Southern Health and Social Care Trust

Quality Care - for you, with you

DAISY HILL HOSPITAL
Pathfinder Group

Personal and Public Involvement (PPI) Involving you, improving care

Final Report

Daisy Hill Hospital

Pathfinder Project

Development of an Unscheduled Care Model through a Co-Production Approach

20th December 2017

Contents

FOREWORD AND EXECUTIVE SUMMARY

The Daisy Hill Hospital (DHH) Pathfinder Project was set up in response to an inability, despite numerous attempts, to recruit senior medical staff to work in the Emergency Department (ED). Following a regional summit meeting, involving the Department of Health (DoH) Permanent Secretary and senior officers from Trusts, the HSC Board and Public Health Agency (PHA), a short-term regional arrangement was made to ensure adequate locum consultant cover. Although welcomed, it was acknowledged that a sustainable long-term solution was required.

It was agreed that a Pathfinder group would be brought together to assess the unscheduled care needs of the Newry and Mourne population and to bring forward recommendations on the best way to meet those needs in the future.

A comprehensive needs assessment process, which included clinically-led audits of patient care, concluded that the continued presence of a 24/7 Level 1 ED on-site was justified and in keeping with the Southern Trust's position. However it also demonstrated that the models of care provided both in and out of hospital have to adapt and change if they are to deliver a long-term sustainable service to the local population.

The Emergency Department is often called the front door of the hospital. The quality and timeliness of the care provided in ED relies heavily on many other parts of the HSC system, including General Practice and community care services as well as other hospital departments, including laboratories, radiology and inpatient specialities. **A robust primary care service both in and out of hours is essential, otherwise the numbers of attendances at ED will continue to rise at a rate which is out of keeping with population demographic change.**

There is policy advice, both regionally and nationally, that alternative pathways to ED should be in place to assess stable patients who are thought by their GPs to need urgent investigation or admission. This differs from the older model, which was not sustainable, of direct GP admission to a bed. NHS Improvement guidance states that with rapid access to senior medical assessment and diagnostics up to one third of patients currently admitted to medical beds could avoid that admission. These

assessment services, located close to but not within ED, allow patients to avoid ED then releasing valuable ED capacity to better serve their own core patient group. **Our report recommends establishment of a direct assessment unit, staffed jointly by medical, care of the elderly and ED staff, in close proximity to ED, which will provide telephone advice to GPs, ambulatory assessment and diagnostics.** This will link closely with the new Acute Care at Home service for elderly patients which has proven to be a success in another part of the Trust area.

Inpatient hospital care when we are acutely ill saves lives, and for that reason it is hard to believe that remaining as an inpatient when that acute care is no longer needed can be harmful, particularly for elderly people. Even in healthy older adults 10 days of bed rest results in substantial loss of lower limb strength and aerobic capacity. This rapid decline in function in older patients can result in a higher likelihood of needing long-term placement in nursing home care. **It is vitally important, but will take time, to embed a culture change that accepts that a long stay in hospital is not the safest place to be, especially for those who are elderly and at risk of confusion, falls and infection. This culture change is required among patients, carers and just as importantly among hospital staff.**

Work done as part of the DHH Pathfinder project has shown that in DHH, as in other hospitals in NI, a substantial number of patients do not have a medical need to be in hospital. It is very important that this model of care does not continue. Historically, community packages of care were not able to start at weekends, resulting in a backlog of patients on Mondays needing assessment and placement. In future a 7 day response from community services is needed.

During the project much time was spent considering workforce issues. Substantial amounts of money are being spent in the HSC on short-term temporary staff. Although the medical staff shortage was first highlighted in DHH ED, there are also shortages of suitably qualified applicants in nursing, radiography and community teams. Implementing new models of care across the HSC requires a regional approach to workforce planning if it is to succeed. There have already been examples of good progress, such as strengthening the ED medical training

programme and in developing new roles, such as Advanced Nurse Practitioners (ANPs), but there is much still to do.

I have deliberately left my comments on DHH ED to the end. That is to reinforce the point that sustaining a robust ED service is interdependent on the quality of the services which surround it. A survey of ED doctors in NI who are training to become consultants demonstrated that it is those factors that most influence their decisions on job applications. They wish to work on reasonable rotas and in hospitals that have appropriate supporting infrastructure. Our recommendations do include an increase in ED medical and nursing staff, and there may well be challenges ahead in filling those posts despite the welcome increase in potential consultants finishing their training in the next 3 years. Developing a tier of non-consultant doctors, supported by ANPs and other professions is important and will take time and effort, but a sustainable ED workforce model also needs the earlier recommendations to be implemented.

In summary, this report is not just about an ED that was facing problems. It is about the need for transformation of the model of acute care for the population served by DHH. Although a robust staffing structure in the ED is part of that, it is equally important that the DHH of the future should be able to deliver high quality assessment, diagnostic testing and treatment in other areas to avoid unnecessary admissions and shorten unnecessary inpatient stays. The emphasis must be that where at all possible, patients who do not need to be admitted, or to stay in hospital, should have their assessments done in an outpatient or ambulatory setting. The report recommendations are therefore in keeping with those set out in *Systems not Structures* and *Delivering Together*.

Finally, I would like to thank the Southern Trust Senior Management team and members of the Pathfinder Group and its workstreams. Particular thanks are due to the members of the community both those who provided their views during the stage before the formal representatives were nominated to workstreams, as well as those who attended our meetings. I have also had the support of an excellent project manager, Ms Charlene Stoops, and project team comprising Dr Diane Corrigan, Dr Brid Farrell and Dr Rachel Doherty.

The energy and commitment of a wide range of people both regionally and locally have contributed to this proposed new model of care for the Newry and Mourne population and are looking forward to its implementation.

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Dr Anne Marie Telford

Project Director

1.0 INTRODUCTION

1.1 Background

1.1.1 On 16th June 2017 the Department of Health (DOH) issued a Project Initiation Document (PID) (**Appendix 1**) providing guidance to the Southern Trust on establishing a clinically led, managerially supported Pathfinder Project to "develop an operational model for a long term ED service for the Newry and Mourne area with identification of regional learning". The PID was endorsed by the Board of the Southern Trust on 27th June 2017.

1.1.2 A Daisy Hill Hospital (DHH) Pathfinder Group was then established to develop an **exemplar Model** to meet the unscheduled care needs of the Newry and Mourne population, fully aligned with the principles and recommendations within 'Systems not Structures' and 'Delivering Together'.

The main focus has been:

- To develop a long term plan to **stabilise** the Emergency Department (ED); and
- To identify additional measures across primary, community and hospital services to deliver a **sustainable** service.

1.2 The Approach

1.2.1 The DHH Pathfinder Group adopted a co-production and co-design approach from the outset. It established 'Task and Finish' Groups to take account of co-production and stakeholder involvement in undertaking a population health needs assessment, in developing proposals and in preparing a high level implementation and investment plan.

