Department of Health
An Roinn Sláinte
Männystrie O Poustie
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REVIEW OF URGENT AND EMERGENCY CARE SERVICES IN NORTHERN IRELAND

CONSULTATION REPORT & STRATEGIC PRIORITIES

16 MARCH 2022

FOREWORD: MINISTER

My vision for the future is to ensure that all citizens in Northern Ireland have equal access to safe urgent and emergency care services, tailored to their specific needs at the right time and in the right place.

When the Urgent and Emergency Care Review was launched on 26 November 2018, its stated aim was to establish a new regional care model for Northern Ireland, with a particular focus on meeting the needs of the rising proportion of older people in the population. I am determined that we meet this stated aim and the proposals set out in this consultation report is a first step towards that.

I would like to thank everyone involved in the developing this Review, from clinicians, service users and other stakeholders. A large number of people have provided input, with some 1,400 stakeholders having already influenced the proposals set out in the consultation report. I would particularly like to thank John Maxwell for leading the Review during all of its most critical phases.

This consultation report is a milestone in the development of a better urgent and emergency care system for Northern Ireland. The stated vision for the future of our urgent and emergency care services is important as it will guide efforts to implement the final proposals, once the consultation has concluded.

I firmly believe that implementation of the service reforms set out in this consultation report will achieve that vision. However, it must be recognised that this will take both time and strategic investment to achieve. It is also important to recognise that given the projected increase in urgent and emergency care needs, as set out in the population health needs assessment underpinning the proposals, we will need to 'run just to stand still'. The fact is that our urgent and emergency care system, across all of its aspects from GP services, to our Emergency Departments, to our services in the community, will continue to face increasing pressures. In this context, reforming a complex system is going to be challenging.

I would strongly encourage everyone to respond to this consultation - it is important that we hear from a broad spectrum of citizens, stakeholders and interests to inform the future direction of urgent and emergency care.

ROBIN SWANN MLA

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1. INTRODUCTION

1.01 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'[1].

1.02 Urgent and Emergency Care was one area that had been identified as in need of reform and since 2018 a significant amount of work had been undertaken to progress the Review. As the COVID-19 pandemic engulfed Northern Ireland, 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.

1.03 As we came out of the first wave of COVID-19, there was a recognition in HSC that the virus 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 through the development of the No More Silos Action Plan and the Intermediate Care Project (ICP), which have allowed some of the emerging conclusions from the Review to be rapidly implemented. No More Silos has tested new ways of delivering urgent and emergency care services across primary care, secondary care and in the community. The ICP aims to improve outcomes for service users who receive intermediate care services, ensuring they are supported to lead the best life they can. Importantly, the service models tested and experiences gained through No More Silos and ICP have influenced the proposals set out in this consultation report.

1.04 While there was a necessary pause in the work of the Review, the Department of Health (DoH) remains of the view that the Review Team Report (2020) which was developed prior to the Pandemic, continues to be relevant and that the strategic direction, as set out in this consultation report, provides an appropriate response to the longstanding issues. The Review Team Report is part of the suite of consultation documents. This Review therefore continues the strategic direction set out in the No More Silos Action Plan and the Intermediate Care Project.

[1] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

1.05 Public debate about urgent and emergency care often focuses on Emergency Departments as this is where the gap between demand and capacity in unscheduled care becomes manifest. However, it is so much more than that. Our primary care sector is essential to managing urgent care needs and often the most appropriate source of assessment and advice. Equally, intermediate care models such as Hospital at Home often offer the best and most appropriate service.

1.06 In fact, pressures in Emergency Departments are often caused by capacity failures elsewhere in the health and social care system, whether this is in the hospital, in the community or out of hospital setting. As set out in the Review Team Report, there is clear evidence that our unscheduled care system was under increasing pressure even before the onset of the COVID-19 pandemic. Attendances at Emergency Departments had increased year on year and the number of service users seen in Emergency Departments requiring admission to hospital had continued to rise. For several years performance had been on a steep downward trend with unacceptable levels of crowding in Emergency Departments, particularly during the winter months, resulting in large numbers of service users waiting more than 12 hours on hospital trolleys while waiting for assessment and admission to the correct medical setting.

1.07 Furthermore, the DoH Population Health Needs Assessment undertaken in 2017 to inform the Review has clearly set out the challenges posed by the projected increase in older people needing to use the service over the next 10 years. This has further been reinforced by more recent Northern Ireland Statistics Research Agency population projections, which estimates that between mid-2018 and mid-2043:

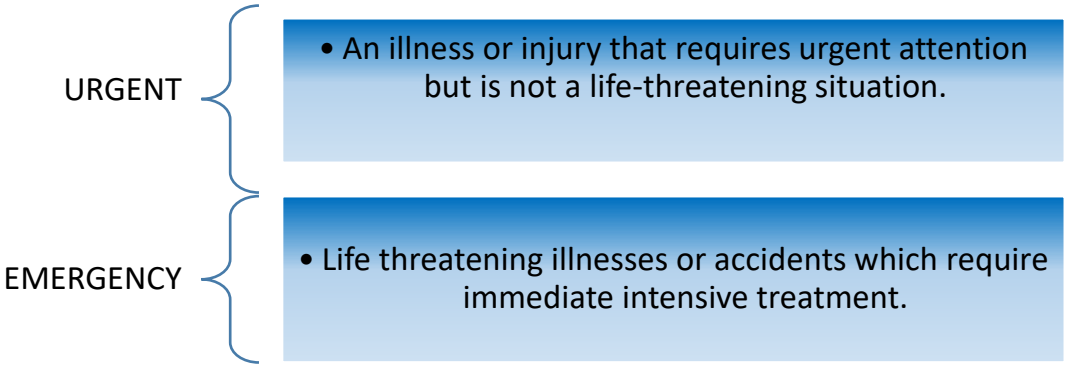
- Population aged 65 and over is projected to increase by 56.2%
- Population aged 85 and over projected is to increase by 106.4%

1.08 At the same time, it is important to recognise the impact and implications of the COVID-19 pandemic. The experience of the pandemic has demonstrated the risk of overcrowding in terms of nosocomial infections. Crowded Emergency Departments are simply not appropriate environments for vulnerable service users and we have heard clearly the wish to be cared for at home where possible, by staff with the right expertise in regionally consistent services.

1.09 There is often confusion about the terminology used by services users, providers and commissioners of urgent and emergency care services. Different terms such as “unscheduled care”, “unplanned care”, “urgent care”, “crisis response” and “emergency care” are often used interchangeably despite the

fact that they may mean very different things according to the point of view of those delivering and using them.

1.10 As set out in Chapter 2 of the Review Team Report, the following definitions of urgent and emergency care were adopted early in the Review process:



1.11 There is a growing body of evidence to inform the design of services providing urgent and emergency care, including the experience gained locally through No More Silos. Wide ranges of guidelines and toolkits have been developed by professional bodies to improve and standardise the delivery of urgent and emergency care. Successful unscheduled care systems around the world demonstrate a high level of coordination, integration and cooperation that allows the service users to access the right care, first time, in the right place. This is often not through the emergency care system, but by directly engaging specialist teams, in and outside the hospital environment, to achieve better outcomes for service users, thus avoiding unnecessary delays and inefficient duplication.

2. URGENT AND EMERGENCY CARE SYSTEM IN NORTHERN IRELAND

Primary Care

2.01 Whilst the General Practice (GP) contract is outside the scope of this review, General Practice is a critical element of the provision of urgent and emergency care.

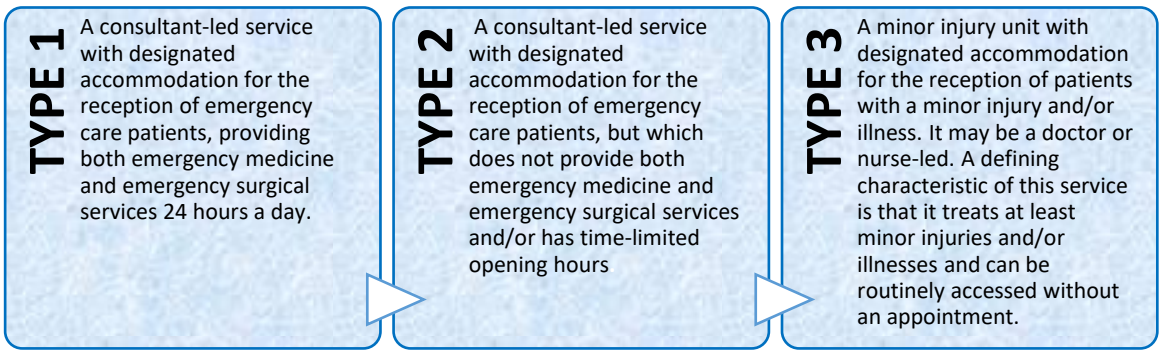
2.02 Prior to the pandemic, GP has been experiencing increased demand. The pandemic has accelerated a move that was already underway towards a telephone-first consultation model, as a means of managing that increased demand. This model has allowed a greater number of people to access their GP than would otherwise be the case. Critically, the telephone-consultation model allows the GP to determine the most appropriate approach to safely addressing the patient's needs. Where a face to face appointment is appropriate, that will be arranged. Alternatively, the GP may decide, based on their clinical assessment, that a telephone consultation is appropriate or that the patient should be signposted or directed to other relevant services.

2.03 General Practice currently conduct approximately 200k consultations per week, with around 40% of these being face to face.

2.04 The challenge now is to build upon the work that has been done to introduce the telephone-consultation model; to ensure consistency and quality of experience across Northern Ireland and ensure the potential of this new technology is fully exploited to the benefit of patients.

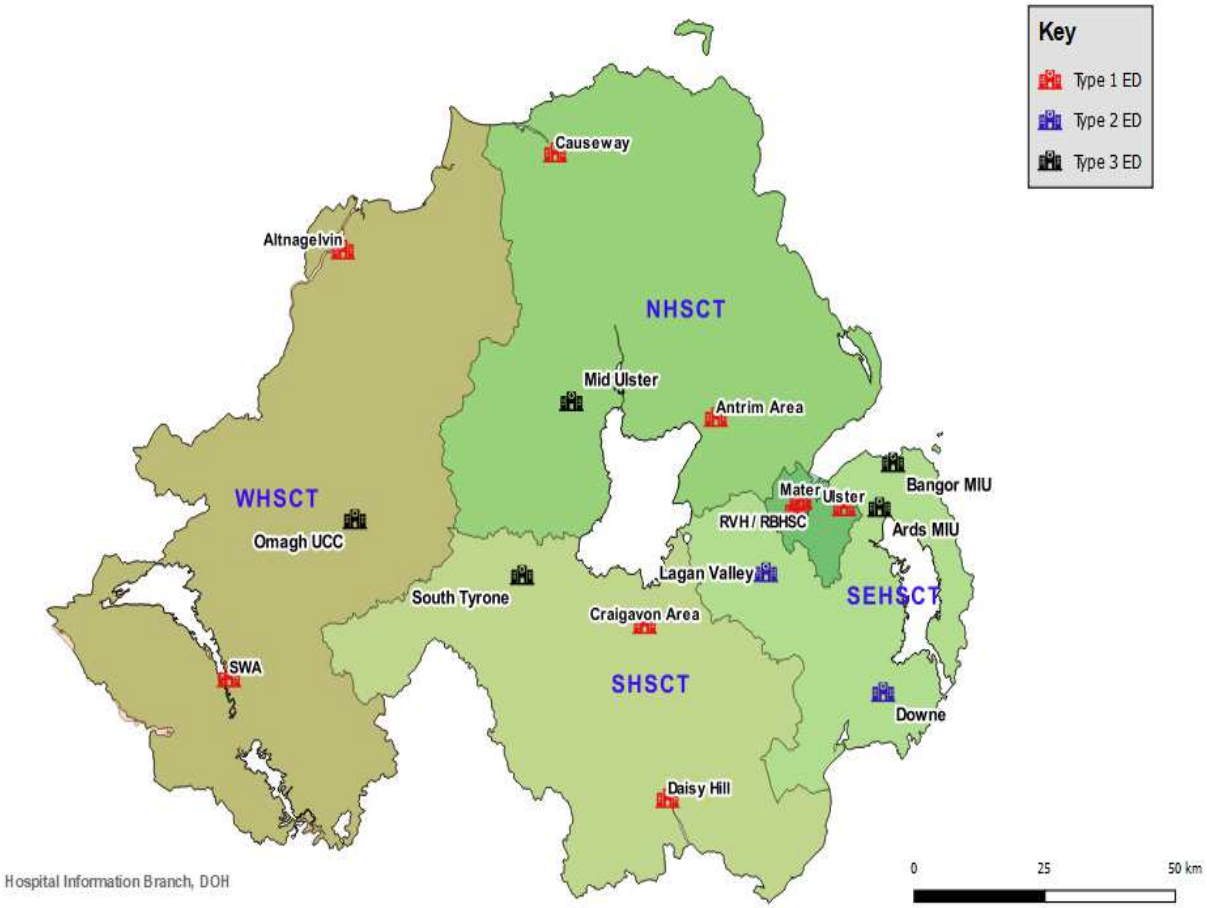
Secondary Care

2.05 Emergency care is provided through the acute hospitals in Northern Ireland. The type of Emergency Departments can be categorised as follows:



