REVIEW OF URGENT AND EMERGENCY CARE SERVICES IN NORTHERN IRELAND

REVIEW TEAM REPORT

Abstract

Report from the Review Team looking at the provision of Urgent and Emergency Care Services in Northern Ireland, commissioned following the publication of the Northern Ireland Population Needs Assessment for Urgent and Emergency Care

2020

Table of Contents

Foreword: Dr John Maxwell 6
Chapter 1 – Context 9
Introduction 9
The need for change 9
Background to the Review 12
Next Steps 13
Application of Learning from the Review to COVID-19 Response 14
Chapter 2 – Current Position 17
What is Urgent and Emergency Care? 17
What services are provided at present? 17
What pressures are services experiencing? 18
Key Findings of the Population Needs Assessment 20
Learning from experience in other regions 24
England 24
Scotland 25
Wales 26
Denmark 26
Netherlands 27
Conclusion 30
Chapter 3: What have we heard from service users, carers and staff? 31
Introduction 32
Approach to stakeholder involvement 32
Urgent and Emergency Care Stakeholder Summit 33
Involvement and Co-Production Working Group 33
Involvement Plan 34
Involvement Workshops 37
Staff engagement 39
Summary of involvement with service users, carers and staff 40
Chapter 4 – Urgent or Emergency 42
What drives attendances at ED? 43
Does ED deliver the best outcome for all patients? 43
Chapter 5 – Standardisation, Coordination & Accessibility 46

Integration, navigation and accessibility 46
Standardisation 48
Rapid Access, Assessment & Treatment 49
Improving co-ordination 50
Phone First Systems – Telephone Triage and Clinical Assessment 52
Chapter 6 – Paediatric Care 58
Current model of care 60
Emerging models of care 60
Ambulatory/Short Stay Assessment Units 62
Primary Care HUBs 62
Paediatric Mental Health Services 64
Paediatric ED/CAMHS interface 65
Conclusion 65
Chapter 7 – Mental Health and addiction Services 67
Background 67
Current delivery of liaison mental health services 70
Current Challenges 74
Principles of Care 75
Right person, right place, right skills, first time 75
Coordination and standardisation 76
Barriers and Silos 76
A holistic approach 76
Safer, more appropriate environments 76
Better outcomes 76
Models of good practice 76
Towards Zero Suicide 77
Protect Life 2 - Suicide Prevention Strategy 77
Community Crisis Intervention Services 77
MATT Pilot 78
Alcohol Recovery Centre 78
Mental Health services in NHS England Urgent Treatment Centres 78
Crisis Response – Mental Health Liaison 78
Edinburgh model 79

Safe Haven: The Royal Oldham Hospital (NHS England) 79
Frequent attender programmes 79
NICE - Achieving better access to 24/7 urgent and emergency mental health care 79
Conclusion 80
Recent developments 80
Chapter 8 – Improving Care of Older Persons 84
Emergency Departments and Admissions 85
System Variance 86
Workforce 87
Frailty 87
Social Care 92
Palliative Care 93
Current work and strategic direction 94
NIAS Frequent Attenders 94
Intermediate Care 96
Dementia 99
Regional Emergency Social Work Service 100
Palliative Care 102
Service Provision across Nursing & Residential Homes 105
Care Home Support Teams 107
Access to General Practitioners 109
Care Home In-Reach 109
Neighbourhood District Nursing 113
Palliative Care in Partnership 114
Primary Care Infrastructure Development (PCID) 116
Infrastructure Model 118
Principles for Older Persons who become Admissions 120
Trauma 123
Development of Options for optimum configuration of UEC services 124
Standardisation 126
Northern Ireland Ambulance Service: Direct Admissions & Related Referral pathways 127
Examples of Best Practice 131

The Future Hospital Programme 131
The Kings Fund 132
Medicines Optimisation 132
Local good practice 133
Chapter 9 - Workforce and Training 140
Workforce Strategy 140
Objectives 140
Themes 140
Royal College of Emergency Medicine Survey 141
Emergency Medicine Workforce Plan – 2014-2022 142
Multi-professionalism 142
Workforce and capacity 143
Culture and Trust 144
Creating a collaborative culture 145
Chapter 10: Capacity and Flow 150
Capacity 150
Occupancy 155
Flow 157
Length of Stay 159
Admissions 162
Discharges 164
Standards, Measures and Performance 167
Future Requirements 168
Planning Future Hospital Bed Capacity 168

REVIEW OF URGENT & EMERGENCY CARE

Foreword: Dr John Maxwell

As an accident and emergency consultant who has worked in the NHS for over 20 years, I felt humbled and privileged to be given the opportunity to lead a review of urgent and emergency care in Northern Ireland. It has been an amazing journey that has afforded me the opportunity to engage and meet with both the people who use the health system and the dedicated professionals who tirelessly deliver outstanding care. I was inspired by the passion, innovation and best practice already present in many of the healthcare settings I visited. However, it was also obvious from listening to users, carers, and professionals that things need to change.

Even before the spectre of COVID loomed over us, everyone recognised that the urgent and emergency care system would need transformed to continue to deliver an outstanding service for the people of Northern Ireland. An increased number of people waiting more than both 4 and 12 hours in Emergency Departments demonstrated our health and social care system was currently under severe pressure. This, coupled with a population assessment which projected an increase in people over 65 needing hospital admission over the next decade, made it obvious that transformation of the system was essential. The unforeseen and catastrophic pandemic which engulfed the world halfway through this review made the need for change of the system even more obvious and acute.

The review itself was divided into two phases. The first phase engaged and consulted with a wide range of stakeholders such as professional bodies, specialty networks, healthcare trusts, universities, charities and key user and carer groups to name just a few. We particularly focused on what the users and carers thought a future urgent and emergency system needed to deliver. Workstreams with a diverse mix of stakeholders were developed for each of the key clinical and supporting areas of work. The first phase culminated in a health summit which give a clear indication of how people wanted their future urgent and emergency care service delivered. The second phase saw the workstreams provide reports which detailed evidence, examples of best practice and conclusions to transform the current system. These have in turn fed into the final report presented in this document.

There was nearly unanimous agreement in the need for a standardised, coordinated system that delivered care locally in the community wherever possible. Older people's care, paediatrics and mental health were specific areas of concern that were

highlighted on numerous occasions. The need to plan accurately for and develop and retain a clinical workforce was seen as a priority, which is perhaps even more evident since the advent of COVID. The number of acute beds available in the healthcare system was also a key issue. Discussions centred around delivering more care in the home and community setting as well as understanding exactly how many acute beds in total were necessary in hospitals given the current configuration of our health and social care system. There was widespread recognition that the challenges facing unscheduled care were not just about Emergency Departments and there was urgent need for a whole system approach to change and transformation.

This review has involved and engaged people from across Northern Ireland and gathered advice and opinion from experts both nationally and internationally. It has described in detail the key issues, looked at the evidence, studied best practice and drawn conclusions which will deliver an outstanding urgent and emergency care service for the future.

These are challenging and difficult times, it is vital that everyone works together to deliver the change and transformation that is desperately needed.

SECTION 1: INTRODUCTION

Chapter 1 – Context

Introduction

The Health and Social Care (HSC) system in Northern Ireland was already facing huge strategic challenges before COVID-19 hit in early 2020. Prior to the pandemic, there were significant issues in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments as outlined within 'Health and Wellbeing 2026: Delivering Together'. This was all being managed against a backdrop of financial constraints and single year budgets.

Urgent and emergency care was one area that had been identified as in need of reform and much work had been undertaken on a Review of Urgent and Emergency Care before February 2020. As the scale of the impending crisis started to become clear, however, HSC responded swiftly by directing all available resource towards the pandemic response. One unfortunate consequence of this necessary action was that work on the Review was paused.

As we came out of the first wave of COVID-19, there was a recognition in HSC that this new infection would be with us in one form or another for the foreseeable future and that we would have to manage COVID-19 alongside other pressures in the system. Work on the Review, therefore, recommenced alongside delivery of the No More Silos Action Plan, which allowed some of the emerging conclusions from the Review to be rapidly implemented. No More Silos ensured that urgent and emergency care services across primary and secondary care could be maintained and improved in an environment that was safe for patients and staff.

While there was a necessary pause in the work of the Review, the Department remains of the view that the evidence base developed since 2018 continues to be relevant and that the strategic direction, as set out in the associated Consultation Report and Strategic Priorities document, provides the most appropriate response to the longstanding issues. Given the significant impact on Emergency Department (ED) attendances during the COVID-19 surge periods, largely as a consequence of lockdown measures introduced during these times, the Department is clear that the evidence and data captured pre-pandemic remains the most appropriate on which to base decisions for long-term change. This is indeed reflected in the remaining sections of this evidence report.

The need for change

There is clear evidence that our urgent and emergency care services have been under significant, and increasing, pressure. In recent years, it has become normal for those

attending Emergency Departments (EDs) to experience overcrowded waiting rooms and long waits to be seen and treated.

The most commonly used measures of performance at Emergency Departments are the 4 hour and 12 hour targets. These targets are set by the Minister and state that:

> **'From April 2019, 95% of patients attending any Type 1, 2 or 3 emergency care department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency care department should wait longer than 12 hours.'**

In ten years, from 2008 to 2018, the number of patients spending more than 4 hours in EDs quadrupled.

More strikingly, in 2009/10, 3881 patients waited longer than 12 hours. In 2019/20 this had risen to 45,442 – almost 5% of the total number of those attending EDs.

Patients and their carers have told us about their poor experiences caused by spending long periods in EDs, and also of their frustration at being unable to access the care they need without sitting for long periods in crowded ED waiting rooms.

Longer term projections indicate that the number of people, particularly older people, requiring urgent and emergency care will continue to rise over the coming decades.

The Figure 1 below shows projections for the population of Northern Ireland by age group from 2016-2026.

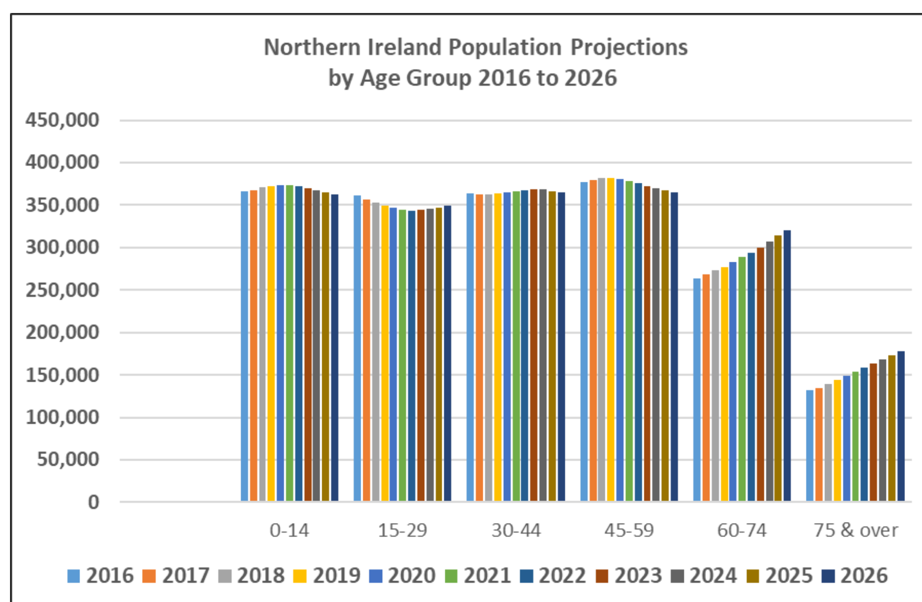


Figure 1: Northern Ireland Population Projections by Age Group 2016 - 2026

During this period, the population of Northern Ireland is projected to grow by 77,600. The number of children aged 0-15 years is projected to rise by 600, however, the population aged 65 and over is projected to rise by 74,500. This is a significant change

in the demographic profile of the country which will have a significant impact on demand for urgent and emergency care services.

Attendance rates at Emergency Departments and emergency admission rates rise steeply in the oldest age groups. The pressure on services will not relent and is likely to increase, with admissions for people aged over 65 years projected to increase by 25,807, between 2016 and 2026.

Staff are reporting personal stress and fatigue, and some services are experiencing difficulties in recruitment. While the Review team heard of many examples of good or innovative practice, it is clear that fundamental changes to the overall model of care are required.

Furthermore, in the context of the ongoing pandemic, it is not tenable to allow Emergency Departments to reach the levels of crowding that has been experienced in previous years. As the Royal College of Emergency Medicine has stated:

> *"There is a moral imperative to ensure our Emergency Departments never become crowded again. If we are crowded, we cannot protect patients and staff. Crowding has long been associated with avoidable mortality, and COVID-19 reinforces and multiplies this risk. Emergency Departments will need to continue to operate in segregated streams, with an absolute focus on minimising nosocomial infections.*
>
> *There will be a 'nosocomial dividend' from implementing these recommendations, with reduced infections to staff and patients and improved safety and quality of care. This will also need to be the case within the whole system, and the challenge that this represents cannot be underestimated. The whole health system must adapt and change."*

There is little doubt that the pressures at Emergency Departments are a symptom of a much wider problem relating to capacity across health and social care. 24/7 urgent and emergency care services have become the safety net for the entire system. As other avenues into the health system come under pressure, EDs have gradually moved from being the place of last resort to the path of least resistance.

Our current model of unscheduled care is heavily focused on accidents and emergencies despite the fact that the majority of patients attending EDs are not in that category. In the past, we have inaccurately described the attendance at an ED of many of these patients as 'inappropriate'. In fact, it is our own system that makes these attendances inevitable, and channels patients through an Emergency Department because in many cases it is the most viable, and the most user friendly, option. In effect, the Emergency Department has by default become the front door for all unscheduled care, emergency or otherwise.

The problems of overcrowding and long waits are not, however, solely due to the numbers of patients arriving at an Emergency Department. One of the most important factors leading to these issues is the situation often known as 'exit block', whereby patients who have been assessed in the ED wait for long periods on trollies due to a lack of admitting capacity in the rest of the hospital.

The problems at our EDs are therefore often the symptoms of wider issues and, consequently, any solutions must look beyond the walls of the hospital and across the wider health and care system. Any changes to Emergency Departments will only succeed if they are part of a whole system approach to managing demand for urgent and emergency care services.

Countries around the world are wrestling with these problems and many are dealing with similar scenes of overcrowding and long waits to be seen. However, while all health systems face challenges, there are also systems that appear to deal more effectively with unscheduled care. In developing our own model of care for the future, we must learn from best practice here and elsewhere.

Background to the Review

The first step in carrying out an extensive review of urgent and emergency care for Northern Ireland was to complete a Population Health Needs Assessment (PHNA). The PHNA was published in November 2018[1]. An overview of the key findings is set out in chapter 2 of this report.

On 26th November 2020, the Department announced a review of urgent and emergency care services across Northern Ireland's hospitals. The overall aim of the Review was to establish a new regional care model for Northern Ireland, with particular focus on meeting the needs of the rising proportion of older people in the population.

To inform the recommended actions, the Review team has:

- carried out an extensive programme of engagement, including workshops with patients, staff, representatives of key organisations and senior leaders across the system;
- reviewed a wide body of reports relating to service arrangements in the United Kingdom and internationally;
- visited centres across the UK and internationally to see alternative models of care; and
- commissioned additional research and analysis to inform the review.

[1] https://www.health-ni.gov.uk/sites/default/files/publications/health/NI-population-needs-assessment-report.pdf

Workstreams were established to review particular elements of services and to focus on the needs of specific groups, including:

- arrangements for urgent care;
- arrangements for emergency care;
- integration and co-ordination of services;
- improving flow and assessing system capacity;
- the future use of technology in urgent and emergency care;
- care of the elderly;
- children and young people; and
- people with mental health problems.

This report sets out the main findings of an extensive body of work carried out by the Review team. It is intended to create a blueprint for a model of provision, which will meet the needs of our future population. This report is the end of the development/analysis phase and represents the review team's conclusions for the long term model of urgent and emergency care in Northern Ireland.

The conclusion of the Review is not the end of the process, rather it signals the end of the analysis phase and the transition into implementation. There is still significant work to do, particularly in the areas of capacity and workforce, to ensure that these services remain sustainable in the longer term.

Next Steps

As a brand, and as a service, our urgent and emergency care services are known and trusted by the population. Unfortunately, the numbers set out above clearly show that the current service model is not delivering the level of service the population should be able to expect. Staff are working harder than ever, in increasingly difficult circumstances, while patients wait longer. Scenes of crowded Emergency Departments with lines of vulnerable patients lying on trolleys, and lines of ambulances queued up outside, have become increasingly familiar in the winter, and even sometimes at other times of the year.

This already unsustainable position has been further exacerbated by the impact of the COVID-19 pandemic. This has necessitated increased focus on implementing infection prevention and control measures, including the requirement to facilitate social distancing.

There are no simple solutions to the problems in urgent and emergency care, but there is growing evidence that alternative models of care and new ways of working more collaboratively across the system could offer real benefits. The actions set out in this report represent the most significant changes to our urgent and emergency care

services in decades. They will require different ways of working for staff and different ways of using the services by patients.

As part of this work, the Review Team met with a range of service users and staff from across the system. There is tremendous frustration with the current model, particularly from healthcare staff who desperately want to provide the best possible care for their patients. However, there is also tremendous energy, a willingness to try something new, and a desire to work more collaboratively and break down the artificial silos we have created for ourselves. There is no doubt that delivering the reforms set out in this document will be challenging, but with collective will and effort of committed health and care staff across the system, there is every reason to believe it can be done.

Any major change can be a source of anxiety for those who use or work in the affected services, and this is particularly true when it comes to health and social care. However, it must also be accepted that the current position and future trajectory of the unscheduled care system is unsustainable. If we do nothing, we are simply accepting that waiting times will increase and EDs will become ever more crowded. This is not acceptable. Radical transformation is required.

In considering the conclusions of this report, it is important to keep four key points in mind:

- **The current model is failing;**
- **Demand is increasing;**
- **In a pandemic situation, overcrowding in EDs simply cannot be allowed; and**
- **As well as increasing capacity, there are better ways of working**

Application of Learning from the Review to COVID-19 Response

While the report draws conclusions about changes to the model of urgent and emergency care in the long term, there are also a number of immediate priorities where the demands of the pandemic have meant that action has been required to maintain urgent and emergency care services through the pandemic.

All health and social care settings need to be organised to ensure that infection control is maximised and this also applies in Emergency Departments. The HSC system's response to the pandemic so far has helped to break down professional and administrative boundaries and demonstrated that a better way of working is possible. The challenges of the pandemic have produced fundamental changes in primary care, leading to universal patient triage, virtual consultation, shared learning and new clinical pathways. Secondary care colleagues have reached out to GPs with offers of new pathways and opportunities for working together. These initiatives are fully consistent with the findings of the Review and can be developed to support an enhanced range

of safer and more effective elective and unscheduled care services to patients, which could extend well beyond the pandemic.

SECTION 2: CONTEXT

Chapter 2 – Current Position

What is Urgent and Emergency Care?

Urgent and emergency care services perform critical roles in responding to patient needs. While closely related, it is important to understand the differences between urgent and emergency care. NHS England has recently provided helpful definitions for each, in relation to the models of care which are being provided there[2].

Urgent: An illness or injury that requires urgent attention but is not a life-threatening situation. Urgent Care Services in England now include: a phone consultation service; pharmacy advice; In and Out Of Hours GP appointments; and/or referral to an urgent treatment centre (UTC).

Emergency: Life threatening illnesses or accidents which require immediate intensive treatment. Services that should be accessed in an emergency include ambulance (via 999) and Emergency Departments.

For the purpose of this review, we have adopted the same definition

What services are provided at present?

Hospitals with Type 1 and Type 2 Emergency Departments and the Northern Ireland Ambulance Service (NIAS) provide Emergency Care in Northern Ireland.

Providers of urgent care in Northern Ireland at present include:

- General practitioners during weekdays
- GP Out of Hours Services at night and weekends
- Pharmacies
- Minor Injury Units (Type 3 Emergency Care Departments)
- Type 2 and Type 3 Emergency Departments.[3]

---

[2] https://www.england.nhs.uk/urgent-emergency-care/about-uec/

[3] Type 1 Emergency Care Department: A consultant-led service with designated accommodation for the reception of emergency care patients, providing both emergency medicine and emergency surgical services on a round the clock basis.

Type 2 Emergency Care Department A consultant-led service with designated accommodation for the reception of emergency care patients, but which does not provide both emergency medicine and emergency surgical services and/or has time limited opening hours.

Type 3 Emergency Care Department / Minor Injury Unit (MIU) A Type 3 emergency care department is a minor injury unit with designated accommodation for the reception of patients with a minor injury and/or illness. It may be doctor or nurse-led. A defining characteristic of this service is that it treats at least minor injuries and/or illnesses and can be routinely accessed without appointment.

- 'Hear and treat'[4] and 'See and treat'[5] responses by NIAS

The distribution of Emergency Departments[6] across Northern Ireland is shown below.

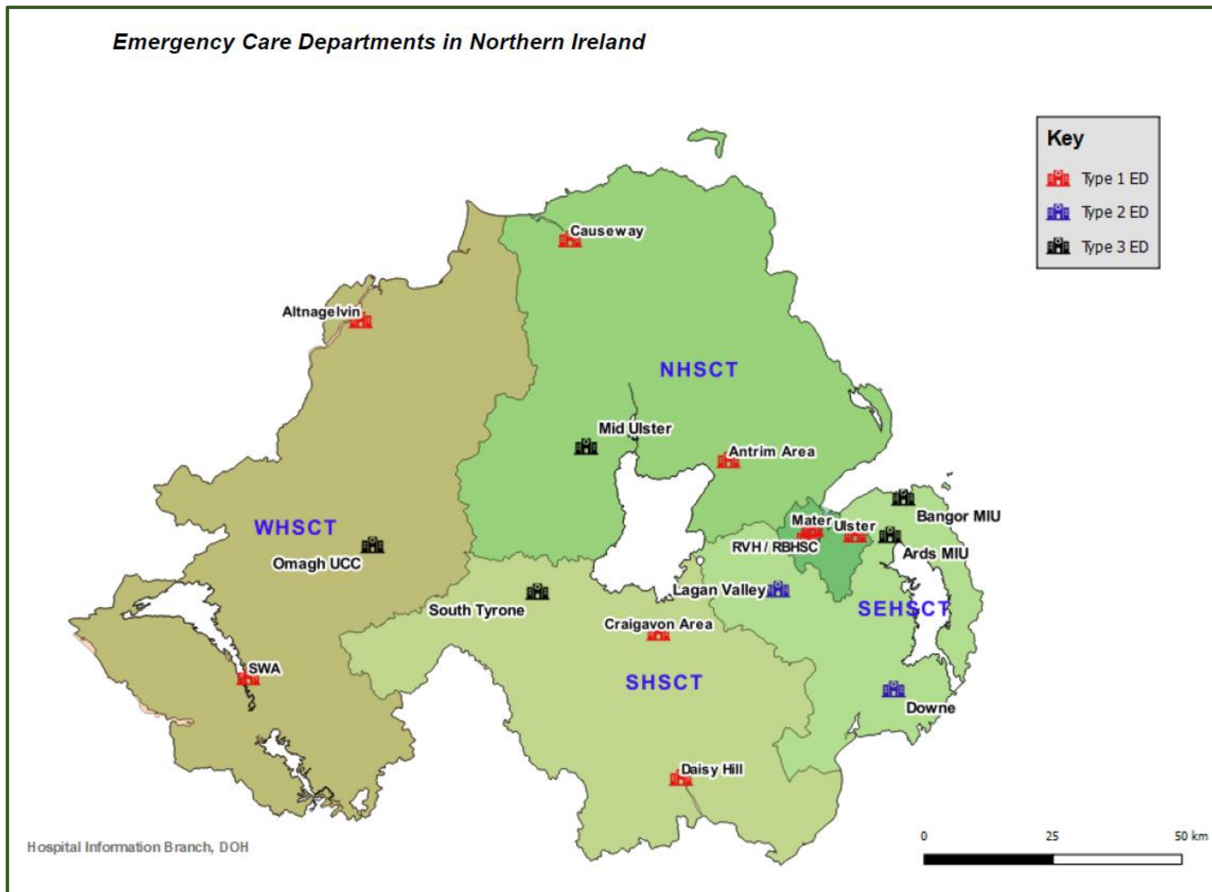


Figure 2 Emergency Care Departments in Northern Ireland, 2019

What pressures are services experiencing?

In the five-year period between 2015/16 and 2019/20, the total number of attendances at EDs in Northern Ireland increased by 76,521, from 763,185 to 839,706.

Statistics outlined in the infographic below show that there was a 47% increase between 2015/16 and 2019/20 in the number of patients arriving at ED assessed as having life threatening and very urgent conditions. The number of patients referred by GPs increased by 15% during this period.

[4] http://www.nias.hscni.net/our-services/your-ambulance-service-is-changing/hear-treat/

[5] http://www.nias.hscni.net/our-services/your-ambulance-service-is-changing/see-treat/

[6] https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-ecwt-q2-19-20.pdf

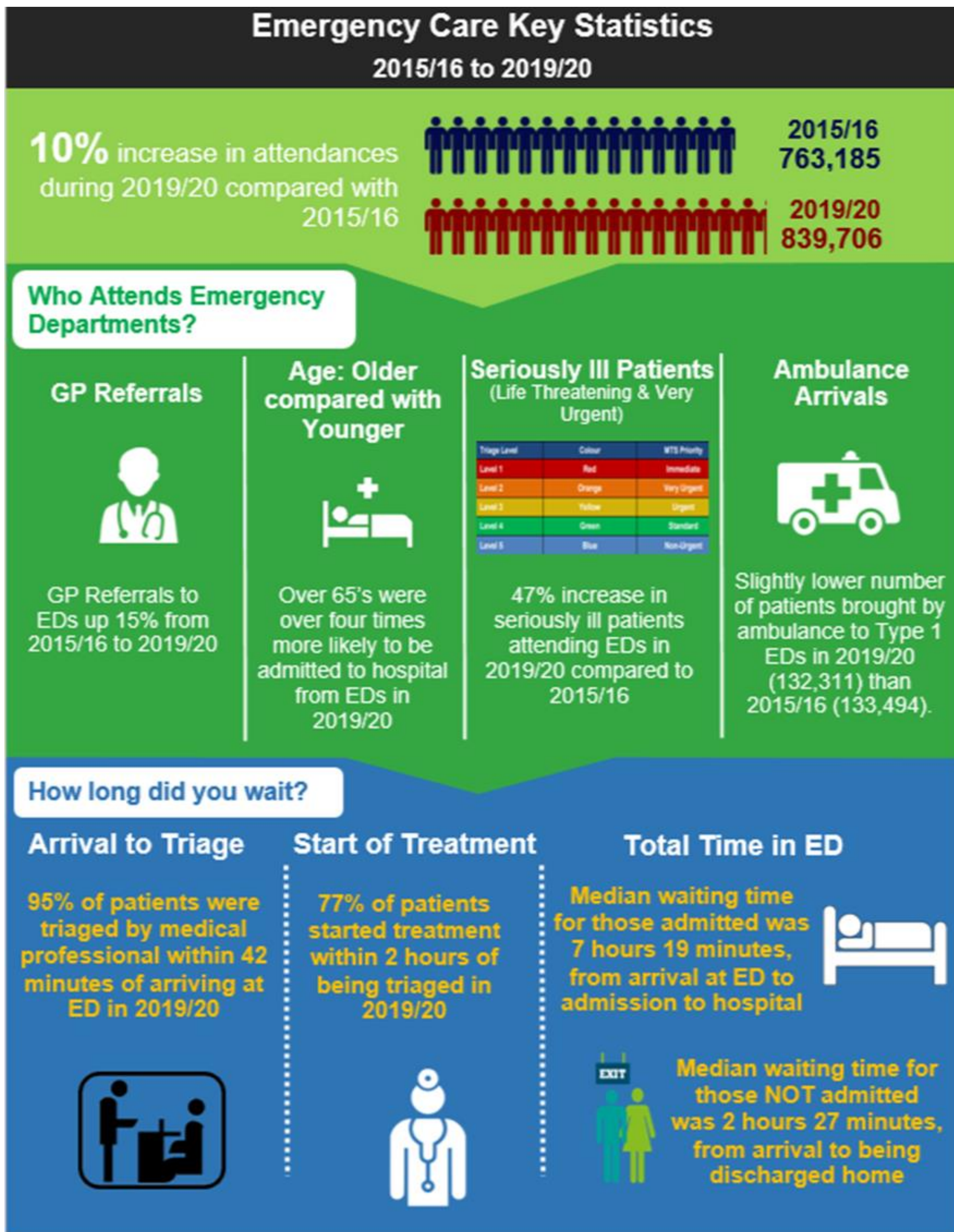


Figure 3 Emergency Care Key Statistics Infographic: 2015/16-2019/20[7].

The data also shows a rising trend in the median length of time people spent in EDs between 2014/15 and 2019/20. During this period, the number of patients who waited over 12 hours in EDs has increased more than sevenfold, from 3,875 to 45,401.

[7] https://www.health-ni.gov.uk/publications/hospital-statistics-emergency-care-activity-201920

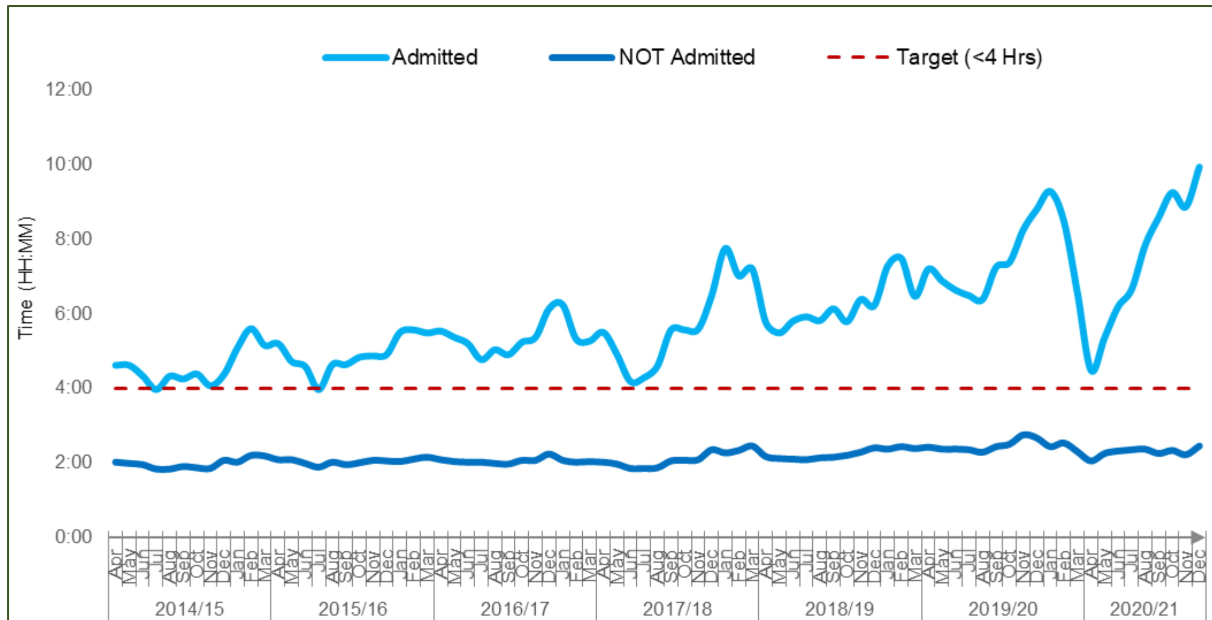


Figure 4 Median time spent in an Emergency Care Department for patients (1) admitted to hospital and (2) Discharged Home: April 2014 to December 2020.

Key Findings of the Population Needs Assessment [8]

As outlined in the introduction, the population of Northern Ireland is projected to grow by 77,600 between 2016 & 2026. The number of children aged 0-15 years is projected to rise by 600, however, the population aged 65 and over is projected to rise by 74,500.

Figure 5 illustrates the projected impact that this changing demographic will have on the number of patients being admitted to hospital. Emergency admissions for people aged over 65 years are projected to increase by 25,807, between 2016/17 and 2025/26.

[8] https://www.health-ni.gov.uk/sites/default/files/publications/health/NI-population-needs-assessment-report.pdf

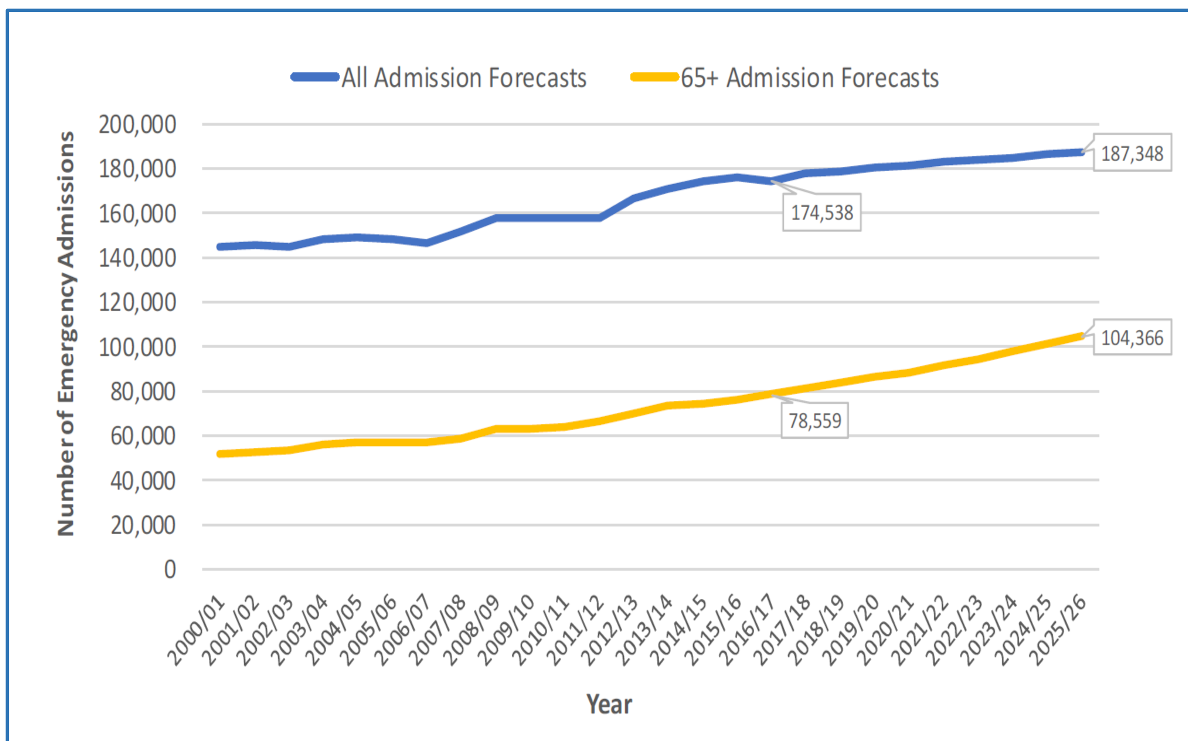


Figure 5 Projected number of Emergency Admissions to Hospitals in Northern Ireland until 2025/26.

Attendance rates at Emergency Departments and Emergency Admission Rates rise steeply in the oldest age groups. (Figures 6 and 7) There is a need to design services, which are tailored to the needs of frail older people.

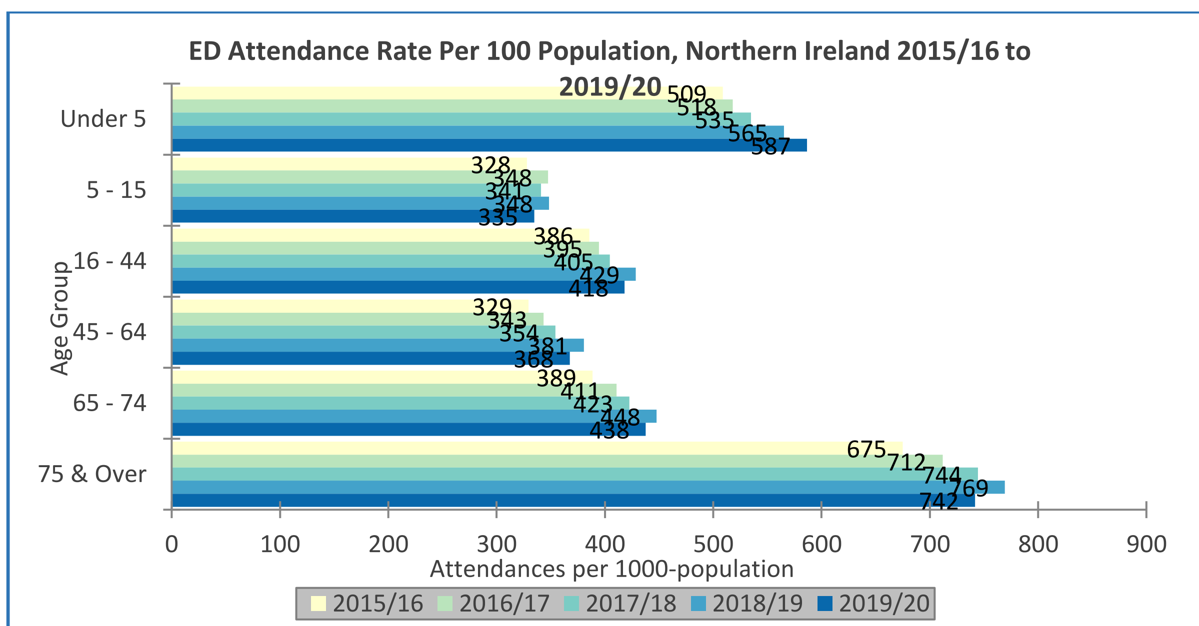


Figure 6: ED Attendance Rates by Age: 2015/16 to 2019/20

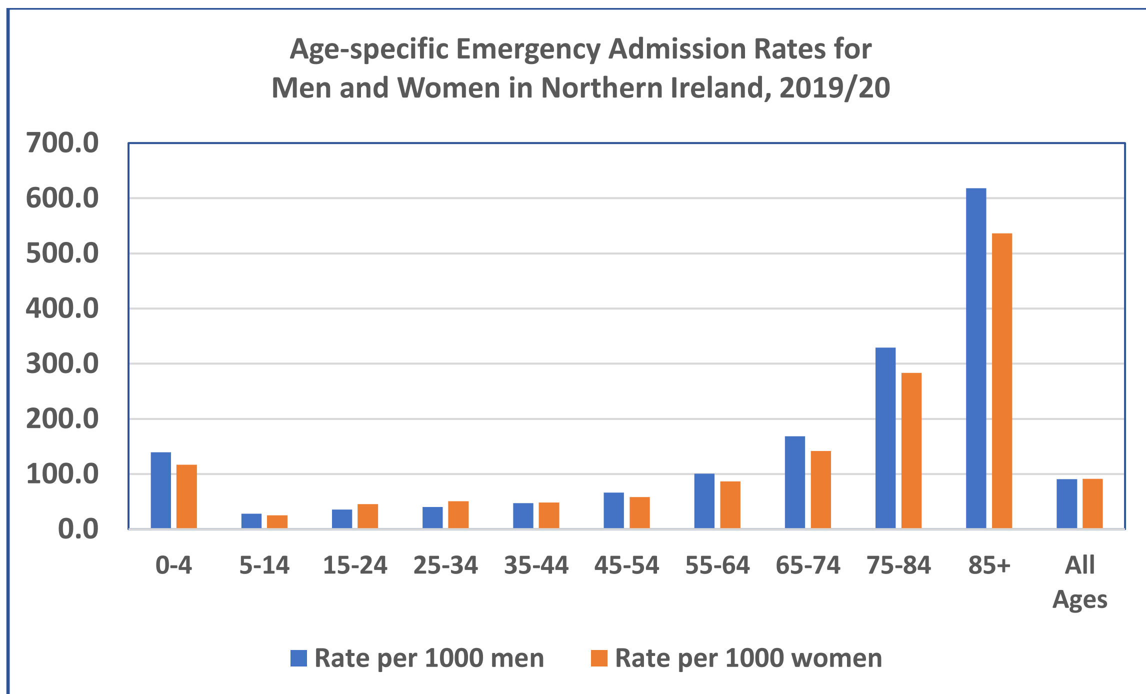


Figure 7: Emergency Admission Rates by Age: 2019/20

The 'Medical Take-in' Specialties of General Medicine, Thoracic Medicine, Gastroenterology and Cardiology accounted for 3,306 (22.5%) of a total increase of 14,669 emergency hospital admissions between 2009/10 and 2019/20 (Figure 8). These specialties have higher emergency admission rates among older people. It is widely recognised that where alternatives such as acute care at home, dedicated respiratory assessment teams and other out of hospital models of care are available, these can reduce the need for these patients to attend an Emergency Department.

The proportion of discharges from hospital which are complex rises in older age groups. Patients staying longer than seven days after being declared medically fit for discharge are predominately in the age groups over the age of 75 years. (Figure 9).