1.2.2 The development of the model was informed by local and regional data, clinical audits, regional and national policy and guidelines and a number of literature reviews.

1.2.3 The project has drawn on a wide range of knowledge, skills and experience. Professional advice was provided by clinicians working in DHH and across

the Southern Trust, General Practitioners, the Public Health Agency (PHA), the Health & Social Care Board (HSCB), the Royal College of Emergency Medicine (RCEM), Northern Ireland Medical & Dental Training Agency (NIMDTA), Critical Care Network (CCaNNI) and Northern Ireland Ambulance Service (NIAS). Significant contributions were also made by community and staff representatives, HSC staff working locally and regionally and people living in the DHH catchment area.

1.3 Reports

First Phase Report & Population Needs Assessment Report

1.3.1 The DHH Pathfinder Project submitted its First Phase Report to the Department of Health on 30th August 2017. It was subsequently presented to Southern HSC Trust Board on 28th September 2017 for information. The report was endorsed by the Emergency Care Regional Collaborative (ECRC) at its meeting on 5th October 2017.

1.3.2 The First Phase Report focused on a comprehensive Population Health Needs Assessment (**Appendix 2**). It concluded that the continued presence of a 24/7 Level 1 ED on-site was justified and supported the Trust's position that a 24/7 Emergency Department (ED) should be maintained at DHH.

- It demonstrates that DHH ED is the 6th busiest ED in N Ireland with over 53,400 attendances in 2016/17; 77% of those attending were classified at triage as in need of urgent, very urgent or immediate assessment.
- Between 2014/15 and 2016/17 ED attendances at DHH had increased by 15% among adults, 28% among children and medical admissions between 8pm and 8am had increased by 35%.
- Population projections between 2017 and 2039 predict a much significantly higher increase in the total population of Newry and Mourne of 18% compared to the NI average of 8%.
- The predicted growth is most significant for the older population. Between 2017 and 2039 those aged 65 and over is projected to rise by 82% in Newry and Mourne compared to the NI average of 64%.

- The birth rate is also demonstrably significantly higher in Newry and Mourne at 73/1000 female population (15-44 years) compared to NI rate of 66/1000.
- The report identifies the challenge that would be presented should a 24/7 ED service not be available at DHH based on road networks and journey times. The proportion of people in NI living within a 1 hour drive time would reduce from 99.6% to 97.5%. It should be noted that there is no definitive standard that indicates an appropriate drivetime to an ED. The delivery of safe care by appropriately trained staff in the right environment must be the overriding principle.
- The needs assessment also considered the results of two clinically led audits in DHH which help identify key priorities when planning future models of care:
    - The first audit examined all emergency admissions to DHH via ED over a 7 day period in October 2016 and showed that 38% of medical admissions could have been avoided had alternative pathways been in place.
    - The second audit involved a review of a sample of 50 inpatients in DHH wards, assessing their need for ongoing inpatient care and whether or not they had timely access to diagnostics, senior decision making and multidisciplinary team assessment where appropriate. This indicated that for 20% there would be scope to consider alternative pathway development. It also identified a number of areas for improvement. These included the need for:
        - Senior decision making both at the time of admission and twice daily reviews as an inpatient
        - Timely declaration of being ‘medically fit’ for discharge
        - Increased access to diagnostics with minimisation of ward based delays in arranging investigations and actioning results
        - Active discharge planning.

Second Phase Interim Report and the Report of the ED Workforce Group

1.3.3 The PID required that the Second Phase include:

- "Scoping of any DHH Pathfinder Group workstream plans which will be clinically led and managerially supported in keeping with principles in Delivering Together;
- Consideration by each workstream of relevant policies and guidance, and relevant current proposals for future policy development and initiatives related to acute and emergency care;
- Stakeholder engagement; and,
- Development of a high level implementation and investment plan."

1.3.4 The first workstream to be established in Phase 2 was a group to develop a workforce model for the ED at DHH. The ED Workforce Report, which is included in **Appendix 3**:

- describes recommended staffing levels based on guidelines & standards compared to current levels;
- identifies opportunities presented through new roles and when trained staff will enter the workforce; and
- explores ways to improve recruitment & retention of medical, practitioner and nursing staff.

1.3.5 On 18th October 2017 the Second Phase Interim Report and the Report of the ED Workforce Group were submitted to the Department of Health. These were endorsed by the Transformation Implementation Group (TIG) on 1st November 2017.

1.3.6 These reports were presented to the Southern Trust Board for information on 30th November 2017.

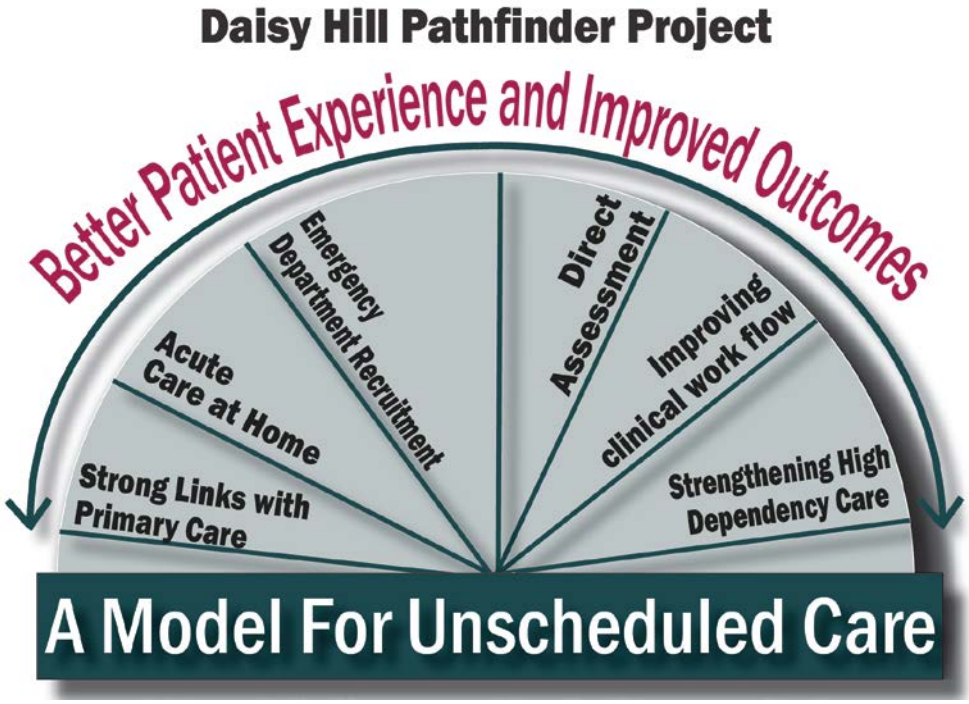
Final Report

1.3.7 This Final Report focuses on the overall Model developed to meet the unscheduled care needs of the Newry and Mourne population and the wider catchment population of DHH. It describes the data and the evidence base

that informed the proposals and the key elements of the Model that are interrelated and interdependent. These are:

