GETTING IT RIGHT FIRST TIME

Review of Emergency Medicine

Northern Ireland

Implementation Plan

Updated March 2025

Introduction

This document outlines the implementation plan for the recommendations from the Getting It Right First Time (GIRFT) Review of Emergency Medicine (NI) report finalised in 2024.

The recommendations are being delivered through the Department of Health's (DOH) Unscheduled Care Management Unit's programme, structured across the following key workstreams:

- USCMU Business As Usual (BAU)
- Task & Finish Groups (T&FG)
- Strategic Review of Demand and Capacity of Acute and Integrated Services
- Commissioning and Business Case Development

Progress to date on the actions required to meet the Review's *regional recommendations* are detailed in Appendix I.

Site-specific recommendations will be implemented by Health and Social Care (HSC) Trusts with support by the DOH Strategic Planning & Performance Group (SPPG) and the GIRFT Urgent & Emergency Care Team.

Some recommendations are revenue dependent, which may affect delivery timelines.

Background

The Urgent & Emergency Care Review was initiated in 2018 to establish a new regional care model for Northern Ireland. Following a public consultation in 2022. three strategic priorities were identified:

1.) creating an integrated urgent and emergency care service;
2.) capacity, coordination and performance; and
3.) a review of intermediate care.

The DOH Unscheduled Care Management Unit (USCMU) was established with the SPPG in July 2022 as the operational lead for delivering strategic priority 2

(Capacity, Co-ordination and Performance). Key commitments under this priority include:

- Completion of the 'Getting It Right First Time' (GIRFT) Review of Emergency Medicine in NI in July 2023.
- Commissioning an evidence-based capacity review, following the completion of the GIRFT Review, by March 25.
- Using the findings from the GIRFT Review's report and capacity review to identify areas for additional investment in both in hospital and out-of-hospital urgent and emergency care services.

In March 2023, in collaboration with GIRFT and NHS England, DOH launched a regional Summary Emergency Department Indicator Table (SEDIT) for Northern Ireland. This provides benchmarked performance data for Emergency Departments in England and Northern Ireland (and latterly Wales).

Data from the SEDIT was presented at each of the 10 Emergency Departments during the GIRFT Review in June 2023. The final GIRFT report sets out regional and site-specific recommendations.

In April 2024, the No More Silos (NMS) Programme and part of the Programme Team transferred to the USCMU to facilitate a shift from implementation phase to standardisation.

Recommendations

The GIRFT report categorises recommendations into the following areas:

- Social and Community Care
- Urgent Care Centres
- Hospital System
- Ambulance System
- Site-Specific Actions

Local delivery plans for site-specific recommendations will be developed by the relevant HSC Trusts, with input from the USCMU and the GIRFT team at a regional workshop.

The GIRFT team will provide ongoing support to these milestones, including input into the development of specialist services and the acute medical in-reach model

Implementation Plan Milestones	**Est. Date**	
Receipt of final GIRFT Review of Emergency Medicine NI report	Oct 23	Completed
Soft launch and stakeholder engagement on final report	Nov 23	Completed
GIRFT team review of Implementation Plan	Dec 23	Completed
Presentation to PTEB/Urgent & Emergency Care Implementation Board	Dec 23	Completed
Agreement on Implementation Plan (1-5, 5-10 years)	Dec 23	Completed
Agreement on Terms of Reference for Strategic Review of Demand and Capacity	Jan 25	Completed
Workshop with HSC Trusts to review local recommendations and update locality plans	Mar 24	Completed
Six-month follow up with Trusts to review local recommendations	Sept 24	Completed
Establishment of Task & Finish Groups to support delivery of regional recommendations	Sept 24	Completed

Delivery Approach

1. USCMU Business As Usual (BAU)

The USCMU multidisciplinary team (MDT) will deliver actions through the USCMU Action Plan and regular stakeholder engagement, including:

- weekly MDT meetings
- Fortnightly regional USC Directors' meetings
- Collaboration with the Regional Coordination Centre

Progress on local recommendations will be monitored through these meetings.

2. Same Day Emergency Care (SDEC) Task & Finish Group

An SDEC Task & Finish Group has been established, and is chaired by Clinical Leads. This group will provide clinical and operational expertise to support the delivery of the GIRFT recommendations and local USC transformation. The USCMU will provide logistical and strategic support, with expert input from the GIRFT Urgent & Emergency Care Team.

3. Strategic Review of Demand & Capacity of Acute and Integrated Services

A strategic review will assess demand and capacity needs for acute and integrated services. This will include:

- ensuring community services meet local needs, especially in areas with limited acute services.
- Evaluating urgent care centres and 'Phone First' arrangements.
- Reviewing the feasibility of a 7-day and 24/7 service provision across acute services.

