GETTING IT RIGHT FIRST TIME

For Emergency Medicine

The Emergency Departments of Northern Ireland

Report following visits in June 2023

This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to enable a rapid improvement in the delivery of urgent and emergency care and the adoption of the GIRFT principles to ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.

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1. Foreword

Getting It Right First Time (GIRFT) is a national programme, under the direction of Professor Tim Briggs, designed to improve the treatment and care of patients by in-depth review of services, benchmarking, and the presentation of data-driven evidence to support change. GIRFT aims to reduce unwarranted variation – the variation that is bad for the patient, bad for the healthcare system and bad for the economy – whilst accepting that some variation can be beneficial.

The programme undertakes clinically led reviews of specialties, combining wide-ranging data analysis, with the input and professional knowledge of senior clinicians, to examine how things are currently being done and how they could be improved.

GIRFT is part of an aligned set of programmes within NHS England. The programme has the backing of the Royal Colleges and professional associations.

This report is based on the observations and discussions from visits to all ten of the type 1 (major) emergency departments in Northern Ireland, in June 2023, by the GIRFT for emergency medicine team (Professor Chris Moulton and Mr Darren Best). The Northern Ireland Ambulance Service (NIAS) was also visited. Comparative data were shown to staff, using the Summary Emergency Department Indicator Table for Northern Ireland (the SEDIT-NI).

The SEDIT-NI was built, and the visits conducted, at the request of the Department of Health, Northern Ireland (DoH NI), Strategic Planning and Performance Group (SPPG), following discussions that started in 2021. The aim was to bring GIRFT methodology to Northern Ireland and to allow comparison of the Northern Ireland emergency care system with the much larger dataset of English emergency departments.

The GIRFT for Emergency Medicine team would like to thank our colleagues from the DoH NI, SPPG team who have been extremely positive and supportive throughout the Northern Ireland GIRFT Emergency Medicine process. Gratitude is also due to the clinical and executive healthcare staff from across Northern Ireland who have been candid and honest in sharing their experiences and their knowledge.

This work should provide a real stimulus to restart and embed the recovery of emergency care services in Northern Ireland and should encourage shared learning between the two countries involved in it.

Professor Chris Moulton: National Clinical Lead for GIRFT for Emergency Medicine

Darren Best: GIRFT Senior Specialist Clinical Review Manager (UEC Specialties)

2. Introduction

This report summarises the overall recommendations for Emergency Medicine in Northern Ireland as well as specific recommendations for the 10 Type 1 EDs that the RNOH/GIRFT emergency medicine team visited during two trips to Northern Ireland in June 2023.

A more comprehensive presentation, which includes more detailed descriptions of the SEDIT-NI and shows the data sets for each of the Type 1 EDs visited, can be found in the appendix of this report. The intent of the presentation is that it can be used by the SPPG and members of the Department of Health, Northern Ireland (DoH NI) to present to key stakeholders, either in full format or in parts, as necessary.

3. The SEDIT for Northern Ireland

The Summary Emergency Department Indicator Table for Northern Ireland (SEDIT-NI) was the main source of data for the GIRFT for Emergency Medicine visits. It is a repository of GIRFT emergency care information that is available online to all healthcare staff and is updated monthly. It is a development of the GIRFT SEDIT for England. Information about the EDs of Northern Ireland is compared with the large, combined data set of Northern Ireland and England.

Both SEDITs also address the issue of unwarranted variation in access to urgent and emergency care information. The data metrics are presented in an intuitive and helpful way, in order to show why problems are occurring, rather than providing an operational dashboard of current patient flow. The SEDITs are constantly evolving and responding to a changing NHS and the requirements of their 57,000 registered users. The SEA-IT (the Summary Emergency Ambulance Indicator Table) is now available as a tab on the SEDITs.

4. The three main problems for urgent and emergency care in Northern Ireland

The RNOH/GIRFT team identified three main problems for UEC in Northern Ireland, which are:

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

These problems are greatly accentuated by staffing and other capacity deficits in community services, in primary care, in social care and in most of the hospital services. Positive benchmarking against England does not negate these issues; all of the UK has failing UEC systems, with insufficient capacity to meet the demands of its growing and ageing population.

