Northern Ireland Assembly

Research and Library Service Briefing Paper

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Provision of Emergency Care to Smaller Communities

1. Context and Background to the Briefing

In June 2010, the South Eastern Health and Social Care Trust published proposals for a "*Safe and Sustainable Urgent Care Network in the South Eastern Trust*", as part of its Reform and Modernisation Public Consultation. This included a proposal to remodel the Emergency Department (ED) at the Downe Hospital to create an Urgent Care Co-operative, [1] with the ED remaining a Consultant-led model with a Consultant presence on site Monday to Friday (and available on-call outside these hours); also staffed by middle-grade doctors from 8am to 10pm all week; and the GP Out-of-Hours service would provide cover from 10pm to 8am, with doctors on site until midnight for purposes of handover. The Trust notes that the model assumes that GPs would be adequately supported with direct access to Consultants for support.

[1] Proposals for a Safe and Sustainable Urgent Care Network in the South Eastern Trust, South Eastern HSC Trust, June 2010, pages 5-6, http://www.setrust.hscni.net/involving/reference/Urgent%20Care%20Proposal%20-%2024%20Nov%2010.pdf

The Trust notes that a patient mapping exercise indicates that the system is safe and will allow over 97% of appropriate patients to be managed on the Downe Hospital Site.[2] Final proposals on the reform and modernisation were presented to the Trust Board on 24th November 2010 and were approved, including the above proposal for the Urgent Care Co-operative.[3] The proposals are now with the Minister for Health Social Services and Public Safety and no final decision has yet been taken.[4]

In this context the Committee for HSSPS requested a briefing around the issue of emergency care to determine if other models exist to assist smaller rural hospitals to maintain 24 hour A&E services via, for example, by rotation of doctors from larger hospitals. It was suggested that other jurisdictions of the UK, particularly Scotland might provide a suitable lead in this area.

The particular issue of the Downe hospital has attracted considerable media coverage with campaigners continuing to fight for a 24 hour A&E.[5] The South Eastern HSC Board voted in favour of the proposals at an "*angry public meeting at the Downshire Hospital…packed with hundreds of people opposed to the proposals*".[6] The Northern Ireland Ambulance Service has expressed the view that the proposed changes may result in increased demand for ambulance transport and longer journey times for patients.[7]

The Chief Executive of the South Eastern HSC Trust has blamed, in part, a shortage of middle grade doctors being recruited, noting that the Trust has looked as "*far afield as America, Australia and New Zealand to find suitable candidates*"[8] and that it is costing the Trust "*£250,000 a year for locum cover…while the emergency department is extremely busy during the day, as little as five patients may attend after midnight*".[9]

Such night time closures of EDs due to shortages of doctors are not unique to Northern Ireland as the following examples illustrate. The Health Service Executive (HSE) in the Republic of Ireland has been reported as drawing up plans to close or limit opening hours at emergency departments across the country and cuts across other health services are predicted due to a shortage of junior doctors. The HSE national director of

[2] Proposals for a Safe and Sustainable Urgent Care Network in the South Eastern Trust, South Eastern HSC Trust, June 2010, page 25, http://www.setrust.hscni.net/involving/reference/Urgent%20Care%20Proposal%20-%2024%20Nov%2010.pdf
[3] SE HSC Trust, Press Release, 25th November 2010, Trust Board Approves Revised Consultation Proposals.
[4] Personal communication with Departmental Assembly Liaison Officer, 2/02/2011
[5] A&E closure: battle isn't over, Belfast Telegraph, November 26, 2010
[6] Fury as health bosses vote to shut hospital's A&E at night; Hundreds object at public meeting, Belfast Telegraph, November 25, 2010
[7] Cutting hospital's A&E hours 'will cost lives', Belfast Telegraph, September 24th, 2010
[8] Fury as health bosses vote to shut hospital's A&E at night; Hundreds object at public meeting, Belfast Telegraph, November 25, 2010
[9] Fear over cuts to hospital services, Belfast News, February 11, 2010

human resources said it was "*no longer sustainable to have so many emergency departments open 24 hours*".[10]