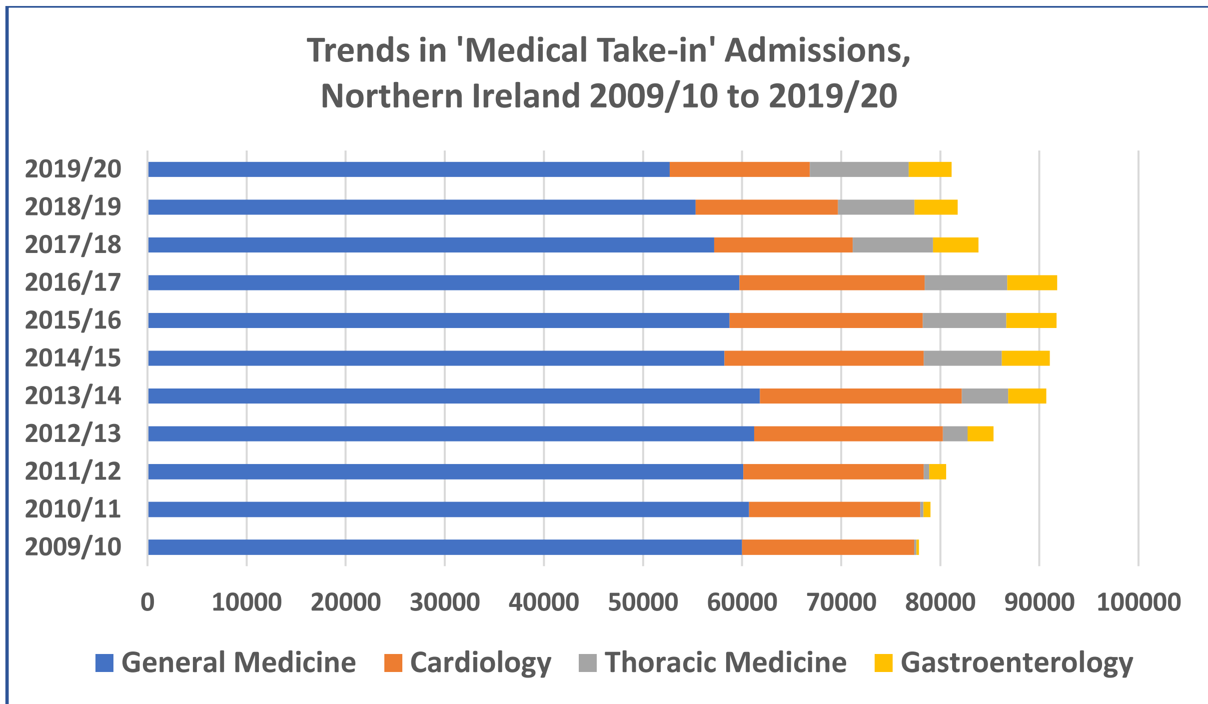


Figure 8: Trends in 'Medical Take-in' Admissions 2009/10 to 2019/20

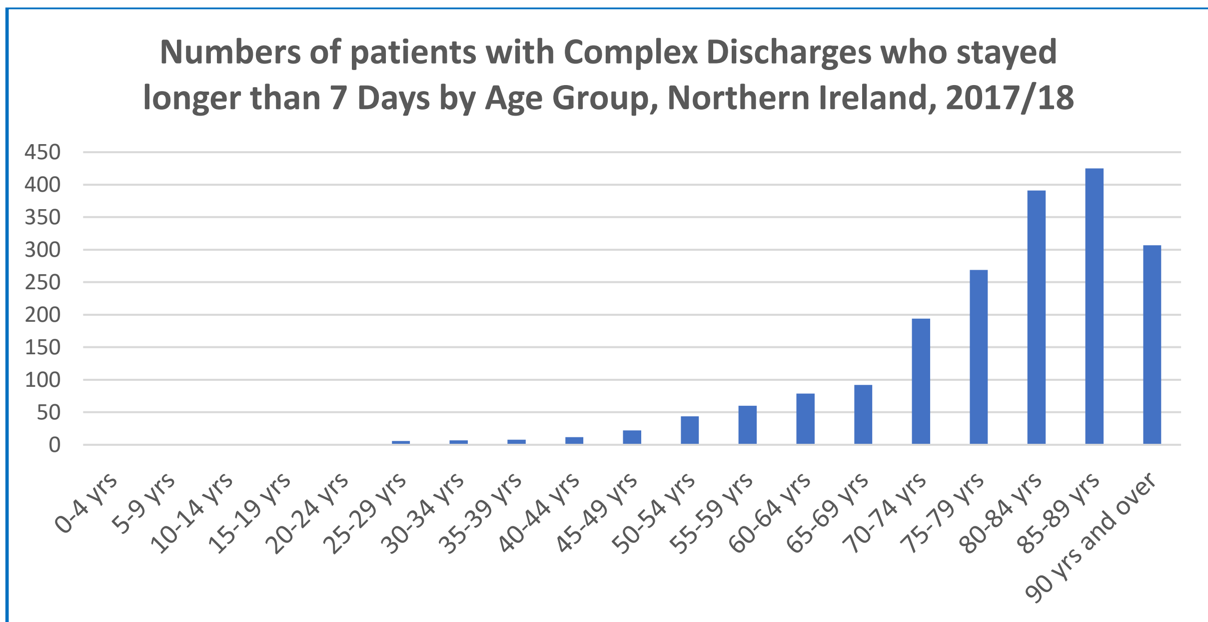


Figure 9: Numbers of patients with Complex Discharges who stayed longer than 7 days after being declared medically fit for discharge, 2017/18

Learning from experience in other regions

England

The most up-to-date policy direction for urgent and emergency care models in England is set out in the NHS Long Term Plan (2019)[9]. The Plan represents a ten year blueprint for services in England and describes measures that should be introduced in order to reform healthcare, including urgent and emergency care services.

Since 2016, NHS England has been testing a variety of new care models in so-called 'vanguard' sites. Following three years of testing these new models, NHS England has concluded that there is enough information to support the redesign of health and care services across England. This includes a range of measures to be rolled out which stem from interventions tested by the urgent and emergency care vanguards[10]:

The NHS England programme for the reform of urgent and emergency care services[11] includes developments such as:

- 100% of the population of England are now able to access urgent care advice through the NHS 111 service.
- Establishment of the Integrated Urgent Care Service, so that more than half of the number of people calling NHS 111 now receive a clinical assessment and can be offered immediate advice or referred to the appropriate clinician for a face-to-face consultation.
- Roll-out of a standardised model of urgent treatment centres[12] across the country, providing a locally accessible and convenient service offering diagnosis and treatment of many of the most common reasons people attend ED.
- The introduction of new standards for ambulance services[13] to ensure that the sickest patients receive the fastest response, and that all patients get the response they need first time.
- The introduction of a national Same Day Emergency Care (SDEC)[14] model for hospitals, reducing the number of patients admitted overnight for an emergency.

---

[9] https://www.england.nhs.uk/long-term-plan

[10] https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

[11] https://www.england.nhs.uk/urgent-emergency-care/about-uec/

[12] https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres–principles-standards.pdf

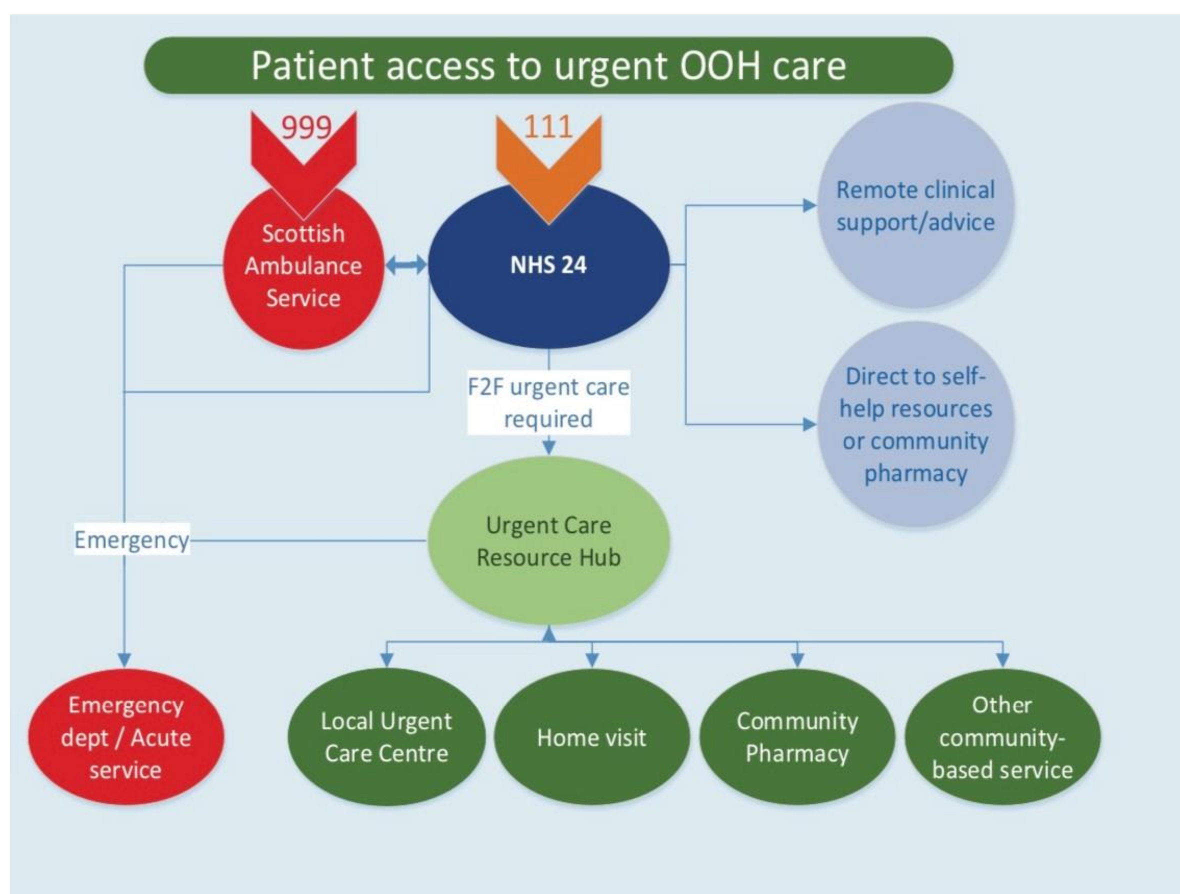
[13] https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/

[14] aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf (england.nhs.uk)

- The establishment of an Acute Frailty programme[15] to ensure the identification of frail patients within a few hours of their arrival to hospital and enable prompt, targeted management based on a comprehensive geriatric assessment approach.

Scotland

In recent years, Scotland has reported the best Emergency Department performance across the UK administrations in the last three years[16]. In November 2015, the Scottish Government published the report of an independent review of primary care out of hours (OOH) services.[17] The Review Group proposed a new model of care: "where a multidisciplinary, multi-sectoral urgent care coordination and communication function will be provided at Urgent Care Resource Hubs which would be configured for both service delivery and training functions. They would be established primarily to coordinate urgent care for OOH services - but should be considered on a 24/7 basis."



[15] NHS England » A new frailty pathway in the Emergency Department led by the advanced nurse practitioner

[16] https://www.isdscotland.org/Health-topics/Emergency-Care/

[17] Scottish Government: Pulling together: transforming urgent care for the people of Scotland. The report of the Independent Review of Primary Care Out of Hours Services. November 2015

Figure 10: New Care Model Scotland

This new model moves away from the traditional model of the doctor being the first point of contact to the employment of other health and care professionals. As shown in figure 10 above, the proposed model incorporates NHS 24, the Scottish Ambulance Service, EDs and acute hospitals. Services are intended to deliver integrated care in a co-ordinated fashion requiring effective partnership working of multi-professional and multi-agency teams. The review report also advocates the establishment of Urgent Care Resource Hubs, networked to local Urgent Care Centres.

Wales

The 2008 *Delivering Emergency Care Services* (2008)[18] strategy provided a framework for unscheduled care services in Wales with the goal to improve services and make it easier for people to access the service appropriate to their needs. This was followed in 2014 with *The Way Ahead for Unscheduled Care in Wales* (2014)[19] which included recommendations around:

- The need to provide rapid, reliable advice when it is needed;
- Support for self-care;
- Easy access to urgent care across Wales;
- Enhanced information systems and care networks that cross organisations; and
- Implementation of a free, 24 hour telephony service to meet out-of-hours, urgent, primary care needs.

It is also notable that Cardiff and Vale University Health Board has introduced a new approach to how patients access urgent care. From Wednesday 5 August 2020, patients have been encouraged to phone first if they think they need to attend the Emergency Department but do not have a life-threatening emergency. This service will be available 24 hours a day 7 days a week where doctors and nurses will triage callers and direct them to the most appropriate service.[20]

Denmark

In the Danish system, as in UK health and care systems, patients who have experienced an accident or an acute illness can attend Emergency Departments without referral. Depending on the severity of the injury or illness patients are first

[18] http://www.wales.nhs.uk/unscheduledandemergencycare

[19] https://www.wales.nhs.uk/ourservices/unscheduledcareimprovement/asharedvisionforunscheduledcare

[20] Cardiff and Vale introduce new 'Phone First' round the clock access to urgent care- CAV 24/7 - Cardiff and Vale University Health Board (nhs.wales)

examined, and then treated or admitted to hospital. Emergency Departments are open 24 hours a day and there are no costs associated with attendance.

Where the Danish system differs from the UK model is in the treatment of non-urgent situations. Following an accident, patients are expected to attend an Emergency Department within 24 hours. If a patient waits longer than 24 hours, a referral is needed from a GP or other appropriate health professional.[21]

In recent years, many Emergency Departments have closed direct access to walk-in patients. Access to Danish Emergency Departments now requires prior referral by the healthcare system – whether through General Practice (in-hours or out-of-hours) or through use of the emergency number.

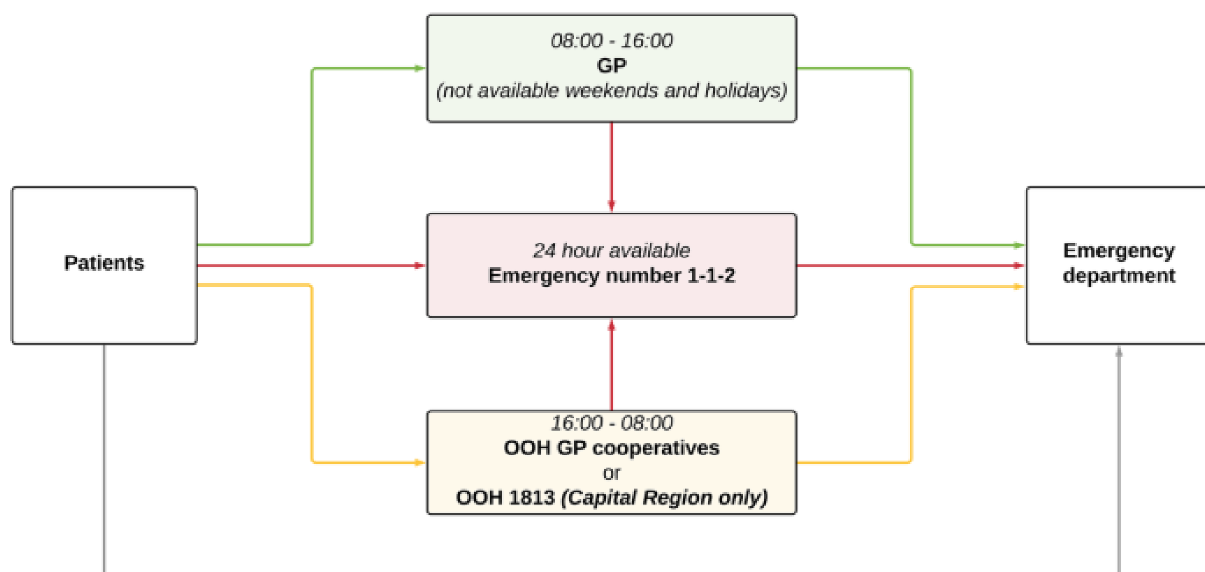


Figure 11: Access to Urgent and Emergency Care in Denmark[22]

Netherlands

The Dutch health care system is recognized as a high performing system in which waiting times are not considered to be a significant problem and where there is universal access to high quality healthcare.[23]

In the Netherlands, patients have three main routes through which they can access medical care in the event of an emergency. They can contact their General Practitioner, call the emergency phone number, or turn up at an Emergency Department as a self-referral. With the exception of situations where an ambulance is required, patients without an acute life-threatening illness or injury are expected to

[21] https://www.euro.who.int/__data/assets/pdf_file/0004/160519/e96442.pdf

[22] https://sjtrem.biomedcentral.com/articles/10.1186/s13049-019-0676-5

[23] http://www.digitalezorg.nl/digitale/uploads/2015/03/netherlands.pdf

contact their GP in the first instance[24]. As an added incentive, if the care can be provided purely through general practice, it is completely covered by basic insurance. Alternatively, if the patient self-refers to the Emergency Department, they must pay a mandatory deductible.[25]

As in other countries, emergency care in the Netherlands has been experiencing greater pressures. While mild compared to the situation in the UK, EDs have experienced greater levels of crowding and GPs have experienced high work-loads in their practice and through the out-of-hours co-operatives. In recent years, a growing number of GP Co-operatives have been integrated with EDs, creating what are now known as Emergency Care Access Points (ECAPs).

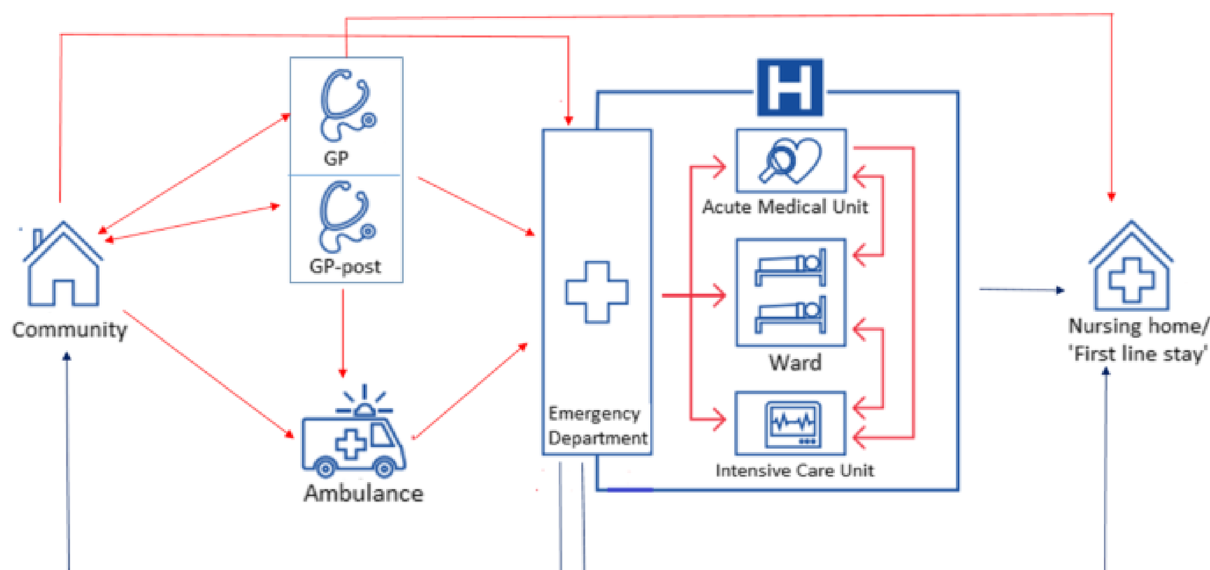


Figure 12: The Acute Care Chain in the Netherlands[26]

The ECAPs offer the opportunity of greater collaboration and co-operation between primary and secondary care. In these settings, initial triage decides whether a patient can be treated by a GP, or whether they should go to the co-located ED. The system avoids unnecessary visits to the ED, shortens waiting times and reduces the volume pressures in the ED[27]. The development of ECAPs has resulted in a statistically significant decrease in Emergency Department usage (from an already low base). The available research would also suggest that the treatment of self-referred patients in ECAPs is a safe and cost-effective alternative to Emergency Department care[28].

---

[24] https://proefschriftenprinten.nl/wp-content/uploads/2019/08/HR_PS_MRutten_voor_druk.pdf

[25] https://www.euro.who.int/__data/assets/pdf_file/0016/314404/HIT_Netherlands.pdf?ua=1

[26] https://bmcemergmed.biomedcentral.com/articles/10.1186/s12873-019-0257-y

[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6660652/pdf/12873_2019_Article_257.pdf

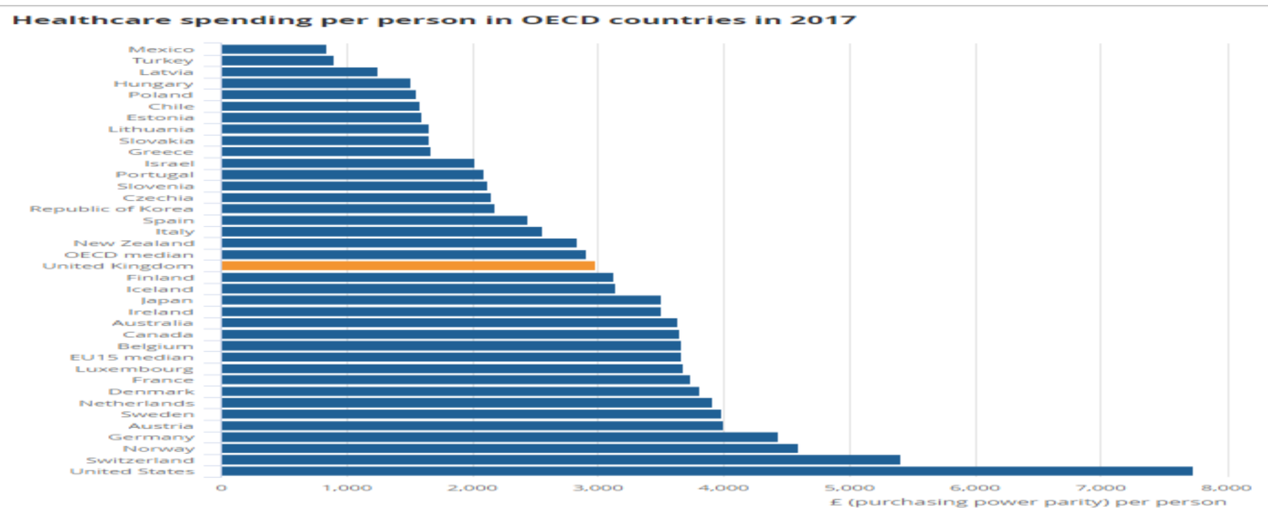
[28] https://pubmed.ncbi.nlm.nih.gov/28418455/

There is no doubt that the Dutch ECAP model represents an effective system in terms of ensuring patients get to the right place as quickly as possible, and also in managing the demand for urgent care that, under our current system, often presents at an ED. However, it is also important to recognise the limitations of this model. For example, this approach does not, and is not intended to, reduce the number of admissions to hospital. While it is a more effective way of dealing with the front door of the hospital, and of ensuring that patients do not suffer any unnecessary waits, it will not reduce the overall demand for hospital capacity. The different funding models between Northern Ireland and Netherlands are also relevant. The health system in the Netherlands is a relatively complex combination of insurance based access and publicly funded care. Under this model, access to primary care is included in patients' health cover whereas attendance at an ED is subject to an excess payment. The model in the Netherlands is therefore based on guaranteed access to an extremely strong primary care sector which has been invested in over many years.

Country Comparisons

It is important to recognise that health systems differ significantly in terms of resourcing and funding, making direct comparisons more difficult. What might be achievable in one country with high levels of health care funding, might not be achievable in others.

The table below shows compare per capital health spending across OECD countries.[29]



Source: Office for National Statistics – UK Health Accounts, Organisation for Economic Co-operation and Development – OECD.stat

[29]https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/howdoesukhealthcarespendingcomparewithothercountries/2019-08-29

This shows that the United Kingdom (and Northern Ireland by extension) spends significantly less per capital on health compared to the EU median and both Denmark and Netherlands.

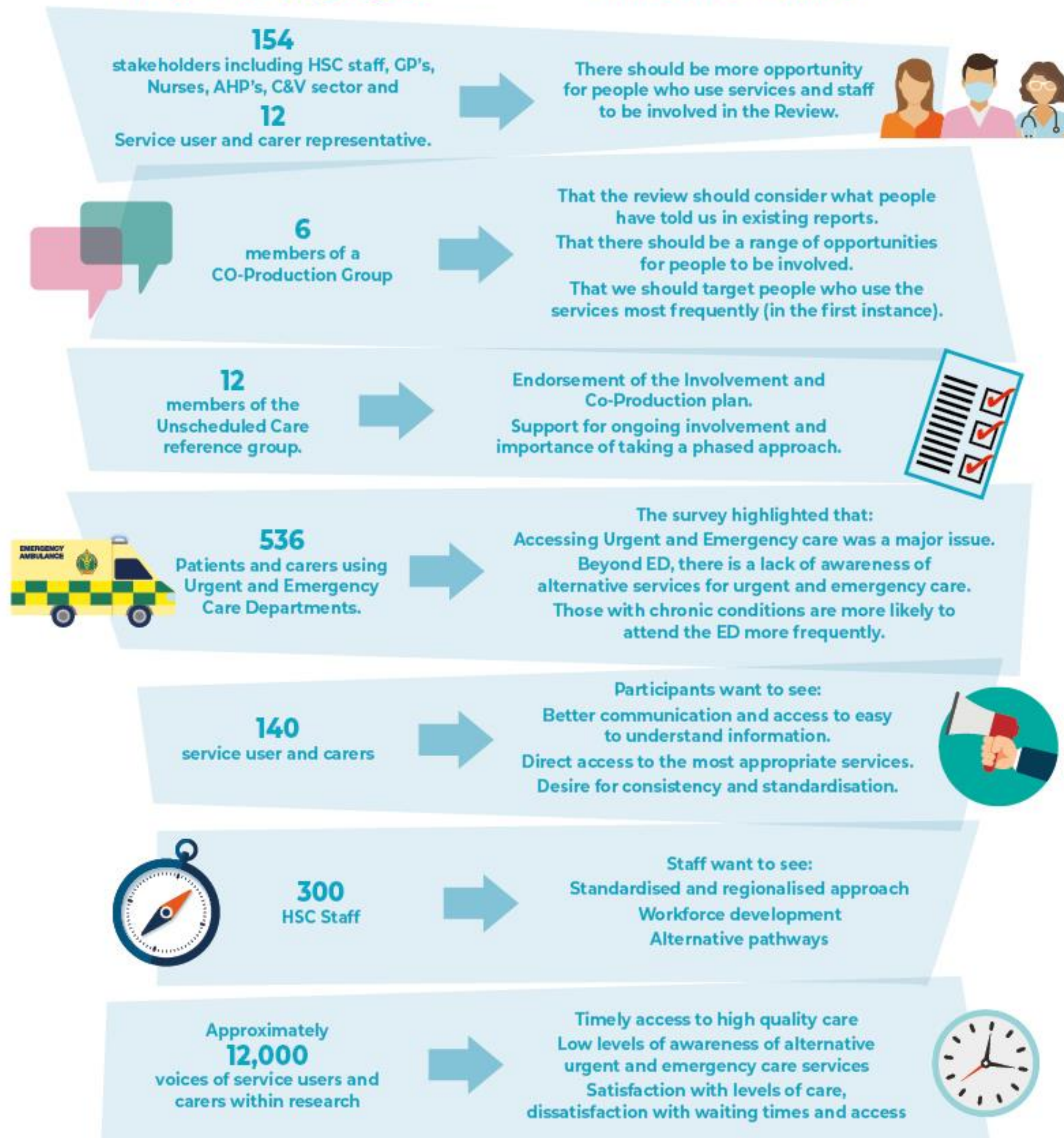
Conclusion

Emergency Department overcrowding has become a serious and growing problem, common around the world. However, while many countries are experiencing the same challenges in terms of demographic change and demands on the health and care system, not all are experiencing the same scale of long waits on trolleys in crowded Emergency Departments.

Care is organised in different ways in different regions and there are systems that appear to be dealing with these challenges more effectively. In this review we have attempted to take the learning from some of the more high performing systems, particularly in the UK and other European countries which also provide universal healthcare.

Nevertheless, while it is important to learn from the experience in other countries, we must not lose sight of the fact that there is also good practice within our own system. Where we may choose to introduce new ways of working, these must complement the aspects of our own system that compare favourably with others.

Chapter 3: What have we heard from service users, carers and staff?



Introduction

The involvement of service users, carers, and staff plays an important role in the design and delivery of HSC services. In Northern Ireland there is a legal obligation to involve and consult people who use HSC services which is set out in sections 19 and 20 of the HSC Reform Act (2009).

Stakeholder Involvement has been identified as an important part of this review from the outset, with a wide range of stakeholders making key contributions towards the findings of this report, including:

- Clinical, Professional and staff groups;
- Service User and Carer representatives;
- Frequent users of urgent and emergency care;
- Public in attendance at urgent and emergency care centres; and
- Third sector organisations.

The review team worked collaboratively with experienced service user and carer representatives from the regional Unscheduled Care Reference Group and partners from the Public Health Agency (PHA) and the Patient Client Council (PCC) to ensure that a comprehensive co-production and involvement methodology was embedded across all areas of the review.

This chapter provides an overview of how this was achieved and highlights some of the key themes identified by those who helped shape current thinking. A detailed report is also available.

Approach to stakeholder involvement

A co-production and co-design ethos was adopted at all levels of the project structure. This included:

a) engaging at the outset of the Review with the Unscheduled Care Reference Group and inviting a number of its service user and carer members to join project structures;
b) establishing an Involvement and Co-Production Working Group to co-produce and implement the involvement strategy and plan. This group comprised of service users, carers, the clinical lead, the Departmental lead and representatives from the Public Health Agency's regional PPI team and the Patient and Client Council;
c) involving frontline clinicians and service user/ carers directly in the work of the Review; and
d) seeking views and input from staff and service users/ carers at appropriate stages and in a number of ways, including through a comprehensive and ongoing program of engagement events and workshops.

A number of key actions were taken forward by the review team, including:

- an Urgent and Emergency Care Stakeholder summit;
- the development of an Involvement Action Plan; and
- stakeholder mapping and targeted engagement.

All aspects of service user and carer involvement were co-produced with the Involvement and Co-Production Working Group.

Urgent and Emergency Care Stakeholder Summit

A Summit was held in June 2019 to bring together strategic leaders and senior professionals from across the HSC and service users and carers. The purpose of the event was to consider key themes and begin to consider some potential solutions. This was an important opportunity for staff, service users, carers and the third sector to collectively influence the development of proposals for a future regional model of urgent and emergency care.

The agenda for the summit was co-produced by health professionals and service user and carer members from the project structures. This included presentations from the clinical lead for the review and a carer representative, as well as a series of workshop discussions.

The summit clearly identified that further involvement with people who use urgent and emergency care services should be central to review as it progressed. The review team then worked with a PPI expert from the PHA to develop a mechanism to embed involvement within the review. The first step was to establish an Involvement and Co-Production Working group.

Involvement and Co-Production Working Group

The Involvement and Co-Production Working Group was set up following the summit event. The primary purpose of the group was to co-produce a plan to get a range of patient and carer voices from across the region to inform the review.

To develop the plan the group first undertook a stakeholder mapping and analysis exercise. This clearly identified key stakeholder groups who use the service regularly, including:

- older people;
- children and young people, and their parents or guardians;
- patients with mental health issues, including users of drug and alcohol addiction services; and
- nursing home residents.

The group also identified HSC staff as a key stakeholder group and recommended that there should be specific engagement with this group.

Involvement Plan

Following the stakeholder mapping and prioritisation exercise, the involvement and co-production group developed a multi-phase involvement plan. This focused on three key tasks:

1. Completion of a literature review to explore what people had previously told us about their experiences of urgent and emergency care;
2. Co-Produced Survey to identify attitudes and behaviours of people using urgent and emergency care; and
3. Involvement workshops in urban and rural geographies to explore experiences and consider how people would like the service to look.

Literature Review

The literature review sought to ensure that the review was informed by existing surveys, reports and data which had considered service user and carer views on urgent and emergency care services. Over 40 documents, focusing on urgent and emergency care in Northern Ireland, were identified and the PCC was commissioned to review these documents and produce a literature review. This explored a range of issues including; levels of satisfaction with the service, public awareness, access to services as well as geographical and condition specific considerations.

Emergency Department Survey

An Emergency Department survey was developed by the co-production working group, supported by the PCC and professionals from the wider project structure. The purpose of the survey was to understand how and for what reasons patients were using our urgent and emergency services.

The survey was carried out over the course of five days in November 2019. They were gathered in person by PCC Involvement Officers from patients in the waiting areas of eighteen local Emergency Departments and Minor Injuries Units across the region. A total of 536 surveys were carried out, and patients were given the option to complete it either electronically on a tablet or on hard copy.

Key Findings of the Literature Review

Timely access to high quality care

People want timely high quality services, which are delivered by well-trained staff who are respectful, caring and compassionate, provide consistent information about care and treatment and involve them and support them in decisions. They also want to see appropriate staffing levels to deal with the volume of patients within the Emergency Department (ED).

Low levels of awareness of alternative urgent and emergency care services

There is a lack of awareness among the public in Northern Ireland of the other urgent and emergency care services which are available apart from EDs. Awareness of GP Out of Hours Services was apparently high, but people still tend to choose the ED as a first option. Awareness of Minor Injury Units was much lower and only one in ten emergency attendances in Northern Ireland were at Minor Injury Units. There was some awareness among the public about using their community pharmacy for urgent care related to minor ailments.

Satisfaction levels

A number of reports show that patients are broadly satisfied with urgent and emergency care services in Northern Ireland and are generally satisfied with the standard of treatment and care they receive, with many service users reporting compassionate and caring staff who introduce themselves, and are professional, compassionate and friendly. Positive experiences were more likely to be reported by those patients who received information and advice about what was going to happen to them, and were informed about their treatment.

While there were many positive experiences. There were a number of areas where patients expressed dissatisfaction with the EDs.

One of the main areas of dissatisfaction was waiting times, including waiting: to be seen in EDs; for a call back from the Out of Hours GP; to be reviewed in EDs; and for admission to an inpatient ward.

Accessing Urgent and Emergency care

Findings from the survey showed that timely access to the full range of urgent and emergency care options had an impact on why people chose to attend ED. While a high number of people were referred to ED or MIU, others chose to present at ED or MIU, as this was viewed as the quickest way to be seen.

The most common reason patients gave for attending the ED was that their GP or Out of Hours GP had sent them there (45.5% of all respondents).

Others felt their condition was serious enough to attend the ED (21.5%), thought it was the quickest way to get treatment (15.2%) or they could not get an appointment with their GP soon enough (10.5%). In comparison, patients attending MIUs were twice as likely to say that they went there because they thought it was the quickest way to get treatment (31.4%).

Based on findings from the survey it would appear that patients' reasons for attending a MIU were largely based around being seen quickly, being able to get more tests and getting test results quicker. MIUs were also more frequently used when patients could not get an appointment with their GP soon enough. Younger patients (aged 5-44 years) were more likely to indicate that a MIU could help with an urgent health problem and were also more likely to have used a MIU in the past. People living in rural locations were also more likely than those living in urban areas to have used a MIU in the past.

The inability to get a timely GP appointment was raised less frequently than might have been expected, with one in ten respondents citing this as their reason for presenting to ED/MIU.

Beyond ED, there is a lack of awareness of alternative services for urgent and emergency care.

Lack of awareness of alternative services to the ED was a key issue among those surveyed. Over one third (36.1%) of respondents were unaware of any alternative options to access treatment for the care need that had brought them to the ED. Those who indicated that they were aware of other options had considered using their GP (46.4%), with much smaller numbers naming the Out of Hours GP service (13.4%), the pharmacist (8.2%) or the MIU (7.2%). Respondents also showed a distinct lack of confidence in alternative services to meet their specific health problem on the day of the survey.

Those with chronic conditions are more likely to attend the ED more frequently.

Patients with chronic conditions were much more likely to have attended the ED more than twice in the past 12 months. Just over one third (37.6%) of patients who had a chronic condition had attended the ED on the particular day in question due to their health condition. Older people (65+ years) and those with chronic conditions were more likely to avail of an ambulance to attend the ED.

Involvement Workshops

The third element of the involvement plan consisted of providing opportunities for people to participate in workshops with members of the Review Team, and the Involvement and Co-Production Working Group. Two workshops were held; in Belfast in December 2019 and in Omagh in February 2020. Altogether over 100 participants from a range of backgrounds participated in the workshops.

The workshops, were facilitated by Anne O'Reilly, Chair of the Unscheduled Care Reference Group, and presentations were delivered by the clinical lead, John Maxwell, and Maria Curran, a representative from the Involvement and Co-Production Working Group, to provide a clear background to the Review and the importance of the workshop feedback.

Session one focused how urgent and emergency care is currently provided. The second session focused on creating opportunities for participants to draw on their own experiences of urgent and emergency care and consider how services should be delivered in the future.

The workshop sessions generated a great deal of discussion and ideas and, as with the literature review and the survey, a number of key themes emerged about the participants' experience and their expectations for future services. These included:

1. the need for better communication;
2. the need for direct access to the most appropriate services; and
3. a desire for standardisation and consistency.

Better communication and access to easy to understand information

Participants stated that the current system can be confusing and indicated that better communication with the public about the range of services available, current waiting times and alternative options would be helpful.

It was suggested that there "should be a campaign in papers and on social media on where to go in an emergency to give the public clear and simple information with phone numbers." It was also stated that the public need to know how to differentiate between urgent and emergency scenarios.

They also suggested that communication between health professionals could be significantly improved to support a better patient journey through each stage of the system. This included referral and discharge to primary and community care.

One group raised the "possibly a single point of telephone entry for urgent care (i.e. same idea as 999 used for emergencies but only a different number for urgent matters)"

Direct access to the most appropriate services

Participants recognised that, in many cases, ED is not the most appropriate place for patients. The examples of older people, people with long term chronic conditions,

addictions, and mental health issues were given as groups who use ED because there is no obvious alternative. It was suggested that direct access pathways should be developed to ensure patients could be admitted to the appropriate specialism or ward. One participant suggested that professionals should work quickly when someone (with addiction) presents for treatment.

Developing better links between urgent and emergency care, primary care and community care was also highlighted as participants thought this would help identify alternatives to ED such as home appointments or specific pathways.

> *"Strike while the iron is hot, there should be easy access and navigation through the service on to other addiction services. If you have someone there and then, you need to be able to offer correct support."* ***Omagh Workshop***

At both workshops, people identified issues with triage of services and asked that consideration was given to introducing one phone number, similar to the English 111 service, and to providing greater access to services over a 24 hour period.

> *"We need to change everyone's thinking as where to go and how, including GP's and Health professionals."* ***Belfast Workshop***

> *"GPs can triage and decide who to send to EDs" and that "GPs should be seeing people at their home to stop people going to EDs and not call out an ambulance."* ***Belfast Workshop***

Desire for consistency and standardisation

Participants identified that they were largely in favour of creating a more consistent, simpler, regional system that would provide the same level of urgent and emergency care for people anywhere in Northern Ireland.

Participants at the Belfast workshop fed back that they wanted a simpler more standardised service and commented "we're a small region and this should not be difficult to do." The participants suggested that there should be:

- better communication and sharing of information between health professionals;
- Continuity and consistency of care across the board; and
- Clear alternatives to ED and directory of services available.

At the Omagh event, participants told us that they wanted to see “money being spent on making services fair and equal across the region.” They discussed the issue of consistency at local Trust level and suggested that availability of appropriate staff in the locality can be an issue.

Staff engagement

The stakeholder mapping exercise identified that frontline staff do not always have the opportunity to participate in strategic planning of new services. For this reason, the Review team carried out a series of ten staff engagement events across each of the HSC Trusts aimed at frontline staff. These events were attended by approximately 300 staff.

All staff who had contact with urgent and emergency care were invited to attend these engagement events including a range of clinical professionals, admin and support staff working with in ED, Urgent Care and OOH staff, as well as those who interact with urgent and emergency care through the Trust. At the session the Review’s clinical lead provided an overview of the work to date and invited attendees to engage in an open conversation.

Three key themes emerged from the discussions with front line staff:

1. the need for a standardised and regionalised approach;
2. the need to address workforce and staffing issues; and
3. the need to develop alternative, more appropriate, pathways to ED.

Standardised and regionalised approach

There was a general consensus among staff that there was a need for change within the existing system. A number of suggestions were made, including:

- the introduction of a single point of contact for urgent and emergency care;
- adopting different staffing models to incorporate a mix of professionals including nursing, AHP and support staff alongside medics;
- introduction of urgent treatment centres at ED;
- more regionally networked urgent and emergency care services; and
- provision of more and better community care services.

Workforce development

A wide range of issues relating to workforce development which impact on the availability of services and quality of care provided were identified by staff. They suggested that the Review should look at the demand of patients presenting at ED for treatment for the service to make use of the best staff mix and competencies available to provide treatment.

They stressed that this was not always a consultant and that use of highly skilled advanced practitioners should also be considered. Concerns were also raised about timely access to training and the opportunity to develop advanced practice skills which would result in better care for patients.

Alternative pathways

Staff recognised that ED was not always the most appropriate way to care for the health needs of some patients. Examples such as frail older people, people requiring palliative care or people with minor ailments who are unable to access primary care solutions.

They suggested increased partnership working across primary, secondary and community services, and 'joined up' thinking to reduce silos. The importance of linking with ongoing transformation projects across the HSC was also highlighted.

Summary of involvement with service users, carers and staff

Co-production and involvement has played a key role, helping the review team to shape the findings and draw conclusions in this report. The service users, carers and front-line staff who participated in the review process came from a range of diverse backgrounds, with different experiences and expectations of what they require in their interaction with urgent and emergency care services. For this reason, it is particularly striking that a number of key principles were consistently raised, namely:

1. Simply sending patients to ED is not the answer. Patients need access to the right care, in the right place, at the right time;
2. There needs to be better communication about the range of urgent care services, and how to determine what is appropriate; and
3. There should be a level of standardisation in the delivery of urgent and emergency care services across the region.

As we move to develop a new model of urgent and emergency care based upon the findings of this Review, it is essential that these key principles are applied. Co-production and involvement will continue to play a key role as we move to consult on the conclusions of the review, and implement its findings.

Conclusions

Co-production and involvement should continue to play a key role in the development, testing and refining of urgent and emergency care services.

SECTION 3:
KEY THEMES

Chapter 4 – Urgent or Emergency

Both urgent and emergency care services play a vital role in supporting patients to receive the right care, from the right people, as quickly as possible. In order to ensure that this can happen, it is important that service providers are working to a common understanding of the service model.

Defining Urgent & Emergency Care

In considering the definitions of urgent and emergency care, it was agreed that the definitions established by NHS England would apply equally in the Northern Ireland context.

These definitions are as follows:

Urgent:

An illness or injury that requires urgent attention but is not a life-threatening situation.

Urgent Care in Northern Ireland includes:

General Practice during weekdays; GP Out of Hours services at nights and weekends; pharmacies; minor injury units; an urgent treatment centre; EDs; and, the Northern Ireland Ambulance Service (NIAS).

Emergency:

Life threatening illnesses or accidents which require immediate intensive treatment.

Our current model of unscheduled care is heavily focused on accidents and emergency despite the fact that the significant majority of patients attending EDs are not in that category. In a direct comparison with other major EDs across the UK, Northern Ireland has the highest rate of attendance (19% higher than England). However, once minor types of EDs or urgent Care Centres are included, England's total rate of attendance is higher.[30]

In fact, it is our own system that makes this higher proportion of attendances inevitable and inappropriately channels patients through a major Emergency Department because there is no other practical option.

[30] Accident and Emergency Statistics: Demand, Performance and Pressure - House of Commons Library (parliament.uk)

What drives attendances at ED?

Attendances at Emergency Departments are driven by a range of clinical and non-clinical reasons. Some of these may include:

- Patients with chronic conditions whose symptoms have changed;
- Patients who have been seen by GPs or NIAS and who require follow up tests or treatment that are only available in a hospital setting;
- Those with minor illness or injury who have no access to, or no awareness of, more appropriate pathways;
- Those with pre-existing symptoms who are already on a waiting list for investigation or treatment; or
- Patients for whom walking in seems more convenient as there is no readily accessible alternative.

As stated by the Royal College of Emergency Medicine, the core purpose of an Emergency Department is the rapid assessment and emergency stabilisation of seriously ill and injured patients.

Does ED deliver the best outcome for all patients?

It has been estimated that up to 43% of patients attending Emergency Departments could be dealt with more effectively in a different setting[31]. While many of these people will require advice or treatment, this is not likely to require hospital admission and may not be immediately time critical. As our system is designed currently, many of these patients will have no other means of accessing the advice or treatment they need other than by attending an ED. Similarly, where GPs identify patients in these circumstances, the only available pathway under the current model is often to refer these patients to an ED.

