N I A O

Northern Ireland Audit Office

Managing Emergency Hospital Admissions

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
8 November 2016

Northern Ireland Audit Office

Managing Emergency Hospital Admissions

Published 8 November 2016

This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of the Order.

K J Donnelly

Comptroller and Auditor General

Northern Ireland Audit Office

8 November 2016

The Comptroller and Auditor General is the head of the Northern Ireland Audit Office. He, and the Northern Ireland Audit Office are totally independent of Government. He certifies the accounts of all Government Departments and a wide range of other public sector bodies; and he has statutory authority to report to the Assembly on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

For further information about the Northern Ireland Audit Office please contact:

Northern Ireland Audit Office
106 University Street
BELFAST
BT7 1EU

Tel: 028 9025 1100
email: info@niauditoffice.gov.uk
website: **www.niauditoffice.gov.uk**

Contents

Contents

Abbreviations

ACAH	Acute Care at Home
ACP	Alternative Care Pathway
ANP	Advanced Nurse Practitioner
ACS	Ambulatory Care Sensitive
CAA	Clinical Assessment Area
COPD	Chronic Obstructive Pulmonary Disease
DHSSPS	Department of Health , Social Services and Public Safety
EC	Emergency Care
ED	Emergency Department
ENP	Emergency Nurse Practitioner
ESRI	Economic and Social Research Institute
GP	General Practitioner
HSC	Health and Social Care
ICP	Integrated Care Partnership
IT	Information Technology
LTCANI	Long Term Conditions Alliance Northern Ireland
MIU	Minor Injury Unit
NESTA	National Endowment for Science, Technology and the Arts
NHS	National Health Service
NI	Northern Ireland
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service
NIPEC	Northern Ireland Practice and Education Council for Nursing and Midwifery
NISRA	Northern Ireland Statistics and Research Agency
OOH	Out of Hours
PHA	Public Health Agency
RAC	Rapid Access Clinic
RBHSC	Royal Belfast Hospital for Sick Children
RQIA	Regulation and Quality Improvement Authority
RVH	Royal Victoria Hospital
3PD	Third Party Developer
TYC	Transforming Your Care
UK	United Kingdom

Key Facts

KEY FACTS

166,000 emergency admissions to hospital in 2015-16

10 per cent increase in emergency admissions over past eight years

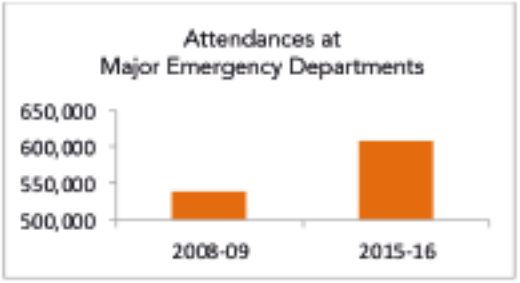
83 per cent of emergency admissions to hospital were admitted from an emergency department

40 per cent of emergency admissions had a hospital stay of less than two days

27 per cent of emergency admissions were aged over 75 years

20 per cent increase in rate of emergency patients readmitted to hospital

12 per cent increase in attendances at major emergency departments over past eight years



In March 2016 **76 per cent** of complex hospital discharges occurred within 48 hours (against the 90 per cent target)

In 2015-16 **26 per cent** of patients leaving a Type 1 or Type 2 emergency department in the last ten minutes of the 4 hour target were admitted to hospital

In 2014-15 emergency admissions to hospital cost **£467 million**

Executive Summary

Executive Summary

A sustained focus on emergency care services by the Department of Health seeks to resolve the problems that have proved difficult to address

1. At the heart of managing emergency admissions to hospital is the effective management of patients through the system. This report shows, however, that, for many patients, their admission to hospital was potentially avoidable, while others can remain in a hospital bed longer than is necessary. Avoiding unnecessary emergency hospital admissions and managing those that are admitted more effectively is a major concern for the health and social care services, not only because of the costs associated with these admissions but also because of the disruption and pressure they can cause to elective services and to the patient.

2. Demand for acute care in our hospitals has grown steadily over the past decade, due largely to an ageing and growing population and increases in chronic illness. As a result, such patients are more likely to present at emergency departments and subsequently require acute admission – 20 per cent of all patients attending emergency departments require admission. To manage such demand, the health and social care services need sufficient capacity and have to use it effectively. The issue of capacity is important and extends beyond the provision of hospital beds for emergency admissions to include care models such as 'Hospital at Home'. Initiatives like this help to free up bed days within hospitals, creating capacity for the next patient on the elective waiting list.

3. Parts 3 and 4 of the report give a flavour of the extent and breadth of work that has been undertaken in recent years to improve the management of emergency hospital admissions. However, despite all the earnest efforts being made to increase the efficiency of the patient pathway through emergency care, involving the primary and community sectors through to the use of secondary care resources, there is still room for improvement in the balance between elective care and emergency department admissions. Many patients are still being admitted to hospital unnecessarily when they could be treated more appropriately elsewhere in the system, thus freeing beds up for those waiting for elective inpatient care. Too many patients admitted as emergencies still face unnecessary delays in their discharge from hospital due to problems in securing appropriate care packages in their homes or the community.

4. The system remains under significant and increasing pressure. For example, reducing the incidence of acute hospital admissions for patients with one or more long term conditions has been a target for the Department of Health since the publication of the Programme for Government 2008-11. However, this has been challenging in the face of a rising number of admissions, which the revised targets reflect:

- initially the target was to reduce unplanned hospital admissions for such conditions by 50 per cent by March 2011 (unachieved);

- the target was amended to 10 per cent in the Commissioning Plan Direction[1] for 2012 to 2014 (unachieved); and

- it was scaled down again to 5 per cent for 2015 (unachieved) and remains at that level for 2016.

5. Tackling the challenges presented by emergency care has undoubtedly been made more difficult by wider constraints such as the financial pressures facing the health and social care sector, shortages of emergency medical staffing, the effects of demographic changes, and an historical configuration of hospital services which appears unsustainable. However, despite such challenges, the level of scrutiny and priority on emergency care services is such that senior executives in the health and social care services take action on a frequent basis to review and change systems and processes, and to monitor performance and outcomes: strategies (most recently Transforming Your Care[2] (TYC)) and specific initiatives have been produced; clear objectives and targets have been set in successive Health and Social Care Board Commissioning Plans; and escalation and intervention approaches have been implemented across the Trusts.

6. Managing emergency admissions has three key aspects which impact on the effective use of resources: preventing patients from being admitted to hospital when they do not need to be; making sure those who are admitted stay no longer than is necessary; and ensuring that they are treated in the most appropriate setting. This also means keeping people healthy in their own homes and supporting discharged patients in the community to minimise the need for future admissions. To fully utilise resources, the report recommends that, where evaluation of innovative initiatives shows evidence of improvement and success in tackling the challenges presented by emergency care, it is essential that such good practice is adopted comprehensively across the health and social care services, becomes part of mainstream activity and quickly replaces traditional ways of working.

7. At the time of drafting our report, the focus on emergency care has increased significantly with the establishment of the Unscheduled Care Task Group and extensive efforts are currently being made in an attempt to ease the issues we have reviewed in this report. The Department's Commissioning Plan Direction for 2016–17, for example, reinforces the focus on emergency care (**Appendix 1**) by including a target seeking a five per cent reduction in the number of unplanned admissions for adults with specified long term conditions.

1 The annual Commissioning Plan Direction sets out Departmental priorities, standards and targets for the period.

2 Transforming Your Care: A Review of Health and Social Care in Northern Ireland, December 2011

Executive Summary

8. We acknowledge that the recently renewed focus on emergency care is positive, and we call on the Department and its health and social care partners to accelerate their efforts to pursue further transformational change in emergency hospital admissions so that this can play a part in achieving sustainable emergency care services for the future. This will involve providing better support for people to self-care; helping people with urgent care needs to get the right advice in the right place, first time; and providing highly responsive urgent care services outside of hospital so people no longer need to attend an emergency department.

Part One:
Introduction

Part One:
Introduction

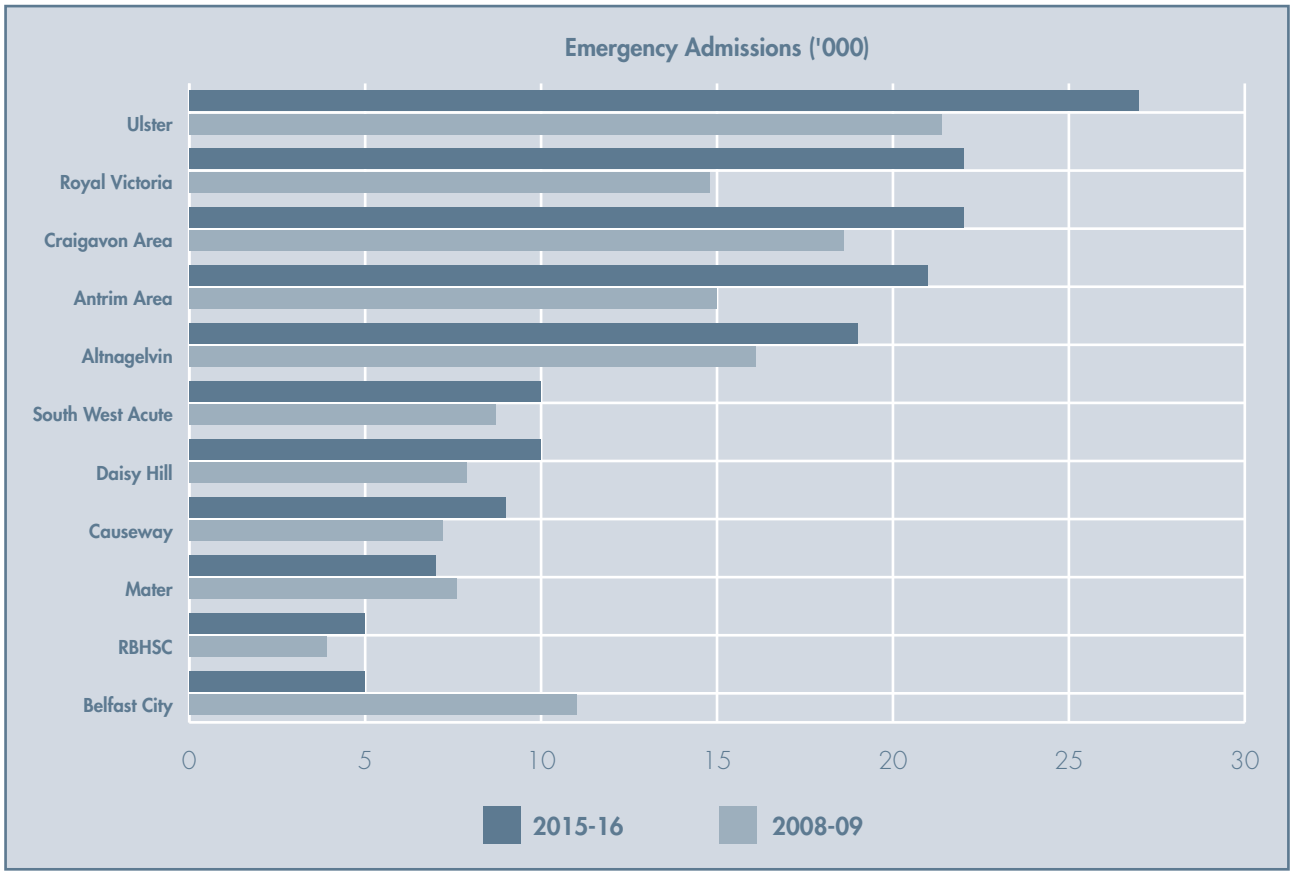
Emergency admissions to acute hospitals are rising quickly

1.1 Emergency admissions currently account for 28 per cent of all patients admitted to hospital in Northern Ireland. The number of emergency admissions has risen from 151,000 in 2008-09 to just over 166,000 in 2015-16, an increase of ten per cent (**Figure 1**). **Figure 2** breaks the increase down by acute hospital and together these show that the increase has primarily been driven by admissions to acute hospitals.

Figure 1: Number of emergency admissions, 2008-09 and 2015-16

	Hospitals		
	Acute	**Non Acute**	**Total**
2008-09	**132,261**	18,821	151,082
2015-16	**157,164**	9,132	166,296
Change (number)	**24,903**	(9,689)	15,214
Change (%)	**19%**	(51%)	10%

Figure 2: Number of emergency admissions to acute hospitals, 2008-09 and 2015-16



Notes:

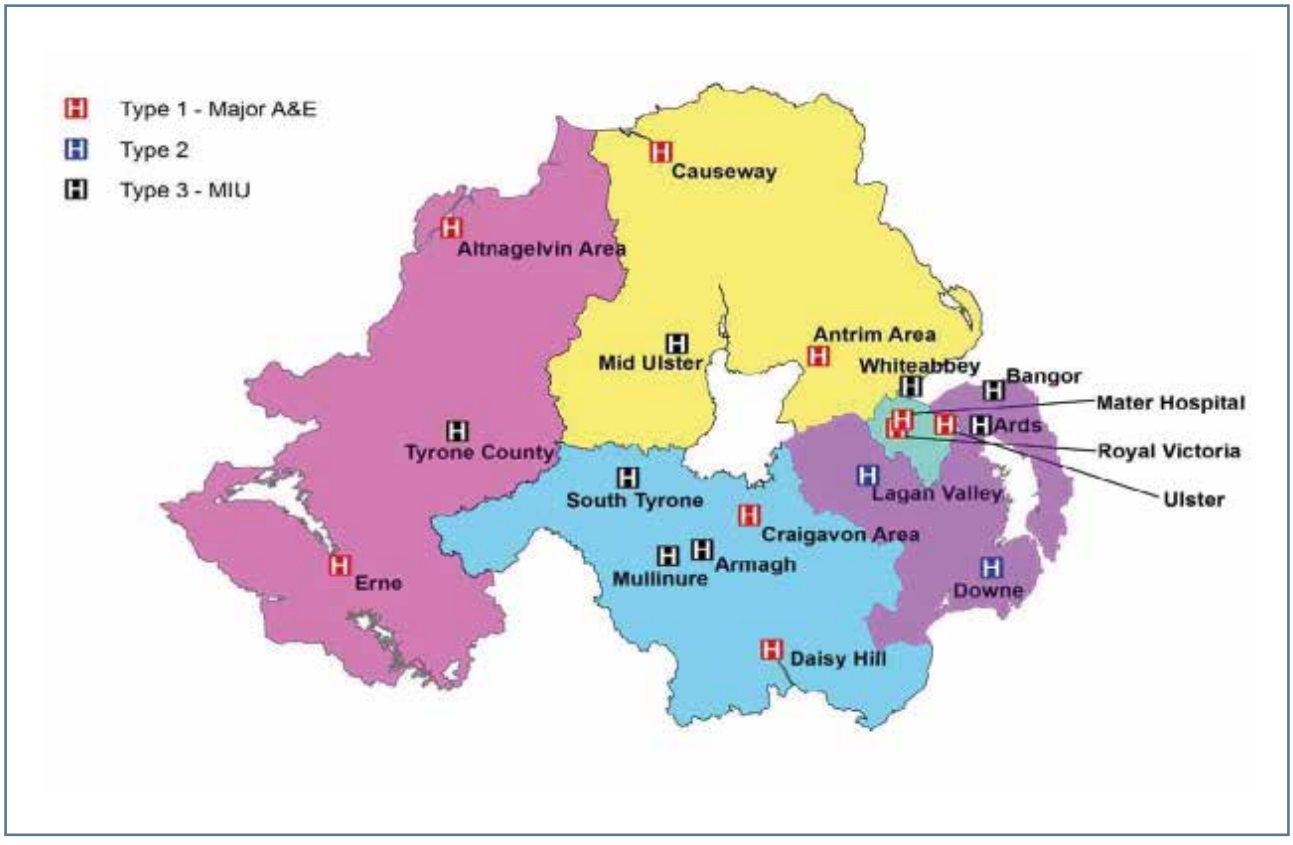
The Belfast City Hospital emergency department closed in November 2011
The South West Acute Hospital replaced the Erne Hospital in 2012
RBHSC refers to the Royal Belfast Hospital for Sick Children

Source: Department of Health, Hospital Inpatient System

1.2 There are a total of 18 emergency departments[3] (EDs) located across Northern Ireland's five Health and Social Care Trusts (Trusts): ten Type 1 emergency departments for the most serious injuries; three Type 2 emergency departments with limited hours and five Minor Injuries Units (MIUs) (Type 3) – see **Figure 3**.

