

Consultation Response

From: Save Our Acute Services (SOAS)

To: Dept of Health

Response to:

Public Consultation on Proposed Regional Obesity Management Service (ROMS) for Northern Ireland

November 2023

(SOAS is registered as a Community Interest Company – Registration# NI694537)

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Attachment 1:

Document: Regional Bariatric Surgery Proposal (SWAH Perspective) 2019
(Pages 31 to 45)

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Document: SOAS Detailed Consultation Response ‘Suspension of EGS at SWAH’ April 2023 *(Pages 46 to 90)*

[1] INTRODUCTION

This document is a response to the Dept of Health Public Consultation on Proposed Regional Obesity Management Service (ROMS) for Northern Ireland. The closing date for the Consultation is 1st March 2024.

‘Save Our Acute Services’ (SOAS) is a campaign group formed in November 2022 to campaign for the retention of all acute services in South West Acute Hospital (SWAH) in Enniskillen, County Fermanagh. The suspension of Emergency General Surgery (EGS) in SWAH in November 2022 was the key driver in our formation.

The core values of SOAS will inform this Consultation Response:

- It is our right to have as a core principle within our NHS that every citizen in Northern Ireland should live within one hour of a Type 1 Emergency Department.
- We demand equal access to safe urgent and emergency care services for every citizen in Northern Ireland.
- SOAS are entirely in favour of the development of an NHS-staffed consultant-led overnight elective centre. We believe that a thriving elective centre will complement the delivery of sustainable urgent and emergency care.
- Our geographic position should not prejudice our health and we call for an unequivocal commitment confirming the permanent reinstatement of full acute services to our South West Acute Hospital.

Fermanagh and South Tyrone is a largely rural area and ranks as one of the most deprived areas in Northern Ireland.

As a result, the population of Fermanagh and South Tyrone is very concerned about the future provision of Health Services within the Southern Sector of the Western Health and Social Care Trust (WHSCT).

This consultation references the proposed creation of a regional obesity management service (ROMS) for Northern Ireland. Key developments to derive from it would be in both Primary Care (using already existing local MDT teams) and Secondary Care (development of Tier 2/3 hospital-based MDT teams and Tier 4 Bariatric Surgery provision).

It is worth reminding ourselves about the two key relevant reviews that were published by the Dept of Health in 2022. SOAS will refer to these during this consultation response:

Review of Urgent & Emergency Care¹
Review of General Surgery²

The Review of Urgent and Emergency Care went out to public consultation and this concluded in October 2022. This enabled this review to proceed appropriately to implementation stage.

The Review of General Surgery was published in June 2022 but has not to date gone out to public consultation. The recommendations from this Review have however gone to Implementation stage without consulting the public.

¹ Doh Review of Urgent & Emergency Care (consulted on fully) <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-review-uec-departmental-response.pdf>

² Doh Review of General Surgery (not consulted on) <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-review-general-surgery.PDF>

[2] CONTEXT

There is a need to consider the overall context in which this consultation takes place.

The consultation document refers to a ROMS strategy that covers both primary and secondary care. SOAS will respond to the entirety of the proposal but will obviously be focused on the secondary care element as this aligns closely with our core objective of the restoration of EGS in SWAH.

SOAS considers that there is insufficient reference to the overall regional context within the consultation document itself.

Individual regional services, particularly in the case when a brand-new service is proposed, should only be considered with regard to the overall delivery of all services across the health and social care sector in Northern Ireland. Overall service delivery needs to be considered, not just in the case of Elective Services, but also in the case of delivery of safe and timely Urgent and Emergency care.

SOAS as part of this consultation response will also refer to the more local context and address the important issue of sustainability around SWAH itself.

Attention to detail with regard to service development at a local level should enable and facilitate the achievement of key strategic regional objectives.

We must also not lose sight of the importance of retaining appropriate and safe Urgent and Emergency care in the determined efforts to address the very significant issues surrounding Elective care.

We will make the case that in the context of development of Elective services – that the local consideration is inseparable from the regional consideration.

We will also make the case that any new service development – such as ROMS – should align with cross border longer term plans. SWAH is very well placed to have a key role in this.

It is the view of SOAS that the area of cross-border working is a vital element in ensuring the long-term sustainability of SWAH.

This has not been sufficiently developed in the 12 years since SWAH opened its doors. We believe it is time to correct this.

These will be developed in this section.

[2.1] REGIONAL CONTEXT

SOAS welcomes the recent return of the Executive and the appointment of a Health Minister.

The regional context within which this consultation is being carried out is one in which the public seems to have both little information and minimal involvement.

We have stated already that the review of Urgent and Emergency Care went out to public consultation and this concluded in October 2022. This enabled this review to proceed appropriately to implementation stage.

The Review of General Surgery was published in June 2022 but has not to date gone out to public consultation. Yet it is stated in the Review of General Surgery Update Report³ published by the Dept of Health in June 2023, that the proposed actions in this review have proceeded to implementation. The lack of clarity and public involvement around this implementation is illustrated by the fact that they have not issued any Minutes since April 2022.

SOAS has concerns with regard to the appropriateness of developing and implementing services based on this review. We see from the Terms of Reference of the Review of General Surgery that there is an inappropriate weighting towards the opinion of clinicians and Trusts & Department senior management. We have made these concerns known to the Department of Health.

We have also made these concerns very clear to the Western Trust in April 2023 during their recent consultation on their Temporary Suspension of Emergency General Surgery (EGS) in SWAH. We have included the EGS consultation response that we presented to the Western Trust in April 2023 as an attachment to this consultation response. It is important that this is referred to in detail – the relevant section is Section 2 of the EGS Consultation Response.

SOAS believes this ROMS consultation would be improved were there to be any reference at all to the overall regional context of transformational change that is clearly required. The consultation is weakened in the absence of this.

It must be repeated that consideration of any transformational change must reference both Elective Care and Urgent and Emergency Care.

The Review of General Surgery itself confirms the importance of the regional transformational context being considered when it states on Page 20:

“It is also clear that any changes to service configuration must be carefully planned, through joined up implementation projects which are fully co-produced and subject to public scrutiny, as they may have implications for other services in hospitals.”

SOAS is rightly concerned that this Consultation process is biased towards the ‘Review of General Surgery’ at the expense of the ‘Review of Urgent & Emergency

³ Department of Health - Review of General Surgery Update Report - June 2023 <https://www.health-ni.gov.uk/publications/review-general-surgery-update-report>

Care". The treatment of obesity in Secondary Care is in the main appropriate to the Elective Care framework. However, the overall effects of any new service development should consider potential derived benefits across both Elective and Urgent & Emergency Care that result from locations of services.

Why do we have concerns relating to potential bias?

It is our view that the 'Review of General Surgery' is driven by the issues in Elective Care and the need to get Waiting Lists under control. This was clearly the focus in 2021 of the Royal College of Surgeons England document "Northern Ireland Action Plan for Surgical Recovery: 10 steps not 10 years".⁴ This document led directly to the Review of General Surgery (Action#7). This exclusive focus on Elective Care is driving decisions – by DoH – that fail to assess adequately the impact of excessive 'time to treatment' for unplanned surgeries on our affected population in the South West. We do acknowledge that waiting lists are absolutely unacceptable and urgent action is needed to address these.

[2.2] SWAH-SPECIFIC CONTEXT

As already stated, SOAS is a campaign group whose main aim is to ensure the restoration of emergency general surgery to SWAH.

The potential location of our new regional service, such as bariatric surgery, in SWAH fits in with our belief that a fully functioning suite of elective services will facilitate a sustainable solution that involves 24/7 presence of consultant surgeons. We identified Bariatric Surgery as one of these key services in our EGS Consultation Response – which is attached.

This section will focus on challenging the unnecessarily strict interpretation that the Western Trust has applied to the guidelines in the Review of General Surgery.

There is a fundamental conflict between the Review of Urgent and Emergency Care and the Review of General Surgery that impacts negatively on the South West region particularly. SOAS believes that the key to the resolution of this conflict is associated with the exceptionality of the location of SWAH within Northern Ireland. Geography cannot be ignored when making key decisions around location of services.

The conflict is best highlighted by the extracts below:
Review of Urgent & Emergency Care:

⁴ May 2021 - Northern Ireland Action Plan for Surgical Recovery: 10 steps not 10 years
<https://www.rcseng.ac.uk/about-the-rs/government-relations-and-consultation/position-statements-and-reports/action-plan-for-northern-ireland/>

“all citizens in Northern Ireland have equal access to safe urgent and emergency care services, tailored to their specific needs at the right time and in the right place.”

(issued by Minister for Health – March 2022)

Review of General Surgery:

“our patients would have better services, with better outcomes for all – disregarding where they live”

(issued by Minister for Health – June 2022)

We believe that this notion of ‘**equal access**’ is of key importance. The newly installed Health Minister agrees with this and stated on his first message after taking up post again:

“We must take the right decisions that will give citizens more timely access to care and treatment.”⁵

(Minister for Health, Robin Swann MLA – 4th February 2024)

The South West region is exceptionally adversely affected by the removal of Emergency General Surgery.

We have collated significant evidence to show that there have not been sufficient attempts made to get surgeons to come to the South West region. It is the firmly belief of SOAS that this is by design. This is evidenced in detail in Section 2 and Section 4 of our Consultation Response to the Western Trust on the removal of EGS. This document is attached and we will not go through all of the details here. It is important to reference the detail in the attachment when considering this aspect of our response.

Why is it necessary to reference the removal of EGS from SWAH while doing a response to a Regional Obesity Management System (ROMS) public consultation? The answer to this is that only by considering the overall context of services in SWAH, is it possible to ensure the long-term sustainability of the hospital while also making sure that SWAH plays its full and appropriate part in the overall transformation of Northern Ireland health services – which by evident necessity should include ROMS.

One of the key elements in the Review of General Surgery is that there be separation of Elective Care from Urgent and Emergency Care when the work of consultant surgeons is considered. The stated intention is that Elective and Emergency surgery should not take place on the same hospital site. This is an important objective and SOAS accepts that there is valid reasoning for this.

⁵ Department of Health – Ministerial Statement – 4th Feb 2024 <https://www.health-ni.gov.uk/news/health-minister-prioritises-pay-talks>

However – it is not the only objective that must be considered when transforming our health and social care system. Timely and appropriate access to Urgent and Emergency Care for all of the population of Northern Ireland is the backbone of the Review of Urgent and Emergency Care – this also needs to be considered.

SWAH is an outlier when the geography of Northern Ireland is considered. It is the only hospital location where the withdrawal of EGS could not be mitigated by using another hospital within 60 minutes travelling time for emergency patients.

Why is ‘time to treatment’ for EGS so crucial to the South West region?

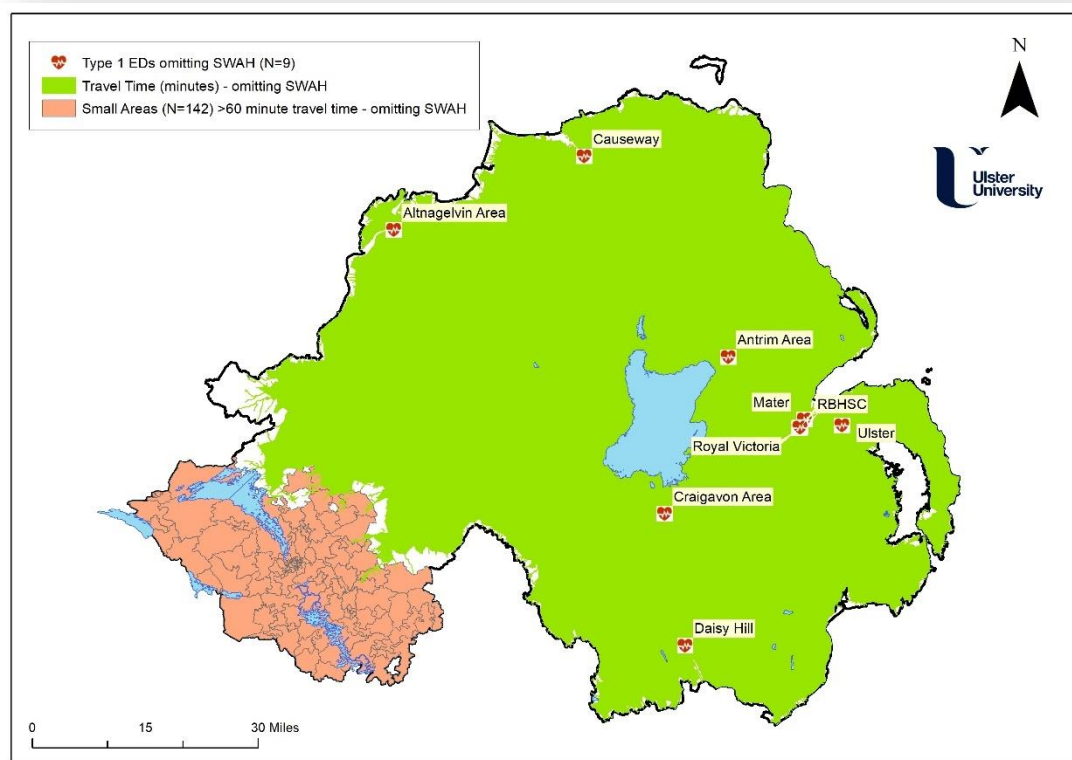
The SOAS Consultation Response - attached - to the Suspension of Emergency General Surgery in SWAH contains substantial information on why the time to Treatment is so important in the case of emergencies – particularly with relation to major trauma. Data from the University of Ulster confirms that – on average - the travel time for every adult and child in County Fermanagh to Altnagelvin is 113 minutes. Just under 2 hours. (Refer to Section 3 of consultation response). This is absolutely unacceptable to the population of one of the six counties of Northern Ireland.

NHS England themselves have considered risks relating to travel time and defined it as follows:

“One hour is taken to be the maximum travel time to hospitals for clinical safety reasons for emergency care”⁶

The diagram below illustrates very effectively how the overall unacceptable travel times impact on mortality and morbidity. This is covered in our EGS Consultation Response Section 3 which is attached.

⁶ NHS England - Technical Guide - For 2023/24 and 2024/25 (Revenue Allocations)
<https://www.england.nhs.uk/wp-content/uploads/2022/04/technical-guide-to-integrated-care-board-allocations-22-23-to-24-25.pdf>



How can this issue of time to treatment be resolved in the case of rural and smaller hospitals?

The sheer distances to both Altnagelvin and Craigavon simply put means that timely access for emergencies from the South West region is not possible.

It is of interest that the Royal College of Surgeons (RCS) themselves provide guidance on how to resolve this conflict in their own 'Standards for Emergency Surgery Guidance':

"Delivering an effective emergency general surgical service requires the entire team to be free of all other commitments, except in a few hospitals with low emergency workloads." ⁷

(Royal College of Surgeons - Emergency Surgery Guidance: Standards for unscheduled surgical care (2011))

RCS go on to specifically comment in their guidance on how management of surgeons' time in hospitals with low emergency workloads is easily achievable:

"Studies have shown that there is a distinct and measureable volume of admissions for emergency surgery, including both common/high volume and less common cases. It is possible therefore to predict, with reasonable

⁷ Royal College of Surgeons: Emergency Surgery Guidance - Standards for unscheduled surgical care (2011)
<https://www.rcseng.ac.uk/standards-and-research/gsp/domain-1/1-2-2-emergency-surgery/>

accuracy, the demand for resources and to plan for it. This will allow the workload to be managed more efficiently.”

The Office of the Minister for Health stated “the General Surgery review was a largely positive piece of work and would provide better outcomes in many cases, it was accepted it shouldn’t be a one-size-fits-all approach. There were of course going to have to be different approaches in different areas.”⁸

SOAS believes that the staffing crisis that enabled the Western Trust to suspend Emergency General Surgery was created more by design than by accident. The Review of General Surgery highlights the likely cascade effect of collapsing services that can result from the loss of Emergency General Surgery. Page 20 of the Review:

“The availability of, or access to, 24/7 surgical services is a key aspect of the safe provision of acute adult and paediatric services”

“It also underlines that the unplanned collapse of a vulnerable general surgery service could have implications across other hospital services. If services remain vulnerable to short term collapse, there is therefore a cumulative risk with regard to the impact this could have on other services.”

These secondary effects from a planned collapse are very difficult to prevent once they have started.

The development of an effective Elective centre at the expense of Emergency Surgery is clearly the intention of the Western Trust. However, even this is at serious risk when other services continue to collapse.

How can this be arrested in the case of SWAH? It is firmly the opinion of SOAS that an immediate statement by the Dept of Health committing fully to a restoration of Emergency General Surgery at SWAH is a vital first step in preventing the drift of consultants away from SWAH.

This must be followed up by genuine, determined efforts by Dept of Health and Western Trust that fully acknowledges that Emergency Surgery must be part of the solution for SWAH.

It is the basis of the SOAS ‘5 Point Plan’ that it be accepted that a different approach in the case of the South West region is appropriate.

Delivering appropriate elective services – such as Bariatric surgery – to the South West region is a key part of our plan.

⁸ DoH Special Adviser on Closure of EGS at SWAH <https://fermanaghherald.com/2023/02/trust-was-given-no-permission-to-do-this/>

[2.3] CROSS-BORDER CONTEXT

One of the main reasons for Enniskillen being chosen as the location for an acute hospital in the South West region was its proximity to the border. It was always envisaged that increased and real cross-border cooperation would be a key factor in the development of sustainable services in SWAH.

Unfortunately, the Western Trust has objectively failed to deliver on the cross-border aspect of health service delivery in the South West region. This has been explicitly acknowledged by the Chief Executive of the Western Trust himself.

The present Chief Executive of WHSCT has been involved with Cooperation and Working Together (CAWT) for at least 10 years. CAWT is a partnership between the Health and Social Care Services in Northern Ireland and Republic of Ireland, which facilitates cross-border collaborative working in health and social care. It is notable that the Chief Executive has ensured significant Northern Sector infrastructure development through CAWT while failing to deliver in a similar way for the Southern sector.⁹ The Chief Executive confirmed this in a House of the Oireachtas Joint Committee discussion in February 2022

"CAWT has played its part. We would not have a cancer centre today [beside Altnagelvin] if it was not for CAWT, and the population of the north west of Ireland has really benefited from that development."

"I have to confirm that we do not have the traction in terms of the cross-Border linkages between South West Acute Hospital and Sligo hospital. It is a great regret that it has not taken off over the last decade."

Former RTE News Northern Editor Tommie Gorman recently commented to The Irish News¹⁰:

"For cross-border trade and travel, there is no frontier. But when it comes to co-operation between north and south in the delivery of public health care in border settings, there is a barrier infinitely more formidable than the trade border in the Irish Sea. It resembles the Berlin Wall of the Cold War era. Part of the problem is health administrators and health professionals who are used to operating in their own patch and not encouraged to think beyond it. "

⁹ House of the Oireachtas - Engagement with Co-operation and Working Together – 10th Feb 2022
https://www.oireachtas.ie/ga/debates/debate/joint_committee_on_the_implementation_of_the_good_friday_agreement/2022-02-10/2/

¹⁰ Irish News - 27 February 2024 - Does anyone have the drive and vision to create a real cross border health service? <https://www.irishnews.com/opinion/does-anyone-have-the-drive-and-vision-to-create-a-real-cross-border-health-service-tommie-gorman-FARGUR7CANFTHOWCWCXW5PDDQI/>

We need to challenge the effectiveness and efficiency of CAWT in the development of cross-border services to date.

SOAS asks if there is not an obvious conflict of interest between the fact that the Derry-based Chief Executive of the Western Trust is also the Director General of CAWT. We question the unbalanced development of services over recent years that the chief executive of the Western Trust himself states has been extremely advantageous in the Northern Sector of the Western Trust clearly at the expense of service development along the border of the Southern Sector.