In attempting to funnel all unscheduled care through EDs, the system wastes patient and clinician time, as well as clinical and managerial resources. One solution that has been introduced widely is the development of urgent care centres. For urgent care centres to be successful, they need to provide seamless, coordinated, locally designed care that puts patients at the centre of service provision. Services must be provided in settings that are accessible and convenient for patients. In considering the design of urgent care centres, the Review team considered a number of different sources, including NHS England's *Urgent Treatment Centres – Principles and Standards*[32] and visits to sites in England, Scotland and the Netherlands.

[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3855530/

[32] www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards/

Scarborough Urgent Care Centre

There are two Urgent Care Centres servicing the Scarborough and Ryedale area. One based in Malton which opens 9am-8pm, 365 days a year, and a second in Scarborough which operates 24/7, 365 days a year service. At the time of Scarborough opening around 3,000 people in the area accessed urgent care services each month. In the 2016 mid-year population figures of the 6,958 people in North Yorkshire aged 90+ the Scarborough area had the second highest proportion in this age bracket with 1,274 recorded, and the Ryedale area recorded the second lowest at 620.

To support the opening of the service a promotional campaign called "Right Care, First Time" was launched, which aimed at raising awareness of the types of health services available by using a simple colour coding approach to signpost patients to the most appropriate service for their needs.

The service notes the best way to access this service is by **calling 111**.They will give you an appointment (if appropriate) to attend an Urgent Care Centre to reduce the time you have to wait at the centre.

Alternatively, you can simply go to one of the centres during opening hours and wait to be seen. However patients are urged to call 111 to reduce the time they may have to wait at the centre. Information in the public domain recommends patients "**Talk before you walk** by calling NHS 111. Where appropriate, a clinical advisor will assess your symptoms, decide what medical help you need and advise where you need to go"

There is a Local Clinical Director for Scarborough and a stable clinical staff team. There are two full time GPs and two part time GPs covering the UCC - Scarborough and UCC - Malton sites. There are four full time nurses and nine part time nurses based at the UCC - Scarborough and UCC - Malton sites. There are 14 bank GPs and eight part-time nurses who split their shifts between Scarborough and Malton. All of the clinicians, permanent and bank, will work across all the centres covered by YDUC as and when required.

The service employs a number of both male and female GPs and nursing staff from the local community. The clinicians are supported by an administration / call handling team, receptionists, drivers and a management team who are responsible *for the day to day running of the service. The service supported the training of GP Registrars; doctors who are training to become GPs.*

On 5 September 2017 the Quality Care Commission (QCC) carried out an unannounced inspection, and awarded an over-all rating as good across the areas of safety, effectiveness, caring, responsiveness and well-led.

The site visits and the available evidence suggested that successful urgent care centres work most effectively when they:

- Are based at the front door to Emergency Department sites and stream patients to the most appropriate service rather than patients being triaged in an Emergency Department;
- Are led by General Practitioners and are ideally co-located with primary care Urgent Care facilities. The most important factor is that they provide an integrated service that meets local requirements and patient needs;
- Are open for at least 12 hours a day, 7 days a week, including bank holidays;
- Provide both pre-booked appointments and walk-in services, however patients should be encouraged to make telephone or internet contact;
- Have an appropriately trained multidisciplinary workforce that can be deployed whenever the UCC is open;
- Provide a scope of practice that includes minor illness and injury in adults and children of any age, including wound closure, removal of superficial bodies and the management of minor head and eye injuries. Urgent care centres with nurse and medical practitioners may be able to deal with further clinical presentations;
- Have access to a range of near blood testing. Bedside diagnostics and plain film x-rays are desirable;
- Can issue prescriptions; and
- Include mechanisms for capturing and acting on patient experience and other feedback.

Chapter 5 – Standardisation, Coordination & Accessibility

Integration, navigation and accessibility

Throughout the course of the Review, there was a recurrent theme from service users and health professionals that EDs have become the default entry point into the hospital system even where they are not the most appropriate place for patients. Users particularly raised issues in relation to services for older people, people with long term chronic conditions, addictions and mental health issues. The service users who spoke to the review emphasised that they would often end up using EDs simply because there was no obvious alternative. One described it as a 'merry-go-round' between the GP and Emergency Department, another talked about being moved from 'pillar to post' but no one seemed able to help or to be the right person for the patient's problem.

Similarly, clinicians in primary and secondary care have reported difficulties in accessing the correct person, specialty, or diagnostic test for patients. In many cases, even within the hospital system, clinicians have complained that they can only access unscheduled care through an Emergency Department even where this was clearly not the optimal option for the patient.

Members of the Ambulance Service were particularly frustrated with a lack of coordination and joined up thinking between provider Trusts when it came to urgent and emergency care. They gave an example of how they had created an app to navigate an increasingly complex system where hospital Trusts did not coordinate care as well as they might.

Other healthcare workers related how coordination between primary and secondary care services were not as coherent and seamless as they should be. Problems also existed in the coordination and transition from acute care to community and social care.

On reviewing other health systems in the UK, Europe and further afield, similar problems of access often presented themselves, however it was clear that the more efficient and effective systems had managed to improve accessibility at many levels.

In Lothian, excellent pathways existed for GPs to communicate with specialties and effectively treat patients[33]. In other localities bed bureaus existed to direct patients to the correct hospital, specialty or assessment unit. Many examples of clinical

---

[33] https://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/NHS_Lothian_Briefing_Submission_for_24.04.18.pdf

assessment systems allowed for patients to either have their problem solved remotely or be booked into a scheduled appointment or rapid access clinic.[34]

European health systems such as the Netherlands[35] had invested in and resourced primary care to enable them to deliver effective and timely healthcare. It was clearly evident that they were able to access the right person, investigation or treatment first time. They were not reliant on the conduit of an Emergency Department for accessing appropriate care. When discussing the subject with the president of the emergency college in the Netherlands, he described a high level of trust that exists between practitioners in their system. This trust deconstructs silos and barriers and improves communication throughout their healthcare system.

With the kind permission of Drs Paul Giesen and Erik Plat, the Review Team visited the ECAP at Canisius Wilhelmina Hospital and saw at first-hand how care is provided in this setting. It is important to stress that no health system in the world is perfect and that clinicians in every system have their own frustrations. However, as a contrast with the situation in Northern Ireland, the visit was revelatory.

The visit took place during the winter and at a time of day when EDs would normally be extremely busy. While the ECAP was certainly busy, it was a calm environment. At this site, GPs were generally responsible for the triage and treatment of walk-in patients who otherwise would present to the Emergency Department outside office hours. As the ECAP is also the out-of-hours hub for the area, the majority of patients were dealt with via telephone triage, with many patients redirected to daytime primary care practices rather than the walk-in centre.

The picture below was taken at the reception area of the Canisius Wilhelmina Hospital Emergency Department at 6.30pm on a Monday evening in February. The picture contrasts sharply with images from recent winters in Northern Ireland of crowded Emergency Departments. Those working in the ECAP suggested that this calm and controlled environment was the norm rather than the exception.

[34] https://www.ncbi.nlm.nih.gov/books/NBK327604/

[35] https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwj5vduI-9v1AhXpQEEAHaERDPsQFnoECAsQAQ&url=https%3A%2F%2Fapps.who.int%2Firis%2Frest%2Fbitstreams%2F1280609%2Fretrieve&usg=AOvVaw31W7xOfPjFfcR0u0PySMJ2

Standardisation

In the course of the work of the Review, it became clear that there is a lack of standardisation in our system. HSC Trusts use a variety of approaches and terminologies to describe their services, sometimes even within the same Trust. What is known as a Direct Assessment Unit (DAU) in one Trust may be called an Acute Assessment Unit, a Medical Assessment Unit, or a Clinical Assessment Unit in others.

Perhaps more importantly, functionality and clinical pathways are often not standardised across the region. This is particularly evident around Trust boundaries, where patients and general practitioners reported that one Trust had a pathway for a condition and the neighbouring trust had a different pathway for the same condition. Anecdotal evidence described how elderly parents had even gone to the length of moving in with relatives at the other end of a street to facilitate access to a better pathway in a different hospital trust.

Health services across the UK have experienced similar problems over the past decade trying to standardise a system of urgent and emergency care. More recently NHS England has settled on specific terminology and functionality of units to avoid confusion and variation. There is a very clear definition of what an Urgent Treatment Centre is and does, but also a recognition that, within agreed parameters, local services should be tailored to local needs.

Similarly, in the Netherlands they have made significant efforts to reduce variation and standardise as much as possible. As well as ensuring that people in different parts of the country can expect the same level of service, this also serves to increase efficiency and reduce waste. An excellent example of this was their unified triage system which was used by GPs, Ambulance Service and Emergency Departments alike.

This point was overwhelmingly supported by a combination of service users, clinicians and managers at an event held in June 2019. When asked if standardisation across Northern Ireland would help patients and staff navigate urgent and emergency care services more easily, 88% of attendees agreed.

It is of course expected that staffing models and services provided in urgent care centres will vary according to the needs of local populations and the available resources. However, as we move to a system that attempts to ensure patients get the right place, and the right person, as quickly as possible, it is very important that services across Northern Ireland are working to common standards and definitions.

Rapid Access, Assessment & Treatment

Throughout the year, there is a significant proportion of patients who attend EDs requiring specialist urgent or emergency assessment or treatment. Much of the growth in admitted non-elective activity is for patients who spend one to two days in hospital. In general, admission to hospital should be avoided unless absolutely necessary. Admission to hospital can lead to deconditioning for the patient and disruption of any care packages that are already in place. From a system perspective, unnecessary admissions reduce the system's overall capacity to function at times of pressure.

Same Day Emergency Care or Ambulatory Care can be defined as the provision of day care for emergency patients who would otherwise be admitted to hospital. Under this model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward and, if clinically safe to do so, can go home the same day that their care is provided.

There is now evidence that many patients could be safely and effectively managed using an approach aiming to deliver assessment, diagnosis and treatment plan on the same day. Same-day care can avoid lengthy admissions and allow community-based care to continue without interruption when the patient needs a period of emergency assessment and intervention in secondary care. There are also opportunities to use the flexibility of same day emergency care to manage frail older people in a way that is planned, personal and much less distressing for the person concerned.[36]

[36] RCEM_Ambulatory_Emergency_Care_Toolkit_Feb2019.pdf

Successful unscheduled care systems around the world demonstrate a high level of coordination, integration and cooperation that allows the patients to access the right care first time. This is often not through the emergency care system, but by directly engaging specialist teams thus avoiding unnecessary delays and inefficient duplication. Our system is too reliant on Emergency Departments as the access point for a multitude of secondary and tertiary care services. This needs to change. It is essential that Emergency Departments are able to deliver the care needs for patients with life-threatening emergencies.

The population needs assessment demonstrated that there are currently long waits to be seen in crowded Emergency Departments and delays in assessment and admission to the correct medical setting. Furthermore, as detailed in Chapter 2, the population will experience an increase in older people needing to use the service over the next 10 years.

When discussing with clinicians and service users it became abundantly clear that there was a problem with easily accessing the correct service. In many cases, it is clear to clinicians in primary care what specialty their patient needs but, too often, the only way for them to access this is through the Emergency Department. The aim of any future unscheduled care system must be to provide easy and rapid access to the correct clinician for advice, assessment, treatment or admission first time.

The opportunity to improve the patient's experience of, and clinical outcomes from, urgent and emergency care is huge. We need to revolutionise the way in which unscheduled care services are provided and accessed by creating an integrated, cooperative and coordinated urgent care system that ensures accessibility for service users.

Improving co-ordination

Many health professionals and users felt that our health system was at times disjointed and could be better coordinated. The theme of a need to improve coordination to deliver effective care was presented in each of the clinical task and finish groups. Furthermore, at the summit on unscheduled care 91% of attendees wanted urgent and emergency care delivered in a regional way.

Leading health systems exhibited high levels of coordination. Many used directories of service to make sense of and to navigate a complex system. The Northwest Ambulance Service made excellent use of a control room which gave them an overview of the entire system from inbound ambulances to discharges from individual hospital sites[37].

[37] https://www.nwas.nhs.uk/

Increasingly command and control centres with access to real-time data and direct support from clinical decision makers are being implemented to coordinate complex health systems. The majority of EDs in Northern Ireland now have control rooms in place showing the current position in relation to capacity, throughput and waiting times. An example of the type of data available, kindly provided by the Royal Victoria Hospital Emergency Department, is included below.

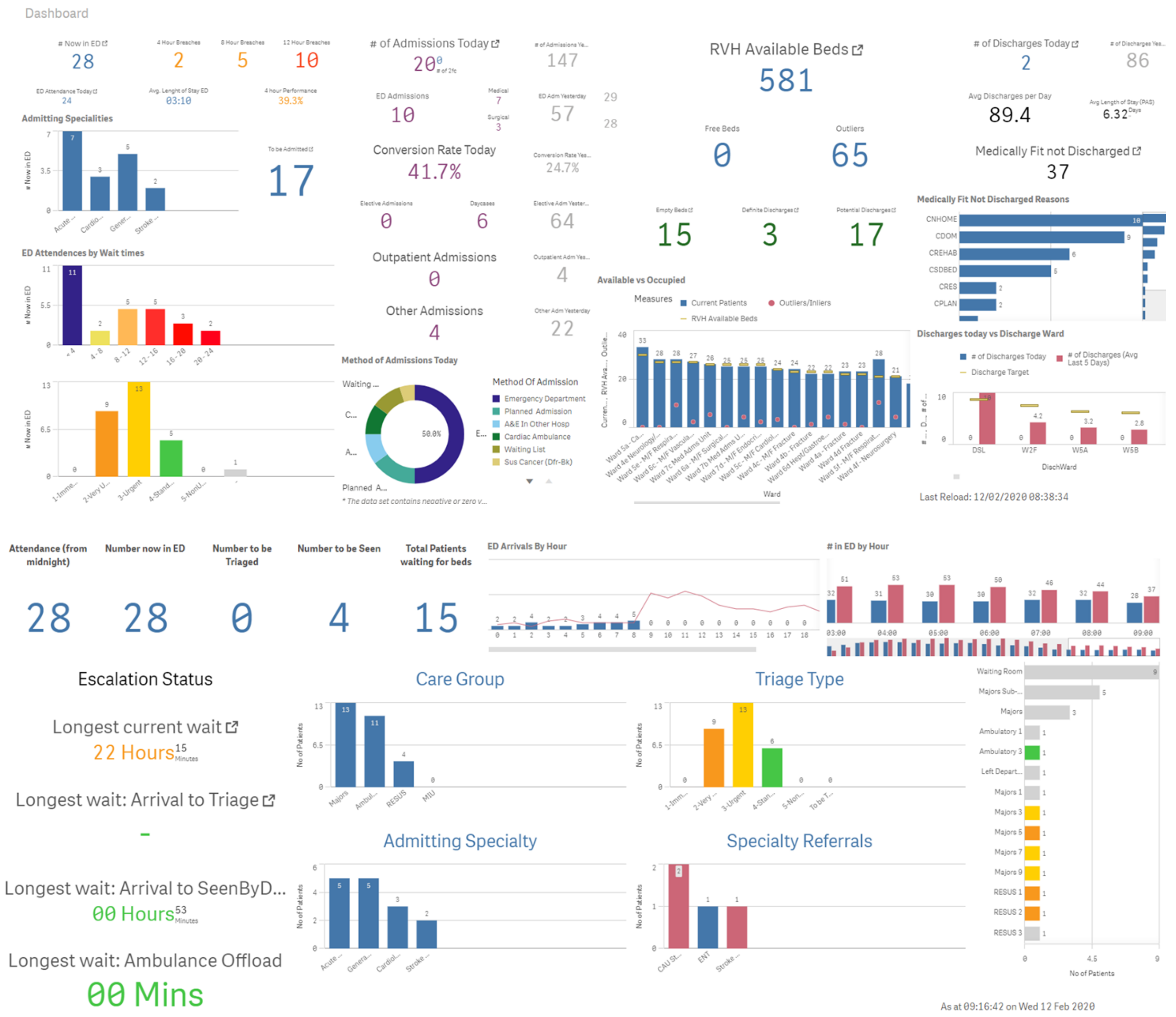


Figure 13: Example of Command and Control Centre Data from Royal Victoria Hospital Belfast ED

With bed capacity in our hospitals regularly running at 90% or higher, it is increasingly important that all capacity and available resources are employed in the most efficient way possible. Hospitals are complex systems and dashboards such as this can provide real time insights into where additional capacity is required, or where performance may need to be improved.

However, the Review team also received feedback on two perceived weaknesses of these systems. Firstly, the information is only useful if it is indeed being used. There was a perception from some staff that while the information looked impressive, it was not being employed consistently as a tool to improve performance across the whole hospital. This is backed up by recent research that would suggest that, for a command centre to be truly effective, it must also be linked to clear rules-based protocols and have a clear place in the hospital's chain of command[38].

Secondly, in a place as small as Northern Ireland, very few of our Emergency Department's operate completely independently of each other. Pressures at one ED will spill over into neighbouring areas, ambulance diverts are relatively common and such occurrences are frequently a source of tension between neighbouring EDs. In Belfast and the surrounding areas, all of the EDs essentially operate as part of one system.

On this basis, a number of people working within the hospital system suggested that there could be merit in the creation of a regional control centre – one that would have access to the dashboard information from each ED, and which could use this to act as an honest broker in decisions around diverts as well as to drive performance improvement. As with local control rooms, for this to work the regional control centre would need real authority and would also require all parts of the system to be measuring the same things and to have the same understanding of the available data. In Emergency Planning, this is known as a Commonly Recognised Information Picture (or CRIP) and is recognised as an important part of any emergency response as it allows a single, authoritative strategic overview of an emergency or crisis that can be used for information sharing and for decision-support purposes[39].

Phone First Systems – Telephone Triage and Clinical Assessment

One of the methods now used in many countries to improve accessibility of clinical advice, facilitate navigation of the system and to improve co-ordination of response is through the implementation of new telephony systems.

In addition to the 999 emergency number, England, Scotland and Wales all use the freephone 111 number as a means of accessing urgent healthcare. However, while

---

38 https://www.researchgate.net/publication/330334261_Use_of_Systems_Engineering_to_Design_a_Hospital_Command_Center

39 https://www.jesip.org.uk/glossary#:~:text=CRIP%20%2D%20Common%20Recognised%20Information%20Picture,briefing%20and%20decision%2Dsupport%20purposes

each country is using the same number, it is important to highlight that the approaches used in each country vary.

ENGLAND

England use non-clinically trained call handlers to triage all 111 calls. The call handlers use NHS Pathways to assist with their decision making. NHS Pathways is an algorithm based clinical decision support tool used to assess, triage and direct contact from the public to other urgent and emergency care services. NHS Pathways is supported by a Directory of Services which lists all the other services the public may require to appropriately manage their needs. While initially believed that this model would lead to financial savings, NHS Pathways is risk averse and had a low threshold for referring to a clinician for further assessment. Approx. 87% of 111 calls which were triaged by a non-clinical call handler required subsequent assessment by a clinician. In 2017 NHS England made new Commissioning recommendations regarding 111 which required that a Clinical Assessment Service (CAS) be added; in order to ensure that a greater proportion of calls were triaged by clinically qualified staff, and safely resolved with advice, reducing pressure in 'face-to-face service' provision. This Commissioning specification required that patients would receive a complete episode of care concluding with: advice; a prescription; or an appointment for further assessment or treatment. It required the development of a multi-professional triage service with virtually all calls passed to a clinician. This will take time to evolve.

SCOTLAND

In Scotland, NHS 24 has been in place since 2002. All GP out of hours calls are triaged using the single number. This regional triage service is provided through one virtual centre, although staff work from a number of sites across Scotland, linked through technology. The triage service links in with local Health Board provided patient services. Since 2014, this service has expanded beyond GP out of hours and now integrates with other areas of the health service. Unlike the previous position in England, NHS 24 has used a range of clinical staff (including nurses, pharmacists, CPNs and dental nurses) to triage calls after an initial sieve by call-handlers. They do not use NHS Pathways.

WALES

The Welsh 111 service uses a similar operating model to Scotland. A prototype service was trialled in the Bridgend / Neath Port Talbot and Swansea areas in 2016 with plans now to roll this out across the region. One of the difficulties that has impeded roll out of the Welsh model has been the lack of a Directory of Services.

Leicester, Leicestershire and Rutland

The Review Team considered a range of English unscheduled care services. Of those identified, the Leicester, Leicestershire and Rutland System Resilience Group may be of most relevant to NI. There are a number of reasons for this.

The provider provides a service for 1.1 million people which is slightly smaller than the population of NI. The provider operates in an urban and rural geography, again similar to NI.

The service operates as a 24/7 network bringing together the Ambulance Service; NHS 111; GP out of hours; and other urgent care services. They share information between services and are able to provide home visits and crisis response visits for people with urgent and acute physical and mental health problems. The service is supported by urgent care centres; an older peoples' assessment unit; and community nursing services -some of which are already available in NI. It offers a range of ambulatory clinics and assessment beds which enable patients to receive monitoring and diagnostic tests without the need to attend ED.

Key lessons learned from England, Scotland and Wales are:

- Ambulance service providers perform better at delivering the 111 service than private providers. Possible rationale for this is because ambulance services are very experienced at call handling and clinical triage and also have infrastructure / telephony systems already in place to support 111. Even where ambulance services are not the primary provider, there are benefits of integrating with them.

- Services experience recruitment and retention problems which can impact service sustainability. There is potential that this will be exacerbated in NI where significant workforce challenges are already apparent. This risk will require careful attention and management.

- Remote clinical triage is associated with risk, even when using clinical decision support software. There have been high profile criticisms from HM Coroner. Frontloading the delivery model with clinicians may seem intuitively more expensive, but produces the best clinical outcomes.

- All 111 models require initial significant financial investment. The introduction of a single number within NI should be focused on improving patient care and not considered a means of achieving financial savings.
- There is a requirement for meaningful service user engagement and attention to population behaviours.
- Using multi-disciplinary teams is expensive but associated with better outcomes and results in less reliance on GPs.
- One virtual system supported by a number of physical sites is associated with improved productivity. Within the NI context, this could save money on estate (negating the need for capital investment to build new call centres), and help with recruitment and retention, if staff don't have to travel significant distances to work. Multiple sites also enhances resilience, and supports business continuity.
- Other providers experienced an initial 10% surge within the first few months of operating. This will need to be considered and managed if introduced into NI.
- Adastra IT system presents challenges in terms of interoperability and integration. Encompass / Epic may potentially provide enhanced functionality and overcome these issues.
- Regional services work better as resources are used more efficiently however, there is a need to ensure all the support services are in place e.g. community nursing / pharmacy / mental health.
- Visits to Scotland and Manchester highlighted the use of enhanced pharmacy services and 'patient group directives' to deliver emergency supply of repeat medications and treat minor ailments. Application of such solutions in NI could help ease the workload experienced in GP OOH, diverting demand for the supply of such medication and assessment away from OOH.

Conclusions

Northern Ireland should introduce an integrated urgent and emergency care system working across primary and secondary care and designed to get the patient to the right place as quickly as possible. The system should include:

- The adoption of NHS England definitions of urgent and emergency care;
- The development of designated urgent treatment centres as an alternative to Emergency Departments for patients requiring urgent care and assessment but who are not experiencing an emergency. These should either be led by primary care or developed as a mixed primary/secondary care model;
- The development of minimum standards to guide the design and delivery of services on a regionally consistent basis;
- A regional, multi-professional telephone triage service to allow patients to receive clinical advice and subsequently access scheduled urgent care in the most appropriate location;
- Access to Emergency Departments only on referral from a health professional (emergency services, telephone triage, referral from an urgent treatment centre, General Practice);
- The further development and expansion of ambulatory care models (also known as Same Day Emergency Care) to minimise preventable admission to hospital; and
- The introduction of a regional control centre with access to real-time data across all ED sites. In addition to co-ordination, the control centre should take a lead role in clinically supported quality improvement where there is significant unwarranted variation in performance.

SECTION 4:

KEY POPULATION GROUPS

Chapter 6 – Paediatric Care

Children and Young People (CYP) account for just over a quarter of all ED attendances in the UK. Children's needs are different to adults' and require a specialist approach in relation to urgent and emergency care. Demand from this section of the population is unlikely to decrease, but adapting how and where care is delivered could help cope with the pressures more effectively.

Data exists from 2014 to 2019 that indicates a 16% increase in ED attendances across all ages but emphasis on infants <1yr old with an NI average increase from 58.8 per 100 births to 75.2 per 100 live births in 2017/18.

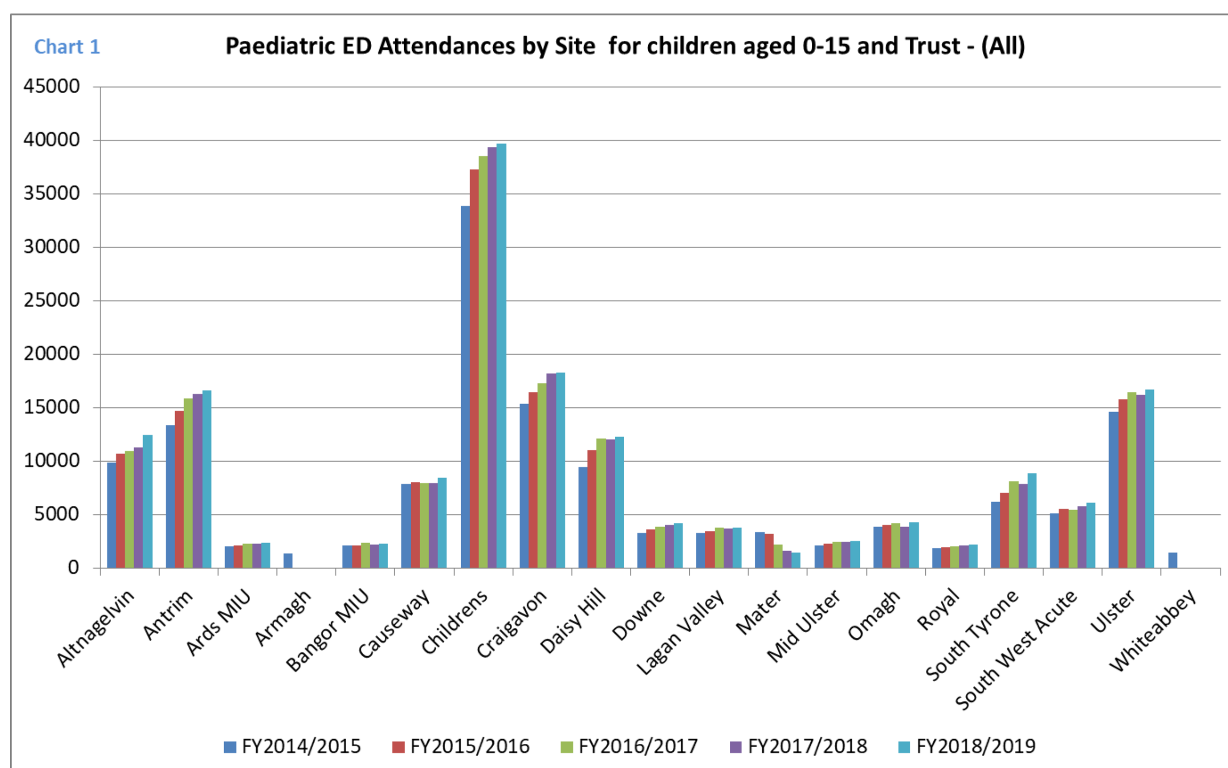


Figure 14: Paediatric ED Attendances by Site for Children ages 0-15 & Trust

Site Name	FY2014/2015	FY2018/2019	% increase from 2014/15 to 2018/19
Altnagelvin	9818	12461	27%
Antrim	13363	16629	24%
Ards MIU	2034	2359	16%
Armagh	1335		-100%
Bangor MIU	2084	2234	7%
Causeway	7850	8412	7%
Childrens	33811	39698	17%
Craigavon	15355	18296	19%
Daisy Hill	9420	12240	30%
Downe	3298	4143	26%
Lagan Valley	3286	3801	16%
Mater	3326	1447	-56%
Mid Ulster	2088	2541	22%
Omagh	3839	4270	11%
Royal	1866	2163	16%
South Tyrone	6205	8818	42%
South West Acute	5084	6075	19%
Ulster	14551	16652	14%
Whiteabbey	1463		-100%
Total	**140076**	**162239**	**16%**

Figure 15: Paediatric ED attendances by site for children aged 0-15 (data provided by HSCB)

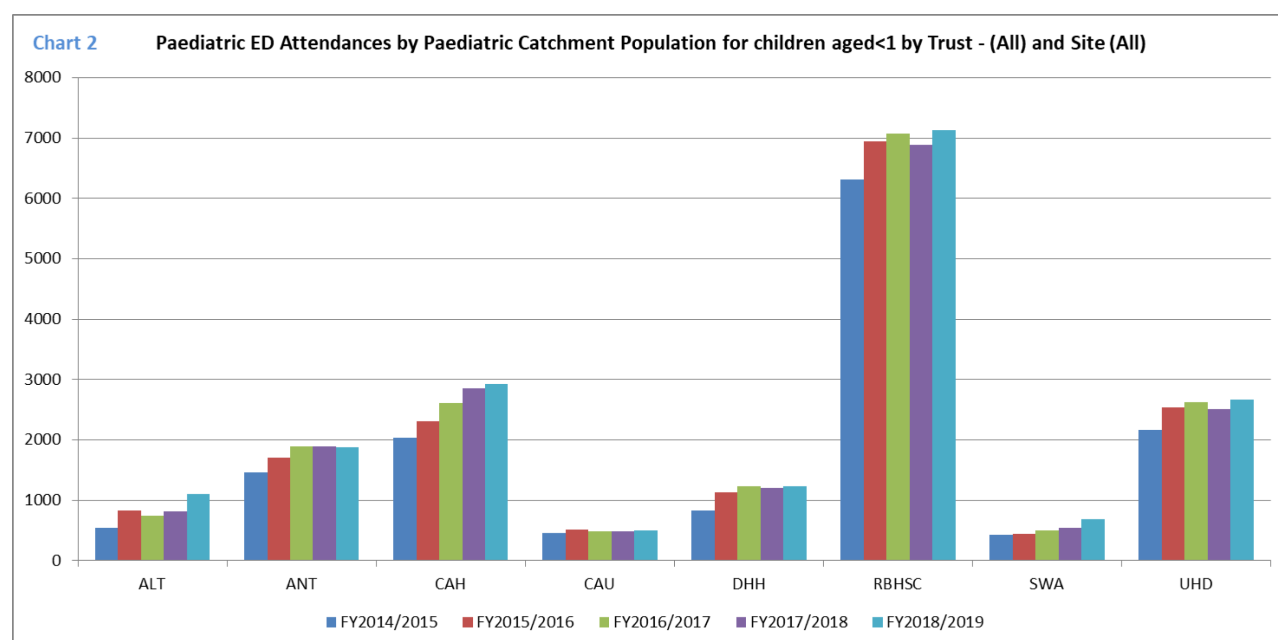


Figure 16: Paediatric ED attendances by paediatric population for children aged <1 by Trust (data provided by HSCB)

During the last 5 years, the total number of ED attendances (new, unplanned, and planned reviews) has increased by 95,770 (13.2%) from 727,466 in 2013/14 to 823,236 in 2017/18.

Current model of care

The current urgent and emergency care system is confusing and fragmented. There is an opinion that a proportion of children who present to Emergency Departments with low acuity conditions could be managed in the community. The poor organisation of services is as likely to put pressure on urgent and emergency services as the health seeking behaviours of those attending.

The Royal Belfast Hospital for Sick Children Emergency Department is the only stand-alone paediatric Emergency Department in Northern Ireland. It is staffed by paediatric consultants with subspecialty training in paediatric emergency medicine. The workforce is made up of paediatric, GP, and emergency trainees. Paediatric advanced and emergency nurse practitioners and paediatric nurses make up the nursing workforce. This dedicated ED paediatric workforce is not reflected in other district general EDs. In district general hospitals care is provided by ED medical and nursing staff, on call paediatricians, paediatric nursing staff and advanced nurse practitioners.

Children and young people 0-19 years make up 26% of all ED attendances and are reportedly the most likely group to attend EDs inappropriately.[40]

Emerging models of care

Rising Emergency Department attendances among CYP have brought the need for new ways of working into very sharp focus for those who commission and provide CYP health services across the UK and further afield. A body of published literature[41] has looked at the benefits of the development of new models of unscheduled care including innovative work across primary and secondary care.

One new model which could reduce pressures and improve care would see the design of "3 speed" Emergency Departments combining assessment facilities for CYP on one site delivered by Children's nursing, Health Visitors, GPs and Paediatricians with a single front door and early triage to each service.

Recent reviews of unscheduled care in Southern Australia[42] have looked at front loading of EDs with early senior decision-making. Active Care at Triage (ACT) where the senior "quick look" has been developed in parallel with The See and Treat service which is designed around the needs and care of patients who do not require bedded assessment or treatment and have simple single-system presentations. This is particularly useful at times of surges in presentation and demand.

---

[40] paediatric-strategy-hospital-andcommunity.pdf (qub.ac.uk)

[41] https://www.kingsfund.org.uk/publications/reconfiguration-clinical-services/paediatric

[42] http://www.cpsu.asn.au/upload/2018-Info-Updates/LMH_ED_MoC_20Mar18.pdf

Improved integration of care for CYP across levels of the health service is a key element of plans to improve outcomes for CYP in the UK. A major component of better integrated care is reducing unnecessary hospital attendances and providing better quality care closer to home when possible.

Improvements in out of hospital care for CYP have focused on either enhancing existing primary care or on new models of care. Enhancement of primary care has included improving access by extending hours in general practice and community pharmacies, given evidence that families generally prefer to access general practice for acute care if services are open and accessible. CYP with better access to GPs have fewer ED visits. Attention has focused on utilising the underused resources of Pharmacists. In the UK, most of the population live within walking distance of a pharmacy.

A further innovation has been the development of GP federations to provide benefits at scale including improved access; a greater emphasis on health promotion, with significant reductions in ED attendance and hospital admissions; and investment in parental and CYP health education, especially for milder illnesses.

Assessments of clinical needs in real time by experienced clinicians in a large sample of CYP presenting to London EDs suggests that high proportions of ED presentations by CYP could potentially be managed in current or new Out Of Hospital Models (OOHMs). In one study[43], it was established that just over a fifth (22.3%) of CYP could have been appropriately managed in current general practice, with a quarter (26%) manageable within the current primary care offer, that is, either in community pharmacy or general practice. Enhancements to general practice such as including extended opening hours and ready access to senior paediatric advice increased this to 28% for general practice alone and to 32% when enhanced general practice was combined with current models for community pharmacy. Further enhancement of the primary care offered for CYP across GP federations, including access to experienced paediatric nursing and capacity to treat minor injuries as well as rapid access to senior paediatric opinion, expanded this to nearly half (44.6%) of ED presentations in this study.

New nurse-led models in primary care or the community also present considerable potential to reduce ED presentations if they provide walk-in opportunities and the range of conditions treated is not excessively narrow. However services focused on ill children with a restricted range of conditions have only a limited potential to reduce ED presentations. More comprehensive models offer the potential to manage very large proportions of ED presentations, up to 75% for an integrated primary and acute model for CYP. The potential for new models to reduce ED presentations was

[43] https://adc.bmj.com/content/103/2/128

markedly higher for children <5 years for primary care and illness-only models, reflecting the higher proportions of injuries or serious presentations seen among older CYP in the study.

Some aspects of these new models already exist in Northern Ireland, particularly in relation to the development of short stay assessment units and the development of GP Hubs.

Ambulatory/Short Stay Assessment Units

Ambulatory paediatric care is an area that has been developed across all Trusts although further developments are required to meet population demands in each Trust area. These needs are variable and current discussion through the paediatric regional network and the Public Health Agency includes the provision of age appropriate ambulatory care (up to the age of 16 years) across the region. Short stay units and clinical decision units are an important development and augment the ability to provide unscheduled paediatric care by facilitating access to services for children and young people who require immediate assessment, management and a period of observation.

Short Stay Paediatric Assessment Units (SSPAUs) can be accessed through a variety of routes including: direct access from ED, following advice line triage; and directly from primary care, following discussion with a paediatrician. SSPAUs provide good opportunities for GPs and paediatricians to train together. Zero day admissions are increasingly common and SSPAUs and clinical decision units are ideally placed to look after these children.

Currently ambulatory care models vary between the Trusts in terms of opening times, bed numbers, staff cover, age of patient seen and single point of access. It is proposed that single point of access for all referrals into SSPAUs needs to be prioritised in order to manage patient flow. Embedding local paediatric ambulatory single point of access/advice lines could prevent unnecessary ED attendances and ensure that children and young people are seen in the right place, at the right time and by the right person.

Primary Care HUBs

NI Paediatricians have been in the vanguard of development of GP Paediatric Hubs where care can be shifted left and delivered at the pre-hospital stage, reducing the number of CYP requiring care in unscheduled care.

An ongoing GP HUB pilot is based on evidence published by CC4C: Connecting Care for Children[44]. This is a paediatric integrated care model that has been used to

---

[44] https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUK

implement whole system change for children's care in North West London. It involves rolling out a clinical and educational ambulatory service bringing paediatrics into the primary care setting to discuss and see cases within a multidisciplinary team (GP, Trainees, Nurse practitioners, mental health services, health visiting services etc). This model supports the current transformation of children's services by delivering specialist paediatric services in community settings and supporting paediatric decision making in primary care. This project work is being shared with RCPCH Project 2040[45]. There are currently 3 HUBs running in Northern Ireland. This is an important model to develop when considering the existing pressures on unscheduled paediatric care.

EwiJ26ON_9v1AhVJasAKHSJhAQoQFnoECAUQAQ&url=https%3A%2F%2Fwww.cc4c.imperial.nhs.uk%2F~%2Fmedia%2Fcc4c%2Fdocuments%2Fpartner-network%2F2-cc4c-child-health-gp-hubs-evaluation-arch-dis-child2015.pdf&usg=AOvVaw37c8WUFtqDw7koiAvmAQX_

[45] https://www.rcpch.ac.uk/work-we-do/paediatrics-2040

Paediatric Mental Health Services

In Northern Ireland there is a high prevalence of emotional and mental health needs among children and young people. It is recognised that referrals to local Child and Adolescent Mental Health Services increased by 21% between 2014 and 2018. This increase is reflected in the number of children and young people accessing urgent and emergency paediatric care. This trend has been exacerbated by the extension of age appropriate care to the age of 16 years.

It is frequently necessary to secure a place of safety for children and young people who demonstrate risk-taking and self-harming behaviour. Admission impacts on paediatric bed capacity either at ED or ward level. Consideration should be given as to where the best place is to care for young people with acute mental health needs as current arrangements impact on patient flow and do not provide appropriate care settings.

The NI Children's Commissioner launched a review[46] in June 2017 with extensive engagement with children and young people about their direct experiences of accessing, or trying to access support for their mental health. It considered the whole system; from support provided by GPs, the education system, the Voluntary and Community Sector, specialist mental health services, EDs and hospital care. It also heard from parents, carers and professionals working within the system.

This identified a significant unmet need that is projected to increase. With a lack of services and long waiting lists for CAMHS, children and young people are presenting to Emergency Departments in crisis. There is a need to understand the broad range of emotional and mental health needs of children and young people in Northern Ireland and develop integrated services that can meet these needs supported by a robust strategy and adequate funding.

Paediatric Mental Health: Facts & Figures

- Around 45,000 children and young people in NI are estimated to have a mental health need at any one time[1].
- 44% of young people in Northern Ireland say they have experienced a mental health problem[1].
- 68% of 16-25-year-olds revealed they always or often feel stressed, 60% said they always or often feel anxious and 33% reported they always or often feel hopeless.[1]
- Parental mental illness is known to be associated with a higher rate of mental health problems in children and young people.
- Northern Ireland has had the UK's highest adolescent suicide rate since 2006 and unless issues are tackled early, and services are in place to meet demand, there is little chance this rate will improve.
- Research on the longer-term consequences of mental health problems in children and adolescents have found associations with: poorer employment prospects; increased risk of drug and alcohol use, particularly for young people with conduct disorder, attention-deficit hyperactivity disorder (ADHD); and emotional disorder.
- The risk of developing a mental health problem is strongly increased by social disadvantage and adversity. 23% of children in Northern Ireland live in poverty.

[46] Children's Commissioner announces Review of Mental Health Services (niccy.org)

Paediatric ED/CAMHS interface

The *Managed Care Network* is discussing the introduction and standardisation of an acute crisis CAMHS team linking to the local ED in all Trusts. The current RBHSC/CAMHS interface model exists also in SEHSCT, with a similar theme in SHSCT. The Crisis Assessment and Intervention Team (CAIT) is a 24/7 service. A "card before you leave" policy allows those deemed medically fit to be discharged and contacted by CAIT the next working day (if not on the day). There will then be a follow up in the community or they will be signposted to an appropriate service and, therefore, not kept in ED or admitted inappropriately to a paediatric ward to wait assessment. Other models exist, but this is the gold standard against which work is being benchmarked by the rest of the UK for CAMHS crisis teams.

Conclusion

There is evidence that health outcomes and patient experience are improved for CYP when care is delivered through use of more efficient flow in EDs where innovation is encouraged. The success of OOHMs of care in other parts of the UK has also demonstrated how services can successfully be transformed.

Future planning of unscheduled paediatric care will need to explore how common and non-acute paediatric conditions can be managed better in community settings. There is a role for a medical advice line, comparable to a "NHS direct" like service, with access to paediatric expertise, such as a paediatric advice line linked to a paediatric ambulatory unit. This would enable specialist triage, paediatric advice and safe signposting to appropriate services to take place.

Consideration of the development of new care models such as Urgent Care Centres and Single Points of Entry for patients have the potential to streamline services for CYP seeking urgent care and improve their experience and outcomes.

The establishment of Urgent Care Centres (UCCs) requires the input of paediatricians with general and specialist knowledge and expertise. This will facilitate a single point of access and comprehensive assessment of the needs of sick children and young people, to ensure that they can access appropriate ambulatory or specialist services in a timely manner.

Conclusions for Paediatric Services

1. The introduction of improved resources for self-care and safety netting for parents;
2. Further development of services in primary care to include outreach specialist clinics and diagnostic hubs;
3. Educational support for GPs who work in both in-hours and out-of-hours services (bringing GPs into paediatric out-patient clinics to take training back to practices +/- GP practices receiving Paediatric staff);
4. Better integration between primary, acute and community services across all areas who manage those aged 0-16yrs in order to help with workforce planning and retention of staff (this includes mental health services);
5. New roles for medical trainees in addition to specialty doctor roles, allied health professional roles and nursing staff in both community and acute paediatrics;
6. Better data collection and analysis (that includes diagnostic coding accuracy) in order to identify and address what needs are to be met;
7. Development of ambulatory care in addition to short stay units to meet population needs;
8. The number of children with complex needs is rising. Young people with complex health needs are looked after in Community Paediatrics until school leaving age. Consideration needs to be given to the needs of young adults transitioning into adult services. Many young adults with complex health needs present to EDs with conditions that could be managed in an integrated transitional service that builds on the comprehensive and holistic care provided by acute and community child health and which to date is not replicated in the adult setting.
9. The National Mental Health survey should be carried out every three years to identify the prevalence of mental health problems among children and young people in order to aid the planning of healthcare services.
10. Compulsory mental health training for all health and care professionals working with children and young people;
11. Local authorities should fund health visiting services which help to identify early signs of mental illness and, in addition, support families by providing health advice and education for new babies.
12. Mental health services must be fully integrated, joining several teams including primary care, local authority and child health services to support all children no matter how they enter the mental health system.