1.3 Demand for emergency care has grown steadily over the past decade, due largely to an ageing and growing population and increases in chronic illness. For example, between 2008-09 and 2015-16 attendances at Type 1 emergency departments increased by just over 12 per cent, from 540,000 to 608,000. The attendance-to-admission 'conversion rate' has remained steady at around 20 per cent for a number of years (**see Figure 4**), meaning that around one in five people who attended an emergency department in 2015-16 was then admitted to a ward.

Figure 3: Emergency departments are located across the health and social care services



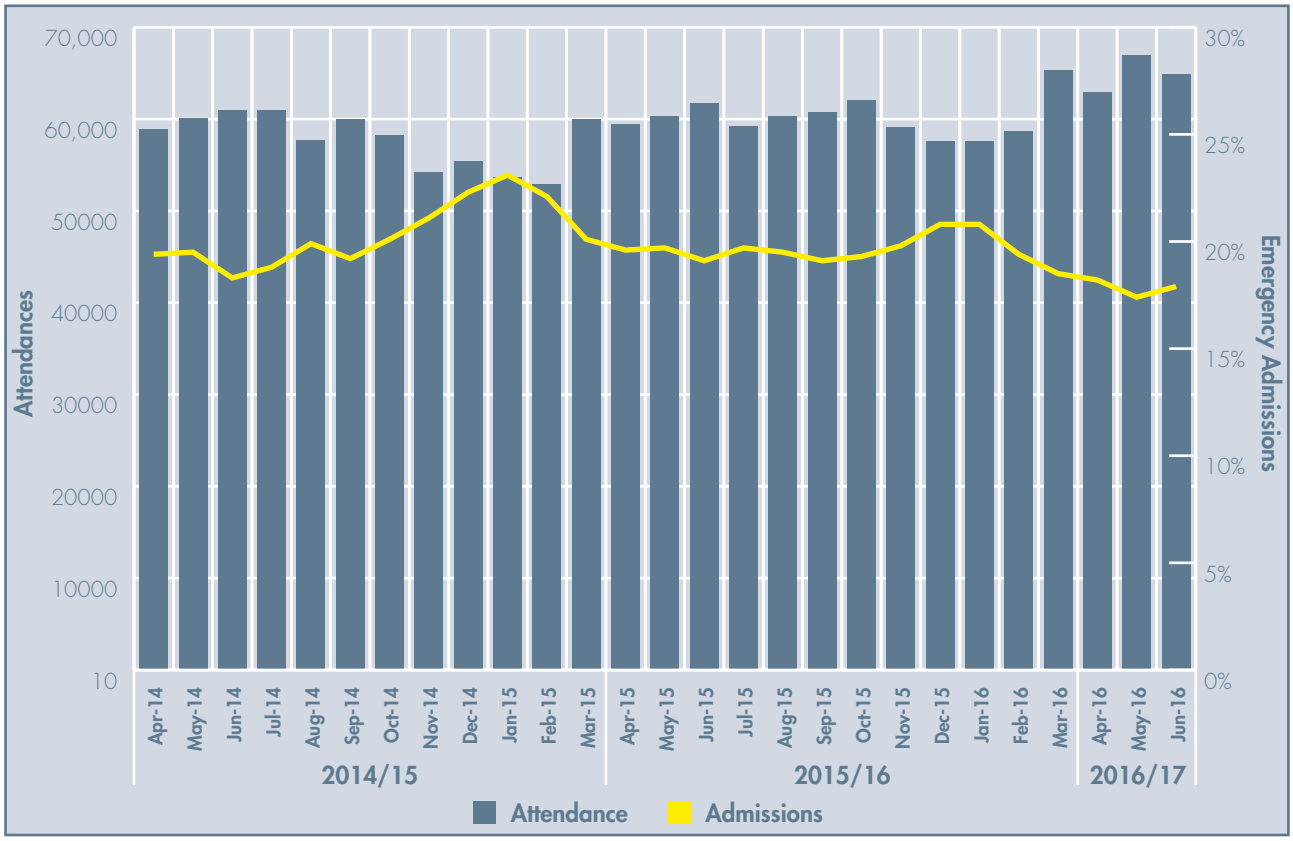
Note: The Minor Injuries Units at Armagh Hospital and Whiteabbey Hospital are temporarily closed.

Source: Department of Health

3 **Type 1:** a consultant-led service with designated accommodation for emergency care patients; providing both emergency medicine and surgical services on a 24 hour basis.
Type 2: a consultant-led service with designated accommodation for emergency care patients; does not provide both emergency medicine and emergency surgical services and/or has time-limited opening hours.
Type 3: A minor injury unit (MIU) designed for patients with a minor injury and/or illness (such as sprains, cuts, bruises); may be doctor-led or nurse-led.

Part One:
Introduction

Figure 4: Attendances at emergency care departments and emergency admissions to hospital (April 2014 – June 2016) [4, 5, 6]



Source: Emergency Care Waiting Time Statistics for Northern Ireland (April -June 2016), Department of Health

Admissions from emergency departments account for the entire rise in emergency admissions

1.4 As well as admission from an emergency department, patients may be admitted as an emergency directly by a GP or from other routes[7] such as an outpatient clinic. By 2015-16, the vast majority of emergency admissions (83 per cent) had come through an emergency department, while those admitted from GP practices and other routes had fallen in the period since 2008-09 (**Figure 5**).

4 Emergency Admissions (admissions via an ED) information is sourced from the ED Administrative Systems and will therefore differ slightly from the information included in the Hospital Statistics: Inpatients and Day Case Statistics which are sourced from the Hospital Inpatient System.

5 Readers should note that those on an ambulatory care pathway delivered outside the ED are not included in these waiting time statistics.

6 Data on emergency admissions are not National Statistics, but have been published to provide users with a comprehensive view of emergency care activity and waits.

7 The Information Standards and Data Quality Team (HSC Board) define emergency admissions from Other Routes as from: Consultant Outpatient Clinic, Bed Bureau or other Health Care Provider.

Figure 5: Emergency admissions by source, 2008-09 and 2015-16

	Emergency Department	GP/Other	Total
2008-09	120,240	30,842	151,082
2015-16	138,736	27,560	166,296
Change (number)	18,496	-3,282	15,214
Change (%)	15%	-11%	10%

Source: Department of Health, Hospital Inpatient System

Around a quarter of emergency admissions are for Ambulatory Care Sensitive (ACS) conditions and are considered potentially avoidable

1.5 While it is important not to lose sight of the fact that the majority of emergency admissions will be unavoidable, some hospital admissions may be necessary in the absence of better developed community and domiciliary services which, if present, could provide optimal care elsewhere. A key focus in managing emergency admissions therefore, should be on that proportion of patients who could be treated more appropriately elsewhere, what form that care should take, and how resources can be targeted to support this service model.

1.6 For some conditions, early intervention and treatment can prevent more serious progression and for others where problems develop over longer periods, the risk of a crisis leading to emergency admission to hospital can be reduced by timely and effective self-care, primary and community care or outpatient management of care. Collectively, such conditions are referred to as ambulatory care sensitive (ACS) conditions[8] which can be categorised as either chronic or acute and include conditions such as dehydration and gastroenteritis; perforated or bleeding ulcers; cellulitis; congestive heart failure and diabetes complications (see **Appendix 2**). Research[9] in the UK indicates that ACS conditions make up one in every five emergency admissions.Locally, approximately 16 per cent of all emergency admissions to hospitals in 2015-16 were ACS conditions and thus potentially avoidable.

1.7 Between 2008-09 and 2015-16 emergency admissions for acute ACS conditions increased by 13 per cent (**Figure 6**). This is broadly in line with the ten per cent increase in emergency admissions overall (for that period). By contrast, the rate of admissions for chronic ACS conditions actually fell by over eight per cent. The Health and Social Care (HSC) Board view this as positive evidence that improved patient care pathways mean that more patients with ACS conditions are now being seen outside a hospital setting.

8 While we acknowledge that in attempting to identify avoidable admissions there can be no absolute categories, high levels of admissions for ACS conditions can be an indicator of poor co-ordination between the different elements of the health care system, in particular between primary and secondary care.

9 Focus on preventable admissions, Ian Blunt, Quality Watch, The Health Foundation/Nuffield Trust, 2013

Part One:
Introduction

Figure 6: Number of emergency admissions for Ambulatory Care Sensitive conditions, 2008-09 to 2015-16

Year	Acute ACS conditions	Chronic ACS conditions
2008-09	13,511	18,778
2009-10	13,699	17,260
2010-11	13,285	16,917
2011-12	13,781	16,161
2012-13	14,605	17,072
2013-14	14,939	16,945
2014-15	14,505	17,322
2015-16	15,256	17,174
Change (number)	1,745	-1,604
Change (%)	12.9%	-8.5%

Source: Department of Health, Hospital Inpatient System

While the rate of emergency admissions in Northern Ireland has consistently been lower than the rest of the UK, it has been rising more rapidly in recent years

1.8 The increase in emergency hospital admissions is not unique to Northern Ireland. Indeed, as **Figure 7** shows, emergency admission rates in Northern Ireland have consistently been lower than those in England, Scotland and Wales. However, in recent years emergency admission rates here have had a higher year on year increase than the other UK countries. **Figure 7** also shows that the Republic of Ireland, which has traditionally had the lowest emergency admissions rate, has also shown a marked increase since 2011-12.

Emergency admissions to acute hospitals impose a heavy financial burden on the health and social care services

1.9 In 2014-15, the cost of emergency admissions to acute hospitals was £467 million[10] - which equates to around ten per cent of the entire health and social care budget. Around 85 per cent of this cost (£395 million) relates to hospitals with a Type 1 emergency department (**Figure 8**).

Figure 8: Cost of non elective admissions (hospitals with a Type 1 emergency department) 2014-15

Hospital	Total Cost £ million
Royal Hospitals[11]	103.7
Ulster	58.5
Altnagelvin	49.8
Craigavon	49.2
Antrim	48.5
South West Acute	30.2
Causeway	21.2
Daisy Hill	17.3
Mater	16.6
Total	**395.0**

Source: Department of Health

10 At the date of publication, aggregated cost data 2015-16 was not available.

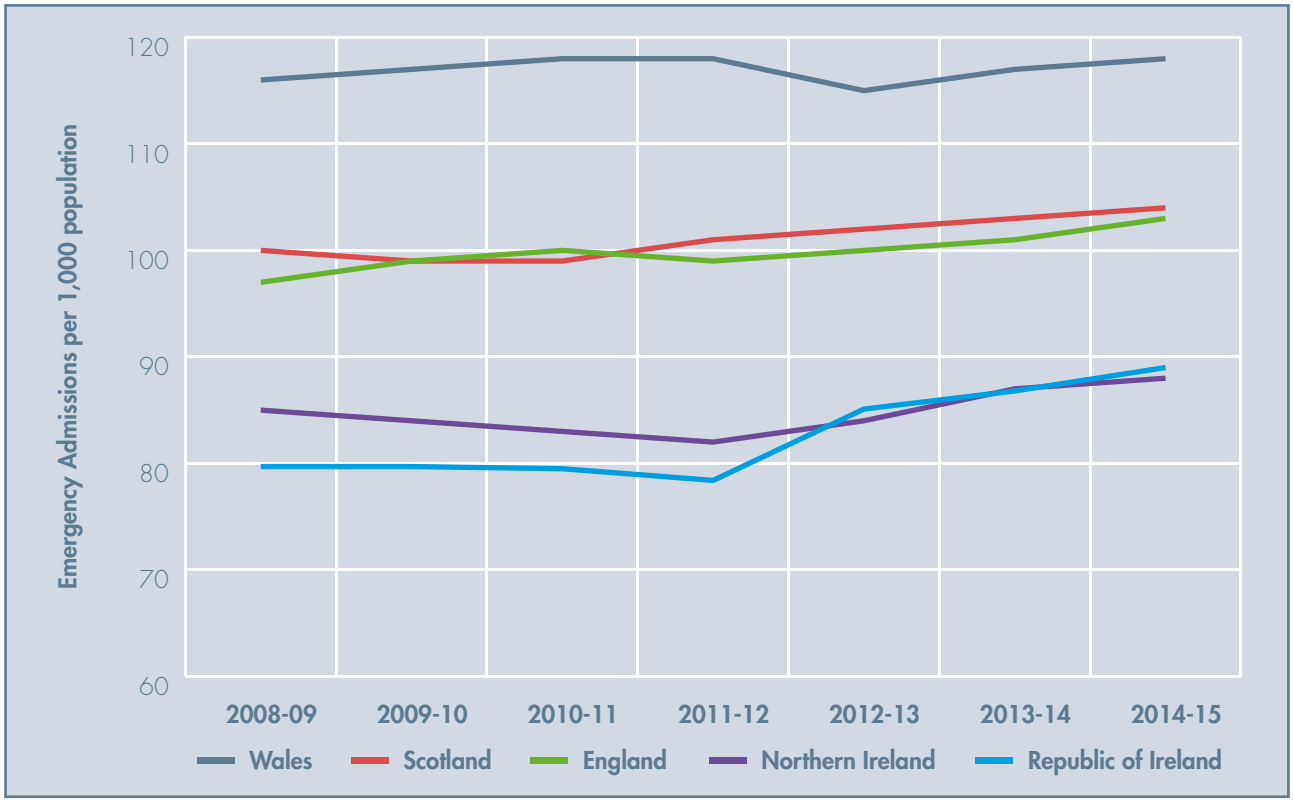
11 The cost of £103.7 million is for both the Royal Victoria and Royal Belfast Hospital for Sick Children (RBHSC).

Oversight and responsibility for urgent and emergency care

1.10 Each year the Department of Health[12] (the Department) sets out its priorities, standards and targets in a Commissioning Plan Direction including those applying to urgent and emergency care. The Commissioning Plan Direction for 2016 reinforces the focus on emergency care and, in terms of the focus of this report, includes targets for reducing the numbers of adults with specified long term conditions being admitted to hospital as an emergency (**Appendix 1** outlines the relevant Commissioning Plan targets).

1.11 The HSC Board is responsible for ensuring urgent and emergency care services are delivered efficiently and that particular failings in local services provided by the five Trusts are effectively challenged and addressed. It monitors key emergency care performance indicators on a monthly basis and, since 2007, has undertaken a rolling programme of Key Actions and Bed Utilisation Reviews across all Trust hospitals, in order to gain operational knowledge of emergency care. The results of these audits have then supported discussions on performance management issues between the HSC Board and the Trusts. For example,

Figure 7: UK and Republic of Ireland emergency admissions per 1,000 population, 2008-09 to 2014-15



Source: Hospital Inpatient System, NISRA and NIAO analysis of Hospital Episode Statistics for England, Patient Episode database for Wales, Information Services Division, Scotland and Activity in Acute Hospitals, Republic of Ireland (ESRI and Healthcare Pricing Office)

12 The Department of Health, Social Services and Public Safety (DHSSPS) became the Department of Health on 9 May 2016.

Part One:
Introduction

where emergency admission to hospital is deemed to have been avoidable or inappropriate, consideration has then been given to potential alternatives; including care at home with support or community care.

1.12 At the time of drafting, the Department has announced its intention to end the current way health and social care is commissioned. In particular, it has signalled its intention to close the HSC Board arguing that the administrative structures in place blur the lines of accountability and weaken authority. Under proposed new arrangements, the Department is to be given a renewed strategic oversight role and the Trusts given greater operational freedom and flexibility.