- **An appropriately staffed ED** at DHH achieved through a 5 year workforce plan.
- The implementation of alternatives to admission to hospital, including direct GP access and the development of a new **Direct Assessment** Unit in DHH to provide 'same day' ambulatory emergency/urgent care services and telephone advice to GPs and NIAS.
- **Strengthened High Dependency Care** that will improve the management of the sickest patients in the hospital and enhance senior decision-making for those receiving inpatient care to improve patient flow and clinical outcomes.
- The **expansion of Acute Care at Home** services across Newry & Mourne along with the introduction of rapid assessment clinics in DHH and a 'Discharge to Assess' model to improve the management of frail elderly patients.
- The **introduction of measures to improve patient flow including** those identified through a commissioned audit undertaken by the HSCB's senior nurse review team in August/September 2017, the 100% Challenge undertaken in November 2017 and new 'Discharge to Assess' processes across the Southern Trust.
- **Strong collaboration with primary care services**.

1.3.8 The following visual image has been developed to represent the model:



1.3.9 A high level implementation and investment plan to support the recommended model is described. The short, medium and long term plans are fully aligned with the principles and recommendations within Systems not Structures and Delivering Together. As required in the PID, the proposals have "given consideration to opportunities for recycling of existing and additional resources for consideration by the Emergency Care Regional Collaborative (ECRC)".

1.4 Next Steps / Phase 3

Phase three will involve the delivery of the implementation and investment plan and will commence early in 2018 upon receipt of endorsement of the Model by ECRC and TIG.

2.0 DEVELOPMENT OF PROPOSED NEW SERVICE MODEL

2.1 A key task for the Daisy Hill Pathfinder project was the development of prioritised proposals that would contribute to an effective emergency care service Model for the people of the Newry and Mourne area. The development of proposals to modernise services was undertaken in the context of:

- The **Regional strategy**, with particular reference to the report by Professor Bengoa and the Expert Panel *'Systems not Structures'* and most notably the recent publication of the vision set out by the Minister for Health in *'Health and Wellbeing 2026: Delivering Together'*;

- The **evidence base** for modern, timely unscheduled care with particular focus on two recent documents – '*Improving Patient Flow in HSC Services'* (DOH, Oct 2014) and *'Good Practice Guide: Focus on Improving Patient Flow'* (NHS Improvement, July 2017);

- A detailed **Needs Assessment** that included an analysis of routine activity data and a literature review of models of urgent and emergency care and their effectiveness.

- The results of **two clinical audits** - The first examined all emergency admissions to DHH via ED over a 7 day period to determine whether alternatives to hospital admission could have been considered. The second audit involved a review of a sample of 50 inpatients in DHH wards, assessing their need for ongoing inpatient care and whether or not they had timely access to diagnostics, senior medical decision making and multidisciplinary team assessment where appropriate.

- The **professional advice of clinicians** including those working in Daisy Hill and across the Southern Trust, Public Health Agency and General Practitioners;

- **Contributions from Community representatives, people living in the Daisy Hill catchment area** and staff working in Daisy Hill and the Southern HSC Trust.

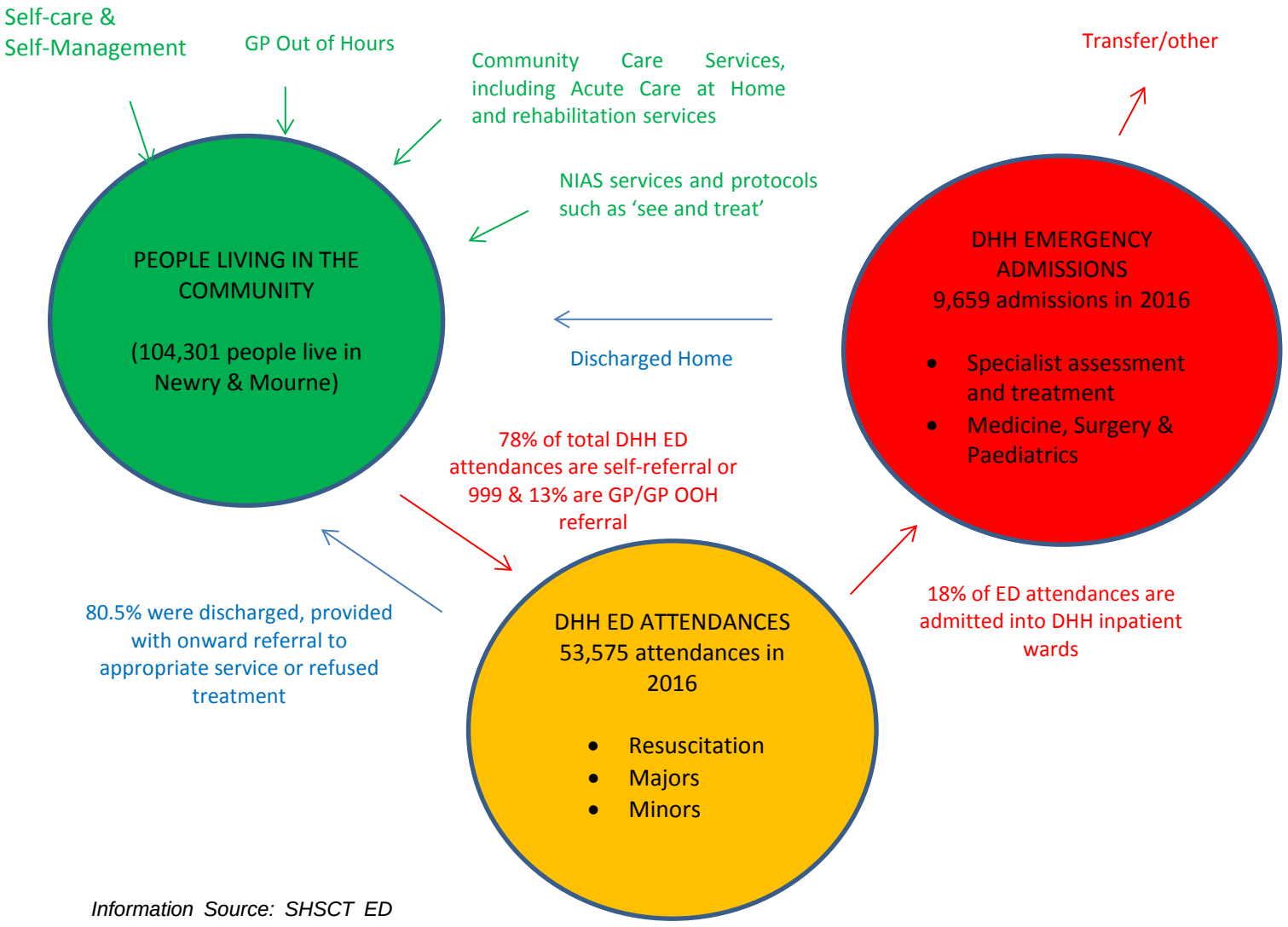
- **Issues raised** in a series of meetings with clinical and non-clinical staff, GPs, staff side representatives, the Southern Integrated Care Partnership (ICP) and the Southern Local Commissioning Group (LCG).