Chapter 7 – Mental Health and addiction Services

Background

This review was initiated to develop a new regional model of urgent and emergency care progressing to a high level implementation plan. It was clear that the current system was not working and change was needed. It was evident from the outset that patients presenting with mental health issues were a key group of users that required specific consideration of their needs. To this end, a dedicated workstream was tasked with examining this area of urgent and emergency care.

Mental illness is one of the most significant causes of ill health and disability in Northern Ireland. At any given time 1 in 5 adults has a mental health issue. Northern Ireland has higher levels of mental ill-health than other areas of the United Kingdom[47].

Jurisdiction	Rate per 100,000 in 2017	Rate per 100,000 in 2018
England	9.2	10.3
Wales	13.2	12.8
Scotland	13.9	16.1
Northern Ireland	18.5	18.6

Figure 17: Age standardised suicide rate per 100,000 in UK jurisdictions

[47] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2016-2021/2017/health/0817.pdf

Suicide rates in the most deprived areas are over 3.5 times the rate in the least deprived areas.

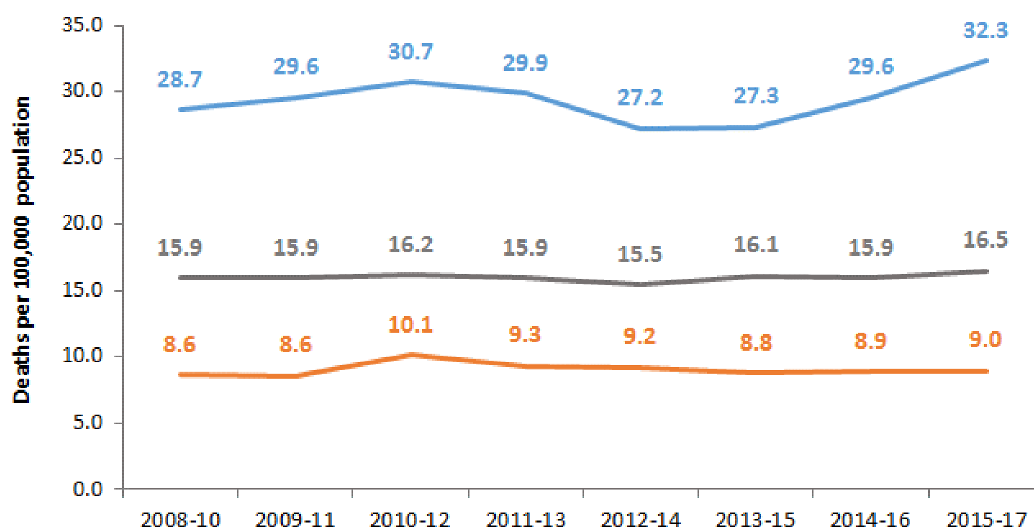


Figure 18: Suicide rate and deprivation time series

Research, commissioned under the Protect Life Strategy[48], involving in-depth analysis of records on almost 1,600 deaths by suicide, highlighted the known associative factors of mental illness (almost 60% of those who died had been diagnosed with a mental health condition), unemployment, alcohol (particularly in young people), and a history of prior suicide attempts. In addition, experience of an adverse incident prior to suicide was common. These experiences centred on relationship difficulties and family discord but also included bereavement, financial difficulties and employment concerns, and physical illness diagnoses.

The study confirmed that the GP was the most frequently contacted healthcare professional prior to a suicide. It also found that, on a per capita basis, deaths in Belfast were 40% higher than the Northern Ireland average and highlighted the likely impact of 40 years of civil conflict in terms of very high levels of (often untreated) post-traumatic stress disorder and other mental health disorders as a legacy of conflict.

Recent research has also pointed to trans-generational trauma where children born after the conflict ended experience poor mental health associated with conflict related trauma and ongoing violence or threat of violence. In this respect, programmes, such as the developing Regional Mental Trauma Network, to assist in building the psychological resilience of victims are important for suicide prevention.

Often patients who experience a mental health crisis will have to attend an Emergency Department to access the treatment they need. Over 20 people are treated daily at

---

48 Protect Life 2 A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024

hospital due to self-harm and 7% of calls responded to by the Ambulance Service are suicide related. Attendances continue to rise and have increased by 133% between 2010 and 2018. In 2018/19 there were 9,242 self-harm and 5,403 suicidal ideation presentations to Emergency Departments in Northern Ireland[49].

Age banding	2018-19	2019-20 (up to end of Sept'19)
Under 5	1	0
6 - 15	9	6
16 - 44	1,078	480
45 - 54	400	226
55 - 64	207	97
65 - 74	62	30
75	17	9
TOTAL	1,774	848

Figure 19: Referrals to mental health unscheduled care teams

USCT Monthly Referrals	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**
Number of Service Users referred to Unscheduled care team	280	257	317	252	347	132

Alcohol and drug misuse are also significant problems associated with mental illness. Many patients presenting to the urgent and emergency care system have issues with substance misuse. The 2018 NCISH Report highlights that 63% of patients in Northern Ireland who died by suicide between 2006 and 2016 had a history of alcohol misuse and 43% of patients had a history of drug misuse[50].

[49] Protect Life 2 A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024

[50] NCISH | Annual report 2019: England, Northern Ireland, Scotland and Wales - NCISH (manchester.ac.uk)

Publications such as the Bamford Review[51], Transforming Your Care[52] and more recently Well-being 2026 Delivering Together[53] have supported a shift in acute mental health services from inpatient care to a community based model in Northern Ireland.

In the rest of the UK there has been a national focus on crisis care, with the Mental Health Crisis Care Concordat[54], and investment is starting to follow with the commitment to provide core 24 Liaison Psychiatry services in 70% acute hospitals in England and Wales by 2023/4[55].

There have been many reviews, reports and strategies published in Northern Ireland which highlight the need for change in our mental health system. This review focuses on urgent and emergency care in general, but a significant number of people with mental illness find themselves in the urgent an emergency system. It is therefore important that we consider their needs in this review.

Current delivery of liaison mental health services

Delivery of urgent mental health services in Northern Ireland is focused around a liaison type model. Liaison mental health services provide mental health assessment and care in a physical health setting. They support clinicians and health professionals in more general health environments, assisting Emergency Departments and wards in the assesment and management of mental health problems as they present or arise among people being cared for in a more general setting. There is unfortunately a wide variation in the degree of provision of liaison mental health services across the country.

Mental health services are often categorised into four main areas of care:

- Adult Mental Health Services (for patients aged 18-65 years)
- Older People's Services (for patients aged 65 years and over)
- Child and Adolescent Mental Health Services (CAMHS) (for patients aged 0-18 years)
- Learning Disability Services (for children and young people and adults with a learning disability)

As part of the review into urgent and emergency care, each Trust to set out the current delivery of mental health services within the urgent and emergency care system. The following table summarises the trusts responses:

---

[51] Bamford Review of Mental Health and Learning Disability | Department of Health (health-ni.gov.uk)

[52] Transforming Your Care (hscni.net)

[53] Health and Wellbeing 2026 - Delivering Together | Department of Health (health-ni.gov.uk)

[54] https://www.crisiscareconcordat.org.uk/

[55] Mental_Health_Toolkit_June21.pdf (rcem.ac.uk)

Health and Social Care Trust	Specialist Teams	Commentary
Belfast	• Unscheduled Care Team • Home Treatment Team	**Adult** • The current ED liaison provision in BHSCT is offered to both the Mater and RVH ED patients. This is 24/7 and initial assessments are mainly by band 6 nurses and/or trainee doctors. At present we continue to offer card before you leave service to ED. • There are twice daily MDT (consultant and TL are in attendance) discussions for each patient and pathways for referral onto statutory and community and voluntary services. • As we move towards the new funded liaison service this provision will be streamlined with other existing liaison services including general hospital liaison services, older adults and substance misuse liaison. **Older persons** • No service for ED at all; it's commissioned for inpatients only
Northern	• Crisis Resolution and Home Treatment Team • Rapid Assessment Interface and Discharge Service	**Adult and Older persons** • Single point of entry for all services; Addictions, Psychiatry of Old Age, Adults and Learning Disabilities. • 2 hour response time to ED (not in Coleraine 10pm-7.30am- covered by on-call), 24 hour response time to wards. CBYL in Coleraine for low risk patients). • 500 referrals per month • Audit C screening on all ED patients • Psychological intervention pathways for regular re-attenders

Health and Social Care Trust	Specialist Teams	Commentary
South Eastern	• Home Treatment Team	**Adult** • Liaison mental health from 9am – 8pm to all EDs in the SET – aim to provide a two hour response time. Staff are based in their respective assessment centres. • Liaison from 8pm- 7 am – staff member is based in the Ulster Hospital – also servicing OOH G.P.s Trust wide. • Separate substance misuse liaison service - 7dpw but not 24/7 **Older persons** • Located at Ards Hospital, operates across 5sites spread over a large geographical area which includes 3 general hospital sites (UHD, LVH and Downe) • Due to such a limited resource the service is unable to provide assessment for individuals >65 years attending the Emergency Department. • However, patients >65 years who attend the ED following an episode of self-harm will be assessed in the first instance by a practitioner within the Crisis Response Service.
Southern	• Crisis Resolution and Home Treatment Team	**Adult** • Liaison service provides ward input Mon-Fri 9-5. There is ED and CDU input for psychiatric presentations 24/7 – provided by Liaison team 9-5 7 days per week and out of hours by junior doctor on call and home treatment team. **Older Persons** • We include addictions, memory, Psychiatry of Old Age and general adult.

Health and Social Care Trust	Specialist Teams	Commentary
		• There is no specific funding for older persons with mental health issues but it is covered by existing teams.
Western	• Crisis Resolution and Home Treatment Team	**Adult** • Crisis Resolution Home Treatment Team (CRHTT) in the Southern Sector of WHSCT have 2 sites; Tyrone and Fermanagh (T&F) Hospital, Omagh and South West Acute Hospital (SWAH), Enniskillen. • 8am - 8pm; 1 band 6 nurse practitioner and 1 band 5 nurse practitioner on each site covering crisis, home treatment and bed management for the T&F Hospital, this includes crisis assessments in ED • 8pm – 8am; 1 band 6 nurse practitioner covers both sites in Tyrone and Fermanagh including crisis assessments in ED and GP out-of-hours and bed manager for the Tyrone and Fermanagh Hospital. • In the Northern Sector there are 3 x Band 6 CRHTT staff, available for assessments and bed management, including ED. This reduces to 1 member of staff overnight. Card-before-you-leave assessments have recently been taken on by this team also. **Older People** • Older Persons staff potentially could be called for an ED assessment, although most input is at the ward level, Monday to Friday 9-5.

There have been several reviews of mental health services in Northern Ireland over the last decade. A review of liaison psychiatric services, carried out by the RQIA

and published in September 2019[56], sets out a detailed analysis of all the psychiatric liaison services across the five trusts. It also describes nine recommendations to improve the service in the future. Of particular interest the RQIA review states the following with regard to liaison services:

> ***'There is a lack of dedicated psychiatric liaison provision into general acute hospital wards during the out-of-hours period. Additionally there is a lack of appropriate physical space to interview patients experiencing a mental health crisis in Emergency Departments.'***
>
> ***'Throughout this review, evidence was found in each Trust that patients are still being referred to Emergency Departments, due to limited access to specialist mental health teams and other services, such as rehabilitation services, supported accommodation (including respite and voluntary) and community support services during the out-of-hours period. Evidence demonstrated that this is the case particularly within children and young people services and older people services.'***

Liaison services are currently in transition and this urgent and emergency care review recognises that some of the changes advocated in previous strategies are in the process of being implemented.

Current Challenges

The task and finish group considered the current challenges which needed to be addressed by any new models of care in the delivery of an effective urgent and emergency mental health service. These challenges are listed below:

- The service is becoming increasingly busy service with growing demand.
- There are insufficient community provisions for onward referral or as an alternative to ED.
- Non-recurrent funding makes it difficult to plan, particularly for a workforce or to embed a consistent model.
- The lack of a regional approach to urgent and emergency mental health presentations impedes the ability of a service to deliver optimal care.
- There is a lack of standardisation in the urgent, emergency and community settings for provision of mental health care.
- Mental health services are stretched across several sites which limits their efficiency and effectiveness.

---

56 https://www.rqia.org.uk/RQIA/files/0a/0a8432b1-d9c0-4620-9ad4-7c2dafc9fc3d.pdf

- There is often no dedicated, appropriate physical space in Emergency Departments for mental health assessments or observation.
- Mental health assessment units which allow people with urgent or emergency mental health problems to be examined outside of an Emergency Department are not always present.
- There are difficulties in ensuring the availability of the workforce, especially covering the days and weekends
- Due to a lack of standardisation and regionalisation, there was an inequity of service depending on location.
- A more inter-organisational and multidisciplinary approach would improve patient experiences and care, as opposed to involvement and reliance on PSNI in the management of people with acute mental health issues.
- The absence of data sharing agreements between Trusts is a major impediment to the effective delivery of care to people with mental illnesses.
- NIAS should develop a role for mental health experts as this does not currently exist.
- Patients and staff are not aware of all the services available to them (e.g. community and voluntary services). A directory of services would be an enabler which would help immensely.
- Social issues are often interlinked with and contribute to the demand on mental health services. A coherent holistic approach would remedy some of these problems.
- Many patients leave before assessment due to prolonged waiting times in Emergency Departments. A dedicated assessment area and team would allow patients to be seen in the right place first time.

Addressing these current challenges with a new model of care should help to improve the experiences and outcomes of users presenting to the service with mental health issues and problems.

Principles of Care

Right person, right place, right skills, first time

The review aims to ensure that patients see the right person with the right skills in the right place, first time[57]. For many people with mental health issues a busy crowed Emergency Department is completely inappropriate. The group wanted to create accessible alternative services providing safer and more appropriate pathways for patients. In doing this there would be fewer people with mental health needs presenting at Emergency Departments.

[57] donaldsonreport270115.pdf | Health (health-ni.gov.uk)

Coordination and standardisation

The group also discussed the need for greater coordination between both Trusts and the secondary and community care systems. The team felt a much greater degree of standardisation and consistency was needed across the region and inter-trust variation needed to be reduced. There should be clearer referral routes and a better understanding of how to ask for help in users' local areas.

Barriers and Silos

The barriers and silos between hospital and community care need to be dismantled and the whole system has to become much more user focused. Patients acute care needs were often treated in the short term but not enough consideration was given to the care and support that needed to be delivered in the community after an acute episode or sudden deterioration in condition. This is necessary to prevent multiple re-attendances and to optimise care. The system needed to be based around the patient not the healthcare silos.

A holistic approach

A more holistic approach from the outset of a care episode is necessary, right from initial referral from the community. If avoidance of an Emergency Department attendance is possible, then that should be the pathway for the patient. It was noted that both the Australian and English systems embed mental health practitioners as part of the initial assessment team, not further down the patient journey as in our system. Mental health teams need to be involved from first contact with a patient to optimise a person's care and ensure the community systems are in place when their acute medical or psychiatric needs are met.

Safer, more appropriate environments

A safer environment for staff and patients than the Emergency Department is necessary in any future system. Ideally patients who do not require emergency intervention will be managed in a different area with a suitable multidisciplinary team.

Better outcomes

Ultimately any new system should aim to reduce suicide and self-harm rates as well as inappropriate general hospital inpatient admissions. There also needs to be improved discharge planning and coordination resulting in shorter lengths of stay and reduced general hospital re-admissions.

Models of good practice

Having established the principles and considered the current system's challenges and problems, the group were able to turn to possible solutions in the form of established models of good practice. They discussed the following initiatives:

Towards Zero Suicide

This strategy emerged within mental healthcare systems in the USA in the 2000s and is reported to have led to significant reductions in deaths of service users.

The USA 2012 National Strategy for Suicide Prevention promotes the idea of “zero suicide” as an aspirational goal that should be adopted by health and social care systems. This strategy assumes that suicide deaths for people in care are preventable, and that the goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept.

The zero suicide model relies on organisational leadership and a system-wide approach to improve risk assessment, safety planning, workforce development and adverse incident learning to inform system and culture change. It also seeks to enhance care pathways for suicidality in order to close gaps in service provision and improve co-ordination across settings (primary care, secondary care, Emergency Departments, mental health services, and third sector services) – including continued support after acute care.

Towards Zero Suicide involves a system-wide commitment to suicide prevention by improving outcomes at all levels and eliminating gaps within the delivery of care. It views suicidal behaviours as directly amenable to interventions rather than as purely secondary to other underlying problems.

Towards Zero Suicide was introduced to the NHS by Mersey Care NHS Trust in England, with early results indicating a reduction in suicides of 23% within three years. The Department of Health recently launched the Protect Life 2 strategy – of which Towards Zero Suicide is one strand.

Protect Life 2 - Suicide Prevention Strategy

Protect Life 2 (2019-24) is a long-term strategy for reducing suicides and the incidence of self-harm with action delivered across a range of Government departments, agencies, and sectors. It recognises that no single organisation or service is able to influence all the complex interacting factors that lead someone to harming themselves or, ultimately, to taking their own life. The strategy sets out what the Department will do to reduce suicide and self-harm over the next five years and looks at the importance of everyone working together on prevention. Protect Life 2 contains a range of new and ongoing actions designed to reduce the suicide rate including greater focus on those bereaved by suicide, more support for those who care for others and enhanced working across Departments. Full implementation of the strategy will require additional funding in future years.

Community Crisis Intervention Services

This is a community led initiative based in Derry. It is a de-escalation service which offers a non-clinical alternative to ED for patients. Current funding has been extended while permanent funding is sought. It operates from 8pm on Thursday

until 8am on Sunday with referrals from community and voluntary organisations. In one year it has assisted over 100 people.

MATT Pilot

The Multi Agency Triage Team (MATT) is a service that comprises of Mental Health Professionals working alongside dedicated Police Officers and Paramedics in a Mobile Community Unit (Ambulance). MATT responds to people with mental health problems, aged 18 and over, who have accessed the 999 system between 7pm and 7am on a Friday and Saturday night. The team can link in with the Alcohol Recovery Centre where individuals are deemed too intoxicated to engage or when they have self-harmed and their injuries require further assessment and treatment.

Alcohol Recovery Centre

The Alcohol Recovery Centre is managed by BHSCT and provides a safe space for individuals. Based in the Bradbury Centre it operates from 11pm-8am with a last client admission at 6am. It allows people to be cared for with alcohol related problems outside of an emergency setting. It has been particularly valuable during events such as concerts.

Mental Health services in NHS England Urgent Treatment Centres

All urgent treatment centres must have direct access to local mental health advice and services, such as through the on-site provision of ‘core’ liaison mental health services where services are co-located with acute trusts or links to community-based crisis services. These provide a more appropriate space away from busy Emergency Departments.

Crisis Response – Mental Health Liaison

Mental Health Liaison is a system developed in Birmingham as a ‘core 24’ model and trialled in the Northern HSC Trust. Physical and mental health staff work together in Emergency Departments to ensure that vulnerable patients are detected and offered prompt, compassionate assessment and care by a mental health professional prior to leaving the hospital (removing the need for some patients to return for assessment the next day as is currently the case with the Card Before You Leave protocol). The aim is to reduce the likelihood of patients leaving the Emergency Department without being seen by mental health staff. The introduction of the Mental Health Liaison Service will ensure that all people presenting to Emergency Departments in crisis are offered a psychosocial assessment prior to leaving the hospital in line with NICE recommendations. There is evidence that follow-up care and engagement with people who self-harm reduces the incidence of repeat self-harm.

Edinburgh model

Psychological treatment (Interpersonal Therapy for ED) is provided over four fixed sessions to patients meeting inclusion criteria. Some members of the group advocated this model as they felt there was initial good outcome data.

Safe Haven: The Royal Oldham Hospital (NHS England)

A new crisis care mental health service for adults providing overnight support in a comfortable environment. The service is delivered together with local charities and has seen 90 patients between January and June 2019. It offers an alternative for people who previously may have ended up waiting in ED.

Frequent attender programmes

There are several patient groups who frequently present to the Emergency Department with a mixture of mental health, substance misuse, and chronic medical problems that benefit from a consistent response.

Several frequent attender programs and models were discussed including, The Oxfordshire Emergency Department Frequent Attender Programme, Red Cross HIU Frequent Attenders Service and the Royal London Hospital Frequent Attenders Project.

To help frequent attenders in the ED, the development of an agreed care plan may alter behaviours and contribute more constructively to the patient's needs. For example, some patients who are well known to services may benefit from a low-key response from the ED, without formal review by liaison staff, but a timely alert to their community team. In other cases, strategies to avoid admission or over-investigation may benefit the patient.

NICE - Achieving better access to 24/7 urgent and emergency mental health care

The National Institute for Health and Care Excellence has produced several documents describing the functioning of mental health services in an urgent and emergency setting[58]. The nice guidelines discuss a core 24 model, an enhanced 24 model and a comprehensive model. The core 24 model lists the following functions as being required on a 24/7 basis:

- Provide a response to mental health crises in EDs and inpatient wards within one hour and to all urgent ward referrals within 24 hours;

---

[58] https://www.nice.org.uk/guidance/qs34/resources/evidencebased-treatment-pathway-for-urgent-and-emergency-liaison-mental-health-services-for-adults-and-older-adults-guidance-pdf-4362198589

- Complete a full biopsychosocial assessment and formulation and contribute to treatment and collaborative care plans;
- Offer brief evidence-based psychological interventions as inpatient or short-term outpatient follow-up;
- Work with general hospital teams to reduce length of stay in general hospitals and improve follow-up care, particularly for older adults;
- Provide advice and support to general hospital staff regarding mental health care for their patients; and
- Provide specialist care for older adults.

An enhanced 24 service offers all the features of the core 24 model but provides further specialist care in areas such as addictions, drug and alcohol misuse and learning disabilities. It has a higher level of consultant input and more follow-up care. The RAID model in Birmingham was a pilot for the enhanced 24 system. The Northern Trust have created a similar service.

The comprehensive model offers yet more services and is aligned with a regional centre. It has greater numbers of senior staff and is able to assess and treat conditions such as chronic pain and medically unexplained symptoms.

Conclusion

There have been many reports and reviews focusing on mental health in Northern Ireland. An overarching strategy has been developed and there is a clear direction of travel and key actions to be implemented. The findings of this review with respect to mental health are consistent with previous reports and have similar conclusions. Perhaps the most important aspect moving forward is to ensure there is a mechanism in place to implement these key findings and conclusions regionally.

Recent developments

Crisis services exist to provide support to some of the most vulnerable patients in a very difficult time of their lives. Over recent years a number of pilots of new crisis services have been tried in Northern Ireland, including cooperation between the PSNI, the ambulance service and HSC Trusts (Multi Agency Triage Team), community crisis intervention service in Derry/Londonderry and others.

Other improvements to crisis and urgent care services include the creation of mental health liaison in Emergency Departments. However, it is accepted that crisis services in Northern Ireland are in need of reorganisation and reform.

The work that has been carried out to date, in particular around suicidal crisis through the Protect Life 2 work, has provided good outcomes. However, it is now time to build on this and continue developing integrated crisis services. By providing help and support to people in crisis through a considered early intervention approach that is

tiered to the needs of the person, further escalation of the person's needs can be prevented, with better outcomes.

Review of Mental Health Crisis Services

The Mental Health Action Plan therefore contained a commitment to reconfigure mental health crisis services and, in late 2020, the Department commissioned a review of crisis services.

The Mental Health Crisis Service Review Report, which was received in April 2021, considered evidence from literature, best practice, and service user perspectives and provided 15 recommendations.

Regional Crisis Service

The new regional crisis service, which was announced on 24 August 2021, was developed together with the authors of the review, and reflects the recommendations in the review. The policy outlines what the crisis service will look like and provides 10 actions to make this a reality. It can be accessed via the following link: Regional Crisis Service

The new regional crisis service in Northern Ireland seeks to provide a regional approach to mental health crisis, where people get care and treatment when they need it, where they need it. It is a policy that focusses on the needs of the person rather than the system, and is a new direction for crisis services.

The new service has three clear outcomes:

- A regionally consistent crisis service that will provide effective help and support for people in a crisis;
- A reduction in the number of people who have to wait longer than two hours for crisis support as laid out in the Regional You in Mind Mental Health Care Pathway; and
- A reduction in the number of people who attend Emergency Departments in crisis.

It is also expected that implementation will lead to better patient outcomes, a reduction in pressures on Emergency Departments, emergency services and mental health services, which will help reduce the demand on mental health services, which are currently under extreme pressure as a result of the COVID-19 pandemic.

Use of Emergency/Urgent Care Provision

The Department's Crisis Service policy recognises that all those who need access to crisis services must be offered help irrespective of the nature of their distress and they

must be directed in a timely and compassionate way to the best place that meets their needs. Access to crisis support should be available disregarding the nature of the crisis, and must be available to those with suicidal ideation, social crisis or mental health crisis.

It therefore commits to ensuring that crisis services are available at the point of need. This means people in crisis will receive an appropriate response regardless of where they present; including primary care multi-disciplinary teams, out of hours primary care providers, Emergency Departments, Lifeline, 999/101 services, the police service, ambulance service and out of hours regional social work service.

A significant number of people attend Emergency Departments with mental health problems. Some have physical health problems with underlying mental health issues; some will attend following an episode of deliberate self-harm and some will access help for suicidal ideation.

Whatever reason a person in mental health crisis attends the Emergency Department, the new Crisis Service recognises that the approach to meeting their needs must be regionally consistent.

It commits to ensuring:

- Mental health assessments in general hospital facilities are provided in a timely way, working in partnership with medical teams to commence assessments at the earliest opportunity (to include support to those accompanying the person in crisis);
- Each general hospital in Northern Ireland with an Emergency Department has a discrete onsite Mental Health Liaison Service that is consistent across all Trusts, and must be able to provide assessments in line with NICE guidelines;
- A (longer term) reduction in waiting times for assessment and ensuring that people are assessed when they attend;
- Delivery of enhanced care pathways with other services via this multidisciplinary approach such as CAMHS and Learning Disability Services to ensure that there is full equity of access;
- Smooth transitions of care between partnership agencies such as the PSNI and Ambulance Service to ensure that they have the capability to return to their other functions in a timely way.

The Crisis Service policy recognises that whilst people do attend Emergency Departments in mental health crisis, this is often not the best place for them, as it is often not an environment that is conducive to providing a mental health assessment. The new Crisis Service will involve mental health services working with Emergency Departments and other Emergency Care Services to provide alternatives. This could include mental health practitioners working in partnerships with Acute Care Centres

providing phone support for those in mental health crisis. Emergency Departments will continue to be designated as places of safety under the Mental Health Order. When alternatives to Emergency Departments are developed, other existing services must also be considered, such as Lifeline and other Protect Life 2 services.

Crisis Service Implementation Plan

The Health and Social Care Board (HSCB) and PHA are leading on the implementation of the new crisis service through the ten actions in the policy, with HSC Trusts responsible for the implementation and delivery of regionally consistent mental health crisis services.

An Implementation Plan for the new service has been jointly developed by the HSCB and PHA, approved by the Department and made available on the DoH website via the following link: Crisis Service Implementation Plan

The Plan provides detail on key assumptions, inputs, stakeholders and outputs across each of the 10 actions. It recognises that delivery of the actions set out in the plan will require balanced meaningful participation, engagement and shared ownership and that this will support the development of effective collaborative partnerships in order to co-design and co-deliver the new Mental Health Crisis service.

This work is reflected in Action 27 of the recently published Mental Health Strategy 2021 – 31 which commits to the creation of a Regional Mental Health Crisis Service that is fully integrated in mental health services and which will provide help and support for persons in mental health or suicidal crisis.

Chapter 8 – Improving Care of Older Persons

Our society is getting older. While this is clear indication that our population's general health is improving, it is also the case that our growing, ageing population presents a major challenge for our health and care systems. The ageing society is often presented negatively as burdening the NHS with excessive costs – the reality is that our health and care services have not changed to reflect our changing society.

Very often, this manifests itself most acutely in our urgent and emergency care services. Our older population are by far the most frequent users of our urgent and emergency care service, very often attending our EDs when very ill and suffering with multiple and complex conditions. Older patients are also more likely than other groups in the population to spend significant amounts of time waiting in Emergency Departments for admission.

The Department's Population Health Needs Assessment[59] confirms that the trend of an ageing population is set to continue, with the number of people aged 65 and over projected to rise by 74,500 by 2026. Further projections suggest by 2040, the number of people over 85 years will have increased by 127% (NISRA 2018) while the working population i.e. under 65 years will have decreased by 3%. Data produced by NISRA in June 2018 demonstrates that the number of people aged 85 and over living in Northern Ireland has risen to 37,700 people (a 1.5% increase on the mid-2017 figure)[60].

These population projection trends, and associated challenges for health services, are not unique to Northern Ireland. Many countries across the world are undertaking significant reform and transformation in an effort to develop sustainable solutions to meet the growing demand on services presented by an ageing population.

As a core aspect of the challenges facing our urgent and emergency care services, the Review established a workstream to consider proposals for the long term delivery model for urgent and emergency services for older people in Northern Ireland.

The purpose of the workstream was:

- To consider the needs of older patients and their carers who avail of urgent and emergency care services in NI;

---

[59] https://www.health-ni.gov.uk/publications/northern-ireland-needs-assessment-urgent-and-emergency-care

[60] https://www.nisra.gov.uk/publications/estimates-population-aged-85-and-over-northern-ireland-2018-and-2001-2017-revised.

- To bring together stakeholders with an interest/ role in delivery of urgent and emergency care for older people and to understand and assess their relative challenges, priorities and proposals;
- To consider key issues and challenges currently facing urgent and emergency care services;
- To review work underway strategically and within each Trust locality to help address issues and challenges and review any plans for future service developments; and
- To take into account service user and carer experience as outlined in research projects - for example 10,000 Voices – and also the engagement workstream of the Review itself. It is of note that "currently the largest resource providing care and support is unpaid carers, normally close family members".

Emergency Departments and Admissions

Attendances at our EDs by older people continue to increase. Data produced by the HCSB shows that, for the period 20 December 2019 to 3 January 2020, while there was 8% decrease in the number of people who attended ED (compared to last year), there was a 7% increase in the number of older patients aged over 65 attending in the most urgent categories. Further, compared to 2014/15, the overall attendances at ED are up by 9%, while for those aged 65 and over there was a 22% increase. Over 45,000 (45,401, 5.6%) of the 814,273 new and unplanned review attendances at EDs waited longer than 12 hours to be either treated and discharged home or admitted. Despite the best efforts of our staff, it is clear that our services as currently configured are failing to meet the immediate challenges, let alone those presented by an ageing population. It is clear that the demographic challenges are significantly contributing to an extremely difficult and pressurised working environment for our staff.

We know that attendance at the Emergency Department is associated with a high risk of admission for older people. For example, since 2014/15 over 60% of patients aged 65 & over arriving by ambulance were admitted to hospital, with almost 70% of patients aged 75 & over being admitted. Admitted older patients also frequently have longer stay lengths in hospital than other patient groups. However, research has shown that 20% to 25% of admissions and 50% of bed days do not require an 'acute' hospital bed as these patients' medical needs could be met at a more appropriate, usually lower, level of care[61].

61 https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwj50av9jNz1AhWkQkEAHXTJBqEQFnoECAMQAQ&url=http%3A%2F%2Fallcatsrgrey.org.uk%2Fw

There is a significant amount of research evidence that suggests frail and older people admitted to hospital are likely to experience poor health care outcomes which can include, for example, increased delirium, inpatient falls, muscle ageing and functional decline. We know also that at times it can be a very distressing and confusing experience for our older people attending EDs[62]. Taken together, this reinforces the absolute need to consider robust, clinically appropriate alternatives to attendance and admission for our population.

In considering proposals, the workstream focused on the following areas with contributions and evidence from each of the workstream members representing different professions and services central to the provision of care for older people.

System Variance

NI Health and social care is delivered through a complex system of relationships across boundaries. There is currently huge variation in the types of care models, pathways and services delivery models available for the treatment of older people attending our Emergency Departments. These range from, for example, Short Stay Units, Older Persons Assessment Units, Acute Frailty Units and direct admissions wards. Older people who have contributed to the involvement aspects of the Review have highlighted that they find the variation in current services confusing and difficult to navigate.

Evidence in England suggests that boundaries can be made more complex through **unwanted variance within and across health and social care both within acute**[63] **and community services**[64]. There is scope in NI to develop consistency in planning and delivery through a tiered approach to skills and knowledge of staff supported by Digital solutions. Given the focus on coproduction, there is an opportunity to learn from the principles of "**Realistic Medicine**"[65] putting the person receiving health and care

p%2Fwpfb-file%2Fguide_to_reducing_long_hospital_stays_final_v2-pdf%2F&usg=AOvVaw2A8p6FKCs5UNLGaftG6Kje

[62] https://10000morevoices.hscni.net/download/10000-Voices-Regional-Report-Unscheduled-care-Feb-17.pdf

[63] Carter, R.P. (2016) Operational Productivity and performance in English NHS Acute Hospitals: unwanted variations. Department of Health (England) [Online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

[64] Carter, R.P. (2016) NHS operational productivity: unwarranted variations. Mental Health Services and Community Health Services. [Online] Available at: NHS England » Lord Carter's review into unwarranted variations in mental health and community health services

[65] NHS Inform Scotland. (2017). Chief Medical Officer Scotland - Realising Realistic Medicine. [Online] Available at: https://www.nhsinform.scot/care-support-and-rights/nhs-services/using-the-nhs/realistic-medicine

at the centre of decision-making and creating a personalised approach to their care, while simultaneously pursuing the aim to reduce harm, waste and unwarranted variation. This will provide an equitable service whilst managing risks and innovating to improve.

Workforce

Workforce is a challenge across all groups. Delivering for our People 2026[66] sets out a workforce strategy to support the transformation agenda. This is underpinned by specific workforce planning strands for different professional groups with varying lead times. The DoH has currently commissioned a Social Work Workforce Review which will consider social work in both community and hospital settings with consideration being given to future models of delivery, the numbers of social workers and the skills required. On defining a new model for urgent and emergency care there is a need for all of these to align. Evidence suggests that "NHS history is sadly littered with examples of policy ambitions that were not underpinned by robust workforce strategies – the most notable being the desire to shift care out of hospitals"[67].

Frailty

'Older people' are not a homogenous group. A systematic review published in the Emergency Medicine Journal (2019)[68] on what older people want from emergency care found – *"Older people wished to have prompt waiting times, efficient care, clear communication and comfortable environments. They had additional and unique expectations for holistic care and support in decision-making. The ED provoked a sense of vulnerability among older people who were likely to have had frailty*."

Fit older people presenting with single organ problems should largely be managed in line with usual care for all adults. This would include equitable access to services including relevant ambulatory care pathways including access to the relevant community teams.

Older people with frailty presenting with a health crisis require a different approach to assessment. Services need to identify frailty and prioritise early holistic assessment /

---

[66] Health and Social Care workforce strategy 2026 – Delivering for our people. (2017). [Online] Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-workforce-strategy-2016.pdf

[67] The health care workforce in England – make or break (2018) [Online] Available at: https://www.kingsfund.org.uk/publications/health-care-workforce-england

[68] Emergency Medicine Journal (2019) What older people want from emergency care: a systematic review [Online] Available at: https://emj.bmj.com/content/early/2019/10/24/emermed-2019-208589

Comprehensive Geriatric Assessment[69] (CGA) for individuals with moderate or severe frailty. Services should be configured so that, where needs could be met at home or closer to home through a range of options including physical activity[70], integrated care teams (core services), intermediate care (IC), palliative care, district nursing, primary care[71] and specialist teams these should be considered first. If secondary care services are required, older people with frailty should have equitable access and be treated by staff with sufficient skills to manage their frailty and co-morbidities. There should be recognition that for these individuals avoidable hospital admissions are likely to cause poor health care outcomes including increased delirium, inpatient falls, deconditioning[72] and premature institutionalisation reinforcing the need for responsive proactive screening and admission avoidance[73] where possible.

Proactive identification[74] of frailty in primary care and community based holistic assessment and intervention offers potential to avoid some health crisis and allow **Anticipatory Care Planning (ACP)** for those with more severe frailty. Evidence would suggest that this will lead to more realistic attitudes, better patient centred care and more appropriate use of intensive health care resources.

A whole system approach to management of rehabilitation is required and learning can be taken from other countries[75] where key principles and enablers have been developed to ensure patients are managed most effectively at the right stage of the unscheduled care pathway.

---

[69] Ellis, G. et al. (2017). Comprehensive Geriatric Assessment for older patients admitted to Hospital. [Online] Available at: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006211.pub3/epdf/abstract

[70] Management of Frailty (2019) [Online] Available at: https://www.jamda.com/article/S1525-8610(19)30618-8/abstract

[71] Nuffield Trust (2016) [Online] Available at: https://www.nuffieldtrust.org.uk/research/the-digital-patient-transforming-primary-care

[72] David Oliver: Fighting pyjama paralysis in hospital wards (2017) British Medical Journal – [Online] Available at: https://www.bmj.com/content/357/bmj.j2096

[73] The impact of a new emergency admission avoidance system for older people on length of stay and same-day discharges Age and Ageing (2014) [Online] Available at: https://academic.oup.com/ageing/article/43/1/116/23376

[74] Unplanned admissions and readmissions in older people: a review of recent evidence on identifying and managing high-risk individuals (2014) [Online] Available at: https://www.cambridge.org/core/journals/reviews-in-clinical-gerontology/article/unplanned-admissions-and-readmissions-in-older-people-a-review-of-recent-evidence-on-identifying-and-managing-highrisk-individuals/CF63674CE9A156EB7FADF9CA76015B7F

[75] Unplanned admissions and readmissions in older people: a review of recent evidence on identifying and managing high-risk individuals (2014) [Online] Available at: https://www.cambridge.org/core/journals/reviews-in-clinical-gerontology/article/unplanned-admissions-and-readmissions-in-older-people-a-review-of-recent-evidence-on-identifying-and-managing-highrisk-individuals/CF63674CE9A156EB7FADF9CA76015B7F

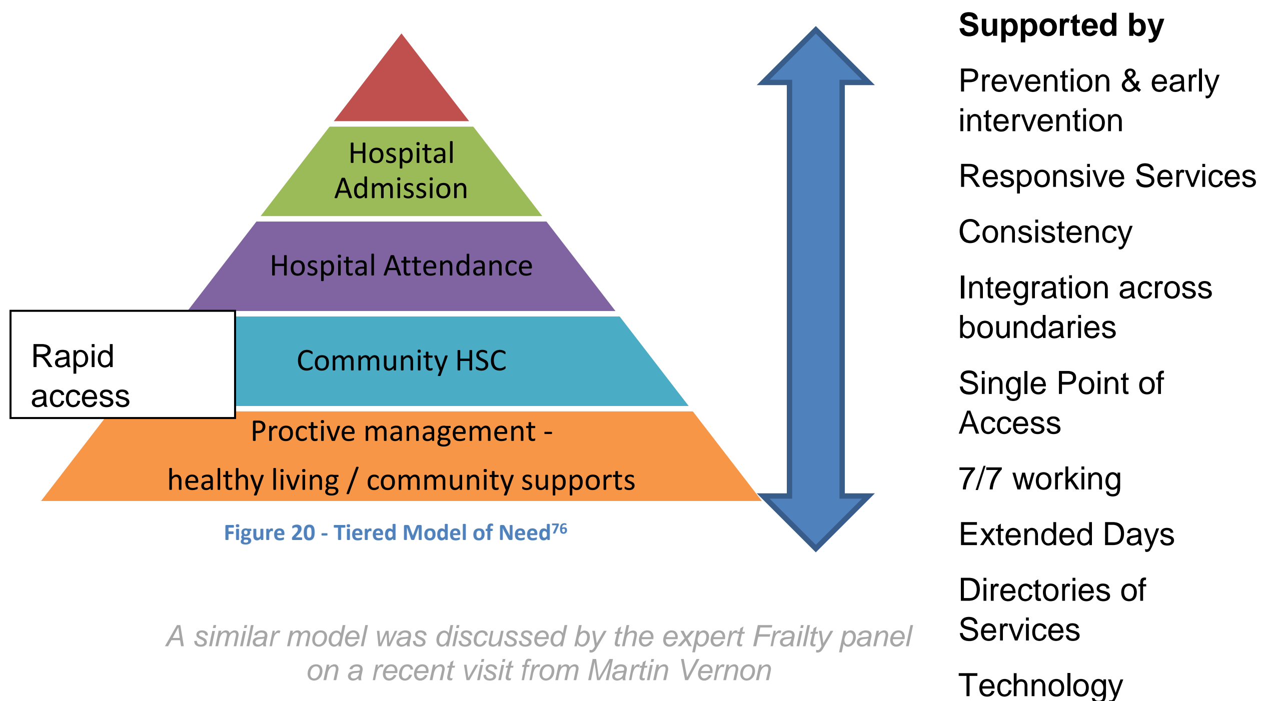


Figure 20 - Tiered Model of Need[76]

The Kings fund[77] advocates that "*improving services for older people requires us to consider each component of care, since many older people use multiple services, and the quality, capacity and responsiveness of any one component will affect others*". The key components to be considered are, and will be referenced throughout this section:

- Healthy, active ageing and supporting independence;
- Living well with simple or stable long-term conditions;
- Living well with complex co-morbidities, dementia and frailty;
- Rapid support close to home in times of crisis;
- Good acute hospital care when needed;
- Good discharge planning and post-discharge support (MD discharge planning as required);
- Good rehabilitation and reablement after acute illness or injury;
- High-quality nursing and residential care for those who need it;
- Choice, control and support towards the end of life;
- Integration to provide person-centred co-ordinated care.

---

[76] NICE Framework for Digital technologies (March 2019) [Online] Available at: https://www.nice.org.uk/about/what-we-do/our-programmes/evidence-standards-framework-for-digital-health-technologies

[77] Oliver, D et al. (2014) Making our health and care systems fit for an ageing population. The Kings Fund. [Online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

The principles outlined in the Kings Fund article chime with the aspiration in Delivering together[78] to:

> ***Reform our community and hospital services*** *so that they are organised to provide care when and where it is needed.*

The British Geriatrics Society defines frailty as a distinctive health state related to but not specific to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people[79] [80] aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years. "Fit for Frailty"[81] identifies five frailty syndromes and encountering one of these should raise suspicion that the individual concerned has frailty:

1. Falls (e.g. collapse, legs gave way, 'found lying on floor'
2. Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck in toilet').
3. Delirium (e.g. acute confusion, 'muddledness', sudden worsening of confusion in someone with previous dementia or known memory loss).
4. Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence).
5. Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

Collard et al[82] provide the following analysis of the prevalence of frailty in the older population.

