HEALTH COMMITTEE BRIEFING

27 NOVEMBER 2025

Introduction – Chair

I want to begin by welcoming the Health Committee to the South West Acute Hospital. You will have seen from your tour, that this is a busy hospital committed to meeting the needs of the local population. It has a Type 1 ED, with a full consultant staffing, an Intensive Care Unit, maternity service, paediatrics, and a range of acute medical specialties. It is also an "Elective Overnight Stay Centre", and alongside our Day Procedure Unit in Omagh, it provides surgery for patients outside the Western Trust.

I want to acknowledge how concerned people have been about the changed pathways for inpatient emergency general surgery, which transferred to Altnagelvin in December 2022, we could no longer sustain that service, with no substantive consultants to staff the rota. However today many people continue to have their surgery on this site, and there are more patients being treated, across more specialities, than in previous years.

I pay tribute to all the staff within this excellent hospital – you will have witnessed their commitment and compassion today and every day. We will expand on the impact of revised pathways for Emergency General Surgery in Neil's presentation.

I want to briefly speak to the geographical, economic and demographic profile of the Western Trust's population. A key priority for everyone in health and social care leadership, and I am sure this Committee, must be to reduce the significant health inequalities which exist across health status in Northern Ireland. Our geography in the West presents challenges with a significant distance from the North of our boundary to the South, and significantly therefore between our 2 acute hospitals sites the distance involved compounded by under investment in the road network. The Trust borders several counties of the Republic of Ireland, which brings opportunities for partnership working, but also brings additional challenges to recruit and retain staff in what has become a very competitive labour market.

Our Trust has some of the highest poverty and deprivation levels in this Region creating high levels of need and demand for care. The Committee will know that 2 Council areas in Northern Ireland – Derry City and Strabane and Belfast, have greater levels more deprived areas that any of the other 374 local authorities in England, Scotland or Wales, and the rest of Northern Ireland.

Derry City and Strabane is a place where we see multiple dimensions of deprivation across the domains of Income, Employment and Health Deprivation and Disability – 5 out of the 10 most deprived areas in Northern Ireland are in that Council's boundary – East, Crevagh 2, Strand 1, the Diamond, and Creggan Central 1.

There is a different but nonetheless concerning picture in Fermanagh and Omagh, which shows that the poor physical and online access domain is most pronounced in this rural geography. 5 of the 10 most deprived areas for Access to Services in Northern Ireland are in this Council area – Belcoo and Garrison, Rosslea, Trillick, Sixmilecross and Owenkillew.

The health status of our population differs quite significantly between the northern and southern sectors. According to the 2025 NI Health Inequalities Report produced by the DoH and the Northern Ireland Statistics and Research Agency (NISRA). That shows that – across a range of 32 health outcome indicators – in our Northern Sector the population has 17 health outcomes that are worse than the NI average, and 15 which are similar to it. By contrast in the Southern Sector there are 8 health outcome indicators which are better than the NI average, 23 on a par with it, and only 1 which is worse than the NI average.

This data shows that we have pockets of need and areas of particular health inequality in the West – some of the worst in the UK. A uniform approach to addressing need and reducing health inequalities will not work for our population, and a targeted approach is needed, and to that end it is urgent that the capitation formula that informs the calculation of the financial allocation for each Trust area includes within it a weighting to address deprivation.

The Committee has invited us to present on Trust wide issues. I will now pass over to Neil who will continue the presentation.

Neil's Presentation

Good afternoon, I want to outline some of the Trust's key challenges but I will give balance by closing with some of the key successes within the Trust.

Health and social care and the Western Trust are faced with unprecedented pressures with significant gaps between our commissioned capacity, and the presenting demand for access to our services. Increased demand will be linked to deprivation, and also to demographic changes, which means we are caring for older, sicker and more complex patients in our hospitals and in the community, but also that we have higher numbers of children in need and in formal care, poorer mental health reflective of the health status of our population.