4.1 Ambulance to ED patient handover delays

- Delays in the handover of emergency patients from ambulance staff to ED staff wastes many hours per month of valuable emergency ambulance time. In fact, it consumes over 25% of the Northern Ireland Ambulance Service's emergency capacity.

- This loss of emergency capacity - both staff and vehicles - is the main cause of poor ambulance response times for patients. As a consequence, people who require urgent help are often left at home in pain or short or breath for long periods.
- This is clearly the biggest single risk to patients in the emergency care system of Northern Ireland.

4.2 ED exit block and hospital exit block

- The main reason for ambulance to ED patient handover delays is over-crowded EDs, with very large numbers of patients waiting for admission to a hospital inpatient bed. These people are often in beds and chairs in ED corridors and there is frequently no space for ED staff to examine and treat new patients. This is called ED "exit block" (or "access block" in some parts of the world).
- The lack of space on hospital wards is usually due to large numbers of patients who are "medically fit for discharge" but who cannot be found a space in a care / nursing home or allocated suitable social or community care.

5. Overall recommendations for Urgent and Emergency Care in Northern Ireland

The overall recommendations for UEC in Northern Ireland are based on two important premises:

1. The current situation in emergency care in Northern Ireland is unacceptable, untenable, and unsustainable. It is wasting Health and Social Care Northern Ireland (HSC NI) money, paralysing the emergency ambulance service, and preventing ED staff from doing their jobs. Most significantly of all, it is harming patients, increasing their risk of dying and giving them very poor experiences of hospital care.
2. Small improvements to emergency processes, whilst still important, have not been sufficiently effective in England and will not remedy the situation in Northern Ireland either. Significant and uncomfortable changes in many different areas are required to deliver the level of improvement that patients and staff require and, more importantly, deserve.

RNOH/GIRFT's recommendations fall into four categories as follows:

KEY: Group **S** = Recommendations about **S**OCIAL CARE

Group **C** = Recommendations about urgent care in the **C**OMMUNITY

Group **H** = Recommendations about the **H**OSPITAL emergency care system

Group **A** = Recommendations about the emergency **A**MBULANCE service

All hospitals and local UEC systems in Northern Ireland should look at these overall recommendations. As there was only a limited amount of time to visit each of the 10 EDs, the recommendations for each department (see later in the report) are brief and limited. Therefore, these overall recommendations, not all of which of course, will apply to each locality, are more comprehensive and may sometimes be more helpful.

5.1 Recommendations S: Improve the social care system

The difficulty in discharging patients from the hospital in a timely and efficient way is the most significant factor that causes a lack of bed availability, ED exit block and ambulance handover delays:

1. The timely flow of urgent and emergency care patients through the hospital system is absolutely dependent on effective and available social and community care. Similarly, avoidance of hospital admission depends on the same out of hospital services. Therefore, 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.

5.2 Recommendations C: Improve the community care system

The difficulties in obtaining a timely appointment in primary care or in finding an alternative to ED attendance or an alternative to hospital admission are the factors that increase patient attendance and ambulance conveyance to hospital:

1. The importance of primary care in the provision of an effective urgent and emergency care system cannot be underestimated. This is true both in and out of hours. Consequently, primary care staffing and availability should be considered in all discussions concerning UEC.
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.

5.3 Recommendation C (i): Consider urgent care centres in specific situations

Urgent care centres and similar facilities are not the solution to ED exit block and ambulance handover delays, but they do have a definite place in the urgent and emergency care system:

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.
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.
3. Call before attendance and similar systems should be carefully evaluated to ensure equitable and effective access across the region.

5.4 Recommendations H: Improve the hospital system

Long stays in EDs and prolonged waits for definitive care harm patients, prevent EDs from functioning properly and paralyse the ambulance service.

1. Each area hospital should have an adequate range of medical specialties. 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.