---

[78] Health and Wellbeing 2026 – Delivering Together. (2016). [Online]. Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

[79] Emergency Admissions to hospital from care homes (2019) [Online] Available at: https://www.health.org.uk/publications/reports/emergency-admissions-to-hospital-from-care-homes

[80] Kings Fund (2010) interventions to reduce unplanned admissions from care homes [Online] Available at: https://www.kingsfund.org.uk/sites/default/files/media/Radcliffe_Keefai.pdf

[81] British Geriatric Society (2014) Fit for Frailty. [Online] Available at: https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-14/fff2_short.pdf

[82] Prevalence of Frailty in Community- Dwelling Older Persons: A Systematic Review (Journal of the American Geriatrics Society, Vol 60 Issue 8, August 2012) Prevalence of frailty in community-dwelling older persons: a systematic review - PubMed (nih.gov)

Table 1 - Prevalence of Frailty in Older Population

Age Group	% Living with Frailty
65-69 Years	4%
70-74 Years	7%
75-79 Years	9%
80-84 Years	16%
85+ Years	24%

Application of the above prevalence rates to the Northern Ireland population would indicate that approximately 32,000 people aged 65+ are currently living with frailty, with this increasing by a further 10,000 over the next 10 years. We know that older people living with frailty are more likely to avail of emergency care services. The NHS Right Care Toolkit[83] suggests that in England there are over 4000 hospital admissions daily for people living with frailty. This same group are more likely to have delayed transfers of care[84].

The overlap between routine and urgent care is perhaps greatest in the frail elderly population. A relatively small change can result in a rapid and significant deterioration requiring an urgent intervention in a short timescale. We know that attendance at the Emergency Department is associated with a high risk of admission for older people[85] [86] [87]. In the UK, almost two thirds of those aged over 85 die during a hospital admission and the likelihood of dying within 12 months of a hospital episode increases with age[88].

83 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf

84 Statistics » Delayed Transfers of Care (england.nhs.uk)

85. [PubMed: 6955965]

86 Lang NM, Kraegel JM, Rantz MJ, et al. Quality of health care for older people in America. Washington, DC: American Nurses Association; 1990 Reducing Functional Decline in Hospitalized Elderly - Patient Safety and Quality - NCBI Bookshelf (nih.gov)

87 (PDF) The National Patient Safety Foundation Agenda for Research and Development in Patient Safety (researchgate.net)

88 https://academic.oup.com/ageing/article/45/3/372/1739735

We also know that hospital admission can lead to a poorer overall outcome for an older person living with frailty as they can become deconditioned. Bed rest in older people in hospital can lead to a range of harms[89]. Even in healthy older adults, 10 days of bed rest can lead to a 14 per cent reduction in leg and hip muscle strength and a 12 per cent reduction in aerobic capacity: the equivalent of 10 years of life[90]. Other negative impacts of hospital episodes include the development of delirium, pressure sores and increased risk of a hospital acquired infection, all of which can lead to higher levels of vulnerability and dependence.

By having a baseline understanding of a person's level of frailty, staff are better placed to determine an individual's potential for recovery and provide the right care in the right place. For example, where someone is identified as having severe frailty, there may be no gain from an acute admission, whereas **Advanced Care Planning (ACP)** and end of life care will be appropriate actions.

Social Care

Social care in Northern Ireland is a regulated workforce. It is also forecast to continue to grow significantly. The current workforce totals 44,677 social care staff working across a diverse range of health and social care provision and across programmes of care. Social care staff for example can work in: day care/centres; care homes; domiciliary care; and be rehab. support workers and care assistants. The workforce provides an invaluable contribution to the overall health system. There are currently around 15,000 domiciliary home care workers currently registered with the Northern Ireland Social Care Council. In 2018, 23,409 individuals were provided with domiciliary care support in their own homes across NI, which included statutory and independent sector providers (source, HSCB data). The domiciliary care work force are the frontline workers who operate in communities and can in many cases be best placed to notice and react to any change in individuals physical or mental health deterioration. Social care support should therefore also be viewed in the context of delivering preventive measures, supporting rehabilitation and independence and providing early intervention.

Social care workers can provide practical, social and emotional support. The provision assists service users to remain at home, maintain their independence, improve their quality of life and wellbeing and is an essential support to carers. Responsive social care works to ensure good quality of care to support and enable people to live longer in their own homes. If increased support can be provided in a timely manner in people's own homes it can support people to recover from the immediate crisis. It can also

---

[89] https://www.nursingtimes.net/clinical-archive/orthopaedics/effects-of-bedrest-3-musculoskeletal-and-immune-systems-skin-and-self-perception-29-06-2009/

[90] https://www.ncbi.nlm.nih.gov/pubmed/?term=Kortebein%2C+P.%2C+et+al.%2C+J+Gerontol+A+Biol+Sci+Med+Sci%2C+2008.+63(10)%3A+p.+1076-81.

support other professionals in targeting priority healthcare intervention in the community to prevent attendance to hospital and avoid hospital admissions. It is also of note that where social care cannot be provided in the home setting, hospital patients in NI have been discharged to Intermediate Care 'transition beds'. Whilst this frees up the hospital bed, the ethos of home first is not being realised.

Within NI and elsewhere in the UK, there is a recognised shortage of social care workers. Often perceived to be a less favourable career pathway, due to less favourable terms and conditions and the standard of training available compared to other healthcare professionals. HSC Trusts have waiting lists for domiciliary care. There are challenges with the recruitment and retention of social care staff and the DoH are currently considering a paper on the reform of care and support at home. Within the paper, there are design principles of the service being: user focused/person centred; flexible and responsive; working in partnership with the user, family, community and provider; innovative; value based and asset /strength based. The proposed new model of care and support at home is outlined below. The involvement of the user and carer in developing the support needs and subsequent plan is of note as is the need to look towards the community and voluntary sector.

Palliative Care

Palliative care is an important area which needs to be addressed in relation to the urgent and emergency care review. There are significant challenges, which will need to be overcome in order to deliver an exemplary service which prevents people from having to use the Emergency Department to access their palliative care needs. Areas which will need to be considered and addressed include:

1. **Education and understanding** of appropriateness of a palliative care approach across all professionals and care settings preventing admissions.

2. **Access to medications** (anticipatory prescribing) in particular during out of hours periods- work undertaken by the Macmillan Palliative Pharmacy Service Improvement Project has piloted the use of 'Just in Case' boxes with encouraging feedback.

3. **Access to palliative care advice** for professionals across all care setting to prevent unnecessary transfers to ED/hospitals. – work underway to look at the provision of advice to professionals 24/7.

4. **Models/pathways to support the community based professionals** (Primary Care, District Nursing Teams and Care Home sector) to provide care in the person's usual place of residence (preferred place) and to reduce inappropriate transfers to hospital in the last years of life.

Current work and strategic direction

With regard to urgent and emergency care there are some key strategic themes on which the most innovative practices are focused. These include:

1. **Helping older people avoid unnecessary attendances through the emergency and urgent care system.**

2. **Ensuring older people are only admitted to an acute setting via Emergency Departments if absolutely necessary.**

3. **Creating a system with direct access to the right care first time.**

4. **Avoiding prolonged and unnecessary admissions and stays in acute hospital settings.**

There are significant ongoing initiatives to try and improve the medical and social service that older people in Northern Ireland receive. The following section describes some of the ongoing initiatives with regard to older people and envisages possible future approaches, which could make a significant difference to their care.

NIAS Frequent Attenders

Approximately 25% of the frequent callers to NIAS are in the over 65 age group. Of this cohort of patients, 25% present with social isolation where they live semi-independently and rely on care packages for their needs. These patients access NIAS mostly out of hours due to anxiety and needs in relation to their daily living activities. In order to manage this particular cohort intensive engagement with their GP and social services is required to establish a more appropriate care pathway or alternatively by seeking support of community and voluntary sector support if this is available in their area. Around 15% contact NIAS due to falls or poorly managed comorbidities (diabetes etc.) and these are managed through engagement with primary care and the local HSC.

Of the remaining 60% of over 65s, the majority present to NIAS with addictions (mostly alcohol) or mental health issues or a combination of these factors. This is the most difficult group to manage as their addictions are often chronic and their behaviour in the use of 999 is learned. The introduction of the community and voluntary sector to assist the patient to engage with the assistance being offered by the Trust is the most effective way of managing these patients, however this facility is not available in all geographical areas and not all patients will engage.

The mental health disorders are often personality disorders and health anxiety. These patients are usually known to and are being managed by the local HSC elderly mental health teams or social care teams. NIAS engage in multidisciplinary meetings in an

effort to manage their needs in collaboration with HSC, however this is the most difficult group as their behaviours are very difficult to manage and cause a huge drain on Ambulance resources.

The Northern Ireland Ambulance Service (NIAS) reports the demand for emergency ambulances is increasing every year and the range of conditions and clinical presentations of patients continue to challenge the Emergency Medical Dispatcher (EMD) and the attending paramedics/EMTs. Sir Bruce Keogh recognised that our "current services are unsustainable". Traditionally the only option for attending paramedics was to transport older patients to the Emergency Department (ED). However, the Keogh Report [91](2013) identified that 50% of 999 calls did not need ED attendance. 45% of all 999 calls are over the age of 65 and will continue to rise with the increasing ageing population.

The ED should now be regarded as just one of a range of pathways[92] that can be utilised to ensure the patient receives the most appropriate care. Success in reducing the increasing workload will rely upon our ability to accurately identify, assess, treat and refer patients to the most appropriate care providers. NIAS has introduced the Rockwood Clinical Frailty Scale on the Patient Report Form (PRF) as part of their assessment of the older person. Work across NI is ongoing on the NHS Benchmarking Frailty & Delayed Transfers of Care Audit[93] and The National Audit of Intermediate Care[94] and has provided in November 2019 an indication of the implementation of frailty screening in acute hospitals and across Intermediate Care.

Our ability to adapt to this new way of working will see patients receive more timely and appropriate care, with the overall patient experience being enhanced.

The Northern Ireland Ambulance Service has provided a Clinical Support Desk in their Emergency Ambulance Control since October 2017 to assist with the provision of the most appropriate response to older patients, including referring patients to alternative pathways and avoiding attendance at ED. The Clinical Support Desk is a team of Paramedics who undertake a secondary telephone triage of emergency calls. Each patient outcome is based on a clinical assessment using the clinical knowledge of the Paramedic and assisted by Manchester Triage. Outcomes include self-care advice, referrals to Primary Care, Direct Admissions and related referral pathways as listed

[91] https://www.england.nhs.uk/2013/11/keogh-urgent-emergency/

[92] https://qualitysafety.bmj.com/content/early/2019/11/03/bmjqs-2019-009729.full

[93] 2019 Managing Frailty and Delayed Transfers of Care in the Acute Setting project – Results published — NHS Benchmarking Network

[94] https://www.nhsbenchmarking.nhs.uk/naic

below with the option of transport to the Emergency Department if required. This needs to link with a Single Point of Access[95] [96] [97] for non-ambulance patients.

The NIAS approach has been a significant success story in recent years. While demand, ED attendances, and admissions to hospital have all been rising steadily, it is notable that the number patients conveyed to Emergency Departments by ambulance has been falling. This is in large part due to the work outlined above. There is a view from those working in these services that this number has the potential to be reduced even further with increased capacity in primary and community services.

Intermediate Care

Intermediate Care like a number of other community pathways should be integral to this review. Properly constructed Intermediate care services can deliver across the spectrum of attendance avoidance, admission avoidance, direct admissions and discharge.

For the purposes of this paper Intermediate care (IC) is defined as a range of services across 4 categories[98] of **IC - Crisis Response, IC - Bed based, IC - Home based IC and IC - reablement**. The National Audit of Intermediate Care[99] *(a partnership project between the British Geriatrics Society, the Association of Directors of Adult Social Services, AGILE, the Royal College of Occupational Therapists, the Royal College of Physicians (London), the Royal College of Nursing and the NHS Benchmarking Network. The Patient's Association and The Royal College of Speech and Language Therapists became partners in 2013)* has indicated that NI has scope to further develop and rebalance IC capacity towards attendance avoidance, admission avoidance and direct admissions. NI has consistently had the highest participation response rate across the UK from service users[100]. Patients want to be managed at home where possible, feedback for home based care and reablement has been consistently high. Given the demographic trends outlined in the needs analysis[101] this service has much potential to grow. Currently there is a significant focus on Trusts to promote referrals from primary and community care and therefore reduce ED attendances and admissions (STEP UP Intermediate Care). Step Up Intermediate

---

[95] https://www.nuffieldtrust.org.uk/files/2018-03/hospital-and-social-care-interface-final-web.pdf

[96] https://www.nice.org.uk/guidance/ng74

[97] https://www.nuffieldtrust.org.uk/research/the-digital-patient-transforming-primary-care

[98] https://www.nice.org.uk/guidance/ng74

[99] https://www.nhsbenchmarking.nhs.uk/naic

[100] https://www.nhsbenchmarking.nhs.uk/naic

[101] https://www.health-ni.gov.uk/publications/northern-ireland-needs-assessment-urgent-and-emergency-care

Care is available for GPs and community care teams. The service provides rehabilitation provided by physiotherapists, occupational therapists, social workers and generic rehabilitation support workers. Through transformation funding there has been an increased focus on promoting step up thereby preventing ED attendance and providing rehabilitation in a timelier manner. Early indications are that this is beginning to happen in some Trusts.

Metrics from National Audit of Intermediate Care (NAIC) and Nice Guidance (NG) 74 in terms of community responsiveness have been adopted by NHS England as part of the new community data[102] set established in October 2019 – aiming for crisis response times of 2 hours and 48hours for home and reablement.

Embedding both of the above across attendance avoidance, admission avoidance and discharge has potential to change system behaviours through consistency and performance management.

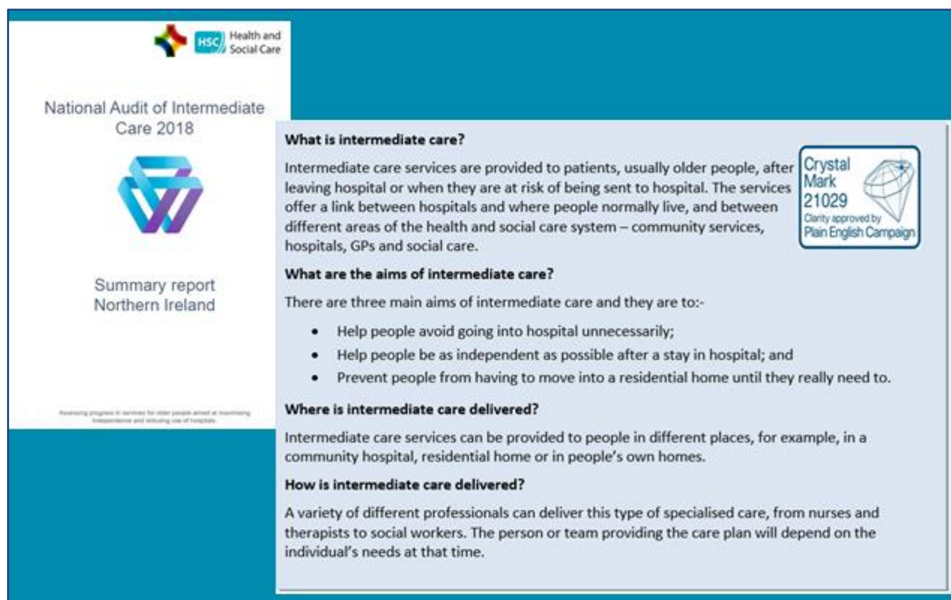


Figure 21 - Intermediate care Definition[103]

Older people will often be better managed through IC and other community services rather that ED / secondary care. Services in the community are responsive and delivered by teams with sufficient skills. Inability to access timely HSC will mean continued presentation to unscheduled care if the need is not addressed. National audit evidence would suggest that NI is too dependent on bed based IC services, that IC services have insufficient capacity to meet the needs of those who could benefit

[102] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb1069-community-services-data-set

[103] https://www.nhsbenchmarking.nhs.uk/naic-resources-key-documents

and are not sufficiently responsive to routinely support admission avoidance. Where admission avoidance is happening the NAIC audit would suggest it is mostly in IC - Reablement services.

In this paper Acute Care at Home (AC@H) and Enhanced Care at Home (EC@H) are considered under Intermediate Care – Crisis response. These teams vary regionally and a consistent regional response would improve access and delivery. Nevertheless, the primary focus is about attendance avoidance - maintaining older people at home/nursing/residential care in the event of an acute illness or unexpected deterioration in health. The service provides triage, assessment, diagnosis and treatment as an alternative to in-patient care to those at risk of or potentially requiring admission to hospital treatment.

For example AC@H in Southern Trust

- There is a response time target of 2 hours from referral to assessment.
- All patients receive a Comprehensive Geriatric Assessment (CGA) based on Silver Book[104] Guidelines.
- There is rapid access to Diagnostics and Labs (within the hospital setting)- same timeframe as patient in an inpatient ward
- The service is only involved for the Acute Care phase
- Average Length of stay on the scheme is 4-5days

Outcomes include

- Prevention of attendance is 66% of all referrals in 2018/19.
- Over 90% of patients remain at home (or their care home) throughout their episode of care with the AC@H team
- 85% of patients who are accepted on to the service are discharged with no change to their pre-existing care package
- 8% of patients required admission to hospital due to a deterioration in their medical condition
- The team supported 3% of patients to allow them to die peacefully in their own home

Independent audits:

Southern Trust - ICD10 Audit (2016)

- 250 random patients selected by clinical coding team
- Codes of patient cared for by AC@H were comparable with patient cared for in Acute hospital.

[104] https://www.bgs.org.uk/resources/silver-book

- Average length of stay for patients on AC@H 5.7 days, those with same clinical codes in Acute Hospital 6.8 days.

Southern Trust - HSCB Audit (2017)

- The AC@H service is managing patients with acute complex needs in the community comparable to patients in the acute setting.
- Audit found there was a rapid response time, including interventions and delivery of equipment.
- It was evident care was patient and family centred
- No patient required any Out of Hours interventions during the period of the audit.
- Antibiotics were administered for shorter durations than in acute hospital.
- Vast majority of patients didn't require any additional support on discharge.
- Improved shared care/confidence with nursing homes.

The National Audit of Intermediate care[105] provides evidence on the different iterations of the scheme regionally. There is a need to harmonise these iterations into a 'one for all' NI model, that interfaces with a Single Point of Access and directory of services, enabling patients to be transitioned to other services when their crisis has been resolved and across boundaries, if necessary.

Dementia

As part of the regional Dementia Strategy implementation programme a multi-agency/multi-disciplinary collaborative was established which included representation from people living with dementia and carers. This Collaborative developed a Regional Dementia Care Pathway. This development is an example of one for all NI model and stresses the need for adequate resources built around a primary care GP led model. This should include Advanced Nurse Practitioners, Social Work, Neuropsychology, Occupational Therapy, Physiotherapy and Psychiatric Nurses to create a dedicated cognitive assessment team with the ability to do domiciliary assessment in addition to care home and hospital based assessment. The proposed new model would include support from Alzheimer's Society and/or Dementia NI as deemed necessary and appropriate. It is inclusive of younger people with dementia, people with a sensory impairment / learning disability and dementia, people from minority ethnic / 'hard to reach' groups and also those with rarer forms of dementia. The pathway would ensure support for the individual and caregiver through the entire dementia journey and complex cases could be referred to specialist networks. The new service will be led by

[105] https://www.nhsbenchmarking.nhs.uk/naic

General Practitioners with support from, or access to, a range of primary care professionals.

The Pathway provides for additional supports closer to the person's own home which may help to reduce the need for hospital admissions. Trusts have all developed their own in-reach / community support teams which provide intensive one-to-one supports in Care Homes and in the person's own home, which may also help reduce hospital admissions.

An opportunity exists to stratify the older population based on frailty as a mechanism to support signposting to specific pathways with a home first ethos utilising the range of services as outlined in Fit for Frailty[106] [107]and the Silver Book[108] to support alternatives to ED.

Regional Emergency Social Work Service

The Regional Emergency Social Work Service (RESWS) provides an emergency out of hour's social work response across the five HSC Trusts and across all programmes of care including Family and Child Care, Learning Disability, Mental Health, Physical Health and Disability and Older Peoples Services. It also provides an emergency response in relation to homelessness on behalf of the Northern Ireland Housing Executive (NIHE). For information on the number of housing referrals received during the reporting period please refer to table 2 below. The RESWS operates from 5pm-9am Monday to Friday and on a 24-hour basis at weekends and public holidays. In 2018/19 the RESWS managed 19,229 referrals, of which 3,045 related to older people. For information on the breakdown of the referrals by service area and Trust please refer to table 3 below.

The RESWS model is based on having a core team of permanently employed senior practitioner social workers (during 2018-2019 this was 29.5 staff) supported by a team of 69 senior practitioner locum staff who provide cover for annual leave, sick leave and training. The Service also has one Service Manager, four Assistant Service Managers and 10 locum shift managers.

In relation to older people the RESWS can prevent attendance to hospital by increasing an existing package of care. Authorising an enhanced package provides a support to the patient and carer in an emergency situation until the service users key worker or delegated other, can review the situation. In this scenario, contact is usually made by the service provider who seeks authorisation to increase the package. The

---

[106] https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-14/fff2_short.pdf

[107] https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff2_full.pdf

[108] https://www.bgs.org.uk/resources/silver-book

ability to prevent attendance is constrained by the service provider's capacity to provide additional support in response to the emergency. The RESWS advise that they are not involved in commencing a new package of care for an individual whilst in hospital.

The RESWS can also assist with emergency admission to a care home and have developed practice guidance to manage this situation in conjunction with RQIA and Trust leads. Referrals for emergency admission to a care home can come from an ED, OOH GP or via a family member /carer. At present the number of service users placed is small – approximately fewer than 5 cases per week. Constraints faced by the RESWS include the following factors:

- Lack of information provided by Trusts as to current care home availability;
- Care Home Managers wishing to assess the patient prior to acceptance to the care home;
- Cut off time to transfer a service user to a care home and reliance on other factors for example pharmacy and NIAS;
- There is a variance within Trusts as to the services provided both in the acute and community settings in the out of hours period;
- Intermediate Care (IC) beds can be ring fenced by the Intermediate Care service or Trust where the care home is based, prohibiting RESWS placing the patient.

Table 2 - REWS - Housing April 2018 - March 2019

TABLE 2 — Housing April 2018 to March 2019

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Belfast Trust	33	33	39	52	45	18	32	26	33	19	20	26	376
SE Trust	9	12	12	15	10	9	7	9	2	8	15	12	120
Southern Trust	5	9	4	14	15	9	21	19	9	10	17	16	148
Northern Trust	19	20	21	19	17	16	29	17	31	26	13	17	245
Western Trust	18	11	7	13	12	11	11	13	11	3	10	12	132
Other	0	0	0	2	0	0	0	2	0	0	5	0	9
Total	84	85	83	115	99	63	100	86	86	66	80	83	1030

Table 3 - REWS - Total No of Referrals by POC April 2018 - March 2019

TABLE 3	Total No of Referrals by POC April 2018 to March 2019						
	Belfast	SE Trust	Southern	Northern	Western	Other	Total
F&CC inc Domestic Violence	3108	1631	1706	2608	1852	17	10922
Mental Health	924	396	364	489	413	17	2603
Older People	920	596	442	796	289	2	3045
Vulnerable Adult	21	9	5	18	5	0	58
Physical Disability	227	151	143	166	63	0	750
Learning Disability	363	116	98	168	76	0	821
Housing	376	120	148	245	132	9	1030
Total	5939	3019	2906	4490	2830	45	19229

Palliative Care

The Marie Curie (MC) Rapid Response Service is available in all five localities during out of hours periods. Via a range of referral mechanisms (depending on locality) including GP OOH, 24/7 Nursing and NIAS, patients who are known to have palliative care needs can be referred to the MC Rapid Response service who can provide appropriate nursing care, advice, reassurance and/or emotional support to the patient and/or carers via a visit or over the phone.

An OOH Palliative Care Flowchart and Guidance has been developed with the NI Ambulance Service which enables paramedics to refer patients with known palliative care needs to the Marie Curie Rapid Response team instead of automatically transferring them to ED/hospital.

It is estimated that 1% of the population are in the last year of their lives, yet the average identification rate for the GP Palliative care registers across Northern Ireland in April 2019 was 0.25%. The average palliative care identification rate of the GP practices who participated in the first phase of the PCIP Early Identification Prototype increased to 0.47%.

47% of all deaths in Northern Ireland occur in hospital. A National Audit Office report suggests 40% of deaths in hospitals have no clinical reason for being in hospital.[109]

[109] https://www.nao.org.uk/wp-content/uploads/2008/11/07081043.pdf

A detailed examination of patient records in one primary care Trust found that 40% of patients who died in hospital in October 2007 did not have medical needs which required them to be treated in hospital, and nearly a quarter of these had been in hospital for over a month. Alternative places of care for these patients identified by our work were equally split between home based alternatives (in a patient's own home or a care home) and bed based care in a hospice. Local data suggest there was sufficient inpatient palliative care capacity to take many of the patients who died in hospital.

Data from NIAS Transformation reports that referral of patients to the MC Rapid Response Service currently avoids approx. 5 deaths per month in hospital for this developing pathway.

Table 4 - Marie Curie- Rapid Response Services – April – November 2019

Marie Curie - Rapid Response Services - 2019/2020										
	South Eastern HSCT		Belfast HSCT		Northern HSCT		Southern HSCT		Western HSCT	
	Visit / calls	Patients	Visit / calls	Patients	Visit / calls	Patients	Visit / calls	Patients	Visit / calls	Patients
April	116	38	279	68	291	111	155	80	210	99
May	123	52	428	73	254	113	210	94	233	104
June	161	47	272	69	224	109	136	69	170	75
July	118	41	352	76	257	115	213	99	242	77
August	171	47	302	69	264	117	188	74	255	83
September	174	48	333	88	263	98	221	86	180	72
October	211	54	320	71	279	118	203	97	188	64
November	189	48	237	70	255	116	212	94	207	89
Grand Total	1,263	299	2,523	430	2,087	721	1,538	564	1,685	539

South Eastern HSCT and Belfast HSCT reconfigured their services to change from a single Registered Nurse and two Health Care Assistants to two Registered Nurses only, from 1st July 2019 and 1st August 2019 respectively. (Some Health Care Assistants are still deployed when the Trust require staff to be provided and no Registered Nurses are available.)

Due to the incremental start and the change in model from July/August, Belfast and South Eastern HSCT have currently spent 54% and 51% of their £174,245 annual budget respectively.

(Data is subject to reconciliation and adjustment)

Table 5 - Marie Curie - Rapid response Services - April - November 2019 (further breakdown)

Northern Ireland Rapid Response Services 2019/20

	Western Health and Social Care Trust								Southern Health and Social Care Trust					
	1 - Altnagelvin Days (8am - 10pm weekends and Bank Holidays)		2 - Enniskillen Days (8am - 10pm weekends and Bank Holidays)		1 - Altnagelvin Nights (10pm - 8am 365 days)		2 - Enniskillen Nights (10pm - 8am 365 days)		Days (8am - 11pm weekends and Bank Holidays)		Evenings (6pm - 11pm Monday to Friday)		Nights (11pm - 8am 365 days)	
Month	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls
April	45	4	21	4	67	9	43	17	29	17	15	5	77	12
May	30	3	23	3	90	19	44	21	40	38	22	12	76	23
June	38		13	2	73	2	41	1	43	6	22	1	60	3
July	51		38		67	1	81	4	52		41		120	
Aug	62		22		117	18	26	10	34	27	21	4	90	12
Sept	47	2	21	2	56	12	33	7	54	23	27	6	86	25
Oct	32		21		71	16	40	8	25	28	34	12	90	14
Nov	30	1	16	1	87	12	44	16	38	27	32	7	94	14
Total	335	10	177	12	634	91	354	86	320	168	215	50	703	107

	South Eastern Health and Social Care Trust								Northern Health and Social Care Trust							Belfast Health and Social Care Trust			
			Weekday evenings		Weekends		Bank Holidays		Days (8am - 11pm weekends and bank holidays)			Evenings (5.30pm - 11.30pm Monday to Friday)		Nights (10pm - 8am 365 days)		Weekday evenings		Weekends and Bank Holidays	
Month	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls	Base	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls	Visits	Phone calls
April			89	4	27	1	7	1	48	22	1	29	24	112	55	145		123	1
May			69		27		6		57	8		27	22	103	38	272	1	155	1
June			136		41				53	4		51		114	3	164	3	135	
July	54		32		10		1		71			55	1	127	1	206		95	
Aug	94	4	45	1	27				44	28		29	22	124	17	238		94	
Sept	93		51	2	32	1			35	25		25	57	99	22	184	1	110	
Oct	112	1	71		27	3			44	27		29	32	106	41	219	1	118	
Nov	96		58	2	25				46	10		23	29	108	39	138		78	2
Total	456	5	551	9	219	5	14	1	400	127	1	269	193	899	216	1571	6	914	4

The Palliative Care in Partnership (Clinical Engagement Group) is currently undertaking an exercise looking at options for the provision of Specialist Palliative Care (SPC) advice to healthcare professionals across all care settings. It is envisaged that out workings of this exercise will have an impact on reducing transfers to Emergency Departments in the future. Phase 1 of this project is nearly complete, which has looked at the current arrangements for providing SPC advice to professionals across providers both in and out of hours and gathered the views of professionals who might require additional advice regarding palliative care patients. 617 professionals responded to a stakeholder survey and these responses are currently being analysed to inform the next steps of the project.

Retrospective audits have recently taken place in Emergency Departments in the South Eastern (SET) and Belfast Trusts looking at the patients who were identified in ED as having unidentified palliative care needs. Both Trusts found approx. 29% of admissions as having unidentified/unmet palliative care need and one Trust found 80% of these people had at least two other ED attendances within the previous 12 months. The programme is exploring running similar ED audits in other Trust areas and SET is considering another phase of this audit looking at a larger cohort of patients and exploring the reasons for presenting at ED and what could have been done differently to prevent same.

One of the priorities of the Palliative Care in Partnership (PCIP) Programme is to identify patients early and to provide the appropriate supports to help prevent avoidable hospital admissions in the first place. Where admissions are unavoidable and hospitalisation is required, it should be the case that adequate assessments supports have been put in place to cope with the anticipated deterioration of the patient’s condition and therefore expedite discharges back home.

In 2016, a ‘Home for the Last Days of Life Flowchart’ (included in getting patients on the right road for discharge) was developed through the work of the Transforming Your Palliative and End of Life Care (TYPEOLC) programme and incorporated into the regional ‘Getting Patients on the Right Road for Discharge’ guidelines. However, work also undertaken at that time highlighted issues across Trusts in the timely provision of equipment and domiciliary care services for patients with palliative and end of life needs. Whilst Trusts indicated they prioritised palliative care patients there was no standard (at that time) of how to ensure the timely provision of equipment or domiciliary care services for these patients.

Service Provision across Nursing & Residential Homes

There are 10,832 registered Nursing Home beds and 5,237 Residential Home beds across Northern Ireland. The majority of these beds are operated and managed by independent care providers. Where the term ‘Care Home’ is used, this includes reference to both Nursing and Residential Care Homes.

Data provided by the Regulation and Quality Improvement Authority (RQIA) provides an overview of Nursing and Residential beds per geographical Health & Social Care Trust area.

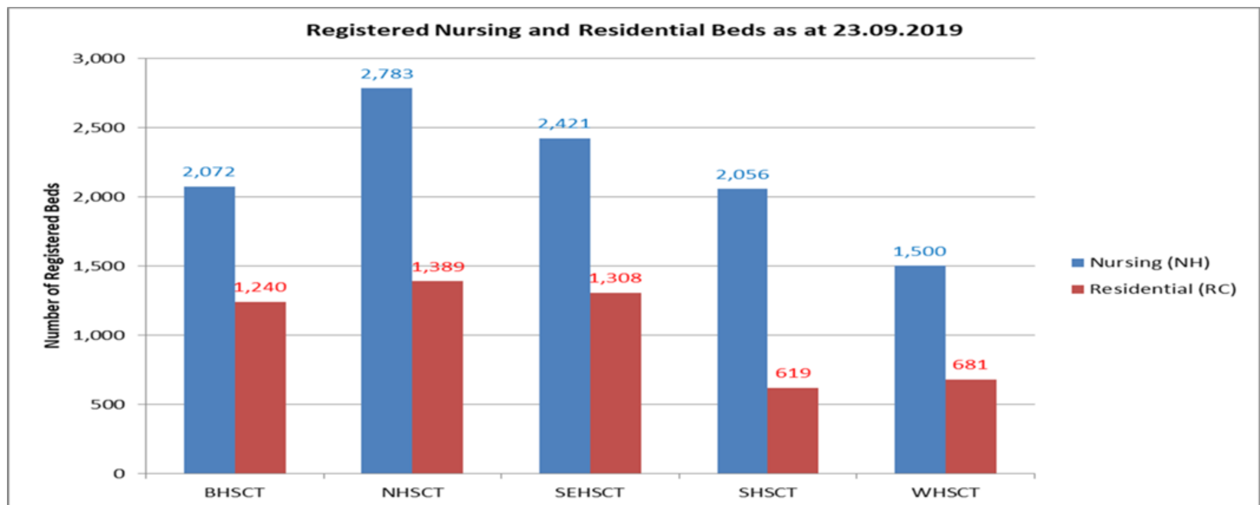


Figure 22 - Registered Nursing and Residential Beds as at 23.09.19

In 2016 NHS Scotland published a report[110] on "The changing functional needs and dependency of people living in a Care Home." This report highlighted that, the overall level of care needs of people residing in Care Homes has been growing in complexity. A survey undertaken as part of this report suggests that 45% of people living in Care Homes in Scotland have a high level of need associated with the required support around activities of daily living. Many people living in Care Homes will have multiple chronic co-morbidities and will require input from various healthcare professionals as these chronic co-morbidities progress.

The Health Foundation (2019)[111] identified that people over the age of 65 years, who permanently resided in Care Homes in England, attended ED on average of 0.98 times per annum. It is noted that people living in Residential Homes attend ED at a rate of 1.12 times per annum versus a rate of 0.85 times per annum for those living in Nursing Homes. Further evidence from The Health Foundation presents people residing in Care Homes in England accounting for 6.5% of overall ED attendances and 7.9% of overall emergency hospital admissions.

Data on the use of the ED's across NI by the care home sector is included in the table below. The care home sector has not been broken down into residential and nursing care. Data was gained from the patient's postcode and did not take into account permanency status or length of time in the care home, therefore some of the patients may be temporary and not permanent residents. It is of note that there is high admission rate for these individuals.

Table 6 - Number of Attendances at ED by Patients Aged 65 & Over from Residential / Nursing Homes

Number of Attendances at ED by Patients Aged 65 & Over from Residential / Nursing Homes

Trust of ED	2018									2019		
	April	May	June	July	August	September	October	November	December	January	February	March
BHSCT	409	422	386	396	359	332	360	334	357	419	375	359
NHSCT	479	560	514	537	523	530	503	506	525	504	490	490
SEHSCT	401	376	394	409	387	345	360	405	372	379	373	347
SHSCT	296	267	264	252	238	238	225	257	258	236	190	217
WHSCT	268	287	265	270	275	290	245	229	229	264	218	210
NI	1,853	1,912	1,823	1,864	1,782	1,735	1,693	1,731	1,741	1,802	1,646	1,623

Source: Hospital Information Branch, DOH

* Data on attendances from Nursing / Residential homes is provisional and may be subject to change.

---

[110] https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2017-02-28/2017-02-28-The-changing-functional-needs-and-dependency-of-people-living-in-care-homes-Report.pdf

[111] https://www.health.org.uk/sites/default/files/upload/publications/2019/Emergency-admissions-from-care-homes-IAU-Q02.pdf?utm_source=The%20King%27s%20Fund%20newsletters%20%28main%20account%29&utm_medium=email&utm_campaign=10751376_NEWSL_HMP%202019-07-30&dm_i=21A8,6EFTC,M36T98,PCJ7G,1

Table 7 - Number of Admissions at ED by patients Aged 65 & Over from Residential / Nursing Homes

Number of Admissions at ED by Patients Aged 65 & Over from Residential / Nursing Homes

Trust of ED	2018									2019		
	April	May	June	July	August	September	October	November	December	January	February	March
BHSCT	209	234	223	222	199	188	210	194	213	228	209	199
NHSCT	284	289	277	280	269	286	284	223	289	273	253	248
SEHSCT	243	214	216	242	208	197	236	244	208	217	208	181
SHSCT	187	179	155	142	143	149	141	172	153	147	109	138
WHSCT	159	175	166	149	154	187	152	122	137	145	146	107
NI	1,082	1,091	1,037	1,035	973	1,007	1,023	955	1,000	1,010	925	873

Source: Hospital Information Branch, DOH

* Data on emergency admissions to hospital from Nursing / Residential homes is provisional and may be subject to change.

Table 8 - Percentage of Patients Aged 65 & Over from Residential / Nursing Homes Admitted from ED

Percentage of Patients Aged 65 & Over from Residential / Nursing Homes Admitted from ED

Trust of ED	2018									2019		
	April	May	June	July	August	September	October	November	December	January	February	March
BHSCT	51.1%	55.5%	57.8%	56.1%	55.4%	56.6%	58.3%	58.1%	59.7%	54.4%	55.7%	55.4%
NHSCT	59.3%	51.6%	53.9%	52.1%	51.4%	54.0%	56.5%	44.1%	55.0%	54.2%	51.6%	50.6%
SEHSCT	60.6%	56.9%	54.8%	59.2%	53.7%	57.1%	65.6%	60.2%	55.9%	57.3%	55.8%	52.2%
SHSCT	63.2%	67.0%	58.7%	56.3%	60.1%	62.6%	62.7%	66.9%	59.3%	62.3%	57.4%	63.6%
WHSCT	59.3%	61.0%	62.6%	55.2%	56.0%	64.5%	62.0%	53.3%	59.8%	54.9%	67.0%	51.0%
NI	58.4%	57.1%	56.9%	55.5%	54.6%	58.0%	60.4%	55.2%	57.4%	56.0%	56.2%	53.8%

Source: Hospital Information Branch, DOH

* Data on percentage of ED Attendances from Nursing / Residential homes admitted to hospital, is provisional and may be subject to change.

Within NI there is work ongoing to develop a regional approach to care home availability. The benefits of which include: real time access to bed availability; increasing the awareness as to the number and types of home within a locality; and reduction of time in collating and sharing information by both HSC Trusts and the care homes themselves. Challenges of the current systems in use include: the accuracy of the data; and systems only currently advise of available beds and not those which may become available. Developing a regional approach will encourage time efficiency, be a support in the repatriation process across Trust boundaries and assist in placing the patient during the out of hours period by the RESW and acute and community teams engaged in 7/7 working.

Care Home Support Teams

Across Northern Ireland, each of Health & Social care Trusts have an aligned Care Home Support Team (CHST). Although there are variances in how these teams operate, the premise of pro-active support and education in-reach to Care Homes is consistent throughout. With the support of Transformation funding, each CHST has been able to appoint additional staff to expand the service. An example of how this

funding has been utilised is that a CHST who previously had capacity to support only Nursing Homes, has been able to expand their support to Residential Homes.

Through existing services within each geographical Health & Social Care Trust, there is an opportunity to closely align services even more. One of the most crucial services for Care Homes supporting diversion from ED attendance/hospital admission is that of the Acute or Enhanced Care at Home services. Due to a variance in the name of these services both Acute and Enhanced Care at Home will be referred to as AC@H. These services support people living in Care Homes receiving hospital level care within their own long term place of residence in partnership with the Care Home and primary care colleagues.

The aspiration should be that services are equitable across NI. At present four out of the five provider Health and Social Care Trusts operate an AC@H service. The Northern Health and Social Care Trust do not have this service. There is a variance across Health & Social Care Trusts as to how Care Homes access AC@H services with – only SEHSCT supporting direct referral.

Broadly, the question must be asked, if a Care Home is required to contact a GP for access to AC@H, what is the potential that a person living in a Care Home will deteriorate whilst waiting for this to happen? If this scenario does occur, it is likely the only option for Care Home staff will be to arrange transfer to an ED.

Whilst not aware of any impact evaluations relating to the AC@H and Care Home interface it would be reasonable to assume that creating a consistent regional mechanism for direct access whereby a GP referral is not required, may provide more timely outcomes for people living in Care Homes and positively affect the patient experience through reduction in hospital attendance/admission. It would be useful to ascertain the frequency and volume of support provided to people living in Care Homes through the existing AC@H services. There is no Regional network/forum for AC@H teams to meet under with an opportunity to sharing practices, modelling and experiences. This may potentially sit as a sub-group under the Regional Frailty Network or under an Intermediate Care umbrella.

With the growing ageing population and the high incidence of malnutrition in care homes, new ways of working to support patient's nutritional needs have been tested. The 'Prevent, Anticipate and Avoid, Treat (PAAT) model in SET is on where Dietitians, Dietetic Support Workers (DSW) and care home staff jointly manage the care of residents with monthly reviews of nutritional information via a virtual electronic data set. Dietitians anticipate and avoid deterioration of patient's nutritional status through early identification of potential problems and direct DSW's and care home staff in appropriate treatment to address this. The 'Health Call Undernutrition Service' in Southern Trust uses an automated remote monitoring service for adult patients identified as at risk of malnutrition and/or are prescribed Oral Nutrition Supplements

(ONS). Information is collected via a secure web portal about patients' weight, appetite and compliance with taking their prescribed ONS. The service then assesses the data and raises alerts based on changes in weight, risk of undernutrition (MUST) and compliance with ONS or appetite

The role of the Home Enteral Tube Feeding (HETF) Co-ordinator is to lead the planning and co-ordination of the adult enteral tube feeding service supporting admission avoidance and hospital discharge and those adults who are enterally tube fed in the community. Within Southern HSCT, the established adult HETF service supports over 100 adults who are receiving enteral tube feeding in their own home, in nursing homes or in supported living. From 1/4/16 to 31/3/17 this service averted 206 attendances at Emergency Departments.

Access to General Practitioners

In recent years, there has been much reporting of the pressures and capacity concerns around General Practice services in Northern Ireland. During this time there have been a number of changes such as the formation and evolution of GP Federations, the expansion of multi-disciplinary professionals within General Practice including practice based pharmacists and advanced nurse practitioners. Whilst this is a welcome addition and these roles can support areas traditionally medically led, the main point of Primary Care contact by Care Homes continues to be the GP. Some Care Homes, more commonly in urban areas, may have up to 14 GP surgeries aligned to residents living in the Care Home. The opportunity to discuss individual cases with the GP is limited as many GPs have reduced their 'phone in' times in an effort to increase capacity for face to face appointments. In reality Care Home staff are competing with members of the general public to have over the phone conversations and/or arrange home visits for those living in Care Homes.

Choice is paramount and a person living in a Care Home can chose their own GP if they wish. Aligning a particular GP surgery to a Care Home would likely have benefits such as continuity for both those living in Care Homes and healthcare professionals, strengthening relationships, increasing opportunities for anticipatory care and improved experiential outcomes to name a few.

Care Home In-Reach

In NI there are small scale GP led pilot projects with regards to care home in - reach. The NHSCT for example have two models in use. The Causeway locality has an anticipatory care service which provides a service across 4 Care Home to 248 people receiving long term nursing care and 41 people receiving long term residential care.