Recommendation

1.13 **The detailed design of new performance management arrangements is currently being worked through. We recommend that the Department should periodically make available information, which provides patients and the wider public with assurance about the performance of Trusts against the specific outcome targets established for reducing avoidable admission to hospital. We recommend too, that given its oversight role, the Department plays an active role in ensuring that emerging learning in the area of avoidable admissions is shared and consolidated across the Trusts, and that this is demonstrated through regular updates.**

Reducing emergency admissions is part of the Department of Health's renewed focus on improving emergency care services

1.14 In 2014, against the background of high and rising demand on emergency care services, the Regulation and Quality Improvement Authority (RQIA) inspected and reported[13] on unscheduled care services in the Belfast HSC Trust. In addition to recommendations on the specific circumstance at the Belfast Trust, RQIA also made a number of recommendations for concerted action across the region to improve the delivery of unscheduled care (**see Appendix 3**).

1.15 Following the RQIA review, the Department established an Unscheduled Care Regional Task Group, co-Chaired by the Department's Chief Medical Officer and representatives from across all professions and disciplines in the health and social care sector into a single project structure.

1.16 In light of the significant progress achieved by the Task Group in developing and introducing a range of improvement measures, the Department decided to move the initiative into full operational mode to ensure that the measures are fully implemented and embedded across the region. The HSC Board and Public Health Agency (PHA) were asked to establish a managed clinical network to take forward the implementation of the key products from the Unscheduled Care Task Group and to take forward the unscheduled

13 Final Report of the Inspection of Unscheduled Care in the Belfast HSC Trust, 31 Jan – 2 Feb 2014, RQIA April 2014; An Independent Review of Arrangements for the Management and Co-ordination of Unscheduled Care in the Belfast HSC Trust and related regional considerations, RQIA July 2014.

care agenda more generally. The revised structure comprises a Strategic Accountability Group jointly chaired by the Chief Executives of the HSC Board and PHA, a Regional Network Group and five locality Network Groups.

1.17 In our view, the establishment of the Task Group provides evidence of renewed focus on emergency care and the specific issue of emergency admissions by attempting to develop a more comprehensive and inclusive approach to their transformation. As a result, we consider that it should have great potential to drive improvement in dealing with the issue of avoidable admissions through its high profile and the fact that it will be supported by a comprehensive structure of work-streams and implementation plans.

Recommendation

1.18 **We recommend that, given its oversight role, the Department should have adequate arrangements in place to ensure that the recommendations flowing from the range of reviews carried out into emergency care, both locally and externally, are properly considered and where appropriate implemented and tracked.**

Scope of the report

1.19 **Part 2** of the report examines the trends and patterns of emergency admissions and factors which have been driving the increases. **Part 3** discusses the progress that has been made across the health and social care services to help reduce inappropriate demand on the acute sector by supporting self-care, developing primary care and community services, and helping to signpost patients to the services which are most appropriate to their needs. **Part 4** of the report examines the steps which have been taken to ensure that all patients admitted as emergencies do not remain in hospital any longer than is deemed clinically necessary.

1.20 A methodology for the report can be found at **Appendix 4**.

Part Two:
Understanding the rise in emergency hospital admissions

Part Two:
Understanding the rise in emergency hospital admissions

2.1 The reasons for the increase in emergency hospital admissions are complex and include an ageing population and changing social factors increasing the demand for formal care. **Figure 9** provides a simplified framework for outlining the many interacting factors that can influence emergency admission to hospital.

An ageing population is a key driver in the demand for emergency hospital beds

2.2 The reasons for the rise in demand for emergency care services are complicated but one factor is the ageing population and the increase in the number of frail, older people attending emergency departments. Such patients generally have more acute needs, which are more complex to manage. This can affect patient flow. A growing frail and elderly population means that many more people are living with a long-term condition and may not have sufficient and systematic support to self-manage. Moreover, many of these older people will be vulnerable to deterioration in their conditions, which in the absence of suitable primary and community care services can often result in an emergency admission to hospital.

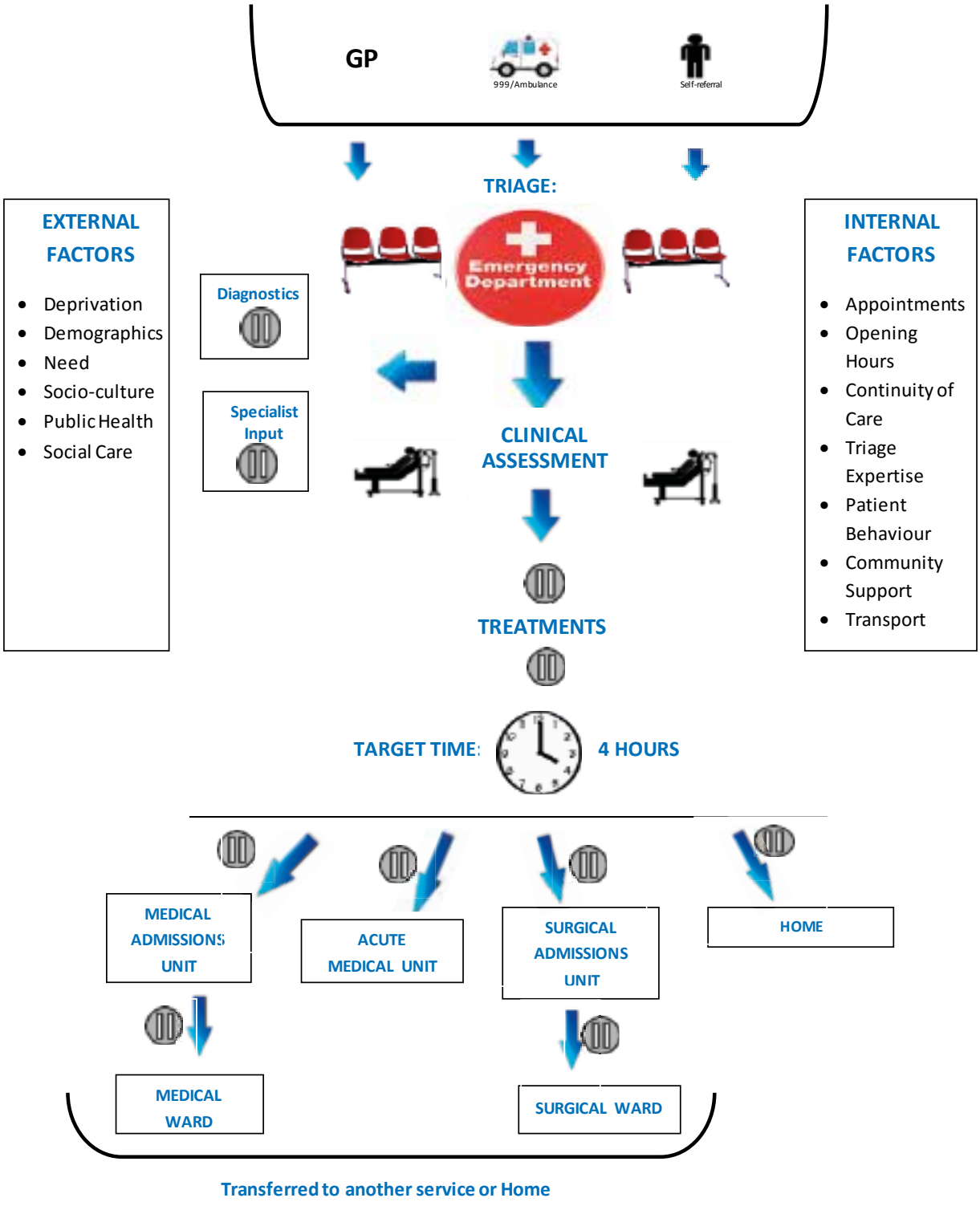
2.3 As **Figure 10** shows, people over 60 years of age have a disproportionate impact on emergency admissions – accounting for just under 21 per cent of the population but 47 per cent of emergency admissions. In particular, the cohort of patients over 75 years of age (seven per cent of the population) accounted for over a quarter of all emergency admissions to hospital in 2015-16.

2.4 The growth in the older population and the forward projections of a continuing upward trend has particular consequences for the emergency care system: not only is the number of older people increasing but there are also changes in the health conditions in the older population. The prevalence of co-morbidities[14] comprising a combination of long-term conditions, including cognitive impairment as well as physical illness, is likely to be especially important. Further research will be required to fully understand and evidence the links between an ageing population, increased acuity and appropriate service supports, in order to appropriately manage the longer term impact on reducing emergency hospital admissions.

2.5 Of the top ten reasons for emergency admissions in 2015-16 (by primary diagnoses) over 55 per cent of patients admitted were aged 60 and over: one third were over 75 years of age. **Figure 11** shows a number of primary diagnoses that have significant levels of emergency admissions aged 75 years and over.

14 Co-morbidities are two or more diseases existing at the same time in the body.

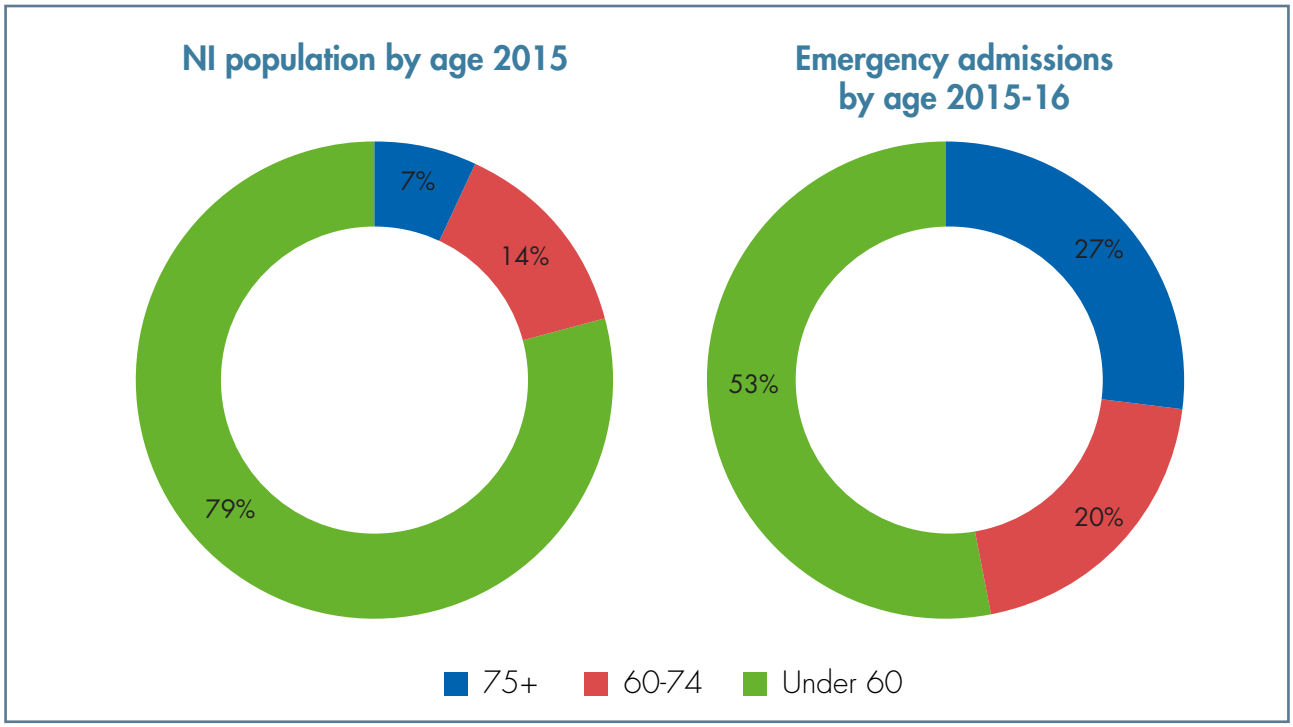
Figure 9: Patient journey through the emergency department to an emergency admission



Source: NIAO

Part Two:
Understanding the rise in emergency hospital admissions

Figure 10: Whilst older people over the age of 75 represent only 7 per cent of the population, they account for 27 per cent of all emergency admissions



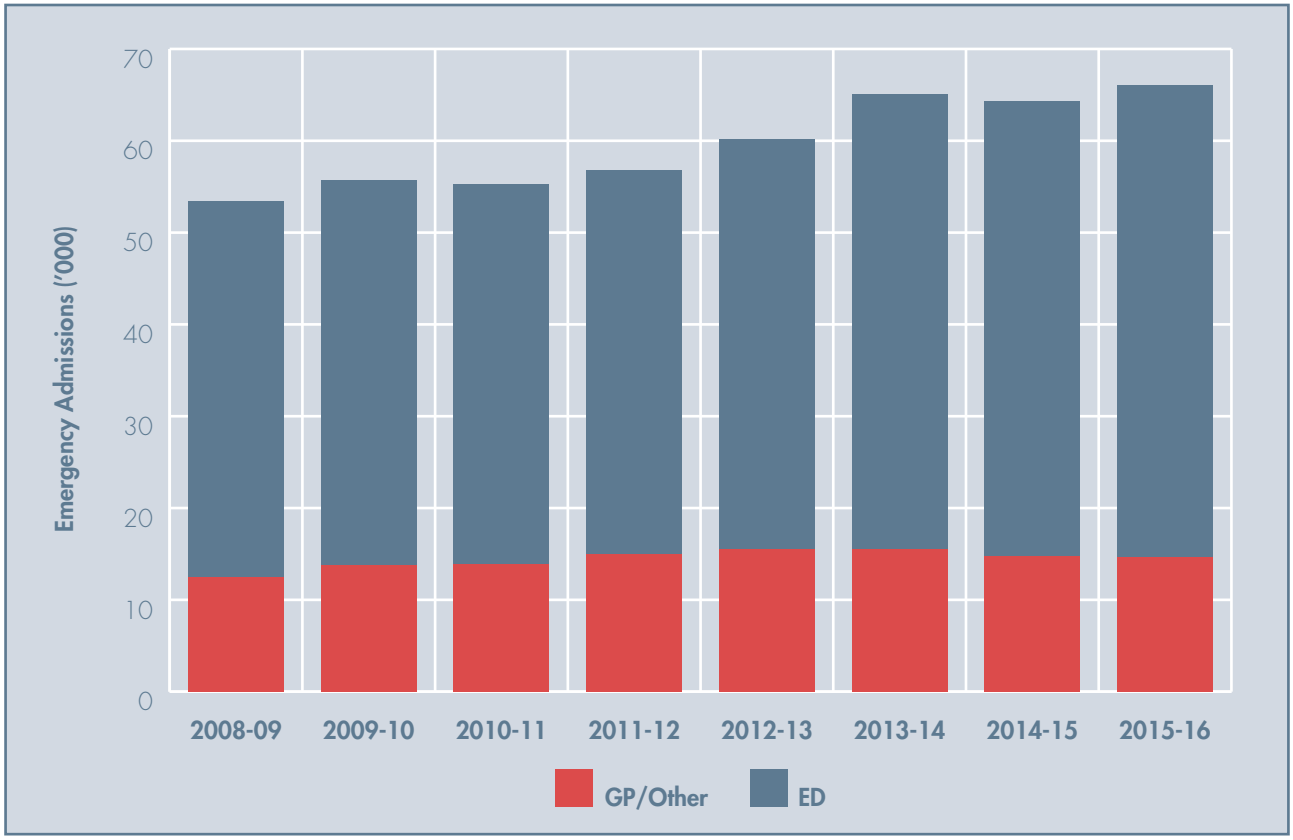
Source: Department of Health, Hospital Inpatient System

Figure 11: Top 10 primary diagnoses for emergency admissions by age group, 2015-16

	Number of emergency admissions			% of emergency admissions	
	Total	Aged 60-74	Aged 75+	Over 60 years	Over 75 years
Pneumonia, organism unspecified	6,808	1,755	3,672	80%	54%
Other disorders of urinary system	5,072	1,006	2,531	70%	50%
Cough - Pain in throat and chest	4,992	1,387	922	46%	19%
Abdominal and pelvic pain	4,898	560	391	19%	8%
Other chronic obstructive pulmonary disease (COPD)	4,022	1,879	1,529	85%	38%
Unspecified acute lower respiratory infection	3,471	636	1,437	60%	41%
Viral infection of unspecified site	2,715	49	46	4%	2%
Mental and behavioural disorders due to use of alcohol	2,461	355	39	16%	2%
Heart Failure	2,139	527	1,505	95%	70%
Syncope and collapse	2,054	431	801	60%	39%
Top 10 diagnoses	**38,632**	**8,585**	**12,873**	**55.5%**	**33.3%**

