

# Recommendations for Unscheduled and Emergency Care in Northern Ireland



# Introduction

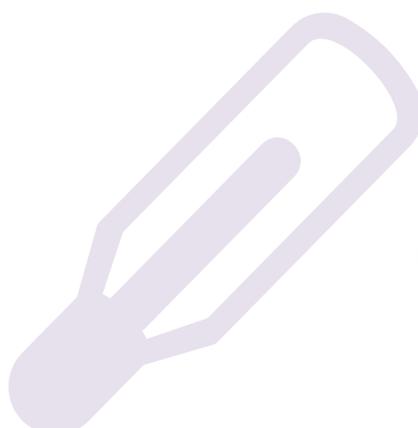
## & overview

Unscheduled and Emergency Care services in Northern Ireland are facing profound challenges to deliver safe, efficient and effective patient care as demand continues to rise. This policy paper sets out 18 key recommendations to address the current challenges. These recommendations are based on the outcomes of two College of Emergency Medicine (CEM) summits held in April and June 2014. The summits were attended by regulators and key stakeholders and they examined the issues and challenges facing unscheduled services both regionally and nationally; they also received support from the Chief Medical Officer and the Chief Nursing Officer. The aim was to identify best practice strategies on which to build greater capacity and resilience across the system.

The purpose of these 18 recommendations is to maximise the effectiveness of Unscheduled and Emergency Care services whilst improving patient and staff experience. The recommendations are incorporated into six general themes ranging from improving access to Unscheduled and Emergency Care through to addressing Exit Block and workforce issues.

The CEM is committed to promoting excellence in Emergency Care throughout the United Kingdom and Ireland. We look forward to working collaboratively with the recently established Regional Taskforce to improve the standard of care across the Unscheduled and Emergency Care system.

**Dr Richard Wilson,**  
Chair of Northern Ireland Board  
The College of Emergency Medicine



# Access to Unscheduled and Emergency Care: An integrated systems approach

## Recommendation 1

Each Trust should develop and maintain an updated Directory of Services that allows direct access and communication for primary, secondary and community care, Northern Ireland Ambulance Service and secondary care teams.<sup>2</sup>

This will create improved communication across the entire unscheduled care system and allow direct access to specialist teams where the skills of the Emergency Department (ED) are not required. Best practice directs patients to the right care, first time and will minimise delays and unnecessary duplication of effort.

*Responsibility for information lies with individual Trusts.*

## Recommendation 2

Current best practice for patients bypassing the Emergency Department to specialist wards and units should be expanded throughout the NHS. Establishment of dedicated care pathways and guidelines is recommended to improve flow.<sup>9</sup>

Examples of this type of ED bypass include:

- Post-surgical complications returned to surgical teams
- Early pregnancy services
- Stroke patients transferred directly to stroke units
- Patients suffering from falls first assessed by ambulance falls service
- Older aged patients receiving assessments or investigations by multidisciplinary health and social care teams outside of the ED

*Department of Health, Social Security and Public Safety (DHSSPS) is responsible for sharing best practice whilst implementation and accountability is with Hospital Executives, Northern Ireland Ambulance Service and Health and Social Care Board.*

## Recommendation 3

Acute Care specialties with responsibilities for providing unscheduled care must have a designated assessment area and capacity within their own unit to receive patients to prevent congestion and Exit Block in the Emergency Department.<sup>5,6</sup>

Crowding of EDs is the result of Exit Block and is directly linked to poorer patient outcomes. To ensure patient safety and the delivery of high quality care it is essential that patients are treated efficiently by the appropriate speciality, and not left to unnecessarily wait for transfers from the ED. There must be separate resources to provide urgent out-of-hours care outside of the ED. It is not appropriate for A&E to provide non-Emergency Care and be used as a default to access care.<sup>1,16</sup>

*Responsibility and accountability for implementing this lies with Trusts, Commissioners and Health and Social Care Board.*

## Recommendation 4

Every Emergency Department should consider having a co-located and integrated Primary Care Out-of-Hours facility.

There must be separate resources to provide urgent out-of-hours care outside of the ED. It is not appropriate for A&E to provide non-emergency care and A&E should not be used as a default to access care.<sup>1,16</sup>

*Responsibility and accountability for implementing this lies with Trusts, Commissioners and Health and Social Care Board.*

## Improving patient flow and preventing Exit Block

## Recommendation 5

At times of peak activity, the system must have the capacity to deploy or make use of extra senior staff.