This service is an additional medical service and patients retain their own GP. Pathways have been agreed across primary care in and out of hours, with NIAS and ED. There is a proactive medical management and anticipatory planning (to include medication) using the Rockwood scale as part of risk stratification. A flag on the GP OOH system and NIAS system identifies those Care Homes that are part of the scheme and whose patients have an anticipatory care plan. Other initiatives include a standardised approach to the management of falls in conjunction with the Falls Prevention Team and in consultation with RQIA. The project is in its infancy commencing in April 2019 and as yet there is no data to ascertain the outcomes. Outcome measures will be determined by the markers below:

- Improve service use / family experiences
- Reduction in calls to GP's – 10% target
- Reduced ED attendance – 10% target
- Reduced acute bed days – 10% target
- Reduced NIAS call outs
- Increase end of life episodes in Care Homes

The second model is the East Antrim GP Federation Nursing Home service which commenced in October 2018 and does not include Residential Homes. Fortnightly GP visits are completed to the Nursing Homes and contact is made with the GP's own patients. Decisions about who to assess and prioritise on the day are based on contacts with patients, relatives, care staff and on medical concerns. The model has baseline data and data from the commencement of the service as illustrated below, which demonstrates positive outcomes for the target population.

Table 9 - Care Home In Reach Model

Oct'17-Mar'18		**Oct'18-Mar'19**	
NH Patients	1360	1428	4.76%
A+E	464	335	-27.80%
Admissions	352	241	-31.53%
OOH	804	604	-24.88%
Death Hosp	53	29	-45.28%
2' Referrals	250	225	-10.00%

It should be noted that, each of the pilot models have received additional nursing support from the NHSCT Responsive Education and Collaborative Health (REaCH) Team, providing enhanced levels of proactive education to colleagues in participating Care Homes.

The British Geriatric Society (BGS)[112] state that the health needs of people living in Care Homes are complex and that to achieve best outcomes, a culture of partnership, support and shared clinical governance is paramount.

The benefit of Care Home in-reach, has been recognised by NHS England whose Ageing Well model has specified the need to upgrade NHS support to all care home residents who would benefit by 2023/24, with the Enhanced Health in Care Homes (EHCH) model being rolled out across the country across the next decade as staffing and funding grows.[113] England developed an EHCH Framework in 2016 with specified sub-elements as detailed below.

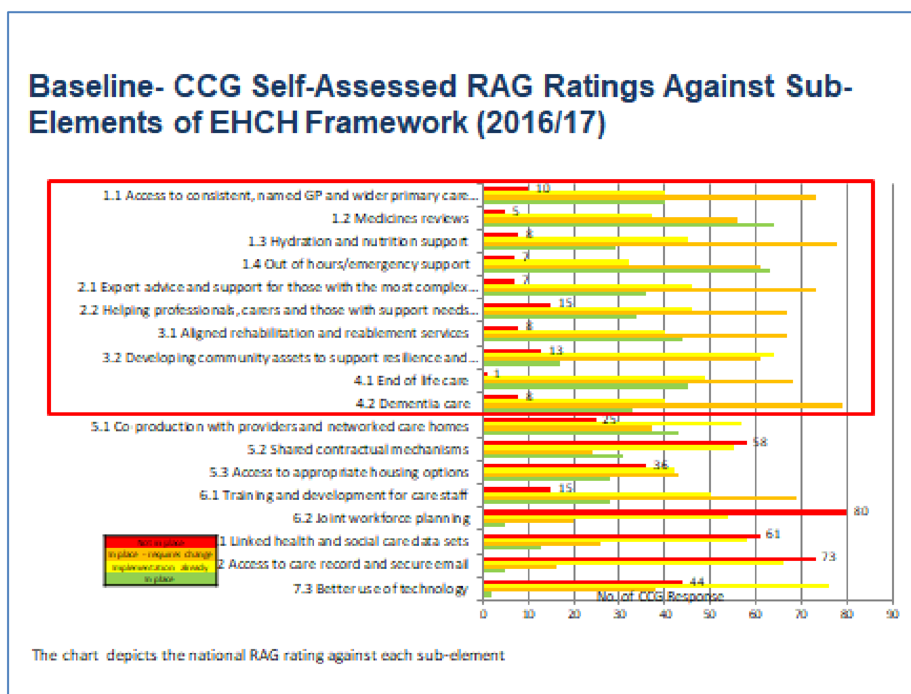


Figure 23 - Martin Vernon Expert Panel Frailty Group 20.11.19

In collaboration with Palliative Care in Partnership, copies of Your Life Your Choices[114] booklets were distributed to all Care Homes in Northern Ireland. This booklet contains key information regarding Advanced Care Planning suggesting that a collaborative approach led by either the GP or a Specialist Nurse is required.

---

112 https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-10/2016_bgs_commissioning_guidance.pdf

113 the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)

114 http://be.macmillan.org.uk/Downloads/CancerInformation/TestsAndTreatments/MAC14376YourlifeandyourchoicesNIE01lowrespdf20131104.pdf

Consistent use of any clinical decision support tool is vital to tailoring approaches to pro-active education and the links to specific care pathways. For non-HSC healthcare services in NI including Care Homes, consistent and evidence based decision support tools are not available

This picture is mirrored throughout the rest of the UK as the National Early Warning Score 2 (NEWS2) tool is being implemented in acute services, is not validated for the Care Home setting and as such not endorsed by its authors, the Royal College of Physicians or by NICE. As an interim measure SEHSCT have developed and implemented a Community Early Warning Score, which itself is not externally validated but is used by trained staff to support clinical decisions aligned to clinical observation recordings. This structure facilitates timely contact with and intervention by a suitably trained person who can support the triage of an acutely unwell person with escalation pathways linked to SEHSCT systems and structures. At a Regional level it is viewed that implementation of any non-validated tool presents risk which the implementing Trust/Organisation must mitigate.

NIAS are piloting several decision support tools relating to nursing and residential home triage and also in relation to falls management. Further work is required to determine overall costs and the benefits of these tools as well as the evidence base behind them. Through the HSCQI Regional Sepsis Collaborative there is also a desire to explore a bespoke Sepsis Screening tool for Care Homes for which the ownership has been explored and agreed, although testing would be required. It is worth noting that the amber and red flags within the Sepsis Tool are endorsed by NICE.

It seems from exploration that one distinct clinical decision support tool will not support every eventuality which may lead to ED attendance/hospital admission, there are a number of options to be considered. The most viable option would seem to be creating a suite of tools with related Care Pathways. This suite and associated pathways may further support direct access to AC@H teams, potentially even referral to Direct Assessment Units.

The Public Health Agency currently have a live survey exploring the future educational needs that Care Homes see themselves as requiring. The results of this survey should be used to support a strategic Care Home education commissioning plan, providing a consistent approach to education and clinical skills within the sector with built in support mechanisms to support the application of theoretical knowledge and skills in delivering real improvements in quality of care and real outcomes for people living in Care Homes.

The Review team considered it important that, in future, consensus should be sought around a quality data set and what this might look like. A bespoke dashboard may be developed displaying possible metrics such as ED attendance time brackets, reason for ED attendance, the type of Care Home a person lives in, conversion rate from ED

attendance to admission and average length of stay, utilising data to further design and develop support structures.

Care Home functioning and practice is underpinned by the following legislation & standards for Nursing & Residential Homes:

- Nursing Home Regulations[115];
- Nursing home standards[116];
- Residential Home Regulations[117];
- Residential Home Standards[118];

Rapid Access Clinics exist in most Trusts but their make-up varies. For example - In SHSCT, there are Rapid access clinics available across the Trust. Referrals are mainly from primary care but also from NIAS, falls coordinators and community teams.

Appointments are made within 72 hrs of referrals and at the clinic, a full multi-disciplinary comprehensive geriatric assessment is carried out.

Reasons for referral may include:

- New mobility problems;
- Falls;
- Acute balance impairment;
- Mild chest infections;
- Urinary tract infections;
- New onset of confusion.

The rapid access clinics allow for older patients to be seen in a timely manner, to be assessed and treatment to be started therefore preventing the need for ED attendance.

Neighbourhood District Nursing

One outcome in the DoH District Nursing Framework[119] is that *'a regional community nurse-led model of care prototype will be agreed regionally by Mar 18'.*

---

[115] www.legislation.gov.uk/nisr/2005/160/made

[116] https://www.rqia.org.uk/RQIA/media/RQIA/Resources/Standards/nursing_homes_standards_-_april_2015.pdf

[117] www.legislation.gov.uk/nisr/2005/161/pdfs/nisr_20050161_en.pdf

[118] https://www.rqia.org.uk/RQIA/media/RQIA/Resources/Standards/care_standards_-_residential_care_homes_August_2011.pdf

[119] https://www.health-ni.gov.uk/sites/default/files/publications/health/district-nursing-framework2018.pdf

The *Neighbourhood District Nursing (NDN) model* aims to improve safety, quality and experience by developing a 'one team' approach, provided by a Neighbourhood District Nursing team 24 hours a day within a designated community and aligned to the GP Practice, with the ethos of home being the best and first place of care.

The main outcomes are to:

- Test a new model of District nursing linked to Primary Care Multi-Disciplinary Teams;
- Promote a new public health model for District Nursing;
- Improve patient care through proactive management of population health;
- Develop self-organised teams under a collective leadership model;
- Test a coaching model for district nursing;
- Reduce bureaucracy and maximise the use of technology[120] in care;
- Test Delivering Care Phase 3 staffing recommendations in District Nursing.

Five Neighbourhood District Nursing prototype sites are testing the model and they are in Moy, Limavady, West Belfast, Newcastle and Ballycastle. All test sites with the exception of Moy are situated within the Primary Care MDT roll out sites.

Population health needs assessment is key within the model and all teams will be completing a local population health needs assessment. The Moy Neighbourhood District Nursing team has completed a Community Neighbourhood Profile, in collaboration with the three GP Practices. Hypertension, was identified as a presenting condition of concern. The team have identified community groups, which they can target to share health promotion and education activities to reduce the risk of illnesses associated with Hypertension, such as Stroke. This is meeting the Population Health approach of the Pilot and the strategic direction to ensure that people can understand and take responsibility for their own health needs.

Palliative Care in Partnership

The four key priorities of the Palliative Care in Partnership (PCIP) programme all aim to improve the support and services available to people with identified palliative and end of life care needs and ultimately to reduce avoidable admissions to and deaths in hospitals.

---

[120] https://www.nice.org.uk/about/what-we-do/our-programmes/evidence-standards-framework-for-digital-health-technologies

The Early Identification Prototype is underway in over 40 GP practices across NI. Patients identified by the Anticipal algorithm which runs directly in the GP clinical systems are discussed at monthly MDT meetings and appropriate actions are taken to provide additional support and /or services for those patients where it is agreed they would benefit from a palliative care approach. Initial findings have indicated a 70% increase in the number of patients on the Palliative Care registers of GP practices participating in the prototype.

In 2017, all five Trusts endorsed the Palliative Care Keyworker Role and Competencies framework, which states that the District Nurse will typically be the keyworker. This role has been included in the Delivering Care consideration of District Nursing time. The Trusts are at varying stages of fully operationalising the elements of the keyworker role. A focus group with District Nurses in the Northern Trust found the keyworker role helps build better relationships with the patient and those who are important to them and aids proactive planning, avoiding crisis situations which may previously have resulted in a visit to ED and/or an avoidable admission.

The PCIP programme actively promotes the regionally agreed advance care planning tool 'Your Life, Your Choices – Plan Ahead' booklet. This booklet encourages people to think ahead, discuss and ideally document their preferences for future care (i.e. preferred place, DNACPR, ADRT decisions via an Advance Care Planning Summary and the Key Information Summary) and as a result provides valuable information to professionals when a patient presents in a crisis situation. Having access to the patients advance care planning wishes can aid professionals when making best interest decisions and when considering whether to transfer to ED/hospital.

A QI Project (2019) undertaken with the Ballycastle Neighbourhood District Nursing team focussed on implementing the role of the Palliative Care Keyworker, identifying patients with palliative care needs in the community and discussing and recording their preferred place of care.

- 87% (20/23) of people wanted to be cared for at home;
- 85% (17/20) of people died in their preferred place, for 70% (14/20) this was at home;
- 15% (3/20) of people died in hospital, NI average 47%.

The PCIP Programme is also working in partnership with the Care Home Transformation Project to deliver key messages, training and tools and resources for best practice in palliative and end of life care to the care home sector. Data and recent reports tell us:

- 20% of deaths in NI happen in care homes (up from 15% in 2007);

- 80% of care home residents are likely to be in their last year of life and would benefit from a palliative care approach yet this is not fully recognised by care home staff - a survey of Care Home Managers in the Southern Trust area found that they only recognised 18% of their residents as having palliative care needs;
- The average length of stay in an NI care home is 18 months before death;
- Around 41% of care home admissions to hospital could have been avoided.

In 2017, a survey conducted by the RCN Independent Nurse Managers Network on behalf of the PCIP Programme highlighted the following keys areas which require particular focus across the sector to avoid transfer of residents out of care homes at end of life:

- Out of Hours (OOHs) access to medical advice and drugs;
- Timely access to, support from and responsiveness of GPs involved in care homes to avoid transfer out of nursing homes at end of life through a range of interventions to include;
    - GP support with advance care planning including DNACPR status in partnership with patient, those who are important to them and nursing home staff;
    - Increase in anticipatory prescribing;
- District Nurse and Specialist Palliative Care Nurse Support as specific to patient need;
- Nursing Home nursing staff access to education and learning opportunities so as they are equipped with knowledge, skills and competencies to undertake;
    - Palliative care clinical skills
    - Verification of Life Extinct (VOLE)
    - Use of SBAR when seeking specialist palliative care advice from GPs

The information already referenced in this section about Intermediate care and other schemes under attendance avoidance is equally applicable in this section.

Primary Care Infrastructure Development (PCID)

Feedback from GPs suggests that one of the reasons that frail elderly patients turn up in ED is because of the lack of other options. Giving GPs direct access to a greater range of diagnostics with rapid reporting would be very beneficial. The opportunity for example to get same day reporting of urgent chest x-rays without the need to go anywhere near an ED department has greatly reduced unnecessary attendances. Likewise, the opportunity to refer patients to designated medical assessment units or similar again bypassing ED has been very beneficial.

A PCID service model was developed by the HSCB and approved by the Health Infrastructure Board (HIB) in September 2012. It provides the baseline components of the PCID service model, based on the co-location of primary and community care and complementary secondary care services, grouped within a single facility for the purposes of delivering integrated care services and patient care.

It effectively provides a framework, which would be adapted on a case by case basis to ensure that patient needs are met within each local area. It includes integrating a number of the following services based on local population need

AHP Services	**Outpatients**
Speech and Language Therapy	Long-term Condition Clinics
Physiotherapy	Integrated Clinical Assessment and Treatment Services (ICATS)
Occupational Therapy	Services for Older People
Podiatry	Maternity Services
Dietetics	Paediatrics
Diagnostics	Family planning
Diagnostics Inc. X ray and Ultrasound	Mental Health
Point of Care Testing	Minor Surgical Procedures
ECG	“Special Interest” Clinics
GP, Primary Care Team and GP Out of Hours	Social Work
GPs	Health & Well Being
Treatment Room	Sports Injury
District Nursing	Parenting Support

Health Visiting	Family and Childcare
Out of Hours and Urgent Care	Counselling
Minor Injuries	Population Screening Programmes
Other	Advocacy
Community Space	Audiology
Bookable Clinical Rooms	Dental Services
Commercial Space – Pharmacy and Other	

The PCID service model promotes the concept of a one-stop-shop approach for the delivery of diagnostic services in primary care hubs that will include treatment, care and information, chronic condition management programmes and will be highly dependent on providing accessible diagnostics and imaging services, which in some areas are only currently available in a hospital setting. The service model noted the importance for health and social care planners to consider what diagnostic services can and should be made available through the hub facilities.

The service model document also makes reference to additional services which may supplement the clinical service model, such as the provision of public services and retail/commercial opportunities. It further notes that consideration should be given to the provision of services to enable local people and community groups to access information and space to support a healthier lifestyle. This may include the likes of access to training rooms, social space, information, and include consideration of extended opening hours.

The key success factor is the creation of integrated or multidisciplinary teams comprising all the professionals and clinicians involved with the service or user group. Evidence supports the argument that sharing space makes integrated working easier and that facilities that support this will enable an effective integrated care model. This must be provided within fit for purpose accommodation that supports integrated working.

Infrastructure Model

The infrastructure model identified to support the primary care service model is based on a hub and spoke approach, with hubs providing core services for its range of

spokes. The hub facilities will essentially encompass those services which do not require a hospital bed but which are too complex or specialised to be provided in a local GP surgery (a spoke). In the main, hubs will include the capacity to deliver GP and Trust-led primary care services and those services which will "shift-left" from secondary care. The spokes will be local GP surgeries and health centres which include practitioners such as GPs, practice nurses and Trust services where there is localised demand.

Effective integration between community-based infrastructure and hospital services is a key component to the success of the model. The need to define and delineate between these settings is important to those planning and delivering the service, as well as to service users.

A Strategic Implementation Plan (SIP) for investment in primary care infrastructure has been developed to support the programme. This was completed and approved by the HSCB in March 2014. It identified a regional prioritised list of required hub developments. The list of hubs is as follows:

Belfast	Northern	Southern	South Eastern	Western
Shankill Centre	Ballymena	Portadown	Downpatrick	Omagh
Bradbury Place	Newtownabbey	Banbridge	Lisburn	Enniskillen
Carlisle Centre	Magherafelt	Newry	Bangor	Lisnaskea
Beech Hall	Antrim	Dungannon	Ards	Cityside, Derry
Holywood Arches	Cookstown	Lurgan		Strabane
Grove	Larne	Armagh		Limavady
Knockbreda	Carrickfergus			
Dundonald	Ballymoney			
Everton	Moyle			
Andersonstown	Coleraine			
Whiterock				
Lower Falls				
Lower Crumlin				
Dunluce/Bradbury/Finaghy				

Operational	In construction	In procurement

Those which include diagnostics are:

- The Arches;
- Portadown;
- Banbridge;
- Ballymena;
- Downe;
- Omagh;
- Newry.

In 2018/19 the prioritisation of the next tranche of hub developments was reviewed. This resulted in the following draft list of priorities to be taken forward as Tranche 2.

- Lisnaskea;
- Ards/ North Down;
- Newtownabbey;
- Cityside (L'Derry);
- Dungannon.

Principles for Older Persons who become Admissions

Where a hospital attendance / admission is necessary**,** "The Silver Book" [121](Quality Care for Older People with Urgent and Emergency Care Needs), addresses the care needs of frail older people, during the first 24 hours of an urgent care episode and the competencies required to meet these needs. On presentation to an Emergency Department, where there is no record of a frailty score, this should be completed. It is suggested that this should take account of the person's wellbeing status 2 weeks prior to the ED attendance. The Silver Book recommends that upon presenting in emergency care, all older people should also have a holistic assessment for:

- Pain;
- Delirium and dementia;
- Depression;
- Nutrition and hydration;
- Skin integrity;
- Sensory loss;
- Falls and mobility;
- Activities of daily living;
- Continence;
- Vital signs;

[121] https://www.bgs.org.uk/resources/silver-book

- Safeguarding issues;
- End of life care issues.

Generic recommendations that apply to all settings in the first 24 hours:

1. An acute crisis in a frail older person should prompt a structured medication review; this may require the support of pharmacists in some settings;

2. When suspecting lower urinary tract infections[122] in people unable to express themselves, urine dipstick testing should only be considered in patients with unexplained systemic sepsis (which may manifest as delirium). A urine dip should not be used to diagnose a urinary tract infection in coherent patients without lower urinary tract symptoms, it can be misleading;

3. Older people should not be routinely catheterised unless there is evidence of urinary retention;

4. End of life care at home should be encouraged and facilitated when appropriate and in keeping with the older person's preferences.

Key Principles with respect to medicines should include:

- Targeted optimisation of polypharmacy/ frailty and its syndromes and other high risk groups e.g. dementia, delirium, care homes;

- Increased awareness and understanding of medicines management needs prior to admission to inform better prescribing decisions;

- Improving prescribing and delivery of robust de-prescribing plans;

- Comprehensive medicines communication at transitions of care and follow up care.

Northern Ireland health and social care is an integrated health and social care system. Work is ongoing across all NI Trusts to ensure a Home First ethos (discharge to

[122] https://www.niinfectioncontrolmanual.net/uncomplicated-urinary-tract-infection-uti-adults

assess[123]) is embedded across unscheduled care in line with regionally agreed principles/concept:

- Initial multidisciplinary assessment in the hospital setting to determine need – hospital professionals (hospital social work and AHP's) experienced and expert in working with older people for example OPALS Team;
- Hospital multi-disciplinary team to be based in the ED of the hospital ensuring timely assessment and helping to avoid admission;
- Services to be community facing;
- The involvement of the service user and carer in the decision making process;
- Maximise use of the community and voluntary sector in meeting need;
- Community services to be responsive in meeting the need ensuring patient safety and timely discharge;
- Community service to quickly re-assess the service user to maximise opportunities to regain independence and redirect the home care support.

NHS England (2018) sets out a number of key priorities to help reduce long hospital stays[124]

- Ambulatory emergency care;
- Therapy at the front door;
- SAFER patient flow bundle;
- Expected date of Discharge and Clinical Criteria for discharge;
- Red2Green Days;

[123] NHS England – Discharge to Assess (2015) [Online] Available at: https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

[124] Guide to reducing long hospital stays – NHS Improvement (2018) [Online] Available at: NHS England » Reducing length of stay

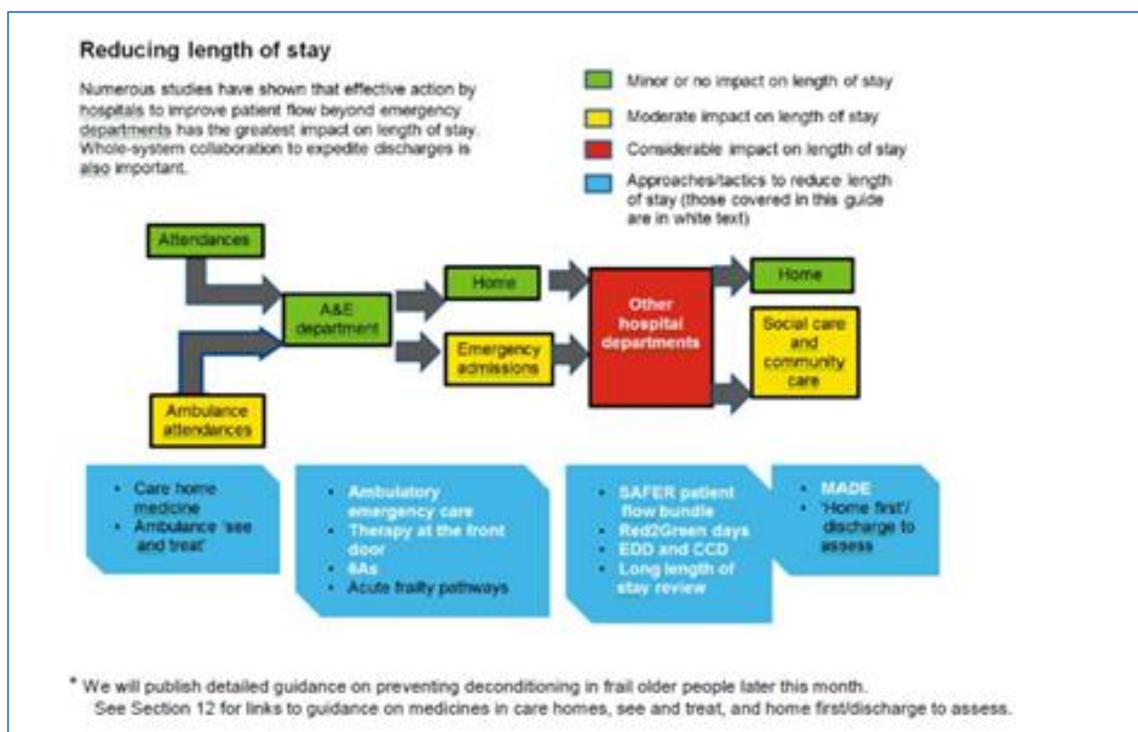


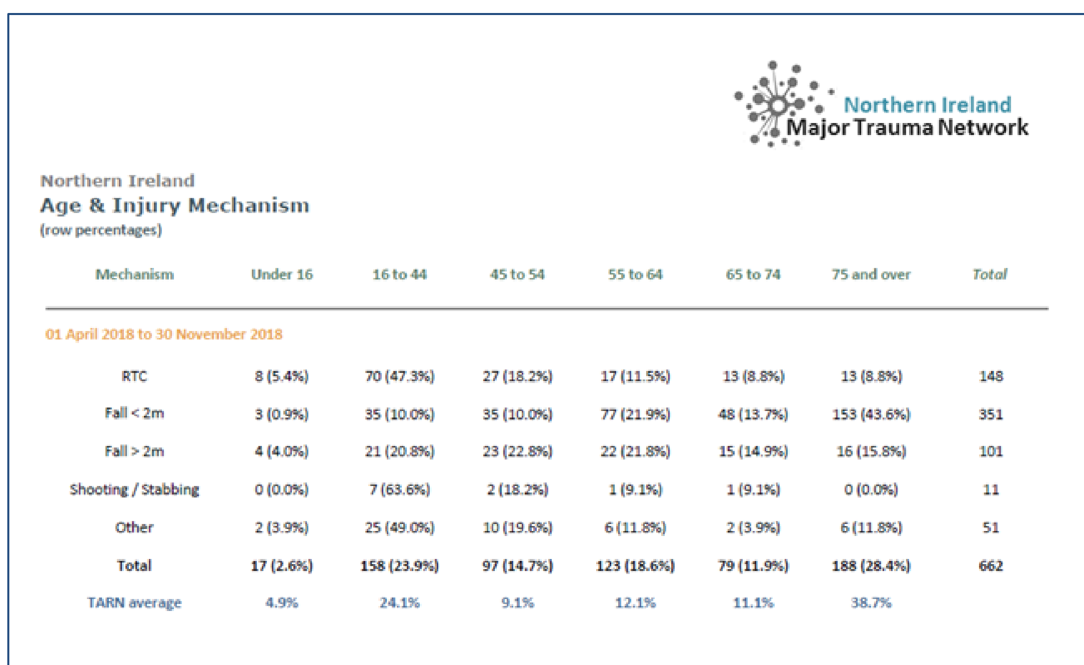
Figure 24 - Where to Focus for maximum impact on reducing LOS - Source (NHS England)

Trauma

Evidence from the Trauma Audit Research Network[125] (TARN) 2017 indicates the typical major trauma patient in the TARN data has changed from being young and male to being older with a lower degree of male predominance.

An evaluation for NI Major Trauma Network over an 8 month period in 2018 indicated a high frequency of falls broken down by age group.

[125] Trauma Audit Research Network [Online] Available at: - https://www.tarn.ac.uk/



Northern Ireland
Age & Injury Mechanism
(row percentages)

Mechanism	Under 16	16 to 44	45 to 54	55 to 64	65 to 74	75 and over	*Total*
01 April 2018 to 30 November 2018							
RTC	8 (5.4%)	70 (47.3%)	27 (18.2%)	17 (11.5%)	13 (8.8%)	13 (8.8%)	148
Fall < 2m	3 (0.9%)	35 (10.0%)	35 (10.0%)	77 (21.9%)	48 (13.7%)	153 (43.6%)	351
Fall > 2m	4 (4.0%)	21 (20.8%)	23 (22.8%)	22 (21.8%)	15 (14.9%)	16 (15.8%)	101
Shooting / Stabbing	0 (0.0%)	7 (63.6%)	2 (18.2%)	1 (9.1%)	1 (9.1%)	0 (0.0%)	11
Other	2 (3.9%)	25 (49.0%)	10 (19.6%)	6 (11.8%)	2 (3.9%)	6 (11.8%)	51
Total	**17 (2.6%)**	**158 (23.9%)**	**97 (14.7%)**	**123 (18.6%)**	**79 (11.9%)**	**188 (28.4%)**	**662**
TARN average	4.9%	24.1%	9.1%	12.1%	11.1%	38.7%	

Figure 25 - NI Ireland Major Trauma Network - Age & Injury mechanism (April - November 18)

TARN 2017 also indicated that:

- Current pre-hospital triage systems are not good at identifying older major trauma patients.
- Older patients are much less likely to be transferred to specialist care and have longer times to both investigation and intervention.

The NI Trauma network are working to improve this pathway, however the message here is that there are occasions when admission is indicated.

Development of Options for optimum configuration of UEC services

The Future Hospital Programme[126] work carried out by the Royal College of Physicians was published in 2017 in response to a Future Hospital Commission report.

Key successes of the programme were:

- Patients receiving comprehensive geriatric assessment from a specialist multidisciplinary team tended to have a shorter length of stay in hospital;

---

[126] Royal College of Physicians (2017) Future Hospital Programme: Delivering the future hospital [Online] Available at:
https://www.rcplondon.ac.uk/projects/outputs/future-hospital-programme-delivering-future-hospital

- Specialist medical care extended seamlessly into the community so that patients at home, or close to home benefit from integrated specialist and community-based care;
- Patients with frailty who received specialist care in the community experienced fewer emergency visits to hospital;
- Frail, older patients given enhanced community assessment, experienced a reduction in admissions to hospital due to falls;
- Hospital sites reported improved resilience, staff morale, team working and collaboration across healthcare boundaries. There was also expansion and replication of their projects in new locations.

Specific projects had the following outcomes[127]:

- Betsi Cadwaladr University Health Board – Frail and older people;
    - Utilised telemedicine to deliver specialist opinion to rural areas;
- East Lancashire Hospitals NHS Trust – Frail and older people;
    - Integrated community based teams demonstrating the impact of rapid response, intermediate care, single point of access & homefirst ethos.
    - Rapid frailty assessment for those who needed to attend hospital.
- Mid Yorkshire Hospitals NHS Trust;
    - Shared multidisciplinary competencies, standardisation and, reduced length of stay.

Workforce availability and collaborative multi-professional strategic workforce planning will be essential for any proposed model. This should be considered in the context of work already done across professional groups. This may mean rotation of roles[128], new roles and substitution to deliver against the objectives and planned outcomes of the new model. Given this, context consideration needs to be given to the best way to design the service balancing the need to reduce variation[129] while delivering for the local population.

One option may be to develop standards that would be expected. Nationally recognised standards or recommendations are available in Fit for Frailty and Silver

---

[127] Royal College of Physicians (2017) Future Hospital Programme: Delivering the future hospital [Online] Available at:

https://www.rcplondon.ac.uk/projects/outputs/future-hospital-programme-delivering-future-hospital

[128] Royal College of Physicians. (2012). Acute Care Toolkit 3 - Acute medical care for frail older people. [Online]. Available at: https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-3-acute-medical-care-frail-older-people

[129] Understanding variation in unplanned admissions of people aged 85 and over: a systems-based approach BMJ (2018) [Online] Available at: https://bmjopen.bmj.com/content/9/7/e026405

Book [130]documents. An overall framework is described in the Kings Fund paper already discussed.

Key Elements:

- Assessment by a suitably trained assessor / trusted assessor within 30 mins of a health crisis;
- Routine identification of frailty;
- Appropriate assessment area;
- Early holistic assessment or CGA[131];
- 'Home first' approach if suitable services are available;
- Ability to discharge to IC & other core services 7 days per week;
- Locally developed pathways for common presentations e.g – delirium, falls etc;
- Input from specialist care of the elderly teams/in-patient care as per local protocols and resources;
- Trusts demonstrate adherence to relevant guidelines or participation in relevant audits – Silver Trauma, National Hip Fracture database, Acute Care of Older People Benchmarking[132].

However, the design of in hospital services cannot be designed in isolation of the out of hospital care or vice versa[133].

Standardisation

The British Geriatrics Society (BGS) carried out a scoping exercise on the range of services in place across NI Trusts. Critically the identified that services had evolved over time in different ways in different parts of Northern Ireland, leading to variation in terms of access and no single preferred model for Northern Ireland.

The workstream proposes the following principles that should be applied to services across Northern Ireland.

1. The model should emphasis attendance and admission avoidance.
2. Patients who attend ED should have access to a frailty friendly environment and rapid access to comprehensive geriatric assessment by a specialist team.

---

[130] The Silver book (2012) [Online] Available at: https://www.bgs.org.uk/resources/silver-book

[131] Ellis, G. et al. (2017). Comprehensive Geriatric Assessment for older patients admitted to Hospital. [Online]. Available at: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006211.pub3/epdf/abstract

[132] NHS Benchmarking (2017) Older people in Acute Settings [Online]. Available at: https://www.nhsbenchmarking.nhs.uk/news/older-people-in-acute-settings-benchmarking-report

[133] What actions could be taken to reduce emergency admissions? NHS England (2014) [Online] Available at: https://www.england.nhs.uk/wp-content/uploads/2014/03/red-acsc-em-admissions.pdf

3. A short stay assessment unit close to the Emergency Department and a specialised frailty unit for those patients who will require to stay longer than 48 hours.
4. These need to be considered in the context of what already exists both in terms of beds, clinical workforce & the multidisciplinary hospital resource, to determine what is new and what can be reformed.
5. Culture needs considered to ensure equity of treatment for older patients on other specialty wards throughout the hospital.
6. The establishment of a single point of access for older patients in acute crisis would allow for direct admission to the short stay assessment unit.
7. Patients cohorted in any unit must be specifically selected.
8. These units should exist as part of a wider older persons system[134] with rapid access diagnostics in community H&C centres (as outlined in this paper) with those admitted to the unit being those whose needs can only be addressed in hospital.

Northern Ireland Ambulance Service: Direct Admissions & Related Referral pathways

Accessing referral pathways helps to ensure patients receive the most appropriate care at the right place at the right time. Attending paramedics are mindful that inappropriate transport to an ED may not be in the patient's best interests. Inappropriate ED attendance may lead to a poor patient experience and also an increased risk of contracting a hospital acquired infection.

Direct admission options across Northern Ireland are:

1. Craigavon Area Hospital Older Persons Assessment Unit (OPAU).
2. BCH Direct.
3. Antrim Area Direct Assessment Unit.
4. Daisy Hill Hospital Direct Assessment Unit.
5. Downe & LVH direct admissions by GPs OOH

District Nursing Services

District Nursing offer a number of services that enable patients to be treated in the community and avoid unnecessary visits to the Emergency Department. NIAS paramedics are now able to refer appropriate patients to the community nursing teams.

[134] Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. NHS England (2014) [Online] Available at: https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

The NIAS district nursing referral pathway is available regionally but with different hours of operation:

- South Eastern Trust – 24/7
- Belfast Trust – 24 /7
- Western Trust – 7 day service 0900 – midnight
- Northern Trust – 7 day service 0900 – 2000
- Southern Trust – 7 day service 0900 – 2300

Marie Curie service is available at night therefore ensuring a 24 hour service is available in all HSC Trusts.

Falls Referral Pathway

Falls are the most common 999 call to the ambulance service in Northern Ireland, with NIAS responding to approximately 24000 falls related calls per year. The National Institute for Health and Care Excellence (NICE) (2014) identify falls and fall-related injuries as a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. 50% of patients who fall will fall again within 12 months. The incidence of hip fractures in the UK is 86000 per year and 95% are as a result of a fall.

By referring the patient to the multidisciplinary community based falls team, the patient is likely to receive a more appropriate assessment, be inconvenienced less, have a better patient experience and ultimately reduce their chance of a subsequent fall. NIAS crews also avoid potentially long handover times and therefore improve availability for subsequent emergency calls.

The falls referral pathway is available in **ALL** Trust areas 24/7.

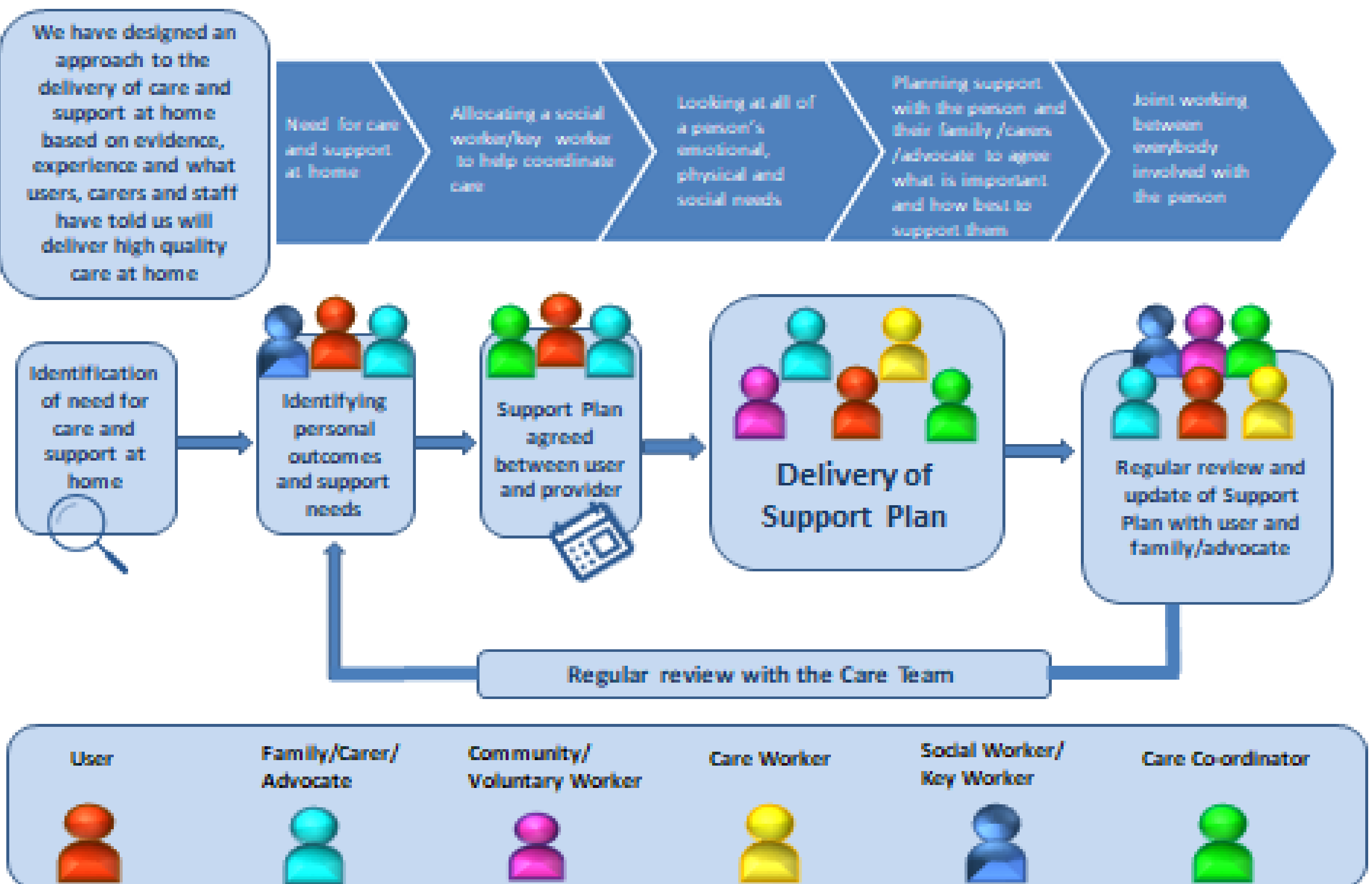
Opportunities for further exploration

1. To reduce the 999 call volume upon NIAS, the option of Direct Admissions and referrals to other parts of HSC should be explored. Areas such as Intermediate Care services, Palliative Care services could be developed through the introduction of a suite of triage and assessment tools to signpost older persons to appropriate services through a Single Point of Access. This would also facilitate General practice.
2. Explore Paramedic prescribing - through existing working groups and governance structures.

Based upon best practice in the NHS and the national problem in the management of falls patients, the NEAS introduced a Falls Prevention Strategy incorporating a multi-disciplinary team who reduced 999 related falls by 75% this would equate to a possible

reduction of 18,000 fall calls for NIAS. One of the work streams was the introduction of ISTUMBLE. Based upon work Adapted from West Midlands Ambulance Service - NIAS, has adopted the algorithm to suit Northern Ireland in DRAFT format.

A New Model of Care and Support at Home



Examples of Best Practice

The Future Hospital Programme

The Future Hospital Programme[135] work carried out by the Royal College of Physicians was published in 2017 in response to a Future Hospital Commission report.

Key successes of the programme were:

- Patients receiving comprehensive geriatric assessment from a specialist multidisciplinary team tended to have a shorter length of stay in hospital.
- Specialist medical care extended seamlessly into the community so that patients at home, or close to home benefit from integrated specialist and community-based care.
- Patients with frailty who received specialist care in the community experienced fewer emergency visits to hospital.
- Frail, older patients given enhanced community assessment, experienced a reduction in admissions to hospital due to falls.
- Hospital sites reported improved resilience, staff morale, team working and collaboration across healthcare boundaries. There was also expansion and replication of their projects in new locations.

Specific projects had the following outcomes [136]

- Betsi Cadwaladr University Health Board
    - Utilised telemedicine to deliver specialist opinion to rural areas.

- East Lancashire Hospitals NHS Trust
    - Integrated community-based teams demonstrating the impact of rapid response, intermediate care, single point of access and a home first ethos.
    - Rapid frailty assessment for those who needed to attend hospital.

- Mid Yorkshire Hospitals NHS Trust
    - Shared multidisciplinary competencies, standardisation and reduced length of stay.

---

[135] Royal College of Physicians (2017) Future Hospital Programme: Delivering the future hospital [Online] Available at:

https://www.rcplondon.ac.uk/projects/outputs/future-hospital-programme-delivering-future-hospital

[136] Royal College of Physicians (2017) Future Hospital Programme: Delivering the future hospital [Online] Available at:

https://www.rcplondon.ac.uk/projects/outputs/future-hospital-programme-delivering-future-hospital

The Kings Fund

The Kings fund[137] advocates that "***improving services for older people requires us to consider each component of care, since many older people use multiple services, and the quality, capacity and responsiveness of any one component will affect others***". The key components to be considered are:

- healthy, active ageing and supporting independence
- living well with simple or stable long-term conditions
- living well with complex co-morbidities, dementia and frailty
- rapid support close to home in times of crisis
- good acute hospital care when needed
- good discharge planning and post-discharge support
- good rehabilitation and reablement after acute illness or injury
- high-quality nursing and residential care for those who need it
- choice, control and support towards the end of life
- integration to provide person-centred co-ordinated care.

Many of the enablers and mechanisms to deliver against the vision of both the Future Hospital vision and the Kings Fund vision have been described through-out this paper. When considered in the context of other regions the need for an overarching strategy for older people does have merit.

Medicines Optimisation

Consultant Pharmacist led Medicines Optimisation for Older People demonstrates improvements in medicines use in older people with positive patient-related outcomes and reduced healthcare resource usage and should be considered central to any emerging model from the review of urgent and emergency care. This is an established network with proven evidence of reproducible models[138] [139] which requires further resource to continue with scale and spread.

