Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

# Review of Urgent and Emergency Care

# Consultation Findings Report

**OCTOBER 2022**

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# 1. Consultation finding Overview - Review of Urgent and Emergency Care

- The consultation ran for a period of 15 weeks from 16 March 2022 until 1 July 2022.
- 242 responses were received by writing, with a further 185 people attending online consultation events.
- Feedback is mainly in agreement with the proposals set out in the consultation paper. This is supported by both statistical and narrative information.

## Strategic Priority 1.

a. 54% agreed with the introduction of a Phone First model, 34% disagreed and 12% neither agreed nor disagreed.
b. 64% agreed with Urgent Care Centres and rapid assessment in all Trusts, 27% disagreed and 10% neither agreed nor disagreed.
c. 71% agreed a reshaped, integrated Out of Hours GP service would improve services, while 18% disagreed and 12% neither agreed nor disagreed.

## Strategic Priority 2.

a) 58% agreed that the proposed actions would improve the efficiency and effectiveness of the urgent and emergency care system in Northern Ireland, while 27% disagreed and 15% neither agreed nor disagreed.
b) 53% agreed that the proposed actions would provide sufficient evidence and data to inform capacity requirements for our future urgent and emergency care system, while 25% disagreed and 22% neither agreed nor disagreed.

## Strategic Priority 3.

a) 62%, agreed that the proposed introduction of the regional Intermediate Care model would improve urgent and emergency care services, while 24% disagreed and 13% neither agreed nor disagreed.

A number of points were raised during the qualitative analysis, which have been grouped as follows:

## 2. Introduction

In March 2022 the Department of Health (DoH) published the Review of Urgent and Emergency Care for public consultation. This followed an extensive period of co-production and pre-consultation. During the consultation there was significant engagement with stakeholders from various sectors and backgrounds which resulted in a strong level of response and thought provoking feedback for consideration.

Each consultation response has been reviewed, analysed and given due consideration and will be used to inform an implementation plan that will set out how the recommendations in the Review will be progressed.

This report provides a summary of the comments made in response to the consultation, both in virtual consultation events and in formal consultation response submissions to the Department. It also highlights how issues raised during the consultation will be considered and addressed as work progresses in Urgent and Emergency Care.

It is clear from the feedback received that consultees are generally in support of the Review and the strategic priorities outlined. This is evidenced in the response to the quantitate questions, where a majority of respondents agreed or strongly agreed with all questions asked, and the supplementary comments and responses received from consultees. There were however some issues of concern raised, reflected in the number of people who disagreed or strongly disagreed with the questions posed. The summary of feedback from all consultation responses shows the main issues raised by consultees in response to the questions asked.

It is also important to note that a number of concerns were received from members of the public about the future of services at specific hospital sites in rural locations. The strategic priorities set out in this consultation sought to enhance access to urgent and emergency care for all members of the public. This report endeavours to fairly reflect the views presented during the consultation.

This report provides an analysis of the responses in relation to the questions posed relating to the three strategic priorities. There is also a thematic analysis identifying the themes that occurred through the breadth of the consultation responses.

## Background

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*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. Minister for Health, Robin Swann MLA*

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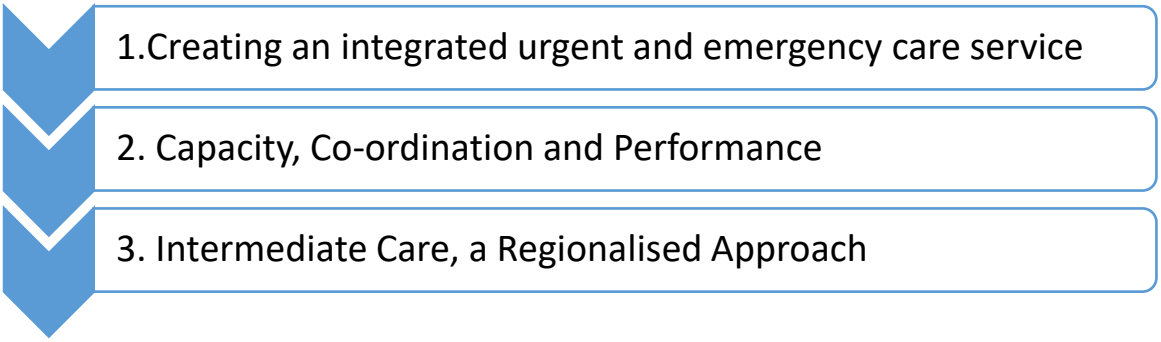
Urgent and emergency care services have been under significant, and increasing, pressure for at least the past decade, with additional pressures arising from the COVID-19 pandemic. A review of services has been in development since 2018 but with a necessary pause in the work as a result of the pandemic. This work was re-established in autumn 2021 by the Department of Health (DoH), which resulted in a Review report and identification of strategic priorities which formed the basis of the public consultation.

The purpose of the Review was 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. Access should be in a location most suited to the service user, without necessarily having to attend an Emergency Department. This builds on the experience gained in relation to new service models, through implementation of the No More Silos programme.

The consultation report highlighted plans to protect access to emergency care, whilst providing alternative services/pathways for urgent but not life-threatening conditions.

These focused on three strategic priorities:

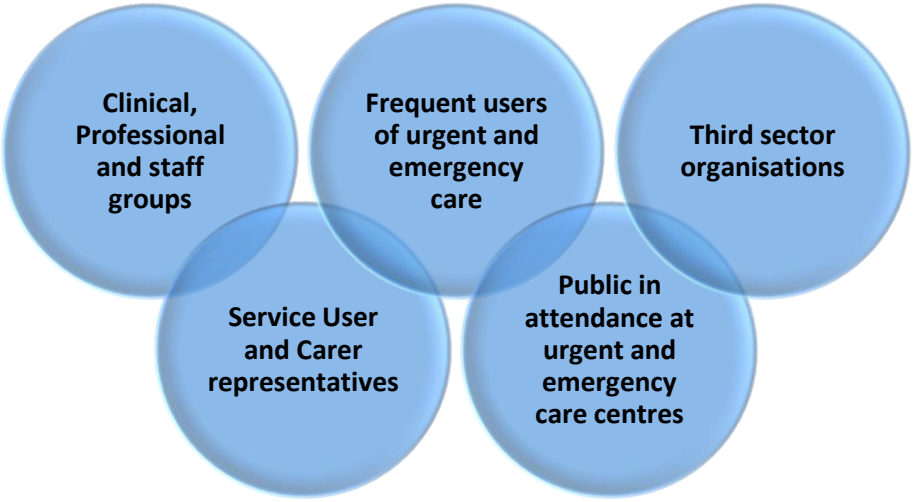



There should be no doubt that the proposals from this Review will integrate feedback from the public consultation, however they will take considerable time to implement in full and will require significant additional strategic funding. An implementation plan will be developed to provide detail on the actions required to progress this work.

## Co-Production and stakeholder involvement during the Review development

Co-production was key to the work of the Review and before reaching the public consultation stage the DoH had engaged with a diverse range of 1400 stakeholders to shape the content of the consultation report. This was done using a mixture of methodologies and ranged from co-production with clinicians, service users and carers who worked at a strategic level through to wider involvement and engagement methodologies with service users, carers, clinical professionals, the third sector, and health and social care staff.

The involvement of service users, carers, and staff plays an important role in the design and delivery of HSC services. In Northern Ireland there is a legal obligation to involve and consult people who use HSC services which is set out in sections 19 and 20 of the HSC Reform Act (2009). Stakeholder involvement was identified as an important part of this Review from the outset, with a wide range of stakeholders making key contributions towards the findings of this report, including:



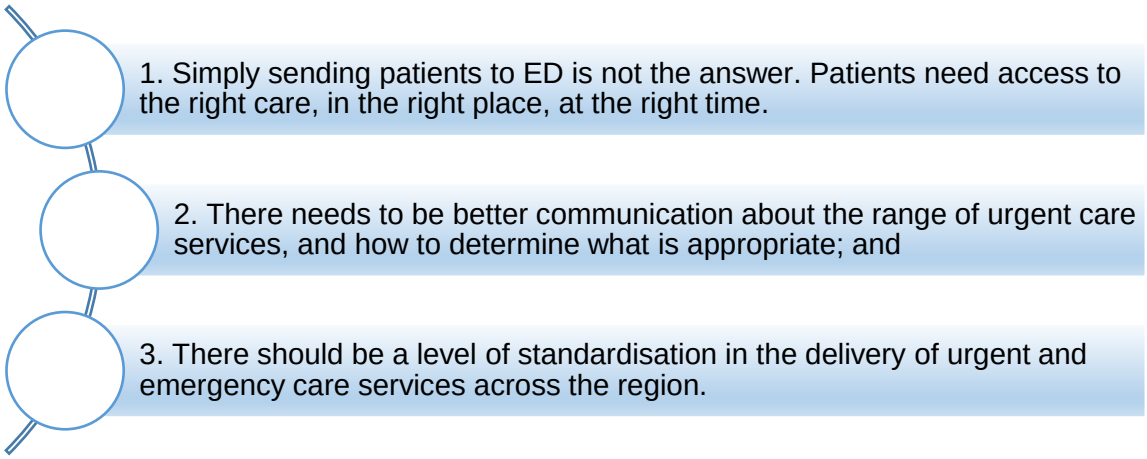

The review team worked collaboratively with experienced service user and carer representatives from the regional Unscheduled Care Reference Group and partners from the Public Health Agency (PHA) and the Patient Client Council (PCC) to ensure that a comprehensive co-production and involvement methodology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

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

a) Engaging at the outset of the Review with the Unscheduled Care Reference Group and inviting a number of its service user and carer members to join project structures, including the Project Board and workstreams that undertook the Review.
b) Hosting a stakeholder summit at an early stage of the Review to bring together a wide range of stakeholders, ranging from clinical professionals in urgent and emergency care medicine, General Practitioners, service users, carers, commissioners, community and voluntary sectors and others.
c) Establishing an Involvement and Co-Production Working Group to co-produce and implement the involvement strategy and plan. This group comprised of service users, carers, the clinical lead, the Departmental lead and representatives from the Public Health Agency's regional Personal and Public Involvement team and the Patient and Client Council.

d) Seeking views and input from staff and service users/ carers at appropriate stages through a comprehensive and ongoing program of engagement events, workshops and a survey conducted with patients in emergency department waiting rooms.
e) Embedding service user and carer representatives within the No More Silos programme at strategic and local implementation levels.
f) Hosting a series of workshops in HSC Trusts to engage with local members of the public on urgent and emergency care services.

Through this engagement three themes emerged:




All aspects of service user and carer involvement were co-produced with the Involvement and Co-Production Working Group. Further detail can be found in chapter three of the Review team report.

## Pre-consultation Engagement

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. 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.

The public consultation has allowed DoH an opportunity to further test the findings of the Review with the population of Northern Ireland; this will then provide the basis for reform of urgent and emergency care.

## 3. Consultation process

The aim of the consultation process was to provide an opportunity for as many people as possible to share their views and feedback on the co-produced Review and the strategic priorities outlined.

The Department was specifically consulting on the Consultation Report and the Strategic Priorities for the Review of Urgent and Emergency Care. The consultation also included three draft impact assessments for Equality and Human Rights, Regulatory and Rural Needs.

Requests for meetings with individuals and groups were facilitated and requests for additional response time were accommodated.

All documentation was published on the Department's website. The documentation was available in alternative formats on request. Supporting documentation was provided in the form of:

- An Executive Summary.
- A Consultation Report setting out supporting information and strategic priorities.
- A Review Team Report setting out detail on the Review and its findings.
- An Easy Read version of the consultation and questions.

Respondents could respond to the consultation via a number of routes:

- By completing the online questionnaire provided on the Northern Ireland Government Citizen Space website.
- By completing the MS Word response questionnaire and either posting or emailing to the Department.
- By submitting views and comments in an alternative format, eg, an email, letter or free submission; and
- Following feedback from the public we also worked with the Patient Client Council to provide a dedicated consultation feedback phone line.

## Public Consultation Events

Five virtual consultation events were also held to support wider engagement and consultation with stakeholders. This enabled people from across all areas of Northern Ireland to participate at a time that was suitable for them. These events were held virtually in line with Public Health advice at the time of the consultation; and in recognition of the regional nature of the Review and strategic priorities presented. Sign Language Interpreters services were available for two of the events. All events were advertised on the Department's website, through press releases to regional and local media, via social media, the Patient and Client Council and other Networks. Three public facing online consultation engagement events took place on the following dates and times.

- Monday 16 May 2022 - 10.30 am - 12 midday
- Thursday 19 May 2022 - 7 pm - 8.30 pm
- Wednesday 8 June 2022 - 2 pm - 3.30 pm

Two additional stakeholder events were specifically targeted for clinical professionals and Trade Union representatives.

Each session lasted approximately 1.5 hours and over the five workshops, a total of 269 people registered and, of those, 185 people attended, including representatives from HSC organisations, staff, members of the public, service users, carers, Third Sector organisations, HSC professionals, Trade Union representatives, Universities, Local Government and other stakeholders.

The engagement exercise focused on the three strategic priorities outlined in the consultation report and used questions adapted from the consultation questionnaire. The discussion was led and facilitated by the workshop contributors and senior DoH and HSC officials in smaller breakout rooms of approximately 15 people. Attendees had an opportunity to share their views and suggestions. These findings were captured by scribes and key points shared by the facilitators during each workshop. A report on the feedback received was

prepared by the HSC Leadership Centre and the views of participants have been factored into the overall consultation analysis. The report can be found in Appendix 3.

## 4. Analysis of consultation responses

A wide range of feedback has been received from a diverse range of stakeholders on all aspects of the consultation. This section provides more detail on the responses received. It is structured to show how many responses were received, who responded, and provides an analysis of quantitative and qualitative feedback received.

In addition to responses to specific questions six themes have emerged, these are:

1. Accessibility/ Access to services,
2. Standardisation and adopting a whole system approach,
3. Communications, clarity and public messaging,
4. Workforce,
5. Digital and IT,
6. Partnership working.

### Response rate

The consultation ran for a period of 15 weeks from 16 March 2022 until 1 July 2022, during that time 242 response were received. These included online responses, email and letter, a small number of people contacted the dedicated consultation phone line (these responses were captured by the Patient Client Council using the online questionnaire). A further 269 people registered to attend online consultation events with 185 people participating in these events.

As part of the consultation process, we asked people to identify what best described them as a respondent. Data shows that many responses were received from members of the public with significant number of responses from professional bodies/trade unions, community and voluntary sectors and Health and Social Care, local councils and political parties.

Table 1. below has been created using the data captured on the completed consultation questionnaire, emails and written responses. A list of consultees can be found in Appendix 1.

| Category | Number |
|---|---|
| **Member of the Public** | 177 |
| **Health and Social Care** | 21 |
| **Professional Body / Trade Union** | 19 |
| **Community and Voluntary sectors** | 7 |
| **Local Council** | 3 |
| **Political Party** | 4 |
| **Other** | 11 |

**Table 1.**

## Service user and carer responses

Of those who responded as a member of the public to the online questionnaire, 38 also identified as a service user and 10 as family carers. It was also clear that a significant proportion of the emails received from members of the public came from people who had direct experience of using urgent and emergency care services and/or working within the HSC.

## Demographic mix

Data from the online questionnaire indicates that responses were received from both rural and urban settings. With 46.67% of respondents coming from rural areas and 42.96% coming from urban areas and a further 10.37% indicating that this question was not applicable (or did not provide a response).

We also asked a range of equality questions to determine who was responding to the consultation. While not everyone chose to respond to these questions, the information showed that people from a range of groups were represented in the feedback. Those that responded indicated that 58.52% were female respondents, 26.67 were male, 1.48% identified as other and 13.34% did not specify gender. Responses also identified that 17.68% had a disability with a further 17.78% telling us that they cared for a family member and had caring responsibilities for a child, adult or older person. The data also shows that there was a mix of religious belief

with 34.07% identifying as catholic, 26.67% identifying as protestant, 16.30% identifying as having no religious belief and 2.96% identifying as other. In relation to political status 22.22% identified as unionist, 22.22% identified as nationalist and 26.67% identified as other. Full details can be found in Appendix 2.