I want to start with our significant challenges within mental health services.

Mental Health

Mental health services are experiencing extremely high levels of need with all areas of the service experiencing more people needing support as well as more complex needs.

We have conducted a 'deep dive' review into adult mental health services with a number of ways to improve patient experience identified, however more funding is required to support these to get the full benefit.

There is also work needed improving how different parts of the system work together making it easier for people to navigate.

More, longer-term funding is required if we are to properly transform our mental health provision.

The sickest of our MH patients are cared for in our acute MH hospitals in Derry and Omagh. We are commissioned for 56 inpatient beds across the Trust to care for people, including 10 Psychiatric ICU beds. We often operate at over 120% capacity which puts pressure on staff and is not the standard of care provision we would wish for these very vulnerable patients.

In our MH services, we are heavily reliant on agency locum doctors, and have struggled to recruit a single consultant despite agreement from DoH for a recruitment and retention premium of 20% for a number of specialist areas. Our psychiatry funded staffing levels do not reflect the level of need linked to the deprivation in the West.

The Department of Health's report on consultant and SAS doctor workforce as at May 2023 showed our consultant psychiatrist numbers as 5.6 per 100,000 population, with the Northern Ireland average at 10.7 – we have 50% of the consultants of other Providers in the region. Whilst the challenges are at their most extreme in Psychiatry, the Trust is experiencing staffing challenges in a range of specialties and I will cover that in a bit more detail shortly.

Mental health is not all about beds and psychiatrists. Much of our care is given in the community and through crisis support, however the high level of need, and the level of gaps in our medical workforce to treat that need, do create risk. Investment across beds, medical staffing and community crisis services is required.

Medical Staffing

I have highlighted to the Committee before about the disproportionately low level of medical staffing in some specialties in the West and the consequent reliance on agency locum staff.

The Western Trust continues to face significant medical workforce pressures, with 104 active medical and dental vacancies representing around 13% of our funded establishment. The most sustained challenges are in Psychiatry, ENT, Radiology, Paediatrics, Obstetrics and Gynaecology at Altnagelvin, Uro-oncology and OMFS.

These pressures are reinforced by long-standing issues with medical trainee supply, including a mismatch between the number and type of NIMDTA doctors in training and service need for those trainees, a low number of senior trainees in key areas, and rising numbers of less-than-full-time trainees. All of this creates ongoing rota fragility, higher dependence on locums and associated costs, and impacts on waiting times, staff wellbeing, and service resilience.

ENT remains an area where we have particular concern, though we continue to maintain safe services. We currently have one substantive consultant supported by a locum consultant, an international appointee, and temporary agency cover. While this provides day-to-day stability, it does limit the depth of the rota and has contributed to the loss of allocated trainees. Recruitment efforts are ongoing through local, regional and international routes, and we will continue to build on these to strengthen the service.

Other specialties, including Paediatrics, Radiology and OMFS, continue to depend heavily on locums or retired consultants returning to practice to maintain continuity.

Radiology in the west receives disproportionately low numbers of senior trainees from NIMDTA, relies heavily on internationally recruited doctors, and faces increasing competition from GB Trusts offering more attractive terms.

In Obstetrics and Gynaecology we are seeing differing pictures across our sites. SWAH now has a fully staffed consultant rota, which has significantly improved stability here. However, Altnagelvin continues to face real difficulty attracting candidates because we operate a combined obstetrics and gynaecology rota; this differs from the separated rotas available in other Trusts and is a barrier for applicants seeking subspecialist focus or a more manageable on-call pattern.

So what are we trying to do about it? With stabilisation measures including significant investment in international medical recruitment including a bespoke campaign to India, talent pipeline development, targeted attendance at national and

international psychiatry events, the development of Specialist Doctor roles, use of Physician Associates and Clinical Fellows, and increased flexibility through retire-and-return and part-time options. However, to secure long-term sustainability, we do need regional action: a strategic review of future trainee supply by specialty, more equitable NIMDTA allocations (both in number and seniority), a fairer distribution of New to NI doctors across Trusts, and ensure Northern Ireland pay and conditions are aligned with GB to enhance competitiveness with other UK regions and internationally for scarce medical talent.