It has been reported that Health Boards across Scotland are struggling to maintain services with fewer junior doctors, particularly in regions providing 24/7 acute services on more than one site. For example, NHS Fife has prepared a contingency plan to tackle the shortage of junior doctors to staff A&E units and closed Kirkaldy's A&E unit at night over a weekend in May 2010 and expected to have to repeat this on other weekends.[11]

The Pennine Acute Hospital's Trust in England has closed the Rochdale Infirmary's A&E unit at night since August 2010 and it is being changed to a 24-hour urgent care centre which no longer receives ambulances.[12] From September 2009, the Sidcup A&E (part of South London Healthcare NHS Trust) closed to emergencies from 8pm to 8am.[13]

With regard to the wider issue of the overall viability of an ED, the College of Emergency Medicine has confirmed that safety is the main consideration and that Northern Ireland was being impacted by the shortage of emergency medicine doctors affecting the whole of the UK. Smaller hospitals have the added difficulty of an insufficient volume of patients to support doctor training posts with only larger hospitals having sufficient back-up to be designated training hospitals.[14]

2. Introduction to Emergency Care in Northern Ireland

Accident and Emergency (A&E)/Emergency departments provide important access to the healthcare system in Northern Ireland. They are hubs that interact directly with primary care, in-hospital care and community care services. The College of Emergency Medicine have highlighted that service development in emergency care in Northern Ireland has not been associated with the investment in staff and facilities which has taken place in the rest of the UK and that there are "*real challenges in Northern Ireland in delivering high quality care in geographically remote areas and ….this results in high ambulance usage*".[15]

Between 2005/06 and 2009/10 the total number of attendances at emergency care departments increased by 4% from 698,937 to 727,935. However, since 2008/09 to

[10] A&E closures planned as cuts take their toll, Sunday Business Post, Ireland's Financial, Political and Economic Newsletter, May 9th, 2010

[11] Overnight closures to continue at Kirkaldy A&E, Fife Free Press, May 20th, 2010

[12] Infirmary services wiped out, Manchester Evening News, November 6, 2010

[13] SIDCUP: Night-time A&E closures likely to be permanent, This is Local London, 8th September 2009, http://www.thisislocallondon.co.uk/news/4585209.SIDCUP__Night_time_A_E_closure_likely_to_be_permanent/

[14] Personal communication with the Northern Ireland Representative for the College of Emergency Medicine, January 2011

[15] *The Way Ahead 2008-2012, Strategy and guidance for Emergency Medicine in the United Kingdom and the Republic of Ireland*, The College of Emergency Medicine, December 2008, page 43

2009/10 they have decreased by 1% from 732,022 to 727,935. These figures include both new attendances and review attendances and during the past 5 years, the number of new attendances has increased by 7% from 626,994 to 669,085 and the number of review attendances has decreased by 18% from 71,943 to 58, 850.[16]

Of the total attendances approximately:

- 27% were in the Belfast HSC Trust;
- 21% were in the South Eastern HSC Trust;
- 20% were in the Northern Trust;
- 19% were in the Southern Trust; and
- 14% were in the Western Trust.[17]

With regard to the development of emergency care services in Northern Ireland, it would appear that two of the concerns of the DHSSPS are the high attendance numbers at EDs and within the general high attendance, the high number of 'inappropriate' attendances.

A review of unscheduled care in Northern Ireland suggested that attendances at A&E are 20-30% higher than in the rest of the UK, which may be partly due to the lack of development of other types of unscheduled care service.[18] For example, in Northern Ireland, out-of-hours centres do not allow open access and there are no walk-in primary care health facilities. At present, emergency departments/ A&E are the only 'walk-in' centres.

