Report on Antrim Area Hospital and interface working

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Introduction

Over recent months, General Practitioners (GPs) within the Northern Health and Social Care Trust (NHSCT) area have expressed concerns regarding the admission of patients to Antrim Area Hospital (AAH) and the communication across the primary – secondary care interface. Poor performance, particularly regarding waiting times within the Accident and Emergency (A&E) department at AAH, reached a peak in January 2012.

This report presents the findings of my review, looking at the current system from the patient's perspective and identifies recommendations to improve this interface.

Terms of Reference

Work has been ongoing within the NHSCT and Northern Local Commissioning Group (LCG) to address these concerns, however it was considered that the situation would benefit from external review. Terms of Reference were developed to define the remit of the External Clinical Adviser's role and these are attached in full in Appendix 1.

Method

I was asked to undertake a short report. Evidence has been gathered through a series of meetings with individual and groups of Consultants, GPs, NHSCT senior management and written evidence provided both by NHSCT and the HSC. The weight and scale of soft evidence gathered means that while caution needs to be used and further work done, in some cases to verify what has been reported, it should not be ignored.

The Terms of Reference outlined that I would have 10 sessions to undertake the analysis of the situation and to deliver a report outlining the findings of the assignment and recommendations to improve the service. Therefore, given the tight timescale for completion of the assignment, it must be highlighted that this report cannot provide a fully comprehensive review of the system.

Background Information

NHSCT is one of six Trusts which were established on 1st April 2007 under the Review of Public Administration (RPA). It was established from the merger of three former trusts: Causeway, Homefirst and United.

NHSCT provides health and social care services to members of the public within the ten Local Government Districts (LGDs) of Antrim, Ballymena, Ballymoney, Carrickfergus, Coleraine, Cookstown, Larne, Magherafelt, Moyle and Newtownabbey. It is the largest geographical Trust out of the six Trusts within Northern Ireland. Figure 1 below illustrates the area that is covered within the NHSCT.

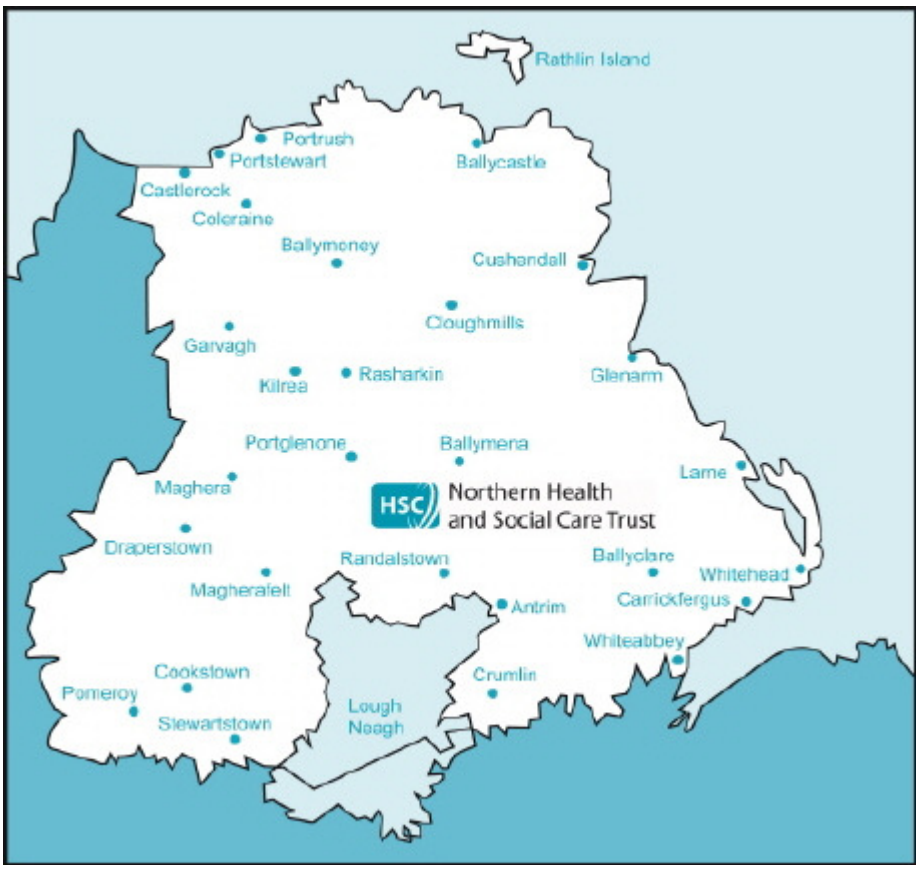


Figure 1: Map of NHSCT

The registered GP practice population of the NHSCT area is 448,026 people. The population of each LGD within the NHSCT area is illustrated in Table 1 below:

LGD	% of Total Population
Antrim	12%
Ballymena	16%
Ballymoney	6%
Carrickfergus	9%
Coleraine	14%
Cookstown	8%
Larne	6%
Magherafelt	9%
Moyle	5%
Newtownabbey	15%

Table 1: Population of Local Government Districts

NHSCT is coterminous with the Northern LCG, which is responsible for commissioning services to meet the needs of the local population. The composition of the population of the Northern LCG area, according to age category is depicted in Table 2 below:

Age	Number	% of Total Population
Under 16 years	90,325	20
16-64 years	289,148	65
Over 65 years	68,553	15
Total	**448,026**	**100**

Table 2: Population Composition in Northern LCG Area According to Age

NHSCT delivers its services from nine hospitals and a number of community settings within the area. Two hospitals provide acute and inpatient services at Antrim Area Hospital (AAH) and Causeway Hospital, Coleraine. Sub-acute services are provided at Mid-Ulster Hospital, Magherafelt and Whiteabbey Hospital. Both of these hospitals were previously acute hospitals, each with a 24-hour A&E department. However, in May 2010 the A&E departments at both hospitals were closed and since this time, only nurse-led minor injuries units operate from 9am to 5pm. Initially, this led to an increased demand for services at AAH A&E department, although this has since reduced. Appendix 2 provides detailed information on monthly figures for A&E attendances at AAH over the period since the closure of the A&E departments at Mid-Ulster and Whiteabbey Hospitals. Community hospital services are provided by NHSCT at Braid Valley Hospital, Ballymena; Dalriada Hospital, Ballycastle; Moyle Hospital, Larne; and Robinson Hospital, Ballymoney. A range of acute and inpatient mental health services are provided at Holywell Hospital, Antrim.