### Location based responses

Data from email and online responses captured a significant number of respondents from Down, from the South West and from Newry areas. With 34 responses from the Down/Downe Hospital area and 22 from the South West/South West Acute/Omagh and 6 Newry/Daisy Hill, these contained a mixture co-ordinated responses with examples of patient stories and one off responses.

## 5. Consultation Findings

The key quantitative findings from the consultation questionnaire are made up of both online, email and written responses received. The statistical information represents the 156 (or 65%) of responses that completed the consultation questionnaire. The qualitative findings also include responses that were received in other formats including feedback from those who attended the consultation events. The responses include a variety of views on these questions however overall responses indicate a high degree of support for the proposals set out in the consultation.

In the main, the consultation was welcomed by consultees and there was a recognition that the existing urgent and emergency care services require reform to meet the needs of the population.

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*"The Council welcomes the current review and acknowledges the volume of work undertaken by the Department since 2018, as well as the co-production nature of this review – including the input received from over 1,400 stakeholders. Four years on, fully understanding of both policy and practical pressures of responding to the COVID-19 pandemic, the consultation is finally welcomed. This is an extremely important review, emphasised by the volume of input received so far, and it is vital that urgent and emergency services are improved and revitalised across Northern Ireland." Fermanagh and Omagh District Council*

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*"We warmly welcome measures included which would improve co-ordination between different parts of the healthcare system here. We regularly hear from our members and from service users about difficulties in accessing healthcare services at the right time and in the right place. The challenges experienced by members vary from context to context." Homeless Connect*

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*"I welcome this review and the proposed improvements outlined. I am conscious of the need for urgency and the need for more specific plans to address these issues. I*

*also understand the complexities and the amount of work needed to realise the potential this review can have and look forward to receiving more detailed information on the implementation of the proposals, following the consultation process." Commissioner for Older People*

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We also received feedback from consultees who were more apprehensive about the consultation and the need to change existing services.

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*"No one will deny that urgent and emergency care services need to be reshaped to meet the rising need of the population but in order to this, you must invest in the services we already have.*

*Rural locations do not need urgent care and rapid access services. They require proper investment in their existing services" Member of the public*

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*"It is difficult to constructively comment on a consultation paper that states in the foreword "will take considerable time to implement, require significant additional strategic funding…leading to an investment and implementation plan. It is disconcerting to commence a consultation with the usual statements of time and money. The health service needs stabilising and investment now. Therefore, the paper appears 'aspirational' as opposed to grounded." Member of the public.*

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This report endeavours to address all views expressed during the consultation in a balanced fashion. It is not possible to include comments or details of every consultation response; therefore, the report focuses on the specific questions asked during the consultation, as well as themes that have emerged during a thematic analysis exercise carried out on all consultation responses received.

## Responses to consultation questions

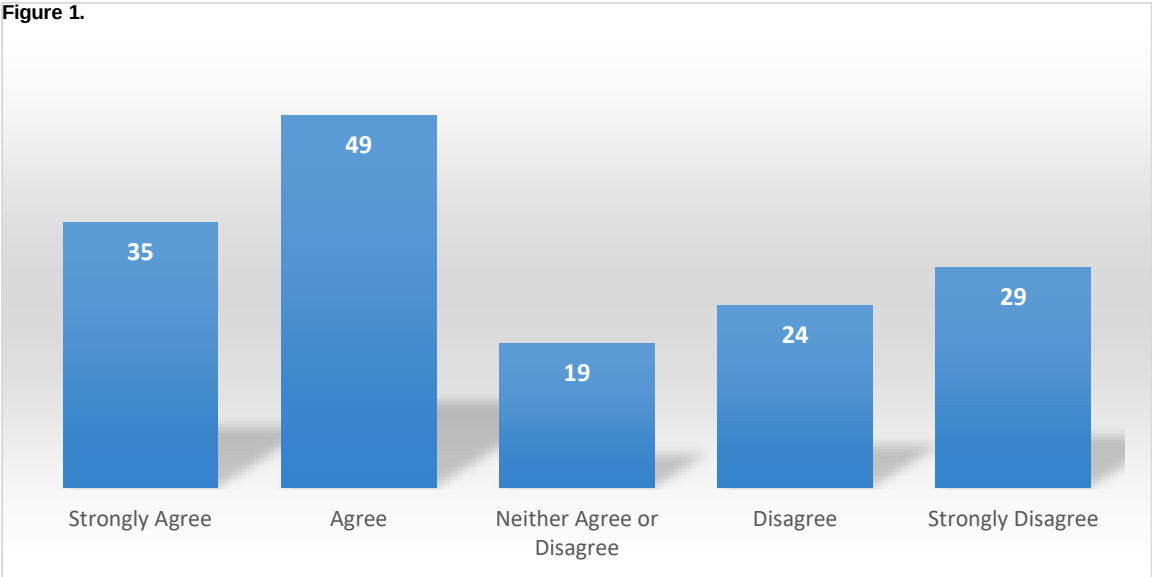
Participants were asked a series of questions based on the consultation documentation and/or presentations on the three strategic priorities. There were a total of 156 responses, 135 via the online questionnaire and 21 responses from returned consultation questionnaires. An analysis of responses received to each question is as follows:

## Strategic Priority 1.

- **To what extent to do you agree that the introduction of a regional 'Phone First' service will improve urgent and emergency care in Northern Ireland?**

Most respondents to this question, 54%, strongly agreed or agreed that the introduction of a Phone First model, as outlined in the consultation documentation, would improve access to urgent and emergency care services. However, 34% of respondents either disagreed or strongly disagreed that introducing this service would improve these services, while 12% identified that they neither agreed nor disagreed.

**Figure 1.**




| Option | Total | Percent |
|---|---|---|
| **Strongly Agree** | 35 | 22.44% |

| | | |
|---|---|---|
| **Agree** | 49 | 31.41% |
| **Neither Agree or Disagree** | 19 | 12.18% |
| **Disagree** | 24 | 15.38% |
| **Strongly Disagree** | 29 | 18.59% |
| **Not Answered** | 0 | 0.00% |

**Table 2.**

Respondents were mainly positive in response to this issue and identified that a single number for Northern Ireland, that ensured that patients received the right service in a timely manner was essential.

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*"Phone First worked really well for me on the one occasion I needed it. An improvement on what would have happened before Phone First was up and running. I had no trouble getting through to a member of staff on the phone who took my details. I received another call from a member of staff shortly after that who on speaking to me arranged a fast (within one hour) appointment at Minor Injuries. I felt it much more efficient than being triaged and potentially waiting longer after I arrived at the hospital. A very efficient service in my experience." Member of the public*

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Feedback highlighted the importance of having access 24 hours a day, 7 days a week and felt that this would require a strong infrastructure behind any 'Phone First' service. The feedback also emphasised support for the adoption of a regional approach rather than at HSC Trust level model.

It appears that there is a degree of confusion between the 'Phone First' service being proposed as part of this consultation and existing arrangements where patients phone their GP surgery to access a primary care appointment. A few responses referred to the phone first model which many GP practices have adopted since COVID-19. This misconception may account for some of those who disagreed with the 'Phone First' service. Dissatisfaction and difficulty accessing GP services was frequently stated as a reason not to support the introduction of a 'Phone First' service for urgent and emergency care.

It was also clear that a few respondents had experience of the HSC Trust 'Phone First' pilots, either as a patient or staff member of staff. There was a mixed response to these pilot services, with people identifying both positive and negative experiences. This was variable between different HSC Trusts, with many respondents highlighting the importance of having a consistent regional approach should a 'Phone First' service be introduced for Northern Ireland.

Concern about the best use of financial and human resources were raised by many consultees and was present in both the responses where the consultee agreed and where the consultee disagreed. Some felt that any proposed service required investment and staffing while others suggested that funding may be better used within the existing urgent and emergency system rather than creating new ways of working that divert staff and money.

Respondents who were supportive of 'Phone First' also identified that any service of this nature would require highly skilled staff, with the ability to send people to the right services. They pointed to the importance of working with existing GP Out of Hours services and including appropriate training and support of existing and new clinical staff.

Many respondents highlighted the requirement for a high level and far-reaching public communication campaign to support public understanding of the service.

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*"The public need to be reassured that services are there should they become unwell. A comprehensive information campaign with messages tailored to different stakeholder groups to support the necessary behavioural change required to realise the vision set out in the consultation document is required." Member of the public*

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It was suggested that the introduction of a new system has the potential to cause confusion in relation to when to use 'Phone First' services and where it sits in relation to the emergency 999 and GP services.

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*"Phone First is the most confusing and unnecessary action for the health service- I don't know when to use it… is it instead of a GP … do I have to contact them if I'm returning to ED… honestly you have added another step into an already confusing system … you are missing clarity." Member of the Public*

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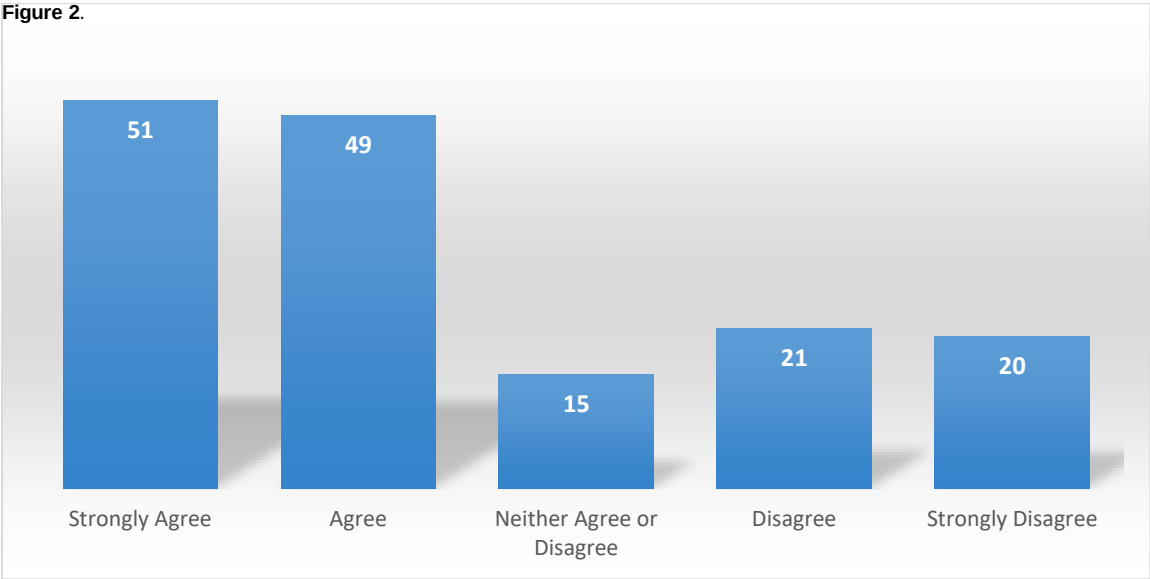
A small number of respondents were concerned that introducing a new phone line will lead to the creation of a barrier to accessing service for those who need urgent or emergency care. There was a misapprehension that 'Phone First' was being proposed as the only way to access urgent and emergency care, with some respondents concerned that patients believed that they would no longer be able to turn up at an Emergency Department without phoning first.

**Departmental response:** It will be important to ensure that the development of a new regional 'Phone First' system, which will operate in addition to current services for urgent and emergency care, incorporates further work to sufficiently prepare structures, staff and the public for a new way of working. Feedback indicates that there is a desire for any system to be efficient, easy to access and ultimately provide a faster and safer patient journey. Any system will be designed by working in partnership with staff and patients; and will include clear information for all members of the public on how to use services.

- **To what extent to do you agree that the introduction of Urgent Care Centres and rapid assessment and treatment services in all Trusts, to accompany the 'Phone First' service, will improve urgent and emergency care in Northern Ireland?**

A high percentage, 64%, of those who responded to this question strongly agreed or agreed that the introduction of Urgent Care Centres and rapid assessment and treatment services in all Trusts, to accompany the 'Phone First' service, will improve urgent and emergency care in Northern Ireland. However, 27% disagreed or strongly disagreed and 10% neither agreed nor disagreed. This was also reflected in the written responses and feedback from those who attended the consultation events.

**Figure 2.**




| Option | Total | Percent |
|---|---|---|
| **Strongly Agree** | 51 | 32.69% |
| **Agree** | 49 | 31.41% |
| **Neither Agree or Disagree** | 15 | 10.62% |
| **Disagree** | 21 | 13.46% |
| **Strongly Disagree** | 20 | 13.82% |
| **Not Answered** | 0 | 0.00% |

**Table 3.**

Respondents told us that having access to Urgent Care Centres and rapid assessment and treatment services was vital for any 'Phone First' service to work. They also highlighted the potential for confusion and asked for more clarity on the role of Urgent Care Centres in relation to existing Minor Injuries Units.

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"Phone First without adequate urgent care resource integrated to the system will be of little benefit to increasing capacity in Urgent/Emergency care."

Member of the public

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Several respondents from rural areas highlighted that access to these services was vital for rural communities with a number suggesting that these services should be available in more than one hospital site in their Trust locality. Others sought more detail and local level engagement and consultation on any proposals to introduce Urgent Care Centres and rapid assessment and treatment services, highlighting that the location of these services will be an important consideration.

Other issues highlighted included the importance of resource and workforce implications. These issues were raised both by those who agreed and disagreed with the proposal. Those who disagreed indicated that Urgent Care Centres should not be introduced until there was stabilisation of the existing workforce in existing Type 1 Emergency Departments across the region. This is also reflected in concerns raised about availability of GP, Emergency Medicine Clinicians, Nurses, Allied Health Professionals and associated staff.

As with 'Phone First' some respondents raised the confusion caused by introducing new services with new names. Some felt that this would lead to lack of understanding and greater potential that patients would not access appropriate care in a timely manner. Respondents again suggested that any new services should be developed in partnership and include a comprehensive communication and information campaign.

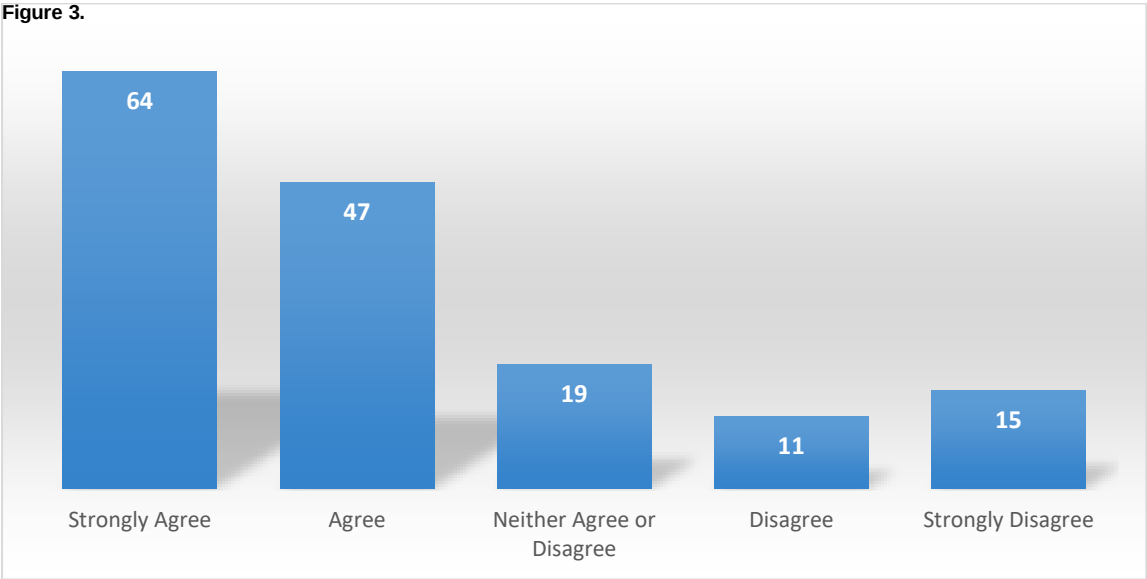
While a few respondents from rural areas raised concerns about retaining access to emergency medicine within 45 minutes or the 'golden hour', the purpose of the review is to enhance access to services for all members of the public, regardless of location.