In recognition of the increasing focus given to emergency care elsewhere, the DHSSPS commissioned a review of the provision of A&E and other emergency services (out-of-hours, minor injury units and ambulance service) in Northern Ireland. One of the main concerns was the 24% of A&E attendances that were regarded by A&E staff as 'inappropriate',[19] and the DHSSPS produced a range of recommendations to address these 'inappropriate' A&E attendances including[20]:

- Review of Minor Injuries Units – opening hours, future co-location, referral sources and availability of diagnostics;
- Review benefits of observation wards in A&E to promote, as appropriate, early consultant review and discharge;
- Increased primary-care gatekeeping, for example, locating GPs in or adjacent to A&E;

[16] Northern Ireland Hospital Statistics: Emergency Care (2009/10), DHSSPS, NISRA, August 2010, page 6, http://www.dhsspsni.gov.uk/hosp_stats_2010_-_a_e2.pdf

[17] Northern Ireland Hospital Statistics: Emergency Care (2009/10), DHSSPS, NISRA, August 2010, page 6, http://www.dhsspsni.gov.uk/hosp_stats_2010_-_a_e2.pdf

[18] *The Way Ahead 2008-2012, Strategy and guidance for Emergency Medicine in the United Kingdom and the Republic of Ireland*, The College of Emergency Medicine, December 2008, page 43

[19] Transforming Emergency Care in Northern Ireland, Northern Ireland Audit Office (NIAO), April 2008, paragraph 1.3

[20] Transforming Emergency Care in Northern Ireland, Northern Ireland Audit Office (NIAO), April 2008, Appendix 1

- Review the scope of increased nursing input in out-of-hours provision;
- Review role and resourcing of NI Ambulance Service, including staff role development;
- Consider pilots of triaging patients from A&E to other alternatives;
- On-going public awareness campaigns; and
- Focus on initiatives for older people and those with chronic conditions who tend to have multiple attendances at A&E.

3. Possibility of Rotation of Doctors to Maintain Smaller EDs

As stated in Section 1, the main purpose of this briefing is to determine if other models exist to assist smaller hospitals to maintain 24 hour ED services via, for example, rotation of doctors between hospitals and Trusts. By way of answering the question of the feasibility of rotation of consultants between Trusts, the new consultant contract was introduced in April 2004 and was designed to allow a more effective system of planning and timetabling consultants' duties and activities for the health service. According the British Medical Association (BMA), Northern Ireland branch,

> *"there is nothing in the contract that allows NI health and social care, as an overarching entity, to compel or direct people to work in, for example, Enniskillen rather than Belfast or Omagh".*[21]

Posts for doctors are advertised and doctors apply to the employing organisation, for example, Belfast HSC Trust. However, that said, many consultants do work outside their own Trust and help another service, and these other work locations are agreed in a consultant's job plan where appropriate. The job plan will include any duties for other HSC employers, for example, medical staff may perform their surgical list in one hospital and their outpatient clinics in a range of hospitals so that patients do not have to travel undue distances to visit a clinic.[22]

Clinical networks have been developed in Northern Ireland for certain clinical areas that involve rotation of staff between the core and peripheral units.[23] Examples of such networks include NI Cancer Network (the first regional managed clinical network in NI)[24], Vascular Managed Clinical Network and the Hepatitis C Clinical Network.[25] The Committee has also recently been advised of the establishment of the Emergency and Urgent Care Network for Children, the aim of which is to ensure that unscheduled care services for children in Belfast are developed to deliver on required outcomes.[26]

[21] Consultants Contract fact sheet, BMA Northern Ireland, bma.org.uk/northernireland, page 1
[22] Consultants Contract fact sheet, BMA Northern Ireland, bma.org.uk/northernireland, page 2
[23] Consultants Contract fact sheet, BMA Northern Ireland, bma.org.uk/northernireland, page 5
[24] www.cancerni.net/cancerinni/yourcancernetwork1
[25] www.hepcni.net
[26] HSSPS Committee Hansard of 27th January 2011, Modernisation and Reorganisation of Services, http://www.niassembly.gov.uk/record/committees2010/HSSPS/110127_Consultation.pdf

However, in connection with the specific issue of an emergency care network with rotation of doctors between smaller and larger hospitals, the Northern Ireland representative for the College of Emergency Medicine has confirmed that, as far as the College is aware, there are no examples of such rotation in order to maintain smaller EDs and instead various approaches have been taken to provide emergency care in such areas (see Section 4).

