Introduction

What is General Surgery?

1. General surgery is a wide ranging specialty with many subspecialties. As one of the largest surgical specialties in the UK, general surgery plays a key role in the provision of elective and emergency surgery. As such, a sustainable general surgery service is a key element of delivering planned and unscheduled care in acute hospitals.

2. There have been major changes in general surgery over the last two decades with training becoming much more subspecialised and focused (e.g. colorectal surgeon, upper GI surgeon).

3. A significant number of elective procedures are carried out by general surgeons (e.g. gall bladder and hernia surgery). However, with subspecialisation, nearly every surgeon has a specific area of interest in their elective practice (colorectal surgery, upper gastrointestinal surgery, endocrine surgery etc). Some general surgeons provide regional specialised surgery (e.g. oesophagogastric cancer surgery, hepatobiliary and pancreatic surgery, transplantation).

4. Emergency general surgery concerns the treatment of patients presenting with acute abdominal pain, infections, bleeding, trauma etc. It covers seven simultaneous areas of care: undertaking emergency operations at any time, day or night; providing assessment and management of patients presenting with an acute surgical problem; providing ongoing care to patients who have had an operation and to other patients in the hospital (including 'non-surgical' patients who suddenly become unwell); undertaking further 'rescue' operations for complications in patients who have recently undergone surgery whether following initial planned (elective) operations or after emergency surgery; providing assessment and advice for patients referred from other areas of the hospital, other hospitals in the network and from their GP; providing early and effective acute pain management and supervising out-of-hours palliative care; and communicating with patients and their relatives[1].

5. The changing landscape of subspecialisation and modern intervention has led to a greater multidisciplinary management of patients with surgical pathology. There is greater dependency on interventional radiology, 24 hour imaging, gastroenterology, anaesthesia, critical care, allied health professionals and clinical nurse specialists. The management of some acute conditions has moved away from the option of a major operation to radiological insertion of drains or stents (e.g. tube cholecystostomy, perforated colon abscess drain).

6. Gastrointestinal bleeding management, which historically was a surgical condition, is now the domain of gastroenterologists on bleeding rotas in some centres. Such

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[1] Emergency General Surgery.pdf

advanced therapeutic endoscopic interventions, and the number of procedures required, have made it difficult for surgeons in training and consultants in practice to keep skilled in the same way as gastroenterologists have.

7. Vascular and breast surgery were once the domain of the general surgeon but both specialties have formed their own specialty advisory committees (SACs). In many centres throughout the UK such specialties no longer take part in the unscheduled emergency general surgical take. In practice, changes such as this reduce significantly the staffing resources available to cover a 24 hr service for non-elective surgery.

Policy Context

8. In 2016, The Bengoa Report[2], *'Systems Not Structures'* recognised that there is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes. Continuing to invest large sums of money in trying to keep unsustainable services in place will only serve to delay their collapse and represents a significant opportunity cost to reforms elsewhere in the system. More importantly, it is also contributing to variation in terms of the quality of care received by those using services in different Trust areas.

9. In October 2016 the former Health Minister, Michelle O'Neill MLA, launched *'Health and Wellbeing 2026: Delivering Together'*, which seeks to radically reform the way health and social care services are designed and delivered in Northern Ireland, with a focus on person-centred care, rather than on buildings and structures. It is aligned with the aspirations set out within the Northern Ireland Executive's draft Programme for Government, and aims to improve the health of our people, improve the quality and experience of care, ensure the sustainability of our services, and to support and empower staff; but also recognises the challenges that need to be overcome if this is to be achieved.

10. *Health and Wellbeing 2026: Delivering Together* remains the overarching strategy by which the Department continues to reform. Decisions on the nature and approach to service changes and the wider rebuilding of services will be considered in adherence to the overarching principles of Delivering Together and will take place in the context of this broader strategic approach.

Change or Withdrawal of Services

11. The Department has set out the roles and responsibilities of the different organisations in relation to the Change or Withdrawal of Services[3]. The Guidance

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[2] Systems, Not Structures - Changing Health and Social Care - Full Report | Department of Health (health-ni.gov.uk)
[3] change-or-withdrawal-of-services–guidance-on-roles-and-responsibilities.pdf (health-ni.gov.uk)

sets out that HSC bodies should aim to provide a minimum consultation period in accordance with their equality and consultation schemes, including allowing adequate time for groups to consult among themselves as part of the process of forming a view.