2.06 The distribution of our Emergency Departments is shown below:

Figure 1: Distribution of Emergency Departments

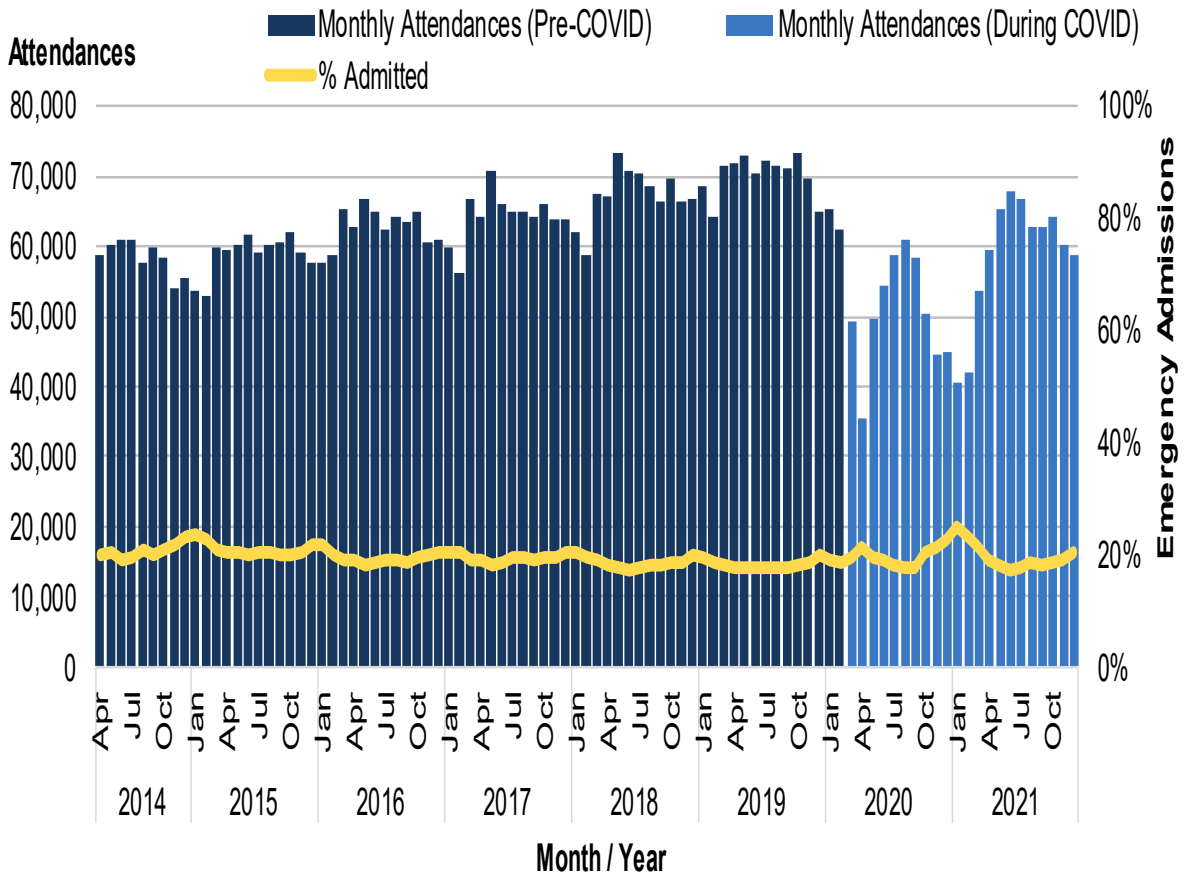


2.07 Emergency care statistics are regularly published on the DoH website, with the latest made available on the 11 February 2022 [2]. The pandemic has undoubtedly impacted on the emergency care statistics and the introduction of new models of care, such as those set out in No More Silos, will need to be reflected in the statistics as soon as possible.

[2] https://www.health-ni.gov.uk/news/emergency-care-waiting-time-statistics-october-december-2021

2.08 Figure 2 below shows both attendances at Emergency Departments and admissions to hospital in each quarter from 2014 to 2021. It is clear that the pandemic has had an impact on the level of attendances, particularly during periods of high COVID-19 transmission and lockdowns.

Figure 2: Attendances at Emergency Care Departments and Emergency Admissions to Hospital (April 2014 – December 2021)



Source: Regional Data Warehouse, Business Services Organisation

2.09 Table 1 below details the number of new and unplanned review attendances at each Type 1 Emergency Department during December 2021 and the same month in 2020. It also details the total number of attendances at Type 2 and 3 Emergency Departments during this period[3] [4] [5].

Table 1: Attendances at Emergency Care Departments (December 2020 – December 2021)

Department	New Attendances		Unplanned Review Attendances		Total Attendances	
	Dec 2020	Dec 2021	Dec 2020	Dec 2021	Dec 2020	Dec 2021
Mater	1,047	1,922	22	27	1,069	1,949
Royal Victoria	5,687	7,992	84	155	5,771	8,147
RBHSC	2,061	3,444	192	364	2,253	3,808
Antrim Area	5,202	7,415	242	366	5,444	7,781
Causeway	2,620	3,380	128	195	2,748	3,575
Ulster	6,579	7,712	203	329	6,782	8,041
Craigavon Area	4,731	5,626	386	535	5,117	6,161
Daisy Hill	2,953	3,854	234	281	3,187	4,135
Altnagelvin Area	3,978	4,939	298	368	4,276	5,307
South West Acute	2,189	2,739	203	229	2,392	2,968
Type 1	**37,047**	**49,023**	**1,992**	**2,849**	**39,039**	**51,872**
Type 2	**2,646**	**3,023**	**152**	**246**	**2,798**	**3,269**
Type 3	**3,019**	**3,518**	**91**	**132**	**3,110**	**3,650**
Northern Ireland	**42,712**	**55,564**	**2,235**	**3,227**	**44,947**	**58,791**

Source: Regional Data Warehouse, Business Services Organisation

2.10 This information shows that the vast majority of Emergency Department attendances occurred at a Type one Department (88%).

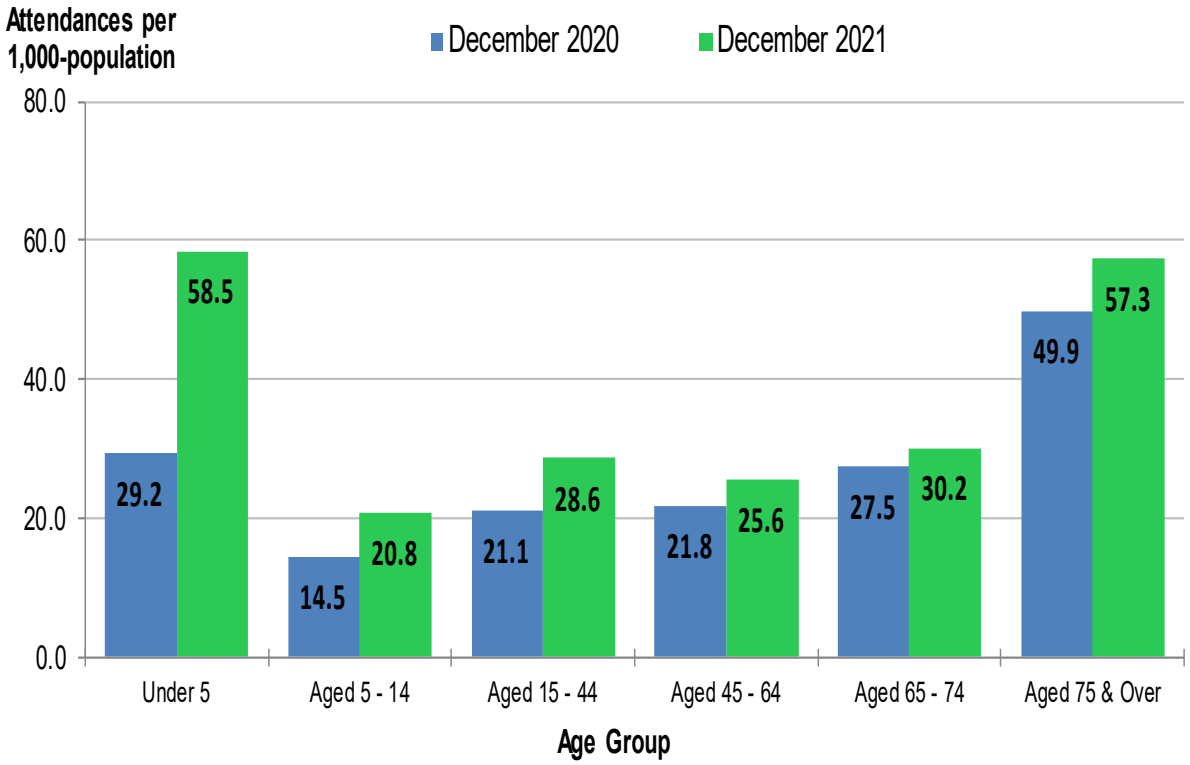
[3] Readers should note that those on an ambulatory care pathway delivered outside the ED are not included in these statistics.

[4] Readers should note that Craigavon ED includes figures for Craigavon Respiratory (COVID-19) ED (29th March 2020 - 19th October 2020), Craigavon Paediatric ED (31st March 2020 - 12th June 2020) and Craigavon Minor Injuries Unit (2nd - 14th December 2020)

[5] Readers should note the impact on attendances and changes to EDs because of the COVID-19 pandemic from the start of 2020.

2.11 Figure 3 presents information on the number of attendances at Emergency Departments per 1,000-population, broken down by the age group of those attending[6 7 8]. This clearly demonstrates that the largest groups attending are those aged under 5 and those aged 75 and over. As the DoH population health needs assessment demonstrated, the 75 and over age group is projected to grow in the coming years, which will drive an increase in demand for emergency care.

Figure 3: Attendances at Emergency Care Departments per 1,000-population, by Age Group (December 2020 – December 2021)[9 10]



Source: Regional Data Warehouse, Business Services Organisation

[6] Data on the age of those attending ED are not National Statistics, but have been published to provide users with a comprehensive view of emergency care activity and time spent in ED.

[7] Readers should note that those on an ambulatory care pathway delivered outside the ED are not included in these statistics.

[8] Readers should note the impact on attendances and changes to EDs because of the COVID-19 pandemic from the start of 2020, see Appendix 2 for details.

[9] Excludes cases where the DOB could not be determined.

[10] Based on the NISRA 2020 mid-year population estimate, which was published on 25th June 2021.

Intermediate / Community Care

2.12 Urgent care provided in the community is an integral and important part of our overall urgent and emergency care system. Intermediate care through 'Acute Care at Home' is currently being delivered in three (Belfast, Southern and Western) of our five Health & Social Care Trusts (HSC Trusts).

2.13 This consultation report suggests that we should build on this momentum to provide a regionalised '**Hospital at Home'** service. This will provide intensive hospital level care for acute conditions that would normally require an acute hospital bed, in a service user's home for a short episode, through multi-disciplinary healthcare teams. Service users under the care of the 'Hospital at Home' team will not normally attend hospital for clinical assessment for any care or treatment within the remit of the team. Suitable arrangements will be made to ensure access to telephone advice or virtual consultation, assessment in the community and if necessary admission to the Emergency Department or directly to the hospital based speciality. This will require partnership working across the urgency and emergency care service areas and is core to the ethos of the new models.

2.14 Whilst outside of the scope of this Review, the important role played by community pharmacies in managing urgent care needs must also be recognised.

3 REVIEW THEMES

3.01 During the course of the Review, a number of key themes emerged that should guide transformation of the urgent and emergency care model. These are set out below.

Accessibility

3.02 As the review team advanced work it became abundantly clear that there were problems with accessibility throughout the system.

3.03 Service users and carers complained that they often found themselves in a complex environment where they were unable to access the correct person, specialty, test or treatment. 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.

3.04 Clinicians equally reported difficulties in accessing the correct person, specialty or diagnostic test to expedite the service users' care. Many clinicians complained that they could only access care via an Emergency Department and this was often not the best or correct place but was unfortunately their only option. We heard clearly of the need for standardised alternative pathways, such as Hospital at Home, with responsive multidisciplinary capacity.

3.05 On reviewing other health systems in the UK, Europe and internationally 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.

3.06 By creating an integrated urgent care system with rapid access assessment and treatment services, services users and health professionals will have much better access to the correct person and place first time. A direct booking and scheduling service linked to urgent care centres, assessment units, Hospital at Home teams and rapid access treatment services reduces the system's dependence on crowded Emergency Departments. Service users will have better experiences and ultimately outcomes.

Co-ordination

3.07 Many health professionals and service users felt that our health system was at times disjointed and could be better coordinated. Members of the ambulance service particularly pointed to a lack of coordination and joined up thinking between providers when it came to urgent and emergency care. 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 hospital-based care to community and social care.

3.08 Leading health systems exhibit high levels of coordination. Many use directories of service to make sense of and to navigate a complex system. 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 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 healthcare summit held in June 2019, 91% of attendees wanted urgent and emergency care delivered in a regional way. Coordination is essential for any healthcare system to work effectively. This is especially true for urgent and emergency care.

3.09 Service users and healthcare workers related how coordination between many parts of the healthcare system was disjointed. Developing an integrated urgent care system with rapid access assessment and treatment services will improve the coordination throughout the system. Key enablers such as a regional Phone First system, the directory of services and a direct connection with specialists through a single point of access will improve coordination between primary, secondary and specialty care, and intermediate care services.

Standardisation

3.10 At the June 2019 healthcare summit, 88% of attendees indicated that they wanted to see standardisation across the region. Healthcare practitioners, service users and carers complained of a multiplicity of terminologies and processes. Clinical pathways were also often not standardised and this was especially evident around HSC Trust boundaries where service users and general practitioners reported that one HSC Trust had a pathway for a condition and the neighbouring Trust had a different pathway for the same condition. Anecdotal stories described how elderly parents had been moved in with relatives to facilitate access to a better pathway in a different HSC Trust.

