The Regulation and Quality Improvement Authority

Review of the Pathways Associated with the Temporary Suspension of Emergency General Surgery at South West Acute Hospital (SWAH)

October 2024

Contents

Section 1: The Regulation and Quality Improvement Authority

1.1 Role of RQIA and Legislative Remit

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA was established under the Health and Personal Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[1]. RQIA has at its core duty to keep the Department of Health (DoH) informed about the quality and access to health and social care services in Northern Ireland. This duty is fulfilled by registering and inspecting services that are required to register with RQIA under the 2003 Order legislation, and by carrying out Reviews, Investigations and Inspections of services provided, or commissioned, by HSC Trusts and other bodies set out in the legislation. RQIA Reviews identify best practice, highlight gaps or shortfalls in services identifying areas or issues requiring improvement and in doing so encourage service quality improvement. RQIA Reviews are supported by a core team of staff from within RQIA and by drawing in the knowledge and expertise of a number of independent Expert Review Team (ERT) members, who may be experienced practitioners or experts by experience. Our Review reports are submitted to the Department of Health to inform the Minister for Health and are published, available on our website at www.rqia.org.uk.

RQIA is committed to conducting Reviews, Investigations and Inspections, taking into consideration our four key domains:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

RQIA will assess the pathways, bearing in mind the Quality Standards for Health and Social Care (March 2006)[2]. These are the minimum standards expected for HSC Services provided by the HSC Trusts. They set out five Quality Themes including effective governance and oversight of services. Reviews may be undertaken by RQIA under its own initiative, based on an assessment of intelligence we may receive and through engagement with stakeholders. The RQIA may also be commissioned or directed by the DoH to undertake a Review of an issue or service.

1.2 Membership of the Expert Review Team (ERT)

Dr Paul Kerr

Dr Kerr retired in December 2023. He was previously a Consultant in Emergency Medicine in the Southern Trust from 1999 and was Clinical Director when left to take up a post in the Royal Victoria Hospital in Belfast Trust from 2016- 2023.

Dr Kerr was Deputy Head of the School of Emergency Medicine for the Northern Ireland Medical and Dental Training Agency from 2010 -2017, and also the Vice President of the Royal College of Emergency Medicine and Regional Lead for Northern Ireland from 2020-2023. Dr Kerr was a Clinical Expert, on the Task and Finish group, to review Urgent and Emergency Care services, in Northern Ireland.

Lewis Andrews

Mr Andrews is the current Chief Operating Officer of the College of Paramedics, an organisation based in England. Mr Andrews commenced his current post in July 2022. Mr Andrews is a state registered paramedic who still practices. Prior to taking up his current post, Mr Andrews was the Head of Quality Improvement & Professional standards and was Deputy Clinical Director from 1996-2022.

Mr Andrews has significant experience in multidisciplinary working in specific areas such as mental health, trauma and maternity services. Mr Andrews is an experienced investigator covering areas such as, clinical and professional standards, including, presenting at hearings and chairing hearings and human resource matters.

Mr Andrews has led numerous investigations, including serious incidents, proving evidence at Coroners Court and representing the Ambulance Trust at Coroners Inquests.

Dr Anthony McBrearty

Dr McBrearty is a Consultant in General Surgery with experience in management of the full breadth of general surgery elective and emergency patients. Dr McBrearty is currently a Consultant in General and Laparoscopic Colorectal Surgery working in the South Eastern Trust since 2019. He is a sub-specialist in colorectal surgery, minimally invasive surgery and advanced endoscopic resection for complex benign and malignant disease.

Dr Miriam McCarthy

Dr Miriam McCarthy is a retired public health consultant. Dr McCarthy has previously acted as Senior Medical Officer, Director of Secondary Care, and Deputy Permanent Secretary for the Department of Health. Dr McCarthy is also a previous Director of Commissioning for Northern Ireland, and a Consultant in the Public Health Agency.

Brian O'Hagan

Brian O'Hagan is an independent member of the Department of Health and Transformation Advisory Board, a member of the Inquiries Implementation Programme Management Board, Chair of the Independent Neurology Liaison Group, Co-Chair of the HSC PPI Regional Forum and a member of the HSC Ethics committee. He has worked for over 15 years with service users and carers to strengthen their voice, influence and involvement across the HSC system.

1.3 Membership of the Project Team

Emer Hopkins	Review Director (to April 2024)
Briege Donaghy	Review Director (from April 2024)/Chief Executive
Dr Ian Steele	RQIA Medical Lead and Responsible Officer
Dr Richard Gamble	Project Manager
Lheanna Kent	Project Support Officer
Anne Wilson	Senior Project Manager

Section 2: Review Introduction

The Terms of Reference for this RQIA Review have been developed to review the clinical pathways associated with the temporary suspension of Emergency General Surgery at the South West Acute Hospital (SWAH), with a view to identifying any aspects for improvement.

In November 2022 the Western Health and Social Care Trust (WHSCT) announced the temporary suspension of Emergency General Surgery at SWAH, a decision which was effected on 18 December 2022.

On 22 February 2024, the DoH wrote to RQIA to commission a review of the pathways associated with the temporary suspension of Emergency General Surgery at SWAH.

The DoH directed that RQIA undertake a review of the pathways developed as a result of the temporary suspension of Emergency General Surgery and in making a report of our findings, make recommendations to support improvements in accessibility, quality and safety.

RQIA reviews provide informed expert assessments to the DoH, and to the public, about the quality, safety and availability of health and social care services in Northern Ireland. This Review was conducted under RQIA's statutory functions, as outlined within Article 35 of the Health and Personal Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[3]:

"(c) the function of conducting Reviews of, and making reports on, the management, provision or quality of, or access to or availability of, particular types of health and social care for which statutory bodies or service providers have responsibility."

RQIA Reviews and Inspections must consider the statutory duty on public authorities under Section 75 of the Northern Ireland Act 1998[4] and consider the European Convention on Human Rights[5]. Methodologies adopted will support RQIA's compliance with these obligations.

This review will examine the effectiveness of the pathways that have been developed in mitigating the temporary suspension of emergency surgery services at the SWAH. The review will also inquire into the process for their development and explore patient and staff experience as the pathways have come into effect since December 2022.

2.1 Terms of Reference

1. Assessment of the current pathways, developed in response to the temporary suspension of Emergency General Surgery at the South West Acute Hospital (SWAH). To include:

    - Describe the full range of mitigations and clinical pathways developed by Western Health and Social Care Trust (WHSCT) and Northern Ireland Ambulance Service (NIAS) in response to these changes.

    - To describe the process of development, communication/dissemination, implementation and ongoing review of these clinical pathways (to include engagement with relevant stakeholders).

    - Assess the current effectiveness of these clinical pathways in respect of supporting compliance with relevant clinical guidelines and best practice.

    - Identify any omissions in the mitigations, protocols or pathways developed.

    - Assess the effectiveness of arrangements for monitoring the direct and indirect impact of these pathways on accessibility, quality and safety.

2. To seek the views and experiences of Health and Social Care staff, and service users in respect of the pathways and protocols associated with the temporary suspension of Emergency General Surgery at SWAH.

3. To provide a report on the findings and where relevant, make recommendations to support improvements in accessibility, quality and safety.

4. To escalate any emerging patient safety concerns identified during the course of the review to the WHSCT and the Department of Health.

Scope

- The scope of this review is restricted to examination of the clinical pathways associated with the temporary suspension of Emergency General Surgery, and their direct and indirect impacts.

- The scope may require examination of aspects of primary care, referral routes in and out of hospital, paramedic protocols and available capacity within receiving sites, and in transport services.

Exclusion

- This review will not assess the current pathways related to the provision of Elective Surgery.

2.2 Review methodology

The review considered information received from a range of sources which contributed to the findings within this report.

Information and Reports from the Service

- **RQIA information request to WHSCT**
  RQIA shared its information request with the Trust on 29 March 2024 and a submission was received on 11 April and 31 May 2024. A series of further questions were issued to the Trust on 5 July 2024 with a response received on 2 August 2024.

- **RQIA information request to the Northern Ireland Ambulance Service (NIAS)**
  RQIA shared its information request with NIAS on 29 March 2024 and a submission was received on 11 April 2024. Further questions were issued to the Trust on 5 June 2024 and 14 June 2024; responses were received on 31 July 2024 and 14 and 20 August 2024.

Observation / Site Visits by Review Team

- **Observation and Engagement with WHSCT and NIAS staff at SWAH**
  RQIA review team met with a range of WHSCT and NIAS staff of different roles during a two-day site visit to the SWAH on 4 and 5 of June 2024.

- **Observation and Engagement with WHSCT staff at Altnagelvin Hospital**
  RQIA review team met with a range of WHSCT and NIAS staff of different roles during a one-day site visit to Altnagelvin Hospital on 26 June 2024.

- **Observation and Engagement with NIAS staff at NIAS Control Centre Knockbracken Belfast:**
  A member of the Expert Review Team, along with an RQIA project team member, met with NIAS staff on a site visit to the NIAS Control Centre on 3 June, and a further Review Team visit to NIAS was held 5 June 2024.

Lived Experience

- **Patient and Family Engagement**
  An RQIA project team member, along with one member of the Expert Review Team, met or spoke with patients and family members over a range of days, physically in Enniskillen, on-line or by telephone, completing on 12 August 2024.

- **Care Opinion**
  Care Opinion is a platform available across all Trusts, which allows service users, carers and families to share their experience of health and social care. The review team asked WHSCT to further promote the Care Opinion platform during the review period, to enable service users and others to record their experience. This was promoted by the Trust to patients admitted to Altnagelvin between 26 July 2024 and 12 August 2024.

- **Staff Engagement/ Listening**
  Review project team members, along with one member of Expert Review Team, spoke with a number of staff from across services and organisations, completing by 12 August 2024.

The views and experiences shared by patients, families and staff are reflected throughout this report. The information shared with the review team has been considered alongside the information received and observed during site visits and in combination with the review of documents and data received. All of these elements have been analysed by the review team in developing the review recommendations.

Engagement with Stakeholders

RQIA's Chief Executive (Review Director from April 2024), and on some occasions with attendance of other members of the review team, engaged with a number of community groups, GP Practices and statutory organisations. A list of those stakeholders engaged with is listed in Appendix 1**.**

Relevant Strategy, Policy, Standards and Guidelines

These are referred to throughout the report, where relevant. A full list of reference documents is available in the References section at the end of the report.

2.3 Clinical Pathways, Mitigations and their Development

The WHSCT developed a number of patient pathways which were required to address the temporary changes taking place with emergency general surgery at SWAH, from 18 December 2022. These were tested for a two-week period from 5 December 2022 to 17 December 2022, while the on call rota at SWAH for consultant general surgeons was still in operation.

The Trust consultation document[6] setting out the clinical pathways that would take effect due to the temporary suspension of emergency surgery at the SWAH, refers to the issues experienced by the Trust in securing sufficient substantive consultant general surgeons to reliably sustain an out of hours rota for emergency general surgery at SWAH. The Trust reported this had become increasingly difficult with a rapid reduction in the substantive consultant workforce which occurred late Autumn 2022. The consultation document also referred to the Department of Health Review of General Surgery in Northern Ireland, published in 2022[7] (referred to hereafter as 'The Standards'), noting that SWAH does not meet these standards, and would require "fundamental change in a number of areas to do so".

The review team considered that clinical pathways are a term used to describe how patients move though the health care system, from presentation of symptoms, through assessment, diagnosis, treatment plan and review.