**Departmental response:** The implementation plan that will result from this review will progress the establishment of Urgent Care Centres and rapid assessment services across all Trusts. The plan will take into account the issues raised during this consultation regarding workforce, resource, location and communication issues. The implementation will be taken forward with stakeholders to ensure that local and professional issues are considered as part of planning and implementation.

- **To what extent to do you agree that the introduction of a reshaped, integrated Out of Hours GP service will improve urgent and emergency care in Northern Ireland?**

A high percentage, 71%, of those who responded to this question strongly agreed or agreed that the introduction of a reshaped, integrated Out of Hours GP (GP OOH) service will improve urgent and emergency care in Northern Ireland, while 18% disagreed or strongly disagreed and 12% neither agreed nor disagreed. This was also reflected in the written responses and feedback from those who attended the consultation events.

**Figure 3.**




| Option | Total | Percent |
|---|---|---|
| **Strongly Agree** | 64 | 41.03% |
| **Agree** | 47 | 30.13% |
| **Neither Agree or Disagree** | 19 | 12.18% |
| **Disagree** | 11 | 7.05% |
| **Strongly Disagree** | 15 | 10.62% |
| **Not Answered** | 0 | 0.00% |

**Table 4.**

Most responses welcomed the reshaping of GP OOH to meet the demands of the population. It was clear that GP OOH is a valued service and that respondents wished to see greater access to the service outside of normal hours rather than only

having access to a telephone consultation. Concerns were raised about the location of GP OOH, especially in rural areas.

In response to this question there was considerable feedback in relation to the workforce and resource. The recruitment and retention of GP's, specialist nurses and GP OOH workforce was seen as essential to successfully reshaping GP OOH services. The issue of who employs this workforce and how they would be recruited was highlighted. As GPs are not directly employed within HSC Trusts it was suggested that more detail was needed regarding how this workforce would be integrated into these models and which body has ultimate managerial responsibility.

As with 'Phone First', Urgent Care Centres and rapid assessment and treatment services, a concern was raised regarding the potential for confusion with different numbers and routes of access.

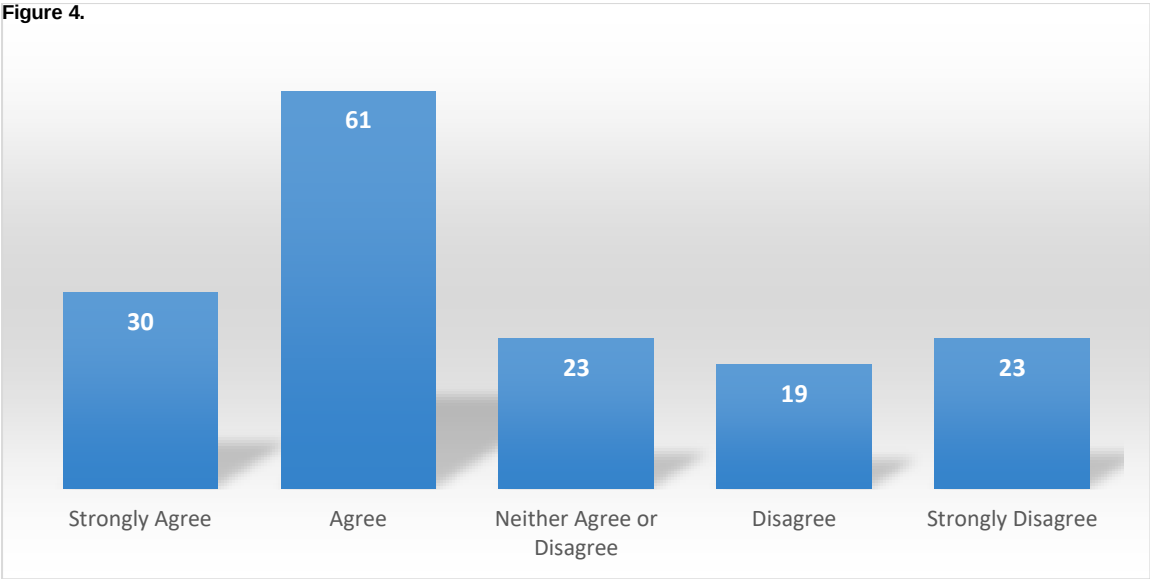
**Departmental response:** The implementation plan that will result from this review will progress work in relation to the integration of GP OOH services. The plan will consider the issues raised during this consultation regarding workforce, resource, location and communication issues. The implementation will be taken forward with stakeholders to ensure that local and professional issues are considered as part of planning and implementation.

### Strategic Priority 2.

- **To what extent to do you agree that the proposed actions under Strategic Priority 2 will improve the efficiency and effectiveness of the urgent and emergency care system in Northern Ireland?**

Of those who responded to this question, 58% strongly agreed or agreed that the proposed actions under Strategic Priority 2 will improve the efficiency and effectiveness of the urgent and emergency care system in Northern Ireland. However, 27% disagreed or strongly disagreed and 15% neither agreed nor disagreed. This was reflected in the written responses and feedback from those who attended the consultation events.

Figure 4.




| Option | Total | Percent |
|---|---|---|
| **Strongly Agree** | 30 | 19.23% |
| **Agree** | 61 | 39.10% |
| **Neither Agree or Disagree** | 23 | 14.74% |
| **Disagree** | 19 | 12.18% |
| **Strongly Disagree** | 23 | 14.74% |
| **Not Answered** | 0 | 0.00% |

**Table 5.**

Feedback on Strategic Priority 2 focused on the need for clarity in relation to capacity across the urgent and emergency care system and beyond, to include social care, discharge, domiciliary care, access to services in the community and primary care. There was a variety of suggestions on how to support and build capacity, including strengthening pay and conditions to enhance staff recruitment and retention, providing training and development opportunities and better use of digital solutions. Respondents also suggested that further consideration should be given to population health and public health campaigns that would promote greater public health among the population leading to less stress on urgent and emergency care.

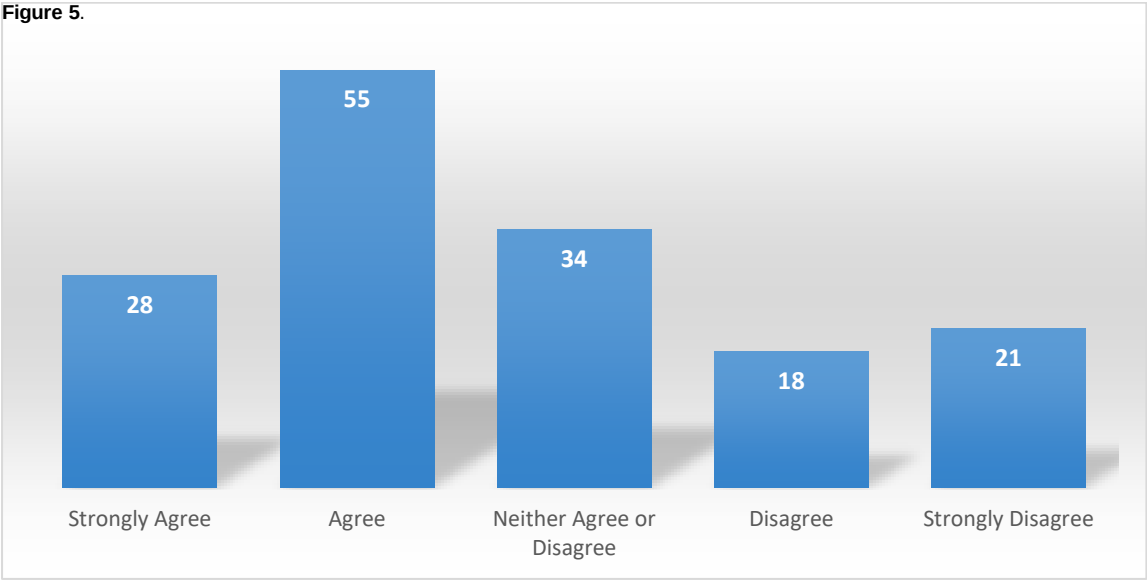
Respondents highlighted the need for greater clarity in relation to who was responsible for the implementation of Strategic Priority 2 in terms of governance and accountability. Clarity was also sought in relation to how many Emergency Departments would be affected.

**Departmental response:** DoH will establish oversight, governance and monitoring structures to oversee progression on all three strategic priorities. In addition, appropriate mechanisms will be used to operationally manage implementation. This will include the creation of programme management structures to progress each of the strategic priorities. This will be outlined in the implementation plan.

- **To what extent to do you agree that the proposed actions under Strategic Priority 2 will improve provide sufficient evidence and data to inform capacity requirements for our future urgent and emergency care system?**

Of those who responded to this question, 53% strongly agreed or agreed that the proposed actions will provide sufficient evidence and data to inform capacity requirements for our future urgent and emergency care system, while 25% disagreed or strongly disagreed and 22% neither agreed nor disagreed. Many people who attended the public consultation events also told us that was an area that they would like more detail on before agreeing or disagreeing. This is reflective of the higher percentage of those who neither agreed nor disagreed with the survey question and in can be seen in the written responses.

**Figure 5.**



| Option | Total | Percent |
|---|---|---|
| **Strongly Agree** | 28 | 17.95% |
| **Agree** | 55 | 35.26% |
| **Neither Agree or Disagree** | 34 | 21.79% |
| **Disagree** | 18 | 11.54% |
| **Strongly Disagree** | 21 | 13.46% |
| **Not Answered** | 0 | 0.00% |

**Table 6.**

There was much support for undertaking an independent capacity review and the use of the Getting It Right First Time (GIRFT) review methodology to determine the current status of Emergency Medicine in Northern Ireland. It was also notable that respondents highlighted the importance of working with professional bodies, staff groups and relevant stakeholders. This included counterparts in in the UK and Ireland to ensure that any recommendations are progressed in partnership to utilise existing infrastructure and staff resources while planning current and future workforce requirements. It was also suggested alongside any GIRFT review that further consideration should be given to the needs of rural populations, carers, clinical and non-clinical aspects of urgent and emergency care, social demography and existing infrastructure for road and travel. It was felt that without these considerations more rural hospitals may be disadvantaged.

The proposals for investment in Northern Ireland Ambulance Service (NIAS) Clinical Response Model were widely welcomed as important for delivering fast and effective access to ambulance services. Many consultees also highlighted the particular importance of NIAS in rural communities and recommended that DoH work closely with NIAS to progress this work and reduce disparity in ambulance waiting times for rural residents.

The issue of delayed discharge was raised by several respondents as a reason for long waiting times to access Emergency Departments and suggest that it an area that requires further focus in relation to this Review.

**Departmental response:** DoH will progress the GIRFT review in line with the proposals outlined in the Review. This will be done using a partnership approach

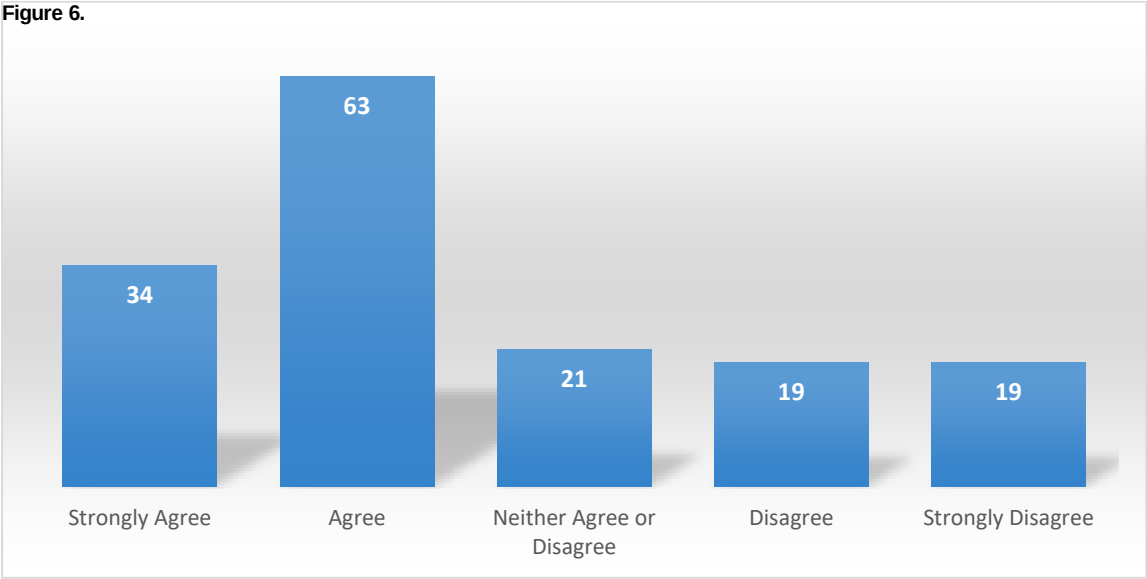
with clinical bodies and professionals. Further work in relation to capacity will be guided by the outcome of the GIRFT review. The Department will also work with NIAS to progress the business case underpinning the Critical Response Model and seek to secure the necessary funding to deliver the required increase in NIAS capacity.

### Strategic Priority 3.

- **To what extent to do you agree that the proposed introduction of the regional Intermediate Care model will improve urgent and emergency care services in Northern Ireland?**

Most consultees who answered this question, 62%, strongly agreed or agreed that the proposed introduction of the regional Intermediate Care model will improve urgent and emergency care services. However, 24% disagreed or strongly disagreed and 13% neither agreed nor disagreed. As with other questions this is reflective of the feedback received in writing and during the consultation events.

Figure 6.




| Option | Total | Percent |
|---|---|---|
| **Strongly Agree** | 34 | 21.79% |
| **Agree** | 63 | 40.38% |

| | | |
|---|---|---|
| **Neither Agree or Disagree** | 21 | 13.46% |
| **Disagree** | 19 | 12.18% |
| **Strongly Disagree** | 19 | 12.18% |
| **Not Answered** | 0 | 0.00% |

**Table 7.**

The proposed intermediate care model was widely welcomed by consultees. There were however a small number of consultees who suggested that the Hospital at Home model would mean that people would not be getting as good a service as they would in a hospital setting. Others felt that younger people were at a disadvantage as they did not at present have access to Hospital at Home services. Many responses focused on the opportunity for patients to receive the most appropriate treatment and care, that would lead to better clinical and social outcomes using an effective Hospital at Home service. Further work is required in relation to communication and clarification about the role of intermediate care within the urgent and emergency care system.

A high number of respondents emphasised the importance of a standardised regional approach for Hospital at Home, with some citing variation of the Acute Care at Home model across different Trusts and even within Trusts. As with other issues, this was a considerable concern among rural population as they wish to have access to the same level and quality of service as someone living in an urban setting.

As with previous questions, consultees raised the issue of investment and staffing and highlighted that this is a service that will also require both to be effective. It was suggested that further training and development, better pay and conditions, greater workforce planning and opportunities for promotion should be provided, especially for specialist roles such as Advanced Nurse Practitioners, Allied Health Professionals and domiciliary and social care staff.

**Departmental response:** The implementation plan that will result from this Review will incorporate proposals for intermediate care services across all Trusts. The implementation will be taken forward with stakeholders to ensure that local and professional issues are considered as part of planning and implementation.

# 6 Thematic findings

Through the qualitative analysis of all the consultation responses a number of high-level themes have emerged. Set out below are the main areas identified, all of which arises multiple times across responses from different groups. Under each theme there are a range of issues that will be addressed as part of the implementation plan. It is also worth noting that where issues raised are outside the scope or reach of the review of urgent and emergency care, DoH will share the issues raised with the appropriate leads/organisations and, where applicable, work in partnership to ensure consistency of approach.

### 1: Accessibility/ Access to services

There were a high number of responses from consultees that highlighted the difficulty in accessing services, including reference to pathways of care in urgent and emergency care situations, such as GP services, Phone First, Urgent Care Centres, GP OOH and Ambulance services.