3.11 In healthcare we prevent harm to service users by reducing variation and standardising pathways and practice. The lack of standardisation in our system is very apparent. HSC and provider organisations should standardise as far as possible clinical pathways, functionality and terminology. A regional approach with regards to telephony and a directory of service will support a move towards a reduction in variation between areas.

Silos, barriers and poor communication

3.12 When discussing our health care system with clinicians and practitioners and service users at the many engagement events that were held, the subjects of siloed working, barriers to the patient journey and poor communication were frequently brought up.

3.13 The Northern Ireland healthcare system seems to have drifted towards a silo mentality at many levels. It was evident in the separation of primary, secondary and intermediate 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 prevented a smooth patient journey. One service user described it as a 'computer says no' attitude in the healthcare system. We need to re-establish trust, improve our communication and rid our health system of silos and barriers.

3.14 By creating enablers such as a regional directory of service, organisational interoperability and regionalised clinical pathways we will ensure that different aspects of the health care system work together to achieve the best experiences and outcomes for service users. The No More Silos Action Plan and Intermediate Care Project are aimed at tackling these issues and this Review reinforces that direction of travel.

Workforce and Training

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

3.16 On discussion with healthcare practitioners in Northern Ireland, many voiced frustrations regarding what they felt was a more limited scope of practice than some of their counterparts in England. Most were keen to take on extended roles and expand their scope of practice. Medical practitioners, royal colleges

and professional bodies alike propounded a view that their specialty needed to increase training numbers to prepare for future challenges and changes.

3.17 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. Urgent Treatment Centres and assessment units were often managed by Advanced Clinical Practitioners from many professional backgrounds. It is critically important that we take into account workforce in any new model moving forward as we will need to consider well in advance the volumes of staff required and how we train and retain the staff to support our new models. Without proper workforce planning and investment, it will not be possible to deliver on the proposed strategic priorities.

Capacity and Flow

3.18 The efficient movement of service users through a health care system is vital for both the effective use of limited resources and the achievement of safe care. Crowding of Emergency Departments and delays in the discharge of service users to the most appropriate environments were themes that regularly came to the fore during the Review, alongside missed opportunities through admission avoidance and supporting earlier discharge through intermediate care services.

3.19 There is a debate on the balance between increasing the number of hospital beds, increasing capacity in the community and improving the flow through hospitals. Proponents of increasing capacity point out that we have fewer beds per thousand of the population than some other health systems. Advocates of improving the flow through the system argue that we cannot simply 'build' our way out of the crowding problem but need to concentrate on improving the efficiency of the overall health system. This may also mean additional capacity in the community to support timely discharge and flow through our hospitals. Above all, we need to understand this problem across the whole unscheduled care system in much more detail. An evidence based capacity review will assist in informing future action on these interconnected issues.

An Inefficient System

3.20 While engaging with both healthcare professionals, service users and carers groups there were multiple reports of inefficiencies within our systems.

3.21 Health professionals pointed out that there was unnecessary duplication at many stages of the service users' journey. For example, if a GP refers a service user for an opinion about an urgent problem, the individual will likely see a junior doctor in the Emergency Department who will then refer the service user onto

another junior doctor in a specialty who will then refer onto a registrar who may then speak to the consultant. At any point in the process the service user may be referred back to their GP without the medical issue being definitively resolved. Often the whole process then starts again.

3.22 Better performing health systems in other parts of the UK and Europe eliminated these redundant processes by ensuring the service user saw the right person, first time, in the right place. Clinicians and service users alike were frustrated by inefficiencies in the system. By involving specialties more directly in the care of service users, we remove duplication and resolve medical problems more quickly and efficiently. By facilitating direct admissions and assessments and fully exploiting community based services, fewer service users will be queued and delayed in crowded Emergency Departments. Emergency physicians will then be able to dedicate more time to those that require their immediate attention.

Building on good practice

3.23 On discussing our urgent and emergency care system with the healthcare professionals, service users and carers, it was also clear that there were many areas of excellent and innovative practice. Several Trusts were already beginning to model the concepts of urgent treatment centres or exploring medical and surgical assessment units. Others had invested further in the expansion of intermediate care models such as Hospital at Home and anticipatory care. New practices were also emerging in paediatrics. Prior to the pandemic, significant technological advances in the form of an electronic medical records as well as a directory of services were being developed. The implementation of the No More Silos Action Plan and the Intermediate Care Project have built on this existing good practice. The proposals in this consultation report builds on these experiences and we now need to go further.

Digital Solutions

3.24 In a context of limited resources and growing demand for urgent and emergency care services, we need to support reforms by harnessing digital solutions. Important lessons have been learned both before and throughout the pandemic and we now need to build these to maximise the opportunities that digital solutions affords.

3.25 One recent example is the 111 Pandemic Helpline. At the outset of the pandemic, this was activated in Northern Ireland. We coupled this with the introduction of a triage script for COVID to help assess the severity of

symptoms: potential for self-management; and diagnosis of symptoms. This had a significant impact in reducing onward referral to GPs and the GP Out of Hours (OOH) service.

3.26 At peak the helpline was managing 6,000 calls daily and was managing an average of 2,300 calls during March 2020. On 23rd March 2020, the Department released an app and online symptom checker; a smart search 'chatbot' to answer questions; and a link to COVID resources. Following the launch of the app, calls to the helpline decreased substantially, falling to under 300 per day. Use of the app rose to approximately 6,000 per day, with some 29% involving symptom checks. Only 13% of those checking symptoms were advised to seek clinical assistance. The remainder were advised self-isolate, get tested and provided with advice on how to self-manage (or advised that they didn't have symptoms).

3.27 Digital resources can help citizens make sensible decisions in managing their own care, reducing the need to seek professional advice on every occasion. With limited capacity and staffing in the HSC sector, a digital shift in the management chronic illness could significantly alleviate pressure on services. If this was coupled with monitoring solutions and Artificial Intelligence, care planning and community intervention with specialist nurses, the unrealised potential is very significant.

3.28 Likewise the Encompass programme and wider use of consistent data in monitoring and performance managing services will be important as we progress our urgent and emergency care reform agenda.

3.29 Once we conclude this public consultation, identify final proposals and move to the implementation phase, it is essential that digital solutions is at the forefront of our plans to support future delivery of urgent and emergency care. In doing so we will recognise the limitations for some service users, such as those who lack access or knowhow to effectively use digital services.

Mental Health

3.30 While much work has taken place in recent years to improve mental health crisis services, such as multi-agency pilots and the creation of mental health liaison in Emergency Departments, it was accepted that mental health crisis services in Northern Ireland were in need of reform.

3.31 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, completed in April 2021, considered evidence from literature,

best practice, and service user perspectives and provided 15 recommendations.

3.32 A new regional crisis service was announced on 24 August 2021. This new service seeks to provide a regional approach to mental health crisis, where people of all ages 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.

3.33 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. This is true for all age groups, including children and young people. The new crisis service involves mental health services working with Emergency Departments and other emergency care services to provide alternatives for people of all ages. This could include mental health practitioners working in partnerships with Urgent 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.

3.34 The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are leading on the implementation of the new crisis service, with HSC Trusts responsible for regionally consistent delivery. 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.

3.35 The HSCB is due to close in March 2022. The functions of the HSCB will transfer to a new Directorate within the Department of Health, which will be called the Strategic Performance and Planning Group (SPPG). Where the HSCB is referenced in this consultation report, the roles ascribed to it will become the responsibility of the new SPPG group.

Paediatric Services

3.36 The Review Team Report suggests that around a quarter of all Emergency Department attendances are children and young people. It is important to recognise that children's needs are different to adults' and require a specialist approach in relation to urgent and emergency care.

3.37 The Department's Paediatric Strategy[11] recommended and has supported the development of short stay paediatric assessment units. Currently children can be referred straight from the community to the paediatric assessment units in all HSC Trusts, except for Belfast. These short stay paediatric assessment units are a crucial part of the Urgent and Emergency Care system.

3.38 More generally the services envisaged in this report, including Phone First, Urgent Care Centres and the integrated Out of Hours service, will serve the whole population from the youngest to the oldest. It will be important that paediatric pathways are in place to support these service models and this will be a key part of the implementation phase of this Review.

Discharge

3.39 Timely discharge was raised as an important issue both during the course of the Review and during the pre-consultation engagement. Whilst discharge is outside of the scope of this Review, work has been undertaken elsewhere by the DoH, the HSCB and the PHA.

3.40 A Regional Discharge Group co-chaired by the HSCB and the PHA has been established. This Group has identified three key priorities in an effort to help expedite discharges from our acute hospitals. These are Nurse Facilitated Discharge; Home for Lunch; and Discharge to Assess.

3.41 The Regional Discharge Group is working in partnership with HSC Trusts to enable the implementation of these priorities. Monitoring arrangements have been developed to provide oversight of performance against the 3 key priorities. Targets for improvement were agreed with HSC Trusts in September 2021. To date improvements have been delivered across two of these areas. Nurse facilitated Discharges have increased from 7% to 11% since September 2021. The number of patients discharged under the Discharge to Assess pathway has doubled since August 2021.

3.42 The Minister also invested £23m in November 2021 to improve the terms and conditions of Independent Sector domiciliary care workers. The aim was to add capacity in to the system to facilitate timely discharge. HSC Trusts are also in the process of developing proposals on how they can support the care home sector's move towards a '7 day per week' assessment / admission model. This will assist patient flow by enabling discharges to the care home sector to take place more easily at weekends.

[11] https://www.health-ni.gov.uk/sites/default/files/publications/health/paediatric-strategy-hospital-andcommunity.pdf

Summary

3.43 It must be stressed at this stage that the issues in our Emergency Departments are in no way the fault of the service users who attend them. However, the fact is that our system has been far too reliant on Emergency Departments as the access point for a multitude of secondary and tertiary care services.

3.44 This needs to change. It is essential that we put in place systems to deal with the growing number of service users requiring urgent care, while also ensuring that Emergency Departments and hospitals are able to deliver the timely care that service users with life-threatening emergencies need.

3.45 The purpose of this stage of the Review is to set out and consult on a new approach to urgent and emergency care services across Northern Ireland. The ambition is to improve the service and improve the service user experience by ensuring greater accessibility to services and by making it easier to access the most appropriate service as quickly as possible in a location most suited to the service user, without necessarily having to attend an Emergency Department to do so. This builds on the experience gained in relation to new service models, through implementation of the No More Silos programme.

3.46 In parallel, the DoH and HSCB are advancing with colleagues from NHS England a Getting It Right First Time (GIRFT) review of emergency medicine in Northern Ireland, which will complement the work of the Urgent and Emergency Care Review. The GIRFT programme in England examined the delivery of emergency care across the country. Through the collection and analysis of relevant data, including the development of new metrics, GIRFT enabled NHS England to better understand the causes and consequences of variation. In so doing, GIRFT has been able to identify the dominant constraints relevant to each emergency care system. It is anticipated that the work on a Northern Ireland GIRFT Emergency Medicine report will continue and that emerging findings will become available during summer 2022.

3.47 The opportunities to improve the service users' 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. Digital solutions will need to play a key role, building on existing capability and lessons learned to date.

4. CO-PRODUCTION / USER ENGAGEMENT

4.01 This consultation report has been informed by input from over 1400 key stakeholders who have been involved through a range of co-production, involvement and engagement methodologies. Stakeholders include service users; carers; clinical professionals; the third sector; and health and social care staff.

4.02 Co-production has been an integral part of the Urgent and Emergency Care Review and No More Silos projects. This has been delivered in partnership with the Regional Unscheduled Care Service User and Carer Reference Group (USCRG); local Implementation groups; and HSC Trust based service user and carer reference groups.

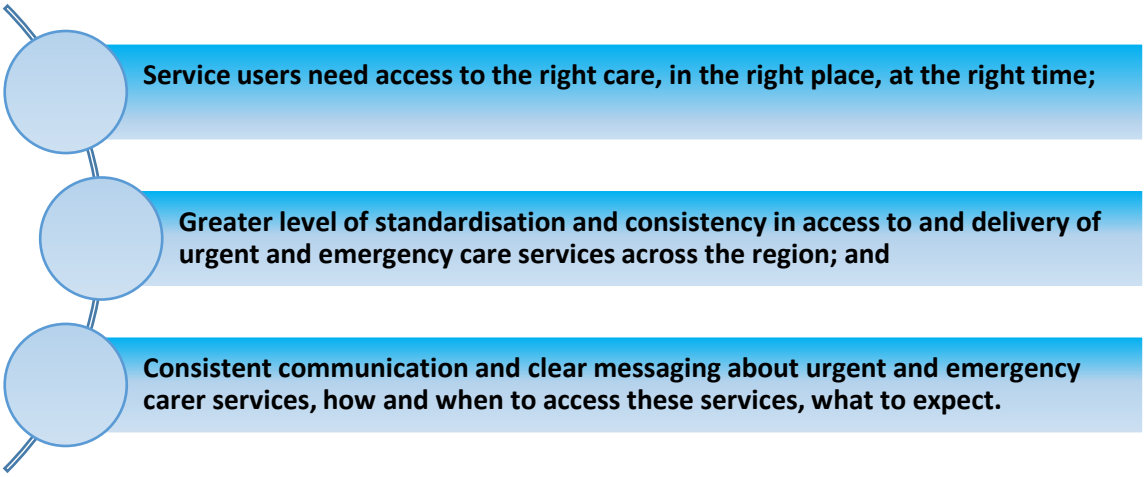
4.03 Since 2018 there have been three phases where stakeholders have informed the contents and recommendations set out in this consultation report:

- The review of urgent and emergency care project – 2018-2020
- No More Silos project – 2020 -2022; and
- Pre-consultation - early 2022.