Source: Department of Health, Hospital Inpatient System

Figure 12: Short stay emergency admissions by source, 2008-09 to 2015-16



Source: Department of Health, Hospital Inpatient System

The pattern of length of stay for emergency admissions is changing

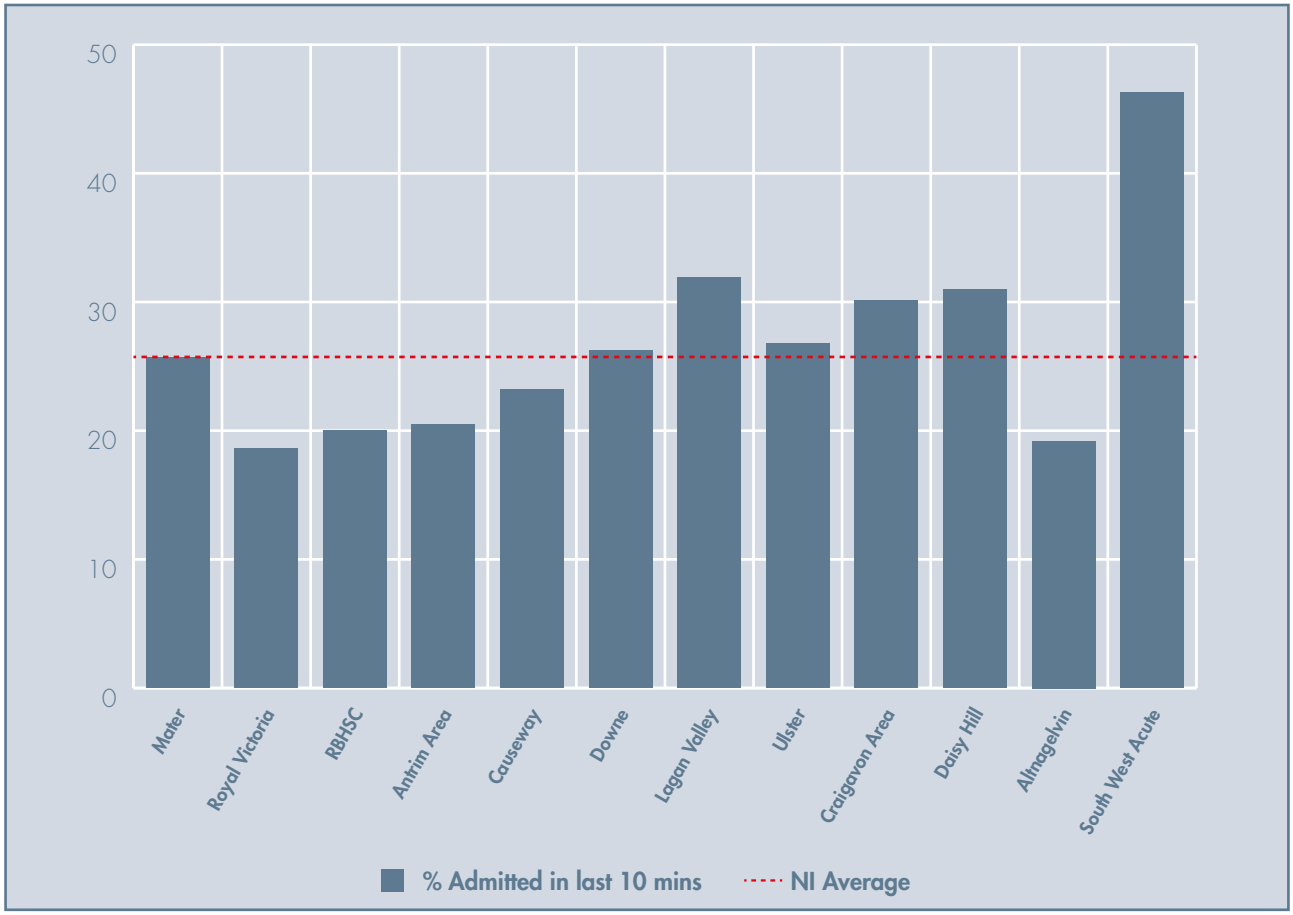
2.6 An increasing number of people who are admitted to hospital as an emergency stay for less than two days ('short-stay' admissions). In 2015-16, 40 per cent of emergency admissions had a hospital stay of less than two days, compared to 35 per cent in 2008-09. Short-stays accounted for almost an extra 12,000 emergency admissions in 2015-16 compared to 2008-09, with most of the increase coming through emergency departments and occurring since 2012-13 (**Figure 12**).

There does not appear to be any association between the introduction of a four hour wait target in emergency departments and the regional increase in emergency admissions

2.7 A four hour emergency department wait target set by the Department requires 95 per cent of patients attending emergency departments to be seen, treated, admitted or discharged in under four hours. We found that an increasing number of patients had been admitted from an emergency department as the four hour target approached, peaking in

Part Two:
Understanding the rise in emergency hospital admissions

Figure 13: Emergency admissions and the four hour target, 2015-16



Source: Department of Health, Hospital Information Branch

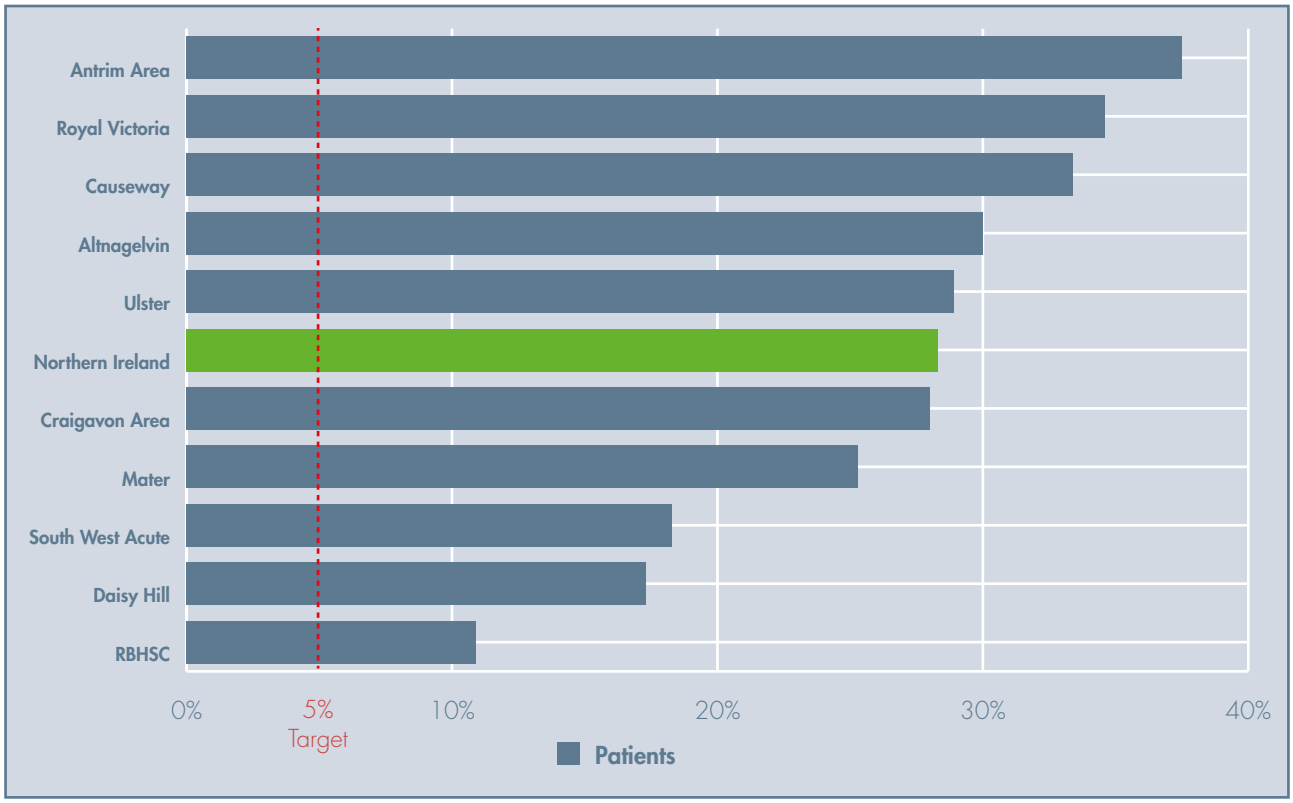
the last ten minutes of the waiting period. On average, during 2015-16, just over a quarter (26 per cent[15]) of patients discharged from Type 1/2 emergency departments in the last ten minutes of the four hour period were admitted to hospital (**Figure 13**); this compares to 32 per cent during 2014-15 and 28 per cent in 2013-14.

2.8 If patients were being systematically admitted to hospital to avoid breaching the four hour target then it could be expected that the number of patients waiting more than four hours would reduce as short-stay admissions increased. However, as **Figure 14** shows, in 2015-16, Type 1 emergency departments have all breached the 95 per cent target in relation to four hour waits to a greater or lesser extent. This would demonstrate that there is little evidence of substitution between breaches of the target and short-stay admissions at a regional level.

2.9 Rather than short-stay emergency admissions being driven by the four hour

15 A revision to the list of codes used by HSC Trusts may have contributed to some of the reductions in the percentage of patients admitted to hospital in the 10 minute period prior to them breaching the four hour target.

Figure 14: Patients spending more than four hours in Type 1 emergency departments, 2015-16 (against a target of 5 per cent)



Source: Department of Health, Hospital Information Branch

target, research has attributed it more to advances in clinical care and the increased use of clinical protocols and standards[16] which have helped to improve patient outcomes, and therefore reduced lengths of stay. For instance, as we discuss further in paragraph 4.13, hospitals have been making increasing use of acute assessment units[17] to improve the admission process. There is evidence that these units improve outcomes for patients by limiting waiting times in emergency departments, reducing the length of stay and reducing the likelihood of mortality[18].

2.10 In terms of efficiency, the increase in short stay admissions has been matched by a fall in the number of hospital beds. The average number of acute beds available in hospitals continues to decrease, from 4,369 in 2008-09 to 3,874 in 2015-16, whereas average Northern Ireland occupancy rates have stayed around 84 per cent (**Figure 15**). Current bed occupancy levels in many acute hospitals regularly exceed the agreed safe level of 85 per cent and increase further in the winter months, creating less flexibility within the system (**Figure 16**).

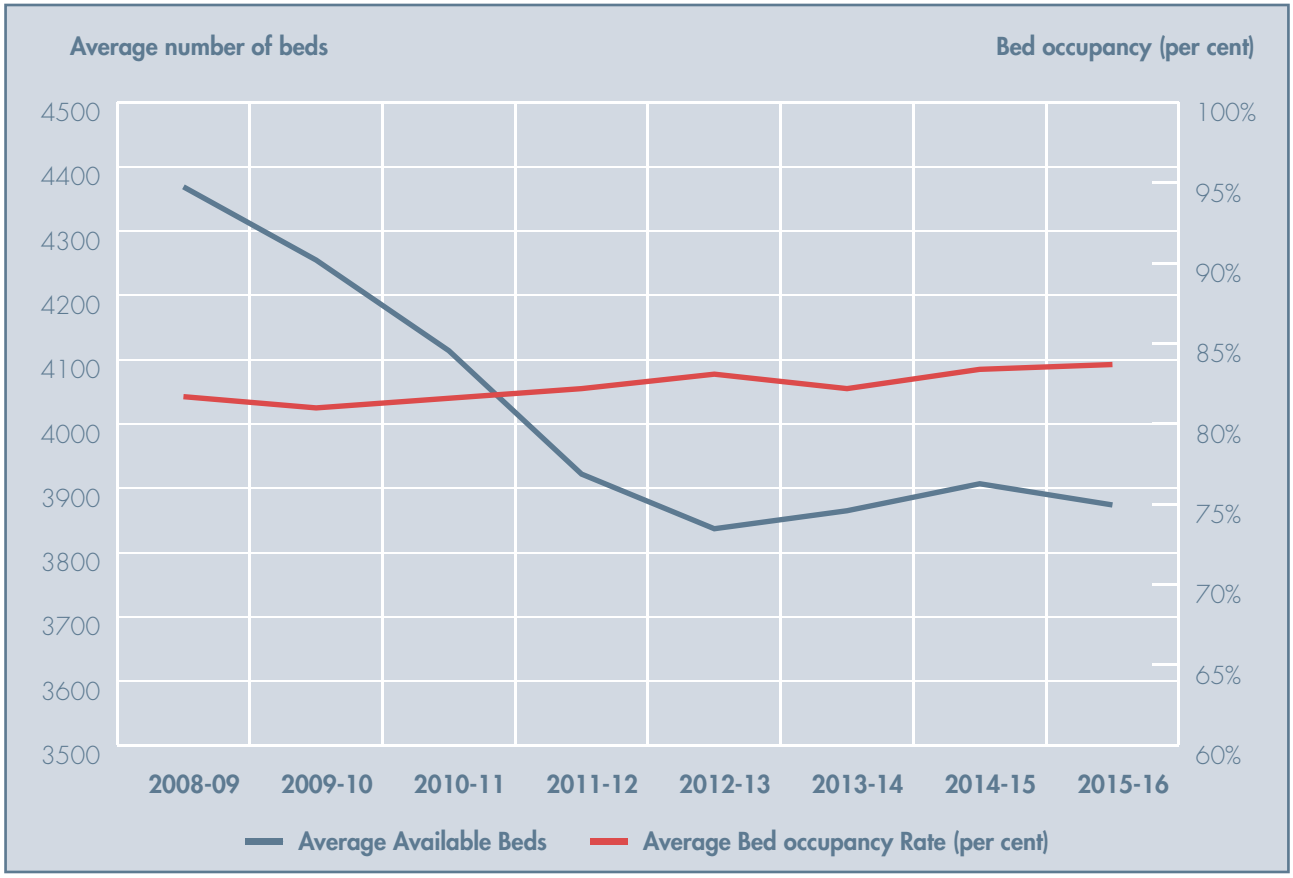
16 Trends in emergency admissions in England 2004-09: is greater efficiency breeding inefficiency? Ian Blunt et al (2010), Nuffield Trust.

17 Acute assessment units are areas where patients from an emergency department can undergo further tests and stabilisation before they are transferred to the relevant ward or discharged - note some assessment units allow direct admission by a GP.

18 NHS England (2013) NHS Services, Seven Days a Week: evidence base for the development of the clinical standards.

Part Two:
Understanding the rise in emergency hospital admissions

Figure 15: Average number of available beds in acute programme of care, 2008-09 to 2015-16



Source: Department of Health, Hospital Information Branch

Figure 16: Average bed occupancy rates in acute hospitals, 2015-16

Hospital	Bed Occupancy
Mater	91%
Ulster	89%
Royal Victoria	87%
Craigavon Area	86%
Antrim Area	86%
Daisy Hill	85%
Causeway	84%
South West Acute	84%
RBHSC	84%
Northern Ireland	**84%**
Altnagelvin	79%
Belfast City	71%

Source: Department of Health, Hospital Information Branch

Conclusion

2.11 The analysis in this section is important in providing some explanation for the increases experienced in emergency admissions to acute hospitals over recent years. We recognise that to help inform the future development of policy and practice the HSC Board carries out routine analyses of demand and admissions at a local level. This will allow it to build up a greater understanding of the actual needs and clinical conditions of people using emergency care services. For example, Integrated Care Partnerships[19] (ICPs) produce a quarterly report providing analyses of patients admitted for specific long term conditions which is used as part of a risk stratification analysis at primary care level. It is hoped that the use of predictive analysis will also support further work on the analysis of trends within specialties.