As part of the development of the clinical pathways that were put in place at SWAH, the Trust described how it had engaged with partners in the Southern HSC Trust, NIAS, Sligo General Hospital and the NI Trauma Network to develop and establish these clinical pathways for patients. These agreed pathways were considered by the Trust to be well-defined and clinically based. They set out the list of clinical conditions and circumstances where patients would 'bypass' the SWAH following assessment by NIAS with the patient taken directly to Altnagelvin Hospital. On some occasions the patient may be taken to another acute hospital depending where the location of the incident has occurred. The NIAS crew also consider the NI Trauma Network 'Major Trauma Triage Tool'[8] to determine the hospital destination.

These clinical conditions (and some with age factors also referred to) are referred to hereafter as the 'bypass pathway'.

2.3.1 Bypass Pathway

The following sets out the clinical conditions that fall within the bypass pathway as set out in the Trust Consultation document.

Upper Gastrointestinal (GI) Bleeding (this refers to bleeding from the oesophagus, stomach or duodenum) – Patients with any of the following will bypass SWAH Emergency Department (ED) to go to Altnagelvin or Craigavon Hospitals based on Paramedic assessment and location they are in:

- Vomiting fresh clots of blood.
- Three or more recent episodes of coffee ground vomiting.
- Acute onset Melena (refers to black stools as a result of bleeding)
- Any GI Bleeding with signs of hypovolaemic shock (this is an emergency condition caused by severe blood loss meaning the heart is unable to pump enough blood supply to the body).

Acute Scrotal or Hernia Pain – Patients with acute scrotal or hernia pain will bypass SWAH to Altnagelvin or Craigavon based on paramedic assessment and location they are in – with the exception of those aged five and under who will transfer to Royal Belfast Hospital for Sick Children, in Belfast.

Abdominal Pain – Any patient over 55 years of age complaining of abdominal pain will bypass SWAH to Altnagelvin or Craigavon based on Paramedic assessment and location they are in.

Trauma Management – All non-major accidents will continue to present to SWAH. The major trauma triage tool used by Northern Ireland Ambulance Service (NIAS) has been amended to reflect that those critically unwell or with penetrating trauma, are not brought to SWAH Emergency Department (ED) and are taken to Altnagelvin, or another acute hospital, based on paramedic assessment and the location of incident.

Patients with Post-Operative Complications (14 days or less) – In order to ensure continuity of care, it will be important that patients return to the site where they had their operation, which is where their Consultant is based.

Children with head injuries – Children who sustain a minor head injury and require admission for a short period of time will be admitted to SWAH under the care of the paediatric medical team as is the practice in other District General Hospitals. Those with associated trauma or an isolated major head Injury will need discussion with the neurosurgical team in Belfast after a CT scan (scan of the patient's head).

Colorectal Surgery – All patients requiring colorectal surgery during the period of the temporary changes to service will have their surgery in Altnagelvin Hospital.

Obstetrics (Obs) and Gynaecology Care (Gynae) (this is used to describe a wide range of care to women, including fertility, reproduction and post-menopausal concerns including bleeding) – These services will remain. Patients under the care of

the Obs & Gynae team will have an early assessment for possible complications during pregnancy. This will ensure that patients are cared for in the most appropriate setting.

General Day Case Surgeries
General Surgery patients who have not sufficiently recovered from their day procedure in Omagh Hospital and Primary Care Complex (OHPCC) and SWAH will now be admitted to Altnagelvin Hospital with the exception of Gynae who will still be managed at SWAH.

2.3.2 Transfer Pathway

Patients who are in contact with NIAS and following assessment of their condition by a NIAS crew, may still be taken to the SWAH if the patient's assessed clinical condition, and age where appropriate, is not listed in the 'bypass pathway'. So NIAS ambulances continue to arrive at the SWAH with patients who may have an emergency general surgical diagnosis, outside of the bypass pathway.

In addition, patients will arrive at the SWAH of their own accord, presenting with a range of potential surgical symptoms. Some of these will fall into the conditions that have been set out in the bypass pathway, and other possible clinical conditions, but because the patient has been a walk-in to the SWAH ED, the NIAS service has not been involved. These walk-in patients will need to be assessed by the SWAH ED staff, and subsequently by non-consultant surgical doctors on the SWAH site 24/7 (these surgical doctors are not consultant staff). These surgical doctors will assess the patient and discuss with a general surgeon at Altnagelvin, and if they require a surgical admission, the patient will be accepted by the on-call surgical consultant and the patient will be transferred to Altnagelvin Hospital.

This is referred to hereafter as the 'Transfer Pathway'.

2.3.3 Other Pathways

The bypass pathway and the transfer pathway are the primary pathways this review will focus on, however, there are additional ways that patients from the southwest area may arrive at or be referred to Altnagelvin Hospital. These are set out in Table 1 below.

Table 1: Bypass Pathway and Transfer Pathway	
GP Referral	A patient may attend their own GP in the Practice surgery, or attend the GP out of hours' service; or speak with a GP in a practice based or out of hours based telephone conversation, or on a home visit. Based on the information the patient supplies to the GP, the GP assessment, coupled possibly with

	the GP knowledge of the patient (as a family doctor), the GP (being aware of the temporary change to emergency surgery in SWAH) may direct the patient to go directly to Altnagelvin Hospital and not to the SWAH. GP's can also refer to Surgical Ambulatory Care in SWAH.
Patient self-directed	A patient may make their own decision, based on information they may have on the temporary service change at the SWAH, to go directly to Altnagelvin Hospital (or another acute hospital). The patient may or may not be aware of the temporary service change affecting emergency surgery conditions.
Patient change/ deterioration in another specialty in the SWAH	The SWAH continues to provide consultant led in-patient medical services, as well as other consultant led specialties including obstetrics and gynaecology. It is possible that a patient being cared for in a medical specialty, condition may change or evolve, requiring a surgical intervention. In these circumstances these patients would transfer to Altnagelvin Hospital.

2.3.4 Development of the Pathways

The Trust consultation document described two main pathways: namely bypass and transfer; and those set out in what this review refers to as 'other' pathways, would also be put in place to mitigate the temporary suspension of emergency surgery services at the SWAH.

The consultation document described that these pathways were developed, at pace. During the two week testing period, it was reported by the Trust that daily safety huddles were in place for those involved to come together to review any issues arising in the operationalisation of the pathways. It was reported by the Trust that all primary care colleagues had information letters issued to them on the temporary change, with details on how to refer to new ambulatory surgical pathway based in SWAH. This was followed up with information cards and contact details sent to each practice based on feedback from local GP's. The Trust worked with partners in the Southern HSC Trust, NIAS, Sligo General Hospital and the NI Trauma Network. The Trust reported that the development of the pathways involved clinicians from across Trust services, in general surgery but also in other specialties and services including ED, paediatrics, obstetrics and gynaecology, intensive care, radiology, and with engagement with allied health professionals (for example physiotherapy and occupational therapy). NIAS contributed to the development of the bypass pathway drawing on experience gained from facing a similar situation within

the Southern Trust following the suspension of emergency surgical services at the Daisy Hill Hospital site. Communication about the clinical pathways took place internally in the Trust but also externally with NIAS, the Trauma Network and with General Practice. Engagement and awareness of the clinical pathways more widely was initially through a public awareness raising campaign, followed by public meetings during the consultation process.

Details of the public awareness raising campaign consisted of:

- A public Information Guide published in newspapers, and on the Trust web site and social media platforms
- A radio advertising campaign
- A poster campaign widely circulated.

Internal Trust staff engagement included:

- Briefing sessions with Trust staff affected
- General briefings to staff within SWAH
- Briefings to Trades Unions
- “Surgeries” offered where individual staff could meet directors in the hospital on a weekly basis.

Section 3: Review Findings

3.1 Assessment Services at SWAH

Since the temporary cessation of emergency surgery at the SWAH, the hospital continues to have a Category 1 ED with ambulances continuing to arrive, conveying surgical patients whose presenting symptoms and clinical profile are not covered by the bypass protocols set out in the bypass pathway.

The regional Major Trauma Triage Tool, developed and overseen by the Regional Trauma Network, directs that if the journey time for an ambulance, to convey the patient from the location of an incident, to the Royal Victoria Hospital, Belfast (RVH), is under 45 minutes then the ambulance should go directly to the RVH, or Royal Belfast Hospital for Sick Children (RBHSC) if the patient is under 14 years old. This applies throughout NI and applies to all acute hospitals. The RVH (including RBHSC) is the Regional Trauma Centre.

In any circumstance where there is need for immediate patient stabilisation e.g. an unsecured airway, uncontrolled external bleeding or cardiac arrest, then the ambulance is directed to go directly to the nearest ED, including SWAH.

If the journey time from an incident is more than 45 minutes, then the Major Trauma Triage Tool directs the ambulance crew to convey the patient to the nearest ED. This includes the SWAH. For patients with penetrating trauma or vital signs that are set out in the highest (red) category, the SWAH will be bypassed by the ambulance, the patient going to the next nearest ED. During the site visits to the SWAH, senior staff and service managers reported to the review team that they had not seen any particular difficulties in relation to management of major trauma, following the introduction of the temporary pathways associated with emergency surgery. They referred to having the surgical staff grade doctors on site, ED consultants and ED staff, critical care team and anaesthetists that afforded services for appropriate major trauma cases that may be conveyed to SWAH.

Patients also continue to attend the SWAH ED using their own transport (referred to as ‘walk-ins’) with a range of potential surgical conditions.

For both ambulance arrivals and walk-ins, patients arriving to ED are clinically assessed by the ED team. For those presenting with a surgical condition there is a need to determine if the patient needs to be transferred to emergency general surgical services at Altnagelvin Hospital (or other hospital) or if the patient’s condition could be treated within the ambulatory care service at the SWAH (which operates weekdays).

The SWAH has a number of surgical doctors on site 24/7. These doctors are post-foundation doctors and middle grade doctors. These are fully qualified doctors and are not in training. These positions are not consultant surgeons. Whilst the Trust advised that there is clinical supervision of SWAH surgical doctors, it was noted that this is provided by the surgical consultants based at Altnagelvin Hospital, by telephone. The review team was told that a consultant surgeon is on the SWAH site when elective surgical services are operating, reported to the review as normally Tuesdays and Wednesdays.

There is no formal direct involvement between the consultants undertaking elective surgery and the emergency surgical service. There is therefore no requirement for involvement of the elective surgical team in any emergency surgical service, other than as defined by professional obligation. This separation of emergency surgery and elective surgery, is in keeping with The Standards for delivery of general surgery which requires the separation of emergency care from elective care. The Standards say that ***"there must be a separation of emergency and elective general surgery pathways in terms of teams, time and facilities to ensure safety and access for all"***. Therefore, the development of the elective service at the SWAH does not contribute to the provision of emergency general surgery at SWAH.

The surgical doctors at the SWAH will assess presenting surgical patients and determine the need for transfer to Altnagelvin Hospital.

The acute ambulatory surgical unit, provided by the SWAH surgical doctors, provides the opportunity to assess surgical presenting patients. Patients are referred by the ED and by GPs. The service operates weekdays and it is reported by the Trust that there have been 1,368 assessments undertaken, an average of 3.3 per day since it was introduced in December, 2022.

During the site visits to the SWAH, staff with whom the review team engaged with noted the ambulatory care unit was seen as a positive benefit, providing for patients who did not need admission and could continue to be managed and discharged from the SWAH. It was reported, 12 to 13 patients per day can be seen within surgical ambulatory care at SWAH, though some staff remarked they understood it was capped at 10 patients per day. The Trust reported that the unit has capacity to review up to 13 patients per day dependent on case mix. The data supplied to RQIA reported an average of 3.3 patients per day. Since then the Trust reported the average rising to 4.6 patients per day in the period April to July 2024.

Patients assessed by the surgical doctors at SWAH, working with colleagues in the ED, as needing surgical admission, are accepted by the receiving surgical consultants at Altnagelvin Hospital. It was reported that the patient is under the care of the surgical service at Altnagelvin Hospital from that point on. Clinical staff reported that they were confident in the surgical assessments provided at the SWAH. Patients who had been

identified as in need of transfer to Altnagelvin Hospital had been transferred there and had been appropriately assessed.