Examples of this exist in NI:

---

[137] Oliver, D et al. (2014) Making our health and care systems fit for an ageing population. The Kings Fund. [Online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

[138] D'Arcy, C et al (Dec, 2019) Pharmacists optimising medicines for Older People – British Geriatrics Society Newsletter: British Geriatrics Society Newsletter Nov Dec 2019 Pages 1-36 - Flip PDF Download | FlipHTML5

[139] Miller, D. (2018). Medicines optimisation in older people (MOOP) - the journey from pilot to permanent service. Journal of Medicines Optimisation 9; 4; 2 p27 – 36: JOMO March 2018 (pharman.co.uk)

- Specialist case management pharmacist for Adherence (Adherence Pathway)
- Specialist case management pharmacists for **Care Home** (IC Bed based)
- Specialist case management pharmacists and technicians for **Intermediate Care** (IC Home based & reablement)
- Specialist case management pharmacists for **Frailty**
- Clinical Pharmacists providing specialist **Falls** medicines reviews
- **Acute Care at Home** (IC Crisis Response) (e.g. WHSCT/SHSCT)

Local good practice

Intermediate Care

Intermediate Care services should be further scaled up and enhanced. Multidisciplinary IC at home in particular should be focused on and developed. Any improvements and changes should be in the context of a consistent regional model and within the parameters discussed in this paper. Evidence from the National Audit of Intermediate Care[140], NICE Guidance for Intermediate Care & Reablement[141], and NICE Impact Adult social care report[142] proves that Intermediate care works. This is further supported by Positive Deviance[143] methodology indicating what good looks like.

Professional links

Geriatricians & other professionals are already linked with older persons services across the HSC system with a focus on community prevention and early detection[144].

---

[140] The National Audit of Intermediate Care (2019) {online] Available at: https://www.nhsbenchmarking.nhs.uk/naic

[141] NICE guidance for Intermediate Care and Reablement NG74. (2018) [Online] Available at: https://www.nice.org.uk/guidance/ng74

[142] NICE impact adult social care report (2019) [Online] Available at: https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-use-of-nice-guidance/impact-of-guidance/niceimpact-adult-social-care

[143] NHSBN Positive Deviance in Intermediate Care [Online] Available at: https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20(Providers)/2018/Positive%20deviance%20inintermediate%20care%20services%20FINAL.pdf

[144] BGS - Healthier for longer (2019) [Online] Available at: https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-11-04/BGS%20Healthier%20for%20Longer.pdf

It is important to consolidate and develop these linkages to optimise the care delivered to older people.

The Frailty Network

In March 2019, the Northern Ireland Frailty Network was launched. This brings together a range of professionals, organisations and individuals each with an interest in frailty, under the mantra of "Frailty is Everyone's Business". The network has developed a structure in partnership with Age NI to take a collaborative approach to improving care and support for our population living with frailty, as well as having a strong focus on promoting ageing well. An Expert Advisory Panel for Frailty has been established and five priority areas have been identified for investigation:

- Key Public Health Messages – prioritising key messages to support our population to age well
- Identification of Frailty – we know that through identification of frailty, we can better understand a person's health status to ensure their best possible recovery when they become unwell
- Screening and Assessment Tools – there are a wide range of screening and assessment tools available, we hope to provide a "menu" of options which will support staff across a range of settings
- Development of a Regional Framework – this will describe the key features of services aimed at supporting people to age well, as well as those designed to provide care and support for people with frailty they require.
- Education – this work will consider any changes required to existing education systems to ensure that staff entering our full range of services have sufficient levels of skill and awareness about the specific needs of older people living with frailty

It is anticipated that through this collaborative approach, a model of care can be developed for Northern Ireland based on a better understanding of the needs and wishes of our older population and deliver a more person-centred approach in the management of an individual's care, across a range of settings.

In-Reach to Care Homes

There is the need to scrutinise current models used in NI in terms of outcomes, costs, sustainability and workforce with the opportunity to be replicated in other areas. NHS England Ageing Well; Integrating Care for Older People[145] has in place six Enhanced

[145] Enhanced health in care homes vanguards [Online] Available at: NHS England » The framework for enhanced health in care homes

Health in Care Home (EHCH) vanguards working to improve the quality of life, healthcare and health planning for people living in care homes. Underpinning the vanguards is a Framework developed in 2016, which has three key principle aims. One of which is to "ensure that we make the best use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for residents." [146]

[146] The Framework for enhanced health in care homes [Online] Available at: https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

Conclusions

1. The concept of a designated **key worker** has emerged recurrently across engagements with networks. This should be as close to the service user/patient as possible with strong links to developing primary care multidisciplinary teams, system navigators and directories of services.

2. Where appropriate the service user has the opportunity to discuss and document their **Advanced Care Planning preferences (ACP)**; supported by appropriate and equitable access to the relevant generalist and specialist service. It is important that next of kin/carers are involved and that all concerned are aware of the plan. Plans should be SAFE : Safe, Agreed, Feasible, Explained and understood

3. A **tiered model of care based on clinical need** with a focus on health improvement, timely access to primary care & community services for home based care with responsive diagnostics and clinical decision making. Home must be regarded as the hub of care. Attendances and Admissions to hospital should be targeted at those whose needs can only be met in a hospital setting.

4. **Standardisation and Removal of unwarranted variance** across organisations to develop once for NI models of care. Realistic Medicine would suggest putting the person receiving health and care at the centre of decision-making and creating a personalised approach to their care, while simultaneously pursuing the aim to reduce harm, waste and unwarranted variation, all while managing risks and innovating to improve.

5. **Maximising a single point of access** manned by clinical staff and **supported by technology** (including Directories of Services & capacity), which is **responsive** and accessible to patients, GP's, NIAS and HSC with clear responsive directly accessible pathways for the identified clinical need.

6. **Frailty should be identified and assessed at point of referral / front door, using a validated tool** to inform decisions around appropriate interventions, with a focus on home first, provided there is not a specific condition or issue requiring hospital admission e.g. Fracture of neck of femur, GI bleeding, acute abdomen etc. .
   For those persons scoring:
   - Moderate - consider alternatives to admission, ambulatory pathways with intermediate care support
   - Severe – consider end of life pathway and alternatives to admission

   Fit older people presenting in a crisis with single organ problems should largely be managed as per usual care for all adults. This would include equitable access to services including relevant ambulatory care pathways and access to the relevant community teams.

7. **Expand capacity & responsiveness of community services** (including Intermediate Care, core services for example Integrated Care Teams and Rapid Response Social Care – most HSC targets are elective and acute facing with few community targets. Adoption of NG 74 provides an opportunity to focus on response times for crisis response (2 hours) and other IC services (48 hours). These exist within the NICE quality standard and were referred to at the recent Martin Vernon workshop & are being implemented in England through the VANGUARD sites. There should be expansion of the role of Community Geriatricians & specialist care of elderly teams to support intermediate care services.

8. When an **older person attends ED or Urgent Care services** they should experience holistic assessment and care delivered in line with national standards and by staff with appropriate competencies.

9. **Medicines Optimisation and nutrition** should be considered throughout the Older Persons pathway as evidenced through this paper.

10. There should be a **regionally agreed approach to enhance support** to residents living in care homes. Services should be commissioned according to national and regional standards.

11. **Workforce** – Workforce may be a challenge for any model. Therefore systematic multidisciplinary workforce planning across boundaries needs to be considered to support the proposed model that emerges. This should include substitution and new roles where appropriate to deliver against the proposed model. Extended roles for Allied Health Professionals and nursing should also be considered in line with advance practice frameworks.

12. **Extended working hours and 7/7 working** – Further development of extended working hours and 7/7 working in both the acute and community settings. Both settings need to be considered in tandem as the hospital multidisciplinary team (to include hospital social workers and AHP's) will be limited in their ability to prevent admissions or affect discharge if community resources are not available to them. Maximise use of the community and voluntary sector in meeting need.

13. **Overarching Strategy** – The current Active Ageing Strategy 2016-2021 is approaching the end of its life. There is an opportunity to consider the learning from it and develop a wider older person's strategy for NI.

14. Effective implementation of many of the above conclusions would be enhanced by development of a **regional clinical network** linked to commissioning and monitored through agreed outcomes.

SECTION 5: ENABLERS

Chapter 9 - Workforce and Training

Any changes to a health care system need to take into account workforce and the possible training needs for the future. This is especially important as it takes a considerable length of time to train healthcare professionals. We therefore have to understand many years in advance what our population health care needs may be.

Workforce Strategy

Central to Northern Ireland's health and social care Transformation Programme[147] is the workforce, who work tirelessly to provide high-quality care to a growing and ageing population with increasingly complex health and social care needs. The Department has developed an eight-year Workforce Strategy[148], published in 2018, which has three objectives and ten themes:

Objectives

1. By 2026, the reconfigured health and social care system will have the optimum number of people in place to deliver treatment and care with the best possible combination of skills and expertise.

2. By 2021, health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported.

3. By 2019, the Department and health and social care providers are able to monitor workforce trends and issues effectively and be able to take proactive action to address these before problems become acute.

Themes

1. Attracting, recruiting and retaining
2. Sufficient availability of high-quality training and development
3. Effective workforce planning
4. Multidisciplinary and inter-professional working and training
5. Building on, consolidating and promoting health and wellbeing
6. Improved workforce communication and engagement
7. Recognising the contribution of the workforce
8. Work-life balance
9. Making it easier for the workforce to do their jobs
10. Improving workforce business intelligence

Each of these ten themes is of clear relevance in the context of urgent and emergency care. As the first point of contact for most patients requiring care, General Practice

---

[147] Department of Health, Transformation Programme

[148] Department of Health, Health and Social Care Workforce Strategy 2026

and Emergency Departments are at the heart of health and social care in Northern Ireland. With increasing pressures on general practice and lengthy waiting times for elective hospital care, EDs have increasingly become a safety net for people with any sort of healthcare needs, emergency or otherwise.

Royal College of Emergency Medicine Survey

As a specialty, emergency medicine presents a fast moving, varied and rewarding career. However, there is also no doubt that the working environment in Emergency Departments, even at the best of times, can be challenging and intense.

In 2018, the Royal College of Emergency Medicine's Northern Ireland Board designed a questionnaire for RCEM's Fellows in Northern Ireland to better understand the pressures facing NHS staff on the frontline[149]. Of the 64 doctors who responded to the survey:

- 98% of respondents felt that Emergency Medicine in Northern Ireland is in a state of crisis;
- 89% agreed that the situation in their Emergency Department felt worse than previous years;
- 94% considered that patient dignity was compromised daily because of crowding in their ED;
- 91% 'strongly agreed' that patients are at an increased risk of poorer outcomes due to crowding in Emergency Departments;
- 98% of respondents agreed that there was an insufficient number of medical and nursing staff to cope with current demand in EDs;
- 97% said that they have at times felt stressed during their working day because of an inability to deliver high-quality care to patients;
- 91% did not believe that it is sustainable working in emergency care in the current environment;
- Increased social care capacity, more acute hospital beds, increased resource and recruitment to Primary Care and more nurses were listed as the main solutions to making EDs in Northern Ireland safer for patients.

Improving urgent and emergency care services is a core priority for the Department. To do this is vital that our services are appropriately staffed and that the workforce have the necessary support and training to allow them carry out their roles to the best of their abilities.

[149] Annual_Report__Accounts_2018.pdf (rcem.ac.uk)

Emergency Medicine Workforce Plan – 2014-2022

In the past, discussions on the ED workforce have focused heavily on the numbers of emergency medicine consultants and trainees. There has been significant investment in growing the number of emergency training places

In 2014 the Department of Health (DoH) commissioned the Public Health Agency (PHA) and the Health and Social Care Board (HSCB) to progress medical workforce planning across medical specialties. The RCEM, along with other stakeholders, contributed to the 'Emergency Medicine Medical Workforce Planning Report 2014-2022', which was submitted to the DoH in October 2015.

This report concluded that a further 42.64 Emergency Medicine Consultants would be required to staff the current service configuration in Northern Ireland. The report also recognised the fact that demand is continuing to rise for Emergency Care, with a continuing trend for increasing attendances compounded by demographic changes. The report additionally concluded that 'For the current service configuration, a MINIMUM additional 87.6 WTE Middle Grade EM doctors, i.e specialty trainees (ST4-7) and NCCGs (Non-Consultant Career Grade) doctors are required to provide for this grade of doctor to be present 24/7.'

The report also recommended the continued training and appointment of Emergency Nurse Practitioners (ENPs) and Advanced Nurse Practitioners (ANPs). There is no doubt that the future of emergency medicine will require effective working across multi-professional teams, with no single group able to provide a complete service in isolation from their colleagues.

Multi-professionalism

On discussion with healthcare practitioners from a variety of professional backgrounds in Northern Ireland they voiced frustrations regarding what they felt was a more limited scope of practice than some of their counterparts in other parts of the UK. Most were keen to take on extended roles and expand their scope of practice. Medical practitioners and royal colleges alike propounded a view that their specialty needed to increase the numbers to prepare for future challenges and changes.

When visiting health care units in England it was obvious that they had invested in a variety of roles and had extended their scope of practice. Professional groups such as advanced clinical practitioners, pharmacist clinicians and physician associates are all being trained and supported to take on new, collaborative clinical roles in EDs[150]. Urgent Treatment Centres and assessment units in particular are often managed by Advanced Clinical Practitioners from many backgrounds. Different professional groups form an important part of today's emergency care workforce, giving it greater

[150] NHS England » Strengthening our workforce

resilience, increasing the depth and breadth of cover available, and the overall resilience and sustainability of services.

Advanced Nurse Practitioners in emergency care have a significant role to play in ED's in Northern Ireland providing advanced nursing practice and improving patient outcomes. They also complement the ED workforce, supporting nursing and medical colleagues working autonomously and also as part of the multidisciplinary team. The Department, through the CNO post registration nursing education budget, has funded the first cohort of 9 emergency care ANP trainees locally trained in Northern Ireland, who will complete the Masters level programme later this year at UU and take up posts in each of the 5 Trusts.

An Emergency Nursing Career pathway has been commissioned by the Chief Nursing officer and developed via NIPEC. This work is now completed and provides nurses wishing to pursue a career in emergency care nursing with a clear career pathway and professional development this area.

During the pandemic the value of skill mix and staff working at the top of their professional licence in advanced and extended roles has enabled primary and secondary care services to be responsive to the emerging complexity and volume of demand. There is clear potential to extend the role and scope of advanced nurse practitioners, specialist AHP's and consultant nurse and AHP roles to maximise the capability and flexibility of the workforce to aide rebuilding of services.

As well as considering the number of emergency consultants, it is essential that a new workforce plan should take into account the role of wider professional groups in delivering urgent and emergency care services.

Workforce and capacity

In the next section, we will consider the issues of capacity and flow. These issues are also of relevance as we consider the workforce requirements for a new model of care.

Continuing to increase the emergency consultant workforce will help to stabilise the current issues in Emergency Departments. However, over the past 5 years there has been a 15% increase in the number of patient attendances to EDs in NI, rising from 738,665 in 2014-2015 to 850,522 in 2018-2019. If demand continues to increase at this rate it will ultimately be impossible to recruit enough Emergency Medicine Consultants, or build large enough Emergency Departments, to deal safely with the number of patients coming through the door.

It is widely recognised that overcrowding in Emergency Departments is to a large degree a symptom of wider problems across the health and social care system, and that resolving it for the longer term will require a multidisciplinary and system-wide

approach.[151] It will not be enough to increase capacity in Emergency Departments, we need to look at capacity across the system.

As part of the Population Health Needs Assessment, a trend analysis was performed to project the impact of demographic changes on the number of emergency admissions to hospitals in Northern Ireland up to 2026. According to the analysis, it is projected that the number of admissions for the population aged 65 and over will increase by 25,800. The number of admissions for younger groups is projected to reduce, so that the overall increase in admissions is projected to be around 12,800 by 2026.

There is therefore no question that the HSC will require additional capacity, but given the pressures on the health service, it is vital that investment is directed where it will have the greatest impact, whether this is in primary care, other high demand hospital services, and in community services, to ensure that patients can move rapidly through the system, getting to the right place as quickly as possible and spending as little time in hospital as possible.

The Royal College of Emergency Medicine's position statement on resetting Emergency Department care[152] makes a number of important points that are relevant to this issue. These include:

- Hospital bed occupancy must be maintained at a level that promotes good infection control;
- Clinicians from all spheres of practice will need to become more involved in the urgent and emergency care pathway so that patients can receive early specialist opinions when the patient needs it, and be moved on to the most appropriate facility more rapidly for definitive care;
- Patients should be discharged as soon as they are medically fit therefore the positive reduction in the numbers of patients stranded in hospital must be maintained;
- Patients under active speciality care who present with a problem relating to that speciality, should be managed through their existing specialist teams.

The work on capacity will help us to understand where the blockages in our system are manifesting, and therefore guide our investment in building the workforce and services for the future.

Culture and Trust

The vital importance of trust between different parts of the system was an issue that was stressed by staff in different parts of the Dutch urgent and emergency care model.

[151] https://emj.bmj.com/content/20/5/402

[152] RCEM_Position_statement_Resetting_Emergency_Care_20200506-3.pdf

Regretfully, it must be conceded that this level of trust appears to have been eroding steadily over a lengthy period of time in the Northern Ireland HSC.

The realities of serious workload pressures, rising waiting lists, service delays and patient demands means that everyone is working at maximum capacity across the health service. It is not unusual for clinicians in one part of the system to become absorbed in their own pressures and to forget that colleagues in other specialties or departments are facing burdens and challenging circumstances of their own[153].

Perhaps at least partly due in large part to these issues, the Review team heard many variations of a sentiment that things would be better if only 'they' would do their job. Depending on the nature of the conversation, 'they' could refer to staff in primary or secondary care, to different professions, to different HSC Trusts, to different EDs within the same Trust area, or even to different specialties in the same hospital.

Anecdotal evidence from those working in the system suggested that this kind of silo mentality has not always been the case, that in the past there was better communication between primary and secondary care and, indeed, between hospital specialties. While it was difficult to identify a clear point at which a change happened, or a specific decision that led to it, there appears to have been a gradual shift into a more fractured system characterised by bureaucratic or professional silos. This is evident in the separation of primary and secondary care as well as between specialties and other groups of practitioners. Rigid operating policies with lengthy exclusion criteria and an attitude of protectionism to a perceived scarce healthcare resource all detract from a smooth patient journey. One user described it as a 'computer says no' attitude in the health and care system. At least partly as a result of this shift in culture, EDs have over time effectively become the main route into the hospital for almost all unscheduled care.

Creating a collaborative culture

Organisational culture is notoriously difficult to change and this may be even more pronounced in a complex organisation like Northern Ireland Health and Social Care, which is really a collection of sub-cultures, with different values and behaviours, albeit all based on a desire to provide the best possible care for patients. While many organisations may tacitly acknowledge the need for culture change, embedded values and behaviours can be hard to modify. There is a school of thought that a major shock to the system is often required to act as a catalyst for meaningful and lasting change[154]. With the impact of Covid-19, there can be no doubt that the HSC has received such a shock. The pandemic has been, and continues to be, an immensely challenging situation that has tested our health and care services to their extremes. However, the

[153] https://www.rcgp.org.uk/-/media/Files/RCGP-faculties-and-devolved-nations/Northern-Ireland/2019/RCGP-principle-leaflet-2019.ashx?la=en

[154] Managing Change, 6th Edition, Burnes B, 2014: Burnes, Managing Change, 6th Edition | Pearson

system's reaction to the pandemic has also shown that a more integrated, more collaborative, system is possible.

As one example, the establishment of primary care Covid-19 centres was an urgent and immediate response to the challenges posed by the Covid-19 pandemic; ensuring that primary care services could be maintained, by enabling patients who had Covid-19 symptoms to be treated separately from those patients with other conditions which require assessment or treatment in primary care.

The Covid-19 Centre model has been successful in separating Covid and non-Covid services, reducing the risk of infection and allowing GPs to protect and continue a range of ordinary primary care services such as vaccinations. The Covid-19 Centres have also proved highly effective in dealing with a high level of demand and in effectively triaging and advising patients. This has undoubtedly reduced pressures on our Emergency Departments. The way primary and secondary care services worked together through the centres showed the very real benefits to patients of removing artificial barriers and creating much closer collaboration.

In care homes, pharmacy teams from the HSCB implemented a system to provide anticipatory care boxes to care homes for palliative care and to provide increased access to oxygen. Consultant pharmacist team members in Trusts joined with practice based pharmacists to participate in virtual ward rounds for care homes. Training sessions were provided by pharmacists to care homes staff on swallowing pandemic packs and palliative care.

These are just two example of many new ways of working that have been developed between primary care, community services and secondary care over this pandemic period. As we move to transform our urgent and emergency care services it is important that we continue to build on and embed this new, collaborative culture, guided by the overriding principle of creating a system that is better for patients and staff across Northern Ireland.

The Royal College of General Practitioners in Northern Ireland, in conjunction with the other medical Royal Colleges, has developed 10 key principles to guide and improve professional communications and behaviours between healthcare practitioners across Northern Ireland.

The purpose of these principles is to help to renew a sense of professional respect and to allow professionals in all parts of the system to overcome barriers in the future. The principles are underpinned by the conviction that the ability to deliver care as well possible to patients at all stages of their journey through health and care is heavily

Professional Behaviours and Communication Principles for Working Across Primary and Secondary Care Interfaces in Northern Ireland

Ten principles to improve effective communication and behaviours to maintain good relationships

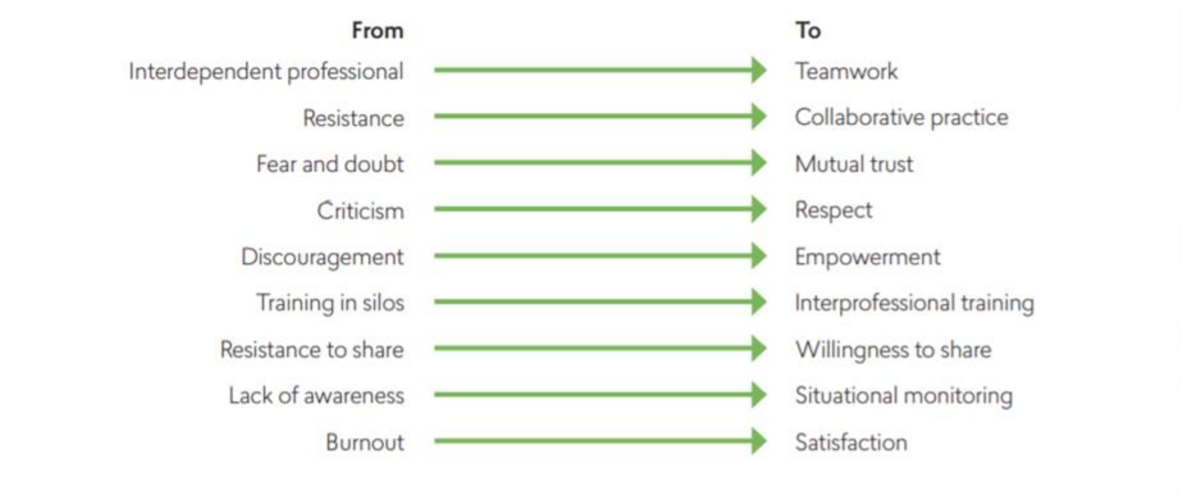
1. Lead by example – Respect all of your colleagues at all times, not only in front of patients and other colleagues. Be particularly mindful of your attitude and the language that you use in front of medical students and trainees — your behaviour can have a considerable impact on how they view and value the various professions.
2. Everyone should have active consideration of the workload and pressures facing other colleagues. All clinicians' workloads will involve issues about which you may not have any understanding or concept.
3. If a doctor is aware of significant changes in a patient's treatment or there is an important or unexpected change in their status, it is essential to update all who need to know quickly. Minor amendments can be communicated through the usual methods.
4. When transferring a patient to the care of another colleague (or seeking an opinion) ensure that all the information that colleague may need is sent to them in a clear and concise format, ideally outlining a specific aim where appropriate.
5. Be mindful of your communication with patients — give them all the information you can — use appropriate language and avoid raising unreasonable expectations. A lack of clear information can cause issues when they see their next healthcare professional. The Academy has produced guidance on writing letters to patients.
6. Try not to commit other individuals or teams to any particular action or timescale without checking that it is reasonable and practicable.
7. Try not to hand over work to a colleague in another team if you or a member of your team can do it, unless you are sure that the task can be done more appropriately elsewhere. When handing over care, check that all relevant tests and treatment plans have been instigated, where practicable and plans are in place to forward additional information, when available.
8. Remember it is the responsibility of the requesting doctor and/or their clinical team to review the results of any test requests and take appropriate action.
9. If one colleague is unsure whether another can take responsibility (e.g. for ongoing care, prescribing or monitoring), get in touch directly and confirm the course of action.
10. If contacted by a professional colleague, make every effort to respond to them as quickly as possible or pass them onto another individual who can respond.

reliant on the ability of professionals from different backgrounds and sectors to work well together.[155]

Representatives of the Northern Ireland Medical and Dental Training Agency (NIMDTA) recognise the importance of developing new inter-professional training in

[155] https://www.rcgp.org.uk/-/media/Files/RCGP-faculties-and-devolved-nations/Northern-Ireland/2019/RCGP-principle-leaflet-2019.ashx?la=en

order to ensure that this more collaborative approach can be embedded across professions delivering health and care in future.



The General Medical Council's Shape of Training programme has identified 5 key actions for medical training in future.

1. A need for more doctors who are capable of providing general care in broad specialties across a range of different settings.
2. A need for more doctors who are trained in more specialised areas to meet local patient and workforce needs.
3. Postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties.
4. Medicine has to be a sustainable career with opportunities for doctors to change roles and specialties throughout their careers.
5. Local workforce and patient needs should drive opportunities to train in new specialties or to credential in specific areas.

These are being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations. Without a change in approach, our hospitals, and our services, will rapidly be overwhelmed. The ability to deliver the care patients really need, particularly in rural areas, will require more doctors trained in broad specialties, including general practice. They will have to be equipped to deal with acute illness in a community setting but, crucially, without necessarily relying on admitting patients to hospital.

The Shape of Training report suggests that involving specialists in community care and involving GPs and doctors trained in general areas of a specialty in co-ordinating hospital and community care leads to:

- Improved patient outcomes;
- Higher levels of patient and staff satisfaction;
- Shorter hospital stays;
- Fewer emergency readmissions of acutely ill patients.[156]

It seems clear that the NHS of the future will require a more integrated approach to healthcare that will have GPs and hospital doctors working together to allow patients to access targeted and specialist care in the community, rather than always in a hospital setting. To deliver safe care in any setting, all doctors will need generic knowledge and skills coupled with the ability to diagnose, initiate treatment and manage the interface between different services and specialists. As such, we may need to ensure that urgent and emergency care services are designed to meet future needs, rather than continuing to expand the current models of care.

Conclusions

1. The Department should commission a new urgent and emergency care workforce plan. The plan should take into account the new model of care and the role of wider professional groups in delivering urgent and emergency care services.

2. With the increasing pressures on the system, the Northern Ireland HSC must embrace new professional groups such as Advanced Clinical Practitioners and Physicians Associates. Where there is evidence that such roles are working elsewhere, they should be adopted and included in any new workforce plan.

3. NIMDTA should continue to develop new inter-professional approaches to training in order to ensure that a more collaborative approach can be embedded across professions delivering health and care.

4. Health professionals across the HSC should adopt the 10 key principles to guide and improve professional communications and behaviours between healthcare practitioners across Northern Ireland.

[156] https://www.gmc-uk.org/-/media/documents/Shape_of_training_FINAL_Report.pdf_53977887.pdf

Chapter 10: Capacity and Flow

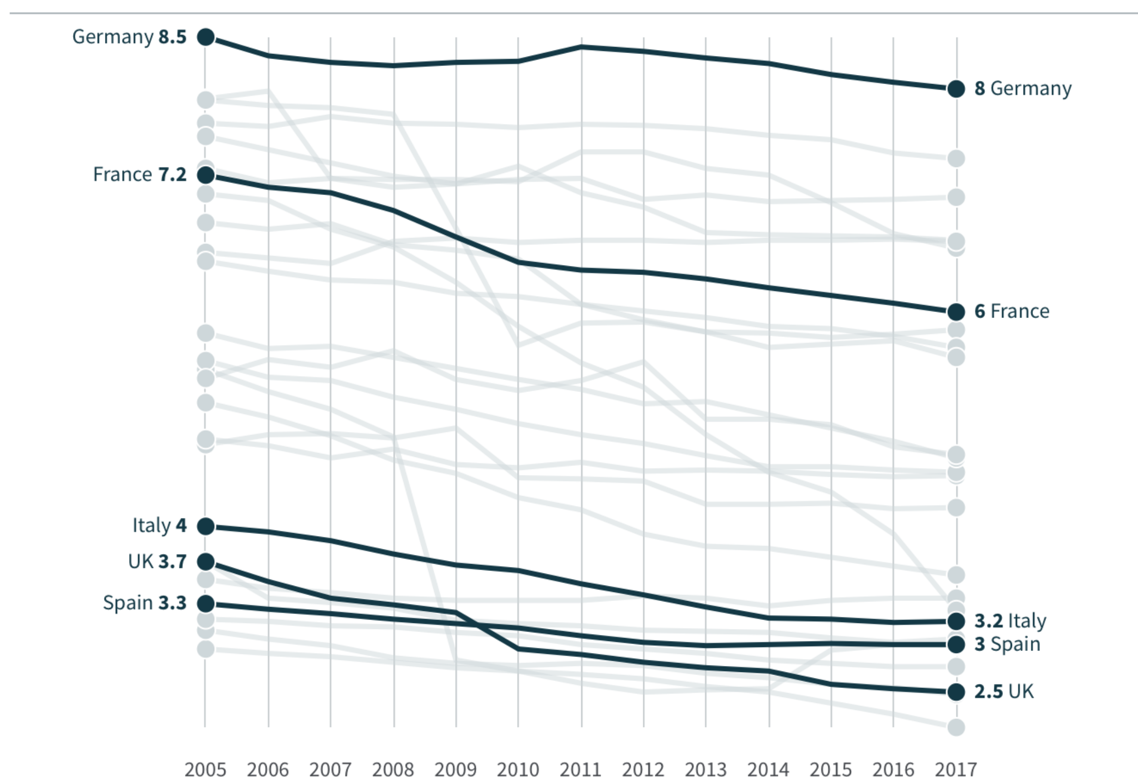
There is little doubt that beds not being available for patients has been a major factor in the growing number of patients spending long periods in Emergency Departments. Beds being unavailable in hospitals have been reported as the "the primary cause of admission and surgery cancellations, delays in emergency admissions, early patient transfers from intensive care units, delays in patient transfer between units, and early patient discharge."

There are two main schools of thought around this issue; these can effectively be categorised as increasing capacity vs improving flow. With respect to increasing capacity, there are those who argue that the most effective way to resolve the problems of lack of bed availability and Emergency Department crowding is simply to increase the number of hospital beds. Alternatively, there are those who disagree and point to the fact that Northern Ireland already has a similar bed capacity to the Netherlands, Norway, Italy and Spain, and significantly more than the rest of the UK with 3.1 beds per thousand of the population. Under this argument, the problem lies not with overall bed capacity, but with the flow of patients through the system which is a consequence of inappropriate numbers of admissions, longer lengths of stay and the system's inability to discharge patients in a timely fashion. In short, some believe we do not have enough hospital beds in Northern Ireland, others believe we do not use the beds we have as efficiently as we should.

Capacity

The number of beds in hospitals in many advanced health care systems has been reducing in recent years.

Figure 1. Worldwide reduction in total hospital beds per 1,000 inhabitants



Source: Kings Fund

The Organisation for Economic Co-operation and Development (OECD) reported that the United Kingdom had 2.5 total hospital beds per 1000 people in 2017. As compared to 3.0 per 1000 people in Ireland; 3.1 in Italy; 3.2 in the Netherlands; 5.9 in France and 8.0 in Germany.[157]

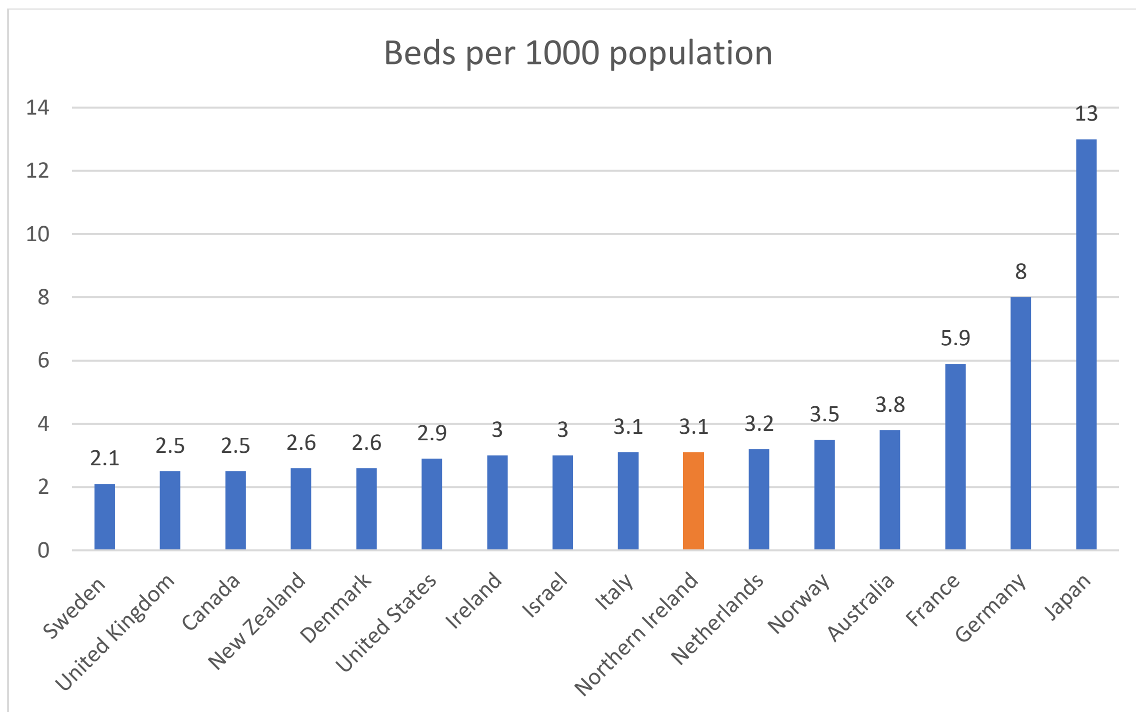
In 2018/19, the total number of hospital beds in Northern Ireland was 5830.4 which is equivalent to 3.1 beds per 1000 population. This is higher than the number available in the United Kingdom as a whole and similar to Ireland, Italy and the Netherlands.

---

[156] https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

[156] https://data.oecd.org/healtheqt/hospital-beds.htm:

Figure 2. Hospital Beds per 1000 of population in different countries



Source: OECD

The total number of available beds in hospitals in Northern Ireland for all Programmes of Care fell from 8237.6 in 2005/06 to 5830.4 in 2018/19. The numbers of beds fell in each Programme of Care (Figure 3). The largest percentage reductions occurred in the Learning Disability, Mental Health and Elderly Care settings. Programmes of Care' as patients were increasingly cared for in community settings. The number of beds for the Acute Programme of Care fell by 575.6 over this period.

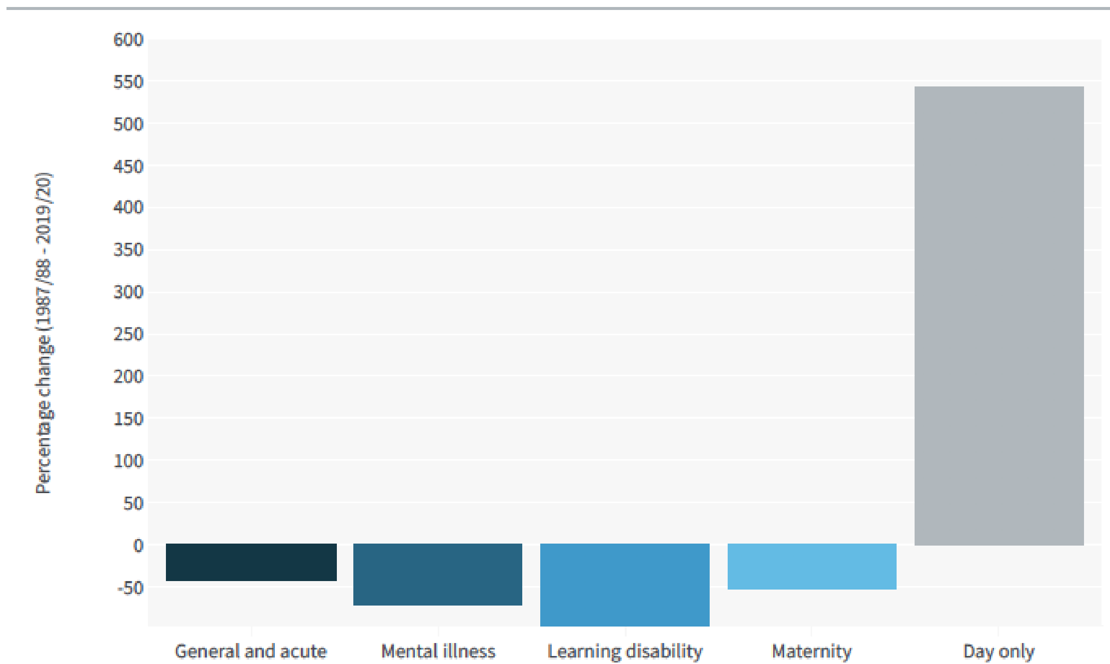
Figure 3. Reduction in Beds by Programme of Care for Northern Ireland Hospitals 2005/6 to 2018/19.

Programme of Care	Available Beds 2005/06	Available Beds 2018/19	Change	% Change
Acute	4457.1	3881.5	-575.6	-12.9%
Maternity & Child Health	659.0	457.8	-201.2	-30.5%
Elderly Care	1473.8	873.5	-600.3	-40.7%
Mental Health	1110.2	510.7	-599.5	-54.0%
Learning Disability	537.5	106.8	-430.7	-80.1%
All Programmes	**8237.6**	**5830.4**	**-2407**	**-29.2%**

Source: Department of Health

NHS England has recorded similar falls in the total number of beds available. Since 1987 acute and general beds fell by 44%, mental health by 73%, learning disability by 97%, and maternity by 52%. In contrast day only care has increased by 541%. Figure four demonstrates this decrease.

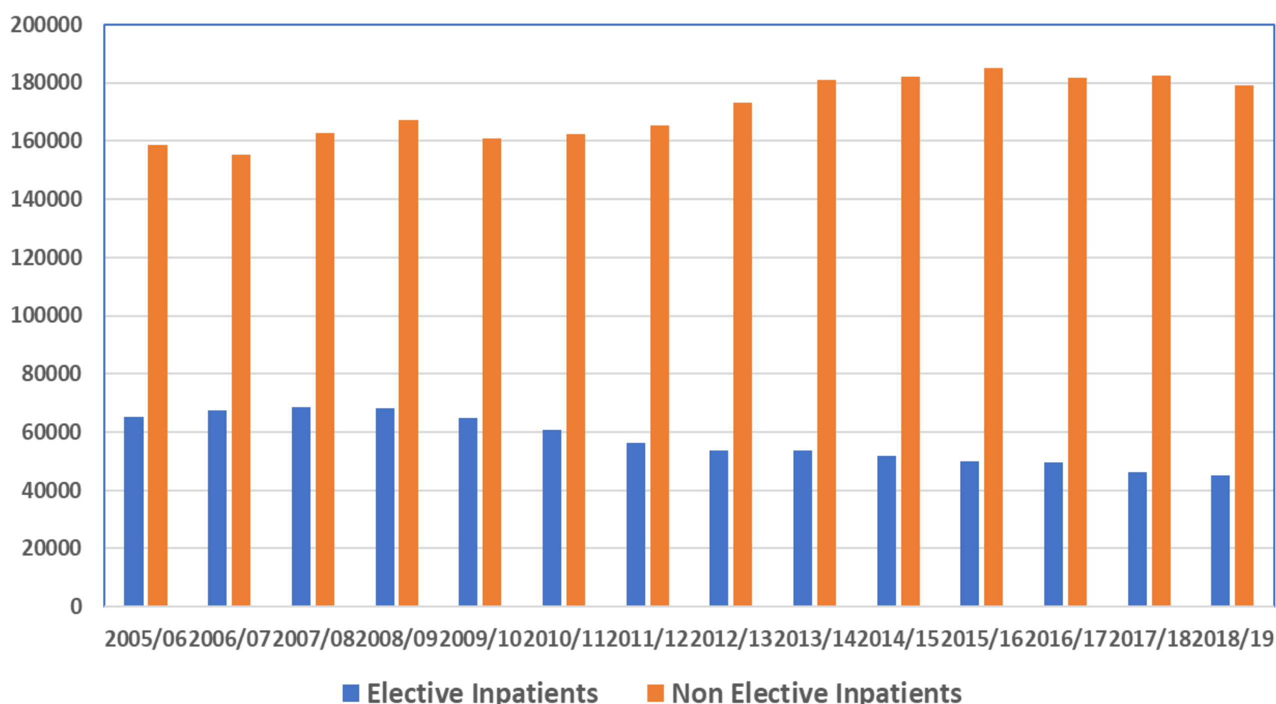
Figure 4. Change in NHS England hospital bed availability



Source: Kings Fund

For the Acute Programme of Care in Northern Ireland, Figure 5 shows the trends in numbers of elective and non-elective inpatients between 2005/06 and 2018/19. There was a rise in the number of non-elective inpatients from 158,575 in 2005/06 to 179,028 in 2018/19 with a fall in the number of elective inpatients from 65,120 to 51,636. The number of day cases rose from 154,720 to 198,306 during this period.