19 17 Integrated Care Partnerships (ICPs) have been established between 2011 and 2015. They are a key element in the move to transform health and social care services and establish a new way of working for the health service in Northern Ireland to transform how care is delivered. They are collaborative networks of care providers, bringing together healthcare professionals (including doctors, nurses, pharmacists, social workers, and hospital specialists); the voluntary and community sectors; local council representatives; and service users and carers, to design and coordinate local health and social care services.

Part Three:
Interventions to reduce avoidable admissions

Part Three:
Interventions to reduce avoidable admissions

Introduction

3.1 Often, for many health conditions, problems can develop over a protracted period of time, and the risk of a crisis leading to an emergency hospital admission could have been reduced had timely and effective self-care, primary and community care or outpatient care been available. Moreover, this applies, particularly, to many of the ambulatory care sensitive conditions referred to at paragraphs 1.5 to 1.7. This section of the report examines the range of interventions which have been introduced across the Trusts to help reduce emergency admissions to acute hospitals.

While steps have been taken to develop self care among patients more progress is required

3.2 It is essential that individuals are encouraged and supported in looking after their own health and well-being. Enabling patients to self-manage chronic conditions is a key component of effective care and improved patient outcomes. For example, research[20] into chronic obstructive pulmonary disease (COPD) has shown a significant reduction in the probability of hospital admission among patients receiving self-management education compared to those receiving usual care.

3.3 A key feature of the Department's policy framework *Living with Long Term Conditions*[21], is that people should be supported to self manage their condition effectively in order to maintain or enhance their health and well-being. A personalised care plan will provide details on how the individual or their carer can access support and assistance when needed, in particular, where there is a sudden exacerbation or when out-of-hours help is required.

3.4 In 2014-15, 856 education/self management programmes[22] were delivered to 13,069 participants, of which 46 per cent related to Type 1 and Type 2 Diabetes. Attendance at the programmes increased by 13 per cent on the numbers attending in 2012-13 (11,531). However, progress towards developing greater self care among patients has faced some criticism. For instance, the Diabetes Review Steering Group[23] concluded, recently, that provision of structured diabetes education for patients was variable and insufficient to meet the numbers of people with diabetes. It called for a strategic approach to ensure the development of a consistent and needs based delivery of structured education to ensure it was not simply based on an individual's home location. The Department told us that as part of their review of care pathways, ICPs (see paragraph 2.11) have identified gaps or deviations from the regional model, particularly with diabetes and respiratory conditions, and they have made proposals to those commissioning services to rectify any deficiencies or variability.

20 Self-management education for patients with chronic obstructive pulmonary disease, T. Effing et al, 2007; Self-management education for patients with chronic obstructive pulmonary disease, M. Zwerlink et al, 2014.

21 Living with Long Term Conditions, DHSSPS, 2012.

22 Patient Education/Self Management Programmes for People with Long Term Conditions 2014-15, DHSSPS March 2016.

23 Reflecting on Care for people with Diabetes 2003-2013, Report of Diabetes Review Steering Group, 2014.

3.5 In 2014, a report by Sir Liam Donaldson[24] also concluded that people in Northern Ireland needed to be given the skills to manage their health care more effectively. In general, he found local provision to be *"inadequate and fragmented"* and his report called for a specific programme to give people with long term illnesses the skills to manage their own conditions (**Appendix 5**). His report recommended that the programme should be properly organised with a small full-time coordinating staff and it should be overseen by the Long Term Conditions Alliance[25].

3.6 We recognise that those who live with long-term conditions already contribute hugely to their own clinical outcomes. However, a study by NESTA[26] has argued that relatively small organisational investments which support these individual efforts will allow them to realise further improvements in outcomes, quality of life and value for money. In terms of financial savings, the evidence is mixed: while the NESTA study has estimated that, in England, £4.4 billion could be saved in the NHS through greater participation and self-management of long term conditions. Another study[27] found that while there was evidence that self-management support interventions can reduce hospital use and total costs, the effects were generally small.

Recommendation

3.7 **The Donaldson Report concluded that progress in the development of self care education programmes has been variable and limited. While the evidence base may not yet be unequivocal, our contention is that there is enough evidence to support further scaling up of those approaches which have been shown to make a qualitative and quantitative difference on the ground. In particular, we recommend that, given the oversight role of local Integrated Care Partnerships (see paragraph 2.11), going forward, they should play a key role in identifying gaps and deviations from regional models of patient education and self-management by continuing to make proposals to commissioners to rectify deficiencies or variability where they see fit.**

Survey data shows that patients regard access to primary care as generally good however, it will be important to ensure that there is sufficient capacity to sustain its role in treating urgent care needs

3.8 Urgent care can be provided by GPs and other primary care professionals and is a vital part of the unscheduled care system in Northern Ireland. In essence they act as gatekeepers to

24 The Right Time, the Right Place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland, The Donaldson Review, December 2014 – see **Appendix 5** for a summary of the ten recommendations.

25 The Long Term Conditions Alliance Northern Ireland (LTCANI) is an umbrella body for voluntary and not for profit organisations working with and for people with long term conditions in Northern Ireland. Collectively LTCANI member organisations represent approx 500,000 people with long term conditions in Northern Ireland.

26 The Business Case for People Powered Health, National Endowment for Science, Technology and the Arts, Innovation Unit, (NESTA), April 2013.

27 Reducing Care Utilisation through Self-management Interventions, M Panagioti et al, December 2014

Part Three:
Interventions to reduce avoidable admissions

the rest of the health and social care system and as such the efficiency and effectiveness of GP services can have a significant impact on attendance at emergency departments and potential acute hospital admissions. For instance, if patients are unwilling or unable to access primary care services urgently, their only recourse may be to attend an emergency department which is costly and can increase demand elsewhere in the system.

3.9 In a survey by the Patient and Client Council[28] in 2014, almost three quarters of those surveyed reported that they were satisfied with their access to GP services. However, just over half of respondents said they found getting through to their GP practice by phone 'not easy'. When asked where they would go if they were not able to access treatment or care at their GP practice, almost a third indicated they would approach out of hours (OOH) services and around 27 per cent said they would go to an emergency department. Just over half of those questioned said they would like GP practice hours extended, especially to Saturday and weekday evenings.

3.10 Continuity of care - in the sense of a patient repeatedly consulting the same GP and forming a therapeutic relationship - has been shown to lead to more satisfied patients and staff, reduced costs and better health outcomes. This is reflected in the views of those patients who took part in the Patient and Client Council survey where familiarity, consistency and continuity of care were identified as the most important considerations for respondents who preferred to see a particular GP.

3.11 It is important to acknowledge that a "one-size-fits–all" approach is unlikely to be appropriate across the board and that a flexible approach is important. For example, the Unscheduled Care Regional Task Group[29] (paragraph 1.15) has called for the establishment of an enhanced approach to enable hard to reach patients to access GP services more easily. In its view, having a named GP-of-the-day within a practice who would have specific responsibility for providing home visits, or telephone consultations would be preferable to GPs running both regular surgeries and carrying out home visits. While this may not satisfy the needs of continuity, such an approach would allow emergency patients to be attended to more quickly than if they had to visit the GP surgery. It may also potentially reduce the likelihood of patients having to be admitted to hospital as an emergency. This approach could also be taken forward in collaboration with other nearby practices.

3.12 The HSC Board has developed a Locally Enhanced Service to enable practices to provide additional patient appointments outside contracted hours and provide increased access for booked appointments in-hours during the winter period. The Locally Enhanced Service is also designed to help meet the additional demand for home visits with the aim of speeding up the triage

28 Access to GP Services, Patient and Client Council, May 2014.

29 Improving patient flow in HSC services, Unscheduled Care Regional Task Group paper, 24th October 2014

and assessment of patients who present with an urgent acute problem and may require admission to hospital. Evidence shows that delays in triaging and assessing these patients later in the day can often result in the patient being admitted to hospital overnight.

3.13 There have been a number of developments in the way in which data is used to provide insights into patient admissions and GP referral practices. For example, GPs have received information on the emergency admission of their patients and the admission rates for the other GP practices within their local area. This information was provided for a number of specialities where medical care planning has the most potential to reduce admission rates. In addition, GP practices were able to record and read the specific medical diagnosis code in each secondary care discharge letter they receive which provides for further analysis of emergency care admissions. The Department told us that many GP practices also participated in a programme developed and administered by the HSC Board which risk stratified patient populations with the aim of identifying those patients with a higher risk (based on complexity of need) of emergency hospital admission. This means that health and social care professionals are better able to actively manage their care and potentially avoid attendances at emergency departments which in turn can result in a reduced number of avoidable emergency admissions.

Recommendation

3.14 **The Department should continue to ensure GPs receive and analyse data on emergency admissions and participate in stratifying their patient populations on the basis of their risk of hospital admission. Engagement in this way can be used to:**

- **promote opportunities for practices to learn from each other around areas of good practice;**
- **explore ways in which data on emergency admissions can be used to influence changes in behaviour; and**
- **understand the reasons for variation across practices around urgent access performance and introduce measures to reduce this variation.**

GPs have been taking steps to optimise the services they provide

3.15 There has been a trend towards the 'scaling up' of general practice with individual practices joining together under different arrangements. For instance, a network of 17 federations[30] of GP practices is beginning to be developed and implemented to support primary care to work at a scale envisaged in Transforming Your

30 GP Federations will cover about 100,000 patients and on average 20 practices. The organisational model is based on "not for profit" community interest companies.

Part Three:
Interventions to reduce avoidable admissions

Care (TYC). According to the report of a working group set up by the Department to review GP-led services[31], the federations *"…have already had a significant impact in areas such as acute care at home and in managing demand for elective services in a community setting."* However, the Department told us that it is too early in the development of federations to draw any firm conclusions on whether they are leading to an increase in service provision and numbers treated.

3.16 While it is recognised that GPs can play an important gatekeeper role in filtering patients away from the acute services where hospital admission is genuinely avoidable, the working group noted that because the number of appointments in general practice is so large and because GPs only refer a small percentage of cases on, small changes in access to and responsiveness of GP services can have a huge impact on other services. The working group's report included recommendations aimed at addressing the pressures facing GP-led services, including the need to build a sustainable GP workforce through training, recruitment and retention; and develop the wider primary care team to support GPs in managing patients in the primary care setting. The Department intends to respond formally to the working group's recommendations in the near future.

3.17 The working group's review noted a recent report on GP workforce requirements undertaken by the HSC Board and the PHA for the Department which pointed to a significant workforce deficit already affecting the delivery and sustainability of primary care services. The report recommended increasing the number of GP training places commissioned each year from 65 to 111, beginning in 2016-17 and phased over four years. Acting on this, in January 2016 additional investment of £1.2m per annum was released to provide an additional 20 GP training places, bringing the total number of GP training places available to 85 for recruitment in 2016. The working group recommends building on this investment to further increase the number of GPs to reduce pressures facing GPs and ensure that general practice is seen as an attractive career option for trainee and newly qualified doctors.

3.18 Given the views expressed above, there is a risk that the key role intended for primary care may not meet the expectations set for it in helping to reduce avoidable emergency hospital admissions. We acknowledge that the Department recognises the importance of accessible, high quality GP-led care services in treating people effectively in a primary care setting and avoiding emergency admissions to hospital.

31 Review of GP-Led Primary Care Services in Northern Ireland, Recommendations of the Working Group, March 2016, Department of Health.

Recommendation

3.19 **In echoing the views of the working group set up to review GP-led services, we recommend that the Department takes immediate steps to identify and address the root causes of training, recruitment and retention problems among GP practices in order to make primary care practice a more attractive career option.**

While out of hours services play an important role in managing emergency care, some problems remain to be addressed

3.20 In 2004, a new General Medical Services contract for GPs was introduced across the United Kingdom which enabled GPs to opt out of providing out of hours (OOH) services. The HSC Board is now responsible for providing five GP OOH services: three by Trusts (Belfast, South Eastern and Southern) and two by mutual organisations - Western Urgent Care and Dalriada Urgent Care.

3.21 In 2010, the RQIA carried out a review of OOH services and made a series of recommendations, including:

- the need to clarify the future strategic direction for the service;
- the development of regional guidelines for OOH providers on referral pathways for mental health patients;
- sharing best practice by rolling out the emergency care summary, which allows for the sharing of patient information among clinicians across the region; and
- measures to make sure that doctors are not working excessive shifts across the service.

3.22 Patient awareness of OOH services is also an important factor in the push to reduce avoidable hospital attendance and potential admission. For example, a National Audit Office survey found a correlation between lack of awareness of OOH services and emergency department attendance in England[32]. Locally, a Patient and Client Council Survey in 2013[33] found 89 per cent of questionnaire respondents indicated that they knew how to contact the OOH service.

3.23 OOH services play a key role in the management of unscheduled care. However, some services have experienced medical manpower shortages and have struggled to recruit both GPs and nurses. Moreover, the lack of comprehensive comparable performance information makes it difficult to assess what association the change in out of hours provision has had in terms of emergency hospital admissions. A Strategic Direction Framework for OOH was established in 2014 which aims to simplify access to OOH services, improve operational efficiency and improve alignment with other services.

32 Out of Hours GP Services in England: National Audit Office, London, 2014.

33 "Care when I need it": A report on urgent care services, Patient and Client Council, March 2013.

Part Three:
Interventions to reduce avoidable admissions

3.24 In 2015-16, additional investment of £5.1 million was provided to the HSC Board to address a range of challenges faced by GPs, both in-hours and out of hours, as well as to support a scheme encouraging experienced GPs to return to work. Up to £10m was also made available to support investment in practice premises to ensure they meet the needs of patients and are reflective of the needs of a modern health service.

3.25 Included among the recommendations of a review of unscheduled care by the Royal College of Emergency Medicine[34] was that every emergency department should consider having a co-located and integrated primary care out of hours facility as a way of helping to reduce the burden on secondary care and to ensure that patients receive care that better fits their needs. While the Department pointed out to us that it is under no obligation to implement any recommendation from the College of Emergency Medicine, it has worked closely with the College and the Royal College of Nursing in developing new approaches to improving the delivery of unscheduled care services. The Department sees potential merit in the co-location approach which has been tried by the Southern Trust, where the OOH service is located close to Craigavon Hospital's emergency department. There has also been a pilot in the Belfast Trust at the Royal Victoria Hospital.

3.26 While we acknowledge that having GP OOH services close to emergency departments may potentially help reduce emergency hospital admissions, we also consider such an arrangement may have the opposite effect by encouraging a view among patients that the emergency department is a 'one stop shop'. It may, perhaps, be more effective to focus on strengthening primary care so that it can be more proactive in delivering services closer to patients' homes.

Recommendation

3.27 **Given the issues around the capacity of GP practices, timely evidence on the effective use of their skills will be important. We recommend, that the Department, along with the GP practices concerned, undertake an evaluation to assess the extent to which co-location of a primary care out of hours facility with an emergency department is a sustainable model of care which reduces demand on acute services, and in particular the incidence of avoidable emergency hospital admissions.**

3.28 The Department told us that options on how best to deliver integrated primary and secondary unscheduled care services are being explored by the Regional Unscheduled Care Network Group. These include consideration of co-located and integrated primary care OOH services which have been successful in some Trust areas, for example, Craigavon, Altnagelvin and South West Acute hospitals, whereas the evidence base for similar approaches in Antrim area hospital and the Ulster hospital have been more mixed. In January 2016, the Department announced the establishment of an

34 Time to Act - Urgent Care and A&E: a patient perspective, Royal College of Emergency Medicine, May 2015

Expert Panel[35], to consider, and produce proposals on remodelling HSC services. At the time of drafting the panel had produced a set of working principles (**see Appendix 6**), one of which was that "*only people who are acutely unwell need to be in hospital*".