It was reported that there were eight surgical doctors at the SWAH: five of these referred to by the Trust as middle grade doctors (three of which were locum); and three referred to as 'SHO' Doctors (two of which were locum). There was also a physician associate (it should be noted that this is not a medically qualified individual/role). Currently the locum posts are being recruited through International Medical Recruitment and it was reported these doctors will be part of a larger rotation programme to include SWAH, Omagh Hospital and Altnagelvin Hospital.

The review team considered that there are vulnerabilities within the existing surgical staffing model at the SWAH. Not only were five of the eight positions filled on a locum basis, but it was noted that clinical supervision is remote to the local doctors, being provided from the Altnagelvin surgical team. While there is some surgical consultant presence on site on elective surgical days, these consultants do not provide clinical supervision to the SWAH surgical doctors. As referred to earlier, The Standards for general surgery separates elective surgery and emergency surgery, so elective surgery on the hospital site does not add to the emergency surgery model directly. The review team considered that there was a need for strengthened consultant outreach within this model to support surgical doctors' clinical supervision.

The planned development of an elective hub at SWAH will bring more consultant surgeons on to the SWAH site. This will not provide a consultant led emergency surgery service, however it may strengthen the surgical doctor model at SWAH through more onsite surgical services/ clinical practice opportunities for the 'middle grade' and 'SHO' doctors. However, this will depend on the elective model deployed which may have its own staffing model, including trainees.

The review team considered that these vulnerabilities required attention in order to strengthen the staffing model. This may also help secure substantive middle grade surgical doctors in the ambulatory unit, with greater access to direct clinical supervision. The review team considered that this may be planned as part of the recruitment programme and the reported plan for doctor rotation between SWAH, Omagh and Altnagelvin Hospital.

The Trust has since advised RQIA that active recruitment for substantive doctors continues, and that the Trust intends to take forward rotation of middle grade doctors between SWAH and Altnagelvin Hospital. The impact of these measures should be subject to evaluation.

Recommendation 1
In developing plans for substantive recruitment of surgical doctors to staff the ambulatory surgical unit and surgical assessment service at SWAH, the Trust should include measures to strengthen direct access to consultant clinical supervision. Such plans should also include measures to broaden the skills and experience for doctors working in these areas. This should assist in improving the sustainability of the model.

3.2 Surgical Ambulatory Care Unit at SWAH

As has been described under the assessment service at SWAH, the surgical doctors at the SWAH provide a surgical ambulatory care unit on weekdays. Patients presenting to the SWAH ED who meet the criteria for assessment under the ambulatory care unit, can be referred. GPs can also refer patients to the ambulatory care unit. Ambulatory care offers the opportunity for a patient who does not need an admission for emergency surgery and can be assessed and treated on the same day, not needing an overnight stay, can be provided for at the SWAH.

The acute ambulatory surgical unit operating in SWAH is not consultant led, it is provided by the surgical doctors at the SWAH (details of the surgical doctors at the SWAH are provided in 3.1 above). The 'Ambulatory Care Network'[9] states 'ideally' a surgical ambulatory care service should be consultant led, as it is evidenced to be more effective if lead by a more senior doctor. It does not exclude other models. The review team discussed the criteria by which patients would be assessed as suitable for the ambulatory unit. It was advised that the service is managed by the SWAH surgical doctor with access to the surgical consultant at Altnagelvin by telephone.

As referred to earlier in this report, the Trust advised that activity in the surgical ambulatory care unit has increased from an average of 3.1 patients per day in 2023 / 2024 to 4.6 per day in 2024 / 2025. Detail on the types of symptoms or conditions managed was not available to the review team.

The review team considered that the ambulatory care surgical unit at SWAH should be explored as to its effectiveness at providing for surgical patients who do not need to be admitted. Reports published on the Trust website pointing to volumes of patients transferring to Altnagelvin Hospital, and ambulance arrivals and walk-in patients, did not refer to how successful the ambulatory care surgical unit may have been in avoiding transfers to Altnagelvin Hospital.

It would be important to examine this particularly for patients presenting at SWAH who have been conveyed there by NIAS, i.e. those that fall outside the bypass pathways. This would help confirm how many were managed at SWAH through the ambulatory care unit, or whether they required a further ambulance transfer to Altnagelvin. It should also be

examined if issues arise at weekends when the ambulatory care surgical unit is not available. These issues require to be explored to determine how effective the model is in avoiding onward transfers, and where there may be opportunities to make improvements.

Recommendation 2
The Trust should undertake a formal evaluation of the Surgical Ambulatory Care Unit at SWAH to explore the effectiveness of the model in providing for non-inpatient surgical care at SWAH, including examining the criteria for acceptance, and identifying any opportunities to improve the service. Information on its effectiveness should be made available to the Trust Executives and Board.

3.3 Bypass and Transfer Pathways Overview

When the decision to admit the patient has been taken, agreed with the receiving surgeons at Altnagelvin, patients are required to transfer from SWAH to Altnagelvin. The data showing the average amount of time spent by patients in the SWAH ED before transfer to Altnagelvin was requested by the review team, however, the team was advised the information was not available at that time. This was viewed by the team to be essential information when considering the patients whole waiting time, crossing the two hospital sites, this being a factor when considering clinical outcomes. The Trust subsequently confirmed that average waiting time at the SWAH prior to transfer was 9 hours 35 minutes.

Patients can be transferred by NIAS, or through the use of a private ambulance provider (commissioned and contracted by the Trust), or at times patients may make their own transport arrangements. The decision as to what method of transport is used is made after surgical assessment and will depend on the stability/ acuity of the patient. Stable patients can be transferred via the contracted ambulance service, and several patients may be transferred in the same vehicle. It was reported by some patients that they had been advised by the service at the SWAH that if they were able to, they could make the journey to Altnagelvin under their own arrangements as that may be the quicker option. At times it was reported by patients that they ultimately made their own transport arrangements, from SWAH to Altnagelvin, after having waited for ambulance transport that was not readily available.

3.4 Bypass Pathway

Staff both in SWAH and NIAS confirmed to the review team that they felt that the bypass pathway was now well established. There had been some uncertainty at the outset as the pathways were developed and put in place in a short period of time. The Trust advised that there had been a need for a bedding in period initially while staff familiarised themselves with the new pathways, noting there had been a “test” period in December

2022. There was confusion expressed by some staff regarding the finalisation of some documentation in relation to the pathways. Some staff the review team spoke with, were under the impression documentation was still in 'draft' while others advised documents had since been finalised. The review team considered this matter should be remedied, with final versions of documents made available.

Patients who are brought directly to Altnagelvin Hospital by NIAS under the bypass pathway, wait for clinical assessment in the same way as other patients presenting from all localities within Altnagelvin ED. It was reported that the bypass protocol (for certain conditions as set out in the section 'Clinical Pathways, Mitigations and their Development') meant that for these cases the ambulance crew were leaving their local area, going outside this to Londonderry. While arriving with the patient, they often had to wait to be able to handover the patient to the Altnagelvin ED Team, an issue that has been widely reported across acute hospital EDs and the impact on ambulance services.

The issue of ambulance turnaround time at Altnagelvin ED had been a persistent issue from the outset of the temporary change to emergency surgical services. It was reported that recent discussion between NIAS and the Trust had been considering identifying space within ED for NIAS handovers, to release the ambulance crew back to their local area. There was an expressed concern that the extended journeys for bypass, and the demands from transfers, removed ambulance service capacity from the wider area and that this was having an impact on NIAS response times.

Patients from the Fermanagh area who make their own way to Altnagelvin directly (i.e. those who do not attend SWAH ED first) have to attend and wait within Altnagelvin ED for assessment; these patients are referred to as 'walk-ins'.

Bypass patients and walk-in patients to Altnagelvin ED cannot be admitted directly to the ward. This is only possible for patients who have already been assessed at SWAH ED and an admission agreed between the SWAH team and Altnagelvin surgical team. For this reason, the review team noted that 'direct to ward/bed' admission rates should only be calculated for patients transferring from SWAH to Altnagelvin Hospital, which had not been the method used for the figures being provided to Trust Board and published, in advance of the review. The review team understood the Trust now plan to address this.

3.5 Transferred Patients from SWAH

The number of patients who were transferred by NIAS, those who transferred by the contracted ambulance service and those who made their own transfer arrangements was not available from the Trust's information systems. However, it was reported that NIAS were able to report how many patients they had conveyed to Altnagelvin, and the private

ambulance provider reported that the number of patients transferred under their service was reported as part of their contract monitoring. While these sources can provide the number of patients conveyed, the information is not patient based, in that it is not 'flagged' in that way on the information systems in the Trust. It was reported that neither the NIAS systems nor the private ambulance provider systems can distinguish emergency general surgery patients from other speciality patients. In addition, it is not 'flagged' in that way on the information systems in the Trust.

It had been the intent in the development of the mitigation pathways for the temporary suspension of emergency surgical services at SWAH, that patients assessed at the SWAH and determined the need for surgical admission would transfer from the SWAH ED and would go on to be directly admitted on arrival at Altnagelvin to the surgical wards.

The Trust reported achievement of a 'direct to bed' rate, on the quarterly infographic published on the Trust web site, states that since the temporary service change (December 2022) until the end of June 2024, the average achievement of 'direct to ward or direct to bed' admissions, is 26%. However, this is a report based on all patients who would have formerly been admitted to the SWAH, so the review team considered it included bypass patients and walk-ins to Altnagelvin ED, who had not attended SWAH ED first. As has been stated earlier in this report, these should be excluded from this calculation to give an accurate figure for transferred patients only, showing those who are admitted direct to the ward and those who had a second wait in Altnagelvin ED.

Since May 2024, when the Trust had established a 'Reset' initiative to focus on improving 'direct to bed' journeys for transferred patients, monthly improvements have been reported by the Trust and this information shared with the review team. It was reported that since May 2024, using the adjusted rate (only patients transferred and therefore appropriate to a 'direct to bed' admission), a 76% direct to the bed/ward had been achieved, with several weeks achieving 95% since early August 2024.

The issue of transferring from SWAH ED having been assessed and accepted for admission at Altnagelvin, was the issue most regularly raised with the review team in our engagement with patients and families and also raised by staff at the SWAH in particular. Some patients may already have travelled to SWAH ED by NIAS, been assessed, determined the need for admission to Altnagelvin and awaited a further ambulance for transfer to Altnagelvin, two ambulance journeys. In addition, on arrival at Altnagelvin, they found themselves being taken into the ED, because no surgical bed was available. While the detail in regard to time spent in SWAH from arrival to assessment, decision to admit, and time of transfer was not available from the Trust information system, many patients described lengthy waits for the transfer ambulance to arrive. As reported earlier, the Trust has since advised that the average waiting time prior to transfer was 9 hours 35 minutes.

The journey time from SWAH to Altnagelvin was reported as approximately an hour and half by NIAS and up to two hours by private ambulance, and patients noted it could be an uncomfortable and anxious journey. It was also reported similar times for patients and their families making their own transport arrangements for the transfer journey. On arrival at Altnagelvin by any of these means, this was followed by a further lengthy wait. This wait was either within Altnagelvin ED, or alternatively patients waiting for lengthy periods outside the ED in emergency and non-emergency ambulances until they could be physically handed over to hospital staff. The Trust has since reported an average waiting time of 18 hours 16 minutes (Dec 2022 to July 2024) in Altnagelvin ED for those patients who did not transfer direct to ward.