2.2 A number of priorities and common themes emerged. These included a need to:

- develop an agreed staffing structure for DHH ED. This would clarify requirements, provide certainty for staff and help improve recruitment and retention.
- avoid admission where possible through improving access for GPs to specialist advice, establishing one stop assessment services, providing better access to diagnostics and expanding Acute Care at Home services across the Newry and Mourne area.
- strengthen inpatient facilities for the sickest patients.
- improve patient flows with appropriate streaming of inpatients to avoid unnecessary delays and minimising their stay in hospital, such as ensuring planned discharges are completed early in the day.
- focus on the management of frail elderly (>75 year olds) patients in the context of rising admissions after 8pm in this group of patients and problems in DHH in discharging people from hospital when they no longer need an acute bed, exposing them to risks of hospital acquired infection, delirium and decompensation.
- improve local access to out of hours (OOH) advice in primary care and to consider testing innovative alternatives to the traditional GP OOH model.

2.3 It was clear that a new model of unscheduled care to improve patient flow was required to provide the right care in the right place for the catchment population of Daisy Hill Hospital.

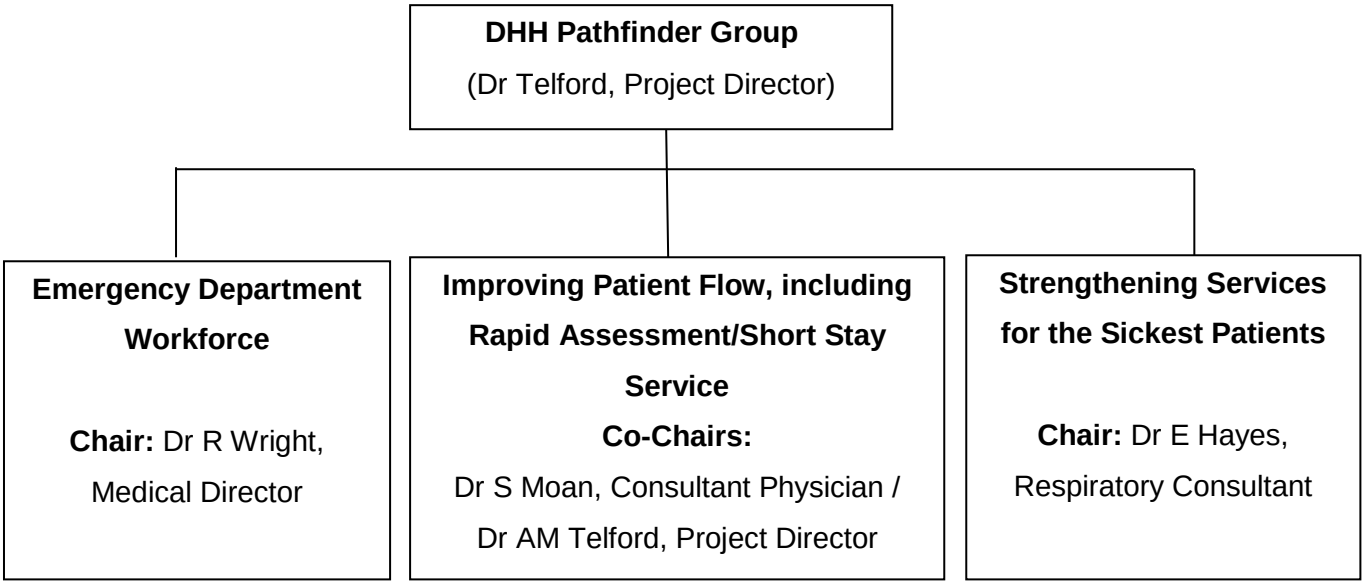
2.4 The scope of the project included consideration of the Emergency Department, its staffing and interfaces with other services that feed into and support it. These included GP Out of Hours (GP OOH), diagnostic services and community based services, such as Acute Care at Home and other rehabilitation services. The following diagram illustrates the complexity of the interface between the ED and other services.



Information Source: SHSCT ED System for Jan-Dec 2016

3.0 PROJECT STRUCTURE

3.1 A summary of the project structure to further develop the proposed Model to meet the unscheduled care needs of the Newry and Mourne population is set out below.



3.2 Each 'Task and Finish' Group was clinically led and reported through Dr Anne Marie Telford as Project Director to the DHH Pathfinder Group. The Chairs of the Groups were supported by Charlene Stoops as Project Manager to ensure delivery of the objectives within the project timescales. Each Group had medical, nursing, managerial, non-clinical, community and staffside representation.

3.3 The following Sections 4.0 to 6.0 provide a summary of the proposals developed by each of the Task and Finish Groups to deliver a model which is an exemplar of good practice. For those patients who are admitted, the new model aims to deliver prompt multidisciplinary care and a patient flow system which will ensure prompt discharge once an acute inpatient service is no longer clinically indicated.

4.0 Emergency Department Workforce at DHH

4.1 Emergency Department Workforce Review

4.1.1 The ED Workforce Group was tasked with a review of current staffing levels in DHH ED compared to recommended guidelines and standards. It was asked to identify plans to secure a sustainable workforce for the delivery of 24/7 services and a timescale for implementation. This included working with other organisations to consider workforce recruitment, training and development plans to improve recruitment and retention of medical, practitioner and nursing staff.

4.1.2 Regional membership of the group included Mr Sean McGovern, Vice-President of the Royal College of Emergency Medicine, Dr Kevin Maguire, Head of the School of Emergency Medicine and NIMDTA representative, Ms Siobhan Donald, Nurse Specialist PHA and Dr Diane Corrigan, Consultant in Public Health Medicine, PHA.

4.1.3 The Report of the ED Workforce Group (Appendix 3) sets out how staff numbers should build up year on year taking account of when doctors, specialist nurses and other professional groups are expected to complete their training. The Workforce Plan aims to increase the number of ED Consultants from 2 in 2017 to 5 in 2019 and 10 in 2022.