12. The guidance also sets out the following exceptional situations in which such timescales may not be feasible:

    a. Changes (either permanent or temporary) which must be implemented immediately to protect public health and/or safety;
    b. Changes (either permanent or temporary) which must be implemented urgently to comply with a court judgement, or legislative obligations.

13. The criteria for the change and withdrawal of services are set out at Annex A.

The Review of General Surgery NI

14. The Department is overseeing a clinically led review of general surgery in Northern Ireland. The overriding aim of the review is to develop a regionally agreed service model for general surgery services across Northern Ireland. The new model should improve the overall sustainability of the service whilst ensuring patient safety and access to high quality services irrespective of postcode. Within this overall aim, the review will consider:

    - The most effective model for the delivery of scheduled care, taking into account; quality, standardisation, productivity and specialism;
    - The development of a regional service model for emergency surgery, taking into account; safety, access, sustainability and specialism; and
    - The optimal service model for the delivery of elective and emergency general surgery of childhood across Northern Ireland.

15. The review is underpinned by the following principles:

    - Consistency in quality and standards of care at all times in all places
    - Deliver financially and clinically sustainable solutions in the short, medium and longer term
    - Evidence based decision making with clear methodology for gathering performance/clinical outcomes data
    - Safe staffing levels with appropriate skills mix and sustainable rotas
    - Appropriate facilities and support services
    - Clinical and Senior Executive Leadership with defined governance structures

16. One of the early objectives of the review was the development of an interim plan on emergency surgery stabilisation by October 2021 to address and mitigate current pressures, for consideration by the Minister.

The Burning Platform for Stabilisation of Emergency General Surgery

17. There are a number of significant challenges to the delivery of Emergency General Surgery across multiple sites and these are described below.

Workforce Challenges

18. Many general surgeons have specialised their practice in order to concentrate on treating particular conditions (e.g. breast, upper or lower gastrointestinal surgery). While this has resulted in improved outcomes for patients requiring planned specialist intervention, it has also created difficulties in having an appropriately trained and available surgical workforce for the treatment and management of emergency patients. Changes to the ISCP (intercollegiate surgical curriculum programme) and the CCT (certificate of completion of training) have led to newly appointed consultants being less exposed to the generality of surgery, particularly in areas out with their specialised training.

19. Delivering Emergency General Surgery across multiple sites is becoming increasingly difficult in terms of rotas, succession planning, skill mix, supporting services and disciplines, best practice and maintaining equality of service. There are specific issues relating to the requirement to maintain multiple 24/7 rotas for emergency surgery for adults and children, and the difficulties this creates in terms of staffing and meeting professionally mandated standards of care. This is not unique to the smaller hospital sites and even larger sites are experiencing difficulties maintaining rotas. Adding to the strain, there are other specialties/areas that often require input from emergency general surgery such as gynaecology, gastroenterology and emergency medicine.

20. The immense challenge of recruiting and retaining staff results in heavy reliance on expensive locum and agency staff. The inconsistency brought about by use of such staff, along with difficulties in continuity of patient care, further exacerbate the difficulty of attracting new substantive appointments. The financial cost of meeting the locum or agency fees places a further burden on the service.

21. Trainees declare a subspecialist interest towards the end of their training and there have been a reduction in surgical training hours. As a result they are less experienced in managing surgical emergencies out with their chosen subspecialty. Therefore, for a newly appointed consultant it is important to be part of a cohesive surgical unit with good support and mentoring.

22. Fragmentation of the workforce is also an issue. Despite many attempts to break down silos, the workforce is still fragmented by organisational and professional boundaries. In the past decade, there have been numerous examples of one Trust recruiting to fill vacancies, only for the successful candidate to come from a

neighbouring Trust, thereby creating another vacancy in the service. In practice, this simply serves to move the problem around Northern Ireland, rather than offering any additional capacity. In future, there needs to be a greater level of regional planning in terms of the available workforce and recruitment to such posts. The move to a single HSC employer as described in the Health & Social Care Workforce Strategy 2026 will be a key enabler for these changes.

