# DEPARTMENT OF HEALTH
# COVID-19 URGENT AND EMERGENCY CARE ACTION PLAN
# NO MORE SILOS

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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## INTRODUCTION

Prior to COVID-19, there was clear evidence that our urgent and emergency care services were under increasing pressure. Growing numbers of people were experiencing long waits to be seen in overcrowded Emergency Departments (EDs). This was already an unsustainable position requiring radical transformation. However, the impact of COVID-19, and the accompanying focus on infection prevention and social distancing, have driven home the urgency of ensuring that we do not allow EDs or hospitals to reach these levels of crowding in future. Immediate changes need to be implemented in advance of further waves of COVID-19.

In the same period, there has been poor co-ordination between primary and secondary care services. With the exception of a few examples, primary and secondary care largely developed their care services in isolation. This artificial compartmentalisation of care has contributed to longer waiting times for patients, poorer patient experience, inconsistency of approach, duplication and organisational waste.

The HSC system's response to the pandemic has helped to break down professional and administrative boundaries and demonstrated that a better way of working is possible. The challenges of the pandemic have produced fundamental changes in primary care, leading to universal patient triage, virtual consultation, shared learning and new clinical pathways. Secondary care colleagues have reached out to GPs with offers of new pathways and opportunities for working together.

These initiatives can be developed to support an enhanced range of safer and more effective elective and unscheduled care services to patients which could extend well beyond the pandemic. This response plan also builds on work carried out by the Urgent and Emergency Care Review team. While the Review team's full report will be published separately, this document sets out some immediate priorities for action, to avoid overcrowding of emergency departments, as often seen in winter, and limit the risk of nosocomial transmission.

Urgent and Emergency Care services in Northern Ireland perform critical roles in responding to patient needs. While closely related, it is important to understand the differences between urgent and emergency care.

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

Urgent care in Northern Ireland includes: General Practice during weekdays; GP Out of Hours (GP OOH) Services at night and weekends; pharmacies; minor injury units; an urgent treatment centre; Emergency Departments (EDs); and, the Northern Ireland Ambulance Service (NIAS).

**Emergency Care:** Life threatening illnesses or accidents which require immediate intensive treatment. Emergency Care is currently provided in hospitals with Type 1 and Type 2 Emergency Departments and by NIAS.

Our current model of unscheduled care is heavily focused on accidents and emergency despite the fact that the significant majority of patients attending EDs are not in that category. Every year, more than 800,000 people will attend an Emergency Department. Of these, only a minority would be defined as an emergency according to the definition above. In the past, we have described the attendances of the majority of patients as ‘inappropriate’. This is not accurate. In fact, it is our own system that makes these attendances inevitable and channels patients through an Emergency Department because there is no other practical option. In effect, the Emergency Department has by default become the front door for all unscheduled care, emergency or otherwise.

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

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

The system wastes patient and clinician time, as well as clinical and managerial resources. In the context of the ongoing pandemic, we can no longer tolerate this level of waste and inefficiency in our system. We need to ensure that front line clinicians and their patients have access to timely, viable, safe and easily accessible alternatives.

This response plan focuses on ten key actions that will be rapidly implemented in order to ensure that urgent and emergency care services across primary and secondary care can be maintained and improved in an environment that is safe for patients and for staff. In the context of the pandemic, we must do everything we can to ensure that our urgent and emergency services are not overwhelmed this winter.

These actions can be developed to support an enhanced range of safe and effective elective and unscheduled care services to patients which do not rely on patients presenting at an Emergency Department. There is no doubt that these actions will be challenging to deliver, but they are driven by the necessity of protecting our services and our patients in the event of further waves of COVID-19.

# 10 KEY ACTIONS

- Introduce Urgent Care Centres
- Keep Emergency Departments for Emergencies
- Rapid Access Assessment and Treatment Services
- 24/7 Telephone Clinical Assessment Service - 'Phone First'
- Scheduling Unscheduled Care
- Regional Anticipatory Care Model
- Acute Care at Home
- Ambulance Arrival and Handover Zones
- Enhanced Framework for Clinical and Medical Input to Care Homes
- Timely Discharge from Hospital

## 1. INTRODUCE URGENT CARE CENTRES

### What does this mean?

It is estimated that up to two thirds of patients attending Emergency Departments could be dealt with more effectively in a different setting. While many of these people will require advice or treatment, this is not likely to require hospital admission and may not be immediately time critical. As our system is designed currently, many of these patients will have no other means of accessing the advice or treatment they need other than by attending an Emergency Department. Similarly, where GPs identify patients in these circumstances, the only available pathway under the current model is often to refer these patients to an ED. These patients are not served well by long waits in a crowded emergency department.