4.1.4 The Trust has had significant difficulties in recruiting consultant and middle grade staff to substantive posts over the past 3 years. This has led to an increasing reliance on locum and other flexible working arrangements to meet the requirements for medical cover to deliver safe services.

4.1.5 NIMDTA has advised that over the next 3 years there will be 33 Consultants in Emergency Medicine who will have completed their training in NI. This creates the potential to achieve the consultant workforce required although some challenges around the recruitment and retention of medical staff remain.

4.1.6 The training and development of staff to take on new roles, including Advanced Nurse Practitioners and Physician Associates, is also addressed building on current arrangements within the Trust to support staff retention. The model also considers Support staff, Allied Health Professional and Social Work staff.

4.1.7 A comparison between the current number of nursing staff in substantive posts and required staffing levels identifies a relatively small shortfall in total numbers. However, the requirement for an increase in Bands 6 and 7 has been identified. If funding was to be made available to enhance nurse staffing levels in line with the recommended model the Trust is confident that it could achieve the current requirements within the next 6-12 months.

4.1.8 It is recognised that in addition to medical and nursing requirements that DHH ED requires support from a range of other clinical and non-clinical services. The table below sets out the current funded staffing levels in DHH ED and the five year workforce plan (2017-2022).

Post	Baseline Staffing Level wte	Current* Standard	Year 1 (2018) wte	Year 2 (2019) wte	Year 3 (2020) wte	Year 4 (2021) wte	Year 5 (2022)
Medical							
Consultant	1.83	**10.00**	3.43	5.03	6.63	8.23	**10.00**
Tier 3/4	2.00	**12.00**	2.00	2.00	3.00 + 1.00 ANP	4.00 +2.00 ANP	**8.00** (Incl. 2.00 ANP)
Tier 2 Junior Doctors (incl. 0.78 GP Sessions)	6.78	**12.00**	6.78	6.78	6.78	6.78	**10.78** 6.78
Physician Associates	0.00		0.00	0.00	1.00	1.00	2.00
ANPs	0.00		0.00	1.00	1.00	1.00	2.00

Post	Baseline Staffing Level wte	Current* Standard	Year 1 (2018) wte	Year 2 (2019) wte	Year 3 (2020) wte	Year 4 (2021) wte	Year 5 (2022)
ENPs	3.45	**4.00-6.00**	3.45	5.45	5.45	5.45	**5.45** **Guidance: 4.00-6.00**
Sub-Total	***14.06***	***38-40***	***15.66***	***20.26***	***24.86***	***28.46***	***34.23***
Nursing							
Band 3 Nurse Support	9.26	**11.20**	9.26	11.20	11.20	11.20	**11.20**
Band 5	38.52	**36.78**	38.52	32.76	36.78	36.78	**36.78**
Band 6	5.44	**11.20**	5.44	11.20	11.20	11.20	**11.20**
Band 7	2.00	**3.80**	2.00	3.80	3.80	3.80	**1.00** Supervisory Ward Sister/Charge Nurse & **2.80** Band 7 12 hours Day Peak Activity
Sub-Total	***55.22***	***62.98***	***55.22***	***58.96***	***62.98***	***62.98***	***62.98***
Non-Clinical Services							
Band 2	5.89	**-**	8.00	10.78	10.78	10.78	**10.78**
Band 3	0.93	**-**	1.00	1.00	1.00	1.00	**1.00**
Band 4	1.00	**-**	1.00	1.00	1.00	1.00	**1.00**
Sub-Total	***7.82***	***-***	***10.00***	***12.78***	***12.78***	***12.78***	***12.78***

** Current Standard – whilst the Trust will aim to fully achieve current standards for medical and nursing services the above workforce plan recognises the difficulty in reaching the standard for medical staffing levels within the next 5 years.*

4.1.9 The Group's recommendations are consistent with the Royal College of Emergency Medicine (RCEM) Northern Ireland Vision 2020 (published on 12th October 2017).

4.1.10 The ED Workforce report was endorsed by the DHH Pathfinder Group, the Trust's Senior Management Team and, on 1st November 2017, by the Transformation Implementation Group chaired by the Permanent Secretary.

5.0 Improving Patient Flow, including the Development of a new Direct Assessment Unit

5.1 Background

5.1.1 Even with achievement of plans for a more sustainable ED workforce over the 5 years to 2022, it is clear that other measures are essential to address the significant year on year increases in ED attendances and medical admissions and demographic change.

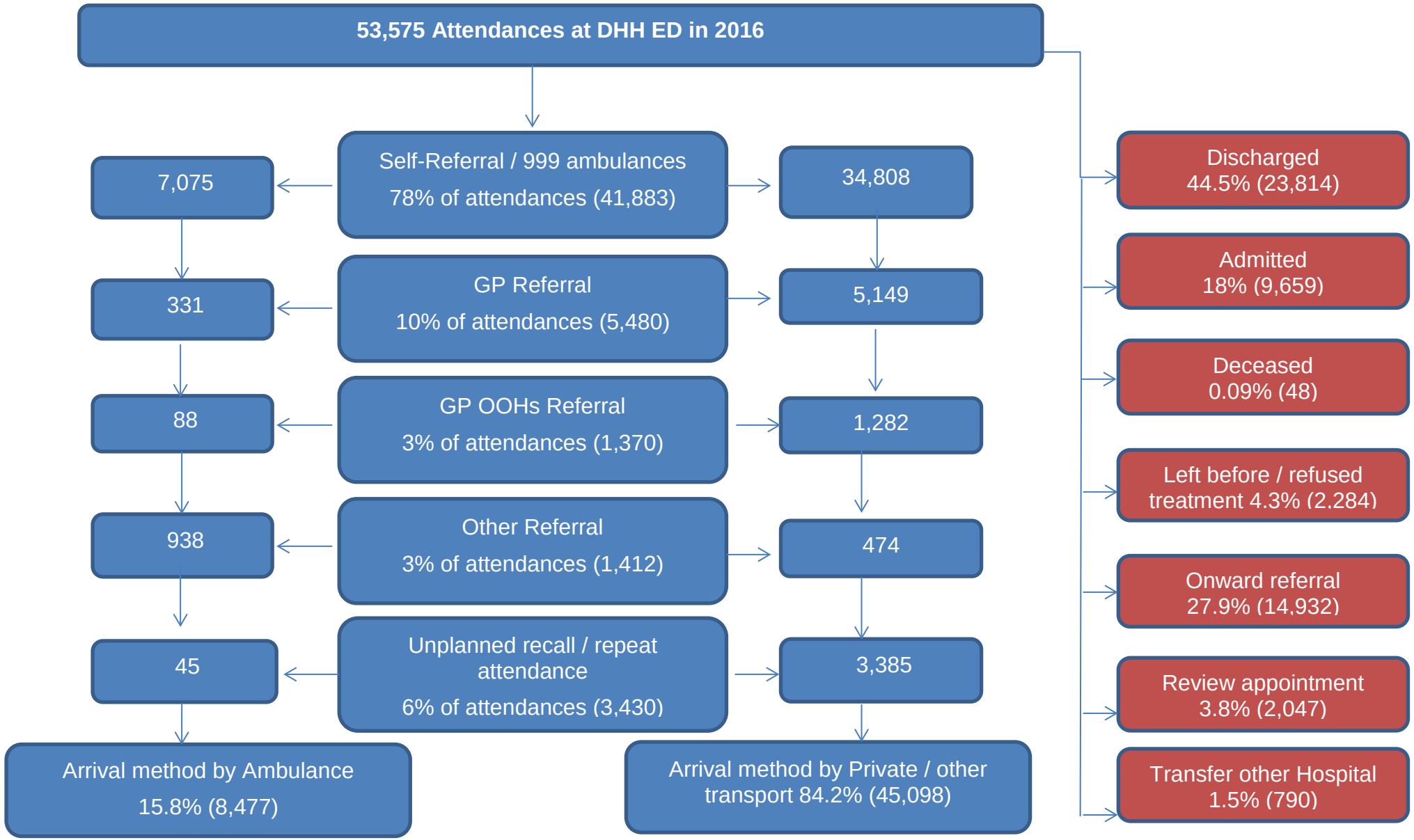
5.1.2 The 2014 report *'Improving Patient Flow in the HSC Services'* and the 2017 NHS Improvement *'Good practice Guide: Focus on improving patient flow'* informed the approach of the Task and Finish group.