Separation of Scheduled and Unscheduled Care

23. The nature of the most complex elective surgery means that it can never be separated entirely from unscheduled care services because of its need to be closely aligned with other specialist services such as critical care. However, for the less complex surgery to be as efficient as possible, there is a strong case for attempting to insulate it from unscheduled care pressures. Before a surgical procedure can be carried out, a range of resources have to be brought together at the right time and the right place: surgical staff, nursing staff, anaesthetic staff, theatre time, beds. Remove any one of these components and the operation has to be cancelled. Where the same staff and resources are required to be available for both emergency and elective care, emergency treatment will always come first and will inevitably result in cancellation of elective.

24. Locally, nationally, and internationally, there are multiple working examples of how efficiently elective care can be provided where there is no competition from unscheduled pressures.

25. In the Covid-19 environment the benefits of separating elective and unscheduled care for infection control purposes are even starker. The Elective Care Framework published by Minister in June 2021 outlines a series of actions to expand the implementation of ‘green pathways.’ Green pathways strive to protect staff and patients from the potential risk of catching Covid-19. Strategies include a separate hospital or clinical area remote from patients with Covid-19, shielding of patients for three days before being admitted for surgery, negative Covid PCR test before admission, regular testing of staff and cancellation of any potentially infected patients. Examples of green pathways and sites such as the Day Procedure Centre in Lagan Valley Hospital (LVH) are already demonstrating benefits for the wider system. While other sites have had to downturn elective cases throughout each surge period, the Day Procedure Centre at LVH has continued to provide a range of priority surgical and diagnostic procedures for the region.

Lack of appropriate Infrastructure

26. Some of the smaller hospitals sites that are currently providing emergency general surgery may not have the supporting infrastructure to continue to provide this on a sustainable basis. For example, lack of access to 24/7 emergency CEPOD theatres, a lack of critical care capacity, no access to MRIs and other diagnostics (particularly out of hours) often means that patients require transfer to larger

hospital sites pre or post-surgery to meet their clinical needs. Such transfers to and from the larger site leads to further demand on NIAS and associated support services. Delays in carrying out such activity may have an impact on the care delivered to the patient and the clinical outcomes.

27. On some of the larger hospital sites the delivery of emergency general surgery is also constrained by the available infrastructure – lack of beds, competition for emergency theatres, pressures of other specialties' clinical requirements (e.g. fractures, acute medicine, ward space and office accommodation). Appropriate reconfiguration of services and investment in infrastructure is required to optimise the space available for the delivery of a high quality emergency general surgery service.

Variation in Care

28. Many of the burning issues described above result in a lack of consistency of care leading to variations in patient outcomes.

29. We must ensure the specialty is equipped to deliver an equitable, sustainable, and high-quality service for every adult and child in Northern Ireland irrespective of postcode.

Increasing demands for service

30. Overall, demand for hospital based services is increasing and this is influenced by demographic changes, particularly an aged population with more chronic health problems and complex health needs. In simple terms, the longer we live, the more likely we are to require hospital treatment at some point in our lives. Demand for care has been outstripping the ability of the system to meet it for many years. This trend will increase in the years ahead and will only be addressed by action to increase capacity, promote healthier lifestyles and tackle health inequalities.

31. Pre Covid-19 there was already a significant shortfall in the capacity of the HSC in Northern Ireland to meet the demand for elective care services and this was reflected in the unacceptably long waiting times.

32. The spread of coronavirus has caused serious disruption to our Health and Social Care system and it was unavoidable that elective care activity would reduce due to the need to redeploy staff to address rising unscheduled demand. Unfortunately, our elective waiting times will be even worse after Covid-19. Waiting lists are now at a level where they will take years to stabilise and even longer to return to their pre-2015 levels.