The review team considered that this 'double' wait in ED for patients transferred from the SWAH to Altnagelvin hospital for surgical admission, was not what would be expected from the transfer pathway. Patients should not be required to wait within Altnagelvin ED and should be admitted directly to the surgical ward, since they have already waited in ED, been assessed and accepted for admission. This 'double wait' in ED extends the total time the patient waits before admission, and this is also coupled with the transfer time between the two hospital sites. It has been reported through Emergency Medicine Services that extended waiting times in ED have an adverse impact on potential clinical outcomes, however this does not differentiate specialties.

The Trust have since advised the review team, that to December 2023 there had been no increase in mortality rates in general surgery in Altnagelvin Hospital. The review team considers that while mortality data is of supreme importance, it is one measure of clinical outcome and should be added to with other clinical outcome measures as part of assurance arrangements.

It is clear that extended waiting times in ED do adversely impact on patient experience. This was expressed strongly by all patients and families who had experienced this and engaged with the review.

Recommendation 3

Patients assessed in SWAH and accepted for admission to the Altnagelvin surgical service should be admitted directly to a surgical ward and should not be required to attend or wait within the ED at Altnagelvin. The Trust should ensure the achievement of this 'direct to ward' admission for transferred patients is accurately calculated and reported regularly to provide assurance it is sustained.

3.6 NIAS Capacity

It was reported to the review team that no additional funding had been provided to support the creation of additional NIAS capacity to facilitate the temporary suspension of emergency surgery at the SWAH. The current additional demands being placed on the NIAS service therefore has a reliance on staff working overtime. Not only are there the additional journeys out of area under the bypass pathway, and the additional transfer journeys, but there may also be delays in the handover at Altnagelvin Hospital due to ED capacity and surgical ward capacity there. This often meant NIAS staff where working hours beyond their expected rota and beyond expected overtime, having a direct adverse impact on staff morale.

The review team was told of further concerns that the increased pressure on NIAS would have an adverse impact on the availability and responsiveness of NIAS services to the wider Fermanagh area. A risk register extract submitted by NIAS to inform this review (risk last reviewed on 14 April, 2024) identifies the importance of including NIAS in future planning and decision making regarding capacity and demand. It was reported to the review team by NIAS that if an acute hospital reconfigures in a way that changes patient transport requirements without taking account of NIAS capacity considerations, there is a risk to service delivery and potentially patient safety.

NIAS submitted information as part of this review which described that an impact assessment of service reconfiguration had indicated that two ambulance crews would be required to mitigate the reconfiguration of services introduced at SWAH. It was reported that the approximate cost associated with this would be in the region of £2 million per financial year.

It was reported that, from December 2022 to March 2024, a total of 38,000 hours of NIAS crew overtime were provided in the Western Health and Social Care Trust area, at a cost of £1.3 million; though NIAS recognised that not all of this cost will have been attributed to the introduction of the temporary pathways at SWAH. NIAS described overtime was initially relatively well received but as time progressed, willingness of staff to voluntarily take up overtime due to their reporting of impact on work-life balance reduced. This resulted in challenges for NIAS in sustaining the ability to maintain core cover in the local area.

This arrangement, relying on staff overtime and goodwill, creates a vulnerability in providing consistent service to support the mitigations set out in the service model. It may also have an impact on the responsiveness of the NIAS service for the wider area.

3.7 Private/ Contracted Ambulance Services

The Trust utilises a contracted ambulance service for patient transfers. The private ambulance service is not involved in the bypass pathway, as that is only for patients contacting the NIAS 999 service.

The number of patients transferred from the SWAH to Altnagelvin Hospital as a part of the mitigation relating to the temporary suspension of emergency surgical services, those conveyed by private ambulance versus those conveyed by NIAS was referred to as "not available" in the information provided by the Trust to the review, nor was this known to the Trust senior team. It was explained by the Trust that this was due to limitations of the information system which, it was reported, does not allow NIAS and private ambulance to be recorded as separate conveyance types.

In the Trust consultation document, it was reported that the plan was to provide 3 private ambulances to facilitate transfers; that these would be available 7 days per week; and would provide complementary rotas, with the service collectively provided from 10.00 am to midnight, 7 days per week. The Trust advised that the private ambulance is available 11.30 am to 7.30 pm on weekdays. In addition, a discharge transport vehicle which has been in commission since before the temporary change to emergency surgery at SWAH, assisting discharging patients to return home or to a placement in a care home, operates 7 days per week at SWAH from 3.00 pm to 11.00 pm and can be called on to assist with transfer of patients to Altnagelvin, if it is not busy with discharge patients. The provider advised they provide a specific level of care in the contract, but they could increase this as need be as they also employ Nurses and Paramedics. This enhanced service level would have to be contracted for.

It was reported by some staff to the review team on the site visits at the SWAH that they understood NIAS and the private ambulance provider may have been in contact with each other about determining which service would transfer a patient. NIAS staff reported that was not the case. The determination of which service would be used was down to the SWAH service and it was SWAH who made contact with NIAS or the private provider.

It was understood that the original plan for the use of private ambulance transfers had involved more than one provider and that later this was streamlined so that one provider now provides that service. The apparent reduced use of number of private ambulance vehicles may have been as a result of a review based on actual usage, numbers suitable for transferring using that mode and possibly peak times of need. It was not evident to the review team what information had been considered in adjusting the balance in use of NIAS and the private contracted ambulance provider for patient transfers.

Recommendation 4

There is a need for the Department of Health to consider the provision of a more sustainable and resilient ambulance capacity to strengthen the model supporting emergency surgical services within the Trust area, and address concerns about the impact on NIAS services more widely in the area.

3.8 Service Access and Capacity at Altnagelvin

Those patients who bypass the SWAH on the basis of their presenting symptoms and the bypass pathway conditions, along with those who have attended the SWAH ED and been assessed as requiring admission, are conveyed to Altnagelvin Hospital, or make their own arrangements for their transfer (by car). In a small number of cases the bypass protocol may have conveyed the patient to Craigavon Area Hospital, and for children to the RBHSC. However, Altnagelvin Hospital is the primary receiving hospital.

When preparing for the temporary suspension, it was estimated that the number of patients projected to come to Altnagelvin as a result, and taking account of their expected average length of stay in hospital, would equate to increased demand on the Altnagelvin surgical in-patient service of approximately 10 to 12 beds. This was consistent with the views of clinicians expressed during the site visit to Altnagelvin by the review team. In reports provided by the Trust to the review, up to July 2023, the actual number of average daily beds occupied ranged from eight on average per day in the month of December 2022, to 20 average daily occupied in the month of February 2023, and 15 in May 2023. The reports provided to the review team, were noted as the Trust Board reports which included occupied bed days at Altnagelvin for patients transferred from SWAH, up until July 2023. At that point the Trust advised that summary information would come to Trust Board and be published on the Trust's website in the form of an infographic, with verbal reports to the Trust Board from the Service Director. These verbal reports were minuted and form part of the Trust Board meeting record.

It was noted in those reports up to July 2023, that a number of patient's length of stay was reported as having exceeded 7 days and this was to be subject to a clinical audit. The terms of that clinical audit and its outcome was not examined by the review team. The review team would have expected that the audit would have considered if this extended length of stay was also a feature of other surgical patient stays, who had not been affected by the temporary change in service at the SWAH. It may also lead to possible consideration of repatriation pathways, if it is found some patients have exceeded their need for surgical care and treatment and had potential for post-operative care to be provided in SWAH under a medical / recovery model. Clinical audit such as this would be a valuable part in assessing the effectiveness of the pathways and identifying potential areas for improvement.

It was reported to the review team that Altnagelvin Hospital had a current surgical inpatient bed capacity of 80 beds and this had not changed since the temporary suspension of emergency surgical services at the SWAH. While no physical additional emergency surgical bed capacity has been reported as being created at Altnagelvin, the Trust's consultation document referred to plans to develop the ambulatory care pathways in Altnagelvin and to improve use of the 'discharge lounge'. These measures were intended to improve patient flow and bed usage at the hospital site. Given these plans to improve patient flow to positively impact capacity were central to capacity planning, the review team would have expected the impact of these initiatives to have been examined and reported on. This was not evident in Trust Board papers. The Trust also indicated that it would aim to 'reserve' surgical beds for SWAH transfers. In reality this was not always a practical option due to demand and clinical need of patients presenting.

Despite the increased demand and pressures, the review team observed that the Altnagelvin surgical team was clearly committed to ensuring patients were treated effectively within the resource available to them. Patients who arrived from SWAH by transfer and were waiting within the Altnagelvin ED, were seen by the surgical team within ED after arrival, and were under the care of the surgical team, while waiting in ED.

In addition to surgical admissions to the Altnagelvin Hospital, some patients who may arrive by ambulance or of their own accord, may not be admitted. These patients are attendances at the Altnagelvin ED. The Trust infographic (published on Trust website) reports that the nett increase of walk-ins and ambulance arrivals at Altnagelvin Hospital from the Local Government Districts of Fermanagh and Omagh are: additional walk-ins, 90 patients per month; and additional ambulance arrivals, 77 patients per month, a total of just under 2000 per year. Total ED attendances at Altnagelvin Hospital for the year 2023/24 are reported as 68,208[10].

The 'double' wait in Altnagelvin ED for those patients transferred from the SWAH has already been referred to in this report. There is a pressing need to rectify this so that it does not occur and that recent improvements are sustained for all transferred patients and that this is routinely and accurately reported. It is recognised that the achievement of a direct to bed admission for surgical transferred patients relies on capacity at Altnagelvin Hospital. The review team considered that, should surgical bed capacity at Altnagelvin not be available to provide for the volume of patients that are now required to be treated there, this will result in continued inefficiencies in ambulance turnaround, continued additional pressures on the ED service at Altnagelvin, on the surgical team, and poor patient experience.

The ambulatory care model that has been developed at Altnagelvin Hospital, and the effectiveness of the discharge lounge, as a means of creating improved patient flow and positive impact on bed capacity, should be evaluated. Clinical evaluation / audit, including that associated with longer stays for patients, would provide valuable insight

into issues that may require adjustments to the pathways, and potentially develop new pathways, such as repatriation to SWAH at an appropriate time post-surgery.

Recommendation 5

The Trust should undertake clinical evaluation / audit to examine the issues that have a direct impact on surgical in-patient bed occupancy at Altnagelvin Hospital. This would help to define the bed capacity required to cater for the predictable additional admissions arising as part of the temporary emergency surgical model for the western area. Such evaluation should also the explore potential for repatriation of patients to the SWAH.

Section 4: Pathways Review

Pathway documentation was reported by some staff, during hospital site visits at SWAH, as having been in draft for a long period, though this was inconsistently reported. Some referred to communication challenges about the status of the documentation and about changes that had been made. It was noted that while pathways were developed at pace, there was a two-week trial period in December 2022 when the pathways were operationally tested. This was during a period where there continued to be full consultant surgical cover at SWAH. The Trust reported, during this period, daily safety huddles were in place for all involved in the development of the pathways to come together to review draft pathways.

NIAS staff reported they had engaged with the Southern HSC Trust to consider protocols put in place there as a result of service change. They had also engaged with ED Consultants and with the Trauma Network. Consideration had been given in developing the pathways to try to avoid secondary transfers. It was reported engagement also took place with paediatrics specialty, considering management of head injuries for example.

A Project Team had been established by the Trust which met weekly, and developed the conditions that would be incorporated into the bypass pathway. Meetings were face to face at that time and the draft pathway had been shared with clinicians. There had been a test period to make sure it would work as intended, making any changes afterwards and then it was adopted from December 2022. It was reported at the site visits to SWAH, where both clinical and managerial staff were engaged with by the review team, that there had been few adverse incidents reported and that a review of those adverse incidents did not point to need for changes to the bypass protocol. It was reported the bypass protocol hasn't been changed since commencement.