5.2 Review of Data on Patient Flow

5.2.1 The group first reviewed recent patient flow data. The flow diagram below illustrates the referrals to DHH ED and discharge pathways based on attendances from January to December 2016.

- 15.8% (8,477) arrived by ambulance.
- 13% (6,850) were referred by GPs (10% in-hours and 3% OOHs).
- 44.5% (23,814) were discharged, 18% admitted (9,659) and 27.9% had an onward referral (14,932). The vast majority of onward referrals were to the patient's own GP, the fracture clinics or an outpatient clinic.

Referrals to DHH ED and discharge pathways Jan – Dec 2016 (Source: Flow Diagram Adapted from Audit Scotland, 2010)



5.2.2 The potential for alternative pathways and opportunities to improve patient flow were explored through two clinical audits.

5.2.3 Firstly a retrospective Audit of Admissions from DHH ED was conducted In August 2017, by a team of multi-specialty and multidisciplinary senior staff, including Consultant ED, Medical, Surgical, Paediatric and General Practice clinicians, Senior Managers and Allied Health professionals. All cases admitted via ED over a seven day period from 10th-16th October 2016 were reviewed (210 admissions in total). Patient notes were examined with regard to clinical details, reason for admission and suitability for alternative pathways of care. Trends in admissions across days of the week and time of arrival in the ED were also assessed.

5.2.4 The audit showed that 29.5% of all admissions (62 of the total 210 inpatients) and 38% of admissions to a medical specialty (53 of a total of 139 inpatients) could have been avoided had alternative pathways been available. Access to Acute Care at Home services and an Ambulatory Medical Unit were the two services that would have made the greatest impact. As ambulatory pathways are already in place in DHH for surgery and paediatrics the audit demonstrated fewer opportunities to avoid admission in those specialties.

5.2.5 Secondly, an Acute Inpatient Review in DHH was completed by the HSCB Senior Nurse Review Team. The review audit randomly sampled the inpatient journeys of 50 patients who were unscheduled admissions to DHH.

5.2.6 A summary of key points is detailed below:

- 78% (39) of patients sampled were medical patients;
- 56% (28) of the patients admitted were aged ≥75 years old, with 24% (12) aged ≥85 years;
- The median age group of those admitted was 75-79 years;
- 92% of admissions (46 patients) were via the ED;
- 20% (10) of patients had the potential for an ambulatory care pathway

5.2.7 The patient flow audit further supported the potential for patients to benefit from an ambulatory care pathway. It also highlighted the need to further strengthen services to meet the needs of the frail elderly.

5.2.8 Thirdly, data on non-elective admissions to DHH for those aged over 17 years between 1st November 2015 and 31st October 2016 were reviewed to assess ambulatory potential. The Directory of Ambulatory Emergency Care for Adults was used to estimate the proportion of patients with a given discharge diagnosis who could potentially have been managed through an ambulatory pathway. Based on this and using the median percentile of the range approximately 24% of total acute medical admissions to DHH with a LOS less than 5 days appeared to have the potential to be managed in an ambulatory setting.

5.3 Key Recommendations

5.3.1 A key priority based on the results of clinical audits, the review of local data and regional and national guidance, was the establishment in DHH of an ambulatory emergency care unit / Direct Assessment Unit (also referred to as a Clinical Assessment Area in the 2014 report *'Improving Patient Flow in the HSC'*).

5.3.2 There is a need to strengthen services for the frail elderly, including expansion of the Acute Care at Home service across the Newry and Mourne area and the application of 'Discharge to Assess' principles.

5.3.3 There is a need for robust primary care services both in hours and out of hours, along with the importance of focusing on collaborative working between primary and secondary care clinicians.

5.4 Direct Assessment Unit

5.4.1 A **literature review** on models of ambulatory emergency care was undertaken (Appendix 4). The Royal College of Physicians define Ambulatory Care as *'clinical care which may include diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed*

base or within the traditional outpatient services, and that can be provided across the primary/secondary interface'.

5.4.2 Literature suggests that all patients should be considered for ambulatory care, unless clinically unstable, to ensure that the maximum number of patients benefit from rapid access to the right treatment. It indicates that 20-30% of emergency admissions can be converted to 'same day' care which supports better clinical outcomes and patient experience.

5.4.3 A visit to the Direct Assessment Unit in Antrim Area Hospital was undertaken. An operational model for a direct assessment unit was then developed by the Task and Finish group.

5.4.4 Objectives and Benefits of the Direct Assessment Unit (DAU)

The DAU aims to improve the quality of overall patient care and experience by delivering the right care, in the right place first time. It also aims to reduce the rise in attendances at the ED and hospital admissions where appropriate.

Service model / objectives of proposed DHH Direct Assessment Unit:

- To provide 'same day' emergency/urgent care services, including telephone advice to GPs and NIAS, in a non-inpatient setting.
- To ensure prompt access to a senior doctor who is responsible for agreeing the case management plan for each patient.
- To ensure referrals to the DAU are appropriate through direct telephone discussion between clinicians and GPs.
- To provide clinical assessment initially to at least 10-14 new patients per day for adults with medical needs and frail older people who could benefit from diagnosis, observation, treatment and rehabilitation in an appropriate area outside the ED. The number of patients able to be seen in the unit is expected to increase over time as the service develops.
- Based on experience in similar units, up to, 70% of new patients seen may be discharged on the 'same day'.