33. At the same time, our urgent and emergency services are continuing to face significant pressures and the number of acutely ill patients presenting to Emergency Departments, and likely to require admission, is also increasing. All too often, the result of these pressures is that planned elective procedures, or

surgery, are cancelled because hospital theatres, beds or staff are needed for urgent and emergency cases. The increasing waiting lists are also placing a burden on ED departments as patients on the long lists present with complications relating to the condition that they are waiting surgery for (e.g. recurring acute cholecystitis waiting for gallbladder surgery).

Why do we need to Change?

34. For all of the reasons listed above, the current model for delivering general surgery in Northern Ireland is neither sustainable nor equitable. With trends towards increased specialisation and increased demand for services, it is expected that services will come under greater pressure and, as a result, variation in practice and outcome will continue.

35. In addition to issues around sustainability, the current approach is inefficient. As highlighted above, stretching staff resources to maintain emergency surgery on too many sites leads to an overreliance on locums, increased pressure on small teams, short term decision making, and services vulnerable to collapse at short notice (which puts further pressure on neighbouring services). This inefficiency is also seen in relation to elective care. Where elective and emergency surgery are delivered on the same site, particularly where a site does not have a sustainable service, elective services will continue to be subordinate to emergency requirements.

36. Evidence would suggest that there are benefits to focusing resources on specialist sites. For example:

- Patients are seen in the right place and by the right person as soon as possible. Evidence shows that having all the services available on the same site improves the care delivered to the patient and the clinical outcomes;
- Staff have the necessary support and equipment to allow them to deliver the highest quality care to patients;
- It is possible to attract and recruit sufficient staff to deliver a safe, high quality, 24/7 service;
- The services are more stable and there is a better environment for patients and staff; There are the right conditions for professional development, quality improvement, leadership, teaching and other activities that are essential to a vibrant workforce expert in delivering care to acutely unwell patients;
- There is capacity for research and a greater ability to engage with academia and industry in generating new solutions and accelerating testing, adoption and introduction of existing solutions; and,
- This achieves the Triple Aim of better population health, better quality care and better use of resources[4]

[4] Systems, not structures - Changing health and social care - Full Report (health-ni.gov.uk)

37. It is also clear that any changes to the regional service model will need to be carefully planned as they may have implications for other services in hospitals. The availability of, or access to, 24/7 surgical services is a key aspect of the safe provision of acute adult and paediatric services. While this underlines the importance of sustainable general surgery teams at District General Hospitals, 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.

38. Under the current model, where it is not possible to maintain safe rotas 24/7 for general surgery, this has the potential to affect the profile of services being provided on specific sites. As we develop the future model for general surgery, it is essential that we learn from the experience of reforms in other areas in terms of how other non-surgical acute services can be retained, and also with regard to the potential benefits of change such as the identification of sites that would become, for example, specialist elective sites supported by general surgery in hours but without on-site support 24/7.

Current Provision

39. The General Surgery unscheduled workstream review team has visited each of the acute hospital sites in Northern Ireland to gather information on the environment for the delivery of emergency general surgery, any immediate stabilisation issues and short-long term challenges and opportunities. The position in each hospital site, as described by the resident clinical teams is set out below.

40. Emergency General Surgery is currently provided across the following sites.

Belfast Trust - Royal Victoria Hospital (RVH)

- In the Belfast Trust emergency general surgery is provided at the Royal Victoria Hospital Emergency Surgical Unit (EMSU). It has a well-staffed consultant rota (19 consultants) that is supported by two tiers of junior doctors (specialist registrar rota and a F2/CT rota).
- RVH has approximately 300 emergency admissions per month and takes a significant number of transfers from other Trusts. The General Surgical service is part of the major trauma service for the region.
- RVH has a surgical ambulatory clinic (hot clinic) that takes referrals from GP and A&E. The clinic triages the patient to determine the most appropriate care. Intervention at this clinic includes senior consultation, diagnostics, return to GP, admission to the EMSU, admission to another speciality (e.g. urology) or discharge.

- There is a subspecialist emergency ‘surgeon of the week’ rota in which patients are triaged to either the colorectal team or the upper GI team on a daily basis.