4.04 Service user and carers have been embedded into the project structures with senior doctors from primary and secondary care, nurses, allied health professionals, policy leads from the DoH, senior managers from HSC Trusts, the HSCB and PHA.

4.05 A healthcare summit was held in June 2019, bringing together: strategic leaders and senior professionals in primary, secondary care and intermediate care; service users; carers; and charities. The summit provided the opportunity for stakeholder discussion and input at an early stage regarding potential solutions that would inform the Review. This has been supplemented with 11 service user and carer workshops; patient and carer surveys; and engagement with the third sector. Further information can be found in the Review Team Report.

4.06 The key messages arising from this engagement can be summarised as follows:



4.07 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 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.

Pre-Consultation engagement

4.08 Pre-consultation played an important part in the development of this consultation report. It provided the opportunity to test the content with specific stakeholder groups who have an interest in and experience of urgent and emergency care services. This process allowed DoH to identify areas for further development and highlighted issues that required further scrutiny in advance of full public consultation.

4.09 Targeted stakeholder engagement and pre-consultation took place with key stakeholders, and resulted in a number of significant amendments being made to the consultation proposals. These include:

- Drawing on experience of new service models developed through No More Silos during COVID-19.
- Greater consideration of hospital discharge.
- The importance of conducting a capacity review and to carefully consider the scope of such a review.

4.10 The formal consultation will provide an opportunity to further test the findings of the Review with the population of Northern Ireland; this will then provide the basis for future plans for urgent and emergency care.

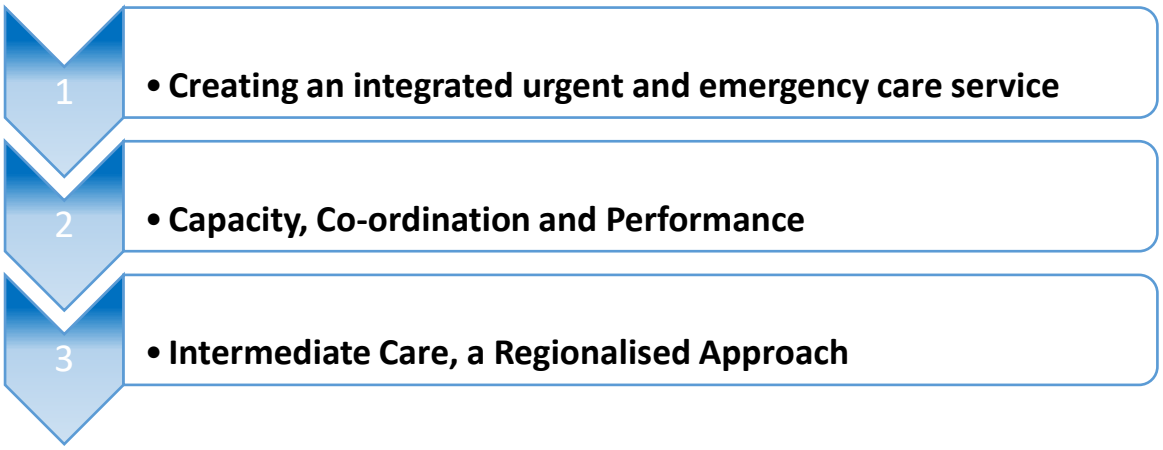
5. VISION AND STRATEGIC PRIORITIES

5.01 Each section of this Review, as detailed in the Review Team Report, has drawn a number of conclusions in respect of developing existing services and improving the provision of urgent and emergency care.

5.02 As we move to implementation, it is proposed that these conclusions should be grouped into three overriding strategic priorities, each with its own associated recommendations. These recommendations will contribute towards achieving the overarching ***Vision*** for urgent and emergency care:

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

5.03 The three strategic priorities are as follows:

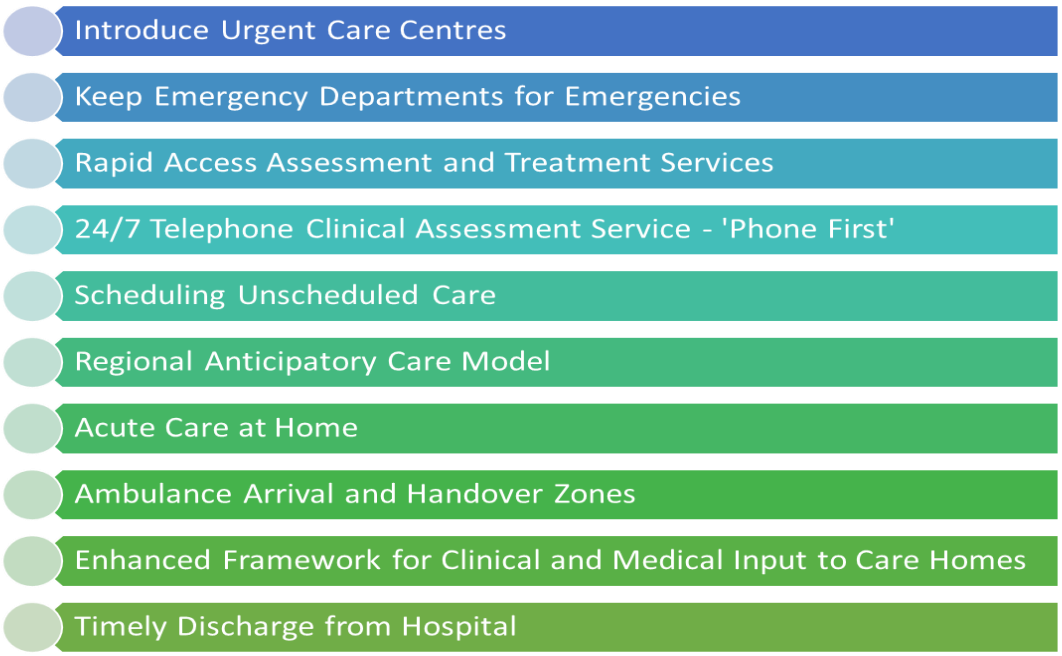


5.04 It is critically important to recognise that transformation of our urgent and emergency care system will only succeed if all three strategic priorities are implemented. They are interdependent and all essential for delivery of an improved urgent and emergency care system.

6. STRATEGIC PRIORITY 1: AN INTEGRATED URGENT AND EMERGENCY CARE SERVICE

No More Silos

6.01 In October 2020, in response to the pandemic and using the learning from the work of the Urgent and Emergency Care Review, the Department published a COVID-19 Urgent and Emergency Care Action Plan. The Action Plan was subtitled No More Silos, reflecting the overriding need for an integrated urgent and emergency care system that operates across professional and administrative boundaries in primary, secondary, intermediate and social care. The **No More Silos Action Plan** set out ten key actions that would help to ensure that urgent and emergency care services across primary and secondary care could be maintained and improved. The ten key actions were:



6.02 Whilst the Action Plan consisted of 10 key actions, it is important to note that the proposals set out under this key priority is focused on the first five actions:

- Introduce Urgent Care Centres in each Trust area.
- The continued expansion of rapid access assessment and treatment services to support urgent care centre referrals and direct access by GPs.
- 24/7 Telephone Clinical Assessment Service – a single 'Phone First' regional telephone number for Northern Ireland.

- These actions will allow for scheduling of unscheduled care; and
- Keeping Emergency Departments for emergencies.

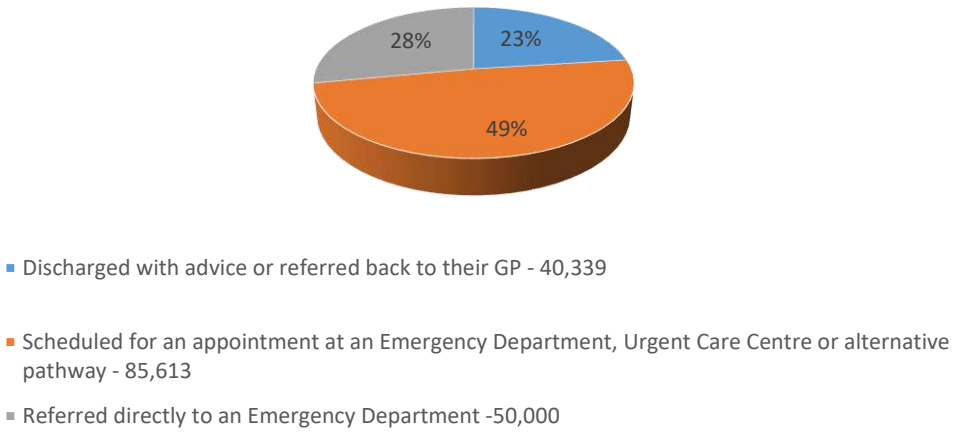
6.03 The remaining 'No More Silos' actions are included under **Strategic Priorities 2** and **3**.

6.04 The DoH has established a clinically led No More Silos network, jointly chaired by primary and secondary care clinicians, to oversee this work and drive continued improvement in urgent and emergency care.

6.05 To date, No More Silos has made significant progress against the ten key actions, with the delivery of Urgent Care Centres and a Phone First service across a number of HSC Trusts. Phone First and Urgent Care Centres provide alternatives to Emergency Departments for service users who require urgent treatment but are not facing an immediately life threatening illness. The Phone First service is currently available in the Northern, Southern and Western HSC Trusts. Lagan Valley Hospital also recently introduced Phone First on a temporary basis and an interim local service is available in Downe Hospital.

6.06 Up until 31st December 2021, almost 176,000 patients have utilised the Phone First and Urgent Care services across Northern Ireland.

Phone First and Urgent Care Services in NI



6.07 In terms of Hospital at Home, the latest monitoring data suggests a significant level of activity. For example, in Belfast HSC Trust between April 2021 and December 2021 there were more than 1,000 referrals to Hospital at Home. In Southern Trust more than 1,200 patients were referred and accepted to Hospital at Home during the period April 2021 to November 2021. The HSCB is currently working on the consistent capture of this data, including the outcomes. However, the early emerging data captured suggests a considerable

impact on Emergency Department attendances, hospital admissions and discharges.

6.08 Delivery of elements of the No More Silos programme has been positive to date. Whilst progress has been made in relation to the development of urgent care pathways for service users not requiring admission, we have not seen the same level of impact in relation to service users requiring urgent assessment by acute medical services. In many cases, these are also the service users who wait for long periods in Emergency Departments following a decision to admit. There is also the potential to develop an equitable standardised approach to 'out of hospital' services. This is included in **Strategic Priority 3**: 'Intermediate Care, A Regionalised Approach' and expands further on the opportunities for 'Hospital at Home' services within the No More Silos Action Plan.

6.09 The nature of the implementation of No More Silos, introduced during the pandemic, with a remit to move swiftly and for delivery predominantly via a local implementation group structure (ensuing collaborative leadership and co-production in each HSC Trust area), means that HSC Trusts have implemented different approaches and models to a number of the No More Silos ten key actions. There must now be a greater focus on standardisation and regionalisation across the key actions, as detailed below, acknowledging that some local variation is likely to be necessary.

Rapid Access to Clinical Assessment and treatment

6.10 The fundamental purpose of rapid access assessment and treatment services is to identify what the patient needs as quickly and accurately as possible, then to be able to connect them with the care they need as seamlessly as possible.

6.11 The new model of rapid access assessment and treatment will streamline and improve patient care across the urgent care system. It fundamentally redesigns the urgent care 'access point' to offer easy access to health care services that are fully integrated with all aspects of the system.

6.12 The changes will see healthcare services cooperating and collaborating to deliver a rapid, high quality, clinical assessment, advice and admission to hospital or a community based crisis response service that improves the service user's experiences and outcomes.

6.13 Introducing new options for assessment, admission and ambulant care with a consistently available community option will appropriately reduce the overall footfall through Emergency Departments resulting in less congestion. Reducing the number of admissions and length of stay by ensuring equitable provision of

community based alternatives such as same day care and intermediate care services that can respond to meet acute needs in the service users own home will help improve flow and ultimately patient experience and outcomes.

6.14 This change will deliver the ***right care, with the right person, in the right place, first time.***

An Integrated Urgent and Emergency Care System

6.15 It is recommended that the No More Silos Network should introduce an integrated urgent and emergency care system across all provider organisations. This will involve 'Phone First', supported by Urgent Care Centres in conjunction with rapid access assessment and treatment services. This will fundamentally change the way service user's access health services, meaning that they will receive a complete episode of care, quickly, in the right setting.

6.16 In establishing the new system, it is recommended that the No More Silos network should ensure all provider organisations adhere to a minimum set of standards, as set out at **Annex A**. Providers may also choose to build upon or add to these, according to their requirements.

Integrating Phone First and GP Out of Hours (OOH)

6.17 In setting up a new integrated urgent and emergency care model, it is important that the public can access care through a single, easily accessible number as opposed to an array of different access points. The information provided by the patient through their first contact with the system should follow them across the health and care sector throughout their episode of care.