The current ongoing transformation of services needs to properly and appropriately engage with service providers in the Republic of Ireland to develop this key element of service redesign. The Western Trust has failed in this regard. It is important that the Dept of Health acknowledges this and ensures that appropriate interactions take place regarding service delivery.

It is also clear that there is availability of significant funding from the Republic of Ireland to ensure development of shared services across our borders.

SWAH has a number of key strengths to enable it to be a key player in cross-border development. These strengths include:

- the most modern hospital anywhere along the cross-border region.
- available capacity in theatres and wards.
- geographically close to areas in the Republic of Ireland that are deprived of appropriate services

The availability of this funding is only due to the fact that the Health Service Executive (HSE) and associated bodies recognise the potential that the border based hospitals in Northern Ireland have to offer to our neighbours.

Are there better ways with which funding from Special EU Programmes Body (SEUPB) can be directed?

Can there be more direct cooperation between The Dept of Health and the HSE? Can the acknowledged expertise across third level be harnessed to develop more appropriate services? Professor David Kerrigan has been highlighted by DoH during the public consultation meetings. He is an acknowledged expert in the UK – what assistance could he be able to bring to the development of obesity services here? We note also the repeated mentions during the public consultation sessions of Dr Alex Miras, who is an endocrinologist based in Ulster University with an established role in Research and Development related to obesity management services within the Western Trust.¹¹

¹¹ Western Trust welcomes Ulster University Professor of Endocrinology - Doctor Alex Miras
<https://www.facebook.com/WesternHSCTrust/posts/pfbid0Rgcy69XEBgRQBVVbaA1LTwTx2uhEhMt4Uf2jfoe6ggFcx23FedymaokpxVoVMLTsl>

The opportunity to develop appropriate obesity management services should align with the obvious benefits would accrue from appropriate cross-border cooperation.

It is important to realise that this potential development of cross-border capabilities can significantly improve both primary care and secondary care availability of obesity management services. These will be developed individually in this response.

[3] PRIMARY CARE

The overall proposed Clinical Treatment Pathway for ROMS is to be welcomed. This is a very simple and straightforward pathway. It clearly shows that Primary Care needs to be a key part of the pathway.

We do have concerns around the feasibility of delivery of the proposed model for Primary Care however.

It is notable that not a single question in the Consultation Questionnaire relates to the primary care pathway.

The key vehicle for the delivery of obesity management in primary care is what is termed the 'local multidisciplinary obesity management service'.

The consultation document states "These multidisciplinary teams already exist in primary care."

The consultation document suggests that it is only a question of training up the already existing multidisciplinary teams.

This may well be the case for those GP practices that have been fortunate enough to secure the funding for multidisciplinary teams. However, it is simply not the case that MDT teams are present in anything like all GP practices across Northern Ireland. The Department of Health Permanent Secretary stated at the NI Assembly Health Committee on 14th February 2024 that only 30% of practices in Northern Ireland have these MDT teams in place.

We are aware that most of the practices in the South West GP Federation do not have these MDT teams set up.

It must be assumed by us that the overall intention of the Dept of Health is to provide funding to all GP practices for these MDT teams. However – this belief must be challenged by the words of the Minister for Health himself when he addressed the Royal College of GPs on 27th February 2024¹²:

"The year ahead is largely going to be about damage limitation for health and social care. The main focus will be on preserving and protecting existing services, with all the limitations that they have."

"I appreciate that many of you will be keen to see the further roll-out of MDTs. Whilst the pace at which we move forward will be dependent on the availability of the necessary recurrent funding, I want to be able to invest in the primary care Multi-Disciplinary Teams."

¹² 27 Feb 2024 - Minister of Health Address to Royal College of GPs <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-speech-gp-270224.pdf>

It does go to reinforce our opinion that the lack of any overall regional context within this Consultation Document is a factor that weakens it.

We do question also what the costs would be of training up every MDT team across all GP practices in Northern Ireland to enable them to fully develop a local multidisciplinary obesity management service.

The consultation document states an expected £1 million-£2 million Year1 recurring cost for the service. We do have concerns that this may be an overly optimistic estimate when it is considered that the Year1 cost relates to both the entire primary care and secondary care provision.

We would assume that the evidence from the randomised controlled trials referred to in the consultation document relates to GP practices for the MDT teams are already up and running.

It is not made clear in the consultation document if the training costs for primary care teams would be part of the recurring costs mentioned. We would assume this is not the case and that training costs – which are clearly once off – would not be recurring and are therefore simply not included in the estimates in the document.

We are acutely aware that GP practices are under extreme pressure across all of Northern Ireland at present. We assume that appropriate communication has been ongoing with the bodies representing GP's as part of this proposed new service development and that appropriate steps have been taken to ensure that these GP practices are able to accommodate the extra work from being part of this clinical pathway.

It is important to be aware of the financial difficulties that all of the health trusts in Northern Ireland are struggling with at the moment. It makes sense to attempt to avail of alternative sources of income with regard to the development of Obesity Management Services in Primary Care.

Programs such as 'PEACEPLUS program (2021 to 2027)'¹³ from SEUPB should be considered in this regard. Theme 4 of this program (Healthy and Inclusive Communities) has an important Collaborative Health and Social Care budget allocation.

*¹³ SEUPB – PeacePlus Program – 2021 to 2027 https://www.seupb.eu/sites/default/files/2023-05/PEACEPLUS_Overview_24052023.pdf

SEUPB funding is informed by an assessment of those healthcare areas which are most suitable to a collaborative, cross-border 'whole system approach' to service delivery. On this basis, obesity management is one of the key areas that PEACEPLUS funding is directed towards.

The Southwest region is very well located to be able to present a very strong case to avail of funding such as this.

Funding applications for programmes such as this can be made in a number of ways – be it through CAWT, through partnerships with 3rd Level organisations, through direct communications with HSE bodies. Whichever is deemed to be most appropriate, can be progressed with a view to developing the key primary care objectives of ROMS.

It must certainly be stated, however, that the proposed significant involvement of primary care in ROMS to be fully welcomed.

[4] SECONDARY CARE

As for Primary Care, SOAS, welcomes the overall proposed Clinical Treatment Pathway for ROMS for Secondary Care.

We will go into some detail below with regard to the Secondary Care MDT teams and with regard to the bariatric surgery proposals.

In summary, SOAS will advocate very strongly for SWAH to be the location for the bariatric surgery prototype service development.

It also makes sense for one of the two proposed Secondary Care-based specialist multidisciplinary weight management services to be co-located in the hospital where the bariatric surgery service is established. We will thus argue that SWAH should be one of these two centres.

[4.1] BARIATRIC SURGERY

It is the position of SOAS that development of appropriate Elective Services is a key element in ensuring the overall long-term sustainability of SWAH. It is also the position that Emergency General Surgery be returned to our hospital. The case for Bariatric Surgery being situated in SWAH is significantly strengthened by the restoration of Emergency General Surgery on the site.

The most recent revision of British Obesity and Metabolic Surgery Society (BOMSS) recommended that Level 2 critical care facilities for post-operative care are not a requirement for bariatric surgery. This standard is dependent on appropriate risk management pre-surgery and also on emergency surgical cover being available post-surgery.

Question 2 in the questionnaire asks if we agree with the principle that bariatric surgery should be carried out on a single site where it can be delivered safely and sustainably.

SOAS strongly agrees with this principle.

Question 3 of the questionnaire asks at which hospital site do you think a bariatric surgical service should be provided?

SOAS firmly believes that the South West Acute Hospital is the most suitable site for a bariatric surgical service. SWAH can make a very strong argument that it is uniquely well placed in Northern Ireland to host the service.

The Western Trust¹⁴ along with the Dept of Health¹⁵ has already identified the suitability of SWAH for the location of bariatric surgery in March 2019. They announced SWAH as the proposed centre for a new regional bariatric centre of excellence in Northern Ireland.

Western Trust statement on 19th March 2019:

"We welcome the Department of Health (DoH) announcement today in respect of Bariatric Surgery and the capability of our South West Acute Hospital to deliver the service and we will be actively contributing to the work of the planning group."

Department of Health statement on 19th March 2019:

"Proposals for Northern Ireland's first health service bariatric surgery centre are to be taken forward by a service planning group appointed by the Department of Health. The assessment will focus on South West Acute Hospital in Enniskillen as the location for the proposed service."

There is a statement appended to Question 3 in the questionnaire that states "location of service will primarily be based on available capacity." It is clear from statements above that SWAH has that available capacity readily available.

SOAS has made a number of Freedom of Information requests relating to services around SWAH. A number of these relate specifically to bariatric surgery provision and around CAWT applications that have been made by the Western Trust/Dept of Health.

A key piece of information that we have received is the 'Regional Bariatric Surgery Proposal (SWAH Perspective)' – we will refer to this as the 'Proposal'. This is a capability document highlighting the feasibility of having a bariatric surgery hub in SWAH. The Proposal was developed in 2019 by the eminent cardiologist Dr Susan Connolly, who at the time was based in SWAH.

This proposal document argues in a more forceful and informed way than we ever could for the provision of a full Bariatric Surgery Tier 4 service at SWAH.

The Proposal document is included as an attachment to this Consultation Response. Certain sections of it are redacted, and we obviously can't comment on those sections. We do assume though that the ROMS team in Dept of Health will have access to the full document. It should be considered a full part of our Consultation Response.

¹⁴ Western Trust Facebook - 19th March 2019 - Department of Health announce plans for Weight Loss Surgery in South West Acute Hospital <https://fb.watch/qgTnBBumwo/>

¹⁵ Dept of Health Website - Department announces weight loss surgery centre proposals <https://www.health-ni.gov.uk/news/department-announces-weight-loss-surgery-centre-proposals>

The British Obesity and Metabolic Surgery Society (BOMSS) Service Standards and Commissioning Guidance have been referred to fully in the Proposal document. These principles underpin the provision of a safe, high-quality bariatric surgical practice. SWAH comfortably meets all of these criteria.

We would draw attention to the following points in the Proposal:

- staffing at SWAH is seen to be sufficient to safely accommodate bariatric surgery.
- almost all equipment required specifically for bariatric surgery is available in SWAH (the only item not available was a bariatric surgical table, which we believe has since been provided at SWAH through CAWT funding)
- sufficient available Theatre space can be utilised
- Hospital infrastructure (beds, chair sizes, door widths, wheelchairs, etc) is of a design that can be considered appropriate for the treatment of bariatric patients.
- SWAH already has a bariatric-capable MRI scanner that can accommodate the required weights.

We note also that the proposal for 100 procedures per year initially is in line with the BOMSS service standards. This is to be welcomed as it ensures adequate experience for both of the bariatric surgeons who would be initially performing this work.

Unfortunately, there is no information in the consultation document relating to the actual numbers on waiting lists for Bariatric Surgery across Northern Ireland. We do assume that in order to adequately address the waiting list that significantly more than 100 procedures would be required to be done per year.

It was stated by Dept of Health in the Public Consultation meeting on ROMS that it is estimated that 5,000 adults across Northern Ireland fit the criteria for bariatric surgery at present.

We would expect that a ramping up of procedures per annum after the Prototype Phase would facilitate the permanent location of bariatric surgeons within SWAH. This align with our long-term aim for consultant surgeons across multiple sub-specialities being based in SWAH. This then feeds into the overall employment of a range of consultant surgeons who can provide an effective 24/7 rota for emergency general surgery.

No information is given in the consultation document regarding the costs of existing Extra Contractual Referrals (ECR's) being made for patients urgently requiring bariatric surgery. Again, we must make an assumption that the cost of these referrals exceeds the costs of carrying these surgeries out in SWAH. This is to be welcomed as

it would reflect an overall saving to the Dept of Health, which should facilitate this speedy implementation of a Regional Bariatric Surgery Centre in SWAH.

We note the comment in Dr Susan Connolly's Proposal document Conclusion Section, where it states "This document outlines how the SWAH already meets many of the requirements to provide this [bariatric] service in terms of theatre capacity, surgical staffing, imaging and medical services. However, the delivery of the service will require cross Trust cooperation in organising a sustainable rota for the bariatric surgeons."

Successful implementation will initially require Consultant release from their current Trust, which should be possible as this is a regional service.

Consideration should also be given to their opportunity for revenue generation related to cross border patients availing of bariatric surgery in SWAH. The available capacity at present in SWAH may be an important factor in enabling a more vibrant elective centre to be set up while facilitating the development of cross-border cooperation.

This feeds this into the overall long-term sustainability of SWAH itself.

[4.2] MDT TEAMS

Question 4 in the questionnaire asks if we agree that specialist obesity management services (MDT's in secondary care) should be located in 2 locations in Northern Ireland.

We strongly agree with the statement.

Question 5 asks at which two hospital sites do we think a secondary care MDT specialist obesity management service should be located.

We believe that one of the sites where this team will be located should be on the same site where the Bariatric Surgery Regional Centre is located. We have presented the case above for SWAH being that centre in the earlier section.

We believe that 2nd hospital site should be located somewhere across the Belfast Trust hospitals. Obviously, the greatest density of population within Northern Ireland is in the greater Belfast area and it makes sense to have one of the Secondary Care MDT specialist obesity management services based there.

The Proposal developed already for SWAH in 2019 (which is included as an attachment) proposed to co-locate the Secondary Care MDT team and Bariatric

Surgery services at SWAH. It was anticipated then that the Western Trust secondary care MDT team complex obesity pathway would include the Our Hearts Our Minds (OHOM) program as one of its options. This would result in having blended teamwork across MDT teams and Bariatric Surgery teams with regard to Allied Health Professionals (psychology, physical activity specialists, and dietitians), and therefore encourage seamless transition from MDT Team to Surgery where appropriate.

The secondary care MDT teams, as proposed in the consultation document, serve a vital function with regard to the management of severe and complex obesity across the region. Currently there are no formal Tier 2 or 3 services in Northern Ireland to support those living with overweight or obesity. The development of the secondary care MDT teams is fully to be welcomed as part of the Tier 3 proposal.

The specialities aligned with the specialist multidisciplinary teams in secondary care align closely with those that are indicated for the provision of Bariatric Surgery itself. These are specialities such as physician, dietician, surgeon, anaesthetist, psychologist, and endoscopist. It seems to be a logical follow on that one of the specialist MDT teams in secondary care be co-located on the hospital site where the Bariatric Surgery is being carried out. This would clearly prevent needless duplication of roles and resulting an overall greater efficiency for the ROMS Model.

The post operative management required after complex bariatric surgery is a key consideration relating to the location of the secondary care MDT teams.

The BOMSS Guidelines¹⁶ states that “it is no longer considered mandatory for level 2/3 critical care facilities to be provided on-site for post-surgical support, provided that (a) 24 hour consultant surgeon and anaesthetic cover is provided to support ward staff and junior doctors; (b) patients are accurately risk-stratified pre-operatively to identify those who might require elective admission to a level 2/3 critical care bed and (c) that robust arrangements are in place at every unit undertaking bariatric surgery for the safe transfer of patients requiring additional monitoring/support to a level 2 (or if appropriate level 3) critical care unit.”

This aligns with comments made by DoH during the online and public consultation meetings. SOAS supports this statement. Again, this aligns with our long-term aim for consultant surgeons across multiple sub-specialities being based in SWAH. This then feeds into the overall employment of a range of consultant surgeons who can provide an effective 24/7 rota for emergency general surgery.

¹⁶ British Obesity and Metabolic Surgery Society - Updated Guidelines - 2021 <https://bomss.org/wp-content/uploads/2021/08/Revised-BOMSS-Professional-Standards-and-Commissioning-Guidance-May-201....pdf>

The secondary care MDT team element of the proposed pathway could present a valuable opportunity for funded cross border community based preventative programmes. The learnings from previous similar preventative programmes run from within the Western Trust can provide valuable sign posts for obesity related programs. Both online and public ROMS consultation sessions have referred to the Our Hearts Our Minds (OHOM) program as a strong example of bringing real benefit to the community. This kind of program can be directly implemented as part of an overall obesity management programme.

OHOM was an innovative preventive cardiology programme that was implemented in 2019 by Dr. Susan Connolly in 3 sites across the Western Trust (including SWAH). She had developed this programme based on research conducted with her colleagues in Imperial (EUROACTION/MyAction) in London and the programme had already run successfully both in both Westminster, London and Galway in the ROI. Delivered by a nurse coordinated multidisciplinary program the programme was associated with a wide range of improved outcomes, including weight loss, dietary improvement, increasing physical activity, quality of life, as well as medical risk factor control, such as hypertension, dyslipidaemia, and disglycaemia. The programme had been adapted in Galway for an obesity population (Croi Clann programme) and its results have been published in a peer-reviewed journal. Formal cost effectiveness analyses have been carried out on the EUROACTION/MyAction intervention and the programme has been deemed highly cost effective.

The OHOM programme in the Western Trust was originally funded through transformation monies and later based on its achievements including transforming into a completely virtual programme during covid became an award-winning renowned programme.^{17 18} Despite this the programme was not re-funded by the DoH in 2021 and after Dr. Connolly left SWAH in 2022 the programme effectively collapsed.

Again – the availability of potential funding for such programmes makes them especially attractive in the present financially-constrained environment.

No guidance as regards the expected number of referrals to the secondary care MDT teams is given in the consultation document. It can be assumed that a significant proportion of the 3% of the regional population (which is 60,000 adults) classified as Obesity Class III might be referred to the secondary care team. This would represent a considerable workload which when combined with the pre and post-operative care

¹⁷ BBC NI – 17th April 2017 - Obesity levels in Northern Ireland get new approach

<https://www.bbc.co.uk/news/uk-northern-ireland-47953366>

¹⁸ Belfast Live – 7th Oct 2021 - Fermanagh doctor scoops prestigious 'Healthcare Hero' award

<https://www.belfastlive.co.uk/news/northern-ireland/fermanagh-doctor-scoops-prestigious-healthcare-21790311>

of bariatric surgery patients would ensure sufficient and complex work to facilitate the full MDT team.

We express the same reservation as to the estimated costs of providing this Secondary Care service as highlighted in the Primary Care section of our response. The direct costs attributed to the Secondary Care MDT teams though should be set against the overall costs spread across primary and secondary care at present where these patients are being dealt with. One of the key arguments for the provision of this service as an integrated regional service is that it will present a real cost saving to the health service while also ensuring that they centralised expertise will bring a greater efficiency that is to be welcomed.

Question 6 asks if we would be prepared to travel to another Trust for regular appointments with an obesity management MDT.

We have answered 'Yes' to this question.

We believe that the general public are far more willing than in the past to travel significant distances to avail of elective appointments that they may have been waiting on for a considerable length of time. The cohort of patients that would be referred to the secondary care MDT teams are likely to be complex with a number of co-morbidities that make it urgent that they receive the appropriate care as soon as possible.

Question 7 asks if we would be prepared to attend obesity management appointments on a remote basis rather than face-to-face.

There isn't really a clear yes or no answer to this question. We have answered 'Yes' but need to put some context on that answer.

We believe that initial patient review through face-to-face appointments for conditions related to obesity can be much more effective when done face-to-face. However, once the initial review of a patient is completed and a full diagnosis and treatment plan is available then subsequent appointments may well be able to be conducted on a remote basis.

It would be important that the patient understands that there needs to be flexibility in this approach.

[5] IMPACT ASSESSMENTS/SCREENINGS

Question 12 in the questionnaire refers to the impact assessments/screenings and whether we agree with the outcome.

The creation of ROMS in Northern Ireland would be a brand-new service development.

This means that no full equality impact assessment and rural needs impact assessment has ever been completed for this particular area.

SOAS believes that there should be full assessments carried out on both the equality and the rural needs aspect of any brand-new service development. This would include an ROMS for NI.