Focusing specifically on AAH, it is the largest hospital within the NHSCT and has 376 acute beds within the hospital, catering for admissions across the specialities of Medicine, General Surgery, Paediatrics, and Ante- and Post-Natal Care. This figure excludes those beds within the Intensive Care Unit, Special Care Baby Unit, Delivery Suites, Gynaecology, Dialysis Stations, Day Surgery and the Chemotherapy Unit.

General Medical Services are provided by GPs who are independently contracted to the Health and Social Care Board (HSCB). Within the NHSCT area, there are 78 GP practices.

Table 3 overleaf presents the number of patient attendances from September 2011 to February 2012 by category. Please note that the row labelled August 2011 refers to data relating to patients presenting on 31st August 2011, in the hours immediately before 1st September 2011.

Arrival Month	Adult Majors	Ambulatory	Minors	Paediatric Minors	Pre-Stream	Self-Care Advice	Triage & Resus	Not stated	Total
September 2011	2609	1	2489	4	32		831		5966
October 2011	2572	1	2421	8	31	2	909	1	5945
November 2011	2575		2155	3	18	2	866		5619
December 2011	2457		2048	6	25	2	1098		5636
January 2012	2518		1968	2	29		1004		5521
February 2012	2523	1	2050		45		1039		5658
Total	**15272**	**3**	**13137**	**23**	**180**	**6**	**5752**	**1**	**34374**

Table 3: AAH A&E Department Number of Attendances by Category

Table 4 overleaf presents the number of attendances by category and according to their arrival hour, from September 2011 to February 2012.

Arrival Hour	Adult Majors	Ambulatory	Minors	Paediatric Minors	Pre-Stream	Self-Care Advice	Triage & Resus	Not stated	Total
00	374		86	4	2		257		723
01	350		70		6		209		635
02	282		51	1	5	1	173		513
03	218		48		5		137		408
04	196		47	1	5		118		367
05	181		35	1	1		87		305
06	169		32	1			87		289
07	248		100		5		100		453
08	318		404	1	3		113		839
09	659		1085		3		161		1908
10	903	1	1164		6	1	210		2285
11	1085		1333	1	10		260		2689
12	1109		1136	2	10	1	247		2505
13	1016		1051		9		236		2312
14	1038		1084	1	6		257		2386
15	978	1	1023		9		272		2283
16	943		952		10		282		2187
17	895		840		9		314		2058
18	992	1	839	1	9	2	396		2240
19	873		749	1	8		417		2048
20	669		448	1	11		381		1510
21	681		278		16	1	389		1365
22	612		168	4	17		355	1	1157
23	483		114	3	15		294		909
Total	**15272**	**3**	**13137**	**23**	**180**	**6**	**5752**	**1**	**34374**

Table 4: AAH A&E Department Number of Attendances by Category, According to Hour (September 2011 to February 2012)

The target for patients to be treated within 4 hours of presenting at A&E is 95%. Table 5 overleaf illustrates the percentage of patients that were treated within this target time from September 2011 to January 2012.

Month	Attendances	% Within 4-hours
September 2011	5966	73
October 2011	5945	69
November 2011	5619	71
December 2011	5636	69
January 2012	5521	63
February 2012	5658	58