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*"I would like to know where the GPs and staff are coming from to staff these centres. We already have huge shortages…The need to understand the role of NIAS and closer links to their clinical response model would improve the overall approach…The location of these centres is also an important consideration." Public consultation event report*

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*"Members of the deaf community, who attended two of the consultation events, expressed their concern about the accessibility of the Phone First service and it was recommended that specific enabling measures would have to be put in place. It was also highlighted that elderly people and people with learning disabilities may struggle when using the phone, with no other options present. Other access issues were highlighted for those patients requiring interpreting services and people who are blind." Public consultation event report*

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A number of responses focused on access to in hours GP and Primary Care services. While this is outside the scope of this consultation, the issues are relevant to support a whole systems approach to urgent and emergency care. We will share this feedback with colleagues in DoH and Primary Care, and work in partnership with them to support better outcomes for patients.

The location of existing and future services was also important to those who responded, as was travel to service and potential for removal or reshaping services in particular geographies, including Down, Newry and Fermanagh.

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*"I have medical needs myself and have mobility problems and at times I need the services of the Downe hospital. There is absolutely no way that I could physically travel to any other hospital apart from the Downe. From my home to the Downe is around 20 minutes to half an hour away but Dundonald, could be anywhere from one hour to a few hours depending on public transport." Member of the public*

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*"The location facilitates appropriate accessible travel times for urgent and emergency treatment, if there was not an emergency department facility for possibly another 30 - 50 miles north or east it would result in severe gap in urgent and emergency care and as highlighted in previous reports, including the Hayes Report, which was commissioned by the Department of Health would have significant negative health consequences for a very large section of the population in the south west of Northern Ireland. Minor Injuries Unites are located at Tyrone County, Omagh and South Tyrone, Dungannon, these both provide a very valuable service and reduce the pressures on a range of Emergency Departments" Ulster Unionist Party*

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Access to and location of services is a clear concern for many consultees, this is recognised and will be addressed throughout the implementation process.

### 2: Standardisation and adoption of whole systems approach

The need for a standardised and consistent approach was a regular theme across responses to all strategic priorities. Consultees who were in favor of proposals also raised the issue of adopting a standard approach to services such as 'Phone First', GP OOH, Urgent Care Centres and Intermediate Care services such as Hospital at Home. Many cited examples of pilots or different ways of working across the region and suggested that in order to provide all citizens with an equitable service some degree of standardisation should be applied.

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*"RCN members have highlighted the need for consistency in approach from all HSC trusts and an associated requirement for stronger and clearer public information and education, as the general lack of understanding of service provision, availability and access can exacerbate these current problems and perceptions. RCN members have pointed out that different pathways - not simply via emergency departments - into acute hospitals must be developed in order to meet this need." Royal College of Nursing*

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This was also mentioned by consultees who were not in favor of proposals, many of whom suggested that rural citizens should receive the same level of service in an urgent or emergency situation, without the need to travel longer distances.

Consultees raised the issue that urgent and emergency care does not work in isolation from the rest of the HSC system and many respondents sought greater integration and better patient flow across services. Respondents stated that urgent and emergency care services are not isolated from wider HSC and primary care services.

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*"Whilst there is great potential to improve the provision of urgent and emergency care there are significant challenges to getting it right. A whole system approach is necessary. Where resources are limited there needs to be public consultation and consensus regarding where and what resources can be committed. There also*

*needs to be agreed expectations about what the service can provide – overpromising will quickly lead to dissatisfaction." Society for Acute Medicine*

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Concern was raised by some in relation to the ambition of the review of urgent and emergency. Suggestions were made that a wider view of health and social care is required to enable a whole system transformation.

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*"The wholesale transformation of our health service relies on a much more comprehensive, far-reaching roadmap than merely the review of urgent and emergency care, as vital as this area of work is." SDLP*

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Clarity was sought in relation to how urgent and emergency care will better integrate with other areas of health and social care provision. There was also strong representation in relation to specific service user groups, including children and young people, older people and people living with mental health or addiction issues, people with sensory or speech and language issues or those with learning disabilities and family carers, as well as people who are homeless.

The Royal College of Paediatrics and Child Health (RCPCH) argued that there should be bespoke plans/pathways for children and young people across urgent and emergency care including Phone First and clinical assessment discharge pathways, mental health and wellbeing app, and short stay Paediatric assessment units. They suggest this work could utilise the standards, research and expertise that they have built up. This was further supported by the Northern Ireland Children's Commissioner and other consultation responses.

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*"[There is a…] disappointing focus on mental health pathways within both primary and secondary care for children, young people and adults and the deafening silence for those with learning disabilities." Unscheduled Care Reference Group*

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Through the delivery of strategic priority one to three, DoH will prioritise the adoption of a standardised approach to service delivery across the region, with intention of providing consistent access to services regardless of postcode.

The Department will work across health and social care and with stakeholders to ensure that there is a joined-up approach to the delivery of the urgent and emergency care implementation plan to be developed. We will make links with existing strategies to ensure consistency.

### 3: Communication, clarity and public messaging

Many consultees stressed the need for the public to fully understand the urgent and emergency care system.

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*"The success of the implementation of the proposals will rest on the department undertaking a public education campaign to raise awareness of changes and where the best place is to seek treatment, depending on the issue. This will need to be undertaken repeatedly." British Medical Association*

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Respondents shared concerns about any changes to services creating more confusion in an already complex system. They cited the difficulty in knowing who to contact or where to go to receive the correct service and stressed how important this is in an emergency.

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*"Suggestions and recommendations received from the online engagement events highlight similar themes across the 3 stakeholder groups, with a strong focus on the need for consistent communication which would simplify the current messaging and inconsistency of how services are described." Public consultation events report*

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The requirement for a multi-channel communications campaign to support the proposed changes was raised on multiple occasions. DoH are committed to working with stakeholders and communications professionals to provide clear and understandable information about urgent and emergency care services.

### 4: Workforce

Throughout all feedback received there was a clear support for health and social care staff and a recognition that all staff groups continue to work tirelessly in an increasingly difficult environment. Members and the public and organisational responses alike shared their support of the workforce and identified that staff morale and burn out is an issue within the existing workforce.

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*"The impact that this is having and will continue to have on staff cannot be ignored. Recruitment and retention of staff is extremely challenging in any setting currently within healthcare, especially so within the Urgent and Emergency care system, where burn out and moral injury are experienced at levels higher than any other specialty." Royal College of Emergency Medicine (RCEM)*

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Consultees point out that both current and new staff are essential to reshaping urgent and emergency care, identifying that many existing issues in the service are a direct result of staffing issues. Respondents were clear that this was an issue that needs to be rectified through working together with staff and their representatives.

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*"If this re-shaping of urgent and emergency care is to be a success, then workforce planning and terms and conditions for staff right across health and social care services must be improved." Rural Community Network*

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In addition, consultees focused on the need for better training and development opportunities across all staff groups and suggest greater Multi-Disciplinary Team working and development of specialist roles.

There were also a range of training tools and resources shared by consultees which apply to specific aspects of the delivery of urgent and emergency care. These include training and development in areas such as Speech and Language Therapy, accessibility for sensory difficulties, working with the homeless community, mental health, paediatrics, older people and drug and addiction issues.

Workforce continues to be a major issue across all health and social care and considerable work is being progressed in relation to workforce planning across professional groups. The implementation plan that results from this review will include a focus on workforce, capacity and training issues within urgent and emergency care.

### 5: Digital and Information Technology

The use of digital technology was raised by many of consultees as an opportunity to better support staff and patients.

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*"RCN members working in urgent and emergency care have highlighted their continuing exasperation at the poor quality and lack of integration of information technology within the HSC, despite the innumerable initiatives and resourcing commitments that have been made over the years.*

*As one RCN member working in the emergency department at one of the major Belfast hospitals stated: "IT systems just don't work properly. They are too rigid and, for example, don't factor staff breaks. Part of the problem is that these systems are always imposed from above by people who have no conception of what nursing is all about, instead of being developed in partnership with nursing staff." The RCN agrees with the consultation document's assertion (paragraph 3.47 on page 21) that "digital solutions will need to play a key role", but there remain huge challenges ahead in moving towards a truly comprehensive and integrated system." Royal College of Nursing*

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There were also a few matters raised about digital connections and infrastructure in rural areas and digital literacy for the population, especially older people. This was also an issue for those who do not have direct access to digital technology, for example the homeless community.

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*"Many older people, especially those with cognitive impairment, who live with dementia, may find it difficult to use phone and digital based solutions. According to research carried out by Age UK in 2020, 39% of over 65s do not feel confident using a smartphone.[1] Furthermore, plans to further roll out a telephone-based service, needs to be conscious of those living rural areas with lower mobile coverage."*
*Commissioner for older people*

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The use of new and emerging technology will continue to be included in urgent and emergency care, while taking into consideration the need for a range of options that suit all members of society.

### 6: Partnership working

Many of the responses urged the Department and HSC to work in partnership with stakeholder to progress this work.

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*"It is very important that meaningful involvement is undertaken with children and parents at all stages of the policy/service development process, particularly those groups known to be common users of urgent and emergency services*." NICCY

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Several consultees have helpfully offered to work with DoH and HSC to support the design and delivery of urgent and emergency care proposals including representative bodies and Trade Unions.

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*"It is vital, therefore, that trade unions across the HSC are involved in the development of this regional workforce plan, which should ultimately be underpinned by safe staffing legislation." Unison*

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DoH remain committed to co-production and involvement and wish to build on the engagement which has taken place during the Review and as part of 'No More Silos'. Where appropriate, the Department will continue to engage directly with professional bodies, unions, frontline staff, service users, carers, the community and voluntary sectors, as well as other key stakeholders such as the Commissioners for Older People and Children and Young People.

## 7. Equality, Human Rights and Rural Needs

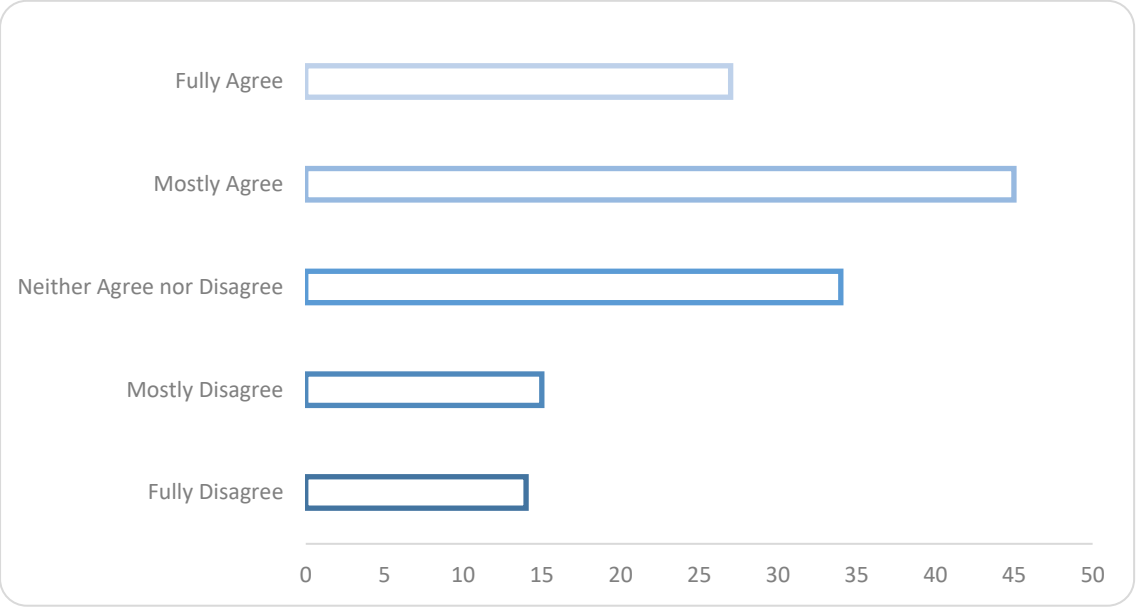
Not all stakeholders who responded to the consultation provided a response to the Equality Impact Assessment (EQIA), however using the information provided by direct answers to the EQIA and Rural needs screening, together with relevant answers to other questions, a number of issues have been identified that will be reflected in the final EQIA and Rural Needs screening.

The information shows that 53% of those who responded to the EQIA question fully or mostly agreed with the information provided, while 21% mostly or fully disagreed and 25% neither agreed nor disagreed.

### Equality Impact Assessment (EQIA)

**A) Do you agree with the Equality Impact Assessment (EQIA)?**

**Figure 7**




| Option | Total | Percent |
|---|---|---|
| **Fully Agree** | 27 | 20.00% |
| **Mostly Agree** | 45 | 33.33% |
| **Neither Agree nor Disagree** | 34 | 25.19% |
| **Mostly Disagree** | 15 | 11.11% |

| | | |
|---|---|---|
| **Fully Disagree** | 14 | 10.37% |
| **Not Answered** | 0 | 0.00% |

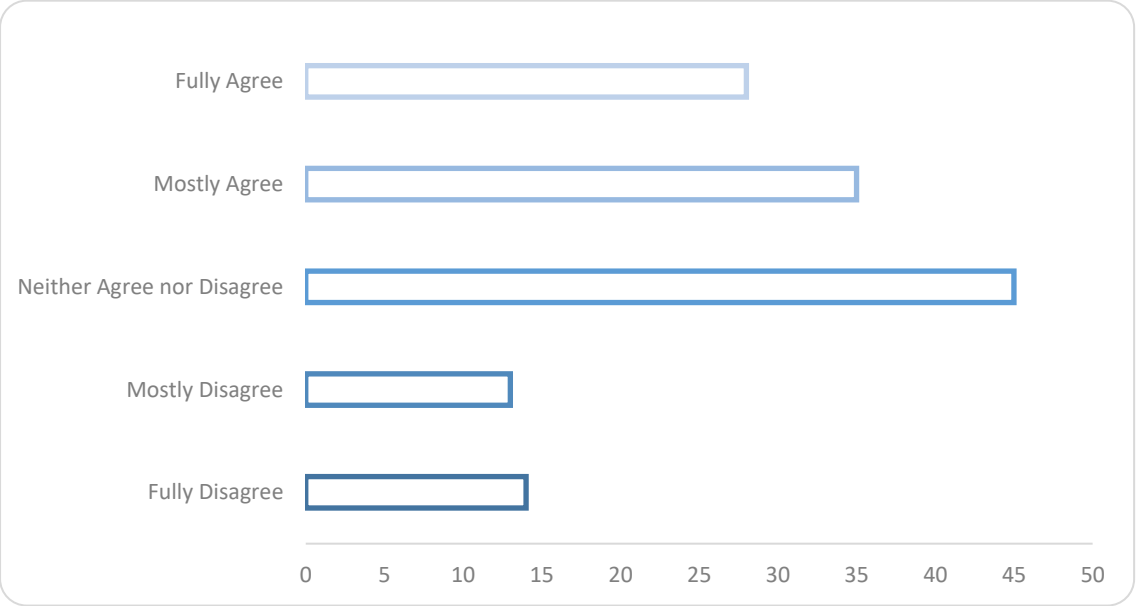
**Table 8**

The information below shows that 47% of those who responded to the Rural Needs Impact Assessment question fully or mostly agreed with the information provided, while 20% mostly or fully disagreed and 33% neither agreed nor disagreed.

## Rural Needs Impact Assessment

**B) Do you agree with the Rural Needs Impact Assessment?**

**Figure 8**




| Option | Total | Percent |
|---|---|---|
| **Fully Agree** | 28 | 20.74% |
| **Mostly Agree** | 35 | 25.93% |
| **Neither Agree nor Disagree** | 45 | 33.33% |
| **Mostly Disagree** | 13 | 9.63% |
| **Fully Disagree** | 14 | 10.37% |
| **Not Answered** | 0 | 0.00% |

**Table 9**

Schedule 9 of the Northern Ireland Act 1998 provides for a comprehensive consideration by public authorities of the need to promote equality of opportunity, giving effect to Section 75 of the Act, between:

- People of different religious belief, political opinion, racial group, age, marital status or sexual orientation.
- Men and women generally.
- People with a disability and people without one; and
- People with dependants and people without dependants.