We would make the following comments regarding extracts from the Rural Needs Impact Assessment in particular:

From Section 2B: “However, as the service will be provided on the basis of clinical assessment, those living in rural areas will have the same right to access the services as others living in non-rural areas.”

Response: As GB Shaw said every man has the right to eat dinner in the Savoy Grill Bar - the problem arises when you come to pay the bill! Total misunderstanding of the challenges for rural citizens especially S75 groups or people in poverty in accessing services - don't know if this is deliberate obfuscation or genuine ignorance

From Section 2C: “However, it is recognised that individuals living in rural areas may be more likely to have difficulty accessing a regional service due to reduced access to public transport connections compared to those living in urban areas. Internet access may also be relevant in relation to virtual clinics or service delivery.”

Response: Absolutely - but more detail and analysis required - what types of individuals (start with S75). Internet access is completely relevant and fundamental to support any virtual service delivery - have they analysed who isn't online - and why?

From Section 3C: “Census 2021 - DAERA publication – Key Rural Issues, Northern Ireland 2022 (referencing NISRA midyear population estimates 2020, Travel Survey NI 2017-19)

Response: Any data on obesity? Can that be broken down rural urban?

Data on access to Transport for rural citizens?

Data on public transport provision?

Would have been more realistic to give options for location of ROMS and then map from there and consider accessibility challenges.

From Section 3D: “In 2022, 82% of rural homes in NI had access to superfast speeds, with almost two thirds (65%) of NI rural households having access to a full-fibre connection.”

Response: Having the poles and fibre at the end of your lane does not equate with 82% of rural homes connected to broadband - they can access if they can afford a connection, have the devices and the skills/confidence to connect - so % of rural homes actually connected to full fibre broadband is much lower than 82% - no data on this as its "commercially sensitive"

From Section 3D: “Distances to railway stations tend to be even longer for rural dwellers. The frequency of public transport services also differs greatly between urban and rural areas.”

Response: This section should include data on access to private car across rural NI

From Section 5b: “Based on the needs identified above, the Department will ensure that the needs of rural populations will be considered during the service design phase following this initial consultation. This will include accessibility in terms of transport and internet access. A number of consultation questions also relate to accessibility, e.g. regarding travelling for services. The post consultation analysis will consider responses to these questions in conjunction with other available evidence, and use this to inform the service design phase.”

Response: Suggest that the Department repeat RNIA when they have decided where their one location for prototype service will be - will be more meaningful then

[6] CONCLUSION

Question 1 in the questionnaire asks to what extent do you support or oppose this proposal for the establishment of a Regional Obesity Management Service (ROMS).

SOAS strongly supports the establishment of such a service.

The current context of financially challenged health service delivery is a key consideration for the development of ROMS in Northern Ireland. It is very clear that there are very significant savings to be made from the implementation of such a service. The cost of obesity to health and social care in Northern Ireland was estimated in 2015/16 at around £457 million. This has almost certainly increased since then. This cost includes both direct and indirect costs. No breakdown has given in the consultation document between direct and indirect costs. However, it seems evident that even the direct costs (which includes costly ECR's) would cost more than the implementation costs listed here.

It is notable that Northern Ireland is the only area in the United Kingdom which does not have any commissioned bariatric surgery provided via specialist obesity management services. It is clearly not acceptable for this situation to continue.

The implementation of an appropriate ROMS for Northern Ireland would align with recommendations set out by their National Institute of Clinical Excellence (NICE). This is to be welcomed.

Overall, there is an overwhelming case to be made for the development of an appropriate Regional Obesity Management Service for Northern Ireland.

Question 10 asks if we have any further thoughts or comments which may be relevant to this consultation?

SOAS would summarise our overall thoughts by drawing attention to the following key points:

- The SOAS '5-Point Plan' – which we supported along with 30,267 others – includes Bariatric surgery being based in SWAH.
- Bariatric surgery will help ensure the restoration of Emergency General Surgery in SWAH.
- SWAH has been already announced as the proposed Regional Bariatric Centre for Excellence for Northern Ireland (Dept of Health – March 2019).
- SWAH has the available capacity for Bariatric Surgery.

- SWAH has also most of the equipment needed for Bariatric surgery already.

The completed questionnaire from SOAS now follows.

[7] CONSULTATION QUESTIONNAIRE

(a word version of this consultation questionnaire is available on the Department's website: <https://www.health-ni.gov.uk/consultations/proposed-regional-obesity-management-service-roms-northern-ireland>)

PERSONAL DETAILS	
Name	Save Our Acute Services (Secretary – Helen Hamill)
Email address	soas.swah@gmail.com
Are you responding on behalf of an organisation?	Yes/No (delete as applicable)
Organisation (if applicable)	Save Our Acute Services (SOAS) - registered as a Community Interest Company – Registration# NI694537
Please indicate in which capacity you are responding to this consultation: (please tick)	
☐ Medical Professional ☐ HSC worker ☒ Organisation representing Members of the public ☐ Person with lived experience	
The Department may publish responses to this consultation, except those from individuals responding in a private capacity. Your response may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR). If you wish your response to remain confidential, it would be helpful if you could indicate your reasons for this. Would you prefer your response to remain confidential? (If so, please tick) ☐ Yes	
Please explain the reason for your request:	
SOAS is happy for its response to be made public.	
CONSULTATION QUESTIONS	
Q1: To what extent do you support or oppose this proposal for the establishment of a Regional Obesity Management Service?	
Strongly support / tend to support / neither support nor oppose / tend to oppose / strongly oppose (please delete as appropriate)	
Please add any further comments you may have:	
Please refer to our detailed response	
Q2: Do you agree with the principle that bariatric surgery should be carried out on a single site where it can be delivered safely and sustained?	
Strongly agree / tend to agree / neither agree or disagree / tend to disagree / strongly disagree (please delete as appropriate)	

Please add any further comments you may have:

[Please refer to our detailed response](#)

Q3: At which hospital site do you think a bariatric surgical service should be provided? (please select one option)

- ☐ Belfast Trust Hospitals (Royal Victoria, Belfast City, Mater)
- ☐ Craigavon Hospital
- ☐ Daisy Hill Hospital
- ☐ Altnagelvin Hospital
- ☒ South West Acute Hospital
- ☐ Antrim Area Hospital
- ☐ Ulster Hospital

Please note: location of service will primarily be based on available capacity

Q4: Do you agree that specialist obesity management services (MDTs in secondary care) should be located in two locations in Northern Ireland?

Strongly agree / tend to agree / neither agree nor disagree / tend to disagree / strongly disagree (please delete as appropriate)

Please add any further comments you may have:

[Please refer to our detailed response](#)

Q5: At which 2 hospital sites do you think a secondary care MDT specialist obesity management service should be located? (please tick 2 options)

- ☒ Belfast Trust Hospitals (Royal Victoria, Belfast City, Mater)
- ☐ Craigavon Hospital
- ☐ Daisy Hill Hospital
- ☐ Altnagelvin Hospital
- ☒ South West Acute Hospital
- ☐ Antrim Area Hospital
- ☐ Ulster Hospital

Please note: location of service will primarily be based on available capacity

Q6: Would you be prepared to travel to another Trust for regular appointments with an obesity management MDT? (please tick)

- ☒ Yes
- ☐ No

Please add any further comments you may have:

[Please refer to our detailed response](#)

Q7: Would you be prepared to attend obesity management appointments on a remote basis (for example, via Zoom, Microsoft Teams, via telephone) rather than face-to-face? (please tick)

- ☐ Yes
- ☒ No

Please add any further comments you may have:

[Please refer to our detailed response](#)

Q8: Having read the consultation document do you agree that the service should initially be limited to those who would be expected to achieve the greatest health gain?

Fully Agree / Mostly Agree / **Neither Agree nor Disagree** / Mostly Disagree / Fully Disagree (please delete as applicable)

Please add any further comments you may have:

Please refer to our detailed response

Q9: Is there any one key element/aspect which you feel is missing from the proposed service model?

If so, please provide further information if appropriate:

Please refer to our detailed response

Q10: Do you have any further thoughts or comments which may be relevant to this consultation?

Please outline below:

- The SOAS '5-Point Plan' – which I support along with 30,267 others – includes Bariatric surgery being based in SWAH.
- Bariatric surgery will help ensure the restoration of Emergency General Surgery in SWAH.
- SWAH has been already announced as the proposed Regional Bariatric Centre for Excellence for Northern Ireland (Dept of Health – March 2019).
- SWAH has the available capacity for Bariatric Surgery.
- SWAH has also most of the equipment needed for Bariatric surgery already.

Q11: Given the current pressure on resources in the Health Service, and having read this consultation document, do you feel there is merit in investing in this type of service?

- ☒ Yes
☐ No

Please add any further comments you may have:

Please refer to our detailed response

IMPACT ASSESSMENT/SCREENINGS – QUESTIONS

Q12: Do you agree with the outcome of the Impact Assessment/screenings?

Fully Agree / Mostly Agree / Neither Agree nor Disagree / Mostly Disagree / Fully Disagree
 (please delete as applicable)

Please add any further comments you may have:

There should be a full Equality Impact Assessment (EQIA) and Rural Needs Impact Analysis (RNIA) completed.

Attachment 1:

Document:

Regional Bariatric Surgery Proposal (SWAH Perspective) 2019

**Author: Dr Susan Connolly (Consultant
Cardiologist)**

Regional Bariatric Surgery Proposal SWAH Perspective

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Regional Bariatric Surgery Proposal SWAH Perspective

Background

It has been proposed that South West Acute Hospital (SWAH) becomes the site for delivery of the region's specialist bariatric service which will include both Tier3 and Tier 4 pathways (bariatric surgery). In this document we review the capability of SWAH in delivering a high quality, effective safe service in this regard. The South West Acute Hospital in Enniskillen was built in 2012 replacing the old Erne Hospital and is a state of the art facility with up to 210 beds (housed in single rooms) as well as 22 day procedure/endoscopy beds. It is part of the Western Health and Social Care Trust and provides accident and emergency, acute surgical and medicine, acute stroke and rehabilitation and care of the elderly services to the local population of Fermanagh and West Tyrone (~120,000). It is also the base for the Trust's maternity, gynaecology and paediatric services for the southern sector of the region. The services currently provided by the Trust that are directly relevant to the proposed bariatric service are discussed in more detail in Section 1.

Section 1. Current Services in SWAH

(a) Medicine and Emergency Department

Acute medicine: There are 16 medical consultants based at SWAH who participate in the acute medical rota including 4 Respiratory Consultants, 2 Consultant Endocrinologists and 3 Consultant Gastroenterologists and 3 Stroke Physicians.

Emergency Department: The 9 bedded ED at the South West Acute Hospital has in the region of 40,000 attendances per year. It receives the full spectrum of adult and paediatric patients with undifferentiated acute illness and injury and the department is staffed by 7 Trust Consultants with a diverse range of special interests and additional qualifications including pre-hospital care, academic emergency medicine, intensive care medicine, medical education and sports medicine.

Respiratory: The respiratory service has 3 funded Respiratory Consultants and includes inpatient and outpatient care with a full range of respiratory investigations including pulmonary function testing, cardiometabolic exercise testing, bronchoscopy and sleep studies (including multichannel). 2 of the Respiratory Consultants have had specific training in sleep medicine and lead a nurse-provided Continuous Positive Airways Pressure [CPAP] service with telemonitoring facilities for CPAP compliance and effectiveness.

Gastroenterology: There are 3 consultant Gastroenterologists, one IBD specialist nurse, one infusion nurse (for biological therapy) and one Gastroenterology Specialist Pharmacist located at SWAH. Acute inpatient care includes management of patients with gastrointestinal bleeding, inflammatory bowel disease or liver disorders. Endoscopy [OGD, flexible sigmoidoscopy, colonoscopy] is provided on site as well as therapeutic endoscopy for GI bleeding, endoscopic stent insertion, dilatation and polyp resection.

Endocrinology/diabetes service: The service is delivered by 2 Consultant Endocrinologists supported by a team of diabetes specialist nurses, pharmacists and dieticians.

Cardiology: There are 2 Consultant Cardiologists who lead the cardiology service which includes emergency inpatient care with a dedicated 9 bed Coronary care Unit as well as outpatient and ambulatory cardiology services. The cardiac physiology department provides a full range of non invasive services including ECHO, Holter, stress testing, ambulatory BP monitoring, tilt testing as well as dobutamine/transoesophageal echocardiography. Cardiac radiology/imaging includes weekly cardiac CT lists and cardiac MRI with the SWAH being a commissioned cardiac MRI unit for NI and the only site in the region that includes parametric mapping.

(b) Surgery, anaesthesia/critical care and radiology

Surgery: There are 6 funded Consultant General Surgical posts. These post holders are supported by 5 staff grades and 6 CT 1/2 trainees. There are 35 inpatient surgical beds (on Wards 8 and 9) with a further 8 beds in the Medical and Surgical Assessment Unit as well as 22 beds in the day case/endoscopy unit. There are 2 theatres in use for both elective and emergency surgery with a further 2 non commissioned theatres. General surgical activity includes laparoscopic cholecystectomy, hernia repair and bowel resection (see table 1 for general surgical activity 2018-2019).

Table 1. General Surgical Activity SWAH 2018-2019

2018-2019	Elective Surgical Activity (n)	Emergency Surgical Activity (n)
Total		
Hernia repair	186	32
Bowel resection	35	16
Varicose veins	34	2
Laparoscopic cholecystectomy	117	53

Anaesthesia and Critical Care: There are 7 full time Trust Consultant Anaesthetists who provide cover for the SWAH's 2 level 3 critical care beds and its 4 level 2 high dependency unit beds as well as the theatre anaesthesia cover and ED trauma cover. There is expertise within the department in difficult airway intubation supported by specialist intubation equipment including fiberoptic laryngoscopy, video laryngoscopy as well as EEG/BIS/Entropy monitoring available for all general anaesthetics.

Radiology and laboratory: There are 7 full time Consultant Radiologists in SWAH and the department provides CT, MRI, ultrasound, fluoroscopy, plain films and DEXA imaging on site with a 24/7 on-call consultant service. Two radiologists provide interventional percutaneous drainage of collections under CT guidance. There are also full laboratory services on the site 24/7.

Section 2: Providing a High Quality Bariatric Surgical Service at SWAH

The British Obesity and Metabolic Surgery Society (BOMSS) published their Service Standards and Commissioning Guidance in 2012 which set out a consensus view of the principles that underpin safe, high quality bariatric surgical practice. In this section we discuss where the SWAH site currently is meeting these criteria and also where equipment/staffing will be required.

(a) Theatres, Anaesthesia and Equipment

It is proposed that one of the non-commissioned theatres in SWAH would be the theatre site for the new bariatric surgical service. Where SWAH surgical/anaesthetic facilities currently meet these requirements and where upgrades/equipment would be required is outlined below in Table 2.

Table 2. Criteria for theatres/anaesthesia (BOMSS Guidance)	Available SWAH	To Be Requisitioned
Bariatric surgical table (electrical) capable of steep reverse Trendelenburg position and that permits patients to sit up to 45°, and to be woken and extubated on the bed. Also includes table leg extensions, footplate and appropriate arm supports and padding		Yes
Suitable transfer facilities, e.g. hoist and/or hover mattress	Yes	
Difficult intubation equipment including availability of fiberoptic laryngoscopy, video laryngoscopy EEG/BIS/Entropy monitoring should be available for all general anaesthetics Suitable ventilator equipment	Yes	
Use of neuromuscular junction monitoring and availability of reversal agents		
Availability of central lines catheters and invasive arterial pressure monitoring	Yes	
Provision for maintaining normothermia	Yes	
Readily available blood for transfusion as per local protocols	Yes	
Blood gas analysis onsite (mandatory)	Yes	
High definition video equipment* with ergonomic availability of monitors for laparoscopic surgery (mandatory)	Yes	
Appropriate instrumentation for laparoscopic and open bariatric surgery available at all times	Yes	

Adequate supply of instruments kept available to enable emergency re-operation, the preceding elective case-load notwithstanding. Equipment for emergency re-operation must include a bariatric grade static retractor system for open surgery	Yes	
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*SWAH has High Definition monitors and laparoscopes but we would propose that current laparoscopic equipment is upgraded to 4K High Definition with the ability to record operations onto a hard drive.

(b) Ward care

The Service Standards state that no patient should spend the initial post-operative hours, usually the night, in a lower than Level 1 ward facility. Beds will be ring fenced on Ward 9 which currently is the surgical ward and it is currently anticipated that postoperative patients would spend 1-2 nights there. This will ensure concentration of nursing experience and nurses will also have training in the delivery of CPAP therapy again as recommended in the guidance (patients will be encouraged to bring their own devices). All beds on Ward 9 are housed in single rooms which are of average size 30 m2 which easily allows accommodation of bariatric size chairs. All rooms have their own bathroom facilities with wide door entry that permits manual hoist use.

The ward will need additional equipment to safely care for a bariatric patient with dignity including

- Beds allowing the patient to sit up to at least 45% angle
- Pressure relieving mattresses
- Appropriate chairs/toilets/wheelchairs/commodes/Hoists
- Weighing scales of suitable range
- Zimmer frames

In the most recent revision of the Service Standards level 2 critical care facilities are no longer a prerequisite provided there is appropriate risk stratification prior to surgery and emergency surgical cover being available 24/7. Nonetheless SWAH as previously stated has 2 level 3 critical care beds and its 4 level 2 high dependency unit beds with 24/7 cover provided by an anaesthetic staff grade and Consultant Anaesthetist.

(c) Imaging

The BOMS guidance recommends include that bariatric facilities should have the availability of cross-sectional imaging and fluoroscopic imaging of the upper GI tract suitable for the majority of their patients. SWAH was the location for the first bariatric MRI scanner in NI with a wide bore magnet (70 cm high X 48 cm depth) with a weight limit of 250 kg. The CT scanner table has the option for bariatric

scans and can take a weight load of 307 kg. There are also bariatric lifts/slings in the radiology department and all radiology staff have been trained in manual handling. Other recommendations include that a senior radiologist should report the images the same day and he/she should be available to discuss the imaging with the surgeon. This already is in place on the SWAH site with same day reporting of scans by consultant radiologists being standard practice.

(d) Outpatient facilities

Outpatient facilities will be provided in dedicated clinic space that has 4 adjacent clinic rooms to facilitate rotation of patients around each member of the bariatric multidisciplinary team (e.g. surgeon, anaesthetist, psychologist, dietician etc). The clinic space will be equipped with the following

- (i) Scales capable to accurately weighing obese patients, that are easily accessible to obese patients both standing and seated
- (ii) Chairs and examination couches that not only have the requisite weight limits, but that are also adequately sized to allow the patient to sit and/or lie comfortably
- (iii) Wheelchairs of appropriate dimensions must be made available and doorways must be large enough to accommodate the same

(e) The bariatric team

The recent revisions in May 2019 to the BOMSS Service Standards and Commissioning Guidance recommend that the bariatric MDT should *as a minimum* comprise bariatric surgeon(s), specialist dietician, bariatric specialist nurse and an experienced bariatric psychologist. It is strongly recommended that either a bariatric physician and/or a bariatric anaesthetist (acting as a peri-operative physician) should be present at bariatric MDT meetings. Preoperative assessment of the likely post-operative care requirements is best achieved with a structured assessment by an experienced bariatric anaesthetist working within the MDT and ideally reviewing patients face to face at the time of first MDT assessment.