4. Commissioning and Business Case Development

Additional commissioning and business case development will be required to support new or expanded services. This will be managed within existing funding allocations to optimise resource use and identify opportunities for repurposing existing resources.

Revenue and Financial Considerations

Several recommendations are revenue dependent. However, many can be implemented without additional funding through improved resource allocation and operational efficiency. A strategic financial approach will be required to manage interdependencies with Priority 1 and Priority 3.

Stakeholders and Governance

The following structures will provide oversight and coordination:

USCMU MDT	-	Day-to-day operational management
SPPG Performance Management	-	Monitoring and reporting progress and impact
Regional USC Directors Group	-	Ensuring strategic alignment and regional consistency
Task & Finish Groups	-	Focused delivery of recommendations
Strategic Review of Demand and Capacity	-	Informing long-term strategic decisions
Commissioning and Business Cases	-	Securing resources and managing funding

Conclusion

The implementation of the GIRFT Review of Emergency Medicine (NI) recommendations represents a significant opportunity to improve urgent and emergency care services across Northern Ireland. Through coordinated delivery, strategic review and stakeholder engagement, the USCMU and HSC Trusts are well-positioned to achieve sustainable improvements in capacity, coordination and patient outcomes.

Appendix I

Progress against each recommendation is detailed in Appendix I (updated March 2025).

Appendix I

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Review of Emergency Medicine

Northern Ireland

RECOMMENDATIONS

Status and Actions Delivered

The three main problems for UEC in Northern Ireland:

1. Patient handover delays from ambulance staff to ED staff and consequent poor ambulance response times
2. ED exit block for patients requiring hospital admission
3. Poor patient flow within hospitals and hospital exit block for patients requiring social and community care

	GIRFT Review Recommendations	Status	Actions Delivered
5.1 Recommendations S: Improve the social care system			
1	Trusts should consider all options to alleviate backdoor pressures which could include internal processes, Trust run nursing homes and terms and conditions of domiciliary care workers.	Ongoing	• Social Care Collaborative Forum (SCCF) established to improve hospital flow and discharge, including reviews of: • *Regional Care Home Contract and Specification;* • *Regional Home Care Contract;* • *Early Review Teams,* • *Care Line Live digital system;* • *Trusted Assessor;* • *Care Home Availability Digital App;* • *Direct Payments.* • Steps taken to introduce the Real Living Wage for social care jobs. • Discharge Lounge best practice guidance issued to all Trusts. • Revised targets for Delayed Transfer of Care introduced. • Repatriation guidance and protocol issued to all Trusts.
5.2 Recommendations C: Improve the community care system			
1	Primary care staffing and availability should be considered in all discussions concerning UEC.	Ongoing	• Trusts continue to engage with primary care on locality plans. • Primary Care representatives attended CMO/CNO Winter Planning workshop March 2025. • Primary Care (GP) representatives involved in SDEC T&FG.
2	The commissioned services in the community and the directory of services (DoS) should be examined to ensure that they meet local needs and provide services when and where they are of maximum benefit to patients.	Ongoing	• Alternative to ED (AtED) exercise completed for NIAS, with Delivery Plan agreed. • Discovery process underway to procure a regional DoS solution as part of HSC 111.
5.3 Recommendation C (i): Consider urgent care centres in specific situations			
1	The current urgent care centres and other type 3/4 facilities provide a valuable service to patients who live in areas that are not well-served by the 10 type 1 EDs of Northern Ireland.	Completed	• Post Project Evaluations of NMS investments in Urgent Care Centres and Streams completed. • Service User event held to review NMS evaluation.

2	There may be a place for similar facilities in some other areas with a high demand for UEC or with a particular geographical requirement.	Ongoing	• Under consideration as part of Demand Capacity Review. • Expansion would be subject to securing additional revenue.
3	Call before attendance and similar systems should be carefully evaluated to ensure equitable and effective access across the region.	Completed	• Post Project Evaluations of NMS investments in Urgent Care Centres and Streams, Rapid Access Clinics and local Phone First services completed.
5.4 Recommendations H: Improve the hospital system			
1	For specialties that are not present on site, there should be clear, time-specific transfer agreements, bypass arrangements (including "stop and x-ray") and helicopter transfers for very sick patients. The range of specialties, and any transfer arrangements, should be reviewed regularly in the light of the changing patient demographics of a growing and ageing population.	Ongoing	• Regional Repatriation Protocol issued. • Ongoing engagement with Trusts to improve bypass and repatriation processes.
2	Any "dominant constraints" to good patient flow in the hospital should be addressed or mitigated (Dominant constraints are staffing (consultants and registered nurses) and space available to treat patients).	Ongoing	• Summary Emergency Department Indicator Table (SEDIT) build completed and data access provided to all Trusts.
3	All acute specialties should have "elastic" reception facilities for both external and internal acceptance of patients. This will require staffed specialty receiving areas.	Ongoing	• SDEC T&FG established with 'Pathways' subgroup formed.
4	The elasticity of the ED should be used to eliminate ambulance handover delays, rather than to accommodate large numbers of patients waiting for a hospital bed.	Ongoing	• Best practice webinar with Walsall Trust organised for Trusts. • DOH, Trust and NIAS representatives visited NHS Hospital to consider LAS Protocol 'W45'
5	Internal professional standards should be implemented throughout each hospital. In the right situation, for instance, referrals from the ED can occur by electronic notification, without the need for negotiations over the telephone.	Ongoing	• SDEC T&FG agreed professional standards for progression.