6.18 GP Out of Hours (OOH) services are closely linked to other unscheduled care services across the health sector, including daytime GP services and Emergency Departments. There are currently 19 OOH centres across Northern Ireland; these are managed by 5 different provider organisations. Three of the OOH services are provided by HSC Trusts while two are provided by Mutual organisations. For a variety of reasons, including demographic change, daytime service pressure in primary care, and increasing demand for services, all of these organisations are reporting ongoing challenges filling GP sessions. During 2020, it was not possible to fill 18% of OOH planned sessions.

6.19 In line with the standards set out in **Annex A** to establish an integrated urgent and emergency care model, it is proposed that the OOH model will be reshaped to form part of the wider integrated urgent and emergency care service. The finance, staff and organisational resources available to the current OOH service would be mobilised within the reshaped model to deliver a service that delivers

the elements of the previous OOH service but in a more integrated and multidisciplinary approach. In the new model the GP practice remains the main contact point for triage and assessment for service users with urgent non-emergency issues during the in hours period. In addition to providing a more joined up service, it is expected that this will improve the sustainability and reliability of the service.

6.20 It is envisaged that the phone service would be delivered by a multidisciplinary team including staff from primary and secondary care, supported where appropriate by existing clinical support software. Referral to other services would be electronic, supported by phone call or virtual consultation as necessary. The team would have access to local acute, intermediate and community teams for advice or referral. The locality based teams would receive appropriate education and training and have access to a single regional directory. This will support the ability for them to work across geographical boundaries.

6.21 Face to Face consultation and home visits, when necessary, would also be provided by a multidisciplinary team reflecting the clinical need of the service user. The No More Silos network should ensure that the new service is integrated with the other urgent care services operating in the OOH period and that there are appropriate links with in hours provision of urgent care services, including general medical and pharmacy services, intermediate care, mental health services, Emergency Departments and rapid access assessment and treatment services.

Mental Health

6.22 As already set out, the DoH has developed a new Mental Health Crisis policy which is being implemented. For this reason, Mental Health is considered outside of the scope of this Review. Importantly, the Department will ensure that mental health policy is joined up with the wider urgent and emergency care activities through appropriate governance arrangements.

Workforce Planning

6.23 As mentioned in the introductory paragraphs, when changes are being proposed to healthcare systems, workforce and training needs must be considered. This is important for both future proofing and for enabling staff to maximise their skillsets and abilities.

6.24 As part of the implementation process for the new model, the Department will oversee the development of a regional, multi-professional workforce plan to ensure we have the appropriately skilled staff to deliver the new models in

urgent and emergency care, considered on healthcare need and based on population projections. This is critically important to the successful delivery of this Review. This work will build on the existing Urgent Care Centre staffing models in relation to this strategic priority and in relation to **Strategic Priority 3** will build on experience of current Hospital at Home staffing models.

STRATGIC PRIORITY 1 - RECOMMENDATIONS

Integrated Urgent and Emergency Care

1. **It is recommended that the No More Silos Network should introduce an integrated urgent and emergency care system across all HSC Trusts.**

2. **This will include a Regional 'Phone First' model with a single number for service users requiring non-emergency urgent care. Phone first is a clinical triage advice and guidance service designed to make it easier and quicker for service users with an urgent need to get the right advice or treatment they need.**

    - **It will provide advice, guidance and navigation for people who are unwell and considering attending an Emergency Department. It operates all day every day.**
    - **At evenings and weekends it also provides access for people who wish to contact the GP Out of Hours services.**
    - **Service users requiring emergency response (such as collapse, stroke, heart attack or major trauma) will continue to use 999 as appropriate.**

3. **The 'Phone First' model will also need to be accompanied by establishment of Urgent Care Centres and rapid access assessment and treatment services in all HSC Trusts.**

4. **As part of the new model, the current GP Out of Hours service will be reshaped to form part of the wider integrated urgent and emergency care service.**

5. **In establishing the new system, it is recommended that the No More Silos network should ensure services adhere to the minimum set of standards (Annex A of the consultation report). Providers may also choose to build upon or add to these, according to their requirements.**

6. **The Department of Health will oversee the development of a regional, multi-professional workforce plan to ensure we have the appropriately skilled staff to deliver the new models of care in Urgent and Emergency Care. This will build on the experience of Urgent Care Centres currently in operation.**

7. STRATEGIC PRIORITY 2: CAPACITY, CO-ORDINATION AND PERFORMANCE

7.01 Performance against Ministerial targets at Emergency Departments has been declining for many years. Waiting times for admission to hospital from Emergency Departments are rising, with older people waiting longer.

Capacity

7.02 During the course of the pandemic, there has been significant work to ensure that management information on bed capacity is as accurate and responsive as possible. Up until October 2020, capacity data reflected commissioned beds. While this was a suitable system prior to the pandemic, it did not take into account pandemic related factors such as staff vacancies or absence, or the reduced physical capacity in hospitals due to the required infection, prevention and disease control measures.

7.03 New data systems were implemented in October 2020 and are reflected in the DoH Covid-19 dashboard. As well as more regular updates on actual operational capacity, the data in the dashboard also now reflect the number of service users for whom a Decision to Admit has been made (e.g. from an Emergency Department), thereby reflecting more accurate occupancy levels across hospital sites.

7.04 The National Audit Office has suggested that hospitals operating with average bed occupancy of higher than 85% can expect to have regular bed shortages. The information in the dashboard shows that our hospitals have been operating above this level for the whole of the period since October 2020, and likely before then given the previous weaknesses in the available data.

7.05 It has been highlighted earlier in this report that there is an ongoing debate on the appropriate balance between hospital bed capacity, community capacity and greater focus on flow and discharge. In this context, it will be important to carry out an evidence based review of capacity to meet future demand. The DoH will give careful consideration as to the scope of this capacity review. This work will be informed by the independent GIRFT Emergency Medicine Review. We will also carefully consider the merits of delivering it using internal resources, or appointing an independent third party.

7.06 It must also be noted that whilst focus has been directed to ensure management information is accurate and responsive for Emergency Departments and acute hospitals, efforts must be continued to ensure similar levels of information are available across all elements of the integrated urgent and emergency care

system with a particular focus on out of hospital care. This allows for whole system knowledge and appropriate co-ordination.

Demand

7.07 While the new integrated urgent and emergency care system will help to encourage more efficiency within the system, it will not resolve the issues around capacity. There are intense pressures currently at all major Emergency Departments in Northern Ireland and these are resulting in long waits and slow ambulance turnaround times, which has an ongoing impact on the wider community. While these pressures to some degree may be attributable to the impact of the pandemic, allied to continued increases in waiting times for planned care, they are part of a long term trend.

7.08 It is projected that the number of admissions for the population aged 65 and over will increase by 25,800 over the next five years. 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.

7.09 Hospitals have been struggling with these pressures for several years. While there was a significant reduction in the number or service users attending Emergency Departments during the initial phases of the pandemic, it is evident that demand is now returning to its long term trend.

7.10 There is also growing evidence that the unacceptable waiting times for elective care are translating into increased numbers of service users presenting to General Practice and hospitals with advanced acute needs. In order to deal with this, and future winters, the system will require the efficiencies delivered through the new integrated urgent and emergency care system; potentially an increase in inpatient bed capacity and unscheduled assessment capacity in key medical specialties; and potentially an increase in unscheduled out of hospital care.

7.11 Through the findings of the DoH Population Health Needs Assessment, we know already that the 'Medical Take-in specialties of General Medicine, Thoracic Medicine, Gastroenterology and Cardiology accounted for 65% of the increase in hospital admissions between 2009/10 and 2016/17. These specialties have higher emergency admission rates among older people. In the coming months, work will be carried out by the HSCB to identify the highest priority areas for additional capacity and the pathways/models that will have the greatest impact on current pressures. The proposed capacity review will be required to provide further evidence on the capacity gap and the balance of where additional investment would best service the local population.

7.12 It must also be noted that when we refer to increasing capacity, this really means increased investment in additional doctors, nurses and other health professionals. Even with additional investment, there are likely to be issues in relation to the supply of trained, qualified staff to carry out these roles. It will

take time to grow the workforce to the level required to meet demand for services. However, this should not detract from efforts to understand the scale of the capacity gap; and the appropriate balance between hospital beds, community capacity and greater focus on flow.

System Capacity

7.13 The pressures at Emergency Departments are the symptom of pressures in other parts of the health and care system. Many of the benefits of the new integrated urgent and emergency care system will only be fully realised if there is capacity in other parts of the system. The DoH has developed detailed plans for eliminating the capacity gap for elective surgery, cancer services and mental health. If the necessary level of investment required to deliver these plans is made available, this will reduce demands on unscheduled care. The delivery of these planned services in a timely way will help reduce the number of service users requiring urgent care. In recognising this, the DoH has commenced work on the Intermediate Care Project through the No More Silos Action Plan and included it as Priority 3 within this Review.

7.14 The Northern Ireland Ambulance Service (NIAS) also continues to face severe pressures resulting in delays in handing over service users leading to poor experience and increased risk, and reduced capacity available in the community to respond to calls waiting. In considering the capacity requirements for the urgent and emergency care system, it is vital that capacity within the ambulance service is also addressed. NIAS is a truly regional service and is absolutely essential to ensure that people across Northern Ireland can access emergency care services.

7.15 NIAS has carried out an extensive demand and capacity review in relation to its services and developed a new clinical response model (CRM). The work identified significant gaps in staffing and vehicles necessary to deliver the new model and meet performance targets.

7.16 NIAS has developed detailed plans for the implementation of the new clinical model but additional recurrent investment is required to enable the service to meet the necessary performance standards. Until this capacity gap is addressed, this will mean more service users waiting longer to be conveyed to hospital.

7.17 NIAS has experienced steadily rising demand and deteriorating response time performance over the last four years. Having the right resourcing in place is critical to the ability of NIAS to improve services and outcomes for service users. The new CRM will improve the quality of service, lead to more efficient vehicle disposition, avoid unnecessary attendance at hospitals and lead to improvements in staff morale. Developments in information systems will allow improvements in the quality of service delivered to service users.

Performance Management

7.18 In addressing the ongoing unscheduled care pressures across the HSC, the HSCB has established an Unscheduled Care Regional Group to consider issues relating to capacity, co-ordination, and flow.

7.19 Ensuring effective use of available capacity will also require effective performance monitoring and performance management functions. In order to be able to improve services and benchmark performance, it is important that there is a shared understanding of performance standards and an assurance that all sites and services are working to comparable standards. The use of common metrics and data will be paramount. The completion of a GIRFT Emergency Medicine report for Northern Ireland will provide a good starting point for a greater focus on evidence based performance management.

STRATEGIC PRIORITY 2 – RECOMMENDATIONS

Capacity, Co-ordination and Performance Management

7. **As part of the implementation of the recommendations of this Review, and taking into account the implementation of the strategies highlighted above, it is recommended that the Health and Social Care Board should lead an initial piece of work to establish where additional capacity would have the greatest impact in reducing pressures on urgent and emergency care services.**

8. **Following the completion of a Getting It Right First Time (GIRFT) Emergency Medicine Report, it is also proposed that an evidence based capacity review will be carried out. Careful consideration will be given as to the scope of this capacity review and to the merits of appointing an independent party to complete it.**

9. **In the longer term, it is recommended that the Health and Social Care Board work, the GIRFT report and the capacity review should be used to guide additional investment in unscheduled capacity both for in hospital services and also for out of hospital services, across provider organisations.**

10. **Alongside work to increase capacity, the Health and Social Care Board has established an unscheduled care hub to monitor urgent and emergency pressures. While this will not reduce unscheduled care pressures, it is expected to improve co-ordination across the region.**

11. **There are already plans in place to significantly increase HSC capacity in key areas such as cancer, elective care, mental health and social care. Provided the necessary levels of investment are available to implement these strategies, this will address some, although not all, of the capacity issues set out in this report.**

12. **Implementation of the Northern Ireland Ambulance Service Clinical Response Model must be a system priority to ensure equitable access to emergency care for people across Northern Ireland.**

13. **As part of a strengthened performance management function, the Health and Social Care Board will, informed by a GIRFT report for Northern Ireland:**

    - **Agree a small amount of comparable performance parameters for acute sites;**
    - **Benchmark and monitor acute performance; and**
    - **Agree and monitor delayed discharge information to inform service development in acute and community services; and**
    - **Further develop and standardise information available across all elements of the integrated urgent and emergency care system with a particular focus on out of hospital care.**

8. STRATEGIC PRIORITY 3: INTERMEDIATE CARE – 'A REGIONALISED APPROACH'

8.01 Responding to the needs of the new urgent and emergency care model along with the predicted demographic changes by delivering out of hospital services as we have done in the past will simply not be enough. As outlined in the Review Team Report, there is a significant body of evidence which suggests that when frail older people are admitted to hospital they are more likely to experience poor healthcare outcomes. These include increased delirium, inpatient falls, muscle ageing and functional decline, which will ultimately result in a poor service user experience and reduced independence post admission. There is no doubt that attending and waiting for long periods in our Emergency Departments can be a distressing and confusing experience for older people.

8.02 For many years the DoH policy has been to promote independence and to move care away from institutions. Intermediate care services must be seen as central in delivering this for out of hospital, unscheduled services.