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).
3. All acute specialties should have “elastic” reception facilities for both external and internal acceptance of patients. This will require staffed specialty receiving areas.
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.
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.
6. A frailty in-reach team should cover both ED and the acute wards. Occupational therapists should be included in the frailty team.
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.
8. An acute medical in-reach model to ED should be considered.
9. Access to MR imaging 24/7 should be regarded as essential aim for all hospitals that have a Type 1 emergency department.
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.
11. Timely access to endoscopy for all hospital patients should be ensured.
12. Access to HDU and ICU services should be timely and hurdle-free.
13. Provision of transfer teams to move ED patients rapidly to the wards and to the imaging departments should be considered.
14. In all the EDs of Northern Ireland, large numbers of ED nurses are engaged for long periods in caring for patients who are waiting for an inpatient bed. There should be a formalisation of these arrangements with a senior nurse responsible for a dedicated (and sufficiently large) team of nurses who rotate into and out of this particular duty. (This, of course, is a temporising measure for reasons of patient safety, until the problems of delays for inpatient admission can be resolved.)
15. More support staff should be employed to free-up the main clinical staff groups and allow them to concentrate on direct patient care.
16. The installation of time - and labour-saving devices, such as automated drug dispensers (e.g., the Omnicell), ambulance trolley weighbridges and ceiling-mounted bariatric hoists should be considered for all EDs.
17. The use of ED reception / waiting room patient-operated streaming systems should be trialled.
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.

19. Staff facilities in EDs require improvement. Adequate provision of toilets, for instance, can obviously save valuable staff time.
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.
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.
22. Seven-day working for all acute specialties should be considered as normal practice; rotas should ensure adequate out-of-hours cover.
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.
24. GIRFT reports from other medical specialties should be reviewed in conjunction with this report, especially those from general surgery, urology and 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.
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.

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.
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.

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.
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.

3. Seven-day working in such hospitals is normalised and internal professional standards become imbedded into everyday practice.
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.

5.7 Recommendations A: Improve the emergency ambulance system

Delayed emergency ambulance response times are almost certainly the greatest risk to patients throughout the UK.

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.
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.
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.
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.
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.
6. For severely ill or injured patients who have been admitted to hospitals where the required specialties are missing, helicopter transfers should be arranged.
7. The Northern Ireland Ambulance Service (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.
8. The Northern Ireland Ambulance Service (NIAS) should consider the possibility of setting up urgent care-coordination hubs.

6. Specific local issues and recommendations for the 10 EDs of Northern Ireland

The following hospitals with Type 1 EDs (10 in total) were visited and the RNOH/GIRFT team have made recommendations for each.

Hospital Name	Acronym	HSC Trust Name
Royal Victoria Hospital	RVH	Belfast Health and Social Care Trust (BHSCT)
Mater Infirmorum Hospital	MIH	Belfast Health and Social Care Trust (BHSCT)

Royal Belfast Hospital for Sick Children	RSC	Belfast Health and Social Care Trust (BHSCT)
Antrim Area Hospital	AAH	Northern Health and Social Care Trust (NHSCT)
Causeway Hospital	CAU	Northern Health and Social Care Trust (NHSCT)
Ulster Hospital Dundonald	UHD	South Eastern Health and Social Care Trust (SEHSCT)
Craigavon Area Hospital	CAH	Southern Health and Social Care Trust (SHSCT)
Daisy Hill Hospital	DHH	Southern Health and Social Care Trust (SHSCT)
Altnagelvin Area Hospital	ALT	Western Health and Social Care Trust (WHSCT)
South West Acute Hospital	SWAH	Western Health and Social Care Trust (WHSCT)

All hospitals and local UEC systems should look at the overall recommendations (laid out earlier in this report) for Northern Ireland, as well as the specific recommendations for their own ED. These four groups of overall recommendations apply to social care, primary and community care, the hospital system and the Northern Ireland Ambulance Service. As there was only a limited amount of time to visit each of the 10 EDs, the recommendations for each department are brief and limited. Therefore, the overall recommendations, not all of which of course, will apply to each locality, are more comprehensive and may sometimes be more helpful.