Table 5: Percentage of Patients in AAH A&E Treated within 4-hour target

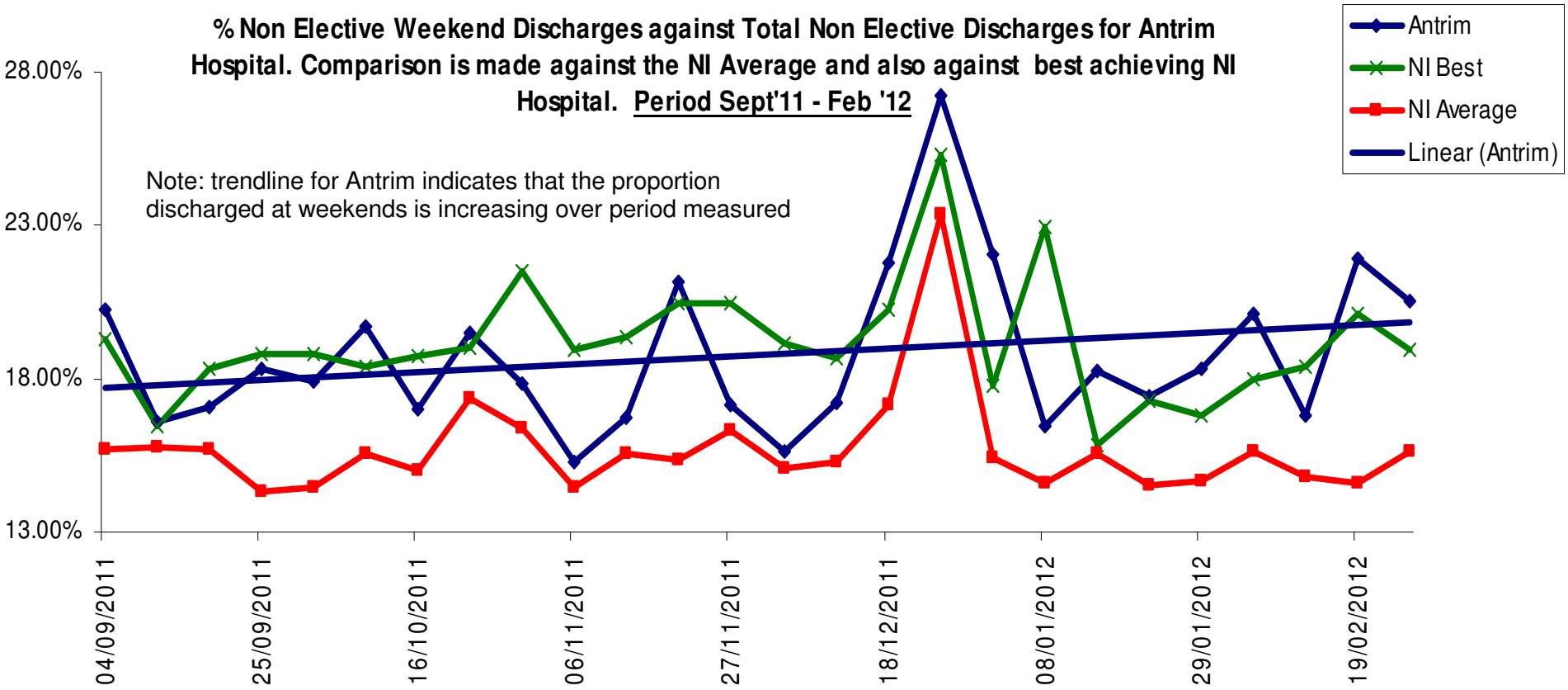
A second target regarding waiting times states that from April 2011 no patient should wait longer than 12 hours to be treated in A&E. Table 6 below depicts the number of breaches of this target within the A&E department at AAH, from September 2011 to February 2012.

Month	Attendances	Number of 12-hour Beaches
September 2011	5966	97
October 2011	5945	252
November 2011	5619	164
December 2011	5636	394
January 2012	5521	446
February 2012	5658	181

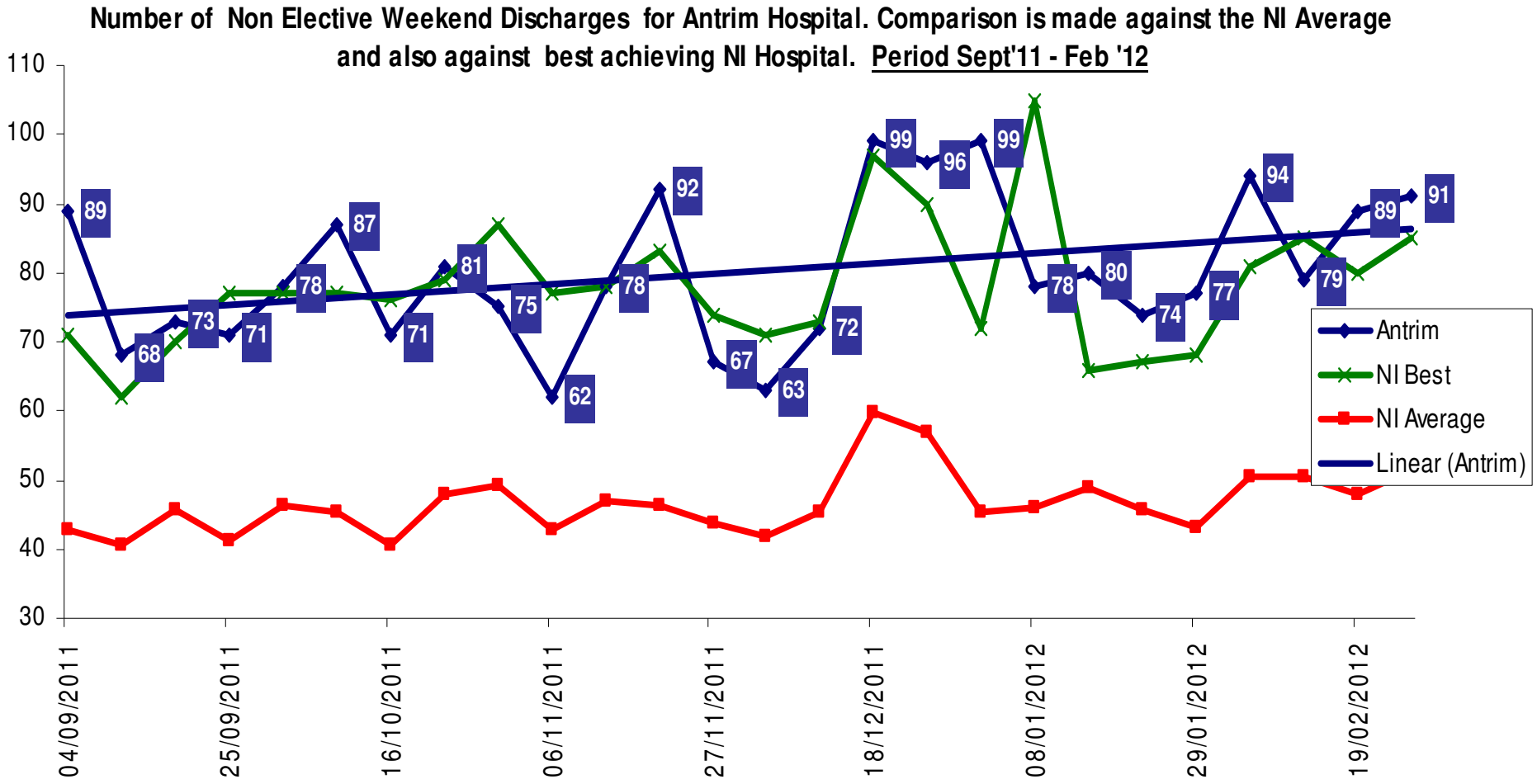
Table 6: Number of 12-hour Breaches at AAH A&E

Patient discharges from hospital wards will have a knock-on effect on the number of patients that can be admitted from the A&E department into a hospital ward, and thereby impacting upon patient flow through the hospital system. This can be a particular problem at weekends. Graphs 1 and 2 overleaf illustrate the percentage and number of non-elective patients discharged at weekends. The detailed statistical information utilised in the development of these graphs is attached in Appendix 3. These graphs indicate that the number of discharges at weekends within AAH is increasing gradually.