The ROMS task and finish group is currently finalising a Tier 4 service specification including a detailed Tier 4 pathway which aligns to this recommendation. The surgical staffing is specifically discussed in the section below on bariatric surgeons/rota. Commencement of the Tier 4 surgical service in SWAH would also require the recruitment of a bariatric physician/anaesthetist, bariatric specialist nurse,

specialist dietician, and psychologist. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

BOMSS guidance also recommends that the MDT must have links to specialist physicians experienced in the management of more complex complications of obesity (metabolic, respiratory, cardiac) and again all expertise that is available in SWAH as previously discussed. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The guidance also states that as a minimum, patients should have access to care by NHS Junior Doctors and RMOs who are ALS trained and supported by the availability of 24/7 consultant bariatric surgical and anaesthetic cover. Currently the SWAH site has in house staff grade surgical cover with a consultant surgeon on call. Similarly there is currently inhouse anaesthetic staff grade cover with a consultant anaesthetist on call. It is also planned that there will be a bariatric surgical on call rota (see surgical staffing below):

(f) Consultant Surgical Activity and Rota

The BOMSS Service Standard revision makes specific recommendations on safe surgical staffing and volume which are as follows.

- (a) the hospital engages at least two bariatric surgeons performing a minimum of 30 major procedures pa each (combined NHS and private experience);
- (b) the unit (whether private or NHS) carries out a *minimum* of 30 major laparoscopic bariatric procedures per year (excluding gastric balloons) and ideally performs upwards of 100 major procedures per annum

It is therefore proposed that the bariatric surgeon attends SWAH for 3 consecutive days of his/her choice but preferably starting on a Monday/Tuesday. It is anticipated that they would perform 3-4 operations per day for the first 2 days with the 3rd day being used for an outpatient and administrative work. A postoperative ward round would also occur on days 2 and 3 and they would be supported by the bariatric

specialist nurse in that regard with including bariatric nurse led discharge. Consultants will be provided with hospital accommodation which is of a high standard. A proposed surgical job plan and rota is outlined in appendix 2. This rota would permit the required 100 cases annually to be performed as well as the individual surgeon's required total. This model has previously been run successfully in SWAH for general orthopaedic surgery. Furthermore this is also the planned model for anterior spinal surgery on a 1 in 10 rota. Implementation will require release from their current Trust which should be possible as this is a regional service.

(g) Tier 3/Tier 4 crossworking and Our Hearts Our Minds Programme for Cardiovascular Health

Patients will be required to have passed through a Tier 3 service before progressing to Tier 4 (Appendix 1). The Tier 3 pathway has been developed by the Task and Finish Group and includes a specialist multidisciplinary team (psychologist, dietician, bariatric physician/nurse, physical activity specialist). There is already a very successful preventive cardiology/lifestyle programme called Our Hearts Our Minds running across the 3 sites of the Western Trust (Derry, Omagh and Enniskillen). [REDACTED] this nurse-coordinated multidisciplinary (dietician, physical activity specialist, psychologist) 12 week programme has a strong evidence base from the EUROACTION randomised controlled trial as well as an established track record in both the MyAction programme in the NHS (Westminster, London) and Galway in the ROI across a range of outcomes including weight loss, dietary improvement, increasing physical activity, improving quality of life as well as improving medical risk factor control such as hypertension, dyslipidaemia and dysglycaemia including in a bariatric population (Appendix 3). Furthermore the programme has been adapted successfully (with publication of their results) by the bariatric service in NUI, Galway as a Tier 3 pathway (Appendix 4). It is proposed to co-locate Tier3/4 services at the SWAH and it is anticipated that the Western Trust Tier 3 complex obesity pathway would include the OHOM programme as one of its menu options. This would result in having blended team working across the OHOM/Tier3/Tier4 teams with regards to the allied health professionals (psychology, physical activity specialists and dieticians) and therefore encourage a seamless transition from Tier 3 to Tier 4 where appropriate.

Conclusion

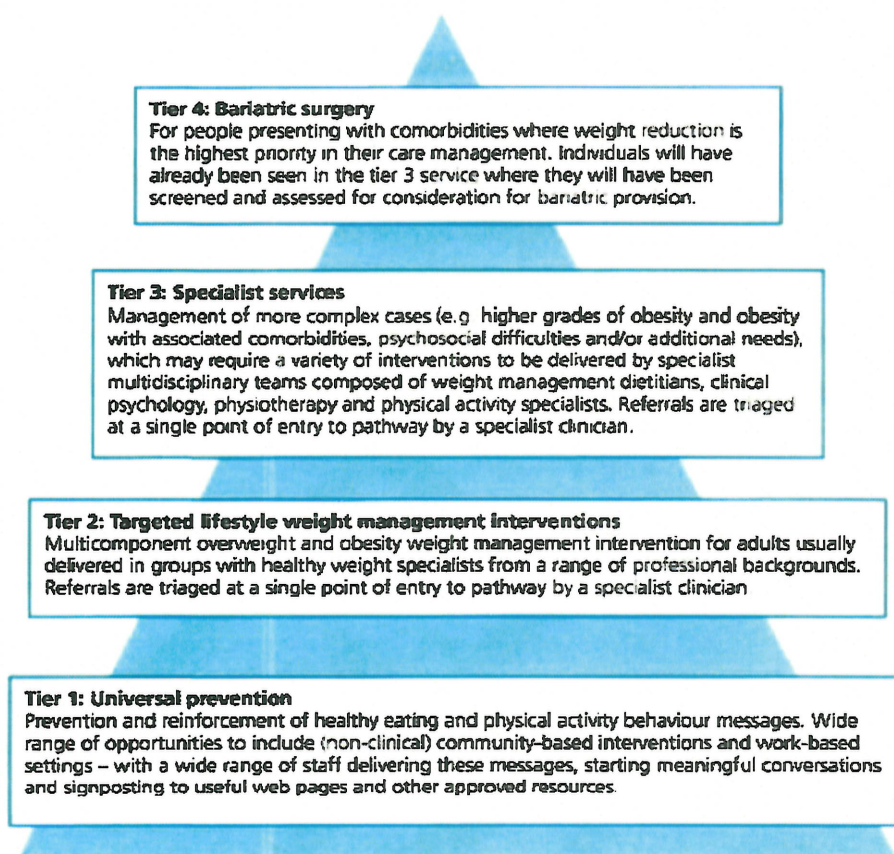
The Western Trust is fully committed to delivering both Tier 3 and Tier 4 of the Regional Bariatric service, and provides assurance that there is capacity and willingness to facilitate this. This document outlines how the SWAH already meets many of the requirements to provide this service in terms of theatre capacity, surgical staffing, imaging and medical services. However, the delivery of the service will require cross Trust co-operation in organising a sustainable rota for the bariatric surgeons. The opportunity to be involved in further discussion is welcomed, and as the specific model is clarified, a full IPT and capital business case can be worked up as clearly there will need to be investment in staffing and equipment. Crucially the Trust will ensure strong clinical leadership is provided so that a safe, high quality effective Tier3 and Tier4 service can be delivered at the SWAH.

DRAFT

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Appendix 1



Source: Adapted from *The UK Obesity Care Pathway* (Department of Health, 2013)²⁰

Appendix 2 Sample Bariatric Surgeon Job Plan

Mon	Tue	Wed	Thurs	Fri
	Ward Round	Ward Round	*	
Theatre session AM	Theatre session AM	Clinic / MDT	Admin	Teaching/Audit
Theatre session PM	Theatre session PM	Afternoon Ward round	Admin	
Evening Ward round	Evening Ward Round			

Sample bariatric operating week rota 1:6 weeks– surgeon follows bariatric surgeon job plan

W1	W2	W3	W4	W5	W6	W7	W8	W9	W10	W11	W12
S1		S2		S3		S1		S2		S3	

W13	W14	W15	W16	W17	W18	W19	W20	W21	W22	W23	W24
S1		S2		S3		S1		S2		S3	

W25	W26	W27	W28	W29	W30	W31	W32	W33	W34	W35	W36
S1		S2		S3		S1		S2		S3	

W37	W38	W39	W40	W41	W42	W43	W44	W45	W46	W48	W48
S1		S2		S3		S1		S2		S3	

W49	W50	W51	W52								
S1		S2									

S1 – Surgeon 1

S2 – Surgeon 2

S3 – Surgeon 3

Following the week of the bariatric surgeon job plan surgeons revert back to their normal unit and regular job plan. A bariatric rota of the involved surgeons will be maintained at SWAH switchboard. General Surgeons from across NI will be informed that they can telephone the bariatric surgeons via SWAH for advice out of hours – S1,2,3 on 1/3 basis. The week the surgeon is working as a bariatric surgeon, that surgeon will be on call that week, the non-operating weeks will be divided out equally so that cover is always available. This rota can easily be modified to include 4-6 operating bariatric surgeons.

Appendix 3

Crowe et al. *BMC Endocrine Disorders* (2015) 15:37
DOI 10.1186/s12902-015-0030-z



RESEARCH ARTICLE

Open Access



Effects of an eight-week supervised, structured lifestyle modification programme on anthropometric, metabolic and cardiovascular risk factors in severely obese adults

Catherine Crowe¹, Irene Gibson², Katie Cunningham^{1,2}, Claire Kerins², Caroline Costello², Jane Windle², Paula M. O'Shea³, Mary Hynes^{1,4}, Brian McGuire⁴, Katrina Killely¹, Helena Griffin¹, Tim O'Brien^{1,5}, Jenni Jones^{5,6} and Francis M Flucane^{1,5*}

Abstract

Background: Lifestyle modification is fundamental to obesity treatment, but few studies have described the effects of structured lifestyle programmes specifically in bariatric patients. We sought to describe changes in anthropometric and metabolic characteristics in a cohort of bariatric patients after participation in a nurse-led, structured lifestyle programme.

Methods: We conducted a retrospective, observational cohort study of adults with a body mass index (BMI) ≥ 40 kgm⁻² (or ≥ 35 kgm⁻² with significant co-morbidity) who were attending a regional bariatric service and who completed a single centre, 8-week, nurse-led multidisciplinary lifestyle modification programme. Weight, height, waist circumference, blood pressure, HbA1c, fasting glucose and lipid profiles as well as functional capacity (Incremental Shuttle Walk Test) and questionnaire-based anxiety and depression scores before and after the programme were compared in per-protocol analyses.

Results: Of 188 bariatric patients enrolled, 150 (81.9%) completed the programme. Mean age of completers was 47.9 $\pm$ 11.2 years. 34.7% were male. There were statistically significant reductions in weight (129.6 $\pm$ 25.9 v 126.9 $\pm$ 26.1 kg, $p < 0.001$), BMI (46.3 $\pm$ 8.3 v 44.9 $\pm$ 9.0 kgm⁻², $p < 0.001$), waist circumference (133.0 $\pm$ 17.1 v 129.3 $\pm$ 17.5 cm in women and 143.8 $\pm$ 19.0 v 135.1 $\pm$ 17.9 cm in men, both $p < 0.001$) as well as anxiety and depression scores, total- and LDL-cholesterol and triglyceride levels, with an increase in functional capacity (5.9 $\pm$ 1.7 v 6.8 $\pm$ 2.1 metabolic equivalents of thermogenesis (METs), $p < 0.001$) in completers at the end of the programme compared to the start. Blood pressure improved, with reductions in systolic and diastolic blood pressure from 135 $\pm$ 16.2 to 131.6 $\pm$ 17.1 ($p = 0.009$) and 84.7 $\pm$ 10.2 to 81.4 $\pm$ 10.9 mmHg ($p < 0.001$), respectively. The proportion of patients achieving target blood pressure increased from 50.3 to 59.3% ($p = 0.04$). The proportion of patients with diabetes achieving HbA1c < 53 mmol/mol increased from 28.6 to 42.9%, $p = 0.02$.

(Continued on next page)

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Attachment 2:

Document:

**Detailed Consultation Response 'Suspension of
EGS at SWAH' April 2023**

Author: SOAS (Save Our Acute Services)

Consultation Response

From

Save Our Acute Services (SOAS)

To

**WHSCT Public Consultation on Temporary suspension of Emergency
General Surgery Services at South West Acute Hospital (SWAH),
Enniskillen**

April 2023

(SOAS is registered as a Community Interest Company – Registration# NI694537)

[1] INTRODUCTION

This document is a response to the WHSCT Public Consultation on Temporary suspension of Emergency General Surgery (EGS) Services at South West Acute Hospital (SWAH), Enniskillen. The closing date for the Consultation is 9th April 2023.

‘EGS’ is just one of the many acronyms that are used in discussions around health at the moment. There is a glossary at the end of this document to assist with this.

‘Save Our Acute Services’ (SOAS) is a campaign group formed in November 2022 to campaign for the retention of all acute services in South West Acute Hospital (SWAH).

The core values of SOAS will inform this Consultation Response:

- It is our right to have as a core principle within our NHS that every citizen in Northern Ireland should live within one hour of a Type 1 Emergency Department.
- We demand equal access to safe urgent and emergency care services for every citizen in Northern Ireland.
- SOAS are entirely in favour of the development of an NHS-staffed consultant-led overnight elective centre. We believe that a thriving elective centre will complement the delivery of sustainable urgent and emergency care.

- Our geographic position should not prejudice our health and we call for an unequivocal commitment confirming the permanent reinstatement of full acute services to our South West Acute Hospital.

Fermanagh and South Tyrone is a largely rural area and ranks as one of the most deprived areas in Northern Ireland.

As a result, the population of Fermanagh and South Tyrone are very concerned about the future provision of Health Services within the Southern Sector of the Western Health and Social Care Trust (WHSCT).

A significant imminent threat is related to the removal of EGS services in our local hospital (SWAH) in Enniskillen.

On 17th November 2022 WHSCT announced the temporary suspension of EGS services at SWAH. This came into effect on 5th December 2022.

The immediate effect of this EGS suspension is that a significant number of local people will now bypass the local hospital in Enniskillen (SWAH) and instead will travel to the hospital in Derry (AAH – Altnagelvin Area Hospital) for surgical treatment. Both SWAH and AAH are hospitals within WHSCT.

There were some initial comments relating to mitigations from WHSCT that patients might also travel to Craigavon (CAH – Craigavon Area Hospital) in SEHSCT and even to Sligo University hospital for treatment. Analysis of GP, Phone First and A&E pathways in place since 5th December 2022 show that AAH has been overwhelmingly the hospital to which patients from SWAH catchment area are being directed to when SWAH is bypassed.

This consultation response will focus on AAH as the main destination for those cases where patients from SWAH catchment area are no longer to be cared for in their local hospital.

It is important to acknowledge what the impacts and effects are as a result of withdrawal of EGS and this will be elaborated on in this response. In the context of this – the affected population are only too aware that we have effectively lost Type 1 Emergency Department status as a result of losing EGS services.

The 'Review of Urgent and Emergency Care' consultation document published by Department of Health (DoH) in March 2022 confirmed there were 10 Type 1 Emergency Departments in Northern Ireland.

A Type 1 Emergency Department is defined in this document as:

A consultant-led service with designated accommodation for the reception of emergency care patients, providing both emergency medicine and emergency surgical services 24 hours a day.¹

It is clear that when WHSCT announced the suspension of EGS services to SWAH on 17th November 2022 that SWAH is therefore no longer a surgical Type 1 Emergency Department based on the DoH definition above.

WHSCT incredibly state that the Type 1 ED status is now dependent on the fact there are consultant obstetricians and gynaecologists on-site on a round-the-clock basis. It is clear that obstetricians and gynaecologists cannot perform any urgent or emergency surgical services outside of pregnancy, birth and women's health. It is a fact that we no longer have urgent or emergency surgery at SWAH. We no longer have a Type 1 Emergency Department and suggest that WHSCT and DoH become more transparent in that definition.

What is at stake here?

We need to be very clear that much more than just Emergency General Surgery at SWAH is at stake.

The future of the acute status of our hospital is at stake.

This was best clarified by consultants from within SWAH recently – in a signed letter sent by SWAH Obstetrics and Gynaecological consultants to health authorities:²

“Obstetrics and gynaecological consultants in SWAH have told health authorities of the dire consequences of any disintegration of services saying harm will come to patients and the reality of this needs to be made clear to the public.

The consultants say the removal of emergency general surgery is unsafe for patients in its current form and puts hospital staff in a very vulnerable situation.

The surgeons cannot support the current proposed change to acute surgical services at SWAH at present.

They also say they cannot mitigate for inadvertent bowel injury in which every patient undergoing abdominal or gynaecological surgery is consented for that risk. We cannot be in a situation where we are in theatre with a major complication, and a general surgeon cannot be mobilised to assist within a timely fashion.”

¹ DoH Review of Urgent & Emergency Care: <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-consultation-report-and-strategic-priorities.PDF>

² Irish Independent – 23rd Oct 2022 - Consequences of removing surgeries at SWAH dire, warn doctors <https://www.independent.ie/irish-news/news/consequences-of-removing-surgeries-at-swah-dire-warn-doctors-42088281.html?>

Patient safety is defined as “the avoidance of unintended or unexpected harm to people during the provision of health care”. (NHS England)³

SOAS will show how the notion of patient safety has been abandoned by WHSCT.

Patient safety is a phrase which only appears three times in the Review of General Surgery and in none of those cases is it evidenced.

Unfortunately, WHSCT's assurances given on patient safety do not reflect any increase in consideration of morbidity and mortality for increased patient ‘time to treatment’. It does not reflect the fact that Altnagelvin is unable to manage its own workload as evidenced in WHSCT's last published Trust Delivery Plan.⁴ How is Altnagelvin expected to cope with this increase in surgical needs.

WHSCT planning does not even address the inadequacy of the Northern Ireland Ambulance Service available resourcing.

It is unlikely that “there have been no adverse incidents for patients since the pathways began” - as WHSCT claim. Many adverse incidents have been reported to SOAS. We continue to catalogue all of this evidence and will present to DoH at an appropriate meeting. The patient journey and patient experience referenced repeatedly do not coincide with the stories we are told.

We must ensure that EGS is restored to SWAH.

³ NHS England - The NHS patient safety strategy <https://www.england.nhs.uk/patient-safety/>

⁴ WHSCT Trust Delivery Plan – Jan to Mar 2022 <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-delivery-plans-8-whsct.pdf>

[2] CONSULTATION DEFICIENCIES

2.1 Concerns

SOAS has major concerns with both the process and the content of the Consultation. We believe that this consultation seeks to drive a deliberate process to permanently diminish the acute services offered by SWAH.

The Chief Executive of WHSCT himself has stated to DoH on 12th October 2022 that there will be a need to consult, in due course, in the context of the regional standards, should any permanent change be required.⁵

The fact that the Consultation started after the suspension of EGS reflects the disingenuous nature of it.

WHSCT have been aware of issues with staffing the Surgery Rota in SWAH since 2014 and issued an Early Alert to DoH in August 2020. It is a failure of management that WHSCT did not develop options to resolve these issues since then. WHSCT could have presented alternative options for an earlier Consultation while EGS Services were still appropriately staffed.

The absence of any proposal in the Consultation that would lead to the reinstatement of EGS is another total failure of management of WHSCT.

2.2 Bias

SOAS believes that this Consultation is built on a premise of a predetermined outcome. The bias inherent in the process illustrates this.

2 key relevant reviews were published by DoH in 2022:

Review of Urgent & Emergency Care⁶ Review of General Surgery⁷

SOAS believes that this Consultation process is biased towards the 'Review of General Surgery' at the expense of the 'Review of Urgent & Emergency Care'. This is a statement of fact which is confirmed by the Consultation documentation itself where the 'Review of General Surgery' is the only link or evidence provided

⁵ Letter – Chief Executive WHSCT to Deputy Secretary for Strategic Planning and Performance Group SPPG – 12th October 2022

https://www.whatdotheyknow.com/request/sppg_documentation_and_dept_of_h#incoming-2262126

⁶ Doh Review of Urgent & Emergency Care (consulted on fully) <https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-review-uec-departmental-response.pdf>

⁷ Doh Review of General Surgery (not consulted on) <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-review-general-surgery.PDF>

throughout the entire document. WHSCT refer to the 'Review of General Surgery' as if this is the only deciding factor in relation to determining services for our hospital. The changing narrative by WHSCT related to the reasons for the suspension of EGS Services illustrates their lack of planning and forethought. WHSCT initially denied that the Review of General Surgery Standards played a direct role when they announced the suspension on 17th Nov 2022.⁸ However – it is now confirmed in the Consultation document that the Standards will now make it difficult to reinstate EGS.