6.1 The Royal Victoria Hospital (RVH): Belfast Health and Social Care Trust (BHSCT)

Local issues

- The ED has multiple areas – probably too many - to cover and this, together with the many patients waiting for an inpatient bed, gives a chaotic and unhappy feel to the department.
- The department is used as a receiving area for patients from other EDs who require specialist treatment, and this adds to the over-crowding and severe pressure on space. Patients who are transferred from other hospitals, with for example hip fractures and urology conditions, experience particularly long waits in the ED.
- The ED also holds patients for long periods who are deemed too sick for standard wards, but not sick enough for the intensive care unit (ICU).
- The urgent care centre (UCC) is really a revamped “minors” area, staffed with ENPs together with some GP input. It has limited opening hours. A lot of the work is triaging GP referrals.
- Both an observation ward and an SDEC are run by ED staff, with little acute medical input to the emergency service. There is no acute medical receiving unit (AMU).
- Nursing skill-mix is not good and there are too few ENPs and ANPs in the ED. Triage cover and the number of nurses at night are particular problems.
- Senior ED medical cover is very limited at night and during weekend evenings.
- The large number of patients waiting for an inpatient bed (40 to 60 on a typical day) require a dedicated team of nurses, under band 7 leadership, to ensure their ongoing care.
- There are many paper-based systems in the ED and a high level of “internal demand”.

- In a large specialist hospital, areas are often at a distance from each other (e.g., the CT scan room is two floors above the ED at the Royal Victoria Hospital). A dedicated patient transfer team would greatly improve patient flow and reduce nursing workload.

Recommendations

Patient reception facilities: As the central teaching and specialist hospital for the whole of Northern Ireland, the functioning of the Royal Victoria Hospital has a profound effect on emergency care throughout the country.

It is therefore essential that the RVH has the facilities to receive patients from other hospitals, without them passing through (and waiting for lengthy periods) in the ED. Such patients must also have their operative care and other treatment performed in an efficient and timely way. This is especially true of orthopaedic and urology patients.

ED and hospital staffing: Out-of-hours staffing for the ED should be improved. More Emergency Nurse Practitioners (ENPs) and Acute Nurse Practitioners (ANPs) are required in the ED and the level of evening and weekend cover by the senior ED medical staff should be reviewed. Seven-day working practices should be normalised for the whole hospital. The provision of a patient transfer team should be considered.

ED patient care and flow: The patient reception and flow issues described above should all be considered and addressed. The current delays for patients are unacceptable and are almost certainly causing patient harm. As a result, staff surveys show that the staff are unhappy and discontent.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.2 The Mater Infirmorum Hospital (MIH): Belfast Health and Social Care Trust (BHSCT)

Local Issues

- The ED has a cramped and old estate, with a small waiting area and only one patient toilet, apart from those in the waiting room. Just two of the ED cubicles have doors, rather than curtains. The resuscitation area is also small.
- There are no medical specialties on site, except general medicine, elderly medicine and the anaesthetic airway team.
- Transfers from ED to inpatient beds and to other hospitals are delayed, with long waits for patients.
- There is an out-of-hours primary care centre, just across the road, that sends patients to the ED but does not accept referrals from the department.
- The whole hospital is very dependent on locums, there is no rotation of ED trainees to the ED and the ENPs are not properly funded.
- There is poor integration of the ED with the rest of the trust.

Recommendations

ED staffing and facilities: The use of temporary staff should be reduced; better rotations with staff from other EDs in the trust would help considerably. The ED estate requires modernisation. Dedicated ED x-ray facilities would be a step forward.

ED patient care and flow: The current delays for patients are unacceptable and are certainly causing patient harm. As a result, the staff are unhappy and discontent. The availability of alternatives to ED attendance should be explored. Emergency ambulances should bypass the ED when they have patients who almost certainly require services that are not available in the Mater Infirmorum Hospital. It is unsatisfactory that there is an out-of-hours primary care service very close to the ED that will not accept referrals of low acuity patients from the ED staff; this issue should be discussed with the relevant managers.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.3 The Royal Belfast Hospital for Sick Children (RSC): Belfast Health and Social Care Trust (BHSCT)

Local Issues

- The estate of the ED is less than ideal. There is no ligature-proof room.
- The work of the children's ED is very centred around primary care work. Although there is a UTC on-site, it does not accept children as patients.
- The ED has no middle grade cover overnight.
- There are lengthy delays for children who require inpatient admission. Patients also wait for long periods to be assessed by CAHMS staff.