Graph 1


% Non Elective Weekend Discharges against Total Non Elective Discharges for Antrim Hospital. Comparison is made against the NI Average and also against best achieving NI Hospital. Period Sept'11 - Feb '12
Note: trendline for Antrim indicates that the proportion discharged at weekends is increasing over period measured
Antrim
NI Best
NI Average
Linear (Antrim)
28.00%
23.00%
18.00%
13.00%
04/09/2011
25/09/2011
16/10/2011
06/11/2011
27/11/2011
18/12/2011
08/01/2012
29/01/2012
19/02/2012

Graph 2


Number of Non Elective Weekend Discharges for Antrim Hospital. Comparison is made against the NI Average and also against best achieving NI Hospital. Period Sept'11 - Feb '12
110
100
90
80
70
60
50
40
30
89
68
73
71
78
87
71
81
75
62
78
92
67
63
72
99
96
99
78
80
74
77
94
79
89
91
04/09/2011
25/09/2011
16/10/2011
06/11/2011
27/11/2011
18/12/2011
08/01/2012
29/01/2012
19/02/2012
Antrim
NI Best
NI Average
Linear (Antrim)

The waiting time for elective care is also a matter for consideration. The data on elective care, outpatient appointment and diagnostics waiting times is presented here in Table 7 below:

Target	September 2011	October 2011	November 2011	December 2011	January 2012
In-patient / Daycase: % >13 weeks	36%	32%	29%	30%	27%
In-patient / Daycase: Number >13 weeks	2,602	2,266	1,901	1,971	1735
In-patient / Daycase: Number >36 weeks	205	209	211	248	222
Outpatients Appointments: >9weeks	13,612	13,757	13,635	14,428	10,861
Outpatients Appointments: >21weeks	6,063	6,310	6,443	6,946	4,538
Diagnostics >9weeks	159	171	174	151	101

Table 7: Data on Elective Care Waiting Times

Overall, the Trust's performance on elective care access is comparable with other Trusts in N Ireland.
In regard to intermediate care/step-down beds, evidence indicates that there are a total of 257 within the NHSCT. The average length of stay for intermediate care beds was determined as follows:

Facility	Average Length of Stay
Step-Up/Step-Down Beds	32 days
Assessment Beds	33 days
Robinson Hospital	30 days
Dalriada Hospital	27 days
Inver Unit, Moyle Hospital	23 days
Overall Average Length of Stay for Intermediate Beds	**29 days**

Table 8: Average Length of Stay Intermediate Care Beds

All of the information presented above is useful in providing an initial indication of the recent situation at AAH. As noted previously, I spent time observing the situation at AAH site, undertaking individual and group discussions with NHSCT clinicians and managers, and holding individual and group meetings with local GPs. NHSCT also provided a written submission to this review

process (Appendix 4). The findings from these observations and discussions will now be presented according to particular themes which have been identified.

Findings

Safety of the Current System

Significant concern was raised by the individual and groups of GPs that I met regarding the whole approach to Urgent Care in AAH. Indeed they agreed and concurred with their Consultant Colleagues that the system has the potential to be unsafe, particularly at busy times. These issues have been recognised for some considerable time. In January 2012, the Trust sought support from the UK College of Emergency Medicine. The College will support the Trust by conducting a peer preview report on the Emergency Department. The Terms of Reference and a programme plan for this Emergency Department Quality Improvement Plan (EDQIP) are enclosed in Appendices 5a and 5b respectively. Recently, the Tribal Report (Appendix 6) identified a range of problems and solutions to the issues. The Trust has agreed the recommendations of the report, and work has been undertaken since that Report to improve the situation with a number of work streams. However, there is frustration at the pace of change. The GPs feel that they have nowhere to go to improve the situation, which they believe is often below standard for their patients. This matter must be addressed.

Recommendation: Direct access for GP admissions. The Trust has committed to taking this forward, and it is important that there is urgency with this. When beds are not available the decision should be given to the GP as to whether A&E admission is now more appropriate or if the patient can wait at home for a bed to become available.

Recommendation: The completion of the Trust-initiated Peer Review Report on the Emergency Department by the College of Emergency Medicine should be progressed and the identified recommendations implemented in a timely fashion, in order to deliver necessary service improvements.

The current situation at AAH A&E department is not acceptable. As noted above, the situation reached a peak in January 2012, and the issues which contributed to this crisis are explored in more detail throughout the remainder of this report, with recommendations to address the problems identified. Although there is clear evidence that the Board regularly discusses unscheduled care performance, I believe that the NHCST Board should be provided with a monthly update on the performance of the A&E department and urgent care. Through the implementation of mechanisms to address these issues, in a planned and managed way, NHSCT has the opportunity to significantly improve the situation and the performance of the A&E department.

Recommendation: The NHSCT Board should be provided with a specific board paper every month on urgent care and the performance of A&E.

