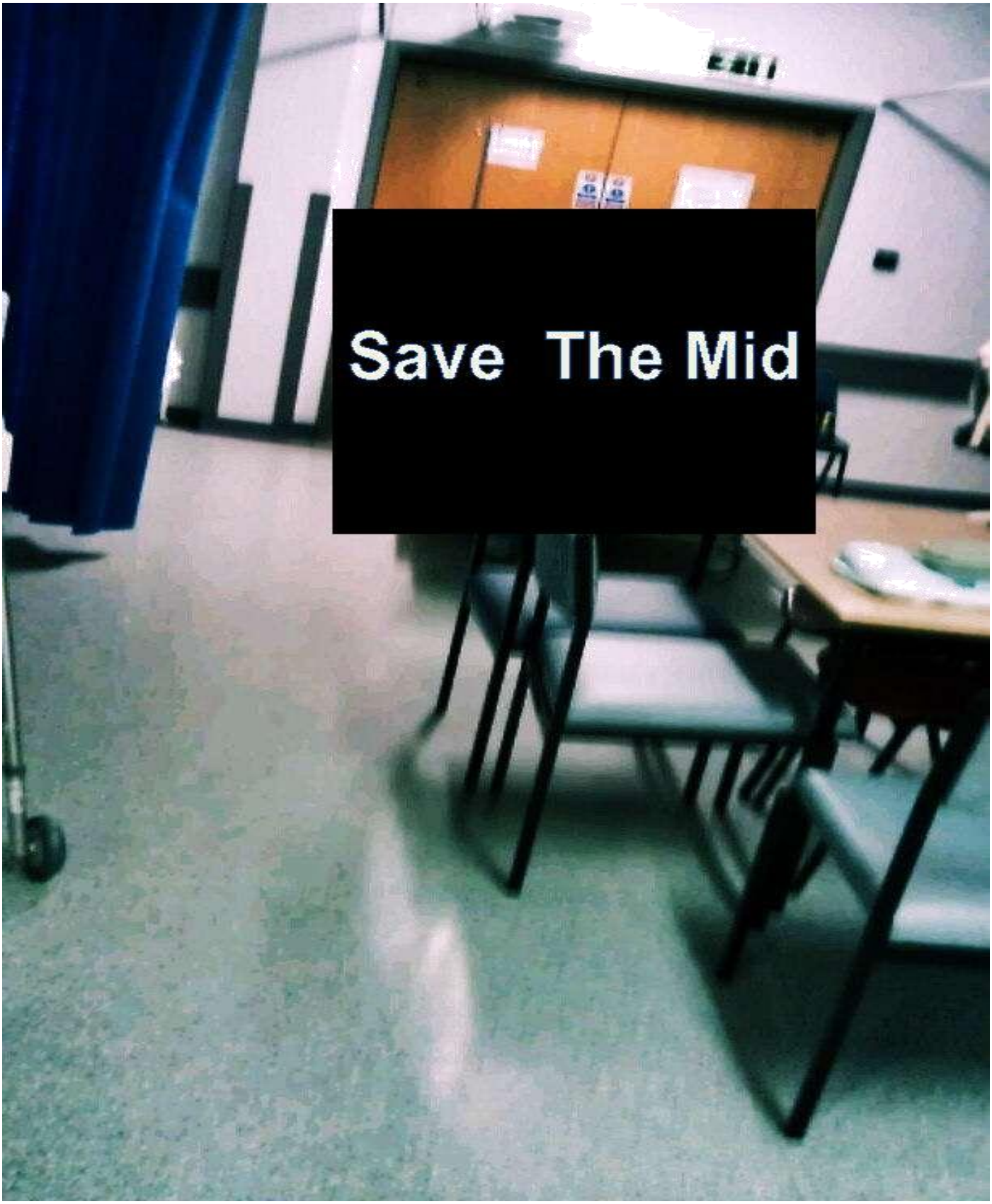
This document sets out shows the difference between supply and demand and shows that despite increasing demand the only increase in services is the increase of the use of private services that is costing the tax payer hundreds of millions of pounds every year at the expense of keeping lifesaving services in rural areas like Mid Ulster.

[20] Mid Ulster mail, Sept 2012 http://www.midulstermail.co.uk/news/patient-waits-50-hours-for-bed-1-4287907

[21] Mid Ulster Mail Jan 2011 http://www.midulstermail.co.uk/news/i-thought-i-was-going-to-die-1-2330467

[22] BBC Jan 2012 http://www.bbc.co.uk/news/uk-northern-ireland-16621447

[23] http://savethemid.weebly.com/uploads/7/4/7/7/7477841/20120425_hmcc200212b_responsealcohol_annexa_bk.pdf



C3 medical ward Antrim Area Hospital joining with maternity through fire doors!