- All GI bleeding is looked after by the gastroenterologists on a separate bleeding rota. Surgical intervention is provided on request

South Eastern Trust - Ulster Hospital

- The Ulster Hospital provides emergency general surgery for SE Trust with elective day procedures carried out at Downe and Lagan Valley Hospitals. It has 11 general surgeons with a surgeon of the week model with 2 surgeons (1 day/1 night) that is supported by two tiers of junior doctors (specialist registrar rota and a F2/CT rota).

- It has 72 beds for unscheduled general surgery and urology. A new Acute Services Block will be ready in November 2021 providing a 24 bed surgical assessment unit to be used by general surgery and urology (subject to funding and staffing). The Ulster utilises hot clinics, a surgical hub and ambulatory pathways are in place.

- The Ulster has approximately 300 emergency admissions per month. The variance with the Belfast Trust is that the SET surgeons still care for patients with head injuries and children over 13 years requiring acute appendicectomy. Given the number of consultants on the rota, subspecialisation is not formally adopted, but surgeons with either a colorectal or upper GI interest are available for advice and surgical support.

- It is the view of the Review team that there are no short-medium term stabilisation issues in South Eastern Trust.

Southern Trust - Craigavon Area Hospital, Daisy Hill Hospital

- In the Southern Trust, emergency general surgery is provided on both the Craigavon and Daisy Hill sites. Craigavon has approximately 250-300 emergency admissions per month with approximately 140-170 in Daisy Hill. Craigavon has 72 shared beds and 18 elective beds. Daisy Hill has currently 23 beds and 12 shared elective beds.

- Craigavon has a 1:9 on call rota. It is funded for 9 consultants and 8 are in post and the shortfall is made up with the use of internal locums. Daisy Hill has a 1:6 on call rota. It is funded for 6 consultants with 4 in post, made up of 2 substantive consultants and 2 long term locums. To ensure future sustainability, additional posts are required at Daisy Hill. Several attempts to recruit to substantive consultant posts have been unsuccessful. To ensure stabilisation of the Consultant Surgeon rota in Daisy Hill, all of the vacant posts would need to be filled.

- Daisy Hill has no level 3 critical care capacity and no MRI scanner. An electrical upgrade is required at the site. Transfer of patients who require post-op critical care capacity requires the anaesthetic team to accompany them to Craigavon and this effectively blocks the theatre capacity at DHH until the team returns.

- Both sites currently deliver a blended case mix of ‘general surgery and other areas such as head injury, trauma, spinal trauma etc.

- It is the view of the Review team that there are short-medium term issues with the sustainability of emergency general surgery on the Daisy Hill site aligned with the consultant rota and reliance on locums and limited critical care cover.

Northern Trust - Antrim Area Hospital, Causeway Hospital

- Emergency general surgery in the Northern Trust is delivered at Antrim Hospital and Causeway Hospital. Causeway has a full complement of six emergency general surgeons in post although there are concerns that sustainability of this service may be more challenging in the longer term. Antrim has eight substantive consultant posts with seven posts substantively filled. The vacancy created by a recent retirement is covered by a locum. General surgery rota in Antrim is 1 in 9 with the ninth slot filled by a long term locum.

- Antrim has a small bed stock and requires investment in infrastructure to increase capacity. The pressures of maintaining emergency surgery at Antrim are leading to loss of elective capacity.

- Causeway deals with a range of cases that are not ‘true’ general surgery such as urology and fractures. It does not have an MRI and there is limited interventional radiology and gastroenterology but support arrangements are in place with Antrim.

- Antrim has approximately 312 emergency admissions per month and Causeway has approximately 180.

- It is the view of the Review team that there are short-medium term issues with the sustainability of emergency general surgery and its interface with elective surgery on the Northern Trust sites. Creating capacity at Antrim Hospital will be a driver for change.

Western Trust - South West Acute Hospital, Altnagelvin Hospital

- In the Western Trust, emergency general surgery is currently provided at Altnagelvin and the South West Acute Hospital (SWAH).

- Altnagelvin has approximately 300 emergency admissions per month. SWAH has approximately 160. Altnagelvin has 2 surgical wards with 52 beds shared with all specialties and approximately 28 emergency general surgery beds.

SWAH has 24 elective beds and 18 emergency beds Mon – Friday and 12 Saturday-Sunday.