Figure 5. Trends in numbers of elective and non-elective inpatients acute programme of care NI 2005/06 to 2018/19



Source. Department of Health

Occupancy

Occupancy, is closely linked with capacity and when assessing future hospital bed requirements, consideration needs to be given to the levels of bed occupancy and length of stay of patients. In March 2018, the National Institute for Health and Care Excellence (NICE) published a guideline on emergency and acute medical care in over 16s.[158] Overall, the evidence suggested that, in general, any increase in occupancy leads to an increased risk of adverse patient outcomes including: mortality; avoidable adverse events reported as hospital-acquired infections; length of stay; 30-day readmission; and delays in admission for patients waiting in ED. NICE recommended that healthcare providers should plan capacity to minimise the risks associated with hospital bed occupancy rates exceeding 90%

[157] Emergency and acute medical care in over 16s: service delivery and organisation: NICE guideline (NG94) National Institute for Health and Care Excellence, March 2018: Emergency and acute medical care in over 16s: service delivery and organisation (nice.org.uk)

Figure 6. Risk of running out of beds related to occupancy

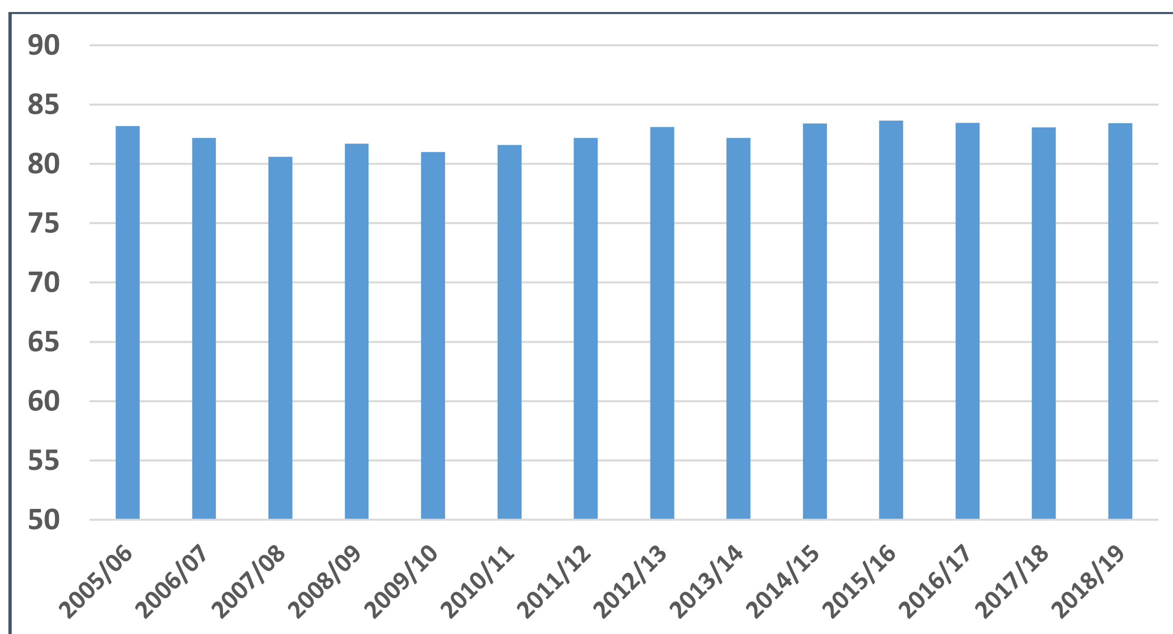
Risk of running out of beds	Bed occupancy
30%	97%
20%	95%
10%	92%
5%	90%
1%	87%
0.5%	85%
0.1%	83%

Source: NICE guideline 94

Between 2005/06 and 2018/19, total bed occupancy rates for the Acute Programme of Care for hospitals in Northern Ireland did not change significantly with 83.6% in 2005/06 and 83.2% in 2018/19. (Figure 7).

According to NICE this should be well below the 90% when risk of running out of beds increases, however it is evident from the crowding pressures in ED that this is not the case. It is important to understand why.

Figure 7. Trends in percentage bed occupancy in acute programme of care in Northern Ireland



Source. Department of Health

Occupancy rates vary by specialty. In 2018/19, medical specialties in the Acute Programme of Care tended to have higher occupancy rates than surgical specialties. General Medicine, which has the highest number of individual beds for a specialty at 1119.0 had an occupancy rate of 90.3% with the 491.2 available beds for General Surgery having an occupancy rate of 87.8%.

Occupancy rates are measured at midnight and often on a quarterly basis. This unfortunately results in a static impression of a complex dynamic system. It is important to note that occupancy levels for hospitals vary throughout the day and by time of the year. When annual average levels are 90% or above, there will be times with very limited flexibility for admission, leading to delays in Emergency Departments.

NICE guideline 94 makes these recommendations with regard to bed occupancy:

- Monitor total acute hospital bed occupancy, capacity, flow and outcomes in real time, taking account of changes in a 24-hour period and the occupancy levels and needs of specific wards and units.
- Plan capacity to minimise the risks associated with occupancy rates exceeding 90%.

Flow

Bed pressures are influenced greatly by ‘patient flow’. This term refers to *‘the ability of healthcare systems to manage patients effectively and with minimal delays as they move through stages of care’.* Discharge delays and increased demands contribute to poor flow. Negative consequences of poor patient flow are highlighted below. Ensuring effective patient flow in hospitals is a critical component in the design and delivery of new arrangements for urgent and emergency care.

The Consequences of Poor Patient Flow in Hospitals

- Emergency Departments become crowded, stressful and unsafe.
- Patients are admitted as 'outliers' to wards that are not best suited to manage their care, which may mean they have worse clinical outcomes.
- Ambulatory care services, clinical decision units, even catheter labs and endoscopy units may fill with patients waiting for ward admission.
- Inpatients are shuffled between wards to make room for newcomers.
- Staff are overstretched and routine activities slow down dramatically.
- Clinical outcomes are measurably worse, particularly for frail older people, who suffer more harm events and may decondition due to extended periods in hospital beds
- Patients' and carers' time is wasted due to delays and slow care processes and their experience is adversely affected.

Good practice guide: Focus on improving patient flow
NHS Improvement, July 2017

Improving Patient Flow

Many initiatives to improve patient flow in hospitals have been taken forward in hospitals across Northern Ireland in recent years. In 2014, a Patient Flow Workstream was established by the Regional Coordinating Group for Unscheduled Care. Figure 8, illustrates an overview of the ways to improve patient flow which were identified at that time.[159]

The report of the Patient Flow Workstream identified a wide range of actions to improve flow through inpatients and therefore overcrowding in Emergency Departments (EDs). Immediate priority areas for action included:

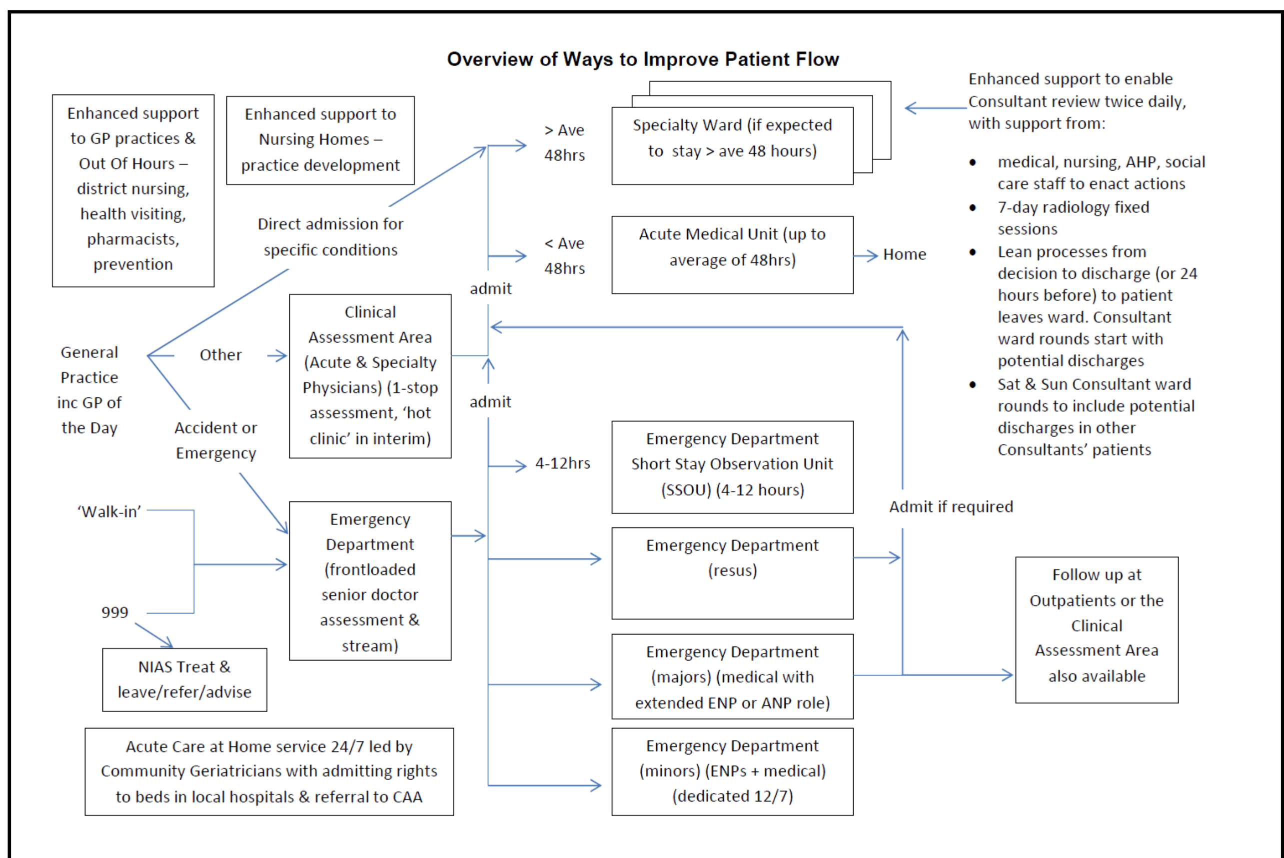
- Providing full radiology services including CT, MRI and ultrasound scans 7-days a week at a capacity that enables same day/next morning radiological investigation and reporting for all radiological work.
- Support Consultant twice daily decision-making for all inpatients – enable a Consultant to review all inpatients twice a day.

[159] https://www.health-ni.gov.uk/publications/improving-patient-flow-hsc-services

- Ward rounds – see potential discharges first to allow the discharge process to start as early in the day as possible.
- Streamline the process from decision to discharge (or anticipate discharge) to the time when the patient goes home – (typically half a day is lost per patient).
- Establish a dedicated minors stream in ED, 7 days a week, at least 9am to 9pm or longer if demand exists.

The report of the Patient Flow Workstream recommended action at all levels and a significant programme of work was taken forward. Nevertheless, as the numbers of patients attending ED and requiring admission continued to grow, pressures on EDs continued leading to the need for the fundamental examination of the future models for urgent and emergency care being taken forward by this review.

Figure 8. Overview of Ways to Improve Patient Flow



Source: Patient Flow Workstream Department of Health 2014

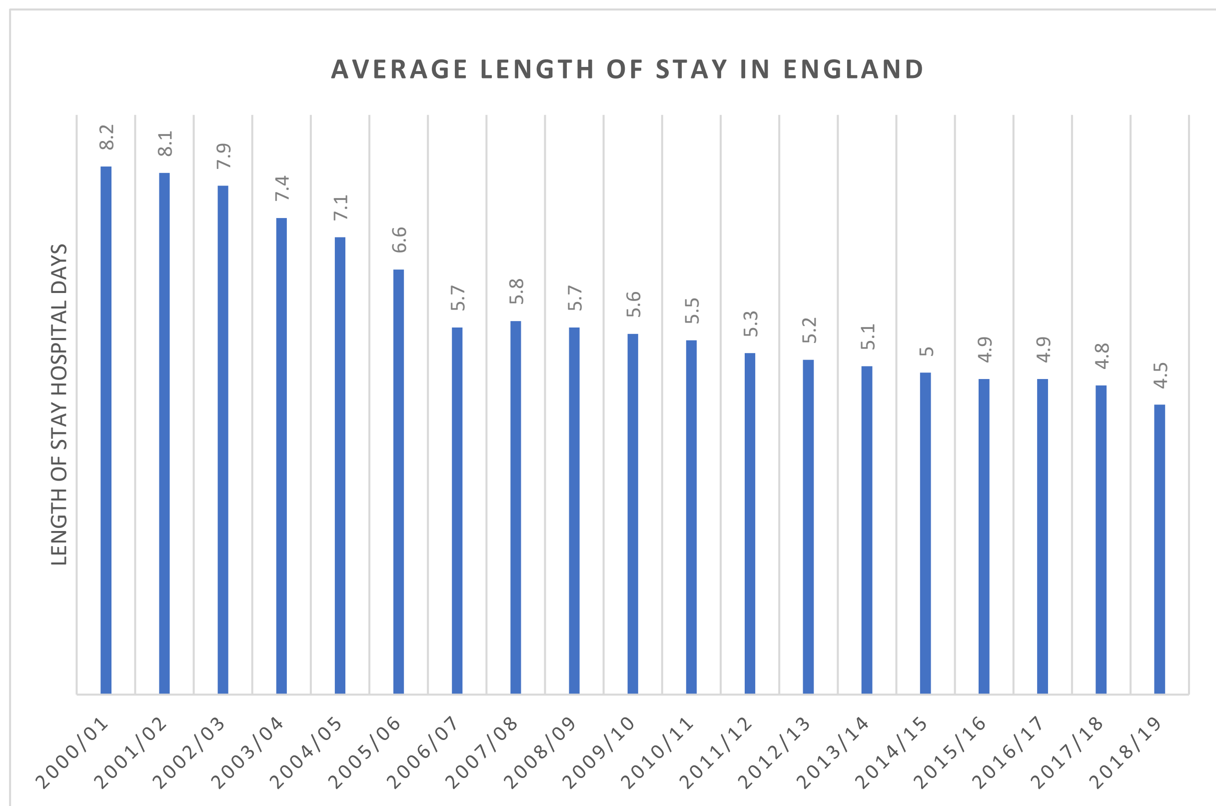
Length of Stay

Both length of hospital stay and admissions are important variables when considering the movement of patients through a healthcare system and the capacity required. Often a greater capacity is associated with a longer length of stay, this is seen in both

Germany and Japan where average length of stays are 7.5 and 16.1 days and the capacity per 1000 of the population is 8 and 13 respectively.

In the United Kingdom the average length of stay has been gradually falling. In 2018/19 it was reported as 4.5 days. The average length of stay in Northern Ireland hospitals has remained stable at 6.0 days in 2018/19.

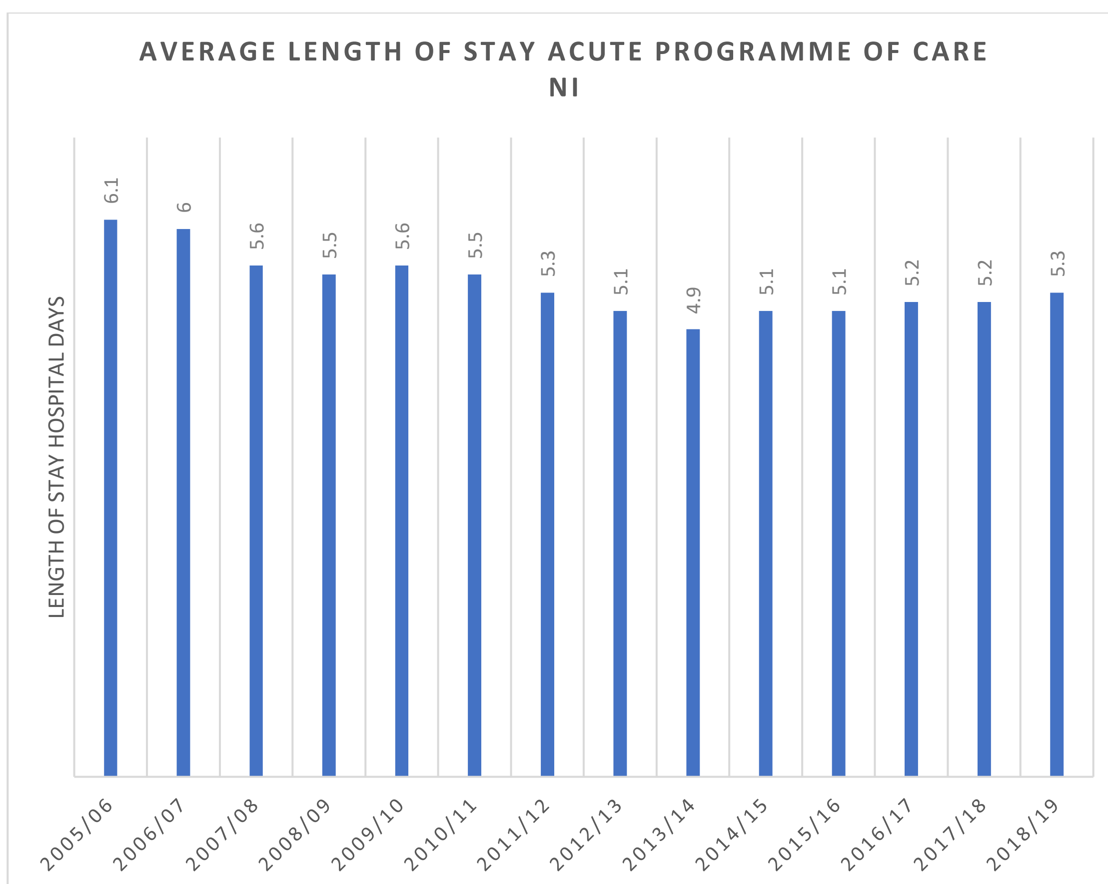
Figure 9. Decline in average length of stay in England



Source: Kings Fund

Figure 10 illustrates the trends in Average Length of Stay in the Acute Programme of Care for hospitals in Northern Ireland between 2005/06 and 2018/19. Average Length of Stay fell from 6.1 days in 2005/06 to reach a low of 4.9 days in 2013/14 before gradually rising again to 5.3 days in 2018/19.

Figure 10. Average length of stay in the acute programme of care in Northern Ireland

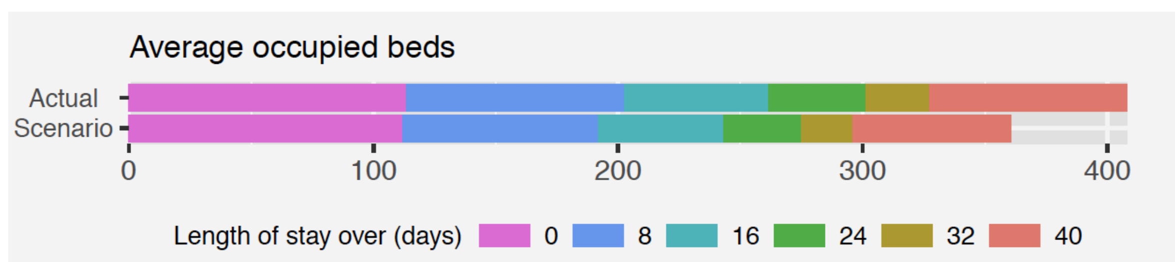


Source: Department of Health

Average length of stay for acute services in hospitals is impacted by a wide range of variables. A recent publication by the OECD indicated that in 2017 the Netherlands, average length of stay was 5.0 days; in Sweden it was 5.5 days; in France it was 5.6 days; in Ireland it was 6.0 days; and in Germany it was 7.5 days.

NHS England and NHS improvement have highlighted length of stay as being one of the most important determinants of occupancy rate. They have run a series of scenarios demonstrating how reducing length of stay will change bed occupancy. Figure 11 below shows a scenario where any patient with a length of stay over 21 days has it reduced by 20% and any patient with a length of stay over seven days has it reduced by 10%; this reduces overall bed occupancy by 11.5%.

Figure 11. Reducing LoS effects bed occupancy



Source: NHS England/NHS Improvement

NHS improvement also discusses the idle time between different patients occupying the same bed space that comes from communication delays, cleaning and portering. They advocate tackling prolonged lengths of stay and improving efficiency to reduce bed occupancy rates.

Admissions

Preventing admission is another potential solution to the increasing pressures in the unscheduled care system. The logic is relatively simple; by reducing attendances and preventing admissions, Emergency Departments will be less crowded and occupancy rates in hospitals will be reduced. A central pillar of the NHS five-year forward plan[160] was focused on prevention, early intervention, admission avoidance and supporting people in their own homes. Many of the Vanguard interventions in England are piloting efforts to divert users and transfer care into a community setting rather than a hospital environment.

The evidence underpinning this approach is mixed. In evaluating the impact of some measures put in place in England, there is some research suggesting that these interventions can be challenging to implement and an absence of clear evidence of success[161]. Nevertheless, there is also research[162] indicating that one in five emergency admissions to hospital are thought to be avoidable with better and more co-ordinated care management in the community. Finally, analysis carried out by the Kings Fund[163] showed that areas that had more integrated services for older people showed lower rates of hospital bed use. This has been demonstrated locally with the introduction of acute care at home programmes and the development of ambulatory care and assessment units. Figure 12 highlights the decrease in admission conversion

---

160 https://www.england.nhs.uk/five-year-forward-view/

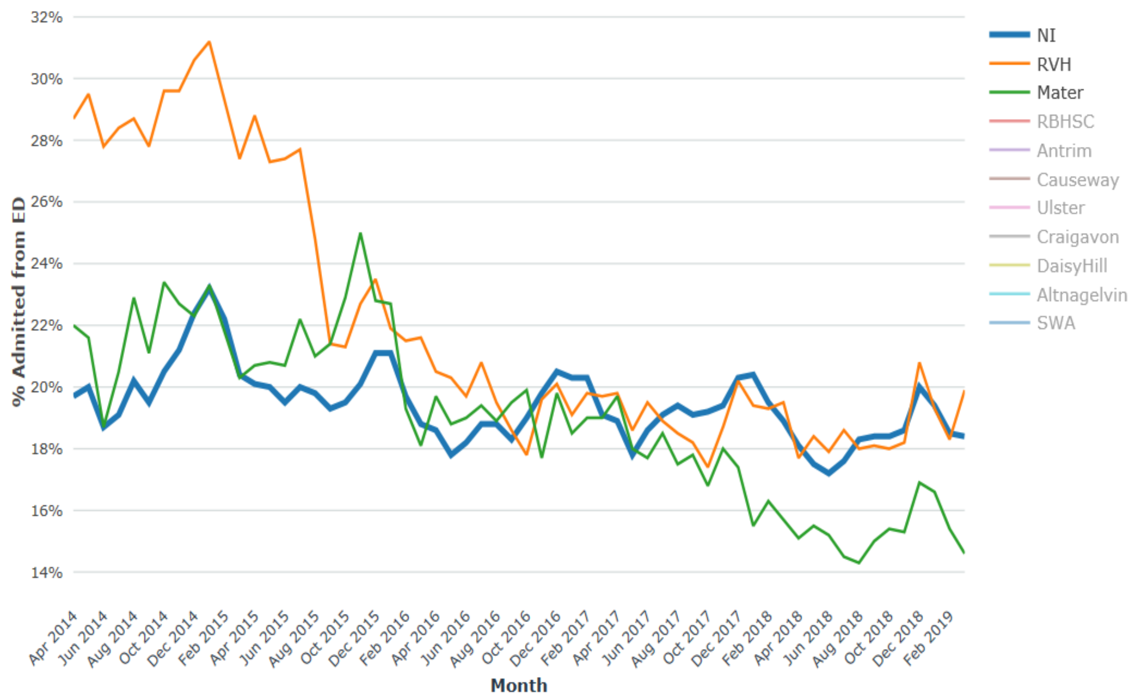
161 http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/unplannedadmissions.pdf

162 https://www.nuffieldtrust.org.uk/research/focus-on-preventable-admissions

163 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/older-people-and-emergency-bed-use-aug-2012.pdf

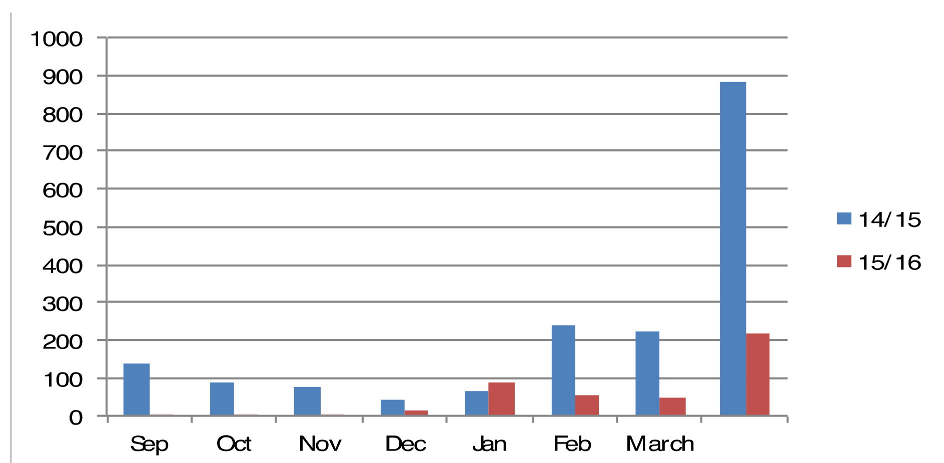
rate when a medical assessment unit was opened in Belfast in 2015. They have argued that this admission reduction leads directly to a decrease in patients waiting more than 12 hours in the Emergency Department. Figure 13 highlights the difference in patients waiting more than 12 hours.

Figure 12. Reduction in admission rates after the opening of a medical assessment unit focusing on ambulatory care.



Source: Department of Health

Figure 13. Demonstrating a 75% decline in patients waiting over 12 hours after the opening of an assessment unit in 2015



Source: Belfast Health and Social Care Trust

NHS RightCare[164] looks at data, variation and evidence across the healthcare system. With regard to emergency care they produce a series of atlases that measure and compare by CCG:

1. Admissions per 100,000 of the population
2. ED conversion rate to admission
3. ED attendances per 1000 of the population

They have pointed out significant variation between different regions. They demonstrated a 3.5 fold variation in the percentage of ED attendances resulting in admission and a more than 4 fold variation in the rate of admission for people aged over 75. They proposed interventions including;

1. Introducing senior decision-making staff (e.g. consultants in Emergency and Acute Medicine working with primary care practitioners) at the “front door” of the hospital.

2. Ambulatory emergency care in treating patients without the need for hospital admission. They state “this service has been shown to be highly effective and should be developed further wherever possible”.

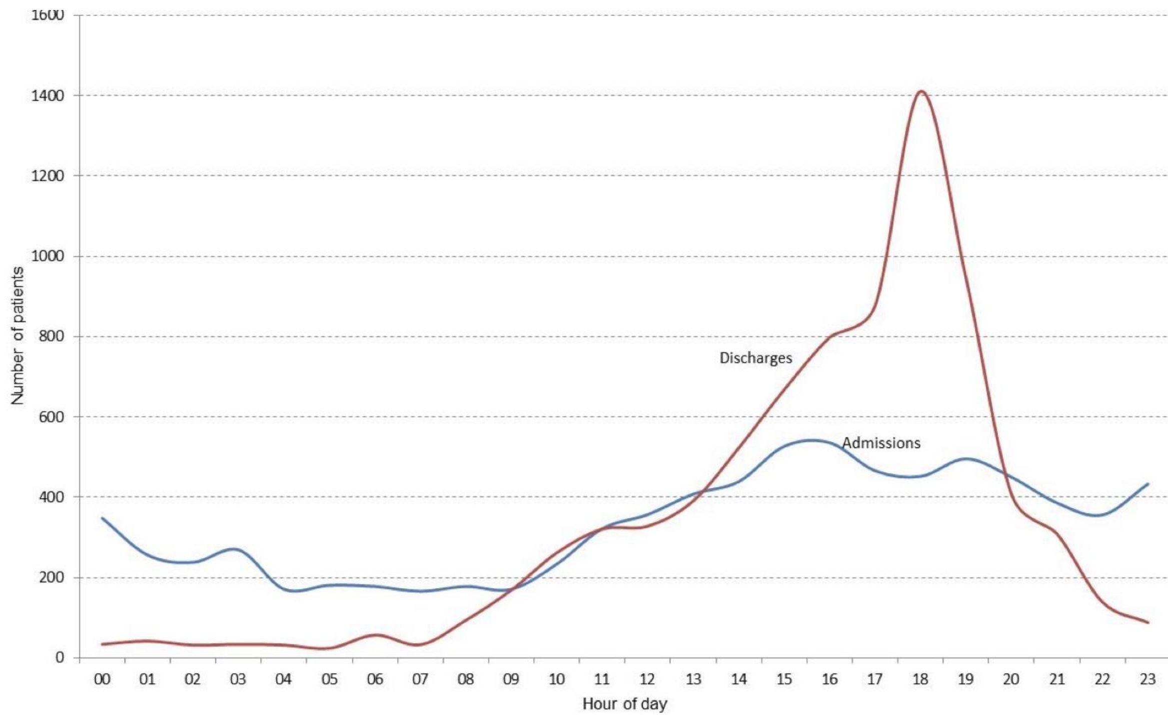
It is important to consider which interventions are most effective in reducing hospital admissions and how we will manage the demand on urgent and emergency services in the future.

Discharges

Like admission reduction, efficient discharge processes are often targeted as a way to improve the flow of patients through the hospital. Once again, the theory is relatively simple; admissions at certain times of the day and on some days of the week (e.g. weekends) do not match discharges. If admissions could be matched to discharges, there would be less variation in occupancy rates and flow would be much better. Figures 14 and 15 demonstrates an example of the mismatch in admissions and discharges in our hospital system.

[164] https://www.england.nhs.uk/rightcare/

Figure 14. Times of admissions to and discharges from hospital wards in a typical hospital trust

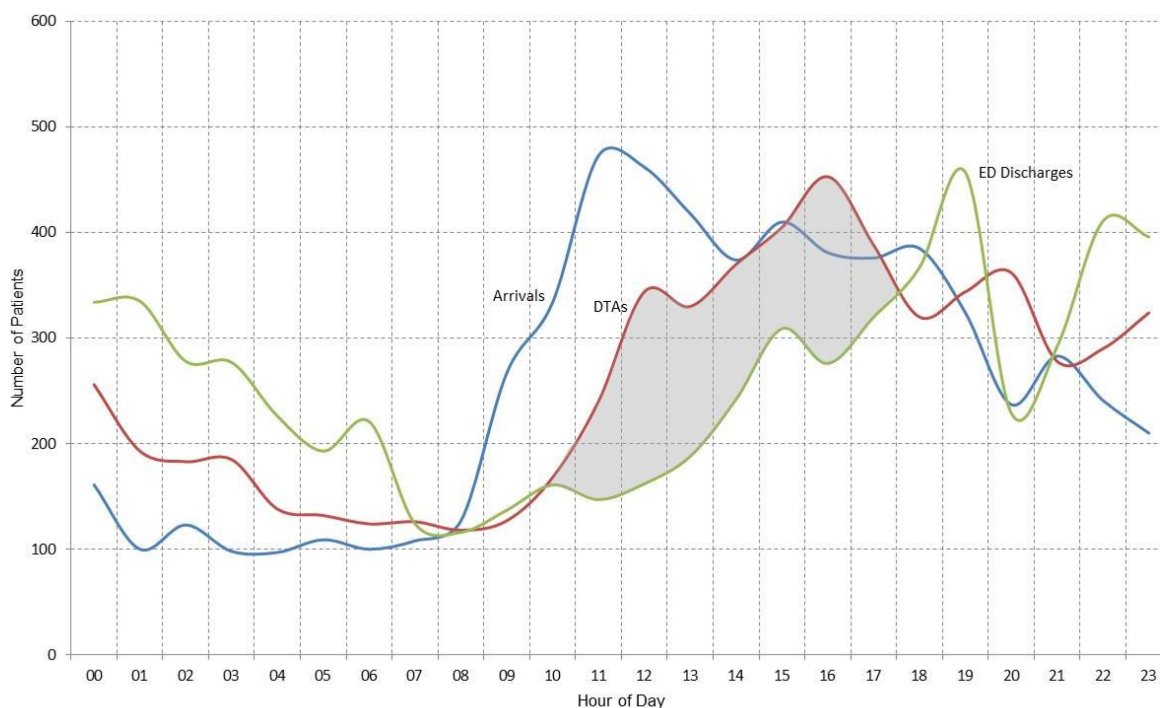


Source: Department of Health

The graph above demonstrates that the peak of discharges from the wards happen between 6:00 pm and 7:00 pm in the evening whereas admissions increase earlier in the day.

The Emergency Department on the other hand sees most of its arrivals peak at 11:00 am, with the peak of admissions being decided at 4:00 pm and the peak of ED discharges to the ward coinciding with ward discharges at 7:00 pm. The grey area in the graph below demonstrates exit block; the mismatch between admission decisions in the Emergency Department and discharges from the Emergency Department.

Figure 15 Graph showing the arrival times, decisions to admit and discharge times in an Emergency Department



Source: Department of Health

Many authors[165] [166] [167] argue that there is only an apparent shortage of beds due to the fact that admissions are occurring at a different time to discharges. It is for this reason that earlier discharges during the day and increasing discharges at weekends are often proposed as a solution to crowded Emergency Departments and exit block[168]. A number of studies[169] [170] focusing on increasing ward discharges before noon would seem to support this.

NHS England and NHS Improvement[171] suggest that most benefit from improving discharge processes is derived when occupancy rates are at a high level. Peaks in

---

165 https://www.researchgate.net/publication/43245522_Managing_capacity_and_demand_across_the_patient_journey

166 https://www.researchgate.net/publication/331586543_Hospital_Bed_Management_Practices_A_Review

167 https://www.sciencedirect.com/science/article/abs/pii/S1553725016300939

168 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4916624/

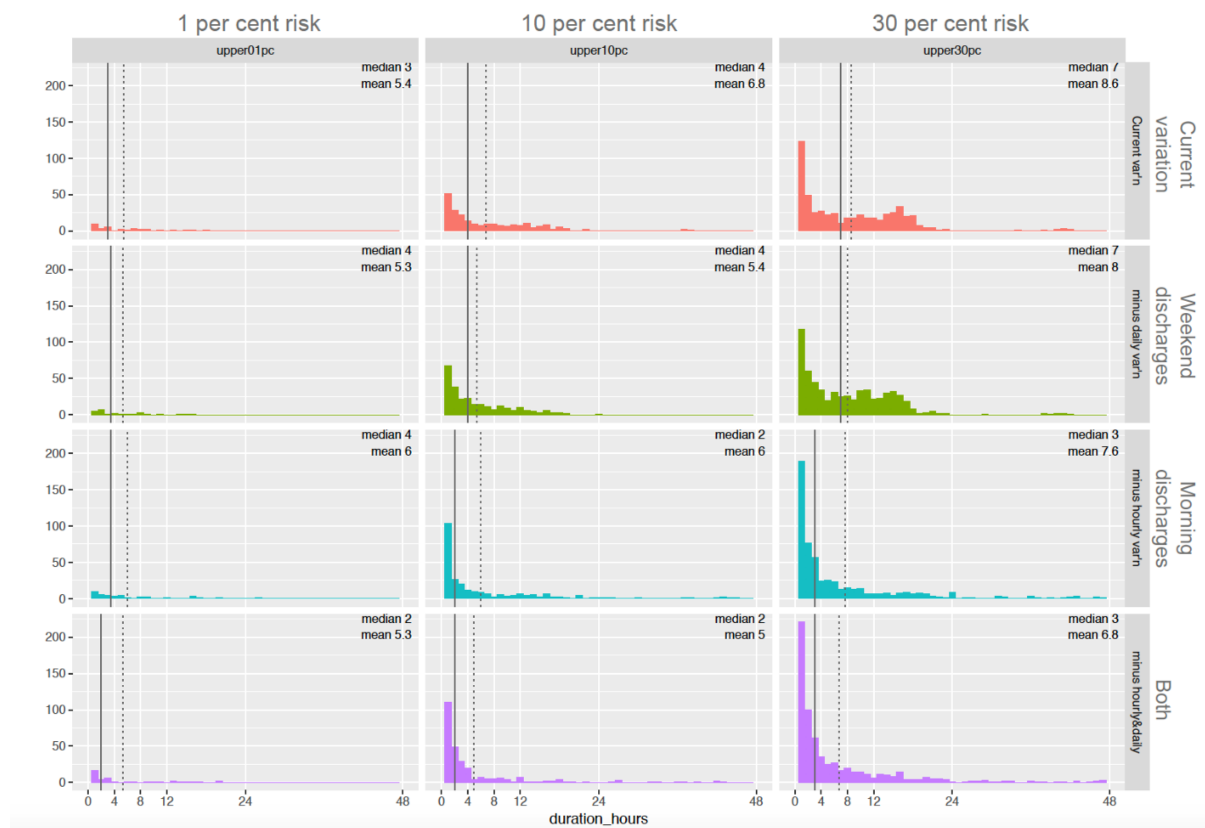
169 https://bmjopenquality.bmj.com/content/5/1/u209098.w3772

170 https://www.journalofhospitalmedicine.com/jhospmed/article/127333/discharge-noon

171 https://gooroo.co.uk/wp-content/uploads/2019/08/Planning_beds_bed_occupancy_and_risk.pdf

12-hour periods with insufficient beds are replaced with larger numbers of short periods. This is shown in Figure 16

Figure 16. With 30% risk of bed insufficiency discharge process interventions have greatest impact.



Source: NHS England/Improvement

Standards, Measures and Performance

In terms of delivering efficiencies and good flow through a hospital system it has been suggested there are three essential components.

1. The first of these components is establishing a set of professional standards which Trusts and healthcare professionals agree to adhere to and can be held accountable against. These are increasingly common in health systems throughout the United Kingdom. In simple terms, they represent a rulebook which healthcare systems and professionals must observe.
2. Any successful modern health care system requires real time accurate data that gives you an understanding of what is going on across the whole system. It allows those coordinating the health system to measure their performance

against the agreed standards. This is very much in keeping with the recommendations in NICE guideline 94. Increasingly large healthcare organisations are using command centres to control the movement of patients throughout the system. Perhaps the most well publicised example of this is at John Hopkins University in the United States.

3. Finally, it is important to ensure that performance management and feedback mechanisms are in place to analyse and interpret the real-time data and ensure that health systems are performing to a high level and adhering to the agreed professional standards. It is important that this team is able and empowered to take the necessary actions to correct any problems within the system and hold those not adhering to the agreed standards to account.

Future Requirements

Projected changes in the age structure of the population of Northern Ireland over the next ten years will lead to increasing needs for health and social care. It has been projected that the total number of emergency admissions in Northern Ireland will rise by over 12,800 between 2015/16 and 2025/26. When planning a future model of urgent and emergency care, it is essential to reach a resolved view as to the number of acute hospital beds which should be planned and provided for patients requiring emergency care.

Planning acute bed requirements is not an easy task. There are many factors which will influence future requirements including:

- Changes in the size and age structure of the population at regional and local levels;
- Changes in patterns of health and disease;
- Developments in diagnosis, treatment and care;
- The future balance between emergency and elective services;
- Changes in the utilisation of hospital beds including: lengths of stay for patients;
- Patterns of hospital working at nights and weekends; and the availability of step-up and step-down facilities;
- Changes in models of care delivery such as Hospital at Home or Same Day Emergency Care;
- Ensuring that services have the ability to meet seasonal variation in demand and emergency situations such as the COVID-19 Pandemic.

Planning Future Hospital Bed Capacity

A systematic review of models and methods for determining the optimum number of beds in hospitals and regions concluded that there are no specific norms for the

required number of beds at hospital and regional levels but that there are a range of methods which can be used to estimate the number in different contexts. Many factors need to be taken into account include demographic, socioeconomic and geographic patterns; clinical specialty groups (surgical and non-surgical); inter-regional access to services, efficiency; and standards for the provision of care. The study has also emphasised that: "*policies should be implemented that are designed to reduce the future need for hospital beds, especially through the expansion of primary health care and health promotion activities"*[172].

In March 2020, the King's Fund published a report setting out an assessment of trends in NHS Hospital Bed Numbers[173]. The King's Fund found that the number of general and acute beds had fallen by 34% since 1987/88. The bulk of this fall was due to closures of beds for the long-term care of older people. Medical innovation, including an increase in day-case surgery, has also had an impact by reducing the time that many patients spend in hospital.

While reductions in bed numbers had slowed, there were opportunities to: *"make better use of existing bed stock by preventing avoidable admissions, reducing variations in length of stay and improving the discharge of patients. Efforts to make better use of the existing stock should focus on the relatively small number of mainly older patients who stay in hospital a long time."*

The report stated that there were signs of a growing shortage of hospital beds. In 2018/19, in England, overnight general and acute bed occupancy averaged 90.2% and regularly exceeded 95% in winter, *"well above the level many consider safe"* with occupancy rates regularly exceeding 95% in winter.

The report concluded that: '*In some areas, it may be possible to reduce the number of beds after advances in medical practice and progress towards moving care out of hospital. However, at a national level, with hospitals under real strain from rising demand and staff shortages and the NHS only now coming to the end of a decade-long funding squeeze, further significant reductions are both unachievable and undesirable.'*

In 2018, the Department of Health in the Republic of Ireland published the report of a major review to inform the planning of health service capacity until 2031[174]. The research to inform the review used a purposely designed demand and capacity model. The model facilitated assessment of two scenarios:

[172] https://pubmed.ncbi.nlm.nih.gov/32143700/

[173] https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

[174] https://www.gov.ie/en/publication/26df2d-health-service-capacity-review-2018/

1. **A Baseline Scenario** which examined capacity requirements over the period to 2031, assuming the status quo prevails,

2. **A Desired Future State for the Health Sector Scenario** to consider the potential impact on capacity of three interlinked reform areas:

   a. Health and wellbeing initiatives

   b. An Improved model of care that repositions the health service towards a community-based care model with a specific focus on older people, and

   c. Productivity measures with a specific focus on acute hospital services.

The report of the review sets out findings in relation to service capacity for hospital and residential services and also for staffing.

The report states that under the **Baseline Scenario**, 7,150 extra hospital beds in public hospitals would be required by 2031 including about 5,800 Inpatient, 100 Day Case, 160 Acute Medical Unit and 190 Adult Critical Care beds.

Under the **Desired Future State Scenario**, full implementation of all three reform areas would alter the capacity required for hospital beds to 2,590 extra hospital beds in public hospitals in Ireland including around 2,100 Inpatient, 300 Day Case and 190 Adult Critical Care beds.

The review concluded that significant investment would be required across all health services over the next 15 years in tandem with a fundamental programme of reform.

The methodology used to inform the Capacity Review carried out for the Republic of Ireland highlights the benefits of using a modelling approach to test the impact of interlinked scenarios to inform future service planning.

Capacity and Flow - Conclusions

1. The establishment of a work group to carry out a detailed exercise exploring in depth the issues relating to capacity, occupancy and flow. This group should verify the current available data and explore new sources of information. This information should be analysed and recommendations with regard to capacity, occupancy and patient movement through the system at both a regional and individual Trust level made.

2. A set of regional professional standards with regards to movement of patients through the healthcare system need to be agreed. Once established organisations and units can be supported to improve in areas where they are experiencing difficulties and ultimately be held accountable for persistently poor performance.

3. The healthcare system needs to work towards the use of real time data to create an environment conducive to effective operational management. The use of command centres to coordinate and direct the flow of users through the system should be explored and considered.

4. Ensure that patients requiring admission are provided with the **Right Care** in the **Right Place** by those with the **Right Skills**, **First Time**. It is important that Emergency Departments are able to focus on patients with emergency conditions. This is better achieved, and overall flow improved if non emergent patients requiring admission are able to access the right care without attending or being delayed in an Emergency Department.

5. Designing and implementing appropriate, alternative approaches to hospital admission, including Hospital at Home, Same Day Emergency Care, Rapid Access Clinics and Assessment Services. These initiatives are centred on demand management and admission avoidance and are detailed elsewhere in this review.

6. Useful data comparisons with other health care trusts and systems need to be established. This could be achieved through working with organisations such as GIRFT, RightCare and NHS benchmarking. This is necessary to fully understand the effectiveness and efficiency of our system in relation to others.

7. A robust performance and systems management team is required to give appropriate feedback and take corrective action if there is significant variation in performance, or operational flow problems are identified at a trust or regional level. It is important this group includes a clinical and peer challenge function.