The Rural Needs Act (NI) 2016 screening provides an analysis of how the strategy might affect people living in rural settings in Northern Ireland.

The EQIA and Rural needs screening documents identified a number of issues for people living in Northern Ireland and provided suggested mitigations to ensure ongoing equality of access for the population. The responses received on the EQIA, and Rural Needs were broadly supportive of the approach outlined in the documents. However, they also provided a range of specific suggestions and additional information to strengthen the existing commitment to equality particularly in the area of carers, children, older people, health inequalities. Other issues raised were specific to accessing services for equality groups, including gender, age, disability and indeed in relation to the rural dwellers.

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*"Access to services, access to travel and scheduling of appointments are referenced and RCN would have expected to see considerably more detail on these issues in this critical section of the RNIA. We would also have expected to see some acknowledgment in this section of lower median salary in rural NI and data in relation to digital exclusion. An understanding of all these issues in rural communities could then better inform the Review of urgent and emergency care." Rural Community Network*

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*"It is vital that equity and equality applies to all individuals across Northern Ireland, regardless of their location/home, and this is primarily about the outcome of the care they receive." Fermanagh and Omagh District Council*

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*"The corollary of the negative impact of homelessness on health is that individuals experiencing homelessness will be more likely to need to access healthcare services, including urgent and emergency care, than those who are stably housed." Homeless Connect*

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It was also clear from consultees that any work that progresses in relation to urgent and emergency care should address the issues surrounding health and digital literacy and communications.

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*"It is often assumed that people living outside of urban areas will benefit from technological health and social care services, but these will be enjoyed only by those people living rurally with a good internet connection, access to devices and high levels of digital literacy." Unison*

---

The draft EQIA and Rural Need screening will be reviewed and redrafted to take into consideration all the feedback received during the consultation. These will be used to inform the urgent and emergency care implementation plan. As this work progresses it will be important to pay specific attention to equality and rural considerations. The adoption of a rights-based approach will be beneficial to the design and delivery of services, to staff working within our services and, ultimately, the population of Northern Ireland who use urgent and emergency care services.

## 8. You Said, We Did

This section of the report will present how the consultation responses will shape the urgent and emergency care implementation plan. The table below will use the "you said, we did" approach to show the correlation between the consultation feedback and the actions taken. Given the breadth and depth of the consultation response, this is a synopsis of feedback received across multiple responses.

| ***You Said*** | ***We Did*** |
|---|---|
| ***To achieve the ambitious aims of the Review a range of key strategic drivers must be put in place.*** | *Established a high-level Programme Board to oversee the progression of all three Strategic Priorities.* |
| ***Provide more detail on how the Review will be implemented, including governance arrangements.*** | *Commit to develop a detailed implementation and funding plan. This will be published in due course, subject to Ministerial agreement.* |
| ***Better communication with the public and Public Information campaign.*** | *Agree a co-ordinated approach to public messaging that will include a communications plan to inform the public about changes to Urgent and Emergency Care services. This will be a multi-media campaign and will be developed using co-production and partnership working.* |
| ***Better links to existing strategies and plans as well as cross Departmental working.*** | *DoH will establish a plan to connect to existing strategies and plans. This will ensure joined up delivery on a whole system approach.* |
| ***Partnership working arrangements.*** | *Establish a plan for partnership working, considering the consultation responses and building on existing relationships. Taking consideration of the specific needs* |

| | |
|---|---|
| | *of service users, carers, children and young people, older people, mental health, drug and addition, homelessness, speech and language difficulties, learning disabilities, palliative end of life.* |
| ***Digital and IT integration.*** | *Build digital and IT integration into the Implementation Plan for Urgent and Emergency Care.* |
| ***Greater consideration of Health Inequalities, Rural Need and Human Rights.*** | *Review and update the Equality Impact Assessment and Rural needs screening, using information gathered during the consultation. This will further inform the Implementation Plan.*<br><br>*Adopt a Human Rights approach in the development of the Implementation Plan.* |
| ***Workforce planning and training and development.*** | *Plans will be developed for each of the strategic priorities. These will link with departmental workforce policy directorate to ensure plans align with the HSC workforce strategy.* |

## 9. Conclusion

The broad support for the proposals outlined in the public consultation mean that the Department can now move in to the implementation phase of the Review. In doing so, the Department recognises, as is to be expected with change of this scale, that there were some stakeholders who did not feel that they could support the proposed approach. The feedback provided by these stakeholders is particularly valuable to the Department and will help shape the upcoming programme of work, to try to allay and address some of the concerns raised as we move into the implementation phase.

While the process of bringing about the changes outlined in the Review will take time, the Department has already moved to establish an Implementation Programme, with associated oversight structures, within the Department. These structures reflect the need, in implementing the Review, to work across Primary, Secondary and Community Care services in a whole system approach, along with the need to continue to engage with key internal and external stakeholders throughout the process.

There has been much feedback received on the need for consistent and accessible communication around this important area of work. The Department has listened carefully to this feedback and will take a proactive approach to communication and engagement throughout the implementation phase.

The next steps for the Programme will see the development of a high-level, multi-year implementation and funding plan which will map out how this work will progress over the coming years. This plan will integrate and continue the work already commenced under the No More Silos programme. This implementation and funding plan will be published in due course, subject to Ministerial agreement. Through this work, the Department aims to deliver a fit for purpose urgent and emergency care service that meets the current and future needs of service users and carers across Northern Ireland.

Appendix 1. List of Consultees

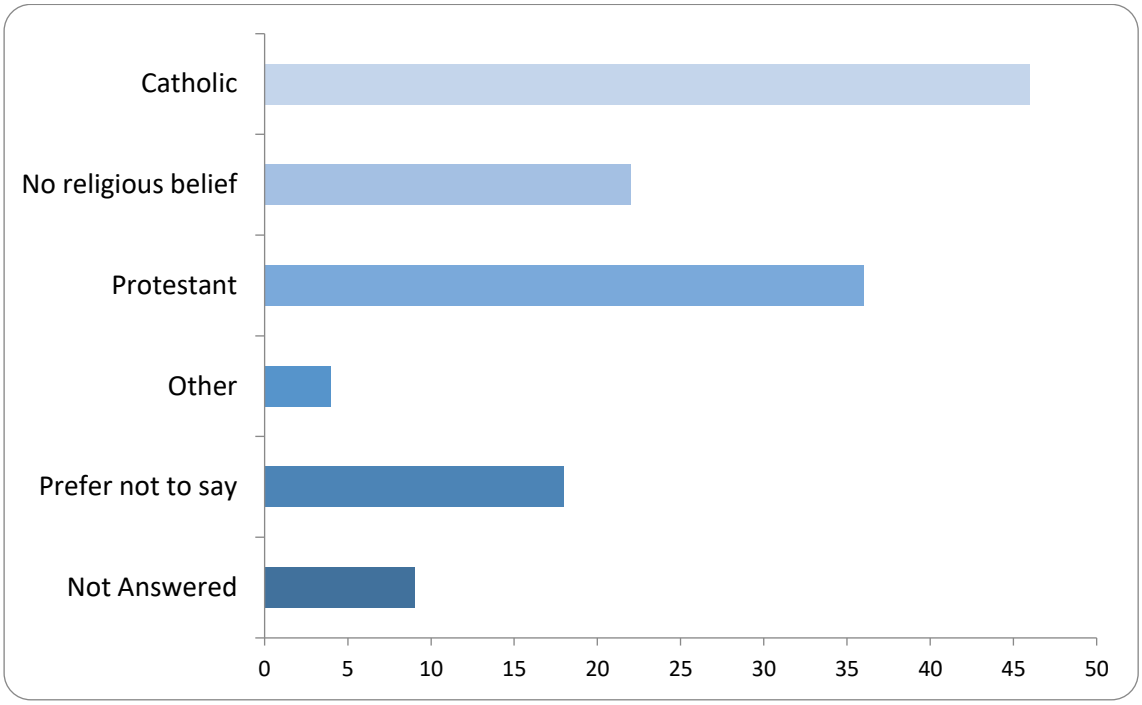
| | Response to Review or Urgent and Emergency Care Consultation |
|---|---|
| 1 | 177 Members of the Public |
| 2 | 14 Other |
| 3 | Carers NI |
| 4 | Fermanagh and Omagh District Council |
| 5 | SHSCT - Southern Area Local Implementation Group |
| 6 | Mid Ulster District Council |
| 7 | Armagh, Banbridge & Craigavon Borough Council |
| 8 | Homeless Connect |
| 9 | Royal College for Emergency Medicine |
| 10 | Society for Acute Medicine |
| 11 | NICCY |
| 12 | RCGP |
| 13 | Marie Curie |
| 14 | NI Practice & Education Council for Nursing and Midwifery |
| 15 | Royal College of Physicians & Surgeons, Glasgow |
| 16 | Royal College of Psychiatrists |
| 17 | Royal College of Nursing |
| 18 | Inspire Wellbeing |
| 19 | General Medical Council |

| | |
|---|---|
| 20 | Stroke Association |
| 21 | Mrs M Hoben |
| 22 | British Medical Association |
| 23 | Fermanagh & Omagh District Council |
| 24 | Royal College of Paedistrics and Child Health |
| 25 | Ulster Unionist Party - Fermanagh Division |
| 26 | Down Community Health Committee |
| 27 | UNISON (Trade Union) |
| 28 | Royal College of Speech and Language Therapists |
| 29 | Royal College of Nursing |
| 30 | Colin McGrath MLA and the SDLP |
| 31 | Commissioner for Older People for Northern Ireland |
| 32 | Sinn Féin |
| 33 | Society of Radiographers |
| 34 | Unscheduled Care Reference Group |
| 35 | Royal Belfast Hospital for Sick Children |
| 36 | Advance Care Planning Team |
| 37 | Health Education |
| 38 | Hibernian Medical Services LTD and NI SPORTS MEDICS |
| 39 | Northern Ireland Ambulance Service |
| 40 | NMC |
| 41 | CEC |
| 42 | Lewis Square Practice |

| | |
|---|---|
| 43 | Age NI |
| 44 | Alliance Party |
| 45 | Belfast HSCT - Intermediate Care service |
| 46 | Independent Health & Care Providers |
| 47 | Scottish Nursing Guild |
| 48 | Community Pharmacy Northern Ireland - CPNI |
| 49 | College of Paramedics |
| 50 | NI Frailty Network |

**Religious belief**

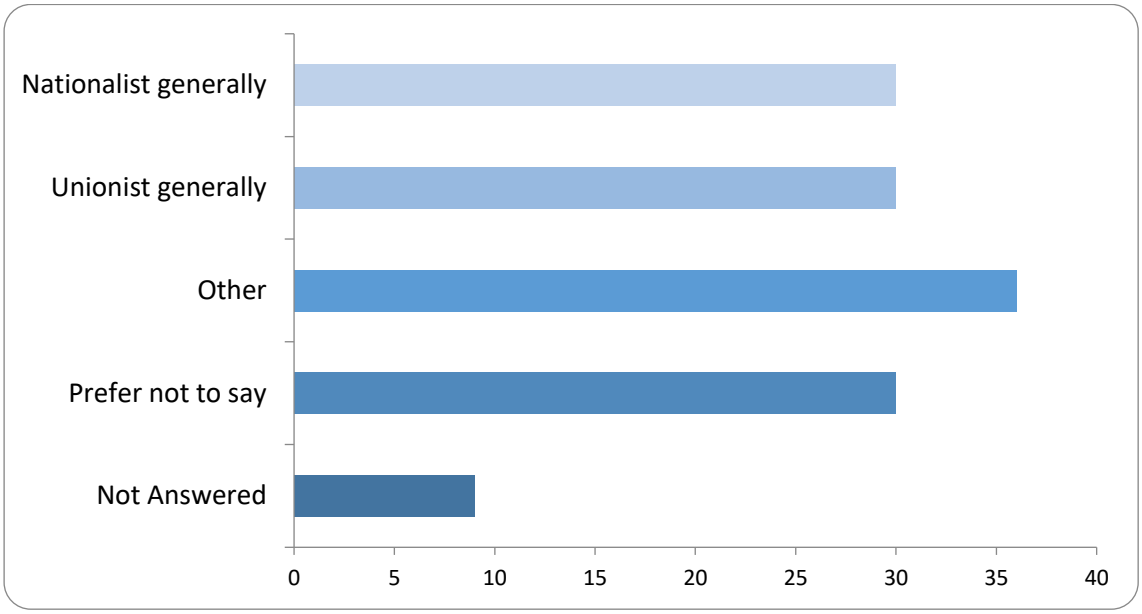
There were 126 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Buddhist** | 0 | 0.00% |
| **Catholic** | 46 | 34.07% |
| **Hindu** | 0 | 0.00% |
| **Jewish** | 0 | 0.00% |
| **Muslim** | 0 | 0.00% |
| **No religious belief** | 22 | 16.30% |
| **Protestant** | 36 | 26.67% |
| **Sikh** | 0 | 0.00% |
| **Other** | 4 | 2.96% |
| **Prefer not to say** | 18 | 13.33% |
| **Not Answered** | 9 | 6.67% |

## Political Opinion

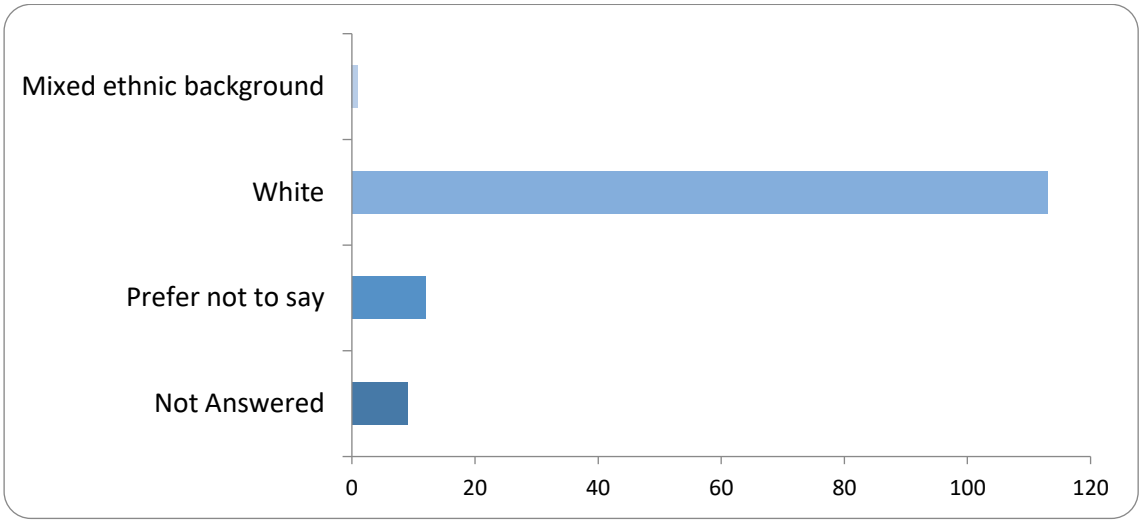
There were 126 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Nationalist generally** | 30 | 22.22% |
| **Unionist generally** | 30 | 22.22% |
| **Other** | 36 | 26.67% |
| **Prefer not to say** | 30 | 22.22% |
| **Not Answered** | 9 | 6.67% |