Social Care

Both our acute hospitals have high levels of patients who are medically fit but are delayed in being discharged from our hospitals.

The level of commissioned nursing home places is much lower in the West than all other Trusts. We have over 500 less nursing home beds than any other Trust in Northern Ireland. We struggle to source domiciliary care in some rural areas in our Southern Sector, delaying people who require packages of care, for safe discharge and this has had a major impact on the numbers of people who are medically fit but remain in our hospitals.

To address our delayed discharges, we have tried, within existing resources, to increase capacity. In 2024/25 we increased capacity by 38 beds across all categories and sectors; this year we intend to put in place a further 53 beds giving over 40 bed increase in 2 years.

Our Domiciliary Care Rota Optimisation Programme has been a major success in increasing the efficiency of existing services. It has increased service hours for clients equivalent to 200 whole time staff on the ground, through Providers and clients working flexibly to maximise the capacity we get from our existing rotas. This has transformed our ability to quickly source care package for clients in the Northern Sector. The issue of rurality in the Southern Sector remains a challenge for us and our Providers. We are in the process of tendering our service Trust wide, but we aim to develop local strategies to try to address rural service provision irrespective of that. We will need support from community groups and a range of flexible approaches to address this challenge.

Emergency General Surgery

Turning to Emergency General Surgery, this sort of debate is ongoing across UK and internationally – the challenge between local access and sub specialisation. I want to highlight a number of key developments. There is a drive to ensure that certain surgical procedures should be done as a day case, and this is a key target set by SPPG for the Trust. Many emergency patients can be treated as an ambulatory surgical patient, same day or next day, with no need for admission to hospital. Hundreds of patients receive a safe service this way every year now at both SWAH and Altnagelvin. The majority of patients who present at SWAH ED with a requirement for general surgery intervention are now treated at the new Ambulatory Unit (over 5 patients per day) with 2.5 patients per day admitted for inpatient care and treatment at Altnagelvin Hospital.

At our last attendance at this Committee there was a focus on the double ED journey – for the first 18 months we struggled with getting patients direct to a bed in Altnagelvin, with only 26% of patients presenting to SWAH ED getting direct to a bed in Altnagelvin. From May 2025, 92% of general surgery patients from SWAH ED now go direct to a bed.

We all accept that delays in EDs are too long across Northern Ireland, I apologise at every Trust Board meeting – this is clearly linked to the complexity of patients, and the ability to assess and provide appropriate social care capacity. The small number of patients who transfer to Altnagelvin ED from SWAH are not the cause of Altnagelvin pressures.

Turning to our revised pathways, it is my role and Dr Lavery's role to assure my Board, the Minister and ultimately the public on the safety of our services. I can confirm that Western Trust is now fully compliant with Minister Swann's revised Standards for Emergency General Surgery. We have transformed our consultant workforce, with a full substantive consultant tier, and a 24/7 Upper GI bleeding pathway in place.

All Trusts in Northern Ireland have contracts with a benchmarking organisation, CHKS, and we submit raw data which is automatically exported from our patient systems to them which they analyse to produce mortality, flow, efficiency and safety and quality metrics.

We now have a number of years of analysis of our revised pathways, and this data shows us that Trust-wide, our general surgery mortality level has reduced by approximately 14%. That means that all general surgery patients, no matter what postcode in the West, have a better chance of survival as their clinical pathway is in line with all of the required standards in NI.

There has also been a 21% reduction in complication rates and a 22% reduction in readmission rates for our general surgery patients, which are important markers of safe and effective care, and good clinical outcomes for patients.

These improvements in outcomes are as a direct result of consolidating our medical workforce, increasing our ability to sub specialise and have the clinical interdependencies referred to in the revised standards available to our surgical team.