Measures must be in place to deal with congested EDs to minimise risks to patient safety by ensuring patients are appropriately diverted from the ED. This must be the responsibility of the entire hospital system.<sup>5</sup> If escalation procedures are a frequent occurrence, (for example weekly), this is evidence of poor staffing models. Inadequate capacity exacerbates Exit Block and this in turn increases mortality for all patients.

*Responsibility for information lies with individual Trusts.*

## Recommendation 6

Senior Emergency Physicians should have admitting rights to all specialties.

Direct referral to specialty teams and specialty wards from the ED reduces congestion and is essential to improving patient flow.

*Responsibility for information lies with individual Trusts.*

## Recommendation 7

Ambulatory Care models should be developed and expanded for Emergency Care as a matter of urgency.

Ambulatory Emergency Care, observation medicine and Clinical Decision Units are proven to be cost effective and efficient strategies for certain groups of patients attending the ED; they lead to safer care and appropriate resources are required to deliver this function.<sup>6</sup> Ambulance services have the potential to reduce pressure on EDs by developing pathways that enable patients to be redirected to the appropriate care locations.<sup>2, 6</sup>

*Responsibility and accountability for implementing this lies with Commissioners and Trusts.*

## Recommendation 8

Focus on effective hospital discharge processes 7 days a week.

For vulnerable patients, discharge is often dependent on the support of community and social care service. Discharge processes need to be simplified to facilitate the safe discharge and timely transfer of care for patients from the hospital to their own home. This must be fully supported by the community infrastructure with access to social workers and pharmacy services 7 days a week.<sup>9, 12</sup>

*Responsibility lies with Social Care Services including Social Workers, Care Homes, Local Government, Primary Care and Health and Social Care Board.*

## Recommendation 9

Community teams should be physically co-located with the Emergency Department to bridge the gap between hospital and primary and social care especially for vulnerable patients.

For those with complex care needs (such as the elderly) and those with acute and long-term mental health problems, access to community teams including general practitioners, social workers and community mental health teams should be available beyond 6pm, 7 days per week.<sup>2, 3</sup>

*Responsibility lies with Social Care Services including Social Workers, Local Government, Mental Health Trusts, Primary Care and Health and Social Care Board. Hospital Executives and Trusts must work in collaboration with these groups.*

## Future workforce models

## Recommendation 10

Every Emergency Department should have the appropriate skill mix and workforce to deliver safe, effective and efficient care.

Staffing levels must reflect the current level of business within the ED environment or risk compromising patient care. Where an ED does not have onsite back-up from particular specialties, there should be robust networks of care and emergency referral pathways. NHS provider organisations should implement the recommendations of the Berwick Report.<sup>4, 8, 13</sup>

*Hospital Executives and Trusts must work closely with Commissioners, DHSSPS and the Health and Social Board to ensure this.*

## Recommendation 11

Senior decision makers at the front door of the hospital 16 hours per day, and in surgical, medical or paediatric assessment units, should be normal practice, not the exception.

This is the most reliable way to deliver safe, effective and efficient care.<sup>7, 8</sup> It should include acute physicians, acute pediatricians, general practitioners, Emergency Care physicians, geriatricians and psychiatrists. Junior doctors and trainees should not be relied upon at weekends to make clinical assessments, diagnosis and discharges. Early senior review has substantial proven benefits, including mortality reduction, lower admission rates, early safe discharge, reduced lengths of stay and more appropriate use of investigations.<sup>8, 12, 15</sup>

*Responsibility lies with Hospital Executives and Medical Directors to implement this.*

## Recommendation 12

All trainee doctors on acute specialty programmes should rotate through the Emergency Department.

In line with recommendations made in the Shape of Training, Medical Royal Colleges should promote the development of core common competencies by all doctors in training.<sup>6</sup> ED experience is an invaluable asset.<sup>6</sup> This will create a medical workforce with the interspecialty skills necessary to meet the clinical challenges of the future. This will improve awareness of the role of Emergency Medicine (EM) and has the potential to increase the number of applications into the EM specialty.<sup>2</sup>

*Northern Ireland Medical Dental Training Agency, Medical Royal Colleges, Shape of Training Review, BMA Northern Ireland and the GMC are responsible for preparation and implementation.*

## Recommendation 13

Further review and development of established and alternative workforces should occur as a matter of urgency. Examples include Emergency and Advanced Nurse Practitioner roles.