## Racial group

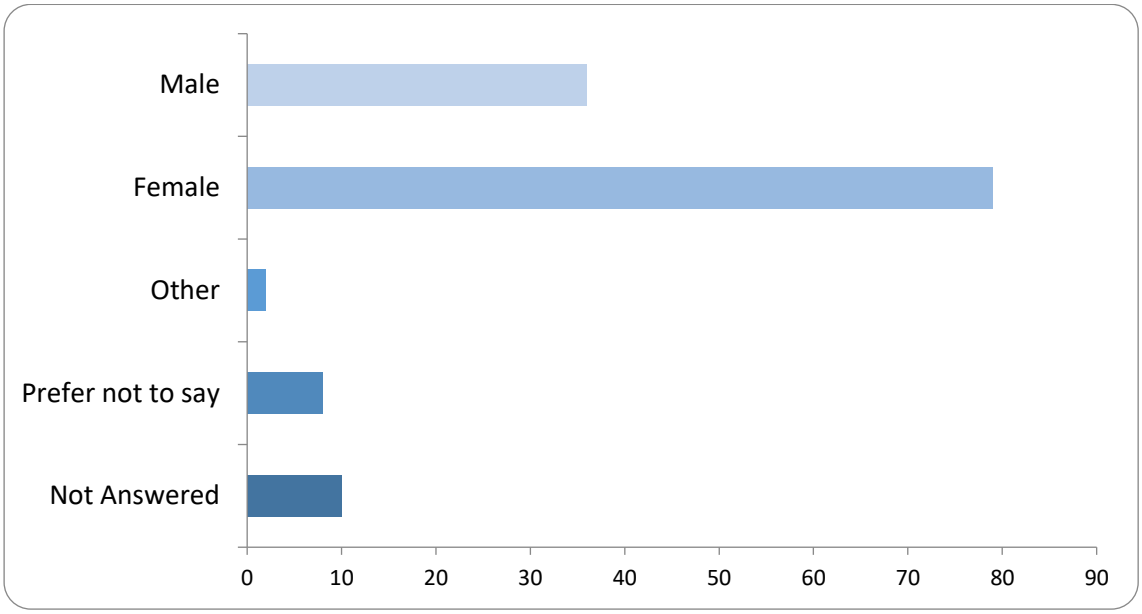
There were 126 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Black** | 0 | 0.00% |
| **Chinese** | 0 | 0.00% |
| **Indian** | 0 | 0.00% |
| **Pakistani** | 0 | 0.00% |
| **Mixed ethnic background** | 1 | 0.74% |
| **Polish** | 0 | 0.00% |
| **Roma** | 0 | 0.00% |
| **Travellers** | 0 | 0.00% |
| **White** | 113 | 83.70% |
| **Other** | 0 | 0.00% |
| **Prefer not to say** | 12 | 8.89% |
| **Not Answered** | 9 | 6.67% |

**Gender**

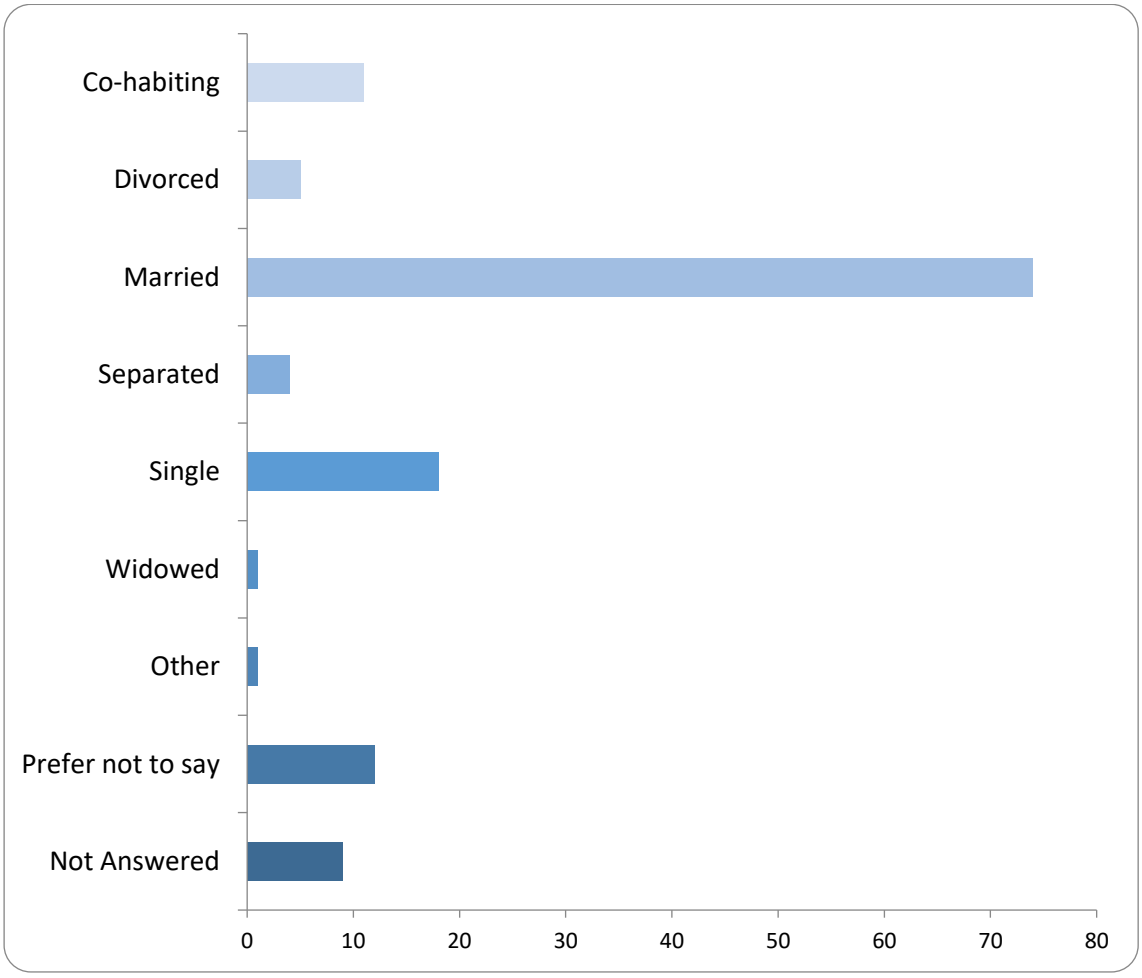
There were 125 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Male** | 36 | 26.67% |
| **Female** | 79 | 58.52% |
| **Transgender** | 0 | 0.00% |
| **Transsexual** | 0 | 0.00% |
| **Other** | 2 | 1.48% |
| **Prefer not to say** | 8 | 5.93% |
| **Not Answered** | 10 | 7.41% |

**Marital status**

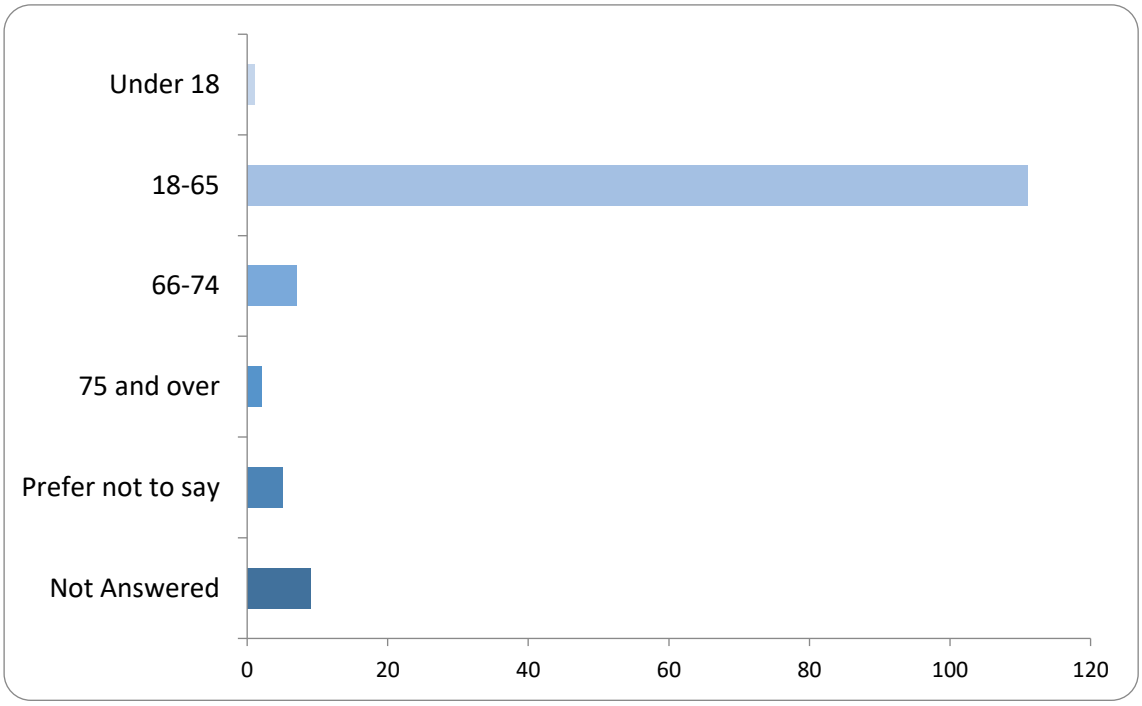
There were 126 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Civil partnership** | 0 | 0.00% |
| **Co-habiting** | 11 | 8.15% |
| **Divorced** | 5 | 3.70% |
| **Married** | 74 | 54.81% |
| **Separated** | 4 | 2.96% |
| **Single** | 18 | 13.33% |
| **Widowed** | 1 | 0.74% |
| **Other** | 1 | 0.74% |
| **Prefer not to say** | 12 | 8.89% |
| **Not Answered** | 9 | 6.67% |

**Age**

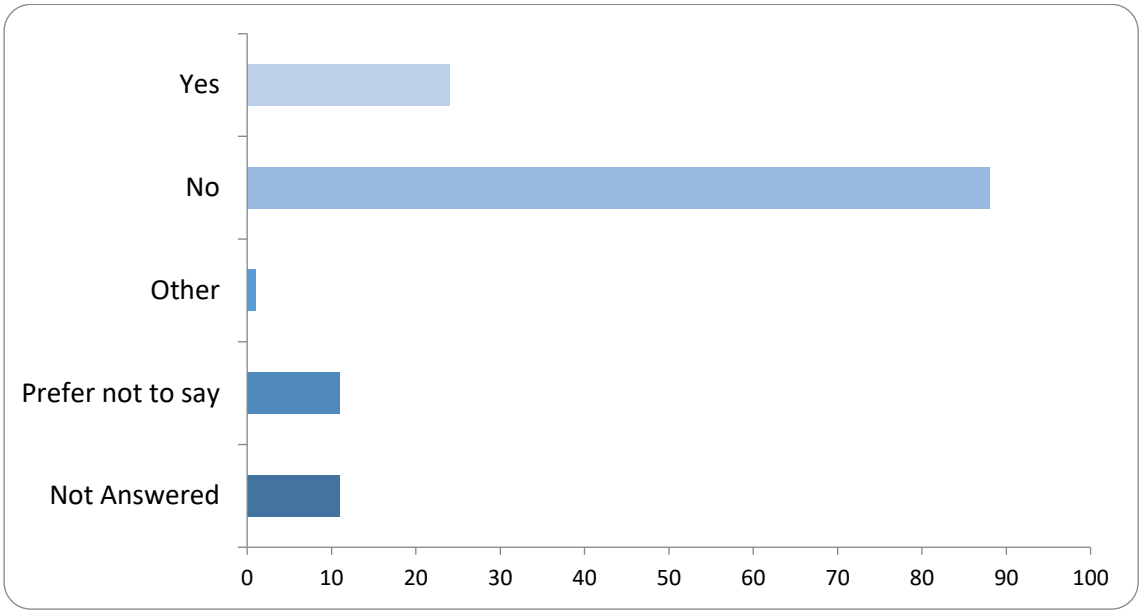
There were 126 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Under 18** | 1 | 0.74% |
| **18-65** | 111 | 82.22% |
| **66-74** | 7 | 5.19% |
| **75 and over** | 2 | 1.48% |
| **Prefer not to say** | 5 | 3.70% |
| **Not Answered** | 9 | 6.67% |

**Disability**

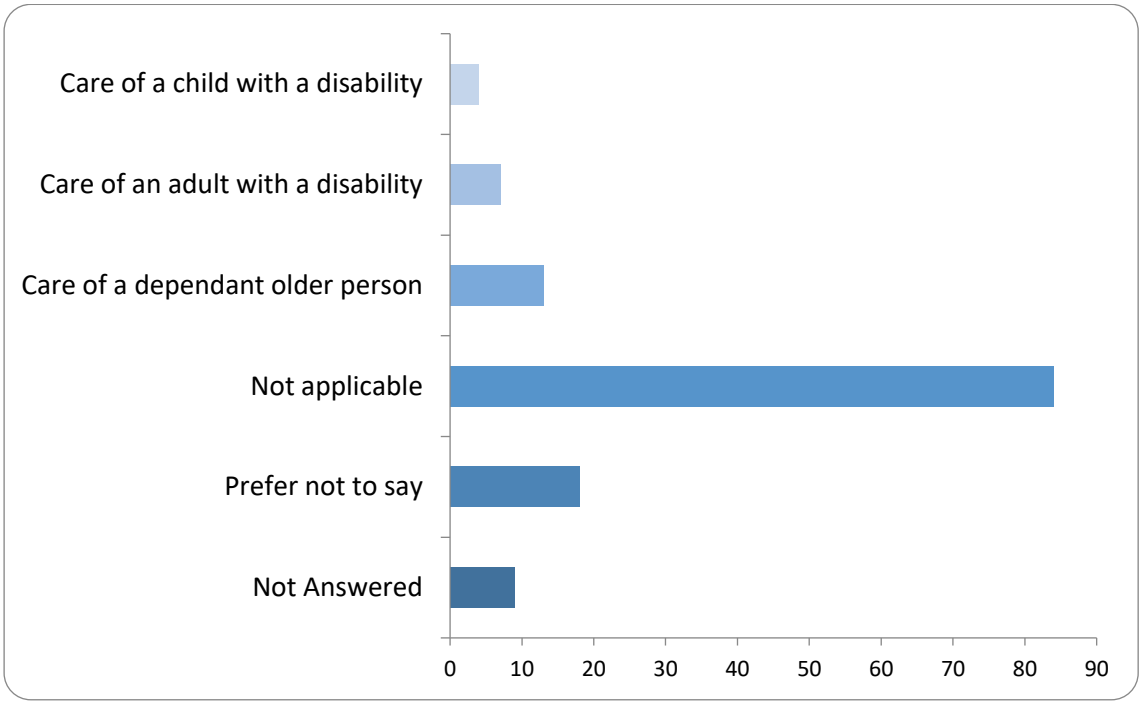
There were 124 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Yes** | 24 | 17.78% |
| **No** | 88 | 65.19% |
| **Other** | 1 | 0.74% |
| **Prefer not to say** | 11 | 8.15% |
| **Not Answered** | 11 | 8.15% |

**Dependants**

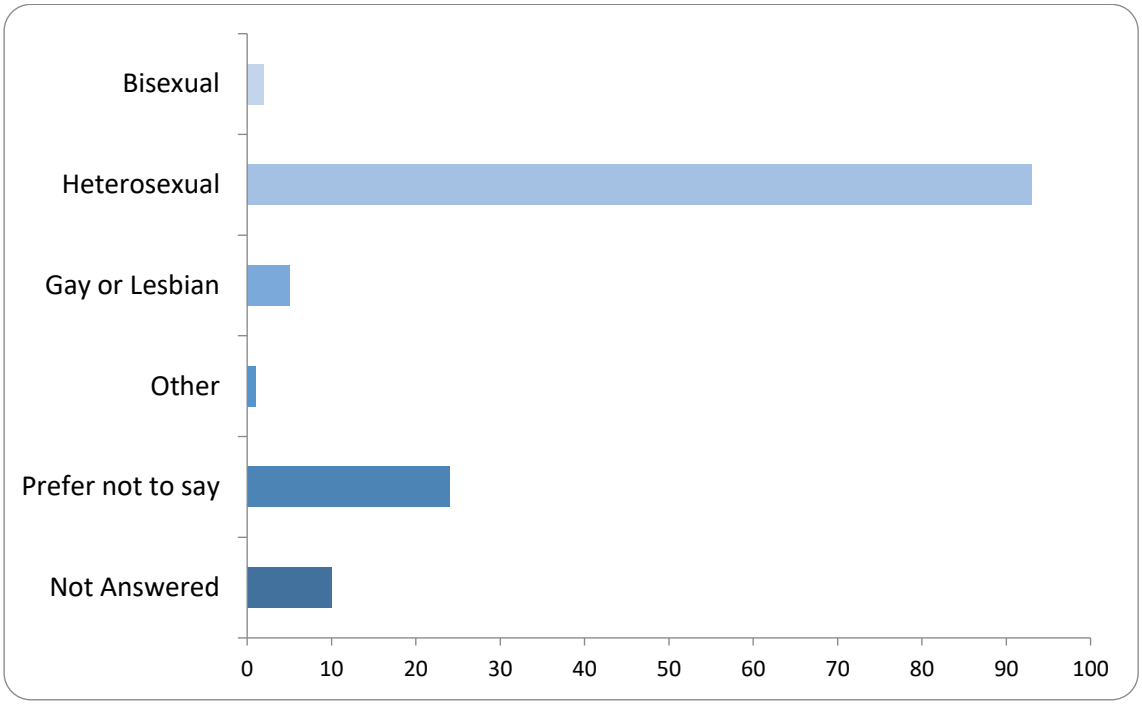
There were 126 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Care of a child with a disability** | 4 | 2.96% |
| **Care of an adult with a disability** | 7 | 5.19% |
| **Care of a dependant older person** | 13 | 9.63% |
| **Not applicable** | 84 | 62.22% |
| **Prefer not to say** | 18 | 13.33% |
| **Not Answered** | 9 | 6.67% |