I have been given many detailed patient journey stories which lead me to believe that these concerns are real and significant. There are some notable exceptions e.g. the recent introduction of the Early Pregnancy Unit, which all regard as a success and the rapid reporting of urgent X-rays, which has a 99% success rate for completion within 2 days. Indeed there are several other projects e.g. direct access diagnostics, which are on the cusp of being started. This then is not a position were nothing has been done; rather the problem is delay in implementation and approach to implementation.

NHSCT should endeavour to rapidly progress the necessary actions which are required to ensure the clinical safety of the current system. The Trust should develop a set of key performance indicators in agreement with the HSCB which will aid this process. To deliver against these indicators will require a high degree of senior and professional input, but I believe that there is potential for NHSCT to significantly improve this situation.

Recommendation: NHSCT should agree key performance indicators with the HSCB. These indicators should show measurable improvements within a 3 month period. With the work which the Trust has already undertaken and has agreed to undertake with the help of a committed group of clinical staff from both primary and secondary care, I believe that NHSCT has the capability to show significant improvement.

Access to Treatment

One of the key issues repeatedly raised was the policy for all urgent care patients to be seen in the A&E department, as it is the only point of entry into the hospital. There are no direct admissions, no co-located GP out-of-hours unit, and long waits for urgent elective care e.g. rapid access chest pain clinic. All of these factors result in increasing the volume of patients going through a unit which is understaffed and under huge strain, despite the best endeavours of a very dedicated team of Doctors and Nurses. This is compounded by the physical design and layout of the facility which has grown and extended into the hospital over time and ironically, by the introduction of the limited Ambulatory Care Pathways which are staffed by the Emergency Care staff. Delays in discharging patients serves to compound the pressure in the A&E unit, as beds often cannot be found to move patients.

The early development of a medical assessment unit, surgical assessment unit and paediatric assessment unit are in development by the Trust. They will allow for assessment within appropriate units and will divert some patients away from the main A&E department, thereby aiding patient flow.

It was noted that an example of good practice within NHSCT surrounds access for patients undergoing chemotherapy treatment who can be directly admitted to a ward within AAH if required. Another good example which was highlighted above is the Early Pregnancy Unit which has recently been

introduced at AAH. Learning from the implementation of the Early Pregnancy Unit should be disseminated to other clinical areas and utilised as an example of successful implementation to facilitate progress in extending such pathways. All of the GPs consulted with during this assignment echoed the call for NHSCT to extend direct access for GPs to refer patients to a medical assessment unit or even for direct admissions to an appropriate ward in AAH, dependent on patients' particular illnesses.

19 Ambulatory Care Pathways were developed by local GPs and NHSCT staff. On formal review in the governance committee, these were not viewed as fit for purpose. It would be beneficial to select a small number of pathways which could initially be implemented successfully to deliver care in a different setting within the hospital or else in the community.

Recommendation: Careful introduction of a small number of Ambulatory Care Pathways. Too many were developed to be practical to implement. The setting of these pathways should be carefully examined as often the care can be safely delivered away from the A&E in the community or a different part of the hospital. Lessons learned from the introduction of the Early Pregnancy Unit and elsewhere in the UK should be used in this work.

Concern was expressed regarding the triage of patients presenting at the A&E department. A related issue which has been highlighted is that patients are queuing to get into the immediate care resuscitation unit. If patients are queuing to get into the unit, the unit cannot possibly be delivering immediate care.

Recommendation: The implementation of the Manchester Triage system in A&E is a matter for immediate attention to ensure patient safety. Following triage, patients should be reviewed and monitored to ensure that no patients fall through this safety net. Care following triage should also include a more holistic approach to ensure that fundamental human needs are delivered while patients are waiting.

The length of time that patients are required to wait to access treatment was highlighted by both local GPs and hospital clinicians. Reported Patient Experience outlines the length of time that one patient with acute chest pain waited to receive treatment in the A&E department of AAH. In addition to this matter, I have been informed and have also witnessed during my visit to the A&E department, that there is not sufficient space to accommodate the number of patients that are presenting at the A&E department. Resultantly, many patients are waiting and also been treated in inappropriate settings. Patient Experience stories related to me highlighted the intertwined issues of communication, waiting times and patient surroundings in A&E.

I believe that expansion of the internal facilities at AAH A&E department is also required, and I am aware that a new department is scheduled to complete by Summer 2013.

A further issue highlighted was that during an admission the patient is often moved from ward to ward on several occasions. This fragmented approach not only leads to a poor patient experience but can cause delays in treatment and is inevitably an inefficient system. Both clinicians and managers must take on responsibility to deliver a more patient-focused journey through the hospital system.

It was also highlighted to me that although integrated health and social care exists within the NHSCT structure, there is actually a lack of integrated working in practice between hospital clinicians, primary care clinicians, district nursing, allied health professionals and social care workers. It was expressed that it appears these teams work in silos and therefore this can lead to duplication of work and delays in patients being seen by a particular healthcare professional or being discharged from hospital. If these units worked more cohesively together this would provide a more satisfactory patient experience and would deliver a more efficient health and social care system. I believe that it is critical that a senior executive takes on responsibility for ensuring that these professionals become truly integrated in their working and thereby aiding patient flow through the entire health and social care system.

Recommendation: The management arrangements for Urgent Care should be reviewed and potentially changed. The Trust operates within The Northern Ireland system and is therefore in a situation of having responsibility for care in the hospital, social care and community care. These different parts of the care system appear to operate as separate units within the Trust causing delays and duplication. A Senior Executive responsible for the whole patient journey should be able to improve the flow of patients through the system.