- Altnagelvin has 8 consultants on the rota with a 1 in 8 on-call rota. However, it must be noted that three of the surgeons are primarily breast surgeons and one a vascular surgeon with a benign vascular practice. Over time it is unlikely that newly appointed breast and vascular surgeons will be trained to cover emergency general surgery rotas. This will mean that the stability of the general surgical rota could be at a medium to long term risk.

- SWAH has three substantive posts as of the end of October 2021 and the requirement for locums to complete a 1 in 6 rota. There has been a period of change with the retirement of senior surgical consultants and the appointment of one to Altnagelvin. In the last 6 months two new colleagues have joined the team (one in October). Attempts are being made to fill the vacancies but previous experience suggests that recruitment and retention of suitable candidates may prove difficult, similar to other DGHs. Agency locum cover is not considered a viable long-term option for continuity of care and patient safety. The resident team did highlight that at times only one consultant is present on site. Given the consultant profile at present, senior mentorship and support may be difficult to achieve.

- At SWAH the continuity of care was raised as locums are required for the rota. Whilst a large component of such staff have come from Altnagelvin, the continuity of care of the patients falls to the resident team which was two up until recent weeks.

- SWAH has level 3 critical care capacity and has an MRI scanner which is operational 6 days per week with some evening and weekend cover.

- There is a small number of gastroenterologists on site (two) and no interventional radiology availability, particularly out of hours. A number of clinical scenarios were discussed that demonstrated difficulties in the management of patients. It was difficult to appreciate a defined pathway to Altnagelvin for interventional radiology, gastroenterology or other surgical specialty support.

- The review team were concerned that the lack of on-site support for the surgical team could have a detrimental effect on surgeon wellbeing.

- Both sites currently deliver a blended case mix of ‘true’ general surgery and others areas such as head injury, trauma, spinal trauma etc.

- Following the engagement with the clinical team at SWAH, it is the view of the Review team that there are sustainability issues associated with the provision of emergency general surgery at SWAH given the number of substantive consultants in post. The WHSCT has since advised of the appointment of an additional consultant at SWAH and has a rota in place until the end of the year. Longer term sustainability remains an issue however given the limited support on site for the surgical team.

The meeting with the clinical team at SWAH also indicated safety issues. These issues have been responded to by the Chief Executive and assurance as to the current service provision have been provided to HSCB.

- The Trust has established a formal project structure to Review General Surgery across the Western Trust, which is up and running.

Paediatrics

41. Major trauma cases involving children who require surgery are brought to the Royal Belfast Hospital for Sick Children (RBHSC) on a case by case basis, unless the condition is time critical or so severe that it necessitates immediate surgery in a DGH. Cases that are time critical, such as testicular torsion; and general surgery of childhood, such as emergency appendectomy, should be performed in the DGH.

42. While some emergency surgery is undertaken at DGHs, feedback from the Trusts indicates that in some areas adult general surgeons are becoming increasingly reluctant to perform emergency surgery for children, particularly within younger age groups. This is due to concerns around appropriate training and skills set, particularly in the area of fluid management.

43. Access to support from both the RBHSC and local paediatricians is key to the safe delivery of paediatric services at a local level.

44. The upper age limit for paediatric care varies between hospitals and the need for age appropriate care settings was raised by Trusts and will be considered as part of the longer term review. All children under 5 requiring surgery should be transferred to RBHSC.

45. At this point in the year we are already seeing the impact of the number of cases of Respiratory Syncytial Virus (RSV) on capacity at RBHSC. As cases rise over the forthcoming winter months, support from the DGHs via a networked model will be essential to the sustainable provision of paediatric surgery.

46. Specific proposals on paediatric general surgery stabilisation are dealt with in a separate paper.

Stabilisation Proposals

47. On the basis of the engagement and site visits, the Review team has identified three Trusts with short-medium term adult emergency general surgery stabilisation issues - Western Trust, Northern Trust and Southern Trust. The Review Team has shared its findings with each of these Trusts and proposed that each Trust develop plans in line with established policy and process. The pace at which these plans are developed should be informed by the timing of the stabilisation issues at each site.