More integrated and targeted community services aim to reduce avoidable emergency admissions by developing care closer to patients' homes

Hospital at Home

3.29 TYC provides a vision of integrated health and social care services that act together to provide a seamless service using resources from the acute care sector and the primary and community care sectors. The aim is to change from a reactive crisis management approach to a more proactive, coordinated and preventative approach allowing more people to be cared for closer to home or in their home. In line with this focus, an Acute Care at Home Service is now in place across the Belfast Trust area having received funding of £1.74 million. Similar services are in operation in parts of the Southern and South Eastern Trust areas and opportunities are being considered to develop existing community services along the same lines in the Northern and Western Trusts. Hospital at Home is based on integrated health and social care teams with a strong multidisciplinary focus on rehabilitative care. Health care professionals provide active treatment in the patient's own home for conditions that would otherwise require acute hospital inpatient care. A systematic review of hospital at home schemes with inpatient care found that, for selected patients, avoiding admission through provision of care at home yielded similar outcomes to inpatient care at a similar or lower cost[36].

Telemedicine

3.30 Telemedicine includes both telecare (using equipment to support the patient in their own home, such as bed and chair sensors, falls detectors, a range of environmental detectors and regular contact by telephone), and telehealth (which tends to complement usual care, for example, by providing equipment for monitoring vital signs such as heart rate, and sending the data to a clinician to interpret).

3.31 Within TYC, digital health provision was identified as a key strand in the delivery of future health and social care services. The Department has been involved with the largest mainstreamed telehealth service procurement in the UK, where an £18 million remote tele-monitoring contract was awarded in 2011 to TF3 (a consortium of Tunstall, FoldHousing and S3). This scheme aimed to support up to 20,000 patients with chronic heart failure, respiratory conditions, diabetes, and post stroke management. Advice from the Centre for Connected

35 The panel was suggested by the Donaldson Report (see footnote 24). It will be chaired by Professor Rafael Bengoa who is Director of the health department at the Deusto Business School in Spain.

36 Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, et al. Hospital at home early discharge. *Cochrane Database of Systematic Reviews,* 2009.

Part Three:
Interventions to reduce avoidable admissions

Health in the PHA is that over 6,000 patients had benefited from the tele-monitoring service as at the end of August 2016.

3.32 Other initiatives have also demonstrated how using digital technology has helped to give patients the confidence to manage their own condition more effectively. For example, in 2006, the Department of Health in England announced the establishment of three pilots, known as the Whole System Demonstrators, to test the benefits of integrated health and social care supported by assistive technologies like telecare and telehealth. In the trial – the largest of its kind to be conducted thus far – over 3,000 patients were recruited from three areas of England (Cornwall, Kent and Newham) to receive telehealth or to act as controls by receiving usual care. A review of the impact of the initiative on hospital admissions and mortality[37] included the following conclusions:

- over twelve months spent in the trial, patients allocated to receive the telehealth intervention had fewer emergency hospital admissions – a difference of around 20 per cent;
- over the twelve months, 4.6 per cent of intervention patients died compared with 8.3 per cent of the control group; and
- these differences in emergency admissions and mortality were statistically significant, so were unlikely to have been caused by chance.

3.33 The Department told us that further research by the Centre for Connected Health has found that when telehealth was added to the standard care patients received, there was an increase in treatment costs, which the researchers concluded was not cost effective. However, the Department notes that technological advances in consumer-owned smart phones and tablets can enable the collection and transmission of health readings and allow patients to have virtual consultations. In view of these developments, therefore it will be important to continually assess the potential contribution which telehealth and other technologies may make to the better management of emergency admissions to hospital.

Integrated Care Partnerships are making use of stratification to target action

3.34 The RQIA review of 2014 (see paragraph 1.14), believes that the ICPs (as described in paragraph 2.11) set up in response to TYC offer an excellent opportunity to re-examine the whole care pathway across the primary and acute care sectors. Seventeen ICPs have been established as collaborative networks across Northern Ireland with an initial focus on the frail elderly and aspects of long term conditions namely diabetes, respiratory conditions and stroke (including end of life and palliative care in respect of these areas).

37 The impact of telehealth on use of hospital care and mortality: A research summary, Adam Steventon and Martin Bardsley, Nuffield Trust, June 2012

3.35 ICPs are working to address the key areas of risk stratification, information sharing, care planning and evaluation. Through the refinement of care pathways and the identification of gaps in local services, the ICPs have been working to improve the integration and effectiveness of care and treatment. Work has also been undertaken with HSC Board clinical information experts to enable the risk stratification of patient populations. This identifies those patients at high risk of hospital admission so that health and social care professionals can actively manage care and support patients to stay healthy.

Initiatives have been developed to address the care needs of older people

3.36 A range of admission diversion initiatives have been put in place for older people across the Trusts, for example:

- in the South-Eastern Trust, the Social Care Response Service operates in North Down and Ards to support the local GP OOH service and the Trust also operates a Frailty Unit which aims to reduce unnecessary admissions by assessing older patients, treating them and returning to their own homes;

- the Western Trust runs an Older People's Assessment and Liaison Service at Altnagelvin Hospital which provides screening and assessment for patients aged 75 years of age and over. The service has been implemented fully and has been effective in co-coordinating services and is currently also being piloted at the South West Acute hospital. The Trust is also piloting a Community Navigator Initiative aimed at enhancing support for older people after discharge from hospital;

- BCH Direct is designed to enable frail elderly patients to directly access services in the Belfast City Hospital, reducing pressure on the emergency department and the acute medical unit at the Royal Victoria Hospital. This is also aimed at reducing the number of transfers across the hospital sites, providing more timely and patient centred care and ensuring quality and safety is at the cornerstone of service delivery. In future, it is hoped the model could support links with community services as envisaged in Belfast Trust Urgent Care Model and in TYC;

- in the Southern Trust, GPs have access to Rapid Access Clinics (RAC) and the Acute Care at Home (ACAH) Service. These are consultant led services which offer an alternative to hospital based care. The ACAH delivers care to patients in their own homes, nursing homes or residential homes. The RACs are based in Lurgan Hospital, South Tyrone Hospital and Mullinure. Both services provide a comprehensive geriatric assessment to older people and aim to promote a better quality

Part Three:
Interventions to reduce avoidable admissions

of life, supporting them to live independently for longer and where appropriate helping them to avoid admission to hospital; and

- in the Northern Trust, a Direct Assessment Unit at Antrim hospital offers assessment for older people in order to try and prevent them being admitted to hospital.

Trusts have established a range of schemes to support patients to manage chronic conditions and to minimise reliance on the acute sector

3.37 Schemes introduced to support the healthcare needs of patients should continue to have a positive impact on preventing unnecessary hospital admissions:

- Respiratory Specialist Nurses are in place in most Trusts and they provide support to patients with respiratory conditions, particularly those requiring oxygen;

- New Falls Services have been established in the South Eastern and Western Trusts. These services allow patients who suffer with a fall, or who are at high risk of falls, to access specialist services to provide rehabilitation and prevent falls in the future;

- in the Northern Trust a Nursing Home In-Reach project is aimed at enhancing the clinical skills, knowledge and confidence of staff in older people's care homes to safely manage the care of residents who are experiencing unexpected illness or a deterioration of a pre-existing condition. This will help to protect the quality of life of nursing home residents and enhance the level of person centred care, reduce the potential distress or onset of confusion that can be created by going to hospital, and promote a quicker recovery. The service also aims to develop and promote sustainable partnership working between the independent sector and primary and community care; and

- the Northern Trust also operates a Hospital Diversion Nursing Team of community nurses who help prevent hospital admissions or facilitate early discharge by providing care such as blood transfusions or intravenous antibiotics to people at home.

3.38 Evaluative data on the clinical benefits of each of these individual initiatives has a crucial role to play in reaching some degree of certainty about the best ways of providing emergency care services. A process for the systematic adoption of best practices, where evidence on how

to provide high quality emergency care is sound, must be embedded in the health and social care sector. Strengthening the capacity for implementing change within the Trusts and supporting the Department and the Task Group as they lead the implementation of better practice models of emergency care will also be critical requirements.

New care models are likely to improve the integration of services in the areas that they serve

3.39 Another component in the strategy of shifting the balance of care away from the acute sector may be the reshaping of services through capital investment in primary care facilities. Central to this has been the HSC Board proposal to take forward a 'hub and spoke' model of care. The aim is to have a number of hubs of various sizes across the region, containing GPs, pharmacy and community health and social services. Hospital outreach clinics and some diagnostics may also be included, with the services in each hub depending on the service model agreed for each locality. Seven centralisation projects have been implemented to date, mainly in the Belfast HSC Trust area (Knockbreda, Shankill, Grove, Beech Hall, Carlisle, Bradbury and Holywood Arches); and three further projects are under construction (Omagh, Ballymena and Banbridge).

3.40 In 2013, under a Ministerial Direction, two further projects in Lisburn and Newry were sanctioned to be progressed as revenue financed projects under the Third Party Developer (3PD) model – a method through which the facilities can be built and operated by a private sector company which provides the up-front capital. Despite a clear finding that conventional financing options for both facilities offered better value for money, the Department told us that the direction to test the 3PD approach in this way was considered necessary, because advice indicated that pressure on the capital budget would have meant a significant delay in delivering a primary care infrastructure programme to support the reform objective of moving care closer to the community. Under conditions set by the Department of Finance, at the preferred-bidder stage in tendering the contract, the Department had to evaluate both pilots and seek approval from the Department of Finance before proceeding further.

3.41 The Donaldson Report (paragraph 3.5) has highlighted that there has not yet been the necessary step change in drawing activity away from more traditional emergency care services within acute hospitals and building sufficient capacity within the social care sector to absorb preventable unscheduled admissions. We recognise that implementing these new models of community care takes time and, once implemented, more time will be required to evaluate them and ensure they are delivering the intended outcomes.

Part Three:
Interventions to reduce avoidable admissions

Recommendation

3.42 **To ensure that progress in shifting to a more community based model of service provision as envisaged under TYC is accelerated, we recommend that the Department sets out how it will: work with primary and community care providers to build a stronger platform for innovation and improvement; and drive evidence based improvements and innovation across the primary, community and social care sectors.**

3.43 In November 2015, the Department announced the establishment of an Improvement Institute for Northern Ireland. This Institute will take the lead in developing a regional leadership which can facilitate, support and build capacity in individuals and within organisations to drive quality improvement and standardisation into the future. The aim is to have Northern Ireland designated as a Centre for Excellence which is a key theme under the Department's Quality 2020 strategy. The implementation of this strategy is led by chief professionals in the Department with representation from across the health and social care sector.

Part Four:
Effective management of emergency admissions in acute hospitals

Part Four:
Effective management of emergency admissions in acute hospitals

Introduction

4.1 With demand rising and funding tight, there is an ongoing annual requirement for health and social care providers and commissioners to achieve significant levels of efficiency savings each year. There have been various initiatives launched to improve the efficiency of how emergency care is delivered within the existing configuration of the secondary care sector. Quality is at the heart of these initiatives and a rolling programme of unannounced inspections of the quality of services in acute hospitals commenced in 2015. The implication for the Department and Trusts is that it will be vitally important to ensure that the range of measures developed to constrain the rise in emergency admissions prove to be cost effective. Otherwise, a rising, or even constant level of emergency admissions will continue to weigh heavily on the ability of Trusts to achieve financial sustainability.

4.2 For those patients who do need to be admitted to hospital as emergencies, it is important that they are managed as effectively as possible to ensure that their stay is as short as is clinically appropriate. The length of time a patient spends in hospital will ultimately depend on the appropriateness of measures taken to stabilise, diagnose and treat the patient, which has substantial clinical and resource implications. Timely discharge can be dependent on a range of factors but is heavily reliant on close integration between the hospital and other parts of the health and social care system.

Emergency care provision has evolved over the years to provide different and more appropriate levels of care to meet the needs of patients

4.3 The five minor injury units (MIUs) shown in **Figure 3** operate as a bridge between GP practices and acute hospital emergency departments. These units all offer a slightly different range of services at varying times but in essence they aim to treat patients with a minor injury or illness and can be routinely accessed without an appointment. Public awareness of MIUs, however, appears to be poor. In contrast to the good understanding expressed about out of hours services (paragraph 3.22), more than a third of respondents (35 per cent) in the Patient and Client Council survey of 2013 indicated that they did not know where their local MIU was located.

4.4 This lack of awareness about MIUs suggests to us that it is likely that some demand continues to be treated in the wrong place within the system. As a result, we consider that there is potential to improve the system so as to avoid patients being potentially pushed towards an inappropriate service.

4.5 The *Choose Well* campaign was launched in November 2013 in response to a number of reports, including from the Patient Client Council, which concluded that the public were not as informed as they could be about the full range of services, including MIUs. It therefore aimed to inform and educate the public about the range of

options available from self-care right up to 999 and to encourage appropriate use of these services. While not solely aimed at reducing demand in emergency departments, the campaign did aim to re-align demand across the range of services provided.

4.6 The *Choose Well* campaign has been subject to ongoing independent evaluation[38] since its launch:

- **Year 1** the campaign focused on raising public awareness on the range of healthcare services available; educating and encouraging people to think about how they use vital healthcare services and supporting people to make better choices;
- **Year 2** continued to build on the level of awareness raised and to move the campaign towards behavioural change. Campaign messaging was strengthened with a stronger call to action. New communication channels and activity targeting specific audiences were developed. These included the development of radio advertising, the use of video on demand and a stronger social media presence. The campaign was also broadened to include information on mental health support; and
- **Year 3** found that after three years of running the campaign, it was felt there was a need for a fresh approach to helping the public stay well over the winter period, access the right services, and to avoid hospital admissions. Views were also expressed that the effectiveness of *Choose Well* was dependant on the availability of viable alternative services which enable people to make appropriate choices. The findings of the evaluation highlighted that there is scope to focus any new campaign on supporting older and vulnerable people, as well as those with long term conditions to stay well, and when they need care, to assist them, their families and carers to make informed decisions on the best services to use. This has the potential to reduce hospital admissions and ease pressures on finite services.

4.7 The fact the evaluation demonstrates that the campaign has enjoyed success in raising awareness and empowering people to choose more appropriately, appears to be at odds with the statistics presented in **Part 2** of this report in relation to demand on emergency care services and hospital admissions. The Department acknowledges that learning from other campaigns demonstrates that it takes a number of campaign runs to reinforce messaging and translate increased awareness of appropriate choices into tangible behavioural and cultural change.

4.8 TYC recommended the launch of a three-digit phone number for urgent, non-emergency care similar to that which exists in England – the 111 service. While it is unclear exactly how such a service would operate, the basic premise

38 Choose Well – Advertising Evaluation 2016, Report of Findings, Millward Brown, March 2016

Part Four:
Effective management of emergency admissions in acute hospitals

is that it would provide a service for callers who need medical help and advice fast but where the problem is not life threatening or one which requires a 999 emergency ambulance.

4.9 The introduction of the 111 service has a number of potential benefits:

- a telephone based assessment process would minimise the repeated reassessments that patients sometimes face when their care takes them to more than one service;
- it could provide a central point for accessing information on the patient's medical history and also arrange appointments in scheduled care services where assessment reveals an immediate response is unnecessary;
- it could avoid confusion and misplaced demand by signposting people to the most appropriate services and by simplifying contact points between various health and social care services; and
- it could result in the collection of a large amount of helpful management information about demand for unscheduled care, and the range of services which are needed to meet this demand.

4.10 Formal evaluations of the 111 pilots in England have indicated a mixed picture of the potential benefits and risks. The Department appears to be taking the pragmatic approach of waiting until the results of the pilots have become clearer before deciding on whether and how to roll out a 111 service locally.

4.11 Another initiative worthy of note is the *AskmyGP* scheme. This is an IT based system that patients can access from their GP practice website that allows them to seek help on a medical or other matter. Answering a series of questions about their symptoms allows a GP to quickly work out the best course of action, either dealing with the patient remotely by phone, or referring the patient to someone with more specific clinical skills. The HSC Board is also in discussion with the system supplier about piloting the *AskmyGP* initiative in the OOH service.