4. Examples of Approaches to Providing Emergency Care to Smaller Communities

The College of Emergency Medicine accepts the real challenges in delivering care to remote pockets of population and plans to produce a report outlining possible solutions, drawing on experience from the whole of the British Isles.[27] However, in the meantime, in its guidance *The Way Ahead 2008-2012* (December 2008) it advocates that with regard to EDs, its position remains[28]:

- Where small/medium EDs are geographically close (within 10km), a more coherent emergency service may be possible by amalgamation;
- Between 10-20 km the local health communities will have to make a judgement on the balance of risk of having ill patients travel further against the benefits of centralisation;
- Where the next nearest ED is more than 20 km away there is a strong argument for retaining an emergency service; (note - the distance between the Ulster Hospital and the Downe Hospital is approximately 38 Km[29]); and
- Any change in organisation should be on the basis of an assessment of the balance of risk with proper planning on how medical admissions will be managed; and
- For a tiny number of patients suffering with serious trauma or ST elevation MI (STEMI) there is a need to centralise services, but the clinical case is not made for the vast majority of ED care. Indeed there is some evidence that mortality increases for some types of severely ill patients who have to travel longer distances.

As might be expected, much of the work in this area has been carried out in Scotland. For **NHS Scotland** the focus appears to have been on staffing rural emergency units with nurse practitioners, having robust patient transfer procedures in place, and the up-skilling of paramedics to provide core services for remote community hospitals.[30]

[27] Personal communication with the College in December 2010 has confirmed that this report has not yet been published.
[28] Direct extract from *The Way Ahead 2008-2012, Strategy and guidance for Emergency Medicine in the United Kingdom and the Republic of Ireland*, The College of Emergency Medicine, December 2008, page 21
[29] http://www.freemaptools.com/distance-between-uk-postcodes.htm
[30] Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Workstream, NHS Scotland, 30th November 2007, page 17

In 2007, the Remote and Rural Steering Group of NHS Scotland published a framework to deliver healthcare, including emergency care, in remote and rural areas of Scotland. With regards to emergency care, the overarching direction was that facilities for the immediate care of all patients presenting with an emergency or acute illness should be available in the community. Assessment as to whether the patient then requires transfer to another hospital or facility should be made by the senior practitioner involved in the immediate care. Crucial to emergency care in rural Scotland is the ability to transport the patient in a timely manner if necessary.[31]

The framework describes the services to be provided in remote community hospitals as varying, according to the local population density and health need. However with respect to emergency care the following core services should be provided[32]:

- A hub for out-of-hours unscheduled care integrated with practitioner-led minor injury/minor illness units;
- First line resuscitation, triage, transfer or admission as appropriate to the risk assessment of the patient's condition and proximity to secondary care; and
- Designated Place of Safety for Mental Health Crisis.

The framework highlights that for a sizeable Community, which is distant from a Rural General Hospital (RGH) or a District General Hospital, a higher level of service is required in the community hospital including a first-line response in an emergency, including assessment, management, admission, or stabilisation prior to transfer. This level of emergency care is relatively similar to that seen in a RGH except that there is no provision of emergency surgery.[33]

Within the framework the emergency care provided by a RGH is described as the "*management of acute medical and surgical emergencies and is the emergency centre for the community, including the place of safety for mental health emergencies*". [34]

An emergency service is required within the RGH and it is envisaged that nurses can manage the majority of the activity with skills in the management of minor injuries and minor illness, but they need to be supported by appropriate clinical decision support. A 24/7 anaesthetic service is pivotal to support the emergency care at the RGH including resuscitation and stabilisation and administration of anaesthesia for emergency surgery, including emergency airway management. [35]

[31] Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Workstream, NHS Scotland, 30th November 2007, page 13

[32] Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Workstream, NHS Scotland, 30th November 2007, page 17

[33] Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Workstream, NHS Scotland, 30th November 2007, page 18

[34] Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Workstream, NHS Scotland, 30th November 2007, page 27

[35] Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Workstream, NHS Scotland, 30th November 2007, page 31

The framework highlights the importance of remote and rural areas as a training resource for doctors in training, through new Specialty Training posts if necessary to ensure the supply of remote and rural physicians, surgeons, anaesthetists and GPs.[36]

In Wales the direction of emergency care is being guided by the 2008 publication *Delivering Emergency Care Services (DECS) Strategy*.[37]

One of the main principles of the DECS Strategy is to ensure that people have a better understanding of the range of unscheduled care services that exist and understand how to access these services.[38] It also encourages unscheduled care in Wales to be viewed with a whole system encompassing emergency departments, primary care and social care.