There is limited joint working between A&E clinicians and colleagues in other specialities within the hospital. Similarly, there is limited opportunity for communication between primary care clinicians and secondary care clinicians. This lack of integration results in repeat admissions of patients presenting with common problems such as abdominal pain and retention of urine. A more integrated way of working between A&E and specialist clinicians would significantly reduce these repeat attendances at A&E, thereby aiding patient flow through the system.

Recommendation: Closer working of the A&E team with other specialist teams in the hospital and with Primary Care needs to be fostered to reduce unnecessary repeat admission for common problems such as abdominal pain, retention of urine and the placing of patients directly onto elective waiting lists.

Another issue surrounding access to treatment refers to the waiting times for standard referrals requesting a Consultant opinion and diagnostic testing. I was informed that due to the delay in patients been seen via this channel, some GPs feel that they are left with no option but to send the patient to the

A&E department for treatment. Comment is made above on the positive work done in introducing additional direct access diagnostics. It was pointed out that these patients need to undergo diagnostic testing and as such will be referred into the system anyway, but that it would be much more beneficial to all concerned if direct GP access to diagnostics was available.

A related issue surrounding access to diagnostics that I have been informed of relates to in-patient access to diagnostics. It was suggested that if a patient presents at A&E and is admitted to a ward, some clinicians will keep that patient in hospital until they can undergo diagnostic testing, rather than discharge the patient, as they are aware that the patient may face a delay for a diagnostic test. This blockage ultimately has consequences for patient flow through the entire hospital system. If there was more direct GP access to diagnostics, this would negate the necessity for clinicians to keep patients in hospital wards unnecessarily and would aid patient flow through the system.

Recommendation: Long waits for elective care are compounded by the lack of direct access diagnostics. These patients are having an unnecessary outpatient appointment.

During this assignment, it was highlighted to me that there are also issues surrounding patient discharge at AAH. I have been informed by GPs and hospital clinicians that there can be lengthy delays in discharging patients that have been assessed and are medically fit to go home. Some of the reasons that have been cited for these delays are waiting for Pharmacy to dispense patient medication, for transport to be arranged to take the patient home, or waiting for a care package to be developed in the community. The fact that these patients remain within the hospital system creates an additional blockage in an already under-pressure system. I was informed that in some cases it can take up to 3 weeks for a community care package to be established. I believe that these delays must be eradicated or significantly reduced in order to improve patient flow through the system. I note that the performance of the Trust against regional discharge standards is good but none the less the discharge team could do much better if given greater support.

Recommendation: The discharge team in the hospital should be given more power to demand more rapid response times from pharmacy, transport and social care, all of which are cited as reasons for delayed discharge.

An inter-related issue pertains to patient discharge from the hospital into the community, particularly into nursing homes, which has also been highlighted during this assignment. These patients typically have the most complex medical needs, often suffering from multiple long-term conditions. International research indicates that 5% of the population spends 50% of the healthcare budget[1] and that the majority of this 5% comprises of elderly patients and those with long-term conditions. These patients often experience

[1] Research In Action, Issue 19, 2006

repeated admissions to hospital which can be very distressing for them and also places an enormous burden upon the health system. Multi-disciplinary management of these patients should be undertaken in a planned manner, with input from all of the appropriate healthcare professionals. If this is undertaken it could significantly reduce the number of these patients presenting on a recurrent basis at A&E.

Recommendation: Work needs to be done across primary and secondary care to identify those patients with multiple complex needs, with several long-term conditions, who are often vulnerable due to cognitive impairment. These are the patients with repeated admissions and where personal care plans and a specialist team working from a multidisciplinary team in the community can dramatically improve care and reduce admissions. One area to start with would be nursing home patients but this should then be extended.

A further issue which has been highlighted regarding access to treatment relates specifically to those patients requiring treatment which cannot be provided at AAH. This is particularly an issue for Orthopaedic patients, for example those patients who suffer a fractured neck of femur. Under the current arrangements, a patient with this fracture and living in the NHSCT area will be taken by ambulance to AAH, despite the fact that it does not have an Orthopaedics service. The patient will be required to wait to be seen at AAH A&E department and then will be transferred to the Belfast HSC Trust to undergo surgery. Having to go through each of these transfer points creates delays in the patient receiving the required treatment. This delay is unacceptable, may lead to poorer patient outcomes and is a wholly inefficient system. I believe that urgent commissioning action is required to address this situation.

Recommendation: Care for all cases when AAH is unable to provide the definitive hospital care should be reviewed by the HSCB and urgent commissioning action taken to improve the situation. This is a particular problem with Orthopaedics when a patient presenting with a fractured neck of Femur is first sent to Antrim which has no Orthopaedics service. The patient waits for an ambulance, waits in Antrim to be seen, waits to be transferred, waits to be seen in Belfast, and waits for surgery in Belfast. All this leads to unacceptable delays, resulting in the real risk of poor outcomes for patients.

Communication

Both primary and secondary care clinicians feel that, with some notable individual exceptions, the opportunities for communicating and learning in a systematic way have been eroded over the years. Both groups would welcome initiatives to improve this situation. While the recent HSC report on A&E usage dispelled some recent impressions, there is a sense that more could be done to reduce clinical variation across the interface. Work in other areas has shown the potential to improve Health and Healthcare e.g. Bolton. The use of clinical dashboards based on practice population demographics

has reduced Myocardial Infarction (MI) and ischaemic heart disease deaths significantly faster than the national average in Bolton. In Oldham this work has led to improved pathways of care for patients into secondary care. Whilst this is a longer term project, the potential is great and should be explored.

Recommendation: The development of clinical dashboards in primary care within a learning environment can improve care, improve health and reduce clinical variation and should be explored.