Why is this bias relevant to decisions regarding SWAH?

It is our view that the 'Review of General Surgery' is driven by the issues in Elective Care and the need to get Waiting Lists under control. This was clearly the focus in 2021 of the RCSE document "Northern Ireland Action Plan for Surgical Recovery: 10 steps not 10 years".⁹ This exclusive focus on Elective Care is driving decisions – by both WHSCT and DoH – that fail to assess adequately the impact of excessive 'time to treatment' for unplanned surgeries on our affected population. We do acknowledge that waiting lists are excessive and urgent action is needed to address these: our alternative plan makes provision for this.

We note the important difference in overall aims for these 2 reviews:

Review of Urgent & Emergency Care:

"all citizens in Northern Ireland have equal access to safe urgent and emergency care services, tailored to their specific needs at the right time and in the right place."

(Minister for Health, Robin Swann MLA – March 2022)

Review of General Surgery:

"our patients would have better services, with better outcomes for all – disregarding where they live"

(Minister for Health, Robin Swann MLA – June 2022)

We believe that this notion of '**equal access**' is of key importance and has been conveniently excluded from the WHSCT Consultation. This is another indicator of bias within it.

SOAS made a number of 'Freedom of Information' (FOI) Requests to DoH regarding a statement from 'The Review of General Surgery Board' that appeared on the DoH website on 22nd November 2022.¹⁰

This was an unbalanced and biased statement that appeared with the endorsement of DoH and was widely reported on in regional media. The statement referred

⁸ Fermanagh Herald – 13th Jan 2023 - Review is hampering efforts to save SWAH surgery
<https://fermanaghherald.com/2023/01/review-is-hampering-efforts-to-save-swah-surgery/>

⁹ May 2021 - Northern Ireland Action Plan for Surgical Recovery: 10 steps not 10 years
<https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/position-statements-and-reports/action-plan-for-northern-ireland/>

¹⁰ DoH Statement 22 Nov 2022 <https://www.health-ni.gov.uk/news/statement-consultants-important-contribution-debate>

exclusively to the 'Review of General Surgery' – with no mention of the 'Review of Urgent & Emergency Care'.

Claims in the statement such as "Although emergency general surgery needs to be done relatively quickly, we are not talking about the race against time seen in other types of medical emergencies" have been shown to be disingenuous. We can see from changes to protocols (e.g. Major Trauma Triage Tool) that many urgent and emergency surgical cases are bypassing SWAH.

Our FOI Requests may have indeed prompted DoH to retrospectively publish the Terms of Reference for 'Review of General Surgery Board'¹¹ enabling us to confirm to whom it is accountable:

"The overall aim of the Regional General Surgery Network is to oversee the implementation of the actions set out in the review of general surgery"

"The Regional General Surgery Network is accountable to the Elective Care Management Team."

We see again very clearly that all of the WHSCT and DoH input to this process is centred around Elective care – at the expense of Urgent & Emergency Care. This again confirms the bias in this Consultation process. We reject the notion that Elective care is incompatible with the continuation of Acute services

The emphasis of WHSCT and DoH policy regarding 'Review of General Surgery' is around centralising Surgical care in fewer hospitals – ignoring valid patient safety concerns of the Fermanagh & South Tyrone population about excessive 'time to treatment'. This policy is frequently couched in opaque language in the hope that the true intention of the 'Review of General Surgery' will not be fully appreciated. We draw attention to a recent comment made by a member of the 'Review of General Surgery Board' which explicitly states their intentions to remove all Emergency Surgery Services from SWAH permanently:¹²

"Each trust needs max one emerg surg centre.

SWAH emerg surg was unsustainable Pre-SWAH."

This is significant because WHSCT is one of the trusts that still has more than one acute hospital – namely AAH and SWAH.

When was this 'decision' made that each Trust needs a maximum of one Emergency Centre? Where is that available? When was it consulted on? We can find nowhere that this is published. Yet it is clearly the policy of the 'Review of General Surgery Board'. To promulgate such a policy without taking account of geographical distances and peoples' needs and safety is both illogical and discriminatory to those it is meant to serve.

This confirms again the bias underlying this tokenistic Consultation.

¹¹ Terms of Reference – Review of General Surgery Board <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-rgsn-tor.pdf>

¹² Comment from 'Review of General Surgery Board' member <https://twitter.com/BarryMcAree/status/1629131714277658624?s=20>

This notion of bias in the consultation is disturbing – and one that affects and concerns our local population.

The General Surgery Standards are presented in the Consultation by WHSCT as prescriptive and we have no option but to accept this. In fact – the Chief Executive of WHSCT has gone so far as to call them “government standards”.¹³ This is factually not the case.

The outputs from the Review have never been subject to a public consultation.¹⁴ The DoH has also confirmed that the ‘Review of General Surgery’ has not introduced any legislative changes.¹⁵

WHSCT are not correct when they state in Section 8 of the Consultation document that the Surgery Standards are ‘formally introduced standards which hospitals will be required to meet to continue providing emergency and planned (elective) surgery’. The DoH state on Page 52 of the Review of General Surgery¹⁶ that “it will be for each Trust to consider what the response to the standards will be”.

The Office of the Minister for Health stated “the General Surgery review was a largely positive piece of work and would provide better outcomes in many cases, it was accepted it shouldn’t be a one-size-fits-all approach. There were of course going to have to be different approaches in different areas.”¹⁷

There is an inherent conflict between ‘Review of General Surgery’ and ‘Review of Urgent & Emergency Care’. SOAS contends that the concept of ‘equal access’ is an overarching aim for the population and its absence in the Consultation cannot be accepted.

2.3 Clinical Interdependencies

The appearance of the phrase ‘Clinical Interdependencies’ is solely from the ‘Review of General Surgery’ and this is stated by WHSCT during all the Consultation public events.

Only 2 of the 8 acute hospitals in Northern Ireland meet this new standard.¹⁸

¹³ Review is hampering efforts to save SWAH surgery <https://fermanaghherald.com/2023/01/review-is-hampering-efforts-to-save-swah-surgery/>

¹⁴ FOI Request ‘Review of General Surgery’ https://www.whatdotheyknow.com/request/the_review_of_general_surgery_no#outgoing-1424772

¹⁵ DoH – on Review of General Surgery <https://www.impartialreporter.com/news/23360861.review-general-surgery-challenged-fermanagh-councillor/>

¹⁶ DoH Review of General Surgery (not consulted on) <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-review-general-surgery.PDF>

¹⁷ DoH Special Adviser on Closure of EGS at SWAH <https://fermanaghherald.com/2023/02/trust-was-given-no-permission-to-do-this/>

¹⁸ Review of General Surgery <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-review-general-surgery.PDF>

“Three hospitals (Antrim Area Hospital, Craigavon Area Hospital and Altnagelvin Hospital) do not fully meet the standards; however, they could be met by putting the necessary processes or resource in place. The remaining hospitals (Causeway Hospital, Daisy Hill Hospital and South West Acute Hospital) require more fundamental changes in a number of areas to meet the standards.”

SOAS believe that our geographic remoteness makes it imperative that full acute services – including emergency general surgery – are provided at SWAH. If DoH believes that fundamental changes in a number of areas are required then it is incumbent on DoH to build this into the Transformation Programme. WHSCT and SWAH were sufficiently concerning to the Health Minister in his last week in office to prompt him to write a statement on DoH website pointing out that he did not have evidence that WHSCT had adequate safe provisions made for our care. Perversely once the Minister left office WHSCT went immediately to the SPPG and were given permission to suspend EGS.¹⁹ Despite appropriate FOI requests, we remain without any of the evidence that there was any modelling of risk benefit analysis carried out.

2.4 Surgeons & Rotas? It's a Retention issue

SOAS maintains that there is a serious issue in SWAH with regard to retention of permanent consultants and this is at the core of maintaining sufficient Consultant Surgeons. The Consultation document – for example – states

“During the period February 2019 until October 2021 the consultant general surgery team in SWAH has been reduced, even though four consultants were recruited during that period, six substantive consultants left.”

It is extremely positive that 4 consultants were recruited over 2 and ½ years. SOAS maintains that this can be repeated.

However – what is concerning is the failure to retain 6 substantive consultants who left during this period. The Consultation document itself confirms that in a 5 month period (October 2022 to February 2023) there were 2 resignations and 1 planned absence following a risk assessment. This can only be categorised as a failure of workforce management by senior management in WHSCT.

We know one of these was a newly recruited, published and award-winning surgeon who was denied access to the main operating theatres.²⁰ He left after 7 months employment. The surgeon asked “what was the common sense to employ a consultant general/colorectal surgeon not giving him an access to the operating theatre”? This is not the only consultant to have left citing poor treatment.

¹⁹ 17th Oct 2022 - Minister comments on SWAH general surgery services <https://www.health-ni.gov.uk/news/minister-comments-swah-general-surgery-services>

²⁰ Surgery at Enniskillen Hospital was simply dying, says consultant <https://www.bbc.co.uk/news/uk-northern-ireland-64339480>

SOAS ask the same question. Why do so many staff seem to be leaving SWAH? We used 2 FOI requests^{21 22} to look at the rate of leavers of Permanent Consultants across both the Northern Sector (where Altnagelvin is located) and the Southern Sector (where SWAH is located):

**Permanent Consultants in WHSCT
Between October 2019 and August 2022**

Sector	Permanent Consultants in place:	Leavers:	% Leavers
	(in Oct 2019)	(up to Aug 2022)	
Northern (Altnagelvin)	199	29	15%
Southern (SWAH)	57	23	40%

Table 1: Permanent Consultant Leaver rate WHSCT: October 2019 to August 2022 (Source: SOAS Research Group).

The rate at which staff are leaving SWAH (40%) is demonstrably significantly higher than at Altnagelvin (15%). Altnagelvin performs at close to the regional average. This retention issue is what has undermined staffing levels. We are fortunate to have public representatives who are willing to speak on behalf of many of the SWAH staff:

"The morale of our hospital workers, in my 10-12 years, I have never seen it so low. They feel neglected, bullied, like they don't have a voice.

That's why consultants are leaving; because of morale. I don't like saying these things in public, but I am speaking on behalf of people who have asked me to speak."²³

(Fr Brian D'Arcy – at WHSCT Public Consultation Meeting 30th Jan 2023)

SOAS accept that there are significant issues across many countries with maintaining sufficient permanent consultant staffing. However – we do not accept that this explains how the leaver rate of permanent consultants is so much higher at SWAH than at Altnagelvin. This reflects shockingly on WHSCT senior management team and encapsulates the reason for our complete lack of belief that they intend to recruit to our hospital.

This is due to a complete failure of management in the Southern Sector of WHSCT. We question why it is only the Southern Sector of WHSCT that is affected in this way?

Part of the answer to this lies in the culture of harassment and bullying which has sadly become the norm in SWAH. Excessive departures as a result of resignation,

²¹ FOI Request - Oct 2019 'List of Medical Consultants within the Western Trust'
https://www.whatdotheyknow.com/request/list_of_medical_consultants_within#outgoing-949909

²² FOI Request – Jul 2022 'List of Medical Consultants within the Western Trust'
https://www.whatdotheyknow.com/request/list_of_medical_consultants_within_2#outgoing-1330666

²³ Fr Brian D'Arcy – on staff morale <https://www.belfasttelegraph.co.uk/news/health/appeal-for-respectful-debate-on-future-of-hospitals-after-heated-meeting-over-swah-proposals/242239942.html>

retirement or ill health are the hallmark of poor management practice and this has been in evidence for some time. Even after WHSCT settled a High Court case in 2016 taken by a consultant for breach of contract against the Trust for £500,000 plus the claimants' costs, management and the Board failed to learn any lessons.²⁴ Their style of management continued to the present time. We are aware of other cases including a constructive dismissal/harassment case which will be heard in 2023.

Two conclusions can be drawn from this. Firstly, WHSCT management is not aligned with their responsibilities to manage their staff and therefore cannot continue in post. Secondly, it is obvious that consultants who have transferable skills will not stay in a threatening, and low morale workplace.

2.5 Disingenuous Recruitment efforts

WHSCT do not plan to fill the vacant Consultant Surgeon posts in SWAH. It is clear that the intention is to move these commissioned 6.5 posts to Altnagelvin. This is evidenced in recent job advertisements for the vacancies in SWAH.

It is barely credible that the Consultation document includes confirmation that WHSCT advertised for vacancies in SWAH but stated the posts would be based in Altnagelvin:

"The Trust completed a recent recruitment drive for four full time Consultant General Surgeons, who, while based in Altnagelvin, will be required to work at hospitals across the Trust.

Unfortunately based on previous experience we do not believe that further advertisements for positions in SWAH General Surgery only, will be successful."

WHSCT are expecting us to believe that consultant surgeons will be somehow tricked into applying for a permanent post that while stating it is based in Altnagelvin is actually going to lead to consultants working in SWAH.

We do not believe this.

More significantly – the Chief Executive of WHSCT does not believe it either.²⁵

"I have made this point previously to Council that the geography of our trust prevents us from covering the South West Acute Hospital from Altnagelvin. The distance prevents us from doing so.

Elsewhere in Northern Ireland the larger acute hospital can cover the smaller hospital for Out-Of-Hours, on-call and other reasons.

²⁴ Belfast telegraph – 30th Sep 2016 - Consultant anaesthetist to be paid £500k in legal settlement against WHSCT <https://www.belfasttelegraph.co.uk/news/northern-ireland/consultant-anaesthetist-to-be-paid-500k-in-legal-settlement-against-western-health-and-social-care-trust/35093334.html>

²⁵ FODC Council Special Meeting – 9th January 2023
<https://www.facebook.com/SaveOurSwahServices/videos/1698546897271542>

That is not physically possible through geography."

(Chief Executive WHSCT to Fermanagh Omagh District Council – 9th Jan 2023)

WHSCT is being disingenuous at best when it states they are trying to fill these posts.

We note the opinion from a number of our SWAH staff contacts that some of the conflicting statements from the Chief Executive of WHSCT regarding rota arrangements might be more by design than by accident.

Both the following comments were made by Chief Executive of WHSCT to FODC on 17th Nov 2022:²⁶

"Rota commitment requires residency within 30 minutes of SWAH. You cannot cover SWAH from Altnagelvin safely."

"We are hoping to attract consultants to the West, so they can do some of the work in Altnagelvin and some of the work in SWAH."

Both comments above at the same meeting.

These conflicting statements can only lead to confusion among consultants who might be considering applying.

Furthermore – the first paragraph of the actual Job Description for these Consultant Surgeon vacancies includes:

"The Western Trust are currently undertaking a Review of General Surgery. This is a Trust wide recruitment exercise. It is envisaged that emergency general surgery may need to be facilitated at Altnagelvin Hospital. Elective sessions will be available at the other Trust sites – Omagh Hospital and South West Acute Hospital."

WHSCT is explicitly stating here that its own still ongoing Review of General Surgery (not to be confused with DoH Review) has a predetermined outcome. It states in its Job Advertisement for Consultant General Surgeons that it envisages emergency general surgery will be based in Altnagelvin. There is clearly no intention to base these posts in SWAH.

More significantly, WHSCT are displaying a frivolous attitude to its own review which will have potentially critical patient safety issues for the population of the Southern sector.

We are concerned when WHSCT states in the Consultation document that 'larger reconfiguration may be required'. We are in no doubt that WHSCT intends to announce the permanent closure of Emergency General Surgery at SWAH. We believe that the situation has been engineered to provide this precise outcome. The disingenuous nature of the job advertisements for the Consultant General Surgeon roles is one of the many examples of this.

²⁶ Chief Executive – conflicting statements on rotas – November 2022

<https://www.facebook.com/SaveOurSwahServices/videos/1299149077599711>

2.6 Elective Centre

SOAS makes it clear in its core value statement that we are in favour of the development of an NHS-staffed consultant-led overnight elective centre. However – this has no place in a Consultation document which is specifically around the suspension of EGS services.

We agree with the comment from the Office of Minister for Health when it was stated they were “pretty sceptical” about the announcement to designate the SWAH as an elective overnight centre, at the same time as suspending the EGS service.²⁷ They warned that it would be seen as a fig leaf and were unconvinced about any desire to make it a true regional centre. SOAS agrees with this assessment.

2.7 Impact Assessments – Rural Needs & Equality

WHST has shown no analytical or medical data to support its temporary suspension of EGS and the subsequent consultation. This shows a blatant disregard to our population and is an indicator of poor planning by management. The lack of any actual impact assessment in the Rural Needs Impact Assessment means that WHST cannot make informed decisions relating to patients or medical outcomes. Similarly, there is no meaningful analysis done in the Equality Assessment for the Section 75 groups.

WHST has not responded to DoH request for its Risk/Benefit analysis.²⁸

2.8 Lack of Proposals

The Questions posed at the end of the Consultation are framed in terms of asking the (non-medical) public for alternative proposals, actions or impacts. This places the responsibility on the (non-medical) public to develop a solution that will resolve, or reverse, a decision taken by a public body. This is a failure of policy and decision making, and an abdication of responsibility of the professionals that are represented on the WHST Board and employed in senior management positions.

The 5 Questions directed at the public in the Consultation are indicated below:

²⁷ Fermanagh Herald – Trust was given no permission to do this <https://fermanaghherald.com/2023/02/trust-was-given-no-permission-to-do-this/>

²⁸ Fermanagh herald – 9th Feb 2023 - Trust was given no permission to do this <https://fermanaghherald.com/2023/02/trust-was-given-no-permission-to-do-this/>

1. Do you consider the temporary suspension of Emergency General Surgery Services a reasonable response to the patient safety concerns outlined in the document? (If not, please identify alternative proposals).
2. Do you consider the patient pathways as reasonable, and do you believe they address some of the challenges faced by the service and will facilitate patients receiving treatment in a timely, suitable and safe environment based on their clinical need? (If not, please provide any comments or alternative actions that could be taken).
3. Do you have any further views on the assessed impact of the proposals and any other potential impacts you feel we should consider?
4. The Trust's Rural Needs Assessment is available on the Trust's website. Do you have any evidence to suggest that the actions taken by the Trust create a negative impact?
5. Please provide any other comments that you wish to make.

How can the non-medical public be expected to 'identify alternative proposals', provide 'alternative actions', give views on 'any other potential impacts', provide 'evidence to suggest that the actions taken by the Trust create a negative impact'? WHSCT provides no Risk Assessment, no costed alternative options, derisory Impact Assessments that fail to evaluate impacts on Rurality and Equality. No information or data is provided to assist the public in coming up with an alternative solution. Indeed, the Trust has made a virtue of refusing to divulge any information on activities, capacities, numbers employed, finances, or any other detail that might enable the public to gain a better understanding of how the hospital is organised and run.

2.9 How to answer this Consultation?

It is difficult to draw any conclusion other than WHSCT do not in fact want to staff the Surgery Rota and intend to recommend a permanent closure to EGS Services at SWAH in the near future. They have created a dangerous patient safety-related situation in SWAH.

SOAS is fully committed to the long-term retention of sustainable acute services at SWAH – including EGS Services.

SOAS reject the underlying intentions of the management in WHSCT regarding this consultation.

DoH guidance states that this consultation should be carried out with the clear intention of re-opening or reinstating the service if an alternative viable means of preventing the change or withdrawal is identified by the consultation.²⁹

We have accepted WHSCT's challenge to provide an alternative viable proposal to the temporary suspension of Emergency General Surgery Services at SWAH. We have consulted extensively with health experts, rurality experts, academics, experienced retired and current medical experts, local business leaders and the public in a determined effort to develop a viable plan for local acute services that will be sustainable into the future.