- Following assessment, if required, a patient may be advised to return for review at the unit.
- To improve the patient journey/pathway and experience, including:
    - Patients should have a nursing assessment within 15 minutes of arrival.
    - Patients should be seen by a senior clinician/speciality doctor within 60 minutes of arrival.
    - Patients should have a consultant management prescribed plan following preliminary assessment and initial investigations within 90 minutes of arrival
- To ensure optimal clinical adjacencies, the Unit should ideally be co-located with or close to DHH Emergency Department and have good access to diagnostics.
- To ensure core operational hours are aligned with times of peak demand Unit staff should accept phone calls Monday – Friday 9am-9pm and face to face appointments 9am-6pm with extension of the service to 7 days per week when feasible.
- To be jointly managed by ED and Medical Physicians and Care of the Elderly Team.

The key benefits to be realised through this development include:

- Greatly enhanced patient experience
- Direct access for GPs & NIAS to senior clinical advice, assessment and treatment
- Improve communication between primary and secondary care clinicians
- Acute admissions avoided and bed days saved
- A reduction in medical outliers in surgical and day unit beds
- A reduction in the rate of increase in ED attendances
- A reduction in the number of patient waits breaching the 12 hour and 4 hour target
- A reduction in cancellations of elective procedures

5.4.5 As the new model is embedded it will deliver significant benefits in improving patient flow which will help alleviate bed pressures in the hospital. During the 2016/17 year, 212 surgical procedures were cancelled and this number is expected to increase in the 2017/18 year (with 186 surgical procedures having been cancelled in the first 8 months). It is anticipated that a reduction in the number of medical outliers will reduce bed pressures and the need to cancel elective surgery.

5.4.6 Draft key performance indicators (KPIs) and data sets have been developed (Appendix 5) to assess the progress and success of the new emergency pathway. These will continue to be developed as the project moves into the implementation phase.

5.4.7 The operational model will be further developed during the implementation phase. GPs, NIAS, senior clinicians, community representatives and other key stakeholders will work together to agree the detailed arrangements.

5.4.8 **Opportunities for Improving Service Integration**

- **Clinical Decision Unit**

  The College of Emergency Medicine recognises clinical decision units along with ambulatory emergency care as important components of emergency systems. The Cooperation and Working Together (CAWT) Partnership[1] has confirmed short term funding to support the ambulatory management of patients who would otherwise have been admitted via ED to an inpatient bed in Daisy Hill Hospital. This service is due to commence in early 2018 within the ED department but will transfer to the Direct Assessment Unit once works have been completed.

- **Day Clinical Centre**

  A recent audit of the Day Clinical Centre (DCC) has indicated that approximately 60% of DCC activity could potentially be delivered through

[1] Cross border health and social care partnership that seeks to add value to health and social care activity by bringing a cross border dimension to the on-going collaboration between the health systems in both jurisdictions, and accessing EU funding of such activities where appropriate

the Direct Assessment Unit. The DCC service is best located on the ground floor and it is felt that the co-location with the DAU could provide for better utilisation of resources, upskilling of staff and improved integration and service delivery.

- **Short Stay Ward**

  The 'Task & Finish' Group considered the potential future service development of a short stay observation ward of 2-4 beds within the ED which could help prevent patients from being inappropriately admitted into medical wards. As nursing and medical staffing levels improve there may be scope for the developments of these beds as part of a medium-term plan.

5.4.9 Surgical Ambulatory Service

The Royal College of Surgeons has suggested that up to 30% of patients in the emergency general surgical take could be managed via an ambulatory care pathway thus avoiding an emergency hospital admission. DHH has already a well-established surgical ambulatory service for patients who are suffering from urgent general surgical problems. This service takes referrals directly from GPs and the ED and works well in its current location on the 3rd floor where it is in close proximity to surgical inpatient beds, making the best use of available staffing resources. There are plans to further enhance service delivery within its current location. The recent ED Clinical Audit identified a very small number of patients attending ED who could have availed of a surgical ambulatory service as an alternative to ED. It was agreed therefore with Surgical Consultants and Management that the new Direct Assessment Unit should provide a focus on adults with medical needs and the frail elderly in the first instance.

5.4.10 Key Requirements

- A range of medical, nursing and AHP staff is required to support the unit. The staffing requirements are set out as follows:

Post	Interim 2 Year Target Staffing Requirements	5 Year Target Staffing Requirements
Medical		
Consultant	2	3.6
Specialist Doctor	3	4
Nursing		
Nursing	8.27	8.27
AHP		
Physio & OT	2.72	6.42
Social Work		
Social Work	0.5	0.8
Radiology/Radiography		
Radiography	2.4	2.4
Radiology	0.4	0.4
Pharmacy		
Pharmacy	2.0	2.0
Discharge to Access		
Community/Hospital Co-ordinator	1.0	1.0
Non Clinical Support		
Admin, Porter & Domestic	4.8	4.8

** It should be noted that the Direct Assessment Unit is a new service and therefore has no baseline staffing level.*

- A lack of available senior doctors and nursing staff at a regional and local level may be a constraint. However it is envisaged that this development will be seen as an attractive opportunity for staff to further develop skills with the potential for sessional input from GPs. .
- A brief has been developed for the accommodation needs of the Unit and service users and community representatives will be involved in detailed design work.
- A suitable location for the DAU close to the ED and the radiology department has been identified. Staff who may need to be relocated

have been advised. Preliminary design work was approved by the Trust Senior Management Team on the 22nd November 2017.

- Whilst there are plans to free some space on the site with the development of a new Community Treatment & Care Centre in Newry this will not be delivered until 2020. Work is ongoing to ensure the best use of existing estate for clinical need and that any interim measures will not compromise long term future development plans.

5.4.11 **Support for the Direct Assessment Unit Model**

The proposed model has the full support of the senior clinical staff in DHH, the Trust Clinical Director for ED, staff side representatives, Community representatives, the Trust Senior Management Team and the Southern ICP.

The DAU will also present an opportunity to strengthen links with NIAS. The NIAS has indicated its strong support for a DAU which will enable them to start patients on the pathway in the ambulance thereby ensuring earlier access to the most appropriate service.