Recommendations regarding the management of the NHSCT

Recommendation 1	• That all reconfiguration within the Northern Health & Social Care Trust be suspended pending a full enquiry into : • A&E • Inpatient capacity • Management decision To further allow any reconfiguration on the basis on Transforming Your Care and Modernisation & Recovery is to allow the continuation of poor and dangerous managerial decisions that have led to the worst performance of any health trust in the history of Northern Ireland.
Recommendation 2	The removal of the entire NHSCT board of executive and non-executive directors on the basis of: • performance • finance This document pertains to acute care; if this was widened into all areas of care performance will be sub-standard. This proof is found in monthly performance charts from the NHSCT that were used to reference this document. Post this removal an immediate risk assessment be carried out to find where failings are at on an operational level now rather than a review that is led to change service policy, like the current one underway by Sue Page CEO NHS Cumbria and specially relating to Antrim Area hospital The NHSCT must adhere to HBN 22 2005, the trust specially stated in a freedom of information “The number of attendances estimated at Antrim Area Hospital Emergency Department by 2018 is approximately 84,000. The Health Building Note (HBN 22 2005), which the Northern Health and Social Care Trust (NHSCT) is required to adhere to, sets out schedules of area for a 70,000 attendance unit and a 90,000 attendance unit; therefore, given the above figure of 84,000, it was Appropriate to design for a 90,000 attendance unit.” .
Recommendation 3	The geographic makeup of the NHSCT is considered and that the placement of acute facilities is subject to an independent body, for example the Royal Colleges.
Recommendation 4	The immediate removal of the corridor ward that is currently in place at Antrim A&E. This is a hideous concept that does not allow for human decency of any patients. Patients who are waiting here are in risk, if their illness worsens they are not stationed in an area where they can receive immediate treatment.
Recommendation 5	Waiting times, although worrying are still not accurately reporting waiting times in emergency care, the trust or an independent review body will need to include the entire emergency care pathway and include t**ime spent waiting for treatment, discharge or transfer in Antrim Area short stay ward.**

Recommendations for the future of the Mid Ulster Hospital site, as Thompson House (wards 5+6) have already been shut down the main bulking of the hospital is the only area for development, This however is in essence a safer clinical environment for all patient's:

Recommendation 6	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.
Recommendation 7	The immediate introduction of out of hours Minor Injury Services at the Mid Ulster Hospital site between the hours of 11pm to 9am
	Both of the above recommendations will provide for Mid ulster residents a level of care that they are currently not receiving. Not everyone who attends A&E needs lifesaving services but if left unchecked or left to wait these illnesses can develop more serious. This will still enable patient who require the larger acute facility the safety net that when they are in need of the specialist services they will be brought directly there.
Recommendation 8	The Dalriada Doctor on call, out of hours GP services is located to the Mid Ulster Hospital site to prove medical back up for the return and extension of services.

Performance in A&E"s currently is due to the fact that capacity cannot meet demand; Antrim Area Hospital could not cope with less than 1 patient extra on average per hour.

By removing less serious patient"s from the larger acute faculty that is Antrim Area & Causeway this will allow the larger facilities more resource"s to tend their patients.

The NHSCT are already using Dalriada Urgent Care to support them hiring out 15 intermediate care beds in Brooklands, this service should be utilised at the Mid Ulster Hospital instead.

With specialist ambulance service bypass protocols it could also be beneficial to take patients from further afield than the Mid Ulster area to the Mid Ulster Hospital for treatment, again this will leave fewer patients attending the larger acute facilities.

Recommendation 9	Provision to be made to allow the Midwife led unit at Mid Ulster Hospital to deliver less serious deliveries. Transforming Your Care makes for a provision to have more home births; this is quite strange given that there are not enough community mid wives in the area to travel with normal duties. The provision of being able to have babies in the Mid Wife led service will centralise the mid wives in the one building and allow mothers to have access to services when required. Ambulance bypass protocols will need to be developed to ensure that mothers are directed to the safest location in and out of hours. A Mid Wife led unit that delivers babies is currently operation in Lagan Valley, as the figures show there is a declining maternity service in the larger hospitals of Antrim & Causeway. As per the risk assessment, Mid Ulster attracted Mid Wives due to the hands on type of service it once delivered. The Mid Wives were so revered that the health trust shut the maternity in Mid Ulster to try and get them into the under pressure Antrim Area Hospital

Recommendation 10	• Re-opening or Wards in the Main building of the Mid Ulster hospital site Ward 2 had been partially reopened to sustain patients from the recently closed Thompson house, every effort should be made to retain this service and where possible expand it for the provision of care for elderly patients. Ward 3 to be re-opened to facilitate patient's required intermediate care and rehabilitation. The wards and single rooms adjacent to Ward 3 could be reopened to accommodate the Mid Wife led Maternity. Extra office space is already being defined in Thompson House that is detached from the main building. The children's unit to be retained, with the NHSCT backing the creation of a new children's / neonatal ward that is too small by RQIA standards this service in Mid Ulster could be utilized more in the future as a backstop.
Recommendation 11	• Reintroduction of the High Dependency Unit, this has been earmarked to be turned into a pharmacy and should not be allowed to change before all proposals are examined
Recommendation 12	• Reintroduction of general medicine and Surgery to the Mid Ulster Hospital site. In 2008, only 4 years ago Mid Ulster was training new doctors, grades FY1, FY2, ST1, ST2, and ST3. By utilizing the recommendation above and reintroducing the wards training could once again be provided. It was established in 2008 when the NHSCT told the public in consultation that Mid Ulster had no training of doctors and could not work on a rota system with Antrim and Causeway was a lie. It had the training posts that were successful and had the rotas with the network hospitals. This move will decrease the reliance of the NSHCT to have to pay the private sector to Health Commission should reflect the change in services in the NSHCT, and recognise that it is the largest residential trust in Northern Ireland and that money commissioned could be used for services within the trust boundaries.
Recommendation 13	Retention of statutory residential services in Westland"s Cookstown • • retention of Older People, Mental Health Dementia Clinics - Dr M Mannion X3313 in Cookstown Clinic • Retention of Mental Health Older People's Team - Base and Clinics Phil Hughes X 3191 in Cookstown Clinic