More generally, staff reported that the communication issues were more difficult in the early period of developing the pathways at the time of commencement, and at that time there was a lot of detail to be dealt with including on-call rotas and escalation procedures. This added to the communication challenges given the level of detail needed. It was reported that there had been engagement across specialties and services including obstetrics and gynaecology and ICU as well as with professionals across services including nursing staff, physiotherapy and occupational therapy staff.

Those with whom the review team engaged during site visits advised they were now familiar with the bypass pathway, and the transfers pathway to Altnagelvin, and the patient conditions affected.

The review team heard of concerns of some staff regarding elderly frail patients and those with terminal / palliative care needs being transferred, consistent with the temporary pathways when they felt there may have been an opportunity to manage the patient at the SWAH.

The Trust provided an age group profile for patients who had been affected through the pathways since December 2022 to mid-July 2024 (see Table 2 below).

Table 2: Admissions with a Method of Admission Code = SI on PAS (to Altnagelvin) Period: 5 December 2022 to 15 July 2024				
Age Bands	**Direct Admission**	**Admission VIA Alt ED**	**Grand Total**	**% of total**
0-17 years	92	46	138	10%
18-64 years	173	528	701	49%
65 - 80 years	99	305	404	28%
80 + years	53	144	197	14%
	417	**1023**	**1440**	

The review team considered that the pathways should be reviewed by the collaborative clinical teams to test if the pathways, which are primarily condition and age based, are sufficiently sensitive to consider the holistic needs of the patient, including those with palliative care and end of life needs. The Trust had since reported taking additional steps relating to frail elderly / palliative care patients.

Recommendation 6

The Trust should review bypass and transfer pathways to identify any areas for improvement, and consider if they adequately allow for assessment of the patient's holistic needs, particularly those with palliative care and end of life needs.

Staff at the site visit to SWAH were not aware of formal complaints from patients about the changes to the service nor Care Opinion experiences. It was reported these are monitored by the Trust. However, some staff were aware of concerns raised by some patients with staff in ED, both at SWAH and at Altnagelvin. It was reported that significant engagement with the public had taken place during the consultation period and it was noted and a patient voice is included within the Project Board. The review team, from listening to staff on site visits, questioned if the review and improvement of the pathways is being sufficiently informed by patient experience.

The review team considered if clinical evaluation / audit related to the new service had been optimised to examine and review the effectiveness of the pathways. As referred to earlier when examining bed capacity at Altnagelvin Hospital, in documentation submitted to the review team, an audit of stays in Altnagelvin over 7 days' stay was referred to. In addition, a further document that was submitted to the review team, showed a review of recorded incidents on Datix (Trust incident reporting system), with key themes identified. Further information on this is provided in 6.2.

The review team considered that a clinical audit programme supporting the review and evaluation of the service change, would offer valuable insight into issues that required

improvement, offer insight into outcomes and provide a mechanism for clinical staff involvement collaboratively across the service.

A ‘Reset’ week in May 2024 focussed on improving ‘direct to ward’ admission for patients being transferred from SWAH to Altnagelvin. This had adopted a Quality Improvement approach (QI). Significant improvement had been achieved in the direct to ward admission rate since that time. The review team considered a QI approach in other aspects of the service model might also be usefully applied.

It will be important to have reliable data, clinical audit findings and feedback information from service users, and from staff, to drive an improvement programme.

Recommendation 7
The Trust should develop a clinical evaluation / audit programme, involving staff from across the two hospital sites and services, to examine how the clinical pathways are working and to consider clinical outcomes, in order to drive ongoing quality improvement of the pathways.

Section 5: Potential for Indirect Impact on wider service model at SWAH

5.1 Obstetrics and Gynaecology

The Trust's reported position has been that the provision of obstetrics and gynaecology services at SWAH are not affected by the change to emergency general surgery provision, and that is these services will remain at SWAH. The consultation document (dated January 2023) supports this position. It describes that women will have an early assessment for possible complications during pregnancy and as a result ensure patients are cared for in the most appropriate setting. The Consultation Findings Report[11] (dated July 2023) clarifies that elective and emergency caesarean sections are carried out by obstetricians and not by surgeons. Nonetheless, the Trust had engaged with the Royal College of Obstetrics in advance of the temporary changes to emergency surgery at the SWAH in December 2022, and determined that patients at high risk of bowel injury during an elective (planned) procedure, these patients would have their procedure at Altnagelvin. It is confirmed this is in place since before the temporary change to emergency surgery. It was reported then (July 2023) that there had been no reported clinical incidents relating to the temporary change that affected obstetrics and gynaecology.

Publicly available births rates[12] in the SWAH are reported as 1130 for the year 2022/23 and 1094 for the year 2023/24. This is a small decrease of 36 cases (3%). However, a reduced number of births was reported across Northern Ireland overall, 20,355 for the 2022/23 year and 19,826 for the 2023/24 year (circa 3%).

On reviewing the notes and papers provided to the review team by the Trust, the review team did not identify evidence of reporting of activity or impact on obstetrics and gynaecology at the SWAH as a result of the temporary changes to emergency surgery there. Nor did the review team see any evidence of activity or impact reported relating to elective gynecology cases at high risk of bowel injury being transferred to Altnagelvin Hospital.

The Trust has since reported that there did not appear to be any clinically significant issues in SWAH obstetrics & gynaecology services since the temporary change of emergency general surgical services in SWAH.

As part of the GIRFT review[13], a site visit to Western Trust had taken place in May 2023, and reported that the Western Trust workforce (at SWAH) had funding for 6 full time consultants, 4 of whom were in post at the time of the visit, although 1 of these was on unplanned leave; the other vacancies were being filled with 2 locums. It was reported to Trust Board on 1 February 2024 that SWAH had now a fully staffed obstetrics unit which had not been the case for a long time.

5.2 Intensive Care Services

At the site visits to SWAH, it was reported that ICU staff provide support in assessing and preparing appropriate patients for transfer to Altnagelvin. On occasion a nurse may need to go along with the transfer and so far, this has been able to be accommodated. This is because ICU nurses are NISTAR trained[14]. This does not happen very often.

Some staff reported ICU is not seeing the same number of admissions as before. The Trust has since advised the review that the position for ICU at SWAH is that 31 fewer patients were admitted to ICU in the year following the temporary change, compared to the year which preceded that change (256 versus 287 admissions / transfers in). It would be important this information is considered regularly and reported on.

5.3 Paediatrics

No impact as a result of the temporary emergency surgical service change was reported to the review team during site visits relating to paediatric services at the SWAH. The management of major trauma for children had not been affected by the temporary service change, it being a regional service. Minor trauma continued to be managed at the SWAH.

5.4 Emergency Department

It was reported by the Trust that SWAH ED has 8 funded Emergency Medicine Consultant posts with 7 filled on a substantive basis.

In terms of attendance levels at SWAH ED, the Trust quarterly infographic report shows the total number of attendances on average per month at the SWAH. It states that the total average attendances per month was 3003, pre the temporary service change, and a monthly average of 3,139 attendances post service temporary change. This is an increase in total attendance activity at SWAH ED of 136 on average per month. NISRA statistics[15] for 2023/24 show SWAH with a total attendance at ED of 39,461 attendances, compared to 39,175 for the year 2022/23.

The review team considered that it is important that indirect or unintended consequences of the temporary suspension of emergency surgery at SWAH on other specialties or services that may have a co-dependency with the service, is monitored and reported on. The potential for impact was a matter that was referenced in the consultation period and engagement with clinical staff across those specialties, demonstrates that the matter has been a consideration. Assessing any potential impact on these other specialties would be important so that where any impact is detected, it can be proactively addressed.

Recommendation 8

The Trust should identify and monitor key indicators of potential impact on other specialties or services at SWAH, so that the Trust Board has the opportunity to identify and address any emerging issues proactively.

Section 6: Governance and Oversight

6.1 Data and Analysis by Pathway

Papers and reports submitted to the review team demonstrated that there was regular reporting on the temporary service change at the SWAH at Trust Board level. Up to July 2023, this had included additional information about occupancy of beds at Altnagelvin as well as volumes of ED at both hospital sites and emergency admissions at Altnagelvin. This had been streamlined since then and the primary report was an infographic, which was also published on the Trust website.

It was reported that a SWAH Strategic Development Group had been established for SWAH, co-chaired by the Trust Chief Executive and a Non-Executive Director of the Trust Board, and a Programme Board, chaired by a senior member of the Management Team, had also been created to develop and oversee the service change. These groups provide valuable opportunities for discussion and reporting, while not being a direct part of the Trust Governance arrangements, it was reported that they are formally accountable to and report to the Trust Board, and to the Trusts Executive Leadership Team through its Strategic Change Board.

There were regular briefings to Trust Board throughout the period and papers tabled up until July 2023, supported by verbal briefings. After that period, verbal updates were given at Trust Board, supported by an infographic.

The review team noted the information reported on the, now quarterly, infographic. Its focus is on levels of activity at the SWAH ED and nett changes in activity at Altnagelvin ED from the Omagh and Fermanagh district council areas.

The infographic displays the number of patients admitted to the Altnagelvin surgical service, that would otherwise have been admitted to the SWAH. This is a cumulative figure, so that each time the infographic is produced the figure increases. In the most recent published infographic, the ‘direct to bed’ rate is provided for a number of weeks. This is referring to patients transferring to Altnagelvin Hospital, however as has been cited earlier in this report, the rate is calculated on the total number of patients admitted and not only those transferred after assessment at SWAH, and therefore provides an inaccurate assessment of the proportion of transferring patients who were able to go directly to a surgical bed and did not require a second ED attendance. This results in ‘direct to bed rate’ being under reported.

It is clear from the Trust reports that the difficulty of securing information specific to each pathway is limited by the information systems that are in place: two separate ED systems and separate Patient Administration Systems (PAS). These systems do not have a common way to trace/ track individual patients and this has limited the Trust in ability to report information on the pathways separately.

This may be resolved in the future by the implementation of Encompass[16], and in the meanwhile the Trust have need to consider ongoing audits and sampling, to drill down into the necessary details. The review team considered that a more substantive prospective audit during the period of temporary service change could have provided valuable information which could have informed service improvement.

Regularly reported information at Trust Board therefore has a focus on activity, with less evidence of regular information on quality indicators, incidents, delays in provision of care or patient experience alongside activity levels. Evidence of such indicators are considered by the review team as essential for effective governance.

6.2 Incident Reporting and Management

Staff during site visits reported there was daily, weekly and monthly oversight meetings at the start of the temporary arrangements. These included safety huddles and project meetings. Some staff engaged with reported they felt this level of oversight had been reduced.

The review team was told by some staff that the Datix system (where staff within the Trust record adverse incidents that occur) may not always be updated with incidents that have occurred because it can be a time-consuming process and also because they felt there was not always feedback on actions being taken as a result. The review team considered this may result in under reporting of adverse incidents. In engagement with patients and families, the review team considered that a reported experience may have met the definition of an adverse incident, though the Team did not have information with which to triangulate the information shared with a clinical perspective or record. Those engaged with had not made a complaint about the issue they raised with the review team. The review team encouraged such patients and families to communicate their concerns to the Trust so that the issues could be explored by the Trust and any learning taken forward to improve patient experiences.

The review team requested information on adverse incidents reported. It was reported 29 such incidents had been reported to June 2024. A report, provided to the Team, showed that 22 of these had been reviewed by the Medical Director (at 14 months' stage since implementation in December 2022). It highlighted key themes that had occurred within several of the incidents and learning that was to be applied as a result.

It was reported that none of the reported adverse incidents met the criteria for a Serious Adverse Incident (SAI)[17]. Two of the incidents were referred to as 'SEA' (Significant Event Audit). The Trust advised that the issues had been effectively examined and identified learning. In addition to the two reported 'SEA' incidents, a further two 'SEA' incidents were reported as outstanding. The review team considered this meant these

two incidents were still being investigated and not yet concluded. It was not indicated what time period these further two incidents referred to.