We will present this viable alternative plan for SWAH in this Response and ask that the population of the SWAH catchment area support us in bringing this plan forward.

²⁹ DoH Guidance – Change or Withdrawal of Services <https://www.health-ni.gov.uk/sites/default/files/publications/health/change-or-withdrawal-of-services%E2%80%93guidance-on-roles-and-responsibilities.pdf>

[3] IMPACTS ON THE LOCAL POPULATION

The decision to suspend EGS is effectively the removal of all urgent surgery from SWAH – apart from obstetrics and gynaecology. It will negatively affect the health and wellbeing of residents of, and visitors to, Fermanagh and Tyrone. The decision will exacerbate existing health inequalities, impact harshest on those with disabilities and from the most deprived and remote areas of the district, and likely trigger the further erosion of specialities offered by the South West Acute Hospital (SWAH).

There are many impacts on the population within the SWAH catchment area that will result from loss of EGS services.

As noted earlier – these have failed to be adequately identified by WHSCT in their Consultation documentation. We must understand these to be able to properly appreciate the impact on our population. SOAS has worked extensively to identify and quantify these.

It is necessary to first focus on the extent of increases in travel time to the nearest appropriate EGS service for our population. It is only when this is identified that we can proceed to assess the implications on our community.

3.1 Travel Time – the legal background

It is worth noting the circumstances underlying the reason why SWAH is located in Enniskillen in the first place.

The then Omagh District Council sought judicial review in the High Court in 2004 regarding the siting of the acute hospital in Enniskillen.³⁰ The judges agreed with the then Minister's decision to site the hospital in Enniskillen because it was crucial that almost 10,000 people in County Fermanagh would have been more than 60 minutes travelling time away from a hospital sited at Omagh.

This is an important foundation stone to our conviction that full acute services including EGS must be maintained at SWAH. The data that will be presented here shows that 83,343 people – many more than the 10,000 considered in the 2004 judicial review – are being told to travel excessive distances.

SOAS believe that – from a legal point of view – the primacy of travel time impacts on access to Urgent & Emergency Care over the need to reduce waiting lists as part of Elective Care has been established since 2004. This does need to be relitigated.

³⁰ Judicial Review – Omagh Council Neutral Citation No. [2004] NICA 10
<https://www.judiciaryni.uk/sites/judiciary/files/decisions/Omagh%20District%20Council%20v%20The%20Minister%20with%20Responsibility%20for%20Health%2C%20Social%20Services%20and%20Public%20Safety.pdf>

3.2 Travel Time – how many people affected?

Travel time to receive urgent & emergency care is one of the primary concerns of our local population.

The Department of Health published their “Review of Urgent and Emergency Care Services in Northern Ireland - Consultation Report & Strategic Priorities”³¹ in March 2022. This review was adopted after public consultation and moved to Implementation in October 2022.

The foreword of this review is important and sets the framework for the level of care that we should all demand:

"My vision for the future is to ensure that all citizens in Northern Ireland have equal access to safe urgent and emergency care services, tailored to their specific needs at the right time and in the right place." (*Robin Swann, Minister for Health – March 2022*)

We must stress the “**equal access**” that the Minister includes here. All of the citizens of Northern Ireland must be similarly treated – we cannot allow our local population to be treated in any way as second-class citizens.

SOAS commissioned a report from Ulster University (UU) to investigate Travel Times to nearest Type 1 Emergency Departments.³²

The findings of the report confirm:

- If SWAH retains Type 1 ED status: all of Northern Ireland is within 60 minutes of a Type 1 ED
- If SWAH does not retain Type 1 ED status: 83,343 people in Northern Ireland will not be within 60 minutes of a Type 1 ED

83,343 affected people is a very significant number:

- 4.4% of the population of Northern Ireland
- 100% of Fermanagh population (64,278)
- 10% of Tyrone population (19,065)
- 71% of FODC population

This analysis provides information at a detailed level that should have been included in WHSCT Rural Needs Impact Assessment but was not.

The figures are very concerning and speak for themselves – but special attention needs to be drawn to the fact that 100% of Fermanagh (population 64,278) and 10% of Tyrone will be significantly adversely affected. The extent of increase in Travel Time was then analysed.

³¹ <https://www.health-ni.gov.uk/consultations/consultation-review-urgent-and-emergency-care-services-northern-ireland>

³² Mackenzie, P. Ulster University (2022). Accessibility to Type 1 ED Across Northern Ireland – A GIS Analysis. Unpublished

WHST has not done any modelling on morbidity and mortality impacts beyond 30 minutes? 60 mins? Or even 150 mins showing “better outcomes”.

3.3 Travel Time – how much longer?

This was analysed by SOAS Research Group as part of their Analysis Report³³ – and presented based on Fermanagh and Tyrone affected cohorts.

For FERMANAGH:			Average Travel Time (minutes):			Extra Miles
Area	Popn	%	To SWAH	To Altnagelvin	EXTRA Travel Time	
Ballinamallard	2,592	4.0%	14	100	86	46
Belcoo and Garrison	2,762	4.3%	43	115	72	37
Belleek and Boa	2,654	4.1%	42	100	58	28
Boho Cleenish and Letterbreen	3,545	5.5%	23	128	105	52
Brookeborough	2,645	4.1%	26	113	87	44
Derrygonnelly	2,900	4.5%	23	120	97	52
Derrylin	2,924	4.6%	36	140	104	52
Donagh	2,447	3.8%	33	125	92	50
Enniskillen	13,776	21.4%	8	106	98	52
Florence Court and Kinawley	2,890	4.5%	33	133	100	52
Irvinestown	2,573	4.0%	16	90	74	36
Kesh Ederney and Lack	3,905	6.1%	19	84	65	30
Lisbellaw	3,089	4.8%	17	114	97	52
Lisnarrick	2,095	3.3%	13	96	83	41
Lisnaskea	2,613	4.1%	27	119	92	50
Maguiresbridge	3,223	5.0%	22	111	89	50
Newtownbutler	2,566	4.0%	46	148	102	49
Rosslea	2,166	3.4%	43	124	81	46
Tempo	2,913	4.5%	18	102	84	44
64,278			23 mins	113 mins	90 mins	47

Table 2: Increase in Average Travel Time to AAH for all Fermanagh population – with SWAH no longer Type 1 hospital (Source: SOAS Research Group). Weighted averages used.

³³ SOAS (2023). Removing Emergency Services: Impact on SWAH Catchment Area. Unpublished

For TYRONE:			Average Travel Time (minutes):			
Area	Popn	%	To SWAH	To Altnagelvin	EXTRA Travel Time	Extra Miles
Beragh	2,705	14.2%	48	85	37	15
Clanabogan	3,300	17.3%	37	81	44	21
Dromore	2,343	12.3%	25	84	59	29
Drumquin	2,310	12.1%	33	73	40	16
Fintona	2,033	10.7%	31	99	68	24
Newtownsaville	2,602	13.7%	43	101	58	20
Sixmilecross	1,263	6.6%	51	76	25	13
Trillick	2,509	13.2%	24	95	71	35
Total	19,065		36 mins	87 mins	51 mins	22

Table 3: Increase in Average Travel Time to AAH for affected Tyrone population – with SWAH no longer Type 1 hospital (Source: SOAS Research Group). Weighted averages used.

Average Travel Time for all of Fermanagh people to Altnagelvin is 113 minutes – almost 2 hours. It is 87 minutes for the Tyrone contingent. Fermanagh people are being told to travel an extra 90 minutes – Tyrone an extra 51 minutes. Travel Time from the Newtownbutler area goes as high as 2 and ½ hours. Almost 20,000 people have travel time over 2 hours.

There is a misconception among many from the more urban parts of Northern Ireland that travel time to Altnagelvin for our community is not excessive: William Crawley on BBC Radio Ulster discussing this specifically is unaware of the real distances involved:³⁴

“You’ve got a few nearby hospitals, I say nearby, I think on average about an hour’s drive.”

WHSCT similarly fail to appreciate the extent of travel time on our local population.

3.4 Travel Time – WHSCT opinion

WHSCT – during this consultation process – have been insistent that Travel Time is not a significant factor on outcomes. Two examples are given below – there are many others:

³⁴ 31st Jan 2023 - BBC Radio Ulster – William Crawley Talkback
<https://www.facebook.com/SaveOurSwahServices/videos/524053503152272>

Chief Executive WHSCT: “The one resounding thing about the new standards is that everyone gets the same standard of service, no matter where you live in Northern Ireland”³⁵

Medical Director WHSCT: “It is reasonable to state that this concept [golden hour] is outdated and is effectively a historical opinion that has become embedded in the public consciousness.

Trauma care has changed beyond all recognition in the last decade. Specifically, there is no relationship of any kind to Emergency General Surgery.”³⁶

Fermanagh Omagh District councillors challenged these statements.³⁷

SOAS contests these statements. Whether or not the phrase ‘golden hour’ is used is irrelevant. What is important is that time matters.

We would remind WHSCT that that most ED presentations are not blue light. A significant burden is being carried by frail older people making senseless, expensive trips up to Derry for care that could easily be done in Enniskillen (e.g., an x-ray following a fall).

We believe that this and similar statements from WHSCT could be considered to be dangerous statements, as they seem to imply there is no such thing as urgency and time doesn’t matter. This goes completely against the public health messaging we see around stroke, cardiac arrest and other conditions where we are constantly being told by WHSCT and other HSC bodies that every minute matters.

Sometimes we have to apply common sense.

Why do ambulances go fast and have flashing lights if time doesn’t matter? The minute a patient gets inside the hospital there are a number of time targets the staff work towards to make sure that key treatments get delivered quickly. Are they saying that time inside the hospital is somehow different from time outside the hospital?

We also remind the public that the ‘golden hour’ is not a travel time target, it's the time from condition onset/injury to definitive treatment. For someone in a farm accident in Belcoo/Newtownbutler/Garrison we also need to factor in the time it takes emergency services to get to the patient.

³⁵ WHSCT Online Consultation Event – March 2023

<https://www.facebook.com/SaveOurSwahServices/videos/1437957216740234>

³⁶ Impartial Reporter – 25th Feb 2023 - Sceptical councillors told ‘Golden Hour’ term outdated by Trust

<https://www.impartialreporter.com/news/23341063.sceptical-councillors-told-golden-hour-term-outdated-trust/>

³⁷ Impartial Reporter on FODC Health & Social Care Services Sub-committee meeting 17th Feb 2023

<https://www.impartialreporter.com/news/23341063.sceptical-councillors-told-golden-hour-term-outdated-trust/>

3.5 Travel Time – Major Trauma Triage Tool

WHST have consistently tried to minimise the impact of excessive travel times. We see this particularly around the 'golden hour' and their statement that is an old-fashioned concept related to trauma treatment in the 1970s. WHST also claim there is no relationship between Trauma and emergency general surgery.³⁸

The Major Trauma Triage Tool (MTTT) which is used across Northern Ireland challenges these WHST comments. This has highlighted once again how Fermanagh patients are now facing longer, and potentially much more dangerous, travel times for treatment in emergency situations than patients anywhere else in the North. The latest version was updated in November 2022 after the suspension of EGS in SWAH.³⁹ The tool is displayed below.

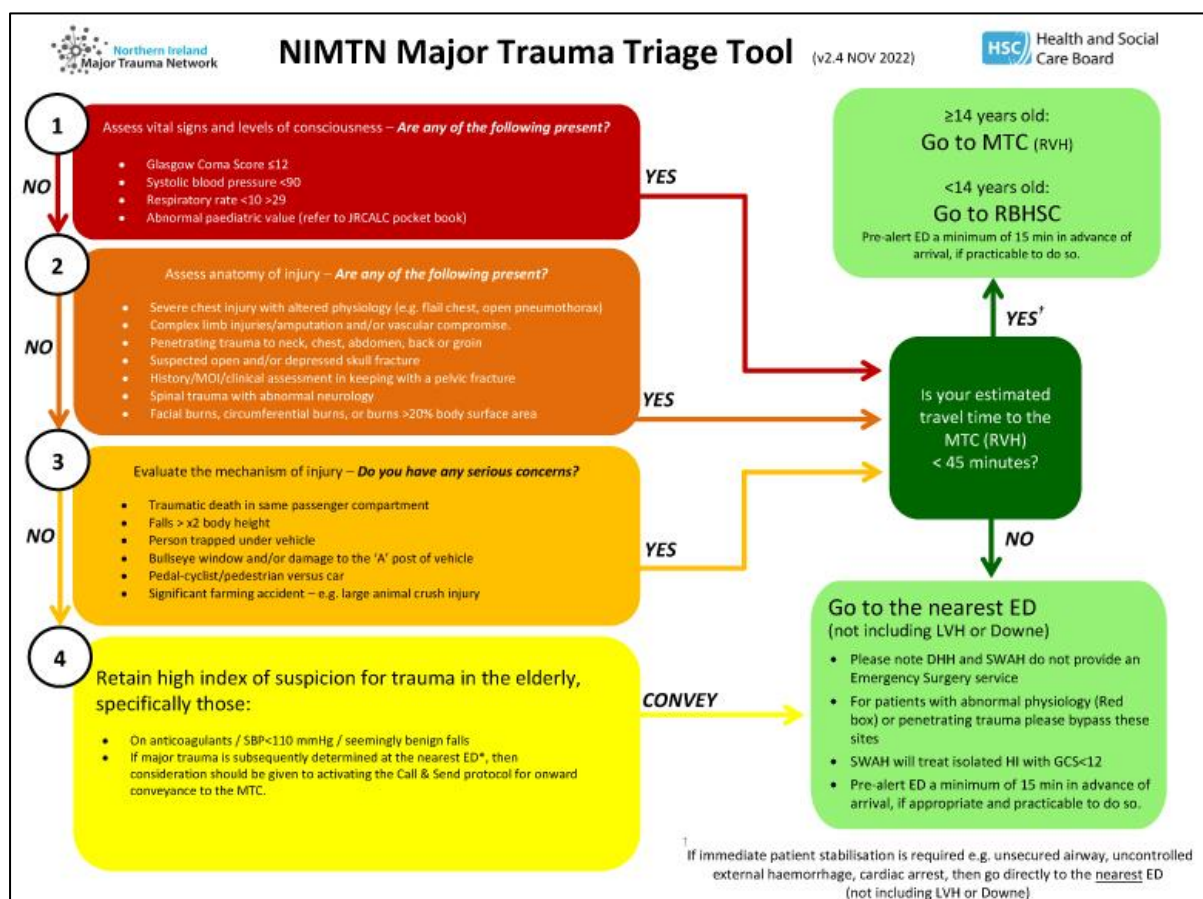


Table 4: Northern Ireland Major Trauma Network – Major Trauma Triage Tool – v2.4 Nov 2022 (Source – FOI Request to DoH)

³⁸ Impartial Reporter – 25th Feb 2023 - Sceptical councillors told 'Golden Hour' term outdated by Trust <https://www.impartialreporter.com/news/23341063.sceptical-councillors-told-golden-hour-term-outdated-trust/>

³⁹ Fermanagh Herald - 5th Apr 2023 - Major Trauma Triage guidelines highlight Fermanagh's isolation <https://twitter.com/saveourswah/status/1642828177218191360/photo/1>

It is clear that 'time to treatment' is a vital factor with regard to trauma.
It is also clear that there is a direct link between trauma the availability of EGS – despite what WHSCT claim.

We can see that for 3 of the 4 Trauma Category's listed that the preferred treatment time is less than 45 minutes.

If the Royal Victoria Hospital is more than 45 minutes away - then go to your nearest ED that has Emergency Surgery. However - the triage tool states clearly that SWAH does not provide an emergency surgery service.

This is extremely concerning to the people of Fermanagh and South Tyrone with most people almost 2 hours away from emergency surgery.
We are being treated as less important than those who happen to live nearer to hospitals with EGS. We are being treated as 2nd class citizens.

We are further disturbed to learn the previous version of the toolkit from 2019 had this travel limit set to 60 minutes.⁴⁰

This means that not only is time critical for trauma, it also means that it is increasingly important to attend as quickly as possible for trauma treatment at an ED.

WHSCT have also stated that this triage tool only applies "east of the Bann".⁴¹
This is not correct. It clearly states that it is a regional tool.
It is another attempt by WHSCT to undermine our legitimate concerns regarding excessive time to treatment that has been forced upon us.

We note from the traumas listed that these are car accidents, farming accidents, industrial accidents, they are falls, they are football match injuries, they are burns. These traumas will not be treated in SWAH while EGS is suspended.

We return to the definition of patient safety as "the avoidance of unintended or unexpected harm to people during the provision of health care". (NHS England)⁴²
Patient safety has been abandoned by WHSCT.

⁴⁰ 2019 - Duncan Redmill - Update On Developing A Major Trauma Network

https://hscboard.hscni.net/download/PUBLICATIONS/conference_slides/Conference-Slides-Dr-Duncan-Redmill-Lead-Clinician-NI-Major-Trauma-Network-Update-on-Developing-a-Major-Trauma-Network.pdf

⁴¹ Fermanagh Herald - 5th Apr 2023 - Major Trauma Triage guidelines highlight Fermanagh's isolation

<https://twitter.com/saveourswah/status/1642828177218191360/photo/1>

⁴² NHS England - The NHS patient safety strategy <https://www.england.nhs.uk/patient-safety/>

3.6 Travel Time – leads to poorer outcomes

It is not just our local council FODC and SOAS who have concerns around travel time.

There is a significant body of peer-reviewed research that relates extra distance travelled to poorer outcomes with increased mortality and morbidity rates.

There is a common consensus in these articles that the longer the distance travelled to the nearest Type 1 Hospital for emergency admission the poorer the outcome. This poorer outcome can be reflected in either increased mortality or morbidity.

It is of interest to note that what is classified as 'rural' or 'very rural' in the key research articles do not result in emergency ambulances travelling distances of more than 40 miles.

SOAS Research Group analysis shows that the average distance travelled for the 64,278 affected Fermanagh people from the SWAH catchment area to Altnagelvin is 58 miles. It is 43 miles for the affected 19,065 Tyrone people.

It emphasises the exceptional nature of the distances that Fermanagh people are being told to travel.

The poor roads infrastructure and the deprivation associated with these areas must also be further considered as factors that further challenge outcomes.

Nicholl et al (2007) found that increased journey distance to hospital for emergencies appears to be associated with increased risk of mortality. The study suggests that a 10km increase in straight-line distance is associated with an approximate 1% absolute increase in mortality.⁴³ Nicholl states "This means that, other things being equal, closing local EDs could result in an increase in mortality for a small number of patients with life-threatening emergencies, who have to travel further as a result."

SOAS applied the information gathered in this section to the scenario where SWAH is no longer a receiving hospital for emergencies and patients travel by ambulance instead to Altnagelvin.

⁴³ The relationship between distance to hospital and patient mortality in emergencies: An observational study (By Jon Nicholl et al, University of Sheffield, 2007) <https://pubmed.ncbi.nlm.nih.gov/17711952/>

For FERMANAGH:		'straight line' distance (KMs)				
Area	To SWAH	To Altnagelvin	EXTRA KMs		Increase in 'blue light' deaths	
Ballinamallard	7	70	63		6.3%	1 in 16
Belcoo and Garrison	26	84	58		5.8%	1 in 17
Belleek and Boa	31	72	41		4.1%	1 in 24
Boho Cleenish and Letterbreen	10	83	73		7.3%	1 in 14
Brookeborough	17	77	60		6.0%	1 in 17
Derrygonnelly	12	75	63		6.3%	1 in 16
Derrylin	24	96	72		7.2%	1 in 14
Donagh	22	88	66		6.6%	1 in 15
Enniskillen	2	77	75		7.5%	1 in 13
Florence Court and Kinawley	19	93	74		7.4%	1 in 13
Irvinestown	11	62	51		5.0%	1 in 20
Kesh Ederney and Lack	16	59	43		4.3%	1 in 23
Lisbellaw	7	79	72		7.2%	1 in 14
Lisnarrick	7	69	62		6.2%	1 in 16
Lisnaskea	18	85	67		6.7%	1 in 15
Maguiresbridge	14	82	68		6.8%	1 in 15
Newtownbutler	32	96	64		6.4%	1 in 16
Rosslea	32	88	56		5.6%	1 in 18
Tempo	11	70	59		5.9%	1 in 17
Total	14 kms	79 kms	65 kms		6.5%	1 in 15

Table 5: Increase in Mortality for all Fermanagh population – for life-threatening Emergencies ONLY to AAH (Source: SOAS Research Group). Weighted averages used.