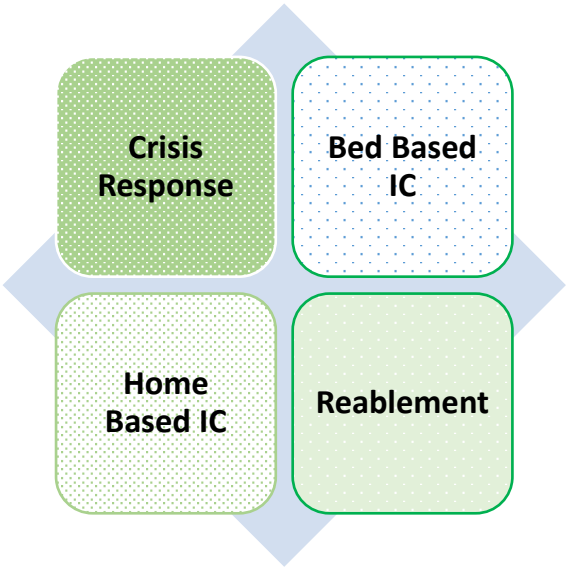
8.03 Intermediate care (IC) is an umbrella term used to cover a wide range of community based services designed to respond to the needs of our older populations' unscheduled events, with the central aim of:

- Proactively caring for service users, thereby preventing unnecessary admission or attendance at hospital;
- Allow individuals to retain their independence and live in their own home as long as possible;
- Provide care outside the hospital environment, in the community or in the individuals own home.

8.04 National evidence gathered on IC services culminated in the production of the National Institute for Clinical Excellence guidelines, 'NG 74' which defines Intermediate Care as:

'*A range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admission and premature admission to long-term care; support timely discharge from hospital; and maximise independent living.'*

8.05 The guidelines describe these integrated services under four pillars of care:



8.06 They recognise that older people's care is often better managed through intermediate care services, rather than in a hospital environment. However, for these to be truly effective within the new urgent and emergency care model it is vital they are provided equitably across Northern Ireland, that they are responsive and delivered by teams with the right skill mix and capacity to respond to the unscheduled urgent need as it arises.

8.07 *Health and Wellbeing 2026: Delivering Together*[12] set out a vision for Acute Care at Home in which service users, often frail and elderly, are treated in their own homes by doctors, nurses and other staff. Conditions such as chest infections, urinary tract infections and dehydration can all be safely treated without the need to go to hospital, which can be a worrying and anxious experience for many. Service users will have, within their own home environment, the same access to specialist tests as those in hospital and receive consultant led assessment and treatment. This is also highlighted as a priority within the No More Silos action plan.

8.08 The DoH has recognised and progressed the work needed in this area. The project team has been tasked with defining a regionally consistent framework for IC services across Northern Ireland to include the four pillars of intermediate care services. To date the crisis response, under which Acute Care at Home / Enhanced Care at Home services currently sit, has been prioritised. This has seen significant progression with the development a one model framework for 'Hospital at Home' services for Northern Ireland.

8.09 The large scope of services provided by IC along with the history of individual service design, localised implementation, embedded cultural practices and

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

variations in management structures both locally and regionally have made true service reform and equity of provision difficult to achieve. HSC Trusts have had local successes within some services and in expansion of service provision to cover greater geographical areas. However there remains significant regional service variation and inequity of provision across Northern Ireland.

8.10 This Review focuses on the need to realise a new integrated urgent and emergency care model, which offers the opportunity to fully exploit the benefits of regionalised IC services. The development and implementation of a regionalised framework for IC services is therefore seen as a strategic priority.

8.11 In recognising the breadth of services delivered under IC, detailed work has begun to co-produce service definitions, describe the nature of the service areas and the teams required to deliver these services. This will be supported with the development of standardised information parameters, which will strengthen the performance management functions in out of hospital care, in line with **Strategic Priority 2**.

Hospital at Home

8.12 Work has progressed at pace on a regionalised 'Hospital at Home' service. This will provide intensive hospital level care for acute conditions that would normally require an acute hospital bed, in a service user's home for a short episode, through multi-disciplinary healthcare teams. Service delivery will be led by what matters to the service user and the realisation of benefits for them. Home should be the hub of care wherever clinically appropriate so that inpatient care is considered only when necessary. The scope and configuration of the service will be sufficient to avoid any unnecessary hospital attendances or admissions of older people. In being truly responsive to meet these needs, teams must mature to provide extended 7 day a week service provision.

8.13 Service users under the care of the Hospital at Home team will not normally attend hospital for clinical assessment for any care or treatment within the remit of the team. Suitable arrangements will be made to ensure they have access to telephone advice or virtual consultation, assessment in the community and only if necessary admission to the Emergency Department, or directly to the hospital based speciality. This will require partnership working across the urgency and emergency care service areas and core to the new models ethos.

8.14 Detailed service frameworks will continue to be developed for the other three IC pillars including Bed Based IC, Home Based IC and Reablement services.

STRATEGIC PRIORITY 3 – RECOMMENDATIONS

Intermediate Care – 'A Regionalised Approach'

14. **It is recommended that a regionalised intermediate care programme should be implemented to ensure equitable provision across Northern Ireland, including in the Care Home sector, to the right intermediate care services, which are responsive, efficient and effective in providing enhanced clinical care in the patient's own home and supporting hospital flow.**

15. **Phase one of the project is the development of the full Intermediate Care service framework covering the four areas: Hospital at Home, Bed-Based Intermediate Care, Home Based Intermediate Care and Reablement. Phase two of the project will move to support implementation and equity of provision of these services for the population of Northern Ireland.**

9. SERVICE USER IMPACT

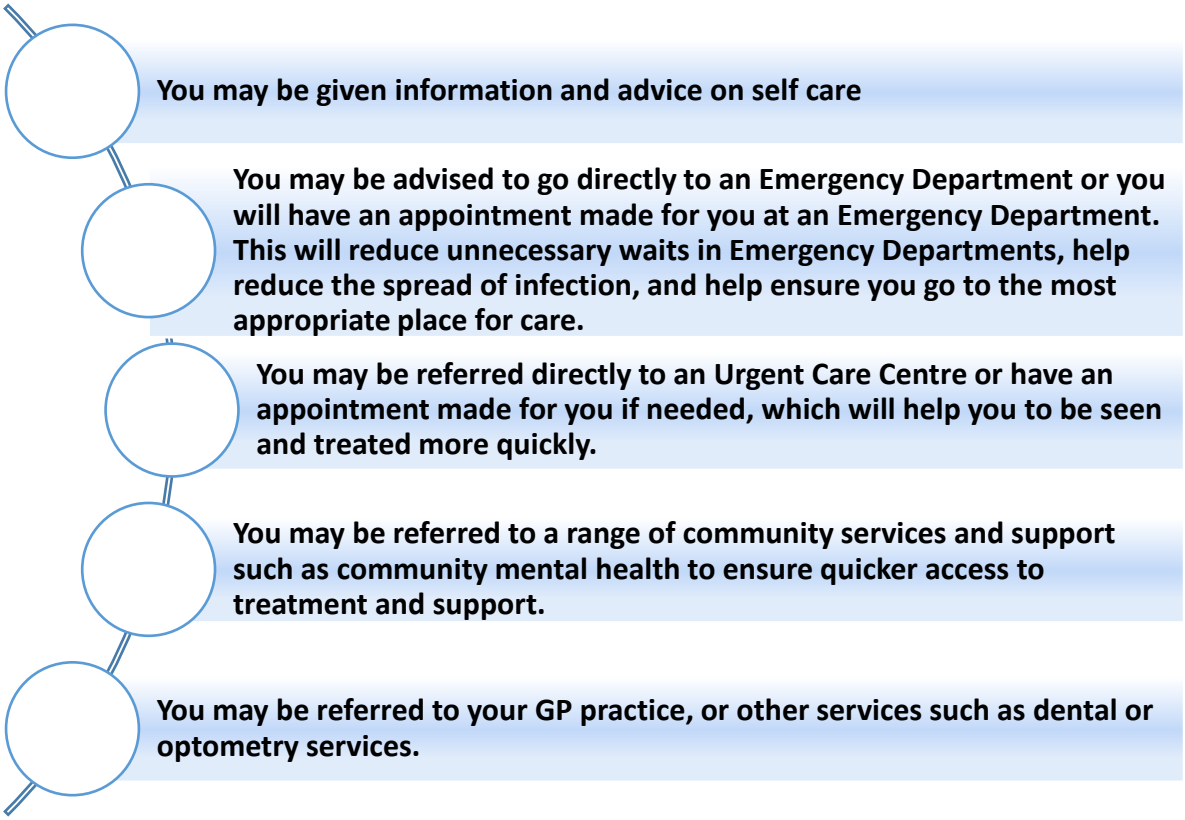
9.01 Emergency care is a vital part of our health and social care service. Emergencies are serious and life threatening. We need to ensure that patients can always access immediate emergency treatment and care in the most appropriate manner. Many of those who attend Emergency Departments may have urgent conditions which, while serious, are not life threatening and could be managed better by another service elsewhere.

9.02 The changes outlined in this consultation report highlight the plans to protect access to emergency care, whilst providing alternative services/pathways for urgent but not life threatening conditions. This will have implications for service users and it is important that these are understood. This section attempts to spell out the impact on service users of the proposed strategic priorities.

Strategic Priority 1: An integrated Urgent and Emergency Care Service

9.03 **'Phone First'** is a new way for the public to access urgent care. Anyone who considers they have an urgent but not life threatening illness and is considering travelling to an Emergency Department will be asked to 'Phone First'. They will be clinically assessed on the phone by a health professional and will then be given advice and, if needed, directed to the most appropriate urgent or community service to meet their treatment or care needs. This could include an appointment to attend an Emergency Department, an Urgent Care Centre, a Minor Injuries Unit or being redirected to their GP, pharmacist or other service. This service is already live in the Northern, Southern and Western Trust areas. It is proposed that this service will be rolled out province wide to become a 24/7, 365 days a year service, supported by one regional number.

9.04 The anticipated impacts and benefits for service users of **'Phone First'** include:



9.05 Importantly **'Phone First'** does not replace 999. For all emergencies that are life threatening always call 999 immediately. This can include stroke, heart attack, loss of consciousness, breathing difficulties, severe bleeding or major trauma. In addition, Phone First does not replace the advice or direction from your own GP practice if they advise you to go directly to an Emergency Department.

9.06 **Urgent Care Centres** are one of the new ways hospital and GP/primary care staff teams are working together to assess and treat adults and children who present with illnesses and injuries which require urgent attention but are not life threatening. Access to Urgent Care Centres will be primarily through 'Phone First' and are envisaged to be rolled out across all of the five HSC Trust areas. The centres will ideally be based at, although separate from, Emergency Department locations. However in some cases they may be stand-alone dependent on local circumstances.

9.07 It is important to note that Urgent Care Centres do not replace existing Minor Injury Units.

9.08 The anticipated impact and benefits of **Urgent Care Centres** for service users include:

- Same day/next day access through Phone First appointment between 8-10pm/7 days per week for urgent care and treatment.
- Access is also available for individuals who 'walk in' to an Urgent Care Centre.
- Joined up care and support provided by a range of health and social care professionals across medical, nursing, and allied health professionals.
- Ongoing referral to the right individual/team to continue the care treatment and support you may require.

9.09 In terms of **Rapid Access Assessment and Treatment centres**, GP's will be able to make direct appointments for service users to be seen rapidly by the right specialist (nurse, consultant, allied health professional) for assessments, tests, diagnosis and, if required, ongoing support at hospital or community clinics. Examples of this include; rapid assessment services for lung, heart and stomach problems.

9.10 The anticipated impacts and benefits for service users include:

- Your GP will now be able to refer you directly to these services if there is a concern you have a serious undiagnosed condition or significant change in a pre-existing condition.
- When you attend the clinic you will be seen by the appropriate team who will have access to appropriate tests and investigations, linking closely with your GP practice.
- More urgent conditions will be seen on the same or next day and less urgent within 7 days.
- Services will mostly be available between 9-5pm on weekdays.
- Specific referral and pathway arrangements will be developed to support individuals experiencing a mental health crisis.
- Specific referral and pathway arrangements will also be developed to support children services and older peoples' services (specific arrangements to be determined by each HSC Trust area).

Strategic Priority 2: Capacity, Co-ordination and Performance

9.11 In terms of **timely discharge from hospital**, there is clear evidence that people who are deemed medically fit suffer emotionally and physically from prolonged stays in hospital. It is therefore critically important that discussions take place

early with the individual, carer or family to agree what the arrangements will be, when the time is right, to be discharged or transferred to an environment, which can provide safer and more appropriate continuing care to meet the individual's need. Discharge arrangements can mean a return to the individual's home or temporary admission to a care home. Where possible, no decisions about permanent long term care should be made in an acute hospital setting.

9.12 Impacts and benefits for service users of **timely discharge** include**:**

- **A full understanding of your particular circumstances i.e. ability to make informed decisions, provide consent and exercise choice, control and personal autonomy irrespective of your health status.**
- **As an individual, carer, family member that you are adequately informed, consulted and prepared for transfer back home.**

- **Your views will be taken into account in relation to any decisions regarding your future care and you will be communicated with in a clear, sensitive, confidential and transparent way.**
- **The setting of an expected date of discharge within 24 hours of admission.**

- **Timely support for discharge over 7 days, discharge to take place between 8am-1pm.**
- **Carers may choose whether they wish to assume a formal caring role, bearing in mind how caring responsibilities might impact on emotional health and well-being, employment, childcare etc.**
- **Access to a carer's assessment, self-directed support/direct payments as needed to support the caring role if that is your wish to do so.**

Strategic Priority 3: Intermediate Care – 'A Regionalised Approach'

9.13 The third strategic priority involves developing a range of services to better support service users, in particular older people, at home and in the community. This includes support to care homes and hospital at home. Improving the care experience of older people is a key priority which must include individuals, carers and family members being actively involved in all key decisions regarding changes to care arrangements.