The review team considered that this use of an 'SEA' methodology may be confusing for staff and for patients and their families, given it is the methodology used as part of the regional SAI procedure for investigating a Level 1 SAI. Where a Level 1 SAI is identified and investigated, the learning outcome from that investigation is shared to the regional Strategic Planning and Performance Group (SPPG) with the potential to inform shared learning across the region. In this case, where there is a temporary suspension of emergency surgical services and mitigating pathways developed, there may be value in sharing learning from incidents investigated in this (SEA) process. In relation to the potential for sharing such learning regionally, the Trust advised that they are able to so, where 'regional learning' has been identified.

Where learning has been identified in the investigation of adverse incidents, follow up is required to establish that the directed changes have been embedded into the service. It would be important that further clinical audit establishes that recommended learning from the two 'SEA' incidents is now embedded.

Recommendation 9
The Trust should ensure that in addition to service activity levels, information relating to service quality, including identified outcomes from adverse incident reviews, and outcomes from an established clinical audit programme, are included in regular reporting at Trust Board to ensure effective governance.

6.3 Patient Experience within Service oversight arrangements

The Trust advised the review team that there were very few complaints made about the service change, only one specific complaint was identified. They also advised there was very little patient experience information on Care Opinion, again just one experience shared was reported to review team. On the site visits to the two hospitals, staff had referred to complaints made by patients. When the Review team engaged with patients, some of those patients (or families) referred to making a formal complaint. One patient referred to the quality of the Complaints response letter received, which was later retracted and a new letter issued by the Trust. Another patient advised of incorrect information in a discharge letter, which was replaced when the issue was raised with the Trust.

During the review period, the review team encouraged the further promotion of the Care Opinion platform, to activity seek patient experience feedback. Subsequently, a small number of further submissions were made.

The review team was concerned that the consideration of complaints made by patients or families and carers, may not have been correctly identified as associated with the temporary service change at the SWAH. The rationale for this concern is that some complaints, although relating to the temporary service change, predominantly referred to ED services. It is therefore possible they were categorised as relating only to ED.

While the Trust communicated the temporary service change as detailed in section 2.3.4, the more pressing matter was the apparent absence of proactive seeking of patient experience as part of the review and evaluation after the service change had been made. Particularly given this had developed at pace and out of a crisis situation, the Team considered it would be important to actively seek views and engagement with service users, and not rely on reacting to complaints being made and the use of Care Opinion, valuable though both are.

Recommendation 10
The Trust should proactively seek patient experience, and demonstrate it is valued as a key component of a patient safety and quality improvement programme. Outcomes from the quality improvement programme should be reported at Trust Board.

Sections 7, 8 and 9 – Overview

The following sections of the review report reflect what was heard by the review team from patients, families, staff and a number of stakeholders engaged with. While there are no specific recommendations made after each of these sections, it should be emphasised that this valuable, personal information has been taken account of in conjunction with information from site visits and from review of documentation and data. As such it forms a pivotal role in the review recommendations.

Section 7: Patient Experience Engagement

As part of this review, service users (or their family or carer representatives) were invited to engage with members of the review team.

7.1 Patient Experience Engagement Methodology

RQIA does not have access to personal information of patients who accessed the services and therefore, RQIA issued 25 letters to the Trust and asked the Trust to issue these letters to 25 patients, selecting patients who had experienced the service since December 2022, considering the time period since the patient had been seen, their age profile, geography gender and the route by which the patient may have accessed the service.

A similar letter was made available to the SOAS group (Save Our Acute Services Group) who wished to distribute this letter to people with whom they engaged.

The letter contained a brief introduction to the review, a link to its Terms of Reference and an invitation to service users and/or their representatives who have experience of the temporary pathways and would like to share their experiences to inform the review. Experiences could be shared with the review via a number of mechanisms which included face to face meetings, telephone call, MS Teams 'online' meeting or to submit a written experience.

A member of the Expert Review Team and RQIA Project team met with service users/ representative via a blend of:

- Face to face meetings over four days in a venue in Enniskillen
- Virtual contact (Microsoft Teams or Zoom)
- Telephone calls
  Written submissions via email

7.2 Patient Experience: Profile Summary

80 contacts were made to RQIA in relation to a patient experience.

51 (64%) were deemed within the scope of the review terms of reference, of which, 19 (37%) were patients; 29 (57%) were family members, and 3 (6%) were other representatives.

Of the 51 experiences shared, 4 (8%) patients only attended SWAH with no onward transfer, 41 (80%) had first attended SWAH, and then been transferred to Altnagelvin, while 6 (12%) arrived directly at Altnagelvin.

The RQIA review team engaged with the 51 patients, family members and representative through the following methods of contact

- 10 (19%) in person, face to face meeting in Enniskillen
- 9 (18%) virtual contact (Microsoft Teams or Zoom)
- 7 (14%) telephone call
- 25 (49%) email in response to written submission

Information from the remaining 29 contacts with RQIA was directed to other routes within RQIA so that the experience shared, where appropriate, could contribute to other aspects of work. This included:

- 15 (19%) had shared information outside the scope of the terms of reference for this Review, and this information is held in the records of the Review information received,
- 11 (14%) shared information outside the scope of the terms of reference for this Review, and referred to other issues relating to HSC services. This information was shared with the RQIA Hospitals Inspection Team,
- 3 (3%) who made initial contact with RQIA, but did not a make a written or verbal submission.

Please note the key themes identified in this review are based on all experiences shared (51 cases), regardless of method of engagement.

The profile of the 51 cases is as follows - note this is the patient profile even where the experience may have been shared by a family member:

- 23 (45%) were female, 28 (55%) were male,
- 48 (94%) were adult, 3 (6%) were children
- 28 (55%) were willing to share their age. The mean age was 62.

7.3 Key Themes

The review team recognised that following invitations to participated, those who come forward essential 'self-select'. The review team understands that their experience is not necessarily representative of the wider cohort of people who utilised temporary pathways.

Nonetheless the lived experience shared with the review team provide valuable insight with areas for potential improvement.

Variability in Transport Arrangements

One of the most prominent themes that emerged from the patient feedback was the significant variation in transport arrangements from SWAH to Altnagelvin. The inconsistencies in how patients were transported added to the confusion and distress during an already stressful situation. Some patients were transferred by NIAS ambulances, on occasion others were asked to arrange their own transport. This lack of consistency created a sense of uncertainty and inequity among patients.

For example, one patient reported being told by SWAH staff to go to ED in Altnagelvin by themselves. In contrast, another patient's family wishing to transport their family member was informed that they could not transport the patient themselves, leading to an extended wait for an available ambulance. This disparity in experiences suggested a lack of standardisation in the transport process. This could have implications for patient safety and well-being.

Long Waits for Transport

The issue of prolonged waiting times for transport was frequently highlighted by patients and their families. Several patients reported having to wait for hours, and in some cases overnight, for transport to become available.

One patient recounted, "There was a two-hour wait for an ambulance before a two-hour journey to Altnagelvin," emphasising the lengthy duration. Another patient mentioned having to wait overnight for a private ambulance because no NIAS transport was available, a situation that the patient reported left the patient in distress during the interim period.

Such delays were perceived as resulting in prolonged patient suffering and created additional anxiety for families who were left uncertain about when and how their loved ones will receive the care they need.

Uncomfortable and Painful Journeys

The physical discomfort experienced by patients during the journey from SWAH to Altnagelvin was another major concern expressed. Given the medical condition of these patients, the rough and lengthy journey exacerbated their pain and discomfort. Several patients described their journey as "uncomfortable," with one noting, "The journey in the ambulance was not comfortable, and blood pressure was increasing due to pain."

It was reported by some that the condition of the roads, combined with a reported lack of adequate pain relief during the journey, made the trip to Altnagelvin not only physically

painful but also emotionally draining for patients. This aspect of the experience highlights the need to examine opportunities for improved transport solutions.

Expectation vs. Reality

Many patients and their families were under the impression that they would be directly admitted to a ward at Altnagelvin upon arrival. However, upon reaching Altnagelvin, they were more often directed to the ED instead, where they faced further delays and had to undergo another triage process.

One patient expressed their frustration, stating, “Felt that she was back in ED again being triaged for a second time.” This discrepancy between expectation and reality caused significant distress, as patients and their families felt misled about the nature of the transfer and the care they would receive upon arrival at Altnagelvin.

Impact on Families

It was reported that the journey from SWAH to Altnagelvin not only affected patients but also placed a considerable burden on their families. All family members had to arrange their own transport to Altnagelvin, often under challenging circumstances, including poor weather conditions and the financial strain of unexpected travel.

One family noted, “All family members needing to accompany patients had to arrange their own way to Altnagelvin, many expressed concerns about the difficult journey.” The emotional toll of worrying about a loved one’s health, combined with the logistical challenges of travel, added to the overall stress and anxiety experienced by families.

Moreover, some families were distressed by the possibility of their family members travelling alone. The lack of support and advice relating to family transport further compounded their concerns.

Experience at Altnagelvin ED Reprocessing and Delays

Upon arrival at Altnagelvin, many patients found themselves reprocessed through the ED, a process that they were concerned delayed their treatment and added to their frustration. Despite having been triaged at SWAH, patients were often subjected to a repeat triage at Altnagelvin, which they considered redundant and unnecessary.

A patient detailed their experience, stating, “I was triaged again at Altnagelvin despite already being processed at SWAH”. These delays in care were reported as particularly distressing for patients who were already in pain or in a critical condition.

The need to repeat information and undergo the triage process again often led to a sense of being stuck in a bureaucratic loop, where the urgency of their medical needs seemed to the patient or family to be secondary to procedural formalities.

Overcrowded and Overwhelmed ED Environment

The ED at Altnagelvin was consistently described as overcrowded, chaotic, and under-resourced. Patients frequently commented on the visible strain on staff, who appeared overworked by the sheer volume of patients. This environment contributed to a pervasive sense of discomfort and insecurity among patients and their families whom we engaged with.

The overcrowding was reported as having a direct impact on patient care, with long waits for attention and a lack of privacy during consultations. The high patient-to-staff ratio meant that care often felt rushed, and some patients felt that their needs were not being fully addressed.

Inadequate Facilities and Equipment

A common complaint among patients was the inadequate facilities and equipment available in the ED at Altnagelvin. Many patients reported having to wait for long periods in uncomfortable chairs or on makeshift beds, with little to no access to proper resting facilities. This was particularly challenging for those in pain or with conditions that required them to lie down.

One patient highlighted this issue, stating, “Was in ED at Altnagelvin for 50 hours on a plastic chair; could not lay down.” The lack of available beds or proper chairs meant that patients were often required to wait in suboptimal conditions, which served to aggravate their discomfort and anxiety.

Another patient described waiting for several days in the ED area due to the unavailability of ward beds, exacerbating their pain and discomfort. This prolonged wait in uncomfortable conditions was a recurring theme, with many patients expressing frustration at the lack of basic comforts during their time in the ED.

Safety, Privacy and Dignity Concerns

The overcrowded conditions in the ED at Altnagelvin also raised concerns about patient safety and privacy. Several patients and families reported feeling unsafe due to the behaviour of other patients in the ED, particularly those who were intoxicated or experiencing mental health crises.

One patient described their experience, stating, “I felt fearful in an overcrowded ED where others were displaying inappropriate behaviours.” Their concern about a visible lack of adequate supervision and security in the ED meant that patients often had to deal with disruptive behaviour from others, which added to their stress and discomfort.

Additionally, the lack of privacy in the ED was a significant concern for many patients. Consultations and treatments were reported as often conducted in close proximity to

other patients, with only a thin curtain or a small partition separating them. This lack of privacy was distressing for patients, particularly when discussing sensitive medical information.