### How will it work?

Urgent Care Centres will be based at, although separate from, the current Emergency Department sites. They may also be established at standalone facilities where appropriate. They will ideally be fully integrated with other urgent care services, such as ambulatory care services, community specialist services and rapid access assessment services. Work will also be undertaken with OOHs providers to integrate the current GP OOH service and new telephone clinical assessment service, providing a seamless regional urgent care response and reduced journeys to ED.

The centres will usually be run and managed with a mixed staffing model of primary and secondary care medical staff and nurses.

## 2. KEEP EMERGENCY DEPARTMENTS FOR EMERGENCIES

What does this mean?

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

Over time, the Emergency Department has become the funnel through which all unscheduled patients are directed into hospital care, even when they are known to the system or where they have already been clinically assessed in a primary care setting. By only providing access to an Emergency Department for patients who have been clinically assessed as having a time critical emergency condition, this is intended to improve access and responsiveness for this time critical cohort of patients. As a result it is evident that the cohort who do not now fit this criteria need to have a plan for the timely delivery of their care.

How will it work?

This action is closely linked to the following action to develop Urgent Care Centres. Under the new arrangements, direct access to Emergency Departments will only be possible for patients who arrive by ambulance or who are referred to the Emergency Department from the Urgent Care Centre or by their GP. All patients who make their own way to a hospital site will be assessed by a health professional who will determine whether they should attend ED, the Urgent Care Centre, or some other service. Care will be needed to ensure this does not lead to an increase in 999 calls for an ambulance to access ED. All patients will continue to have 24/7 access to care and advice on current ED sites.

## 3. RAPID ACCESS ASSESSMENT AND TREATMENT SERVICES

What does this mean?

In the course of the Urgent and Emergency Care Review, users, carers and HSC staff have reported difficulties in accessing the correct person, specialty or diagnostic test to expedite the patient's care. In our current model of care many of these patients will end up in an Emergency Department. This is often not the best, or indeed the correct, place but in many cases it has become the only available option.

In order to ensure the best service for patients, primary care and hospital clinicians must have access to rapid access assessment and treatment services in a range of clinical areas. This should not be through the ED.

Although it is recognised that different trusts have a variety of specialisms, a range of mental health, paediatric, medical and surgical assessment areas and rapid access clinics would be core elements in all trusts. Where clinically appropriate, direct admission to hospital should be facilitated.

How will it work?

Access to the services should include same day or same week assessment depending on patient need and clinical urgency. Referral to these services should be available directly from GPs, Urgent Care Centres or via telephone triage. The services should use flow models and pathways consistent with current infection control requirements taking the learning from recent work in general practice, Covid Centres and HSC Trusts.

## 4. TELEPHONE CLINICAL ASSESSMENT SERVICE – 'PHONE FIRST'

What does this mean?

In the current COVID-19 environment, the principle of triage prior to attendance has become extremely important. As part of improving access to urgent care services for patients, we should consider the development of a dedicated number that is available to the public to receive health advice and information. The number should be available 24 hours a day, 7 days a week, 365 days a year and would be fully aligned with the urgent care centres, including the GP OOH service.

Patients contacting the telephone service will be assessed, given advice and, if required, directed to the most appropriate local service. That could be the Ambulance Service, an Emergency Department, an Urgent Care Centre, an out-of-hours doctor, a community nurse, an emergency dentist or community pharmacy. Community pharmacy will also pilot a 24/7 service in late autumn to coincide with these changes.

The purpose of the number would be to ensure that patients can access assessment, advice and information whenever they need it, and that they receive their care in the most appropriate setting. In time, it is expected that the service will also be able to schedule appointments for services.

How will it work?

Across the HSC we already have significant capacity for clinical assessment through our GP Out-of-Hours providers and through the Northern Ireland Ambulance Service. They have appropriate training, protocols and equipment in place which could be adapted and developed to provide consistent triage services across the HSC.

In the immediate future, HSC Trusts will work with both NIAS and GP providers to establish effective referral and advice processes. In the longer term, work will be progressed to develop proposals for a regional service accessed through a single number.

## 5. SCHEDULING UNSCHEDULED CARE

What does this mean?