9.14 The Covid pandemic demonstrated the importance of increasing and improving support for **care homes and their residents**, The pandemic demonstrated the need for an improved HSC support and care framework for care homes. All HSC Trusts and GP practices are working together to ensure that individuals with complex needs have an appropriate assessment from a multidisciplinary team featuring a range of HSC professionals including; medical, specialist nursing, physiotherapists and occupational therapists. This includes ensuring that every individual will have a future care plan (anticipatory care plan) to support physical and emotional health and wellbeing, provide acute care and treatment as needed, and ensure the individual's wishes for continuing care are known and respected.

9.15 The anticipated impacts and benefits for **care home residents** and their families include:

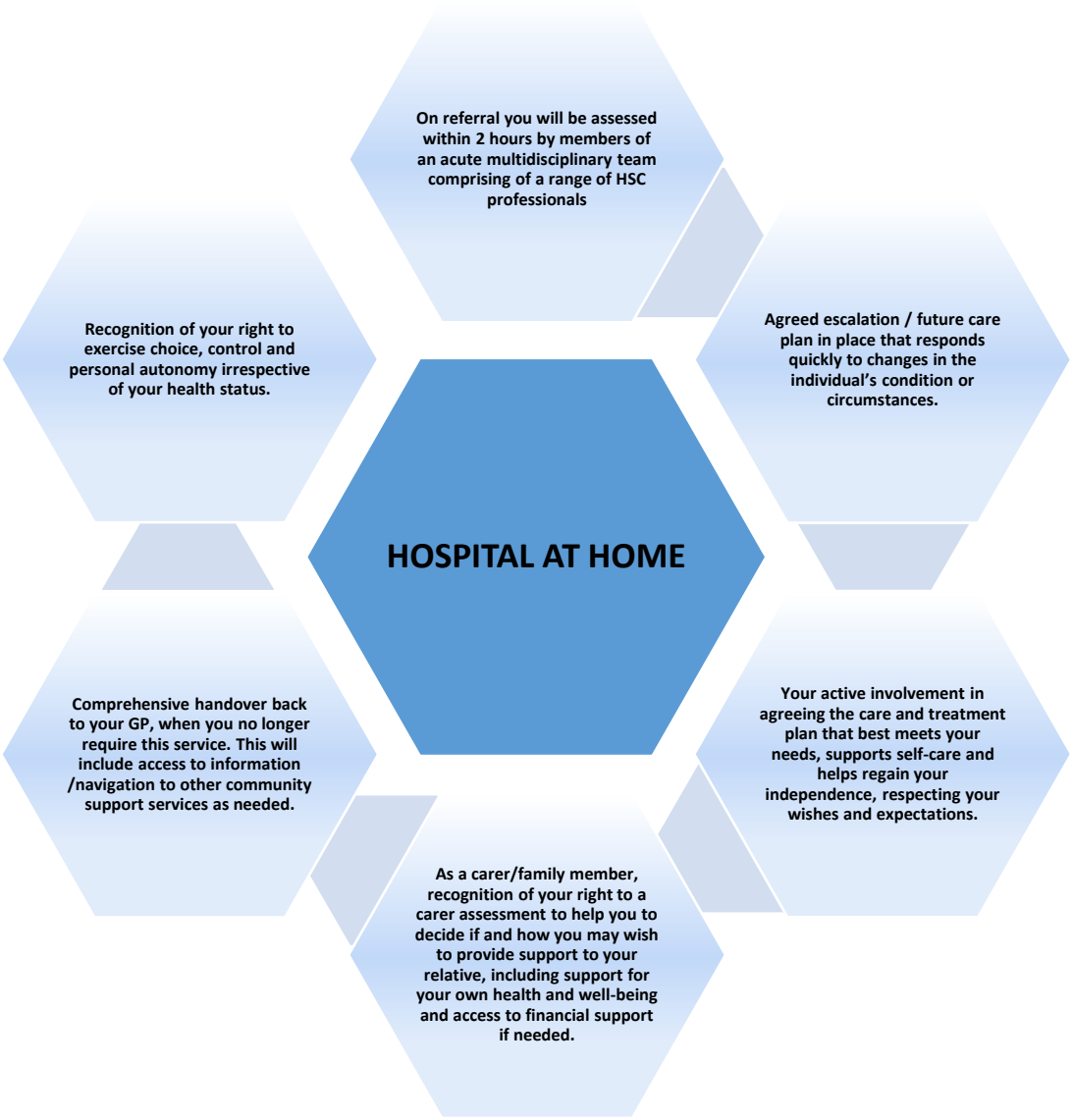
- Recognition of your right to exercise choice, control and personal autonomy.
- Your active involvement (family /staff) in agreeing your care plan ensuring it fully reflects your wishes and enables you and your family to be adequately informed on managing risks in the event of significant changes in circumstances (anticipatory care).
- Timely support and treatment by relevant HSC professionals with regular two way information and communication on the progress of your treatment.
- If circumstances arise, the opportunity to say what will be important to you and your family. This involves planning for end of life care by being involved in deciding how your needs are met, given the chance to look ahead and make advanced decisions if that is your wish.

9.16 **Hospital at Home** is a service that should be developed across Northern Ireland enabling people with more acute care needs to be treated and cared for in their own home. The service is focused on preventing individuals from being admitted to hospital unnecessarily and also to avoid unnecessary trips to

Emergency Departments. It is about having access to the right care, at the right time in the right place.

9.17 If the service user, and their family agree with the care recommendation, the Hospital at Home team will provide acute hospital type interventions in the home. The service will be able to treat a wide range of clinical and medical conditions. Should the person's health deteriorate the individual, where appropriate, they will be admitted directly to a hospital ward without attending an Emergency Department. The individual will remain under the care of the Hospital at Home team 24 hours a day until they are discharged from that team and returned to normal care.

9.18 The anticipated impacts and benefits for service users associated with **Hospital at Home** include:



10. CONCLUSION

10.01 There should be no doubt that the proposals in this report will take considerable time to implement in full and will require significant additional strategic funding. Once the public consultation has concluded, proposals will be finalised and an investment and implementation plan will be developed.

10.02 Each of the key areas set out in the Review are overlapping and interdependent. While dealing with the pandemic has helped to break down traditional barriers and the work on No More Silos and the Intermediate Care Project has enabled much progress to be made, there is much more to be done. We know that many parts of the system are already coping with unsustainable pressure and multiple demands, particularly in Emergency Departments and in Primary Care, where they have experienced significant increases in patient consultations in recent years.

10.03 The majority of people needing urgent care do not have life threatening problems so we must focus our attention on bringing the best care to people as close to home as possible, wherever they live. When service users have serious problems we must equally ensure they are treated as quickly as possible by clinical teams that offer them the best chance of recovery.

10.04 The strategic priorities outlined in this consultation report are nothing less than whole system transformation requiring collaboration and co-ordination of care across professional, administrative and geographic boundaries.

10.05 Without significant transformation we are implicitly accepting year after year of crowded Emergency Departments, long waits for service users, and continued impact on elective care services. Demand for urgent and emergency care is increasing and transformation must include a balance between targeted measures to increase capacity where it can have the greatest impact and new ways of working to make the most of the resources we have.

10.06 This will not happen overnight. It will take time to get this right and there is no doubt that it will require a commitment to recurrent investment to put in place new models of care. The current situation in unscheduled care make it hard for anyone working in the system to see beyond the extreme pressure and the controlled chaos of our Emergency Departments. As we move forward, it is vital that we create the right conditions and environment to allow the new services to be developed safely.

10.07 The transformation set out in this consultation report is ambitious. Throughout the Review, the team was struck by the commitment, creativity and passion of people working in all parts of the system. Ultimately, everyone wants the same thing – a service that allows service users to get to where they need to be as quickly as possible and which enables staff to provide the best possible care.

11. NEXT STEPS

11.08 Once this consultation has closed the Department will carefully consider the consultation responses before developing final proposals and an implementation and funding plan for Ministerial consideration. The final proposals will be published in due course.

11.09 In parallel, the Department intends to develop governance and accountability arrangements to provide strategic oversight during the implementation phase. Importantly, this will allow for a focus on outcomes, on data driven analysis of which service models that work best, are most cost effective and ultimately drive the best value for money for the population of Northern Ireland. The implementation will be driven by ongoing review of the proposed service models.

12. HOW TO RESPOND TO THIS CONSULTATION

12.01 We are seeking views on the consultation of the Review of Urgent Care Services in Northern Ireland and invite responses by no later than **15 June 2022.**

12.02 You can respond online by accessing the NI Government Citizen Space website and completing the **online consultation questionnaire** there. A link to the Citizen Space website can be found by following the link below:

https://consultations2.nidirect.gov.uk/doh-1/review-of-urgent-and-emergency-care-services-in-no/start_preview?token=2cdb62001044eed99e7f9a4b2f5f8c912dfa2595

12.03 The summary of all proposed Strategic Priority recommendations are provided at **Annex B** to this consultation report.

12.04 Easy read versions and an **Executive Summary** are also available on this link and a **Glossary** has been provided in **Annex C**.

12.03 We would encourage you to use Citizen Space, however, if you wish to send an email, please send to:

UECS@health-ni.gov.uk

12.04 A hard copy of your response can also be sent to our office:

Department of Health
Regional Health Transformation Directorate
Annex 3
Castle Buildings
Stormont
Belfast
BT4 3SQ

12.05 If you have any queries, or wish to request a copy of the consultation report in an alternate format (braille, larger print), or language, please contact the Department using the email address below to make your request:

UECS@health-ni.gov.uk

Please note that the Department will not respond individually to responses. However, a summary of all consultation responses will be published after the close of the consultation period.

ANNEX A

NO MORE SILOS: MINIMUM SET OF STANDARDS FOR AN INTEGRATED URGENT AND EMERGENCY CARE SERVICE

1. A single telephone access point, 'Phone First', will be available 24 hours a day, 7 days. Providers will have a robust telephony system in place to support Phone First.

2. Clinical decision support systems will be in place to aid the clinician to make the most appropriate healthcare decisions

3. Clinical workflow systems will ensure service services users are referred to or booked directly into a face-to-face service following clinical assessment if necessary.

4. Rapid access assessment and treatment services will be established by all service areas to ensure Phone First, Urgent Care Centre or general practitioner can directly refer urgent cases.

5. Providers must establish and keep an up-to-date, accurate Directory of Services.

6. Trusts must ensure their Directory of Service entries are configured to respond to specific patient requirements.

7. Healthcare Trusts will ensure there is easy, quick and direct access to specialist senior clinical advice for other Healthcare professionals, to support rapid access assessment and treatment services.

8. Rapid access assessment and treatment services will be directly bookable and accessed, when appropriate, from primary care, Phone First, urgent care centres, Emergency Departments, intermediate care services and by other community and secondary care clinicians.

9. All service services users should be considered for ambulatory management as a first line unless they are clinically unstable and require emergency intervention.

10. All specialties operating within a Trust will have an arrangement for rapid access face-to-face consultations in an assessment unit, rather than an Emergency Department.

11. Rapid access assessment and treatment services will be led by and should have immediate access to a senior doctor. They will be staffed by an appropriately trained multidisciplinary clinical workforce.

12. Rapid access assessment and treatment services should have access to same day diagnostics within a similar timeframe to service services users in an Emergency Department.

13. Trusts should ensure that regularly updated Standard Operating Procedures are in place for managing the day-to-day operation of clinical assessment services.

14. Protocols should be in place to manage service services users who become critically ill. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends, should be immediately available.

15. Trusts must ensure all specialties have a range of rapid access clinics available that reflect the high-volume presentations to the urgent and emergency care system.

16. Trusts must guarantee specialties have mechanisms in place to allow their service services users to contact them directly and arrange for the management of any exacerbation of their condition.

17. Providers will ensure that all specialty teams will be able to admit service services users directly to their care especially if service services users have a known chronic condition or have recently been treated by a specialty team.

18. The Provider shall develop and utilise a standardised audit system for all clinical staff which supports good governance.

19. All clinicians working within the integrated urgent care system need to be supported and appraised to provide a consistently high quality service to service users and service users.

20. A patient's registered GP should always be notified about the clinical outcome of a patient’s encounter with the integrated urgent care system.

21. The Provider shall implement a systematic process to regularly seek out, listen to and act on patient feedback on their experience of using the service, ensuring delivery of a patient centred service.

22. Performance monitoring and reporting will be required at regular intervals.

INTERMEDIATE CARE: MINIMUM SET OF STANDARDS FOR AN INTEGRATED URGENT AND EMERGENCY CARE SERVICE

The following standards will be met:

1. Service protocols or standard operating procedures will ensure safe and consistent working. These will cover triage, clinical assessment and patient clerking, senior medical review (where appropriate), diagnostics and prescribing, care and support and review, including the daily ward round or multi-disciplinary team meeting.
2. Clear accountability for preventing and responding to risks, adverse events and performance reporting.
3. A supportive culture for innovation that allows testing, adaptation and development.
4. An embedded culture of reflection and learning, for example the use of Morbidity and Mortality meetings, to learn from things that have gone well and from those that have not.
5. Teams will be embedded in local governance reporting structures.
6. An effective medicines and appropriate medicine approach which puts person-centred care and shared decision-making at the heart of care planning from the outset.
7. Teams should have access to ECR and record information on an appropriate IT system (and Encompass when it comes online) as well as access to appropriate patient monitoring systems and facilities for virtual consultation.