6	A frailty in-reach team should cover both ED and the acute wards. Occupational therapists should be included in the frailty team.	Ongoing	• Frailty assessment teams/'Frailty at the Front Door' in place in Type 1 EDs. • Ongoing engagement with PHA Frailty Network. • This is being considered as part of the Ministers planning workshops for 2025/26
7	There should be a good range of Same Day Emergency Care (SDEC) and urgent clinics, with a focus on admission avoidance and complex patients.	Ongoing	• Baseline exercise completed. • SDEC T&FG established with 'Pathways' and 'Data & Definitions' sub-groups.
8	An acute medical in-reach model to ED should be considered.	Ongoing	• Commenced as part of SDEC T&FG.
9	Access to MR imaging 24/7 should be regarded as essential aim for all hospitals that have a Type 1 emergency department.	Ongoing	• Included in Demand Capacity Review.
10	Reported ultrasound scans should be available to the ED for a large period of the working week, to help to avoid unnecessary referrals and admissions.	Ongoing	• Included in Demand Capacity Review.
11	Timely access to endoscopy for all hospital patients should be ensured.	Completed	• Capacity in place for unscheduled endoscopy at all site.
12	Access to High Dependency Unit (HDU) and Intensive Care Unit (ICU) services should be timely and hurdle-free.	Outstanding	• Will be considered within SDEC T&FG Pathways.
13	Provision of transfer teams to move ED patients rapidly to the wards and to the imaging departments should be considered.	Ongoing	• Trusts have commenced the introduction of transfer teams in EDs.
14	Formalise arrangements for a senior nurse responsible for a dedicated (and sufficiently large) team of nurses to provide care to patients waiting for inpatient bed	Ongoing	• Increased ED nursing levels in place to support care of patients. • Trusts have increased nurse staffing levels at ED's
15	More support staff should be employed to free-up the main clinical staff groups and allow them to concentrate on direct patient care.	Ongoing	• SEDIT data on lost workforce hours shared with Trusts.
16	The installation of time - and labour-saving devices, such as automated drug dispensers (e.g., the Omnicell), ambulance trolley weighbridges and ceiling-	Ongoing	• Introduction of Regional Epic Digital Patient Record to improve efficiencies.

	mounted bariatric hoists should be considered for all EDs.		• GIRFT recommendations to be considered in future business cases. • Introduction of Care Line Live and Care Home Availability Digital app.
17	The use of ED reception / waiting room patient-operated streaming systems should be trialled.	Ongoing	• Phone First in place in all Trust areas to triage patients to appropriate services.
18	There should be an aim to make the estate of each type 1 ED ready for another pandemic resulting from an unknown pathogen. Preparedness for an incident requiring decontamination is also necessary.	Ongoing	• IPC/pandemic requirements included within all ED business cases.
19	Staff facilities in EDs require improvement. Adequate provision of toilets, for instance, can obviously save valuable staff time.	Ongoing	• GIRFT recommendations considered with all new business cases.
20	Many EDs are dependent on locum doctors, especially for their middle grade rotas, and also bank nurses. Conditions of service should be offered that tempt these staff to accept longer-term contracts, wherever possible, cognisant of trust financial pressures.	Ongoing	• Funding agreed to recruit and retain up to 26 ED consultants completing training over next 6-18 months
21	Senior and junior rotas for both medical and nursing staff should be reviewed to ensure adequate out-of-hours cover for EDs at all times.	Ongoing	• Benchmarking exercise completed within SEDIT and data shared with Trusts.
22	Seven-day working for all acute specialties should be considered as normal practice; rotas should ensure adequate out-of-hours cover.	Ongoing	• Ongoing engagement with Trusts to develop 7-day services. • Some 7-day services in place for Discharge Coordination Teams.
23	Emergency medicine trainee disposition throughout Northern Ireland should be re-evaluated to ensure variety of ED experience and service provision, as well as excellence in training. This will require discussion with NIMDTA.	Ongoing	• RCEM workforce survey completed • Further discussion with NIMDTA required as part of DoH workforce reviews
24	GIRFT reports from other medical specialties should be reviewed in conjunction with this report, especially those from general surgery, urology and	Completed	• Review of GIRFT reports and improvement tools undertaken.