COVID-19 means that crowded emergency departments with long waiting times are no longer safe and cannot be tolerated. A majority of patients presenting to the urgent and emergency care system do not have a health care need which is time critical in nature. Many of these patients end up in an Emergency Department due to the lack of alternatives available to clinicians and patients. It is therefore of much greater benefit to the patient if they can be scheduled to an appointment where they can see the right person in the right place, first time. These appointments are typically on the same day or next day. By scheduling the urgent care needs of people we can ensure that those who do not need to be in an emergency department are treated in a more appropriate setting. This will also help to prevent emergency departments from becoming crowded and will allow them to concentrate on emergency cases which need to be dealt with immediately.

How will it work?

Typically patients will present to their own general practitioner or contact help via the 'Phone First' service. All these points of contact for patients will have the ability to book into a scheduled system of appointments to best meet the person's health care need. Patients presenting directly to an urgent care centre will be triaged and, where appropriate, given an appointment with the most appropriate service if they do not require immediate emergency attention.

Medical units such as urgent care centres, assessment units, rapid access clinics, minor injuries units and mental health hubs will all be accessed via an appointment system after the initial point of contact.

## 6. REGIONAL ANTICIPATORY CARE MODEL FOR NURSING HOMES

What does this mean?

People living in a care home setting experience a predictable range of health and social well-being needs. The effectiveness of the care provided by care home staff and by in-reach services will be significantly improved by taking an anticipatory approach.

Furthermore, regional agreement on a standard falls pathway and a pathway for the management of blocked catheters would avoid the commonest reasons for hospital transfer of care home residents.

How will it work?

The Chief Nursing Officer, Professor Charlotte McArdle, is leading work to co-design a new framework in partnership with the care home sector for the provision of clinical care. This will include examining how we can enhance nursing, medical and multidisciplinary support, clinical leadership and specialist skills in collaboration with care home staff and care home providers. This will include building on the important role of GPs in care homes. This will not be about converting care homes into mini-hospitals but ensuring that we keep supporting homes to deliver the care, with the right level of clinical in-reach available at the right time.

The care of each resident in the care home will be planned and delivered by a team including the home carers, the trust support team and the residents' medical practitioner. The aim would be to ensure that each resident will have regular medical and multidisciplinary review, each will have a proactive medical care plan which will be agreed with them and their family and will be available to secondary care, potentially, though the Electronic Care Record in the event of an emergency. The Trust, care home and GP will liaise regularly to ensure the residents' needs are met. Each care home will have access to a Trust support team. This will be multi-disciplinary in nature and this approach improves the care of people with complex conditions by making full use of the knowledge and skills of team members.

Each resident should have an anticipatory care plan.  Evidence-based assessment tools are a key component of effective care planning. Assessment tools will be agreed and used consistently across all care home facilities and by Trust and GP in-reach services. The Rockwood frailty score is one such tool.

On a regular basis, a Home Round will be led by a lead senior practitioner who will have gathered in advance relevant clinical assessment information using evidence based assessment tools identifying early resident deterioration. The General Practitioner and MDT will agree the most appropriate professional to undertake the assessment and review of each resident and add to the anticipatory care planning process. A risk stratification tool such as Rockwood will help guide the MDT assessment process, to those who are at most risk of acute decline. Medication reviews are also undertaken and any advice from the Care of Elderly Consultant / Palliative Care Consultant should be included in this review.  Ongoing review of the plan should also be agreed and how they will be carried out, e.g. whether some reviews will be virtual or a physical revisit.

## 7. ACUTE CARE AT HOME

What does this mean?

Acute Care at Home is a Geriatrician-led MDT model of urgent care at home for frail people, avoiding hospital admission. In the COVID-19 surge, where multiple residents were symptomatic, the intervention of the Acute Care at Home team working in support of the GP and in partnership with Care Home staff, did in many circumstances enable patients to be safely managed and to recover in the Care Home.

How will it work?

The Acute Care at Home service is not consistently available across NI due to workforce constraints. Either the geographical remit of existing teams will be extended or the work of hospital geriatricians and their MDTs must be reprioritised, allowing access to their expertise.

One possible solution is that the system focuses on implementing a standard regional anticipatory care model (see previously), with a single point of contact, and modifies the job plans of hospital geriatricians to create capacity for them to participate in the Home Round. The regional COVID-19 surge plan should identify triggers for mobilising the Hospital Geriatrician to give enhanced support to the sector. Hospital services would be turned down to enable the Hospital Geriatrician and their clinical team to give increased in person and / or virtual support. The Southern and Belfast Trusts included respiratory and palliative care in their enhanced model.

Digital technology platforms can provide a platform for Independent Sector providers, designated GPs, Acute Care at Home leads and Secondary Care experts to plan and prepare for a response to surge. Care Homes will need additional staffing support when intervention at this level is being provided. Care Homes need additional infection prevention advice so that they are able to take all necessary steps to prevent spread of infection.