The hospitals campaign group SOAS has produced a Roadmap with a range of recommendations. We were disappointed not to have had the opportunity begin a conversation with SOAS on their Roadmap last week – the Trust was keen to do so. There are recommendations we would support, there are recommendations that are for other bodies/partners to take forward and there are recommendations that we cannot support, either because SOAS do not have the full or accurate facts, or because there are patient safety issues with what they are suggesting.

- Having a successful consultation on the temporary closure, we recognise the consultation process we proposed into the future of these services was not good enough. We did not engage well enough with partners, stakeholders and

the public leading to fear and misunderstanding about the future; both of the general surgery provision but also the future of SWAH as a whole

- We are committed to making sure we put that right. We want to have an open and honest conversation with the public about the services we provide at SWAH and beyond, what we can deliver, what we should deliver and how we ensure all the services we do provide are clinically safe and sustainable and meet the needs of local people.
- I want to remind everyone that figures show the patients who require emergency general surgery being transferred to Altnagelvin have not been adversely affected, in fact we have seen a fall in deaths and complications in emergency general surgery since this change has taken place.

Next steps

- A new approach to a conversation with the public, stakeholders and partners is required.
- With the public, partners and stakeholders, we will look again at the population health and care needs of the Fermanagh and West Tyrone (FWT) area, to inform future work and priorities; building together a plan for our local health system, which includes SWAH, but goes beyond to offer improved access to community services, and primary care.
- We will start afresh with a public conversation about our local health services, what we need, what we value and how we provide that in a way that is practical and sustainable both clinically and financially.

We will:

- Build trust
- Reset relationships
- Create, and follow, a transparent, open and clear narrative to support a new, inclusive way forward that builds a culture of cohesion and collaboration
- Provide clear, transparent information rooted in clinical evidence
- We will create mechanisms for service design which creates services the public not only trust and support but which they feel ownership towards
- Engage with our staff so they not only understand, and feel part of any changes but they also feel equipped to speak confidently about what they mean for them and for the people they care for
- Create a co-designed plan for the future which has community buy-in, is centred around the voice of the patient and is practical and sustainable

Turning to Winter Planning

In line with all NHS and care services winter pressures have a huge impact on service provision and it is vital that we minimise the effect this has on the experience of our patients.

To do this we will:

- Continue to strengthen our local partnerships to ensure the care people receive is coordinated, joined up and consistent

- Make sure we are making best use of our existing pathways and initiatives to get people the right care, in the place at the right time for them.
- We have given some detail in our pack, on our preparations for winter. The West generally has to address its own demand rather than rely on system support from other hospitals, given our geography.

Some headlines would be:-

- We have updated our escalation plans, our site co-ordination processes and our site co-ordination hub is well established;
- We have created 8 Additional short stay inpatient beds in ACU Altnagelvin Hospital to help with the flow of patients;
- We have enhanced our staffing cover for ambulance off-load and have a dedicated area set aside for that, to enable the release of ambulance crews, and we have very good ambulance handover performance at SWAH and Altnagelvin;
- We have mobilised 7 day same day emergency care in SWAH;
- We have added an Additional 12 community beds, initially in Altnagelvin, and we will transfer these to Waterside Hospital;
- We have put in place a wide range of flow improvements, such as Community Navigators and Discharge Co-ordination.

Turning to Elective care

We welcome the investment in elective care but recognise there is still further funding required to properly meet the needs of our local population in a truly sustainable way.