	orthopaedics. A GIRFT for acute medicine team visit should be considered. Their tools – the "six to help fix" (for acute medical flow), for instance, may prove to be very helpful.		
25	All parts of the UEC system should aim to improve the quality and usefulness of their data and to ensure its alignment with other services. The GIRFT-EM SEDIT and SEA-IT may be useful in this respect and should be used to drive improvement.	Completed	• SEDIT implemented in NI. • Revised Strategic Outcome Framework and Strategic Outcome Measures implemented. • By May 2025 all Trusts will have moved to EPIC which will ensure more consistency with data quality once fully implemented.
26	The leaders and managers of every service should aim to limit "internal demand" on their staff, such as poorly functioning IT and unnecessary non-clinical tasks.	Ongoing	• Implementation of new Epic system in all Trusts. • SPPG audit of ED flow completed.
5.5 Recommendation H (i): Implementation of equitable and effective call before attendance and ED appointment systems			
1	Urgent and emergency care appointment systems are based on a false premise: that ED attendance is unpredictable and needs to be regulated somehow. In actual fact, demand for emergency care is highly predictable and for any particular ED, the busiest time of the day and even the busiest day of the year are almost always the same and change very little over time.	Ongoing	• Review of Phone First completed as part of NMS PPE process. • Regional "111" service is currently under consideration
2	A streamlined attendance system should be implemented to ensure equal access for all patients, especially those people who already suffer from poor access to healthcare and other health inequalities. Appointment systems in EDs should be set up to ensure they don't lead to a parallel queue that cannot be serviced in a timely way.	Ongoing	• Implementation of new Epic system in all Trusts. • SPPG audit of ED flow completed.
5.6 Recommendation H (ii): Do not underestimate the effect of hospital attitudes, behaviours and cultures			
1	The style of leadership of a hospital, and the attitudes, behaviours and cultures that it engenders, is perhaps the most important factor affecting the care of emergency patients.	Ongoing	• Included within SDEC T&FG workplan.

2	The best hospitals have a highly visible top team who encourage the rest of the hospital staff to see lengthy delays for patients as everybody's responsibility. They regard threats to patient safety as problems that must and can be improved.	Completed	• Lessons shared from ED reset week in January 2025. • Regional seminar on professional standards held with Walsall NHS Trust.
3	Seven-day working in such hospitals is normalised and internal professional standards become imbedded into everyday practice.	Ongoing	• Included within SDEC T&FG workplan. • Additional resource will be required to provide seven day working.
4	For reasons that we do not fully understand, there is a strong positive correlation between contented staff (in the whole hospital) and good ED patient flow. Hospital culture is therefore of paramount importance and should be considered an area for continuous review and improvement.	Ongoing	• Included within SDEC T&FG workplan.
5.7 Recommendations A: Improve the emergency ambulance system			
1	The Northern Ireland Ambulance Service should reduce the overall ambulance conveyance rate and in particular, the rate of conveyance to EDs. However, the rate of conveyance to alternative UEC facilities should be increased. "Hear & Treat" and "See & Treat" rates should also be increased.	Ongoing	• Investment in NIAS ICH to increase Hear & Treat and See & Treat rates, with revised targets agreed. • Expansion of Clinical and mental health expertise within the ICH Team. • NIAS 10-year workforce plan in progress, which will benchmark NIAS against providers in England, Scotland and Wales
2	This will require improvements to both the content and the utilisation of the directory of services (DoS), combined with an increase in the availability and accessibility of alternatives to ED attendance.	Ongoing	• Discovery process underway in support of procuring a regional DoS solution.
3	Patients who have been recently discharged from hospital or who are being admitted from clinics, dialysis units or chemotherapy centres should go directly to the appropriate ward, rather than being taken to the ED.	Ongoing	• Included within SDEC T&FG workplan.

4	Patients who have fallen in care or nursing homes and patients with a care plan in place should be referred to community services, whenever possible.	Completed	• Revised NICE Guidance adopted for falls in care homes.
5	Ambulances should not leave patients at hospitals that do not have the specialties that are required for their anticipated condition. There should be hospital bypass and "stop and x-ray" agreements in place.	Ongoing	• Fracture protocols under review/further development. • Regional Repatriation Protocol issued.
6	For severely ill or injured patients who have been admitted to hospitals where the required specialties are missing, helicopter transfers should be arranged.	Ongoing	• Stakeholder discussions held; significant funding required.
7	NIAS should improve the quality and usefulness of its data and ensure that it aligns as well as possible with ED and other hospital data.	Completed	• NIAS data capture processes updated.
8	NIAS should consider the possibility of setting up urgent care-coordination hubs.	Ongoing	• Engagement underway as part of AtED Delivery Plan.