## 8. AMBULANCE ARRIVAL AND HANDOVER ZONES

What does this mean?

There has been increasing concern about the growing problem of patient handovers from ambulances to Emergency Departments during the pandemic. With the increased emphasis on ensuring effective infection control practices in Emergency Departments, this has reduced the space available and has contributed to lengthy waits for ambulance teams. There should be no doubt that the delays have an adverse impact on patients' experience of the service and may increase risk to patient safety.

It is recognised locally and nationally that handover delays for ambulance services have the potential to result in:

- Increased risk to patients on site due to delays in diagnosis and treatment;
- Increased risk in the community due to limited NIAS capacity to respond to calls;
- The ability to respond to a serious or major incident being seriously compromised; and,
- Reduced ambulance response performance due to lost time.

Emergency Departments will need to put in place arrangements for physical space for the assessment and triage of patients arriving by ambulance.

How will it work?

An escalation framework was put in place earlier this year. In addition to following the established protocols to allow ambulance turnaround within 30 minutes, the five largest EDs should put in place arrangements for space for a minimum of six ambulance arrivals to be handed over as soon as possible. Where there are any delays in handovers the escalation framework should be followed to ensure that these are resolved urgently.

## 9. ENHANCED FRAMEWORK FOR CLINICAL AND MEDICAL INPUT TO CARE HOMES

### What does this mean?

There has been an important shift in the complexity of care provided in care homes over recent years. A greater proportion of care home residents have complex clinical healthcare needs than would have been the case in the past. The learning over the past few months has highlighted the high level of frailty and clinical acuity of residents in our nursing homes.

In order to help maintain people in nursing and residential care homes, we need a new framework for enhancing nursing, medical and multidisciplinary in-reach into care homes. This should both help avoid unnecessary attendances at Emergency Departments and ensure swift discharge of patients from hospital, helping to free up beds, ensure a smooth flow of patients through hospital and minimal delays in Emergency Departments.

### How will it work?

The Department and HSCB will work with Trusts and Care Home Providers and general practice to define a model of supportive care which captures the wishes and needs of the resident and their family, and the experience of the residents, GPs and the care home and trust support teams. This will engage the residents' primary care team in planned care reviews and multidisiplinary work which will enable improved medical and social wellbeing outcomes as well as provide appropriate plans for escalation of care when necessary across the care continuum. Fundamental to this will be a series of multidisciplinary clinical reviews, medical care plans and multi-disciplinary working with other home care and trust staff.

The HSCB GMS Lead, Dr Margaret O’Brien, will work with the Department of Health, HSC Trusts and GPs to define an appropriate enhancement of usual care to deliver the elements described above and contribute to the care of the individual in a multi-disciplinary manner.

## 10. TIMELY DISCHARGE FROM HOSPITAL

What does this mean?

One of the main causes of overcrowding in Emergency Departments is exit block. Exit block is the situation where patients have been assessed and a decision has been taken to admit them but they are unable to leave the ED due to the unavailability of beds in the hospital. During the surge period there will be significant pressure on bed capacity and it is therefore essential that hospital beds are used appropriately and efficiently for those requiring bed based care.

There is also a great deal of evidence proving that patients should not spend any longer in hospital than they need to. The consequences for a patient who is ready for discharge remaining in a hospital bed are that:

- The patient is exposed to an unnecessary risk of hospital-acquired infection;
- Frustration and distress may be caused to patients and/or their relatives whilst waiting for a preferred discharge destination to become available;
- The needs of the person can be more appropriately met in a lower-acuity setting, including a non-hospital environment;
- Negative impact on patients' level of independence, as a bed based environment is not designed to meet the needs of people who are medically well;
- Increased pressure within the Health care system due to the unnecessary use of hospital beds.

This action is intended to support timely effective transfer of care of patients ready for discharge to the most appropriate setting. Patients should not remain in hospital when their needs can be more appropriately met in a lower-acuity setting. This may be a non-hospital care environment or their home.

How will it work?

During the surge period, in order to protect patients and to prevent overcrowding in our hospitals, it will be necessary for patients to be discharged at the point that their needs can be more appropriately met in a lower-acuity setting.

Where the preferred destination or provider is unavailable they will be required to accept an alternative location or care provider whilst they await availability of their preferred choice.

Trusts will make reasonable efforts to facilitate patients and families wishes but this must not be to the detriment of equitable and fair access to services for all patients.