This is essential to relieve pressures on higher speciality trainees and senior doctors. This would improve staff morale, reduce stress levels and underpin the ability to deliver quality care. These roles are established in various parts of the UK and support the team-working ethos and multi-disciplinary function of EDs.

*Responsibility and accountability for implementing this lies with Trusts, Commissioners and Health and Social Care Board.*

### 7 day working

## Recommendation 14

Community and social care must be integrated effectively and delivered 7 days a week.

Integrated care partnerships are key to improving NHS services. Urgent and Emergency Care services are often failing to operate to the highest standards of care 7 days a week as it is not fully supported by the community infrastructure. Effective, joined-up working between hospitals and community services is essential to patient safety and timely discharges.

Psychiatric liaison services are a best practice model of integrated care for the management of patients with long term conditions that would not necessarily need care to be delivered in the ED.<sup>12</sup>

*Responsibility lies with Social Care Services including Social Workers, Care Homes, Local Government, Primary Care and Health and Social Care Board.*

## Recommendation 15

The delivery of a 7 service in the NHS must ensure that emergency medicine services are delivered 24/7, with round the clock senior decision maker and full diagnostic support, including appropriate access to specialist services.<sup>11</sup> This will require additional resources.

This will enable equity of outcomes for all patients. Nevertheless, this will require sustainable staff rotas that encourage recruitment and retention.<sup>15</sup> Urgent and Emergency Care services must also develop and implement credible plans to meet predictable surges in demand, such as on bank holidays and when GP services close. If implemented properly, 7 day services can empower hospitals to return patients home sooner, reduce crowding and improve efficiency. Health services are judged on two key components: the ability to deliver elective care and the ability to deliver urgent and Emergency Care. Neither should compromise the other.<sup>2</sup>

*Emergency Department Clinical Leads, Directors of Acute Care, Medical Directors, Allied Health Professionals, Hospital Executives and DHSSPS are responsible.*

## Recommendation 16

Delivering 7 24/7 services requires new contractual arrangements that enable an equitable work-life balance.

Fairness and sustainability should underpin all staff contracts. Current contracts lack the mechanisms necessary to ensure that acute care specialists have a fair work-life balance. If locum doctors are required to ease workforce shortages, then locums should be rewarded with longer fixed-term contracts. Training time is essential for equipping the medical workforce with skills to handle system pressures. Trusts must also support staff suffering from 'burnout' due to current pressures.<sup>2</sup>

*DHSSPS, Employers, BMA Northern Ireland, Hospitals and Health and Social Care Board are responsible for this.*

## Information Technology

### Recommendation 17

It is essential that each Emergency Department and unscheduled care area has an IT infrastructure that effectively integrates clinical and safeguarding information across all parts of the urgent and Emergency Care system.

IT systems enable accurate data to be collected which can be used to predict with reasonable accuracy times of peak pressures using a calendar and system dashboards. This data will inform capacity planning for medical staffing, bed planning, transport and diagnostics. It enables a hospital-wide or holistic approach to patient flow and working to prevent Exit Block. The use of smart systems would enable direct contact between hospital and community teams to speed up the discharge process by ensuring patient care packages are in place.<sup>2, 11</sup> Current data are often of poor quality and certainly cannot be used with confidence to provide an accurate reflection of urgent and Emergency Care.

*DHSSPS, Business Services Organisation, Hospitals and Health Boards are responsible for this.*

## Engagement

### Recommendation 18

Structured engagement and involvement between the Emergency Care clinicians, Executive teams of provider Trusts and local commissioners is essential in order to develop a shared vision and delivery strategy.

Joined-up working and constant communication between all of those responsible for delivering patient care services is essential to ensuring safe, efficient and effective urgent and Emergency Care services are delivered both within the hospital and across the community.<sup>6</sup>

*This is the responsibility of Health and Social Care Board, Trusts and Commissioning Boards.*

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