**Sexual orientation**

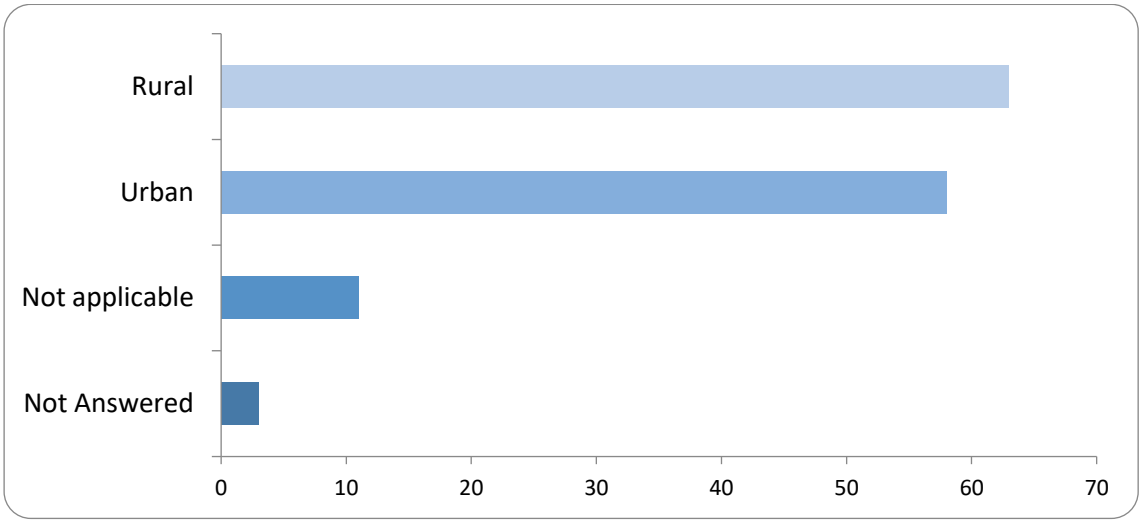
There were 125 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Bisexual** | 2 | 1.48% |
| **Heterosexual** | 93 | 68.89% |
| **Gay or Lesbian** | 5 | 3.70% |
| **Other** | 1 | 0.74% |
| **Prefer not to say** | 24 | 17.78% |
| **Not Answered** | 10 | 7.41% |

**If you are responding as an individual, do you live in a rural or urban area?**

There were 132 responses to this part of the question.




| Option | Total | Percent |
|---|---|---|
| **Rural** | 63 | 46.67% |
| **Urban** | 58 | 42.96% |
| **Not applicable** | 11 | 8.15% |
| **Not Answered** | 3 | 2.22% |

HSC Leadership Centre

Department of Health | An Roinn Sláinte / Männystrie O Poustie

Appendix 3. Consultation event feedback

# REVIEW OF URGENT AND EMERGENCY CARE SERVICE NORTHERN IRELAND

## Online Consultation Report

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# 1 BACKGROUND AND INTRODUCTION

The purpose of this review is to 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.

**This vision was articulated by the Minister for Health, Robin Swann, MLA:**

*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*

The changes outlined in the 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 a impact across the service and for service users. The review will aim to establish a new regional care model for Northern Ireland, with particular focus on meeting the needs of the rising proportion of older people in the population.

# 2 CONTEXT OF THIS REVIEW

**The Urgent and Emergency Care Review was originally launched on 26 November 2018. Completion of the Review was delayed due to the COVID-19 pandemic. In October 2020, the Department of Health (DoH) launched the No More Silos Action Plan, which built on learning from the Review, with the aim of improving co-ordination between primary and secondary care services.**

This work on the Review was re-established in autumn 2021 and the Department of Health held the view that the Review Team Report continues to be relevant and that the strategic direction, as set out in the main consultation report, provides an appropriate response to the longstanding issues. This Review also continues with the strategic direction set out in the No More Silos Action Plan and the Intermediate Care Project.

The Report was underpinned by a ***Population Health Needs Assessment*** that highlights that demographic change is a major factor behind growing demand for urgent and emergency care, with pressures due to intensify significantly in coming years.

## 3 CONSULTATION APPROACH

As part of the consultation exercise, the Department of Health held a number of online public events. These two-hour events were facilitated by the HSC Leadership Centre and delivered via Zoom. Three public events were held and two specific events for Trade Unions and HSC Staff. A total of 185 people attended. Sign language interpreters attended two of the public events to support members of the public who attended. This online engagement events were part of the wider consultation exercise which closed on 1 July 2022. A copy of the consultation exercise presentation slides and dates are attached in Appendix 1.

The format of the online consultation events included an overview of the Review's strategic priorities, delivered by panel members. Subsequent questions were then posed and feedback sought. To ensure consistency of approach, the questions used during the online events were aligned with the questions asked in the wider engagement exercise.

This report will set out findings from the online consultation exercise under the strategic priorities. Feedback from the specific stakeholder groups will be summarised separately with the conclusion section setting out collective themes.

## 4 WHAT IS URGENT AND EMERGENCY CARE?

As part of the context of this paper, it is necessary to differentiate between Urgent and Emergency. NHS England has recently provided helpful definitions for each, in relation to the models of care which are being provided:

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

**Emergency:** Life threatening illnesses or accidents which require immediate Intensive treatment.

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

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 (ED). Of these, only a minority would be defined as an emergency according to the definition above (*Review of Urgent and Emergency Care Services in Northern Ireland Review Team Report 2020)*

## 5 REVIEW STRATEGIC PRIORITIES & THEMES

### The initial review identified the following 3 priorities;

#### Priority 1: Development of an integrated urgent and emergency care service

Building on the work of the No More Silos initiative, this will see standardisation of service delivery across the region, including the development of Urgent Care Centres, (UCC) the development of standardised pathways across all Trusts and, ultimately, the development of a regional Phone First number.

#### Priority 2: Capacity, co-ordination and performance

This covers important questions around the bed capacity in our hospitals as well as in acute care delivered in peoples' homes. It is also aimed at ensuring that services are operating as they should and to the highest standard.

#### Priority 3: Development of a regionalised approach to intermediate care

This will focus on healthcare delivered at home, providing better patient outcomes and recovery.

**This report will group findings under the 3 Strategic Priorities.**

During the course of the Review a number of key themes emerged. These are listed below and for the purpose of this report will be used to present the feedback obtained during the online consultation exercise.

# 6 FINDINGS

## 6.1 Priority 1: Development of an integrated urgent and emergency care service

**Question: What do you think we should consider to create a more joined up system?**

## PUBLIC FEEDBACK

### Silos, Barriers and Poor Communication

**Public Messaging**

The need for consistent public messaging was a major theme heard throughout the consultation events. The need for clear public messages setting out what key services are available. This included services available through GP Practice and within a hospital environment. The perceived low levels of public messaging have contributed to a lack in public confidence in the current system, therefore the public need to be better informed going forward.

There were also concerns that the public may not be aware of the differences between emergency and non-emergency care. Subsequently, people are attending EDs when it is not necessary. This creates an increase in numbers presenting at ED, crowded EDs, longer waiting times and potentially being sent home with no advancements, which is causing frustration across the system. It was therefore recommended that a simple "flow-chart" should be developed, detailing who to call and where to go with certain medical issues. Whilst this may be available in some Trust areas, the approach is inconsistent.

**Language and Terminology**

Some participants expressed their concerns at the "over use" of medical jargon which can lead to confusion and dis-empowerment. Even the terms "urgent" and "emergency" are confusing.

### Capacity & Flow

**Pathways**

The need for clear pathways from entry through to discharge is required, with clarity in communication along the pathway. This will minimise duplications and lead to a more "joined up" approach across the system.

It was suggested that if the gap between Primary and Secondary care could be closed via a clear pathway, this would ensure fewer people attend ED and potentially could be cared for in their community with additional support in the home. It was however recognised that local communities find ED the most accessible way to access treatment.

The pathways should also be based on what is currently available, as opposed to new services which maybe in development stages. The pathway should be resourced adequately to ensure the system is working.

There is still a "blurred line" between Primary and Secondary Care e.g., taking up time in a treatment room for those who don't have appointments, time wasted on secondary bloods, people attending ED because they can't get through to their GP after 3 or 4 weeks.

**Phone First**

Comments regarding Phone First were mixed, with some participants querying its overall effectiveness whilst others suggesting it has worked well. There was interest in the overall cost of the service and what it delivers, suggesting if the service turns away only a few potential patients that did not need to attend ED then it is not necessarily value for money.

Others highlighted that Phone First had worked well, as it gave the option to see where other services were available, e.g. HSC South Eastern Trust – Downe Hospital where the experience was positive.

The need for a 24/7 Phone First service was recommended. If this did not happen, then people would have no other option but to go to ED. Identification of appropriate people to "staff" these services will be essential with some concerns being expressed about the recent HSC Southern Trust service which had to be stood down due to staffing problems.

This highlighted the lack of standardised services and also the need to ensure that staff are property trained. It was also suggested that Phone First should be rolled out as a 24/7 service, however to ensure its overall effectiveness the establishments of urgent care centres and seamless pathways to support patient flow is necessary. It was recognised that clear pathways are identified for each service.

For those that were positive about the Phone First services, the confusion with the GP telephony system was highlighted. The need for patient education was suggested, so that patients can understand the system, however, messages must be clear and simple.

It was also highlighted that the Phone First service must consider the more complex needs of patients, and also the need for pathways to support co-morbidity patients. This would hopefully lead to fewer people attending ED, but the importance of having adequate qualified staff working this system was again reiterated.

**GP Out of Hours and Urgent Care Centres**
Many of the comments made about this theme pertained to a lack of standardisation of services available and uncertainty around access. Some comments suggesting that urgent care centres could potentially lead to silo working, even though it was recognised by some that they have been around for two years and working well.

The location of these centres is also an important consideration.

**For many participants it was thought that the implementation of the urgent care centres, unless properly communicated would result in confusion, as along with medical care centres, or out of hours GP centres will all contribute lack of consistency and result in patients phoning 999.**

There was recognition that the roll out of urgent care centres would have major staffing implications, as there were already workforce issues across the current system.
Many of those who attended minor injuries units suggested that it had worked very well, and contributed to lower attendance at Emergency Departments, referring to South Tyrone as a good example.

There was also some apprehension expressed at the challenges currently faced by patients in accessing GP services, with a great deal of concern expressed regarding the resources of both the hospital site and EDs.

*"I would like to know where the GPs and staff are coming from to staff these centres. We already have huge shortages"*

Finally, the need to understand the role of NIAS and closer links to their clinical response model would improve the overall approach.

## Accessibility

Members of the deaf community, who attended two of the consultation events expressed their concern about the accessibility of the Phone First service and it was recommended that specific enabling measures would have to be put in place. It was also highlighted that elderly people and people with learning disabilities may struggle when using the phone, with no other options present. Other access issues were highlighted for those patients requiring interpreting services and people who are blind.

## Digital Solutions

The need for better use of IT systems to help streamline and reduce duplication, as well as ensuring information and communication is rapid and shared was continuously raised. Whilst the Encompass system will go some way towards enabling this, it will not initially be accessed by GPs. This also led onto the need to ensure there are clear and robust governance arrangements in place and the need for the patient's journey being seamless throughout the digital system.

There were some concerns that in this digital age information does not flow between primary and secondary care. The need for sharing and accessing patient information, especially between GP and ED is essential. There were some specific examples of how the "silos" in our system are leading to inefficiencies and impacting on patient care, e.g. blood results and other results.

There were some very real powerful lived experiences, with several service users sharing the challenges they had faced when presenting at the ED with mental health conditions. The need for a more joined up service with access to more timely patient information for members of the multi-disciplinary teams is key.

## Systems Approach

The overwhelming message from participants was the need for a joined up systems approach, which involved inter-agencies working together. The need for clear outcomes and performance management targets were reiterated, as was the need to agree a regional model across Northern Ireland.

## TRADE UNION FEEDBACK

### Silos, Barriers and Poor Communication

It was acknowledged that the public and staff all struggle with the current branding and often are confused with what is classified under urgent and emergency care. This potentially means people are confused "where" they access their services, and what is appropriate for their condition. The need to communicate what each service provides is essential. This will ensure greater public "buy-in" and potentially reduce the number of people attending EDs.

### Capacity and Flow

The impact on Primary Care for Physical Therapy Services is not always considered. Although these initiatives are needed the budget does not always follow. The example given was the Cancer Strategy, 90% falls to the Primary Care sector but no budget with it. The voice of Primary Care needs to be strengthened across the system.

**Phone First**
The need to learn lessons from the Scottish Phone first model were suggested as it was recognised that Scotland is constantly reviewing and refining this service in line with service need.

**Urgent Care Centre**
It was suggested that urgent care centres need to work closer with Emergency Departments to ensure adequate staffing levels across these services. The example of Physiotherapists working in this model was shared but floor plan capacity needs to match their input.

The question of the role of Minor Injury units and clinics was raised and potentially what future services will look like. The pressures and the change of services in Daisy Hill and Lagan Valley is putting pressures on the staff in these EDs and urgent care centres, and also on those now providing the services elsewhere, such as Ulster and Royal hospitals. Important to note that changes in one area will affect others.

### Standardisation

It was acknowledged that standardised systems have merit, however, the Trust structures currently act as barriers which will need to be revised. If services are to be standardised, there must be a question about how the community and voluntary sector are going to manage, and what funding streams will look like.

## Best Practice

It was recognised that if the system is to be more integrated there is a need to look at the good practices, models and approaches by HSC Trusts and also learn from the pilots, i.e. ***"Take the best and leave the rest".***

## Workforce & Training

Workforce should be the key priority, and there are already concerns in the recent HSC Workforce Strategy and plan. There is a need to consider how staff working in health and social care are treated with low pay and poor terms and conditions in comparison with other sectors.

Whilst it was acknowledged that the Trade Unions are already involved in Departmental work on safe staffing/legislation with the DoH Workforce Directorate, the need for ongoing staff engagement is required, as although no ED swill close, the reconfiguration of services will have an impact on staff.

The need to consider the recruitment of more international staff is necessary and systems should be developed to welcome these staff.

It was further recognised that the different approaches by Trusts, whether it is ED or UCC, will mean different things to staff working there and the public using the service. Already there are pilots being carried out, so the local approach may outstrip the regional approach.

NIAS Clinical Response Model still needs investment and staffing; staffing needs to grow by a quarter if to be properly implemented.

## Discharge

When considering capacity, flow and discharge it is important to consider the reform of Adult Social Care, and the importance of integrating the social care system, which should ultimately facilitate quicker discharge. For example, at least a third of those ready for discharge do not have care packages in place.

# CLINICAL FEEDBACK

## Silos, Barriers and Poor Communication

It was recognised that people are afraid to utilise new models due to the lack of information and training. It is important to use common language.