One of the work areas likely to impact on more remote emergency care is *Staff Empowerment,* with the aim being to empower staff to be confident to make appropriate decisions at the earliest point in the clinical pathway. To achieve this staff should be supported through training programmes; knowledge and skills frameworks; access to clinical information in the workplace; clear clinical governance arrangements and supportive organisational cultures. However, it is accepted that staff working in rural or isolated situations will need to be supported to deliver safe services, as locally as possible. The feasibility of developing a national network linking these units to major A&E departments in order to provide remote clinical decision support via video-conferencing technology is being explored. A follow-up publication to the DECS Strategy *Unscheduled care: developing a whole systems approach* published in December 2009 by the Welsh Audit Office noted a lack of progress in this area of developing staff with extended specialist roles to address people's care needs without them having to access further unscheduled care services. [39]

Several of the other work areas of the Strategy will potentially have impact on reducing the level of need for emergency care in remote and rural areas through prevention activities. These include:

- Supporting self-care by linking with the Expert Patient Programme to help people self manage their chronic conditions;
- Introducing telemedicine technology to monitor such conditions as diabetes and asthma; and
- Linking with the Telecare programme which provides a range of remote support enabling people to live independently for longer, for example falls alarms, flood and

[36] Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Workstream, NHS Scotland, 30th November 2007, page 74

[37] Delivering Emergency Care Services, An Integrated Approach for Delivering Unscheduled Care in Wales, Welsh Assembly Government and NHS Wales, February 2008

[38] Delivering Emergency Care Services, An Integrated Approach for Delivering Unscheduled Care in Wales,Welsh Assembly Government and NHS Wales, February 2008, page 4

[39] Unscheduled care: developing a whole systems approach, Wales Audit Office, December 2009, Summary

smoke detectors etc. Activation of a sensor, triggers an alert to a central centre and is responded to.

The Department of Health in England have been focusing on the transformation of emergency care for a number of years and as with Wales are taking a whole systems approach by viewing emergency care as being provided across a range of settings including traditional ED settings, primary care and social care. The overall aim is to maximise the number of instances when the right care is given by the right person, at the right place and the right time and to thereby achieve a 10 percent reduction in the number of patients attending A&E with associated reductions in ambulance journeys and admissions.[40] With regard to Northern Ireland, the local representative for the College of Emergency Medicine highlighted that England is ahead of Northern Ireland in terms of strategy and investment in this area of care.[41]

For a number of years, the Department of Health has been working to ensure that GPs, A&E Departments, NHS walk-in centres, community nursing, pharmacists, out-of-hours services, NHS Direct and the ambulance service work together work together to provide the full range of emergency care across the entire population of England. This work appears to have commenced around 2004 with the Department of Health publication of *Transforming Emergency Care in England* and much has been done since. It is beyond the scope of this paper to provide a full review. Further information on recent developments can be found on the emergency care section of the Department of Health's website.[42].

In order to ensure all of the population has adequate access to emergency care the Department of Health has proposed that *Emergency Care Networks* are a vital part of reforming emergency care and has supplied a framework to clarify their purpose which makes suggestions for membership and terms of reference, with membership including[43] - Acute Trusts, Ambulance Services, Community Paediatric Services, Dental Services, Intermediate Care, Local council, Mental Health Trusts, Minor Injury units, OOH Providers' Primary Care Trusts, Pharmacies, Social Services, and User representation. The Department emphasises, however, that the network size/scale is for local determination and the important thing is that the network enables local delivery of emergency care.