Recommendation

4.12 **With regard to a 111-type service, we recommend that the Department ensures that it learns the lessons of those models which avoid the problems experienced in England and uses the launch of any new system as an opportunity to communicate clearly and widely with the public on how best to access care services urgently.**

A range of initiatives have been developed within the acute hospital sector to try and divert patients from being admitted as emergencies

4.13 Trusts have also taken a range of other steps to provide different and more appropriate levels of care to meet the needs of patients seeking urgent care. This can mean that unnecessary admission to hospital may be avoided for some patients or that their lengths of stay can be reduced, for example:

- Short Stay Observation Units can be used to investigate, review and discharge patients within a maximum stay of 24 hours with admission to a ward only by exception;
- Clinical Assessment Areas (CAA): an important innovation supporting the new emergency department at the Royal Victoria Hospital which opened in August 2015. At the Clinical Assessment Unit patients can have further assessment and treatment as well as a plan for follow up care established as necessary. This aims to significantly improve the patient experience and avoid an overnight stay in hospital, returning patients to their home environment as soon as possible;
- Acute Medical Units for patients admitted from an emergency department or CAAs and expected to be treated and discharged within 48 hours;
- Specialty Wards for patients whose treatment and discharge is expected to take longer than 48 hours;
- Ambulatory Care Unit: established as a new service in the Royal Victoria Hospital in 2010. It facilitates ambulatory investigations, interventions and treatments where patients would previously have been admitted to a hospital bed. The unit has developed a pathway with primary care to facilitate ambulatory blood transfusions rather than GPs sending patients to emergency departments or medical admissions units; and
- Rapid Response Nursing Service: a well-established service in the Western HSC Trust which provides intravenous therapies for patients who would otherwise have to be admitted to hospital to receive these. In the past two years the Trust has also extended this service to two Clinical Intervention Centres - one in Omagh and one in Derry - to deliver blood transfusions, infusions and intravenous antibiotics for those patients who are able to access these centres.

4.14 These approaches aim to ensure that patients with specific conditions can be rapidly assessed and receive treatment that is largely defined by protocols and pathways. The culture of such units should be such that only patients meeting specific entry criteria are admitted to the unit and that

Part Four:
Effective management of emergency admissions in acute hospitals

unscheduled admissions via the short-stay unit should be the exception and not the rule. Making a consultant available to review patients in an emergency department has also been shown to reduce inpatient admissions by 12 per cent and specifically reduced admissions to the acute medical assessment unit by 21 per cent.[39]

While there is a clear awareness of the need to discharge patients from hospital sooner, many still remain in hospital too long

4.15 If the discharge of patients after the completion of their treatment is delayed following a consultant's decision to discharge, many of those admitted as emergencies can spend too long in hospital. Given the age profile of the population, many of those remaining to be discharged are older people and as a result long stays in hospital can have a very negative impact on them, posing risks to their independence as well as impeding the flow of patients from emergency departments to wards. Keeping people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the health and social care services.

4.16 **Figure 17** outlines the relevant targets in the HSC Board's Commissioning Plan in the area of patient discharge and demonstrates that Trusts continue to experience problems in ensuring that discharge is properly planned and prepared for.

4.17 In 2014, the RQIA identified a series of problems with the effectiveness and timeliness of hospital discharge performance[40]. Its review called for a discharge process that: takes effect across a seven day working week; is planned from the point of admission; and coordinates arrangements for the provision of medicines, discharge letters, and transport for patients who require help going home.

Figure 17: Hospital discharge rates have not met targets in 2015-16

Commissioning Plan Target 2015-16	During 2015-16
90 per cent of complex discharges from an acute hospital to take place within 48 hours	79 per cent of complex discharges took place within 48 hours (same as 2014-15)
No complex discharges from an acute hospital to take more than 7 days	1,756 complex discharges took longer than 7 days (an increase from 1,524 in 2014-15)
All non-complex discharges from an acute hospital to take place within 6 hours	95 per cent of non-complex discharges took place within 6 hours (same as 2014-15)

Source: Department of Health

39 White et al, 2010, Impact of senior clinical review on patient disposition from the emergency department.

40 RQIA 'Review of Discharge Arrangements from Acute Hospitals', November 2014.

4.18 Another significant challenge for hospitals in the timely discharge of patients is the ability to bring together all those with a bearing on individual cases. Having a series of discrete, sequential processes involving, for example, physiotherapists, social workers and occupational health therapists can lead to delays. To reduce such delays, we found that some hospitals apply a "discharge to assess" policy whereby the patient is assessed in their own environment, or at least in a non-acute environment. For example, the Belfast Trust has been piloting a Community In-Reach Team consisting of highly experienced in-reach nurses, physiotherapist, occupational therapy and social worker who provide a service which supports early discharge. These pathways include patients being discharged home with a range of conditions such as urinary tract infections, chest infections or cellulitis, with nursing input for a variety of therapies and care.

4.19 While we found positive examples of integration between health and social care services in their approach to emergency care, significant obstacles still impede a truly joined-up approach to avoiding unnecessary hospital admissions and facilitating timely discharges. We found that many patients who are ready to be discharged remain in hospital because of difficulties at the interface between health and social care organisations: for example, the Southern Trust has estimated that Craigavon Area Hospital has, on occasion, operated at 50 per cent of its capacity at weekends, due in part to older patients remaining in hospital until care packages had been put in place the following Monday. Limited availability of domiciliary care packages is a constraint which many Trusts see as being caused by the lack of a suitably trained workforce.

4.20 In 2014-15, the Key Actions and Bed Utilisation Review by the HSC Board found that, while there have been improvements in the appropriateness of emergency hospital admissions since 2007, challenges remained later in patients' journeys, particularly in the incidence of clinicians undertaking twice daily review of patients, and in the timely discharge of patients. In many hospitals action is required to ensure that consultant ward rounds happen as early as possible, so that discharges can take place sooner and patients are not left waiting until late in the day. With support from nursing and junior/middle grade medical staff, consultants should be able to carry out twice daily ward rounds which would help to improve the timeliness of discharges.

4.21 Potentially more important than discharges happening early in the day, is the need for discharges at weekends. One of the strengths of emergency departments is that they operate 24 hours a day, seven days a week. However, their effectiveness is tied closely to the performance of the rest of the hospital. If other hospital departments operate a reduced service at weekends this causes significant problems for the unscheduled care system.

Part Four:
Effective management of emergency admissions in acute hospitals

4.22 The RQIA review (see paragraph 4.17) concluded that early community social work input is important in ensuring a successful discharge. A new communications hub which is being developed by the Southern Trust should help the proactive coordination of all complex and non-complex hospital discharges for patients over 65 years of age at Craigavon and Daisy Hill hospitals. The hub has embedded the use of estimated date of discharge in order to support discharge planning.

4.23 The Department told us that under the Unscheduled Care Task Group an assessment has been undertaken into what have been the key factors delaying the discharge of patients during their inpatient stay, based on direct feedback from ward staff. This exercise has also identified a number of actions that Trusts and other organisations could take to improve patient flow and reduce the length of time patients wait in emergency departments following a decision to admit.

4.24 The National Audit Office has recently reported[41] on the discharge of older patients from hospital. It concluded that after taking account of the additional social care costs of placing older people in more appropriate settings at home or in their community, there were significant savings to be made from the earlier discharge of older patients due to the reduction in hospital bed days. The report also drew attention to a number of key elements of good practice which would help to improve the early discharge of patients: hospitals should identify patients' needs as quickly as possible to determine whether hospital is the best place to meet them; health and social care staff should work together to maintain the momentum of treatment and discharge planning; and staff should assess and rehabilitate patients in their home wherever possible.

4.25 We acknowledge that there is a significant willingness and commitment to improve the patient's experience of discharge. However, there are still challenges in achieving excellent practice in the transfer of a patient's care from hospital to home. Given the impact delayed discharge has on hospital bed costs, it will be important, over the coming period, that evidence is made available to demonstrate how good practice has been translated into improvements in patient discharge against Departmental targets.

Improvements to discharge planning are also important in order to ensure patients do not need to be readmitted to hospital

4.26 While some readmissions are planned, and others may be part of the natural course of treatment for specific conditions, increasingly some hospital readmissions are considered to be avoidable and may indicate missed opportunities to better coordinate care. One of the 2015-16 Commissioning Plan targets for Trusts was to secure a five per cent reduction in the number of

41 Discharging older patients from hospital, National Audit Office, HC 18, Session 2016-17, 26 May 2016.

Figure 18: Emergency readmissions 2015-16

HSC Trust	Readmissions Max Target 2015-16	Readmissions Actual 2015-16	Variance (number)	Variance (%)
Belfast	5,400	8,067	2,667	49%
South Eastern	4,522	5,087	565	12%
Western	4,267	4,975	708	17%
Southern	4,002	5,075	1,073	27%
Northern	3,944	4,708	764	19%
Northern Ireland	**22,135**	**27,912**	**5,777**	**26%**

Source: HSC Board

emergency patients readmitted within 30 days. As **Figure 18** shows, however, emergency readmissions continue to be a significant problem for all Trusts with a regional increase in the rate against the target of 20 per cent.

4.27 In our view, more data and information are necessary to fully understand the scope of the problem, assess the proportion of readmissions that are "avoidable" and to target initiatives accordingly. Current moves under TYC to improve relationships and encourage care coordination between the different sectors of the health and social care system, particularly with regard to discharge planning, provide the change culture within which a project aimed at dealing with the readmission problem can flourish and bring about improvement. For instance, there is strong evidence from a systematic review[42] that an individualised discharge plan for hospital inpatients is more effective than routine discharge care that was not tailored to the individual. This research showed that readmissions to hospital were significantly reduced (by around 15 per cent) for patients allocated to structured discharge planning.

4.28 Better communication between hospitals, primary and community care and social services also has the potential to reduce unnecessary admissions. Whilst work has begun on the design of communication hubs, like the one established by the Southern Trust, this work remains at a relatively early stage. The Department told us that several working groups are examining potential solutions as part of their contributions to the revision of the delivery of outpatient care and improving care pathways.

42 Shepperd, 2010, Discharge planning from hospital to home.

Part Four:
Effective management of emergency admissions in acute hospitals

Recommendation

4.29 **We recommend that the Department works with the HSC Board and the Trusts to consider the development of similar communication hubs in order to support better integration of health and social care with the aim of ensuring that patients who are ready can be discharged from hospital in a more timely way.**

Challenging workforce issues are potentially compromising the safety and sustainability of emergency care services

4.30 Across the UK, emergency medicine is becoming an increasingly difficult specialty to recruit to. In 2013, a survey[43] of UK health authorities (including HSC Trusts) by the College of Emergency Medicine showed that in line with their guidelines, only 17 per cent reported the presence of at least one emergency medicine consultant present for 16 hours. A subsequent College of Emergency Medicine report called for a move to seven day working[44].

4.31 We acknowledge that action is being taken to address the issue of unfilled consultant posts and an increasing reliance on locum doctors. In addition, steps are being taken to improve the recruitment and retention of middle grade doctors to assist consultants in their decision making. For example, in the Belfast Trust a recruitment drive has been established with the aim of increasing consultant staffing levels to allow it to move to 16 hours of consultant presence, seven days a week. It is considered that this will help to reduce the risk that, due to inexperience, junior doctors may demonstrate a tendency to admit more patients than experienced consultants.

4.32 Emergency Nurse Practitioners (ENPs) and Advanced Nursing Practitioners (ANPs) can play a valuable role in emergency departments as they can work autonomously of medical staff. A potential solution to lack of ED cover caused by medical staff recruitment problems could be to increase the number of ENPs and ANPs or other practitioners, such as paramedics, with extended skills. Towards this end we acknowledge the work being undertaken by NIPEC[45] and the Emergency Nursing Network to up-skill the emergency nursing workforce. We recognise too that the Belfast Trust has been the first to commit to supporting the training of ANPs.

Recommendation

4.33 **We recommend that the Department and the Trusts should ensure that emergency department care is reorganised so that patients have access to consultant-led care regardless of the day of the week.**

4.34 **We recommend, also, that in moving towards this objective, the Department and Trusts should take the necessary steps to ensure that emergency medicine remains an attractive career option.**

43 College of Emergency Medicine, Acute and emergency care; prescribing the remedy, July 2014.

44 College of Emergency Medicine, Time to Act-Urgent Care and A&E: the patient perspective, May 2015.

45 Northern Ireland Practice and Education Council for Nursing and Midwifery

Ambulance services have a key role to play in building on existing, alternative care pathways to reduce pressure on overburdened emergency departments

4.35 The Northern Ireland Ambulance Service (NIAS) forms a fundamental part of the unscheduled care system. The timeliness of ambulance responses to 999 calls is critical to saving lives and giving people the greatest chance of recovery. In addition, difficulties experienced within the ambulance service can have negative impacts on the wider unscheduled care system. For example, if the ambulance service cannot provide timely transport home for patients being discharged from hospital, this affects patient flow in the hospital. Moreover, if patients are brought to an emergency department by ambulance when they could have been better cared for elsewhere, this means demand is in the wrong place within the system. Equally, problems elsewhere in the system can have major impacts on the ambulance service and its ability to provide timely responses to emergencies.

4.36 Movement in the proportion of emergency calls that result in a patient being conveyed to hospital is one way of determining the extent to which the NIAS plays a positive role in helping to manage demand pressures and assisting in the development of alternative care models. Departmental statistics show that there has not been a reduction in the absolute number of emergency and urgent patient journeys made by the NIAS: between 2011-12 and 2015-16, the number of emergency and urgent patient journeys made by the NIAS increased by 9,537 (6.5 per cent), from 146,708 to 156,245. However, the proportion of patients conveyed to emergency departments has fallen slightly from 83 per cent to around 80 per cent.

4.37 The NIAS has focused attention on developing appropriate alternatives to automatically transferring all patients to an emergency department. Known, since April 2014, as Alternative Care Pathways (ACP) the NIAS has proposed the development of up to 10 such pathways that utilise a "see, treat and leave or refer" protocol. The development of six ACPs has been supported under TYC funding arrangements with £0.5 million spent at October 2015. One ACP relates to diabetic hypoglycaemia where a paramedic goes out to a patient's home and having established that diabetic hypoglycaemia is the problem follows established protocols to reverse the medical problem. Once the patient has stabilised and the immediate problem is resolved (determined through the testing of blood glucose levels) the patient can be left with a suitable accompanying adult. The NIAS then makes arrangements for an urgent referral with the appropriate clinician (GP or consultant) for a follow-up check-up and any further investigations.

Part Four:
Effective management of emergency admissions in acute hospitals

4.38 The benefit of ACP is two-fold – they often enable patients to stay at home (which is where they prefer to be) and reduce avoidable attendances at emergency departments and potentially hospital admission. Based on performance to date, it is estimated that these ACPs will result in 6,000 less avoidable attendances at emergency departments from 2015-16.

4.39 Paramedics have also been up-skilled to treat a greater number of non-life threatening conditions at the scene under 'see, treat, leave or refer' protocols. In addition, some calls can be referred for telephone triage and assessment so that rather than sending an ambulance, nursing staff can conduct telephone triage and then provide self-care advice or referral. Linked to this approach is a new "dashboard" system, which is in the early stages of development within the NIAS to help ensure that patients' needs are more clearly defined and that the ambulance response they receive is more appropriately aligned to their needs.

4.40 The ambulance service plays a pivotal role in the performance of the entire urgent and emergency care system. Traditionally, it has been seen primarily as a call-handling and transportation service, encompassing some aspects of patient care. Increasingly, however, it is recognised as having a wider role, as a conduit to other NHS services and in ensuring patients can access the facilities they need, close to their home.

Recommendation

4.41 **Models similar to the dashboard have been in operation in other parts of the UK for some time now. It is important, therefore, that the NIAS ensures that the opportunity provided by the dashboard for easing the pressure on hospitals by helping to avoid potentially unnecessary admissions is realised to its fullest extent. Towards this end we recommend that the NIAS works intensively with health and social care partners in order to accelerate the development of alternative and community care pathways for a range of conditions.**

Difficult decisions lie ahead about reconfiguration of hospital services

4.42 Over recent years, the Department has overseen a protracted series of reviews examining the future configuration of health and social care services here. Reference has already been made to the launch of TYC in 2011 (paragraph 5), while the Donaldson Report in 2014 (**Appendix 5**) concluded that the existing network of acute hospital services in Northern Ireland is unsustainable and called for difficult decisions to be made about their future design.