It has been noted that over recent years, the working relationship between hospital clinicians and GPs has changed and that now many GPs do not know the clinicians in their local hospital and their particular sub-specialties. This issue not only makes it difficult for clinicians and GPs to build up a communicative working relationship, but it has also been noted by hospital clinicians that resultantly the GPs make a generic patient referral when seeking a specialist opinion. It would be necessary to identify a mechanism for streamlining communication between GPs and hospital clinicians.

It was highlighted during this assignment that clinicians in AAH are working very hard within a busy environment. Often they simply do not have the time to communicate and engage effectively with their GP colleagues. The development of a safe email system for communication across the primary-secondary care interface was highlighted as a potential mechanism to assist with this problem and should be given due consideration.

It was proposed that electronic discharge summaries should be developed, which would potentially reduce a clinician's number of discharge letters by 40-50 per week and would have the additional benefits of ensuring that the GP would receive critical information within 24-hours of a patient's discharge. It would also ensure that GPs receive patient discharge information in a standard format. I have been informed that on some occasions GPs receive a hand-written version, whilst on other occasions they receive typed versions which are then written over by the Pharmacy department.

It was also expressed to me that GPs can experience great difficulty in obtaining useful information when a patient has been discharged from the A&E department at AAH, as often the discharge letter does not provide sufficient information to indicate how the GP should progress treating the patient. The GP is unable to code the information provided and as such, is required to start again at the very beginning to assess the patient and progress treatment.

I was informed that the quality of the initial discharge letter received depends greatly upon the F1 or F2 doctor completing it. It is unacceptable that discharge letters are not checked for quality and accuracy by a senior clinician. Immediate action should be taken to resolve this issue.

The length of time for discharge letters to be forwarded to GPs was also highlighted as an issue. GPs expressed that it was rare to receive a patient's discharge letter within two weeks and that it can in fact often take approximately 6 months.

Recommendations:

Evidence from GPs and Consultants of waits of over 6 months for routine letters and only 50% of casualty letters being checked for accuracy are poor and unacceptable. Immediate action should be taken to resolve this problem. The opportunities for errors due to this situation can only lead to putting patients at risk. The Trust has informed me that action is being put in place to resolve this situation.

Sharing of knowledge and development of working relationships between GPs and secondary care clinicians should be facilitated further and the work of the GP Forum to be fully supported.

A mechanism for streamlining communication across the primary-secondary care interface should be developed, with a safe email system for correspondence considered as one potential mechanism.

Intermediate Care / Step-Down Beds

The number of intermediate care beds within the NHSCT area has been brought to my attention. During my discussions and collection of data within this process, it even appeared to be difficult to reach agreement on the precise definition of intermediate care/step-down beds and the total number that are available within the NHSCT. Evidence suggests that there are a total of 257 intermediate care/step-down beds and the average length of stay was indicated in Table 8 above. The Trust accepted the Tribal recommendation to review total beds, and this is underway.

I would suggest a review of the number of intermediate care/step-down beds and identification of the most appropriate care packages for patients within these step-down care settings. Where it is appropriate, care packages should be delivered within a patient's own home. I believe that it would be necessary to establish a baseline of the performance of the step-down facilities as an initial starting point for this review.

Recommendation: There should be a review of the large number of intermediate and step-down beds, with a clear vision of the best solutions for care for these types of patients. Buildings should not be the holy grail; it should be the quality of outcomes and care. Much of the evidence worldwide would support home community packages of health and social care as more appropriate and better value for money. This is not to say that many of these beds do not have a useful function. Improved monitoring and assessment of the performance of this large resource as a baseline would be the first step.

Complaints & Critical Incident Systems

I was informed that some complaints and critical incidents which are forwarded by GPs to NHSCT appear to enter the system but that the GP never receives any follow up as to the outcome of the complaint and the learning which has occurred from it. Similarly, the Trust noted that the primary care critical incident system is not fed back to the Trust for relevant incidents. This is concerning to GPs in the area who feel that perhaps individual patient experiences are not being given the appropriate consideration to prevent a recurrence of a similar situation and to improve the wider health and social care system within the Trust. I believe that through a shared culture of learning there is the potential for NHSCT and local GPs to see how the system is learning and improving from individual patients' experiences of the service that they have received.

Recommendation: The Complaints and Critical Incident Systems need to be reviewed so that the whole system across primary and secondary care learns from the problems encountered by individual patients. This needs to take place within a learning culture where those working in the system can see clearly how the system is learning and improving. Examples of excellent practice exist elsewhere.

Recommendations

The recommendations which have been presented throughout this report have resulted from my discussions with a range of hospital clinicians, Trust management and local GPs. I believe that with the implementation of these recommendations NHSCT has the potential to address the current system failures and to progress to deliver the very highest standard of patient care. Below, I have ranked the recommendations in their most critical order of priority.

1. The implementation of the Manchester Triage system in A&E is a matter for immediate attention to ensure patient safety. Following triage, patients should be reviewed and monitored to ensure that no patients fall through this safety net. Care following triage should also include a more holistic approach to ensure that fundamental human needs are delivered while patients are waiting.

2. The management arrangements for Urgent Care should be reviewed and potentially changed. The Trust within the Northern Ireland system is in a unique situation in having responsibility for care in the hospital, social care and community care. These different parts of the care system appear to operate as separate units causing delays and duplication. A Senior Executive responsible for the whole patient journey should be able to improve the flow of patients through the system.

3. The completion of the Peer Review Report on the Emergency Department by the Royal College of Emergency Medicine should be

progressed and the identified recommendations implemented in a timely fashion, in order to deliver necessary service improvements.

4. The NHSCT Board should see be provided with a specific board paper every month on urgent care and the performance of A&E.

5. NHSCT and primary care colleagues should agree key performance indicators with the HSCB. These indicators should show measurable improvements within a 3 month period. With the work which the hospital has already undertaken and has agreed to undertake with the help of a committed group of clinical staff from both primary and secondary care, I believe that NHSCT has the capability to show significant improvement.