## Capacity & Flow

### Phone First

There were some suggestions that Phone First should be rolled out as a 24/7 service therefore, it is important to have Urgent Care Centres and other services/pathways in place first to improve patient flow. There is not always a list of pathways in place.

### Urgent Care Centres

In regards to Urgent Care Centres that are currently staffed by GPs it must be recognised that most GPs are aged in their mid to late 40s, with a considerable number of younger GPs working part-time hours. It was therefore suggested that this would not be the workforce to staff the UCCs. GPs should not be the bedrock of UCCs, and relying on one particular part of the workforce is unrealistic. An alternative option could be Allied Health Professionals.

Due to long waiting lists, patients end up revolving around the system rather than get to the place/service they really need to be.

Considerable problems relating to patients being discharged from hospital due to exit block. The actual physical space for patients being admitted and discharged via an ambulance is problematic due to limited space.

It would be ideal if a GP could refer a patient directly to the service, bypassing the ED. It was recognised that at times GP services feel like a post box.

## Standardisation

The need for a whole system flow was highlighted. There are wide variations in access times and responses to community services across the region, and whilst it was acknowledged this is being worked upon, more needs to be done.

There are potentially more streamlined solutions, e.g. AHP's getting patients home, saving bed days with matching resources to early emergency pathways/day emergency care.
Hurdles faced with too many phone calls and too many forms, Relying more on people who are seeing the patient in front of them.

It was recognised by one staff member what happens in hospital is a grey area and this consultation report focuses on pre-hospital, leaving hospital and going into the community. To ensure a whole systems flow, both acute and internal medicine needs to be considered.

## Best Practice

It was recognised that there are many innovative practices already taking place in the system, and more resources should be bid for to support these.

## Digital Solutions

The single point of access to all services, one route in and one route out is required. Hopefully Encompass should support this standardisation. Tele-medicine should be exploited to its fullest and should be incorporated into the review.

Consider changing/removing some of the terminology in order for people to understand easier.

## Staff

It was acknowledged by some that there appears to be a lack of enthusiasm amongst graduate medics to work in fast paced emergency medicine. The need to enthuse graduates and others to work in this area is necessary. It was acknowledged that COVID have deterred people from working in these areas and this has been confirmed by NIMDTA (Northern Ireland Medical Dental Training Association) who have noticed less people applying for Emergency Medicine.

**There is no appetite to renegotiate GP contracts regarding Out of Hours responsibilities.**

## 6.2 Priority 2: Intermediate Care – A Regionalised Approach

**Question: What do you think we should consider to provide better care for people at home and to help them avoid having to go to hospital?**

# PUBLIC FEEDBACK

### Workforce & Training

The most common theme highlighted the need to ensure there is sufficient staffing levels who are well remunerated with access to career pathways and relevant learning and development.

Concerns were raised at the current levels of pay for domiciliary care workers, and the added challenges with the cost of living and petrol prices which will ultimately have a long-term impact on the ability to both recruit and retain staff.

More general concerns about current staffing levels were highlighted, with challenges in the ongoing recruitment of Consultants, Advanced Nurse Practitioners, Physiotherapists, etc. Staffing issues are having an impact on the flow from hospital discharge and access to care packages, as well as admission to care homes. There were also some suggestions that staff could be used more efficiently throughout the system.

Specific examples were raised for re the challenges for attraction and recruitment into the Hospital at Home service.

### Capacity and Flow

Some concerns were raised that Acute Care and Rehab services are not working over 7 days, therefore, contributing to the problem of patients being admitted during this time. There was a suggestion of a mobile chest x-ray for people in their own homes and in care homes.
High demands and no capacity for social care often results in crisis situations and admittance to hospitals.

**Minor Injury Units**
Further consideration must be given to the role of Minor Injury Units as in some cases these units cater for conditions that are more serious. Again, the need for the public to understand the services provided in these facilities, with greater utilisation of the GP Treatment rooms as in some cases the perception that people are referred to hospital for tests when this could be completed in the GP Practice.

Examples of good practice were cited from rural communities, including Mid Ulster where the minor injuries service is excellent.

### Hospital at home

Responses recognised that patients are much happier to be treated in own home, however it was recognised that current therapy services are not available and that the speed of access to these services is fundamental, especially for stroke victims.

The ongoing need for regular carers would improve the confidence of patients being cared for at home, with support in place for people receiving care at home. It was suggested that care packages are not in place in many areas after 7pm.

Health care at homes saves money, and the cost of more buildings and their maintenance is not the only way to provide healthcare. Short term it may cost more but in the long term it avoids re-admittance to hospital and those costs.

### Care Homes

Responses highlighted that the brand and image of care homes needs to be improved, as often they are perceived as second best.If care is not provided at home or nursing homes patients will deteriorate and end back in hospital.

## Silos, Barriers and Poor Communication

Patient education can often be a reason for ED attendance, therefore, investment in patient education is necessary.

The need for strong patient, carer and patient stories must inform our future plans. This again reinforced the need for people understanding what care is available and that there should be a good level of confidence when accessing these services.

Patient education can often be a reason for ED attendance, therefore, investment in patient education is necessary.

## Standardisation

As in the previous question, the lack of consistency across Trusts was highlighted. It was suggested that good partnership models existed in the voluntary and community sector.

## Digital Solutions

There was recognition that Technology is a key enabler for improving care at home, e.g, zoom calls with consultants.

## Mental Health

It was suggested that if the GP cannot get the service within a day to the patient, then the psychosis deteriorates and inpatient service is required. We recognise the benefits of Acute Care at Home for older people and need the same for Mental Health.

# TRADE UNION FEEDBACK

## Workforce and Training

When it comes to Intermediate care staffing, there should be more lateral thinking, as less staff want to work in the community. One suggestion is the introduction of drivers and cars for AHP's allowing them to do notes in the car, reduce fuel costs to staff, maximise clinical time. (NHS Scotland)

In order to have a better social care system there is a need to provide better pay, career pathways and training for all staff. Workforce is at the core and this is particularly true for district/domiciliary care workers. In addition, HSC are losing staff to agencies as they are paid better.

## Capacity and Flow

The need to review these proposals against the Reform of Adult Social Care, will facilitate quicker discharge. For example, at least a third of those ready for discharge do not have care packages in place.

The need to ensure Voluntary and Community sectors are involved is imperative as they are fundamental when it comes to the delivery of domiciliary care.

It was also suggested that this consultation should learn from the Daisy Hill Pathfinder exercise as if we are to reconfigure services, then consideration needs to be given to what the area needs. It will not solve all the problems but can change the type of conversation.

## Co-ordination

The need to ensure alignment with the 'Making Life Better' Strategy Framework. The new Integrated Commissioning model is currently being developed, which is considering the needs of the population and will bring in the voluntary and community sector providers. This model will align across all five Trusts.

## Standardisation

A standardised model is required to show who delivers the care and where that delivery will take place.

# CLINICAL FEEDBACK

Concerns were expressed by some Consultant Medical Staff that there had not been information provided regarding the services and questions did not **"dig deep enough"** The need for further engagement with GPs was recommended. It also commented that responsibility for care at home starts with primary care.

## Workforce and Training

As with other groups clinical staff highlighted the main challenge is insufficient staffing and resources to deliver services.

There were some suggestions that the partnering with schools to educate public health messages around drug, alcohol and mental health issues at a regional curriculum level is required as significant number of patients presenting with alcohol to ED every few weeks. Treating them and sending them back to toxic environments is not a solution. Partnering with psychiatrists and community clubs to progress  this problem is necessary.

## Capacity and Flow

It was suggested that ambulatory care models provide good pathways for keeping people out of ED. The funding process is key, as is the need for capital investment in equipment such as CT, MRI, and ultra-sound. This will also require additional staffing.

The need to utilise community space with other stakeholders – councils, clubs, charities. There are many local examples across the region, Community initiatives, particularly in rural areas are key in keeping patients fit and healthy which will ultimately keep them at home.

**Especially if one service is quieter then help should be offered elsewhere to lower waiting lists. Consider acute community beds.**

Access to GP surgeries need specialist nurses.

**Hospital at Home**
It was recognised that people in the community would like care delivered at home, or close to home. This should be a key consideration in any model. The Hospital at home team - whenever they can provide input is very helpful but it is not a uniform service.

## Silos, Barriers and Poor Communication

Clinical staff highlighted the need to have a service that is responsive and has capacity to avoid a number of phone enquires. There are also duplications within the system, e.g., tests, x-rays. It holds up the system so there needs to be a better direct service and less duplication.

## Priority 3: Capacity, Co-ordination & Performance

### Question: What can we do to ensure that we improve services?

**PUBLIC FEEDBACK**

### Workforce & Training

The need for a workforce plan across primary and secondary care for the next 10 years is required, though the focus should be on more than recruitment. Greater focus on retaining our existing staff otherwise this will lead to severe knowledge gaps. These figures were reinforced by staffing numbers presented and staff projections.

Recognise that we need to work closer with QUB, UU and other professional bodies to hear from our young people, e.g., why are people moving abroad to take up posts when there are a significant number of posts available Northern Ireland?

Pay and conditions must be on the agenda e.g., the impact of the removal of covid rapid rate payment and how we could incentivise working in the system.

### Standardisation

We need to share best practice and learning across the system. HSC Trusts all have differences in what they are able to offer in terms of services. This should be standardised.

One enabler for standardisation is accurate and current data on current services provisions and resources, including what is working well.

***There needs to be performance management across the service, with more realistic messaging.***

### Capacity

The GIRFT review was welcomed. There was an acknowledgement by some that we need to start first with the capacity that we currently have in the system and then consider what is likely to be needed. Also that this will be supported by accurate timely data sets.

## Digital Solutions

The need for access to more virtual clinics, including telephone clinics. This is especially relevant in rural communities to cut down on travel time. However a number of people in rural communities are digitally excluded whether it was because of age, communication barriers or broadband availability.

## Building on Good Practice

It is important that we look forward, not back and consider best practice elsewhere. We recognise that things can be moved forward and as a system we should learn from the covid lessons. A specific example of taking photos to send to GP and not having to leave home.
The Netherlands was shared as a region for good practice, as there are fewer people presenting to the E.Ds.

## Co-ordination

It was highlighted all facilities are not used 100% of the time. It was recommended here is capacity in the system that could be used for other parts in the system.

## Mental Health

There was a suggestion that there should be more opportunities for mental health service providers to be involved in the design and delivery of the next steps, as originally it was outside the scope of the review.

# TRADE UNIONS FEEDBACK

## Workforce and Training

Trade Union Leads recognise that staffing and resources are key, however, the focus should be on existing staff and resources. It is important that the "ask" in the review does not fall on the people who are currently in post. "A shiny new building" does not mean more staff!

It is important to understand how the review shifts from paper to implementation. People need to see change happen and be taken on that journey.

The suggestion that staff on the ground are closest to the problems and therefore will have the best suggestions. Therefore, it is important to listen to our workforce who can provide real solutions.

Whilst workforce planning exercises are taking place with regards emergency care, there is much more that could be done to ensure the HSC is recognised as a good place to work at a local and international level. Doctors are not attracted to move to Northern Ireland, and those currently employed here tend to leave early.

It was recognised that UNISON have been using partnership approaches with employers and the Trusts to improve services and conditions for staff. This could be a more mainstream approach.

## Capacity and Flow

It was suggested that ambulatory care models provide good pathways for keeping people out of ED. The Funding process is key, as is the need for capital investment in equipment such as CT, MRI, and ultra-sound. This will also require additional staffing.

There is staff engagement through the forum of the NMS Network which represents a wide range of Primary and Secondary staff. Discussing issues and meeting every month, and working on standardisation. Consider joining up the strands of Urgent and Emergency Care,
e.g. the Fair Work Forum as an enabler.

# CLINICAL FEEDBACK

## Workforce and Training

It was recognised that morale is low with staff in the system as agency staff are being paid higher for completing similar work. This needs to be resolved in order to retain staff whilst supporting their morale.

Activity Based GP funding model should be considered. Also noted that on many occasions people are attending the Emergency Department when it is a GP they need to access.

## Standardisation

Clinicians suggested that the current criteria list when referring a patient is long and very frustrating. This could be standardised and streamlined.

The need for a whole system approach is required as certain parts of the system are in the wrong place. Also important to have health care professionals in the community to help with after care.

There is a need for Trusts to accept what is not working, and what is wasting system resources. This should be reviewed before embarking on increasing capacity.

## Silos, Barriers and Poor Communication

There is a delay in getting information shared to the appropriate clinicians. Often, they find out several days later that a patient attended ED, and instead of contacting the clinician, the patient was sent down a different channel. This is inefficient. There should be an option where patients can self-refer. It allows the patient to be the director of their own journey.

The patient's journey could be streamlined if the GP referred the patient straight to the appropriate service, as the perception exists that GPs are referring patients to Emergency Departments.

# 7 CONCLUSIONS

1. The suggestions and recommendations received from the online engagement events highlight similar themes across the 3 stakeholder groups, with a strong focus on the need for consistent communication which would simplify the current messaging and inconsistency of how services are described. At times, there may appear duplication in the report, however, it was felt necessary that key themes were presented from each of the stakeholders.

2. The online consultation provided a consensus that we now need to move to the implementation stage of the strategy and at times, there was a frustration that progress appeared to be limited, albeit, a number of significant reviews providing detailed service analysis have already been completed and have informed the current position.

3. One of the common concerns surrounds the level of confusion with the range of services available due to different service offerings and opening times across Trust areas. The confusion is not unique to any particular group therefore clear public messaging exercise is necessary which must be concise and jargon free. The current messaging is leading to confusion not only with the general public but also with HSC Staff.

4. Clear education and information are key to ensure the effectiveness of any model. More information should also be shared about the importance of self-care. This is a key enabler for population health, and will reduce the numbers accessing an already over-stretched service.

5. Ongoing workforce challenges were continuously raised. Concerns included staffing of the Phone First and Urgent Care Centre, and also the importance of ensuring staff are competent to triage patients. There was a recognition that staff are already over-stretched and struggling to cope with the current system, thus the need for a regional multi- disciplinary plan is necessary to support the implementation of the strategy, commencing with establishing our current resources.

6. It was recognised that a number of initiatives have been introduced to support people stay in their own homes, and there was overwhelming support to reinforce this model of care. Clinicians referred to the recommendations contained within the Getting It Right First Time (GIRFT) national programme which has been considered a part of this wider review.

7. Systems wide collaboration is necessary for planning pathways and service delivery as well as an oversight of the capacity and demand. It was also recognised that a Systems Leadership approach is necessary, otherwise the problems are simply moved from one part of the system to the next.

8. Digital solutions have already enabled some changes in the current system, however, there is inconsistency in the delivery model. Online solutions have and will continue to help with timely responses, but there should be efforts to ensure the population have equal access.

9. Accessibility, and especially to the Phone First service was continuously raised. Community Access UK (CAUK) was recommended in order to help train staff in different communication methods for deaf people, speech and language issues, stammers and non-English speakers. For partially sighted and blind people, it was suggested that an integrated approach with third sector organisations such as Royal National Institute of Blind People (RNIB) is encouraged, due to the factor they play in people leaving hospital, particularly with trips and falls, although it was recognised that this may already be happening in some areas.

10. The public perception of Care Homes and care provided in the home needs to change. All too often it is perceived as a "second best" option which maybe be contributing to ongoing recruitment and retention challenges in this sector.

11. Whilst it was recognised that service users and carers have been involved at each stage of the consultation review, there was a clear recognition that this needs to continue as their voices continue to provide invaluable insights. Strong patient experience stories pertaining to mental health were particularly powerful during the engagement events.

# 08 APPENDIX 1

## WORKSHOP DETAIL

| Date | Stakeholder |
|---|---|
| Monday 16 May, 10.30am – 12.00pm | General Public |
| Wednesday 18 May 1.30 – 3.00pm | Trade Unions |
| Thursday 19 May 7.00 – 8.30pm | General Public |
| Wednesday 8 June 10.30am – 12.00 pm | HSC Staff |
| Wednesday 8 June 2.00 – 3.30pm | General Public |

# 08 APPENDIX 1

## REVIEW OF URGENT AND EMERGENCY CARE - CONSULTATION EVENTS