Recommendations

ED staffing and facilities: The use of temporary staff should be reduced; better rotations with staff from other EDs in the trust would help considerably.

ED patient care and flow: The availability of alternatives to ED attendance should be explored. It is unsatisfactory that there is an out-of-hours primary care service very close to the ED that will not accept referrals of low acuity patients from the ED staff; this issue should be discussed with the relevant managers.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.4 The Antrim Area Hospital (AAH): Northern Health and Social Care Trust (NHSCT)

Local Issues

- There is no on-site trauma and orthopaedics service in Antrim. Patients with fractured hips (and other severe injuries) often wait for several days in the ED corridor before transfer to the ED at the Royal Victoria Hospital in Belfast, where there is no timely reception system and the wait for operative fixation begins again.

- Urology care in the area is fragmented and disorganised; patients wait in the ED for long periods with urosepsis.
- Many of the patients waiting in non-clinical spaces are elderly. There is no front door geriatric in-reach service or use of a clinical frailty score.
- There is limited access to out of hours MR imaging in the hospital.

Recommendations

Hospital inpatient specialties and imaging: The provision of medical and surgical specialties in the Antrim Area Hospital should be urgently reviewed, in the light of a growing and ageing population. An on-site orthopaedic service would seem to be essential. The recommendations of the GIRFT report into urology services in Northern Ireland should be implemented. There must be an aim to obtain access to MR imaging for the hospital – ideally with 24/7 availability.

The acute medical model would be improved by having a seven-day working pattern, which may require input from other medical specialists. The access to SDEC services (such as cardiology) should be increased, with a focus on admission avoidance. Frailty specialist input to the ED and the acute wards is essential. Urgent endoscopy should be available in an agreed timeframe and HDU care should be readily accessible, without difficult negotiations.

Ambulance patients, transfers and referrals: Ambulances that are carrying patients with conditions that cannot be definitively treated at the Antrim Area Hospital should bypass it and go directly to Belfast. “Stop and x-ray” practices should be reviewed and improved. Any required transfers should occur within a short, agreed timeframe. Proper (non-ED) reception facilities for referred patients in Belfast should be mandated.

Patients who have been recently discharged should be returned to the discharging hospital or ward and patients who are referred for admission from clinics, dialysis units and chemotherapy centres should be transferred directly to assessment areas on wards and not be sent to the ED. Patients with care plans and people who have fallen at home, without apparent injury, should be referred to appropriate community services, wherever possible.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm. Understandably, the results of patient surveys are poor. Patient flow could be improved by moving to post-pandemic standards of isolation and practice.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.5 Causeway Hospital (CAU): Northern Health and Social Care Trust (NHSCT)

Local Issues

- The ED of Causeway Hospital has to undertake around 60% of all its clinical work in the small and cramped “Majors One” area, because the other two main clinical areas are full of patients who are waiting for an inpatient bed.
- Therefore, all the nurses in these areas are unable to perform proper ED work. Patients are also kept in corridors and other non-clinical spaces.
- The line of sight in the ED of patients for nurses is poor and there are only five rooms with proper doors, rather than curtains. This is a potential infection and control issue. Portable x-ray facilities are rather inadequate.

- Causeway Hospital is bedevilled by the lack of a trauma and orthopaedics service and by very poor arrangements - and long delays - for urology patients. Catheter care is hard to obtain.
- There is no MR scanning in house and no arrangements for referral to MR out of hours.
- The ED has no trainees in emergency medicine and, as a consequence, is very dependent on locum doctors.
- The hospital has many patients in beds on wards who are medically fit for discharge.

Recommendations

Refer also to the recommendations for Antrim Area Hospital (Northern Health and Social Care Trust).

ED staffing and facilities: The large number of patients who are waiting in the ED for an in-patient bed is preventing the staff from attending to new patients and accessing clinical space.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm; patient surveys reveal negative experiences of care. Arrangements for orthopaedic patients and urology patients should be reviewed urgently. The recommendations in the GIRFT reports for the surgical specialties in Northern Ireland should be implemented. There must be an aim to obtain access to MR scanning for the hospital – ideally with 24/7 availability.