The conditions within the ED and the long waiting times were reported to compromise patient dignity. Issues such as inadequate privacy, poor hygiene conditions, and lack of clear communication contributed to this perception. One patient shared, “There was no comfort, privacy, or dignity; I could hear all about others' care and treatment.”

The lack of dignity was especially evident in situations where patients had to divulge personal information in overcrowded and poorly partitioned areas. The absence of basic amenities, such as adequate seating or beds, further eroded the sense of dignity for many patients during their stay.

Extended Waits for Ward Admission

One of the most reported distressing aspects of the patient experience at Altnagelvin was the prolonged wait for admission to a ward. Many patients reported spending extended periods in the ED, often in pain and discomfort, while waiting for a bed to become available.

A patient described their experience, stating, “There were several days of waiting in the ED area, with long periods in chairs or makeshift beds”. This prolonged wait was reported as exacerbating physical discomfort but also had a significant emotional toll, as patients felt a state of uncertainty about when they would receive the care they needed.

The extended wait for ward admission was particularly challenging for older patients or those with more severe conditions, who required closer monitoring and more specialised care. The lack of available beds and the delays in admission meant that these patients often felt they did not receive the level of care they needed in a timely manner.

Communication

Another recurring theme was a reported breakdown in communication between patients, families, and medical staff. Many patients reported feeling confused and frustrated by the lack of clear and consistent information about their care and treatment.

One patient expressed their frustration, stating, “I was fasting waiting to go to surgery but they didn’t tell me it was cancelled and over three days I had almost nothing to eat,” reflecting the confusion and distress caused by poor communication. Patients and families often felt that they were not being kept informed about the progress of their treatment or the reasons for the delays they were experiencing.

This lack of communication was particularly distressing for families who were trying to advocate for their loved ones. The feeling of being kept in the dark added to their anxiety and made an already difficult situation even more challenging.

Perception of Inadequate Resources: Recognising Staff Efforts

Despite the challenges, most patients and families acknowledged the material efforts of the staff, attributing the issues they faced to systemic resource shortages rather than a lack of dedication. A common sentiment was, “Staff were doing their utmost, but the ED was extremely busy, and the system felt inadequate,” highlighting the staff’s commitment despite the overwhelming conditions.

Patients and families often expressed sympathy for the staff, recognising that the shortcomings in care were due to factors beyond their control. However, the lack of resources—whether in terms of staffing, equipment, or facilities—was seen as a significant barrier to providing high-quality care.

Support for Frail or Elderly Patients

Frail and elderly patients were particularly vulnerable to the challenges posed by the temporary pathway. Many of these patients required more intensive support and closer monitoring, which was difficult to provide in the overcrowded and under-resourced environment of the Altnagelvin ED.

One recurring theme was the difficulty families faced in ensuring that their frail or elderly relatives received the care they needed. Due to the perceived chaotic nature of the ED, families felt compelled to stay with their loved ones to advocate for their care. A family member noted, “Families of frail older patients felt they could not leave their loved ones waiting in the ED area with any confidence that their care needs would be met, as there did not appear to be enough staff.”

The lack of appropriate facilities for frail and elderly patients was a significant concern. Many elderly patients were left waiting in the ED for extended periods, often in uncomfortable chairs or in positions that exacerbated their existing health conditions. The absence of specialised care or dedicated facilities for these patients meant that they were particularly vulnerable during their stay.

One family member described the situation, saying, “Some patients waited days in ED before being admitted to a ward, often in considerable pain and discomfort due to the lack of appropriate seating or beds.”

Burden on Families

The need for families to stay with their elderly relatives in the ED added to their burden, particularly given the long distances they had to travel to reach Altnagelvin. Many families expressed concern about the financial and emotional strain of having to travel repeatedly, often in poor weather conditions, to ensure their relatives were receiving adequate care.

One family highlighted the impact of this situation, stating, “This puts an additional burden on families due to the travel distance”, with many highlighting the personal financial burden and the impact of having to take time off work.

Need for Improved Support and Resources

The experiences of frail and elderly patients referred to the need for improved support and resources within the Altnagelvin ED. This referred to better facilities and equipment but also more of the dedicated staff that were working there.

Families often expressed a desire for a more tailored approach to care for elderly patients, recognising that their needs are different from those of younger, more resilient individuals. The current system, as described by many families, falls short of providing the level of care expected by the patient or their family, leading to a sense of neglect and concern for the well-being of elderly patients. Families stated that if a relative is in SWAH it is much easier to arrange extended family support and help share the burden of care, however, it becomes very difficult to do this in Altnagelvin due to the distance from home and the lack of public transport provision.

7.4 Care Opinion

Introduction and Context

During the Review, the Trust promoted the Care Opinion[18] platform as one means of patients, families or carers to provide their experience of the service they had received, specific to the emergency general surgery pathways. The Trust produced a bespoke flyer with a QR code which was given to patients identified to be on related pathway between 26th July 24 to 12th August 24.

Care Opinion is an independent organisation who seek to empower people to be able to share their experiences of health and care in ways which are safe, simple, and lead to learning and change. It is hosted in Northern Ireland by the Public Health Agency (PHA). It is a moderated service inviting people to share anonymous feedback about their experience of health and social care here, and those experiences are published on the website with responses provided by the services involved.

Summary of Experiences Shared

- There were 5 experiences identified as part of the proactive promotion
- Experiences can be shared by service user, family or carer and in this cohort of experiences one was submitted by the service user, two by a relative and two by a parent or guardian.
- All were submitted directly to the Care Opinion website

Key Messages Shared by Experience

The following key issues were referred to in relation to experience of the pathways associated with Emergency General Surgery and additional issues may also have been referred to. Extracts are provided by way of example of the experience shared.

1. length of time the patient waited to access the surgical service at Altnagelvin Hospital, having first attended the ED at SWAH

"…It took 5 hours to be transferred by ambulance to the ED at Altnagelvin and he had to join the queue to be assessed. He waited from 1.30am until 7am… "

2. Challenges experienced in symptom management

"...He waited [in Altnagelvin] from 1.30am until 7am to assessed sitting in agony in a chair…He phoned <relative> at 11am advising that he was in so much pain …"

This is however not expressed in all experiences with two acknowledging that despite the difficult situation, there had been good care delivered by paramedic and the team in SWAH.

3.Caring staff

"…The treatment given by the paramedics on call and the staff in South West Acute were excellent, however after thorough investigation it was determined that she needed emergency surgery to remove her appendix…"

4. Anxieties related to the transfer process to Altnagelvin

There were several comments which conveyed the need for service user's families to drive their relatives to Altnagelvin to receive care as it was reported there was no ambulance available to provide this journey.

"No ambulance (or timeframe) was available to transfer <patient> to Altnagelvin and it was proposed by staff for family to drive mum there ourselves..."

5. Concern about access to other surgical services following the recent changes to emergency surgery

"…I contacted my GP who advised me to contact surgical appointments. <When I called> I was told that my consultant had left the Western Trust. My GP had not been informed that the consultant had left either..."

Trust Responses to Service User Experiences

All experiences reported received a response by the Trust , these responses provided insight into what can be expected of the associated pathways.

Section 8: Staff Experience Engagement

8.1 Staff Experience: Engagement Methodology

In addition to engaging with patients, family members, and their representatives, RQIA sought to explore staff member's experiences of the pathways put in place.

In a similar approach to service user (or their family or carer representatives) engagement, a flier with an invitation for Health and Social Care staff to engage with the Review was: shared on RQIA's website; circulated by the Trust on RQIA request across the WHSCT to ensure available to front line staff; the flyer was also issued to the Southern Trust (Craigavon site) to also share with staff appropriately. It was issued to NIAS for sharing with staff and issues to the GP Federations in the WHSCT area, for onward sharing with GP Practices.

The flier was shared with Save Our Acute Services group for sharing with staff members they may have engaged with.

The flier contained a link to the Review Terms of Reference and an invitation to staff who have experience of the pathways and would like to share their experiences to inform the review. Experiences could be shared with the review via a number of mechanisms which included face to face meetings, telephone call, MS Teams 'online' meeting or to submit a written experience.

8.2 Staff Experience: Profile Summary

26 staff members contacted RQIA to share their experiences to inform the review. Of the 26 individuals who contacted the review, 24 contacted RQIA before the closing date for submissions on 12 August 2024.

Of these 24 staff members:

- 20 shared details which related to experiences of a Health and Social Care staff member in relation to the temporary pathways;
- 1 shared information outside the scope of the terms of reference for this review, and this information is held in the records of the review information received;
- 1 shared information outside the scope of the terms of reference for this review, and this detail has been shared with the RQIA Hospitals Inspection Team;
- 2 contacted RQIA by email, without written submission, and did not respond further to RQIA contact

Of the 24 staff members who made contact with the review:

- 15 submitted their experiences by email
- 7 shared their experience by telephone / MS Teams

- 2 made email contact but did not share their experience

Staff members who contacted the review worked in a diverse range of settings and roles which included General Practitioners, WHSCT and NIAS roles.

8.3 Key Themes

Capacity

During the site visits, the review team heard from members of clinical staff of their willingness and commitment to make the temporary pathways work effectively. The review team noted that, for staff at Altnagelvin hospital, this commitment was expressed despite the fact that the emergency general surgical service was very busy and often under pressure. It was also in the context that no substantive additional capacity had been provided to respond to the additional demand arising from people with acute surgical conditions travelling from the Omagh/Fermanagh area.

Communication on the Pathways

Staff with whom the Review team engaged, in both Altnagelvin Hospital and the SWAH, were familiar with the bypass pathways and the transfer arrangements and expressed a view that the arrangements as documented in the temporary pathways worked well.

The review team heard from some members of staff that they acknowledged the wider range of specialists and also the greater scope of diagnostic tests available at Altnagelvin Hospital, both of which provided advantages for people being transferred from the SWAH.

Staff recognised the benefit of the Emergency Surgery Ambulatory Assessment (ESAA) in managing patients while avoiding admission. The review team heard from a primary care practitioner regarding how this service permitted assessment and management of a patient in a timely manner without the need to attend an ED.

There were, however, a number of matters on which clinical staff expressed some concern in regard to the arrangements arising from the temporary suspension of the emergency surgery service at the SWAH.

In regard to the assessment at the SWAH and subsequent transfer of patients to Altnagelvin, the review team heard that staff were concerned that a patient's journey was inevitably longer than would previously be the case. Concern was expressed that this was particularly the case for those transferred from the SWAH who required a further assessment in the ED at Altnagelvin instead of being admitted directly to a surgical ward,

as staff understood was the intention when the temporary pathways were put in place. The review team heard of this concern from a number of members of staff within the Trust.

Concerns for Frail or Elderly Patients

The review team also heard from staff of their concerns that some people from the Fermanagh area, particularly those who were frail or elderly, may be reluctant to travel to Altnagelvin. In this regard staff cited examples of scenarios in which it may be more appropriate for someone to be managed at the SWAH rather than being transferred to Altnagelvin even when their clinical condition met the criteria set out in the temporary pathways. For example, the review team heard of cases where the patient being transferred was receiving palliative or end of life care and who would not have been clinically appropriate for surgical intervention. Staff relaying such examples suggested that refinement of the temporary pathways may permit patients to receive conservative management in the SWAH when it is considered that surgical intervention would not be a realistic treatment option.

Some concerns were expressed regarding the discharge and follow-up of patients after an attendance or admission to Altnagelvin. The review team heard that some people had to travel home by taxi (organised by the WHSCT). In regard to follow-up, the review team heard that improvement was needed.

NIAS Services

The review team heard from a number of members of staff that they were concerned that, because of the additional journey times involved for those patients transferred to Altnagelvin, this means that ambulances are taken out of the local area and can result in a shortage of ambulance availability in the Fermanagh area.