ANNEX B

SUMMARY OF THE STRATEGIC PRIORITY RECOMMENDATIONS

	STRATGIC PRIORITY 1 **Integrated Urgent and Emergency Care**
1	**It is recommended that the No More Silos Network should introduce an integrated urgent and emergency care system across all HSC Trusts.**
2	**This will include a regional 'Phone First' model with a single number for service users requiring non-emergency urgent care. Phone first is a clinical triage advice and guidance service designed to make it easier and quicker for service users with an urgent need to get the right advice or treatment they need.** ○ **It will provide advice, guidance and navigation for people who are unwell and considering attending an Emergency Department. It operates all day every day.** ○ **At evenings and weekends it also provides access for people who wish to contact the GP OOH services.** ○ **Service users requiring emergency response (such as collapse, stroke, heart attack or major trauma) will continue to use 999 as appropriate.**
3	**The 'Phone First' model will also need to be accompanied by establishment of Urgent Care Centres and rapid access assessment and treatment services in all HSC Trusts.**

4	As part of the new model, the current GP OOH service will be reshaped to form part of the wider integrated urgent and emergency care service.
5	In establishing the new system, it is recommended that the No More Silos network should ensure services adhere to the minimum set of standards (Annex A of the consultation report). Providers may also choose to build upon or add to these, according to their requirements.
6	The Department of Health will oversee the development of a regional, multi-professional workforce plan to ensure we have the appropriately skilled staff to deliver the new models of care in Urgent and Emergency Care. This will build on the experience of Urgent Care Centres currently in operation.
	STRATEGIC PRIORITY 2 – RECOMMENDATIONS **Capacity, Co-ordination and Performance Management**
7	As part of the implementation of the recommendations of this Review, and taking into account the implementation of the strategies highlighted above, it is recommended that the Health and Social Care Board should lead an initial piece of work to establish where additional capacity would have the greatest impact in reducing pressures on urgent and emergency care services.
8	Following the completion of a Getting it Right First Time (GIRFT) Emergency Medicine Report, it is also proposed that an evidence based capacity review will be carried out. Careful consideration will be given as to the scope of this capacity review and to the merits of appointing an independent party to complete it.
9	In the longer term, it is recommended that the Health and Social Care Board work, the GIRFT report and the capacity review should be used to guide additional investment in unscheduled capacity both for in hospital services and also for out of hospital services, across provider organisations.
10	Alongside work to increase capacity, the Health and Social Care Board has established an unscheduled care hub to monitor urgent and emergency pressures. While this will not reduce unscheduled care pressures, it is expected to improve co-ordination across the region.

11	**There are already plans in place to significantly increase HSC capacity in key areas such as cancer, elective care, mental health and social care. Provided the necessary levels of investment are available to implement these strategies, this will address some, although not all, of the capacity issues set out in this report.**
12	**Implementation of the NIAS Clinical Response Model must be a system priority to ensure equitable access to emergency care for people across Northern Ireland.**
13	**As part of a strengthened performance management function, the Health and Social Care Board will, informed by a GIRFT report for Northern Ireland:** ○ **Agree a small amount of comparable performance parameters for acute sites;** ○ **Benchmark and monitor acute performance; and** ○ **Agree and monitor delayed discharge information to inform service development in acute and community services; and** ○ **Further develop and standardise information available across all elements of the integrated urgent and emergency care system with a particular focus on out of hospital care.**
	STRATEGIC PRIORITY 3 – RECOMMENDATIONS **Intermediate Care – 'A Regionalised Approach'**
14	**It is recommended that a regionalised intermediate care programme should be implemented to ensure equitable provision across Northern Ireland, including in the Care Home sector, to the right intermediate care services, which are responsive, efficient and effective in providing enhanced clinical care in the patient's own home and supporting hospital flow.**
15	**Phase one of the project is the development of the full Intermediate Care service framework covering the four areas: Hospital at Home, Bed-Based Intermediate Care, Home Based Intermediate Care and Reablement. Phase two of the project will move to support implementation and equity of provision of these services for the population of Northern Ireland.**

ANNEX C

GLOSSARY	
Acute Care at Home	This is a short term service to support elderly patients to avoid unnecessary admission to hospital and to provide that acute medical care at home.
Intermediate Care Project	This project is developing a regional approach to intermediate care, such as hospital at home. The aim is to improve outcomes for patients who receive intermediate care services to ensure that people are supported to lead the best life possible.
Population Health Needs Assessment	NI regional population health needs assessment was carried out in 2017 to provide a sound evidential basis for the future configuration of sustainable emergency services in NI utilising available data sources, population profiles and relevant sources of evidence.
Phone First	The Phone First services operates on a 24/7 basis to ensure patients can get direct access to the right care, avoid busy Emergency Departments and stay safe.
Primary Care	It is the many forms of health and social care and/or treatment accessed through a first point of contact provided outside hospitals. It generally refers to a general physician for patients.
Review Team Report	This is the evidence based report completed in 2020 of the Review of Urgent and Emergency Care Services in Northern Ireland.
Secondary Care	This is sometimes referred to as 'hospital and community care' and can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture.

Unscheduled Care Service User and Carer Reference Group (USCRG)	A group of independent service users and carers who work together to share their expertise, lived expertise and insight into a range of strategic and operational issues effecting Urgent and Emergency Care in NI.
Urgent Care Centre (UCC)	These centres are designed to assess and treat patients who present with illnesses and injuries which require urgent attention but are not life threatening. The staff in UCC consist of a multidisciplinary team but will usually be led by general practitioners.

REVIEW OF URGENT AND EMERGENCY CARE SERVICES IN NORTHERN IRELAND - Overview

Introduction

Mid Ulster District Council (MUDC) welcomes the opportunity to respond to Department's Consultation on Review of Urgent and Emergency Care Services in Northern Ireland.

The Mid Ulster Community Plan, which MUDC are the legislative facilitators of, also seeks to ensure that right services are provided in the most appropriate place, at the right time and fully endorses an urgent and emergency care model that **focuses attention on bringing the best care to people as close to home as possible, wherever they live**.

There are however concerns about the significant number of high-level recommendations being taken forward within the health sector, over the next decade, without further prioritisation at this strategic level. Resourcing of this review and corresponding recommendations needs to be secured which will determine how they will successfully delivered.

STRATGIC PRIORITY 1 – RECOMMENDATIONS: Integrated Urgent and Emergency Care

Council is greatly disheartened to find that General Practice does not form part of this review. GPs are most likely to be the first contact a person will make with regards to a health complaint and are therefore a fundamental component to an urgent and emergency care structure. Given the Departments recent commencement of work on an Integrated Care System, reviewing Urgent & Emergency Care without GP services does not bode well for the successful establishment of an truly Integrated Care System.

Like other rural districts, Mid Ulster is experiencing a chronic shortage of GPs. Mid Ulster Community Planning has been working closely with HSCB to monitor this issue and whilst we acknowledge the number of programmes developed by DoH and

HSCB to address the shortage. A concerted effort is required to ensure that they are implemented with the utmost urgency. Without a fully functioning GP Service, Council fail to see how this review will be implemented successfully.

‘**Phone First’ model**

Whilst many reports of late seem to hail the implementation of a phone first consultation model, they all seem to fail to grasp the extreme levels of dissatisfaction of citizens with many GP services, since its conception. Elected members have experienced a notable increase of their constituency work, dealing with complaints about patients being denied in-person access to a GP and other primary care services. Council members are in no doubt whatsoever that this change in service provision has contributed significantly to the unprecedented pressures experienced by all the Emergency Departments across the region. Public perceptions are of a health service that is continually moving away from a person to person service. Given the high levels of public dissatisfaction with the GP phone service, there is a great possibility that the proposed Phone First Service will be unwelcomed by the public. It is important that the public confidence and satisfaction in GP services are restored first and foremost, in order to ensure the success of this proposed Phone First model.

Urgent Care Centres and **Rapid Access Assessment and Treatment Services**

A key strategic outcome for the Mid Ulster Community Plan is for our citizens to have “better availability to the right health service, in the right place, at the right time.” Due to the reduction of services and its peripheral location, Mid Ulster residents (and most especially Cookstown) have the poorest access to acute hospital care provision across all Health Trust areas. Mid Ulster travel time to a hospital with major injury treatment capabilities is over 8 minutes longer than the NI average. Two thirds of Mid Ulster’s population of almost 149,000 are rural; and by 2037 83% will be aged 65+ (against an NI average of 68%). During Mid Ulster District Council’s extensive community consultations to develop the new ‘Community Plan’, the issue causing most concern was the ongoing reduction of health and social care services and facilities in the area and the apparent lack of investment in alternative provision. Timely access to quality services for diagnostics, treatment and recovery should be guaranteed to all citizens. However, travel distances to services can have a huge

impact on their timeliness and quality, impacts on their quality of life and survival outcomes. Due to the rurality of the area, there is a need to have more, better quality, non-acute health services.

Whilst Council supports a service structure that offers the highest quality of service and expertise, improving diagnostic times and treatment outcomes, given what has been underlined previously regarding access to services, particularly for our most rural residents, Council would advocate that Mid Ulster is strongly considered as a location for an Urgent Care Centres and Rapid Access Assessment and Treatment Services. Opportunities now exist across sites which are already in public sector use in Mid Ulster, where other health services have been removed, which would facilitate the co-location of a broad range of provision. These sites have the potential to deliver a comprehensive range of local diagnostic facilities, primary care and elective surgery provision, which will also contribute to alleviating the pressures on acute sites.

GP Out of Hours Service

Similar to the issues raised around pubic satisfaction of GP services, people have also become extremely unhappy with the perceived erosion of Out of Hours GP services. Mid Ulster has lost two Out of Hours services in Moneymore and Dungannon, forcing our residents to make longer journeys to Antrim and Craigavon Hospital sites for these services. Whilst our residents has eventually accepted the fact that they will have further to travel for acute care services, this cannot be allowed to extend now to Primary Care services. Council strongly believe that Primary care should be accessible to our residents at a local level. Forcing our rural residents to travel further and further away for all levels of medical treatment will most certainly lead to poor health outcomes for the people of Mid Ulster. Council understands the challenges the Department faces in recruiting and retaining doctors to General Practice services but it must be given full priority if it is to succeed in creating the services laid out in this plan.

Workforce Plan

It is well documented that the health sector faces significant workforce challenges which has significantly impacted on its ability to deliver adequate services across the

region. Attracting and retaining health service staff is significantly challenging as a result of Brexit, the Covid19 Pandemic, pay and conditions. Many health service staff with years of experience have left the sector due to over working and burnout. Rising abuse of health staff by patients has also been noted by elected members as a growing reason for staff leaving the sector. This review makes no reference to these issues and no plans to mitigate against them, only reference to expanding the roles of health professionals. Increased opportunities for skills development and expansion of roles may be welcomed by some in the sector but for others, already struggling under the burden of current work pressures, it may not. There are a number of other factors regarding current workforce pressures that must be urgently addressed before plans for expansion of roles can be considered.

Council has serious concerns with the sectors ability to resource the Urgent Care Centres and Rapid Access Assessment and Treatment Services with the multi-disciplinary teams they require. Multi-disciplinary teams were introduced by the HSCB to radically reform GP services, reducing pressures on secondary care services. However, the programme launched in 2018 has only been rolled out in 7 of the 17 GP Federations in the region. There are none in Mid Ulster. Issues reported to Council were a lack of specialised staff, appropriate infrastructure in the Primary Care setting and financial resources. Council seeks clarification on whether the roll out of these Multi-disciplinary Teams in GP practices is planned to continue in light plans for the Urgent Care Centres and Rapid Access Assessment and Treatment Services and when they will be rolled out in Mid Ulster.

STRATEGIC PRIORITY 2 – RECOMMENDATIONS: Capacity, Co-ordination and Performance Management

Implementation of the Northern Ireland Ambulance Service Clinical Response Model

The Council supports the development of the proposed new Clinical Response Model but remains to be convinced regarding its contribution towards bringing about the required significant improvement in response times to rural areas across Mid Ulster, in line with urban populations. However, ambulance response times in the

Mid Ulster area have reached an unacceptable level and will deteriorate further; in that context Council welcomes a new solution, if it is appropriately resourced and implemented. This new Model must now be progressed with the utmost urgency by the Department.

The proposed new Response Model will only deliver the requisite results and achieve maximum impact if it is adequately resourced and implemented. Its development should be taken forward as part of a wider strategic framework using a joined up and fully integrated approach to service planning and delivery, not just across the health sector but also from the Departments of Infrastructure and the Economy. For instance, the quality of the roads infrastructure, particularly in a rurally isolated area, has an undeniable impact on travel time. Improvements to our rural roads, broadband and telecoms infrastructure contribute to improving response times; it is imperative that the relevant government departments are involved in developing this new Model from the outset, and identify what improvements they plan to make to enable NIAS to maximise this opportunity to deliver a high performing service to the entire population.

STRATEGIC PRIORITY 3 – RECOMMENDATIONS: Intermediate Care – 'A Regionalised Approach'

Regionalised intermediate care programme

Whilst Council welcomes reform to intermediate care services, especially reforms that will bring equity across the region, it has grave concerns on the actual ability to see them come to fruition, again given the serious lack of staff to meet current and future demand. Council believes that the pay and conditions of these services needs to reflect the level of work these health care workers deliver to our most vulnerable residents. The Department must make it a priority to reform this sector to make it an attractive career option for people.

Hospital at Home

Once again, Multi-disciplinary Teams are designed to play a key role this service and Council would refer to its previous concerns on the resourcing of these teams.