ED litigation: The high cost of litigation per ED attendee should be explored, with the help of staff who are experts in this field.

6.6 Ulster Hospital Dundonald (UHD): South Eastern Health and Social Care Trust (SEHSCT)

Local Issues

- Patients often wait for very long periods in the back of ambulances, before being finally admitted into the ED.
- There are very long waits in the ED for patients with mental health conditions. (A patient had been in the ED for more than 96 hours at the time of the GIRFT-EM visit.)
- The hospital constantly has two full wards of patients awaiting inpatient beds that are under the care of ED nurses. (There are a total of 71 such beds, including 20 on the ED short stay ward.)

Recommendations

ED staffing and facilities: The management and status of the two wards of patients “waiting for admission” who are under the care of the ED nurses should be formalised. These patients have clearly already been admitted to hospital and the facilities on the two wards are sufficiently good to allow patients on the wards to be taken off the “four-hour clock”. The medical care of these patients is already under the inpatient specialties and the nursing team should be separated from the ED team and led by a dedicated senior nurse. If necessary, these ward nurses could rotate in and out of the ED nursing team.

ED patient care and flow: The problem of long waits in ED for patients with mental health conditions should be discussed with the responsible managers, The risk of looking after such patients must not fall entirely on the ED staff. There should be some elastic capacity in the mental

health assessment units where these people can be safely looked after until a definite care plan can be implemented.

6.7 Craigavon Area Hospital (CAH): Southern Health and Social Care Trust (SHSCT)

Local Issues

- The first impression of the ED at Craigavon Area Hospital is one of gross overcrowding. At the time of the GIRFT-EM visit, there were 51 patients in various spaces, waiting for a hospital inpatient bed, and patients waiting outside the ED in ambulances for many hours too. The nurses were running the equivalent of a ward of medical and surgical patients in a cramped corridor, some of the patients on trollies but many of them having to sleep overnight on chairs.
- Surgical patients who are transferred during the night from Daisy Hill Hospital fill up the surgical wards and so surgical admissions from the ED are then unable to be moved to an inpatient bed.
- There are some good facilities in the ED (including two Omnicell automated drug dispensing machines), but there are too many clinical areas to cover.
- The medical SDEC seems to be relatively under-used.

Recommendations

ED staffing and facilities: The working practices of the staff between the two sites of the trust should be discussed, with an intention of reducing the amount of travel between the two hospitals.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm. Understandably, the results of patient surveys are very poor. The medical SDEC should be used to prevent avoidable patient admissions. In addition, there is a large, almost vacant surgical assessment area, adjacent to the ED, which is currently used as an ED minor's area and also as a storage area. This could be used as an admissions area for surgical (and medical) patients, with its own team of nurses. If necessary, these nurses could be rotated out of the ED team in the short term (as they are already doing the job of caring for patients who are waiting for specialty assessment).

6.8 Daisy Hill Hospital (DHH): Southern Health and Social Care Trust (SHSCT)

Local Issues

- Daisy Hill hospital has a Type 1 ED. There is no general surgery, no trauma & orthopaedics, no urology, no ENT and no stroke service.
- The hospital has no acute medical receiving unit or acute medical in-reach service.
- There are constant problems with recruiting nurses for the ED.

Recommendations

ED patient care and flow: The current delays for patients are unacceptable and are certainly causing patient harm. As a result, surveys show that both patients and staff are unhappy and discontented. The availability of alternatives to ED attendance should be explored. Emergency ambulances should bypass the ED when they have patients who almost certainly require services that are not available in Daisy Hill Hospital.

6.9 Altnagelvin Area Hospital (ALT): Western Health and Social Care Trust (WHSCT)

Local Issues

- The ED of the second main hospital in Northern Ireland is rather cramped with many different clinical areas. Consequently, it has poor lines of sight for the nurses who are caring for the patients. This is greatly accentuated by the large number of patients in various spaces who are waiting for an inpatient bed.
- Only five of the major cubicles have doors; the rest are curtained. Infection prevention and control is thus a constant potential problem.
- The portable x-ray facilities are poor.
- Timely access to specialties, such as ENT, has not been reinstated to pre-pandemic levels. Specialty assessment areas no longer accept ED referrals directly, and the resulting poor patient flow impedes the work of the ED and delays patients.