For TYRONE		'straight line' distance (KMs)				
Area	To SWAH	To Altnagelvin	EXTRA KMs		Increase in 'blue light' deaths	
Beragh	35	52	17		1.7%	1 in 59
Clanabogan	26	51	25		2.6%	1 in 38
Dromore	18	57	39		3.9%	1 in 26
Drumquin	25	48	23		2.3%	1 in 43
Fintona	24	56	32		3.2%	1 in 31
Newtownsaville	30	57	27		2.7%	1 in 37
Sixmilecross	38	52	14		1.5%	1 in 67
Trillick	15	64	49		4.9%	1 in 20
Total	26 kms	55 kms	29 kms		2.9%	1 in 34

Table 6: Increase in Mortality for affected Tyrone population – for life-threatening Emergencies ONLY to AAH (Source: SOAS Research Group). Weighted averages used.

There is an average increase of 65 kms for all Fermanagh people in 'straight line' distance in travelling to Altnagelvin rather than to SWAH. This increase is 29 kms for the affected Tyrone people.

For emergency ambulance travel – this analysis suggests a 6.5% increase in the mortality rate for all Fermanagh people based on the extra distance that an emergency ambulance will need to travel to get to Altnagelvin. The increase in mortality for the affected Tyrone people is 2.9%.

On average - 1 out of every 15 'blue light' emergencies for all Fermanagh people will result in one unnecessary death due to the extra distance. This figure is 1 in 34 for the affected Tyrone population.

It is clear that Altnagelvin has extreme difficulties with managing patients from their normal catchment area.

It is not reasonable or safe to expect Altnagelvin staff to accommodate the significant numbers travelling up from the SWAH catchment area.

Time matters.

This has been shown above.

The link between excessive travel times and poorer outcomes is undeniable – supported both by logic and research.

Patient safety is significantly compromised by this suspension of services.

83,343 people cannot be allowed to be treated differently than the rest of NI.

“We as a people in Fermanagh have woken up to the fact we are not being treated fairly, we’re not being treated with respect. In fact, we’re not being treated at all.”⁴⁴

⁴⁴ Fermanagh Herald – 5th Apr 2023 - 'Fermanagh has awakened' – Fr Brian
<https://fermanaghherald.com/2023/04/fermanagh-has-awakened-fr-brian/>

[4] FAILURE OF MANAGEMENT

SOAS will present a viable alternative plan for SWAH in this Consultation Response. This plan will necessitate a separation of the Southern sector of WHSCT from the Northern sector.

What follows in this section is a litany of examples of how the Southern sector has suffered under the present senior management of WHSCT. We must first present the case for separation within WHSCT in order then to be able to present our viable alternative plan in the next section.

The relationship between the 2 sectors has been unbalanced since the formation of WHSCT in 2007 – when Sperrin Lakeland, Foyle and Altnagelvin trusts were merged. There have been media reports using the term ‘derryisation’ going back as far as 2009.⁴⁵ This imbalance has methodically undermined the Southern sector and its hospitals in particular. It results in not just loss of services and specialities but also in preventing SWAH and OHPCC (Omagh Hospital and Primary Care Centre) from achieving their potential.

SWAH is a state-of-the-art hospital and the most modern acute hospital in Northern Ireland. OHPCC opened as a new build in 2017 and is perfectly positioned to be a key part of transformation with its development as a regional Day Procedure Centre.⁴⁶

This imbalance and its effect on the Southern sector are a failure of the senior management team in WHSCT.

It is worth noting that FODC councillors passed 2 motions in November 2022 illustrating their support of SWAH and dissatisfaction with WHSCT senior management.

A motion was passed on 1st November 2022 expressing dissatisfaction with downgrading of SWAH and resolving to investigate and pursue all available legal avenues to defend SWAH.⁴⁷

A further motion on 9th November 2023 expressed No Confidence in the WHSCT Board, called on Board members to resign and called for WHSCT to be put into Special Measures by DoH.⁴⁸

⁴⁵ Impartial Reporter – Health services all heading to Derry

<https://www.impartialreporter.com/news/13849524.health-services-all-heading-to-derry/>

⁴⁶ Royal College of Surgeons welcome new surgical hub in NI Health Minister's plans

<https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/surgeons-welcome-hub-health-minister-plans/>

⁴⁷ FODC Council Meeting – 1st Nov 2023 – Minutes

<https://www.decisiontime.online/face/getDocument/cadc4ab0d9f4ea28149304fbe71b0cd73d235dee/946739/pdf>

⁴⁸ FODC Policy & Resources Committee – 9th Nov 2022 – Minutes

<https://www.decisiontime.online/face/getDocument/cadc4ab0d9f4ea28149304fbe71b0cd73d235dee/946744/pdf>

4.1 Stripping of Services from SWAH

There has been a steady stripping of services and specialities from the Southern sector to the Northern sector.

Local medical personnel refer to ENT as one example of this stating that the consolidation of ENT services in AAH was simply an empire building exercise.

The suspension of emergency general surgery in SWAH in November 2022 is a clear indication of this. The fact that these SWAH consultant surgeon posts are now advertised as based in Altnagelvin is another example of this long-term trend.

We can point to many services & specialities that were previously in OHPCC, SWAH and its predecessor Erne Hospital – but have been reduced or removed since 2007:

- ENT
- Nephrology
- Breast
- General Surgery
- Pain Services
- Orthodontal
- Ophthalmology
- Urology
- Fracture Clinic
- Orthopaedics
- General Paediatric Surgery
- ERCP (gastroenterology)

We have the more recent example of Rheumatology Outpatients being quietly moved out of SWAH on October 2022. WHSCT only made an announcement in March 2023 when members of the public noticed it.⁴⁹

This systematic movement of specialities and services has the effect of gradually undermining the belief in the staff that there is a real long-term future that will enable the potential of the hospitals in the Southern Sector to be achieved. This cannot be allowed to continue. It must be stopped and reversed.

SOAS believes that the current senior management have failed the Southern Sector since the formation of WHSCT and new management is required urgently.

⁴⁹ Anger at removal of SWAH rheumatology <https://fermanaghherald.com/2023/03/anger-at-removal-of-swah-rheumatology/>

4.2 Collapse

Prof Mark Taylor (Royal College of Surgeons) on BBC has described the collapse of Emergency General Surgery in SWAH as “not Transformation. In fact, it is a failure to bring about Transformation”.⁵⁰

This failure can be placed at the door of WHSCT senior management.

The 'Review of General Surgery'⁵¹ confirms that the availability of, or access to, 24/7 surgical services is a key aspect of the safe provision of acute adult and paediatric services.

The Review also underlines that the unplanned collapse of a vulnerable general surgery service could have implications across other hospital services. If services remain vulnerable to short term collapse, there is therefore a cumulative risk with regard to the impact this could have on other services.

We have already had serious concerns raised by a whistleblower about the viability of the maternity unit in SWAH.⁵² The concerns over the legal vulnerability of Obs&Gynae consultants without the safety net of general surgeons was cited as the reason for a number of them announcing they were leaving.

This possible domino effect of failing specialities threatens our acute status.

This potential cumulative risk cannot be allowed to materialise.

4.3 Failing Pathways and Mitigations

WHSCT state both in their Consultation document and in public meetings since November 2022 that they have put in patient pathways and associated mitigations to help reduce the risk for patients.

These mitigations have been shown to be much less than WHSCT claim them to be when challenged by media and the public. There is a significant disingenuous element to WHSCT assurances when challenged on these pathways which lead the public to have valid concerns about their safety.

The claim from WHSCT⁵³ that Royal College of Obstetrics & Gynaecology (RCOG) had been invited in and carried out a review of the Trust's plan and made

⁵⁰ BBC – The View – 20th Nov 2022 -

<https://www.facebook.com/SaveOurSwahServices/videos/1312273586216607>

⁵¹ Doh Review of General Surgery (not consulted on) <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-review-general-surgery.PDF>

⁵² Irish News – 9th Feb 2023 - Trust downplays whistleblower concerns maternity unit at South West Acute Hospital could close

https://www.irishnews.com/news/northernirelandnews/2023/02/09/news/trust_downplays_whistleblower_concerns_maternity_unit_at_south_west_acute_hospital_could_close-3045899/

⁵³ Chief Executive claim – I have invited in RCOG – to FODC Councillors – 17th Nov 2022

<https://www.facebook.com/watch/?v=880146139644404&ref=sharing>

recommendations that the Trust had implemented has been shown to be no more than an informal conversation with a local representative.⁵⁴

WHST insisted to FODC on 17th Nov 2022 that there would be no impact on Obstetrics services and still claim on their website that emergency C-sections will be performed at SWAH.⁵⁵ Yet – 3 months after the suspension of EGS they state that they knew all along that there would be an impact on Obstetrics services.⁵⁶

Initially – it was stated that there was no impact to Gynaecology services. This claim was then changed after it was challenged by councillors and it became ‘a small number of cases will be better carried out in Altnagelvin’.⁵⁷ The WHST website still claims no impact for Gynaecology.

WHST senior managers have claimed that NIAS capacity has been bolstered by overtime – which is in itself an unsustainable solution.⁵⁸ This has been shown to be inaccurate by a NIAS whistleblower in January 2023 who stated that the overtime available in the Western Area would be targeted to the Derry area as NIAS had to target the areas of higher demand.

A NIAS spokesperson said “The changes proposed at the SWAH will result in a need for additional and longer ambulance journeys for a small number of patients which, in the absence of additional resources being made available to the NIAS, does risk a reduced level of ambulance cover in the SWAH area.”

This is unacceptable. We cannot depend on the WHST mitigations.

Initially – FODC councillors were told that surgical patients would be transferred to the nearer of Altnagelvin or Craigavon. However, it is stated in NIAS ‘Destination Triage Tool for Surgical Presentations in SWAH Catchment Area – 6/12/22’ that EGS services are being consolidated at the Altnagelvin site only.

The same NIAS Destination document states that for transfer between SWAH and AHH that WHST staff will determine if personal or public transport or ambulance is appropriate. This is totally at odds with what WHST are claiming in their mitigations where they deny asking people to make their own way to Altnagelvin.⁵⁹ It must be

⁵⁴ Revelations raise doubts over SWAH safety assurances <https://fermanaghherald.com/2022/11/revelations-raise-doubts-over-swah-safety-assurances/>

⁵⁵ WHST – Fact Checker on Removal of EGS <https://westerntrust.hscni.net/about-the-trust/emergency-general-surgery-south-west-acute-hospital/fact-checker-emergency-general-surgery-south-west-acute-hospital/>

⁵⁶ WHST Online Consultation Event – March 2023 <https://www.facebook.com/SaveOurSwahServices/videos/1066614100982156>

⁵⁷ Gynaecology impact - FODC Health & Social Care Services Sub Committee Date? <https://www.facebook.com/SaveOurSwahServices/videos/6096681063733004>

⁵⁸ WHST Claim – NIAS bolstered capacity in Enniskillen and Omagh <https://www.facebook.com/SaveOurSwahServices/videos/1220259002030372>

⁵⁹ Fermanagh Herald - Trust denies patients asked to make own way to Derry <https://fermanaghherald.com/2023/03/trust-denies-patients-asked-to-make-own-way-to-derry/>

stated that SOAS has received numerous contacts from patients in SWAH A&E who have been asked to make their own way to AAH for further assessment and treatment.

WHST claimed to FODC councillors that Ward 31 was set aside for patients from SWAH – it transpired after media investigation that only 2 beds in Ward 31 were in fact set aside.⁶⁰

There was clearly never any real intention of sending patients to Sligo University Hospital as stated by WHST to FODC on 17th Nov 2022.⁶¹

The Irish News in an article by Deirdre Heenan on the current WHST Public Consultation said that mixed messaging, misinformation, confusion has damaged faith in the Western Trust. The article went on to say that the Western Trust have dodged the difficult questions, prevaricated and presented an extremely incoherent picture.⁶²

This catalogue of misinformation from WHST related to their pathways and mitigations have further eroded the confidence of the public in the senior management team of WHST.

Senior managers claimed to the DoH on 12th October 2022⁶³ - a month before the suspension – that they were even then agreeing the necessary contingency arrangements. This is derisory planning at best and suggests either incompetence or ambivalence on the part of WHST management.

4.4 Other Failures of Management

SOAS will include some of the many instances of failures of management over recent years that reinforce our belief that the Southern sector must be separated from the Northern sector.

‘Pathfinder FAST’ (Fermanagh & South Tyrone) was launched by the Chief Executive of WHST in August 2018 aimed at developing sustainable health services at SWAH

⁶⁰ Belfast Telegraph - Altnagelvin Area Hospital: Just two beds set aside for SWAH patients after temporary surgery halt <https://www.belfasttelegraph.co.uk/news/health/altnagelvin-area-hospital-just-two-beds-set-aside-for-swah-patients-after-temporary-surgery-halt/42282373.html>

⁶¹ Impartial Reporter - No surgical patients to be transferred to Sligo University Hospital <https://www.impartialreporter.com/news/23175633.no-surgical-patients-transferred-sligo-university-hospital/>

⁶² Irish News – 28th Nov 2022 - We need to be honest with the public over hospital changes https://www.irishnews.com/paywall/tsb/irishnews/opinion/columnists/2022/11/28/news/deirdre_heelan_w_e_need_to_be_honest_with_the_public_over_hospital_changes-2917563/content.html

⁶³ WHST to DoH 12th Oct 2022 – requesting approval for suspension of EGS https://www.whatdotheyknow.com/request/sppg_documentation_and_dept_of_h#incoming-2238141

specifically. Prof Rafael Bengoa even attended a health Summit in April 2019. Nothing has ever been produced as an output – even after 62 engagement events. A total management failure – at significant expense – of a valuable opportunity to develop services in the Southern sector.⁶⁴

Senior management at WHSCT has allowed the situation whereby the Fermanagh has no representation at all on the Board of Directors. 8 executive directors, 5 non-executive directors, 1 chief executive and 1 chairman – and not a single one from the Fermanagh.⁶⁵

This means that the voice of our area cannot be heard in the board room. SOAS are especially disappointed to discover that last month 3 of the 5 existing non-executive directors were re-appointed to the board for another 4-year term⁶⁶ – this is while it is clear that the Southern Sector needs representation on the board more than ever. These posts are normally advertised – but not so in this case. Another example of ignoring the Southern sector.

WHSCT committed to an internal trust wide Review of General Surgery in 2021 – the output of which was specifically to assist with maintaining the rota at surgery in SWAH. This was due to report in June 2022.⁶⁷ This review has still not reported – in April 2023. Another supposed attempt to enhance services in the Southern sector let go by the wayside. We refuse to accept any outcome of what has been shown to have a preordained outcome.

The present Chief Executive of WHSCT has been involved with CAWT for at least 10 years. Cooperation And Working Together (CAWT) is a partnership between the Health and Social Care Services in Northern Ireland and Republic of Ireland, which facilitates cross border collaborative working in health and social care. It is notable that the Chief Executive has ensured significant Northern Sector infrastructure development through CAWT while failing to deliver in a similar way for the Southern sector.⁶⁸ The Chief Executive confirmed this in a House of the Oireachtas Joint Committee discussion in February 2022

"CAWT has played its part. We would not have a cancer centre today [beside Altnagelvin] if it was not for CAWT, and the population of the north west of Ireland has really benefited from that development."

⁶⁴ WHSCT – Pathfinder website <https://westerntrust.hscni.net/about-the-trust/involving-you/pathfinder-latest-news/>

⁶⁵ WHSCT – Board of Directors <https://westerntrust.hscni.net/about-the-trust/corporate-information/our-structure/cmt-and-trust-board/>

⁶⁶ WHSCT – Board Minutes – February 2023 <https://westerntrust.hscni.net/download/648/trust-board-papers-2023/12747/minutes-of-trust-board-meeting-2-february-2023.pdf>

⁶⁷ Fermanagh Herald – 234rd Apr 2022 - Fears for emergency surgery at SWAH <https://fermanaghherald.com/2022/04/fears-for-emergency-surgery-at-swah/>

⁶⁸ House of the Oireachtas - Engagement with Co-operation and Working Together – 10th Feb 2022 https://www.oireachtas.ie/ga/debates/debate/joint_committee_on_the_implementation_of_the_good_friday_agreement/2022-02-10/2/

"I have to confirm that we do not have the traction in terms of the cross-Border linkages between South West Acute Hospital and Sligo hospital. It is a great regret that it has not taken off over the last decade."

That is 10 years of WHSCT Chief Executive failing to deliver for the Southern sector while ensuring the Northern sector is focused on.

The 'Our Hearts Our Minds' (OHOM) cardiology programme was an innovative lifestyle cardiology programme. It was developed by the cardiology team in SWAH in 2017 and became an award-winning renowned programme.⁶⁹ ⁷⁰OHOM adapted to COVID by launching a new virtual patient platform.⁷¹ This was undoubtedly a Southern sector success story – until the funding for it was withdrawn by the Board with no reason given.

SOAS reasonably asks if such important innovative work would have been shelved had there been any Southern sector representation on the Board. More effective long-term workforce planning would have resulted in cost savings on locums freeing up funds for programmes like OHOM.

DoH initially recommended that SWAH be funded for 8 consultant surgeons. This was immediately reduced to 6.5 on the onset of formation of the WHSCT. This persistent running down of staffing for specialities has undermined the ability of SWAH to live up to its original mandate.

Analysis from 2019 reaffirms the movement of services from the Southern to Northern sector – this time for Outpatient appointments.⁷² The report confirms that despite both Altnagelvin and SWAH being acute hospitals that there is a clear preference from Trust management towards moving more and more outpatient appointments to Altnagelvin with a five percent rise in the previous five years. 23% of patients in Fermanagh travel to Altnagelvin for appointments, with less than 1% travelling in the other direction.

WHSCT has failed to ensure that NIMDTA (Northern Ireland Medical and Dental Training Agency) allocation of doctors delivers sufficient numbers to the Southern sector. Consultants are deterred from coming to SWAH to work when they realise that over the previous number of years SWAH only received one doctor out of 120 in

⁶⁹ BBC NI – 17th April 2017 - Obesity levels in Northern Ireland get new approach

<https://www.bbc.co.uk/news/uk-northern-ireland-47953366>

⁷⁰ Belfast Live – 7th Oct 2021 - Fermanagh doctor scoops prestigious 'Healthcare Hero' award

<https://www.belfastlive.co.uk/news/northern-ireland/fermanagh-doctor-scoops-prestigious-healthcare-21790311>

⁷¹ WHSCT – 11th May 2020 – Our Hearts Our Minds expanding with launch of a virtual patient platform

<https://westerntrust.hscni.net/our-hearts-our-minds-expanding-with-launch-of-a-virtual-patient-platform/>

⁷² Impartial Reporter – 8th Nov 2019 - Fermanagh patients travel over one million miles for appointments

<https://www.impartialreporter.com/news/18024316.fermanagh-patients-travel-one-million-miles-appointments/>

A&E under the allocation afforded by NIMDTA.⁷³ SWAH receives the fewest numbers of any of the acute hospitals under this allocation. We see again that the Southern sector has failed to be provided for adequately by senior management in WHSCT who have failed to resolve this issue.