4.43 Many factors, including rising demand, financial constraints, workforce challenges and problems with patient

flow through the hospital are continuing to place considerable pressure on emergency care services. While we recognise that plans to reconfigure acute hospital services can be controversial, we consider that it is vital that whatever reconfiguration of hospital services eventually transpires, it must be done alongside the transformation of the system of emergency care. To do otherwise would, in our view, cause major difficulties in securing sustainable improvements.

4.44 A central tenet running through TYC is the need to rebalance the system of care away from acute hospital settings towards community and primary care provision. This recognises that too many patients have been receiving their unscheduled care in hospitals when care in the community would be more appropriate. We consider that progressing transformation and reconfiguration in tandem provides an excellent opportunity to drive improvement in approaches to deliver better access to urgent care services within the community.

Appendices

Appendix 1:
The Health and Social Care Commissioning Plan Direction 2016 - relevant targets for 2016-17

Unscheduled Care – from April 2016, 95 per cent of patients attending any Type 1,2 or 3 emergency department are either treated and discharged home, or admitted within 4 hours of their arrival in the department; no patient attending any emergency department should wait longer than 12 hours;

Unplanned admissions – by March 2017, reduce the number of unplanned admissions to hospital by 5 per cent for adults with specified long term conditions; and

Patient Discharge – from April 2016, ensure that 90 per cent of complex discharges from an acute hospital take place within 48 hours, with no complex discharges taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.

Appendix 2:
Ambulatory Care Sensitive conditions – Definition used by Kings Fund 2012

Ambulatory Care Sensitive (ACS) conditions are conditions for which effective management and treatment should prevent admission to hospital. They can be classified as chronic conditions, where effective care can prevent flare-ups; acute conditions, where early intervention can prevent more serious progression; and preventable conditions, where immunisation and other interventions can prevent illness (Ham et al 2010). The box below lists ACS conditions most commonly used in the UK (NHS Institute for Innovation and Improvement).

Acute	**Chronic**
Dehydration and gastroenteritis	Asthma
Pyelonephritis	Congestive heart failure
Perforated/bleeding ulcer	Diabetes complications
Cellulitis	Chronic obstructive pulmonary disease (COPD)
Pelvic inflammatory disease	Angina
Ear, nose and throat infections	Iron–deficiency anaemia
Dental conditions	Hypertension
Convulsions and epilepsy	Nutritional deficiencies
Gangrene	
Vaccine Preventable	
Influenza and pneumonia and other (include as part of acute for purposes of study)	

Appendix 3:
Recommendations from the RQIA Report on Unscheduled Care in the Belfast HSC Trust (July 2014)

The RQIA review of unscheduled care was established following concerns raised about the arrangements for the provision of services in the Belfast Health and Social Care Trust (Belfast Trust) and the declaration of a major incident at the Emergency Department of the Royal Victoria Hospital (RVH) on 8 January 2014. The review team has considered systems within the Belfast Trust, and related regional issues.

RQIA made seventeen recommendations for improvement in arrangements for unscheduled care through the work of this review:

Recommendation 1:

All HSC organisations should review their escalation arrangements for responding to periods of exceptional pressure for unscheduled care. Plans should set out arrangements for: creating additional capacity; bringing in additional staff; and contacting senior decision makers. The arrangements for coordination of responses within and across HSC organisations to exceptional periods of demand should also be reviewed.

Recommendation 2:

Regional and trust plans for coordination and responding to predictable periods of increased demand should be reviewed. In particular, early planning should be instituted for the post-Christmas and New Year period, to better manage system flows, including improved scheduling of elective activity.

Recommendation 3:

It is recommended that the Belfast Trust aims to have the first stage of implementation of new arrangements, for the direct assessment and admission of the majority of frail elderly patients, being treated at the Belfast City Hospital, in operation by November 2014, before next winter.

Recommendation 4:

It is recommended that the Belfast Trust reviews arrangements for the assessment and admission of patients with acute exacerbations of respiratory disease. The potential for developing a direct assessment and admission arrangement to Belfast City Hospital should be explored for suitable respiratory patients. This would enable most patients using respiratory services there, to avoid accessing them via an emergency department.

Recommendation 5:

It is recommended that the Belfast Trust establishes a flow improvement project for acute internal medicine at the Royal Victoria Hospital. This could be taken forward as part of the proposed regional flow collaborative. Plans to avoid the need for acute medical consultants having responsibility for inpatients, not in the acute medical unit, should be implemented as soon as possible.

Recommendation 6:

It is recommended that the Belfast Trust considers the development of an assessment facility at the Mater Hospital, potentially integrated with the Medical Admission Unit, to enhance the medical assessment and admission arrangements there.

Recommendation 7:

It is recommended that the Belfast Trust reviews its flow coordination arrangements across all hospitals in the trust, to ensure that there are effective systems for daily coordination of flows; and for cross-site responses, when there are pressures in unscheduled care.

Recommendation 8:

It is recommended that an improvement collaborative is established between health and social care organisations, using external expertise on approaches to improving flow. The aims should include: building capacity in the analysis and management of patient flows; and sharing learning from local and national improvement projects.

Recommendation 9:

It is recommended that the Belfast Trust reviews the assessment and admission arrangements for all medical specialties at Belfast City Hospital to enhance direct access arrangements. The potential for consolidation of specific medical specialties on fewer sites would be useful to consider for the longer term.

Recommendation 10:

It is recommended that Trusts, together with the other members of integrated care partnerships, examine arrangements for provision of direct access to hospital-based assessment and admission services for appropriate patients.

Recommendation 11:

To support new models of provision, it is recommended that arrangements are reviewed to ensure that specialist clinical advice is available, by telephone, for ambulance staff. This is required to aid decision making to enable appropriate patients to stay at home, rather than take them to hospital, at time of first presentation.

Recommendation 12:

The review team recommends that whole system planning is carried out to design systems to reflect the need for, and timing of non-emergency patient journeys to and from hospitals.

Appendix 3:
Recommendations from the RQIA Report on Unscheduled Care in the Belfast HSC Trust (July 2014)

Recommendation 13:

It is recommended that a regional flow improvement project is established, to ensure that patients requiring assessment for unscheduled care, who are referred by general practitioners or other professionals, can access hospital services as early as possible in the day.

Recommendation 14:

A set of principles should be agreed to guide the future design of urgent and emergency care in Northern Ireland. Systems should be designed to ensure that patients have access to the right care, in the right place, by those with right skills, the first time. When system changes are being introduced, patient views and perceptions of emergency care should be considered during the implementation process.

Recommendation 15:

It is recommended that arrangements between education and service providers are reviewed to ensure that there is effective coordination, when changes to educational programmes or service delivery are being planned.

Recommendation 16:

It is recommended that an assessment is carried out of the requirements for postgraduate training for specialist nurse training in unscheduled care to inform the planning of courses by educational providers.

Recommendation 17:

The review team recommends that a regional task force is established to take forward specific regional projects to improve unscheduled care.

Appendix 4:
Methodology

1. We analysed data to understand the trends behind the increase in emergency admissions and the impact of government policies on reducing emergency admissions. The key data source was the Department of Health Hospital Information Branch and also included published NI Hospital Statistics on Emergency Care and Waiting Times and Inpatients and Day Case Activity.

2. We interviewed five HSC Trusts – Northern, Belfast, Southern, South Eastern and Western. At each Trust we spoke to the finance director or senior manager responsible for urgent care and clinicians involved in providing urgent care. The issues covered included: local trends and factors driving the increase in emergency admissions; the impact of government policies on reducing emergency admissions; good practice in reducing emergency admissions; good practice in managing those who are admitted more effectively; and the current and future local challenges in reducing emergency admissions and managing those who are admitted more effectively.

3. We contacted the HSC Board and met with relevant officials at the Department of Health and the Northern Ireland Ambulance Service. We also met with the Clinical Director for Emergency Care in a HSC Trust in both that capacity plus his other role as member of the Minister's Unscheduled Care Task Group.

4. We carried out a literature review to identify the causes of the increase in emergency admissions, good practice in reducing emergency admissions and how to manage those who are admitted more effectively.

Appendix 5:
Recommendations from the Donaldson Report (December 2014)

A Review Team, led by Sir Liam Donaldson, was set up to conduct an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland.

The report 'The Right Time, The Right Place', known as the 'Donaldson Report' was published in December 2014. A summary of the ten recommendations are as follows:

1. Close local hospitals that cannot provide level of care needed 24/7;

2. Strengthen commissioning - system needs redesigned to make it simpler and capable of reshaping services for future;

3. Transforming Your Care - action not words. Need new costed timetabled implementation plan that includes expanded role for pharmacists and paramedics in pre-hospital care;

4. Self-management of chronic disease. Establish programme to give people with long-term illnesses the skills to manage their own conditions;

5. Better regulation - unannounced routine inspections should take place. Consider outsourcing role of Regulation and Quality Improvement Authority (possibly to Scottish regulator). RQIA to review current policy on whistle blowing;

6. Making incident reports really count. The system of serious adverse incident and adverse incident reporting to be modified - currently falling well below its potential;

7. Make patient safety a beacon of excellence. Establish a Northern Ireland Institute for Patient Safety;

8. System-wide data and goals. Northern Ireland health and social care system has no consistent method for the regular assessment of its performance. Recommend establishing new measures for benchmarking service in areas of safety, quality and patient experience;

9. Technology - establish a technology hub to identify best innovations for quality and safety of care internationally, and look at adapting them to Northern Ireland; and

10. Stronger patient voice. More independents in complaints process, more independent Patients and Client Council.

Appendix 6:
Expert Panel for Remodelling of Health and Social Care in Northern Ireland

Working Principles

Vision Statement

"To create a fair and sustainable, including financially sustainable, Health and Social Care system that delivers universal, high quality, safe services that meet the Northern Ireland population's needs and which deliver world class outcomes for patients and service users."

Ethos

1. *The system should be collaborative, not competitive.*

There are several components to this principle. Firstly, even in the short term it will not be safe or effective to deliver all services locally. Organisations must work together to provide high quality care to patients. Secondly, unwarranted variance across the system should be minimised. Patients should be able to receive the same standard of care anywhere in the region. Thirdly, the HSC should continue to work in partnership across government, with industry, academia, the community and voluntary sector, staff and patients to deliver new models of care. Finally, remodelling of the system should be a transparent and collaborative process.

2. *The system should adopt a population health and well-being model with a focus on prediction and prevention rather than reaction.*

Like many health services worldwide, HSC resources and service developments are often locked into `reactive' disease care, which focuses on increasingly expensive diagnostics and treatment. It must be acknowledged that there should be an increased emphasis on investment in prevention and health promotion, particularly for vulnerable communities who are at highest risk of experiencing inequalities. It must also be acknowledged that addressing wider health determinants requires a cross-sectoral approach, although there is much that the HSC can do in terms of designing new models of care.

3. *Patients should be active participants in their own care, not passive recipients.*

Patients should be treated with respect and empowered to stay healthy and care for themselves where possible. Patients should also be supported and encouraged to take greater ownership of their own health outcomes. The public rightly expects access to safe, sustainable and high quality health and social care services; however, as part of the relationship between the HSC and citizens, the public should also be enabled to take greater responsibility for their own health and well-being, and to use services appropriately.

Appendix 6:
Expert Panel for Remodelling of Health and Social Care in Northern Ireland

Delivery Model

4. Health and Social Care is already integrated in Northern Ireland. Remodelling must build on this strength and take a whole system perspective.

The HSC in Northern Ireland is an integrated system, to the envy of many countries. Remodelling must ensure that different parts of the system are connected, interdependent, that they talk to each other and that they form an integrated whole. Patients should be able to transition smoothly between social care, community care and hospital care.

5. Only people who are acutely unwell need to be in a hospital.

Hospital is often not the right answer. There is evidence that for patients who do not need acute care, being in an acute hospital can be harmful. Research also indicates that hospital use is affected by deprivation, with people in poorer areas more reliant on emergency services, and making insufficient use of planned elective services. Studies have shown extremely positive feedback and satisfaction levels from patients who were treated in community settings and the HSC must continue to develop strong community care models.

6. Very specialist services can be based anywhere in Northern Ireland.

In the face of increased specialisation and ever rising demand, it is not practical or desirable to try to deliver specialist services everywhere. However, it is true that specialist services could be delivered anywhere. Any acute hospital in Northern Ireland has the potential to become a regional centre. Furthermore, the HSC should continue to explore and realise the mutual benefits of collaboration with other jurisdictions in ensuring patients have access to high quality, sustainable services.

7. The location and composition of resources should be based on meeting patients' needs and achieving the best outcomes.

Co-ordinated work force and service planning should be carried out on the basis of the population's need rather than with the aim of maintaining services which are not sustainable in the long term.

8. The real value of Health and Social Care is in its people, not its buildings.

Health and Social Care staff should be given the freedom to innovate and deliver services in a way that best meets people's needs, safely, quickly, and with respect and compassion. This implies more local autonomy and innovation within a defined policy framework. Northern Ireland has a wealth of knowledge and expertise that should be harnessed and developed to allow us to provide the highest quality services to patients. Local initiatives should be encouraged and best practice should be shared across the region.

Implementation

9. *Whole system remodelling is a medium to long term process.*

Funds will continue to flow into the health and social sector but simultaneously there must be significant gains in productivity. New care models allow for increased productivity. Reform and remodelling on this scale will take time and must be supported by an evidenced, costed and resourced implementation plan. This will need policy and political commitment in the long term.

10. The system must be supported to implement change with pace and scale.

Change is inevitable and must be embraced. There is an appetite and a will to implement planned change among staff. Service developments and investment from this point should be geared towards supporting and complementing a long term strategy for sustainable and quality care.

11. Technology should be developed and adopted where it can support and enable transformation.

Northern Ireland has one of the most advanced electronic care record systems in Europe. New technologies offer enormous potential for improved self- management, telemedicine, information sharing and communication across sub- systems. Innovation and new technologies should be embraced in collaboration with industry where they offer the potential to deliver better or more efficient services. This will bring benefits to patients, the Health and Social Care services and the economy.

Leadership and Culture

12. *The panel will engage constructively with elected representatives when designing and communicating a remodelled HSC. The Panel will also engage openly with Health and Social Care staff and the public.*

Implementation will require strong political and technical leadership. Without change, the Northern Ireland Health and Social Care system is not sustainable in the medium to long term. Elected officials will play a key role in analysing proposals and enabling the public to understand the need for change.

13. *Northern Ireland can be a world leader in transforming health and social care*

Many countries are facing the same challenges and difficult choices as Northern Ireland. This process is an opportunity for Northern Ireland to be a pioneer in designing and delivering health and social care services fit for the 21st Century.

NIAO Reports 2015 and 2016

Title	Date Published
2015	
Continuous improvement arrangements in policing	17 February 2015
Cross-border broadband initiative: the Bytel Project	03 March 2015
Protecting Strangford Lough	31 March 2015
DRD: the effectiveness of public transport in Northern Ireland	21 April 2015
General Report on the Health and Social Care Sector 2012-13 and 2013-14	26 May 2015
Local Government Auditor's Report – 2015	23 June 2015
Department of Education: Sustainability of Schools	30 June 2015
The Northern Ireland Events Company	29 September 2015
Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland - 2015	24 November 2015
Invest to Save	15 December 2015
2016	
Governance of Land and Property in the NI Housing Executive	07 January 2016
Continuous Improvement Arrangements in Policing	08 March 2016
Local Government Code of Audit Practice	31 March 2016
Managing Legal Aid	21 June 2016
Contracted Training Programmes	28 June 2016
The National Fraud Initiative: Northern Ireland	07 July 2016
The Rivers Agency: Flood Prevention and Management	13 September 2016
Northern Ireland Public Sector Voluntary Exit Schemes	11 October 2016
Managing Emergency Hospital Admissions	08 November 2016

Published and printed by CDS

CDS 161841

ISBN 978-1-911003-50-2