The funding available will allow us to invest in elective care with:

- 7000 additional CT scans, 2100 additional MRI scans and 1050 additional ultrasound scans per year.
- 1470 additional scopes per year.
- 495 additional general surgery sessions per year
- 84 additional gynaecology inpatient sessions, 42 additional day case sessions and 84 additional outpatient sessions in SWAH per year.
- Increased phlebotomy capacity – additional 225 appointments per week.
- 8 additional trauma beds on a recurrent basis to address increased demand and reduce the impact of this on elective orthopaedics
- Further investment is planned including increased capacity in Breast Services, ENT, Urology, Ophthalmology and Dermatology

There are fundamental demand and capacity gaps across many specialities surgical, medical, older people, children and mental health. Minister has converted the non-recurrent flow of funding for Waiting List Initiatives to create additional recurrent capacity within Elective Care, and the Western Trust patients will benefit from this with improved access as a result. It will take sustained investment alongside

improvement in efficiency over a number of years to address the current lengthy waiting lists, but we are already making good inroads.

As Chief Executive of the Trust, it is my responsibility to set out for the Committee how difficult the world of a Provider Trust can be, and I hope the examples I have given today give you an insight to the scale and complexity of our services and the challenges my teams face daily. It is also my responsibility – and this is the enjoyable part – to let you see that every day we have teams and leaders who want to provide excellent care and change services for the better. Some examples are:

- I have already referenced the Domiciliary Care Rota Optimisation Programme which has transformed this vital service for our community.

- In Primary Care the Trust has taken over the running of 5 GP practices to sustain access for our population, and prevent those Practices collapsing. I want to especially highlight 3 practices in the Southern Sector, in Dromore & Trillick, Brookeborough and Tempo, and Fintona, where we have stabilised the services and then expanded the service offering and organised links with acute care. We have now managed to recruit salaried GPs and we await the roll out of MDTs in the Southern Sector.

- As a Trust we have transformed our adult nursing workforce. This is part of the regional agency reduction programme, and HSC now are able to demonstrate we are the employer of choice. Western Trust now has minimal vacancies, with no

reliance on off contract nurse agency. We are now working towards reduction in contract agency reliance, and this will further enhance and stabilise our teams.

- In child care we have reduced the number of children on the Child Protection Register by almost 30% through engagement and support for families. Our social work vacancy levels have reduced from 21% to 9% in the last 18 months. Also I can confirm that in recent weeks Derry City & Strabane District Council in partnership with the Trust and other partners have achieved the award of the UNICEF Child Friendly Community. This is the first in the island of Ireland and second in the UK.

- We have turned around our Endoscopy performance from having one of the longest waiting lists to now having the smallest number of patients waiting. This diagnostic test is a critical one for early cancer diagnosis.

- Our track record in infection control is strong - Both *C. difficile* and MRSA rates have experienced a significant reduction in recent years.

- Our imaging services are highly efficient and continue to deliver above funded baseline levels for specialist reporting. Our CT service is delivering at 127% of expected levels and our Cardiac MRI at 121%. General MRI is also above expected levels.

- In relation to staff absence, we achieved the DoH target reduction last year and have continued to reduce absence levels in the current year.

One key opportunity for the West is cross border partnership. The Co-operating and Working Together Partnerships has secured significant grant funding from the EU Special Programmes Unit to address border regions.

I can assure the Committee that the Western Trust is at the forefront of cross-border co-operation, with significant services jointly commissioned in our Trust. We remain totally committed to this and are hopeful of further developments in the coming months.

I can confirm that the CAWT partners have agreed 2 developments. First, a scoping exercise to identify further opportunities for co-operation, particularly focussing on acute hospitals in border areas. This will be co-ordinated by CAWT. Second, CAWT is supporting engagement between the 2 Ambulance Services to identify any perceived or real barriers (post EU Exit) to cross border ambulance conveyance to support communities. We know NI Ambulance Service is fully committed to this and it will become a government to government issue. It may be particularly important for mitigating concerns about travel times to Altnagelvin and access to Emergency General Surgery for some small communities closer to Sligo or Cavan Hospitals than Altnagelvin.

Locally we are working with the SAOLTA group to develop a formal partnership agreement to underpin the co-operation over the next decade.

So locally and regionally we are pushing cross border approaches.

Committee again I thank you for coming to the West and we are happy to take questions and comments.