WHSCT has advertised twice recently for Consultant Radiologist vacancies in SWAH. On both these occasions the job description includes the line:

“There are no junior medical trainees in Radiology at South West Acute Hospital, and none are expected in the near future”

This line does not appear in any other recent Consultant Radiologist advertisements. Why this difference for SWAH? We know that these junior trainees perform a very important function as part of efficient radiology departments all across NI – except for SWAH.

WHSCT which manages SWAH has now chosen to discontinue surgical services. Why? Because they cannot employ sufficient consultants to satisfy patient safety standards. But in so doing, the Trust is actually putting patients at risk by requiring them to travel to Altnagelvin. On one hand they invoke patient safety as the reason for cutting the service while at the same time, increasing the risk of mortality on the other. How can this contradictory policy be acceptable?

The people of Fermanagh and South Tyrone have been abandoned by WHSCT senior management.

This process has been ongoing since the merging of the Trusts in 2009.

It has now got to the stage where there is a clear and obvious risk to patient safety. The current structure cannot be allowed to continue.

⁷³ Impartial Reporter – 7th Sept 2019 - Council to challenge training body on allocation of doctors to SWAH
<https://www.impartialreporter.com/news/17882621.council-challenge-training-body-allocation-doctors-swah/>

[5] ALTERNATIVE VIABLE PROPOSAL

WHST management have clearly abandoned the people of Fermanagh and South Tyrone:

“So, it all comes down to, can we reconfigure in the Western Trust to deliver these [Review of General Surgery] standards [in SWAH]?

I believe we can’t.

If somebody can come forward to show me the way, I am very open to it.

However, we can’t do it so either the Dept Of Health do it or this change will not be reversed.”

(Chief Executive WHST to Fermanagh Omagh District Council – 9th Jan 2023)

The comment from the Chief Executive above shows a lack of ambition that if left unchallenged will undoubtedly lead to a permanent withdrawal of General Surgery from SWAH.

As the sole Government appointed body to provide healthcare to the people of the South West, WHST has primary responsibility to fulfil the function it was given. To cut a service without any safe replacement is an abdication of its responsibility.

There is specific Dept of Health guidance⁷⁴ relating to this WHST Consultation. Paragraph 13 states:

In circumstances where consultation has not been possible in advance of a change or withdrawal of service, it is recommended that consultation should be carried out following the event with the clear intention of re-opening or reinstating the service if an alternative viable means of preventing the change or withdrawal is identified by the consultation.

SOAS will present an alternative viable proposal.

We consulted extensively with health experts, rurality experts, academics, experienced retired and current medical experts, local business leaders and the public to develop a viable plan for local acute services that will be sustainable into the future.

We have had to rely on publicly available operational and financial data.

This plan is presented as the optimum solution to replace the existing WHST’s role in providing healthcare. It provides a framework for meeting the Dept of Health’s obligations, for dealing with the urgent shortfall in consultants, for restoring competent and accountable management, and importantly, for providing substantial benefits to the Northern Ireland Health and Social Care system.

⁷⁴ DoH Guidance - Change or Withdrawal of Services – Guidance on Roles and Responsibilities
<https://www.health-ni.gov.uk/sites/default/files/publications/health/change-or-withdrawal-of-services%E2%80%93guidance-on-roles-and-responsibilities.pdf>

It is essential that any sustainable proposal must include full and timely access to Urgent and Emergency care in SWAH as an absolute minimum.

Detailed consideration was given to a number of options that involved amended working arrangements and responsibilities in the Southern Sector with accountability still resting with the existing Board of Directors in Altnagelvin. However - the issues detailed in the previous section with the senior management of WHSCTs inability to manage in the Southern sector are so embedded as to render any alternative viable proposal that includes their involvement unworkable.

Directors for the Southern sector must be based in Fermanagh and South Tyrone. Any alternative viable proposal must have a local Board of Directors as an absolute minimum.

Any proposal must be both feasible and capable of working successfully in order for it to be viable.⁷⁵

Any feasible proposal must include a long-term solution encompassing both Urgent & Emergency Care and Elective Care. The support of the staff is essential to the success of any proposal.

⁷⁵ Viable: capable of working successfully; feasible.

5.1 'SOAS 5-Point Plan'

First Step:

“The most important step is to state that Acute Services
are going to be in SWAH and there to stay”

*(Essam Ghareeb, retired Consultant Surgeon
SWAH and Erne Hospital)*

Aim:

The restoration of a publicly funded and locally accountable NHS Trust for the South West will not only secure better care for our community but will also be a driver of job growth and career opportunities in the region.

1. A separate NHS Trust for the South West area with its own management team will enable us to address the Western Trust failure in its duty of care to our Patients and Staff
2. Restore Urgent and Emergency surgical services at SWAH with Department of Health assistance on rotas.
3. New initiatives to ensure a settled workforce where all staff - including consultants and locums – are respected and valued
4. New surgical specialities to be introduced with emphasis on key areas (e.g., bariatric, colorectal, breast, ENT)
5. Relaunch of all 5 theatres to provide Emergency Care and Elective Care for local and regional needs – including cross-border.

5.2 Accountability

The 5-Point Plan (called the 'Plan' from here on) will require change to the framework within which the existing 5 Health & Social Care Trusts (HSCTs) and NIAS work.

This framework was documented in 2011 as an output from Health and Social Care (Reform) Act (NI) 2009.⁷⁶ This clearly establishes that the 5 HSCT's and NIAS are ultimately accountable to DoH for the discharge of their statutory functions.

The Chief Executive of WHSCT has stated that the temporary suspension of EGS will not be reversed unless the DoH step in. The Framework is clear that each HSCT is locally accountable for its performance, including ensuring that its health services are safe. Telling every Fermanagh patient that they must travel an average of almost 2 hours for Urgent & Emergency care is simply not safe and is a clinical governance failure.

The Framework Document also clarifies that on issues of governance and assurance, WHSCT are directly accountable to DoH. The DoH has a responsibility to hold WHSCT to account for their clinical governance failures that have been previously listed. DoH cannot accept it when WHSCT state that "we can't do it" when considering reinstating EGS.

It is the responsibility of DoH to step in and hold WHSCT to account.

5.3 Creating a new Trust - feasibility

The Plan proposes that a new Health & Social Care Trust (HSCT) is set up for the South West area.

SOAS are not experts in this area. The expertise in this area is in the Dept of Health. We have reached out to DoH on a number of occasions and we look to arrange an information exchange at the earliest opportunity.

A new HSCT would require legislative change.

Article 10 of The Health and Personal Services (Northern Ireland) Order 1991 appears to include appropriate powers for the Department to create, to change and to dissolve a Trust.⁷⁷

⁷⁶ Framework Document – Department of Health, Social Services and Public Safety – September 2011 - <https://www.health-ni.gov.uk/publications/dhssps-framework-document-september-2011>

⁷⁷ The Health and Personal Social Services (Northern Ireland) Order 1991 Schedule 3 <https://www.legislation.gov.uk/nisi/1991/194/schedule/3/made>

There has been significant recent change to the health and social care system in Northern Ireland with the Migration of the Health & Social Care Board (HSCB) to DoH.⁷⁸ This change required legislative change with the introduction of Health and Social Care Act (Northern Ireland) 2022. This reassures us that there is both the appetite and expertise within DoH for Framework change when there is an organisational imperative for it.

DoH itself is in turn accountable, through the Minister, to the Assembly for the manner in which service commissioning and provision is carried out. The lack of a sitting Assembly at present impacts on decision making.

SOAS makes 2 points in this regard.

Firstly, the migration of HSCB to DoH was affected by 2 significant periods during which the Assembly did not sit. This did not prevent the migration; it had a delaying effect on it.

Secondly, DoH can implement appropriate transitional arrangements under legislation to ensure that a domino-style collapse of services in SWAH does not occur. These arrangements would remain in place until the required legislative changes could be implemented after the return of a sitting Assembly. The Plan's First Step – stating Acute Services are going to be in SWAH – would be supported by DoH assistance.

It is clear that changes such as this must be carefully planned, be fully co-produced and subject to public scrutiny, as they may have implications for other services in hospitals. The Plan includes giving consideration to the creation of a transitional management group to support DoH in their interim management. This group should be comprised of local people including some from a clinical background. The principles of Co-Production and Involvement will be embraced with patients, carers and staff being involved in a real way in decision making.

This should be a new forward-looking group focused on freeing up the potential of the Southern sector.

5.4 Creating a new Trust – budgets and costs

Particular consideration needs to be given to the possible cost implications of creating a new Trust and activating the untapped capacity in SWAH and OHPCC.

Transformation

SOAS proposes the implementation of the Plan to be done under the umbrella of Transformation – as a key part of the Plan revolves around freeing up the capacity that is available in the state-of-the-art hospitals in SWAH and OHPCC to assist in

⁷⁸ 1st April 2022 - HSCB Migration into Department of Health <https://hscboard.hscni.net/hscb-migration-into-department-of-health/>

Transformation. The Review of General Surgery tells us that SWAH will require more fundamental changes in a number of areas to meet the clinical standards. This cost needs to be measured against the overarching vision of the Review of Urgent & Emergency Care advocating equal access for all to safe urgent and emergency care services.

We note as an example that £5.3m of overall Transformation funding totalling £200m was made available to improve unscheduled and acute medical services in Daisy Hill Hospital.⁷⁹ SOAS strongly feels that funding opportunities such as this would be merited in SWAH as part of implementing the Plan.

It is a disappointment to see that so little of the £200m Transformation funding was allocated to WHSCT in general – and to the Southern sector in particular.

The expansion of appropriate specialities in the new Trust will be an important factor in freeing up capacity to help manage waiting lists. New specialities should complement other hospitals and will not compete unnecessarily. DoH has a significant part to play in agreeing new specialities and assisting in developing business cases.

Set-up Costs

To set up a new Trust will require some cost, which we believe can be contained.

Firstly, this process is not novel: it has been done before and the lessons and experiences are there to be built on.

Existing staff contracts will be all rolled over into the new Trust on the same conditions. Contracts with suppliers and others can be novated and renewed on the same terms. Subject to a professional review, the IT system currently in use can be used in the short term with software changes to areas such as invoicing and procurement.

Changes to Patient records and data flows will need to be amended. It is a benefit that the Encompass programme currently under way has detailed all care record processes and has in-house expertise to assist in this change.

Many of the overhead costs need not be affected by the movement to a new Trust: insurance, pensions, energy, repairs and renewals, lease. It will be part of the chief executive's job to manage these costs.

The Trust will require new directors as part of the new Board. Remuneration for these along with the CEO would be an additional cost.

Operating Costs

Allocation of resources to the new Trust would necessitate a change to the Capitation Formula to reflect an extra Trust. This would ensure a fair and equitable allocation of revenue to the new Trust.

⁷⁹ Health and Wellbeing 2026 Delivering Together Progress Report – 2021 <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-progress%20-report-full-document.pdf>

Consideration should be given to a premium on funding through processes such as NHS England policy on 'Unavoidable Smallness due to Remoteness'.⁸⁰

It should also be remembered that SWAH was set up and run with a number of specialties, each with a quota of consultants. Today by default, these specialties may be reduced, but the original budget was provided for these services to be delivered. Therefore, in reality while the type of service may be modified to suit present demand, the scope would remain broadly similar so does not imply an increase in budget.

Nursing and ancillary staff associated costs should similarly not be affected.

Savings

Mitigations that have been put in place purely as a result of the removal of EGS have a significant cost to them. These will no longer be required. As an example, the cost of private ambulances to transport patients from SWAH to AHH costs £0.5m per year.⁸¹ These costs are not once-off – they would repeat every year. These resources should be spent on ensuring that full acute services remain in SWAH.

We also anticipate savings in the premium associated with locums as we move to a more settled workforce.

Revenue

WHSCT had revenue in the last year of £33m.

Increasing revenue must be a key objective for the new Trust.

Revenue-generating opportunities through contracts with customers linked to Elective Care should be able to significantly offset if not outweigh setup costs. This revenue stream would be enhanced in the longer term as a result of enhancing capacity through increased theatre usage and additional specialties linked to the Plan.

Better equipped and fully functioning hospitals in the new Trust will offer services to other hospitals in NI thereby freeing up their badly needed capacity and reducing the pressure on them.

Additionally, SWAH's location bordering the Republic is ideal for attracting elective and other treatments which raise external revenue. Sligo, Cavan, and Monaghan have their own health-related constraints and would welcome alternative options.

⁸⁰ NHS England - 2015 - Advisory Committee on Resource Allocation - Unavoidable Smallness Due to Remoteness: Identifying Remote Hospitals <https://www.england.nhs.uk/wp-content/uploads/2016/04/acra-2015-24b-identfy-remote-sites-upd.pdf>

⁸¹ Impartial Reporter – 21st Jan 2023 - Western Trust spends almost £35,000 on patients' transfer costs - HYPERLINK "<https://www.impartialreporter.com/news/23262940.western-trust-spends-almost-35-000-patients-transfer-costs/>

⁸¹ BBC " <https://www.impartialreporter.com/news/23262940.western-trust-spends-almost-35-000-patients-transfer-costs/> ⁸¹

Capital Investment

Capital investment to enable maximum usage of facilities, particularly around the commissioning of theatres, will need to be built into the Plan. We refer again as example to Daisy Hill and the £20m capital development plan being progressed to enable facilities for their elective overnight centre.⁸² It is entirely appropriate that capital investment is freed up to enable maximum use of hospital capacity in NI as part of Transformation. It is also clear that SWAH – with its available capacity – is extremely advantageously placed based on the fact that it is a fully equipped modern state-of-the-art acute hospital.

It is known that CAWT has invested significantly in bariatric equipment and that this is in place in SWAH. It is imperative that this is built upon and SWAH can become the premier location in all of Ireland for bariatric surgery.

Workforce

Costs relating to workforce should not be significantly affected. The major change will be in the increased value for this cost which is returned by a settled workforce. Workforce has been identified by WHSCT as a barrier to enabling EGS to be restored. SOAS agrees that there are significant workforce issues that are specific to the Southern sector of WHSCT. These have been developed on in the previous section and identified as related to failures of senior WHSCT management.

The creation of a new Trust with its own local Board of Directors and new senior management is essential to enable staff to work in a settled workplace that respects and values them.

5.5 Creating a new Trust – working successfully

There is significant untapped potential in the Southern sector – in relation to both staff and infrastructure.

New management can focus on key opportunities to help in ensuring success:

- Utilise all 5 theatres fully
- Introduce new specialities
- Maximise recruitment and retention through initiatives such as Recruitment & Retention Premium⁸³
- Develop elective care capability using consultants based in the new Trust
- Restoration of EGS enabling timely access to urgent & emergency care
- Develop substantial cross border co-operation (CAWT and SEUPB)
- Enhance revenue-generating potential – including cross-border
- Introduce real clinical leadership
- Meaningful oversight of consultant activity and theatre usage

[BBC News – 7th Nov 2022 - Daisy Hill hospital will not have MRI scanner until at least 2028](https://www.bbc.co.uk/news/uk-northern-ireland-63520209)
<https://www.bbc.co.uk/news/uk-northern-ireland-63520209>

⁸³ Consultant Terms and Conditions of Service (Northern Ireland) 2004 <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/consultants-terms-2013.pdf>

- Improve NIMDTA allocation of doctors
- Secure funding through 'Unavoidable Smallness due to Remoteness' (NHS England policy)⁸⁴
- Redirect costs associated with mitigations to new Trust operations

One of the main benefits of a new Trust will be seen in genuine local accountability. Local management having a hands-on genuine approach will see real improvements in productivity as morale improves. It should be remembered that under the mandate of WHSCT, there has been an absence of professional management in the Southern sector. It is hard to underestimate the contribution an effective Chief Executive would make to the running of our hospitals.

WHSCT is already broken into 2 sectors with first line managers already responsible for areas that would broadly align with the new Trust.

The boundaries of the Southern sector will align closely with the local FODC council area who will be one of the key stakeholders liaising with the new Trust.

Co-production is an essential element of the Transformation process. Patients, carers and staff will have real input to all changes.

The natural background of the Lakelands area and the Sperrin mountains are a real attraction to families thinking of settling here for the long term.

We know of a number of former consultants who would genuinely consider returning to the Southern sector if workplace difficulties are resolved.

5.6 Creating a new Trust – support of the public

It is vital that any alternative viable plan presented to WSHCT should have the support of the local population.

The SOAS 5-Point Plan has been presented to the public in Fermanagh and South Tyrone.

30,105 members of the public have submitted their Consultation Response stating that they support the SOAS 5-Point Plan as an alternative proposal to the temporary suspension of Emergency General Surgery Services at SWAH.⁸⁵

This is an overwhelming show of support from the public.

⁸⁴ NHS England - 2015 - Advisory Committee on Resource Allocation - Unavoidable Smallness Due To Remoteness: Identifying Remote Hospitals <https://www.england.nhs.uk/wp-content/uploads/2016/04/acra-2015-24b-identfy-remote-sites-upd.pdf>

⁸⁵ Belfast Telegraph – 5th Apr 2023 - Call for inquiry into SWAH consultation as pressure group delivers 30,000 letters of support for alternative plan <https://www.belfasttelegraph.co.uk/news/health/call-for-inquiry-into-swah-consultation-as-pressure-group-delivers-30000-letters-of-support-for-alternative-plan/579496706.html>

SOAS were exceptionally afforded a full Special Council meeting to present to local councillors on 21st February 2023.⁸⁶

Fermanagh Omagh District Council (FODC) formally expressed its support for the SOAS 5-Point Plan at its full Council meeting on 5th April 2023. FODC has undertaken to make representations to WHSCT and DoH about this.

5.7 In conclusion

Mr Guckian has stated about SWAH recently “we are where we are”.⁸⁷
We, however, feel this is not where we should be and definitely not where we are willing to stay.

Fermanagh has a uniqueness that simply has not been respected or planned appropriately for. Our community was deemed to need an acute hospital and that most certainly remains the case. We are aware that our disperse rurality is neither understood nor served by an Altnagelvin based management and their agenda.

Whilst we can clearly realise the regional drive to reconfigure it must not be at the expense of avoidable deaths for our population. We are a special cohort within the province. Our geography determines that we must have a hospital delivering urgent and emergency care. We can also contribute positively to reducing waiting lists and to the overall health of all citizens in NI.

Take patient safety seriously.

Invest in people.

83,343 lives matter.

⁸⁶ FODC - To receive representatives from Save Our Acute Services (SOAS) regarding the current consultation proposals for South West Acute Hospital and wider concerns regarding current service provision at the Hospital
<https://www.decisiontime.online/face/getDocument/cadc4ab0d9f4ea28149304fbe71b0cd73d235dee/973413/pdf>

⁸⁷ WHSCT Online Consultation Event – March 2023
<https://twitter.com/saveourswah/status/1642275203618054150?s=20>

GLOSSARY

AAH	Altnagelvin Area Hospital (Northern Sector WHSCT)
CAH	Craigavon Area Hospital
DoH	Department of Health
ED	Emergency Department
EGS	Emergency General Surgery
FODC	Fermanagh Omagh District Council
FOI	Freedom of Information
HSCB	Health & Social Care Board
HSCT	Health & Social Care Trust
MTTT	Major Trauma Triage Tool
NIMDTA	Northern Ireland Medical and Dental Training Agency
OHOM	Our Hearts Our Minds
OHGCC	Omagh Hospital Primary Care Centre
RCOG	Royal College of Obstetrics & Gynaecology
RCS	Royal College of Surgeons
SEHSCT	South Eastern Health & Social Care Trust
SOAS	Save Our Acute Services
SWAH	South West Acute Hospital, Enniskillen (Southern Sector WHSCT)
UU	Ulster University
WHSCT	Western Health & Social Care Trust