An example of one such Network is that established within Coventry and Warwickshire. The Director of the network, Mr Paul Devlin, highlighted the need to come up with an effective emergency and urgent care model for the whole community involved and keep control of the emergency and urgent care pathway. This control means making sure the patient accesses the right care first time as far as possible, for example, this

[40] QIPP Urgent Care Workstream, Department of Health, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115468
[41] Personal communication with the Northern Ireland Representative for the College of Emergency Medicine, January 2011
[42] Urgent and emergency care, Department of Health, www.dh.gov.uk/Healthcare/Urgentandemergencycare/index.htm
[43] Emergency Care Networks, Department of Health

may involve a paramedic with enhanced skills assessing someone at home using the medical model and then directing the care accordingly to A&E or other suitable place of treatment.[44]

The vision for this particular network is for a future pathway of urgent care driven by patient's needs and preferences, providing care as close to home as is safe to do so.[45] The Director of the Network highlighted two of the most useful initiatives regarding provision of emergency care in the rural areas covered by the Network as follows[46]:

- **The rural Emergency Care Practitioner (ECP) scheme** set up to operate community based advanced practitioners in an integrated way across a number of local practices as well as the Ambulance Service. The model allows ECPs to visit patients on behalf of GPs, carry out assessments, treat and discharge for minor illness and injury as well as acting as the eyes and ears of the doctor in more serious cases. All ECPs are trained to use the medical model of clinical assessment so they can converse in a meaningful way with doctors. Additionally this allows them to have access to treatment pathways that are not open to traditional Paramedics or District Nurses. These range from intermediate care beds in community hospitals through to Consultant staffed Acute Clinics at University Hospital. The rural ECPs are equipped with fast response vehicles so they can respond to a 999 call within their locality on behalf of the Ambulance Service; and
- The Helicopter Service (HEMS) – this is made available through charitable funds and operates seven days per week between 09:00-17:00. The helicopter carries four crew and one patient. The crew includes a paramedic and a senior doctor with a background of emergency medicine, intensive care and or anaesthetics. This enables a doctor to be at the side of rural patients within 7 minutes no matter where the incident occurs within the locality.

It would also appear that the following workstreams for the Network would have a positive impact on providing more choice of emergency care to smaller communities[47]:

- **Improving GP and community care responsiveness** – the Network wishes to work with GPs to ensure they have capacity to treat more patients in the community through 24/7 access to GP practice based services. This workstream also involves developing the role of the Ambulance Service to ensure it is equipped to manage patients who present via the 999 system with moderate medical problems;
- **Transforming acute services** – The Network will look at providing aspects of acute care within the community through an Acute Outreach Service, initially supporting nursing homes or primary care based clinics;

[44] Personal Communication with Paul Devlin, Director of Emergency and Urgent Care Network, Dec. 2010

[45] Emergency and Urgent Care Network Delivery Plan 2010-2013, Coventry and Warwickshire Health Economy, Final Version 5th August 2010, Paul Devlin, Emergency Care Network Director, page 7

[46] Personal Contact with Paul Devlin, Emergency Care Network Director, Coventry and Warwickshire, 28th February 2011

[47] Emergency and Urgent Care Network Delivery Plan 2010-2013, Coventry and Warwickshire Health Economy, Final Version 5th August 2010, Paul Devlin, Emergency Care Network Director, pages 9-12

- **Urgent-Care Projects with Non-NHS Partners:**
  - *The Community First Responders (CFRs) scheme* - CFRs are lay people (unpaid) trained to provide immediate aid and life support prior to the arrival of the emergency Ambulance Service. (note – a similar scheme also exists in Northern Ireland called the First Responder Scheme. First Responders are volunteers who live or work within a community or village and have been trained to attend certain 999 calls in support of the Northern Ireland Ambulance Service (NIAS). Their purpose is to provide first aid including oxygen therapy and Cardiac defibrillation if required, until an ambulance arrives.[48]); and
  - *The "Message in a bottle" initiative* with the police service for members of the public that are most likely to use healthcare services. This project will make demographic and clinical information available within the home allowing rapid identification of a member of the public along with any relevant condition in a clinical emergency (note - A similar scheme was launched in Northern Ireland in 2007 with plans to distribute 80,000 bottles to older people to record personal and medical details to assist the emergency services. The scheme encourages older people to record their personal and medical details and next of kin in a special bottle and store them in their fridge. Those arriving to provide assistance will be alerted to the scheme by a special sticker on the front and fridge doors.[49])

[48] First Responder Scheme - http://www.niamb.co.uk/docs/our_services_first_response.html
[49] NI Message in a Bottle Scheme, http://www.nio.gov.uk/hanson-launches-scheme-to-help-older-people/media-detail.htm?newsID=14343