6. Direct access for GP admissions through the junior members of the specialist teams. When beds are not available the decision should be given to the GP as to whether A&E admission is now more appropriate or if the patient can wait at home for a bed to become available.

7. Long waits for elective care are compounded by the lack of direct access diagnostics. Urgent direct access should be established. These patients are having an unnecessary outpatient attendance.

8. Communication. Evidence from GP's and Consultants of waits of over 6 months for routine letters and only 50% of casualty letters being checked for accuracy are poor and is unacceptable. Immediate action should be taken to resolve this problem. The opportunities for errors due to this situation can only lead to putting patients at risk. The Trust has informed me that action is being put in place to resolve this situation.

   Sharing of knowledge and development of working relationships between GPs and secondary care clinicians should be facilitated further and the work of the GP Forum to be fully supported.

   A mechanism for streamlining communication across the primary-secondary care interface should be developed, with a safe email system for correspondence considered as one potential mechanism.

9. The discharge team in the hospital should be given more power to demand more rapid response times from pharmacy, transport and social care, all of which are cited as reasons for delayed discharge.

10. Careful introduction of a small number of Ambulatory Care Pathways. Too many were developed to be practical to implement. The setting of these pathways should be carefully examined as often the care can be safely delivered away from the A&E in the community or a different part of the hospital. Lessons learned from the introduction of the Early Pregnancy Unit and elsewhere in the UK should be used in this work.

11. Closer working of the A&E team with other specialist teams in the hospital needs to be fostered to reduce unnecessary repeat admission for common problems such as abdominal pain, retention of urine and the placing of patients directly onto elective waiting lists.

12. Care for all cases when AAH is unable to provide the definitive hospital care should be reviewed by the HSCB and urgent commissioning action taken to improve the situation. This is a particular problem with Orthopaedics when a patient presenting with a fractured neck of Femur is first sent to Antrim which has no Orthopaedics service. The patient waits for an ambulance, waits in Antrim to be seen, waits to be transferred, waits to be seen in Belfast, and waits for surgery in Belfast. All this leads to unacceptable delays, resulting in the real risk of poor outcomes for patients.

13. Work needs to be done across primary and secondary care to identify those patients with multiple complex needs, with several long-term conditions, who are often vulnerable due to cognitive impairment. These are the patients with repeated admissions and where personal care plans and specialist team working from a multidisciplinary team in the community can dramatically improve care and reduce admission. One area to start with would be nursing home patients but this should then be extended.

14. The Complaints and Critical Incident Systems need to be reviewed so that the whole system across primary and secondary care learns from the problems encountered by individual patients. This needs to take place within a learning culture where those working in the system can see clearly how the system is learning and improving. Examples of excellent practice exist elsewhere.

15. There should be a review of the large number of intermediate and step-down beds with a clear vision of the best solutions for care for these types of patients. Buildings should not be the holy grail; it should be the quality of outcomes and care. Much of the evidence worldwide would support home community packages of health and social care as more appropriate and better value for money. This is not to say that many of these beds do not have a useful function. Improved Monitoring and assessment of the performance of this large resource as a baseline would be the first step.

16. The development of clinical dashboards in primary care within a learning environment can improve care, improve health and reduce clinical variation and should be explored.

Conclusion

The issues which have been identified led to the performance figures for the A&E department which were presented above. More crucially, they have led to patient care which lacks dignity and which fails to meet fundamental human needs. Patients have had to endure lengthy delays in receiving treatment, waiting on trolleys in corridors and inappropriate holding facilities. These issues are unacceptable and have the potential to result in patient harm. I have noted within this report that there is a team of highly dedicated Doctors and Nurses endeavouring to deliver a high level of patient care within an extremely difficult situation.

Following the Peer Review Report by the College of Emergency Medicine and the need for improved performance in clearly identified areas of work, within an agreed timetable for implementation, the Trust is clearly demonstrating that it is undergoing major change in the unit to improve performance and care. However, the College report focuses only on the Emergency Unit. Reducing the volume of throughput through the unit will not only improve the experience for those patients who need to be there, but will avoid unnecessary delay and duplication for many patients who's needs would be better served elsewhere in the system. Redesigning the system as a whole, together with the implementation of the College recommendations within the unit, I believe is possible within a short timetable. Indeed there is a profound recognition within all who work in the system – Senior Management, Consultants, GP's Nurses and Patients – that the system needs fixing urgently and real changes need to be put in place. This willingness needs to be harnessed within a clear vision and purpose in line with the Review HSCNI. This area has the potential to be an early implementor site of that Review, with real improvements for health and health care for the population it serves.

Appendix 1

TERMS OF REFERENCE

EXTERNAL CLINICAL ADVISER NORTHERN HSC TRUST

1. **Meet with local GPs (including GP Clinical Leads, LCG GPs) to discuss:**

    - Clinical relationship in relation to Antrim Area Hospital
    - Their views on how relationships and communication channels with the Trust regarding clinical quality and outcomes are working and their suggestions to improve communications
    - Their proposals to improve patient flow and quality of care

2. **Meet with Northern Trust's Clinical Leadership in Antrim Area Hospital to review:**

    - Clinical communication and collaboration across primary/secondary care interface,
    - How a shared culture of continuous improvement of patient safety, quality of care and patient experience is promoted, both within the Trust and across primary/secondary care interface
    - How clinical safety and quality improvement is supported and measured, both from within the Trust and across the primary/secondary care interface; and how any concerns are addressed
    - How the Trust secures feedback from patients

3. **Produce report with recommendations**

Timescale:
Commence February 2012 subject to DHSSPS approval of Single Tender Action.
Dates to be confirmed. 10 sessions – over 2 week period