Associated with this matter, the review team heard from NIAS staff that their shifts often exceeded the expected duration if they were transferring a patient to Altnagelvin Hospital. As a consequence, staff reported that there was increased stress and reduced morale among some NIAS personnel.

Potential for Pathways Review

The review team also heard of some consequences of the temporary pathways that may not have been anticipated. For example, prior to the introduction of the temporary pathways, patients with, for example, post-operative wound problems may have been seen, assessed and managed at the SWAH. It was reported that currently these patients are managed by the Altnagelvin team. The review team heard that it would be helpful if there was scope for minor surgical problems, if they did not require operative intervention, to be managed locally.

Collaboration within/ across the Trust

It was heard from some staff that there was a perceived separation between the northern and southern parts of the Trust, and some of those working in the SWAH felt that communication was more difficult and decision may be made without proper engagement with clinical staff in SWAH. Some reported that staff had left SWAH due to issues of morale.

SWAH ED staff involvement in Morbidity and Mortality (M&M) meetings, led by Altnagelvin surgical service, was to be introduced and it was felt there would be benefit in the collective clinical teams having more opportunities to engage collaboratively.

Section 9: Stakeholder Engagement

Engagement with Stakeholders

Members of the review team accepted requests for meetings from some organisations or groups, and for others the review team reached out and sought opportunities to engage. A table listing those engaged with is set out in the Appendix. Below sets out a high-level summary of some of the issues raised. This engagement provided valuable insight into both personal experiences and impact on communities.

The review team met on several occasions with the Save Our Acute Services (SOAS) group, who provided substantial documentation and materials to demonstrate their very significant concerns about the impact of the temporary loss of emergency surgical services at SWAH and its impact on patients. The information submitted by SOAS was wide ranging and informative. SOAS raised a number of matters including concerns with the process by which the temporary suspension of emergency surgery was introduced; their perception of insufficient efforts to recruit consultant surgeons to the SWAH; and their lack of confidence in the Trust actions on this issue. The review team noted that SOAS had not accepted an invitation by the Trust to meet about their concerns. SOAS also raised concerns with the review team about access to Trauma services; lack of information; geography and journey times in a rural setting; as well as issues of capacity in both Altnagelvin and in NIAS. The group advised the review that they shared information with patients and families to make contact with RQIA to contribute to the provision of personal patient experiences.

Liberty Hill Community Group shared substantial information including information relating to centralisation of acute services in other jurisdictions and their findings. The group also shared information on issues relating to: equity of access; rural access issues and impact on health outcomes; inter-hospital transfers and impact on patient outcomes; human rights in healthcare; a recruit and retain initiative; and issues relating to barriers to active community participation.

Several political party representatives engaged with the review. The opportunity was taken to describe how the review was being undertaken and the areas it intended to explore.

Some GP Practices shared their knowledge of the impact of the temporary suspension of surgical services at SWAH, from a primary care perspective. Those who engaged, shared concerns about patient access to emergency surgery, given the distance to Altnagelvin, particularly for rural communities, and concerns that patients may be reluctant to come forward for services, in the knowledge that it may mean spending time some distance from families. GPs also expressed concern about the impact on primary care services and potential impact for GP recruitment, given practices working in rural

areas already had well known challenges and, in their view, this may be exacerbated with the local acute hospital not providing emergency surgical services.
The Royal College of Nursing, the regional Trauma Network and the Patient Client Council shared their views with the review team.

A full list of those engaged with is set out in Appendix 1.

Section 10: Conclusion

This review did not identify immediate patient safety issues during the review team site visits, and review of the documents and limited data available. The review has identified several issues that are clearly impacting on the effectiveness of the clinical pathways put in place to mitigate the temporary suspension of emergency surgical services at SWAH. The review recommends that these are addressed with urgency. These are:

- the 'double ED wait' for patients who have been assessed in the SWAH, determined as requiring admission and accepted for admission, then on transfer to Altnagelvin Hospital, have been required to wait again in ED.
- the lack of sufficient commissioned capacity of NIAS

Patients assessed in SWAH and accepted for admission, should have a direct admission to Altnagelvin in-patient surgical service. It is encouraging that recent reports since July 2024 show up to 95% being achieved. Any additional wait in Altnagelvin ED, coupled with journey time, will significantly affect the total waiting time for the patient from initial assessment, to decision to admit and onward to admission. This should be avoided. Patients appropriate for direct to ward admission, should be admitted consistently.

NIAS capacity is a fundamental requirement to effect the primary pathways put in place to mitigate the temporary suspension of emergency surgery at SWAH namely: the bypass pathway and the transfer pathway. The bypass pathway is totally dependent on NIAS; and transfer of patients from SWAH to Altnagelvin, appears also to be heavily reliant on NIAS.

If these issues persist, it will undoubtedly adversely affect the effectiveness of the clinical pathways and patient experience.

In addition to these, there is a necessity for the development of robust governance and oversight arrangements. This review has identified the necessity for improved data and a clinical evaluation / audit programme, to provide evidence to establish the clinical effectiveness of the pathways put in place. Engagement with the Trust senior staff indicated a strong commitment to this and to ensuring that information that demonstrates effective oversight is available and appropriately reported.

The information systems within the Trust appear not to have the ability to readily draw out the information required. This will need to be addressed or alternative methods adopted. Supporting data must be recorded and evaluated, with learning points identified, so that targeted interventions can be implemented in the agreed pathways with resulting improvement in patient care. Information which would seem to be essential in demonstrating clinical effectiveness for this group of patients would include: numbers and outcomes for patients presenting with surgical symptoms / pathology to SWAH; numbers

and outcomes for patients transferred to the emergency surgical service and numbers and outcomes for patients subsequently managed at the SWAH and those admitted under care of the emergency surgical service following transfer. A similar approach applied to evaluate the effectiveness of SWAH surgical ambulatory service would be useful in clarifying hospital admissions avoided. This should also examine if issues arise at weekends when the ambulatory care surgical unit is not available. These issues require to be explored to determine how effective the model is in avoiding onward transfers, and where there may be opportunities to make improvements.

For those that are admitted to in-patient surgical services at Altnagelvin Hospital, clinical audit / evaluation should examine length of stay. For those that have had an extended stay, this should examine if there is an earlier opportunity for the patient to be repatriated back to the SWAH, if surgical needs have been met. The post-operative journey for patients should also be examined, including exploring if patients required to be readmitted, should there be a post discharge complication. In such circumstances clarity, on how that pathway is accessed by the patient, and/or with their GP support, would be required.

Clinical evaluation / audit can also examine if the pathways are sufficiently sensitive to the holistic needs of the patient, particularly palliative care and end of life.

The review findings demonstrate that there is a need for clinical evaluation / audit to examine all these issues to determine the effectiveness of the current pathways and if the pathways need modified. This can then inform and drive an improvement programme.

The effectiveness of the clinical pathways put in place cannot be fully determined without this evidence.

It is however apparent that there are issues that need to be addressed that will materially contribute to the effectiveness of the clinical pathways. These are: direct to ward admission for patients who have been assessed at the SWAH and accepted for admission to Altnagelvin Hospital, with no ‘double’ ED attendance; and sufficient commissioned NIAS capacity, for bypass pathway, for transfer of patients and NIAS wider services to the area. It is the view of the review team that these issues are fundamental to the delivery of the mitigating pathways and if not addressed, the ability to evidence effectiveness of the clinical pathways will be limited.

In light of the above, a summary of the review recommendations, reflected on throughout this report, now follows.

Section 11: Summary of Recommendations

All of the recommendations made throughout this report acknowledge the pressing need to assess the current effectiveness of the pathways, identify issues for improvement and to make those improvements. The recommendations made, if implemented, will provide the Trust with the necessary information and the mechanisms to effect this.

The following recommendations should be taken forward with urgency because they have the potential to deliver improvements to the clinical pathways with immediate effect

Recommendation 3
Patients assessed in SWAH and accepted for admission to the Altnagelvin surgical service should be admitted directly to the surgical ward and should not be required to attend or wait within the ED at Altnagelvin. The Trust should ensure the achievement of this 'direct to ward' admission for transferred patients is accurately calculated and reported regularly to provide assurance it is sustained.

Recommendation 4
There is a need for the Department of Health to consider the provision of a more sustainable and resilient ambulance capacity to strengthen the model supporting emergency surgical services within the Trust area, and address concerns about the impact on NIAS services more widely in the area.

The following Recommendations should be actioned promptly, and will strengthen the sustainability of the service model

Recommendation 1
In developing plans for substantive recruitment of surgical doctors to staff the ambulatory surgical unit and surgical assessment service at SWAH, the Trust should include measures to strengthen direct access to consultant clinical supervision. Such plans should also include measures to broaden the skills and experience for doctors working in these areas. This should assist in improving the sustainability of the model.

Recommendation 5
The Trust should undertake clinical evaluation / audit to examine the issues that have a direct impact on surgical in-patient bed occupancy at Altnagelvin Hospital. This would help to define the bed capacity required to cater for the predictable additional admissions arising as part of the temporary emergency surgical model for the western area. Such audits should also explore potential for repatriation of patients to the SWAH.

The following Recommendations should be actioned promptly to ensure the Trust Board have appropriate information to enable it to fulfil its oversight and

governance responsibilities, with particular regard to the effectiveness of the clinical pathways, identifying issues that require improvement

Recommendation 2
The Trust should undertake a formal evaluation of the Surgical Ambulatory Care Unit at SWAH to explore the effectiveness of the model in providing for non-inpatient surgical care at SWAH, including examining the criteria for acceptance, and identifying any opportunities to improve the service. Information on its effectiveness should be made available to the Trust Executives and Board.

Recommendation 6
The Trust should review bypass and transfer pathways to identify any areas for improvement, and consider if they adequately allow for assessment of the patient's holistic needs, particularly those with palliative care and end of life needs.

Recommendation 7
The Trust should develop a clinical evaluation/ audit programme, involving staff from across the two hospital sites and services, to examine how the clinical pathways are working and to consider clinical outcomes, in order to drive ongoing quality improvement of the pathways.

Recommendation 8
The Trust should identify and monitor key indicators of potential impact on other specialties or services at SWAH, so that the Trust Board have the opportunity to identify and address any emerging issues proactively.

Recommendation 9
The Trust should ensure that in addition to service activity levels, information relating to service quality, including identified outcomes from adverse incident reviews, and outcomes from an established clinical audit programme, are included in regular reporting at Trust Board to ensure effective governance.

The following Recommendation should be actioned promptly to ensure patient experience is actively sought and evidenced as part of the improvement programme

Recommendation 10
The Trust should proactively seek patient experience, and demonstrate it is valued as a key component of a patient safety and quality improvement programme. Outcomes from the quality improvement programme should be reported at Trust Board.

Appendix 1: Stakeholders engaged with during the Review Process

Review Team engaged with:
Alliance Party Councillor for Fermanagh and Omagh District Council
Democratic Unionist Party (DUP) MLA for Fermanagh and South Tyrone
General Practice GP Londonderry
Liberty Hill CIC
Northern Ireland Trauma Network (NIMTN)
Patient Client Council (PCC)
Patients and family members
Royal College of General Practitioners NI Chair
Royal College of Nursing
Rural GP Representatives in Lisnaskea and the South West
Save Our Acute Services (SOAS)
Senior Management and staff of the NI Ambulance Service
Senior Management and staff of the Western HSC Trust
Sinn Féin MP for Fermanagh and South Tyrone
Social Democratic and Labour Party (SDLP) Councillor for Fermanagh and Omagh District Council
Staff from across services in Trust area (one to one basis)
Ulster Unionist Party (UUP) MLA for Fermanagh and South Tyrone

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The Regulation and Quality Improvement Authority

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