48. In the course of the work it has become clear that each Trust is currently considering these issues at a local level, although plans are at different stages in each Trust.

49. Where services are vulnerable, it is the view of the Review Team that contingency plans must be in place should the service collapse in an unplanned way before Trust plans are developed, consulted upon and implemented.

Western Trust

50. It is the view of the Review Team that there are concerns about the sustainability of the consultant on-call rota in the SWAH. Over reliance on locums and lack of on-site support for the surgical team may have a negative impact on patient care and safety. The Trust has established a General Surgery Review project to address safety and sustainability issues identified by the Regional Review. This Review involves contribution from HSCB and Northern and Southern Trusts, and will inform short-medium term decisions on the service which will be appropriately consulted on in line with DoH, HSCB and Trust requirements.

51. It is the view of the review team that discussions and potential solutions should include the Southern Trust, given the geographical area that the SWAH covers. Discussions should also take place with NIAS to consider the impact on capacity and the impact of additional journey times.

Southern Trust

52. In the Southern Trust, there are advanced discussions on the future configuration of emergency and elective general surgery. There is an enhanced relationship between the clinicians on the two sites. Clinicians and managers are currently considering options for a configuration of surgical services that will provide a sustainable, equitable and high quality service to the local population for planned and unplanned surgery. While the Trust has not yet developed final proposals, it is likely that a sustainable model would require changes to the service profile of both main hospital sites.

53. The Trust is also working with the region to explore the potential of a Paediatric hub and spoke model at Daisy Hill.

54. There has been a great deal of planning and engagement already undertaken at a local level by the Trust; however, there remains work to carry out further staff and public engagement. The Trust has indicated that it will be early 2022 before this is deliverable and it is the view of the Review Team that the Southern Trust continues to move forward at pace with these proposals following due process. The review team also highlighted that the Southern Trust should engage with the Western Trust in relation to the SWAH and its plans. Discussions should also take place with NIAS to consider the impact on capacity and the impact of additional journey times.

Northern Trust

55. Long term sustainability of the delivery of emergency and elective general surgery across both sites is a concern for the Trust and it is currently considering options for future sustainable delivery. It is the view of the Review team that there would be advantages in moving towards a single centre for unscheduled care within the Trust with a single on-call consultant rota. A prerequisite to this consolidation would be the urgent need to create bed and theatre capacity at the Antrim site. The Review Team will provide support to the Northern Trust as appropriate as it develops its proposals.

Longer term stabilisation – Emergency & Elective Surgery

56. In line with its Terms of Reference, the review will now turn its attention to the development of a long term regional service model for emergency and elective surgery, taking into account safety, access, sustainability and specialism.

57. The Review will develop local and regional pathways and a sustainable, networked approach for the long term delivery of high quality emergency surgery, in and out of hours, and for the long term delivery of high quality elective surgery. It will ensure alignment with relevant interfaces and involvement of stakeholders including staff, service users and carers.

58. It will consider the most appropriate models of care and assess multi-disciplinary workforce considerations, including consideration of staffing levels, skills mix and training.

59. The Review will be underpinned by a comprehensive demand/capacity exercise and will develop and monitor quality and performance metrics, benchmarking against best practice in other parts of the UK.

60. The emerging proposals, pathways and models will be subject to consideration by the Minister and public consultation.

Annex A

Criteria for Reconfiguring HSC Services

Criterion 1:
There is evidence that the outcomes for people using HSC services are below standards recognised by the Department of Health, or statutory requirements are not met, or safety concerns are evident and impact on the long term sustainability of services.

Criterion 2: There are clear pathways for the patient and client population at local and region wide levels.

Criterion 3: The service cannot meet professional standards or minimum volumes of activity, as recognised by the Department of Health, that are needed to maintain expertise.

Criterion 4: The workforce required to safely and sustainably deliver the service is not available/cannot be recruited, developed or retained, or can only be secured with high levels of agency/locum staff.

Criterion 5: There are effective alternative care models as recognised by the Department of Health in place.

Criterion 6: The delivery of the service to the required standard is costing significantly more than that of peers, or of alternative models, due to a combination of the above factors.