Recommendations

ED staffing and facilities: Efforts should be made to improve the infection prevention and control facilities in the ED. This would also positively influence the levels of privacy and dignity available for patients and would help with nursing care.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm. As a result, both patients and staff are unhappy and discontented. There is a high catchment attendance rate and so the availability of local alternatives to ED attendance should be explored. The availability of SDEC, urgent clinics and timely patient assessment in specialty areas should all be increased, with a view to reducing the pressure on the ED and improving patient experiences.

6.10 Southwest Acute Hospital (SWAH): Western Health and Social Care Trust (WHSCT)

Local Issues

- There is no onsite general surgical service in the hospital (since December 2022), and this necessitates transfers of patients by ambulance to Altnagelvin Area Hospital.
- There are no trainees in emergency medicine in the hospital and lots of locum doctors instead.
- More than a third (72 on the day of the visit) of the hospital's G&A beds are occupied by patients who are fit for discharge. Many of these patients are elderly people in difficult phases of dementia. Community and social care is not available to support timely discharge from the hospital.

Recommendations

ED staffing and facilities: The use of temporary staff should be reduced. Rotations with staff from the other ED in the trust would help considerably and would demonstrate the advantages of two far-apart hospitals being in the same trust. The use of screens in the many glass-fronted ED cubicles should be replaced by the installation of external curtains.

ED patient care and flow: The current delays for patients are unacceptable and are almost certainly causing patient harm. As a result, both patients and staff are unhappy and discontented. The availability of local alternatives to ED attendance should be explored. Helicopter transfers

should be utilised for severely ill or injured patients where this offers benefit compared to road transfers by ambulance.

7. Conclusions and Next Steps

The current situation in emergency care in Northern Ireland is badly affected by long delays at all stages. This paralyses the emergency ambulance service, makes the EDs crowded and dysfunctional, and worst of all, harms patients and gives them poor experiences of the healthcare system. We hope that the information in this report, and its subsequent recommendations, will help to change this paradigm rapidly and efficiently. We know that resources are not endless and so our recommendations focus on improved processes and better cooperation between specialties. Most of the things that we suggest are relatively easily achievable and have already been agreed with many people from both clinical and managerial groups of staff.

The final “Getting it Right First Time for Emergency Medicine Report” will be shared with the Urgent and Emergency Care Implementation Programme Board, DoH NI.

Further "implementation sessions" are also planned. The specific content and purpose of, and participation in, these meetings will be determined by the DoH NI, SPPG team.

Finally, we have great confidence in the future of urgent and emergency care in Northern Ireland. The levels of dedication and enthusiasm that we found in all types of staff that we met will ensure that patients finally get the service that they require and deserve.

8. Appendix: Important supporting information for the GIRFT- EM recommendations for the 10 EDs of Northern Ireland

8.1 GIRFT EM report for Northern Ireland

The full GIRFT EM report for the 10 EDs of Northern Ireland is in MS PowerPoint and can be accessed here by clicking on this icon.

GIRFT-EMReportfor NI(June 2023)PPFina

The full report contains all the information in this summary report, and the following additional information:

- Details of the Northern Ireland Summary Emergency Department Indicator Table (SEDIT – NI).
- Evidence and observations to support the national and local recommendations, including the SEDIT NI data for each of the 10 Type 1 EDs.

8.2 GIRFT-EM report for England

The GIRFT for Emergency Medicine National Report for England made 17 recommendations to address three key priorities:

- Match emergency care capacity to local demand more effectively
- Improve patient flow in EDs (using solutions based on data and GIRFT-EM metrics)
- Reduce unwarranted variation in the resources available to EDs

It can be accessed by clicking on this link:

Layout 1 (gettingitrightfirsttime.co.uk)

8.3 Internal Professional Standards

Internal professional standards are important to ensure good ED functioning and timely patient flow through the UEC system. An example of them can be accessed by clicking on this link:

rig-making-internal-prof-standards-work.pdf (england.nhs.uk)