5.5 Enhancing the Management of the Frail Elderly

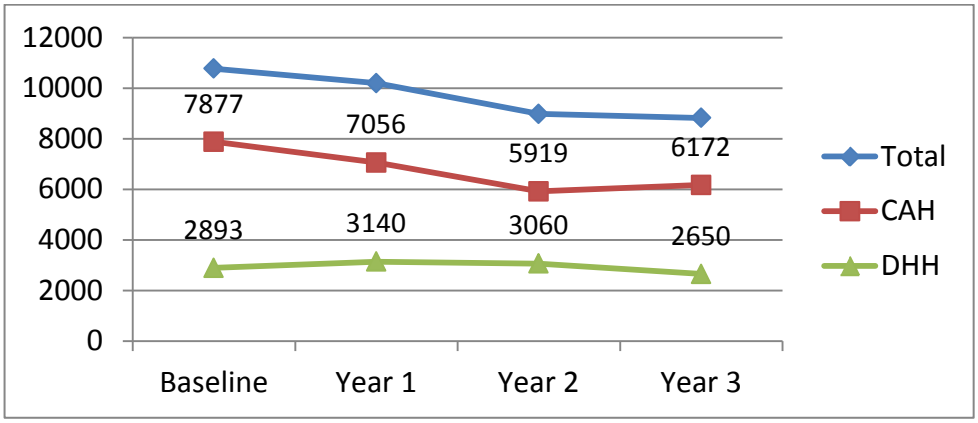
5.5.1 The **Acute Care at Home (AC@H) service** has been a significant success since it became operational in Sept 2014 in the Southern Trust area. AC@H is a dedicated Consultant Geriatrician led multidisciplinary team whose primary focus is on maintaining older people at home in the event of an acute illness or unexpected deterioration in health. The service provides triage, assessment, diagnosis and treatment as an alternative to in-patient care specifically to those at risk of or potentially requiring admission to hospital, i.e. in the absence of such care, they would require inpatient treatment. AC@H is a time limited service – normally no longer than 7 days, and frequently 3 or 4 days or less.

The service was audited by the HSCB's senior nurse review team in June 2016. The audit concluded that:

- The AC@H service is managing patients with acute complex needs in the community comparable to patients in the acute setting.
- A rapid response time, including interventions and delivery of equipment is achieved
- It is evident care is patient and family centred
- No patient required any Out of Hours interventions during the period of the audit
- Antibiotics were administered for shorter durations than in acute hospitals
- The vast majority of patients did not require any additional social care support on discharge
- There was an improvement in shared care/confidence within nursing homes.

5.5.2 The impact of the AC@H service on beds days spent by Nursing Home patients over the last four years has been documented in the annual evaluation report for period 1 April 2016 to 31 March 2017.

Nursing home acute bed days



- Until the end of March 2017 there had been no access to the service for Nursing Homes in the Newry area. The nursing homes covered by the AC@H team would have mainly admitted patients to Craigavon Area Hospital (CAH).

- The chart shows a 22% reduction in bed days spent by Nursing Home patients in CAH over the time period from baseline to year 3. Over the same period there has been a reduction of only 8% in DHH.

- These data emphasise the importance of extending the AC@H service across the whole Newry and Mourne area.

5.5.3 The Trust Senior Management Team has recently agreed funding to expand the Acute Care at Home Services across Newry and Mourne along with further investment in community services. A number of local GPs have expressed interest in providing sessional input to this service, working as part of the Care of the Elderly Team.

5.5.4 The recruitment of staff is underway with plans for a roll out of the service across nursing homes in N&M between January and March 2018.

5.5.5 The requirements for older people have been reviewed and proposals developed to introduce a **new Integrated Frailty Model** to support the needs of older people. As part of the integrated model it proposes that all patients over 65 years of age who attend ED are **screened for frailty**. Identification of frailty at the front door will ensure that patients are monitored and tracked throughout their journey in the acute hospital or their early discharge and followed up by the appropriate community services including the community/voluntary sector.

5.5.6 Other measures agreed by SMT include the development of **new rapid access clinic at DHH** for older persons. Patients will receive an agreed functional assessment to establish baseline functional ability, an appropriate pathway will be identified and when suitable for same day discharge the adequate support networks will be in place to ensure that the patient is safe to return home. The Rapid Access Clinic is part of the DAU model, and a senior Geriatrician will be on the DHH site Monday to Friday to expedite discharge for complex patients.

5.5.7 A Discharge to Assess model is being developed and will apply within the Direct Assessment Unit and Acute Based Wards to expedite earlier discharge of all patients identified as frail. Patients will be followed up on discharge and, if required, a comprehensive assessment by specialist AHP staff will be completed within 1 hour of them returning home.

5.6 Strengthening Primary Care and interface between Primary and Secondary Care

- The DHH Pathfinder Group recognises the need for strong and sustainable primary care services as a key element of the overall unscheduled care model. The Needs Assessment identified a growing problem in the GP out of hours (OOHs) service in the Newry and Mourne area.
- GP Out of Hours Closure (Daisy Hill Base) 2014/15 - 2016/17 (SHSCT data)

Daisy Hill Base Closures by Day of Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total
2014-2015	0	2	2	1	0	0	0	5
2015-2016	3	5	4	8	4	6	2	32
2016-2017	12	6	4	9	14	12	3	60
Total	15	13	10	18	18	18	5	97

- Although the OOHs base could not be staffed on a number of occasions the service still provided a telephone advice and an alternative base appointment.
- The growing pressures on the GP OOHs service reflect pressure in daytime hours but the latter is outside the scope of the DHH Pathfinder project.
- New approaches are likely to be required in primary care as in secondary and community care to meet these pressures. In an effort to support day time General Practice, the Federation and Southern Trust is piloting a day time visiting service to nursing homes/care homes through the Southern Area Urgent Care Service. This will operate on the 27th, 28th, 29th December 2017 and 2nd of January 2018 which are periods of high

demand for day-time General Practice. The aim of the pilot is to take some of the pressure on GPs to allow them to see those patients most at risk of admission and to arrange alternative care for them; to reduce the number of calls to GP OOH between 6pm and 8pm; to enable earlier ambulance arrivals to ED and to reduce the number of ambulance arrivals on these days compared to the previous three years. If effective this approach may be further developed.

- The DHH Pathfinder Group is keen for GPs in the Newry and Mourne area to have the opportunity to pilot multi-disciplinary team approaches being developed by the DoH and HSCB.
- The Group also supports the Royal College of General Practitioners NI in its plans to develop a policy to promote more effective communication between primary and secondary care clinicians. The opportunity for GPs and Consultants in secondary care in DHH to work together on the planning of the new DAU should support this goal.
- Proposals to develop a Direct Assessment Unit at DHH and agreement by the Southern Trust to extend the AC@H service across the Newry and Mourne area will provide direct support to GPs from colleagues in secondary care. GPs will be able to discuss patients directly with a senior hospital clinician and receive advice. Both may also provide opportunities for GPs to have sessional input to the services hence enhancing their skills and experience.

6.0 Proposal for Strengthening Services for the Sickest Patients

6.1 The requirements for inpatient care at DHH have been reviewed to develop an appropriate service model.

6.2 This has included a focus on the role of the current High Dependency Unit (HDU) in DHH. HDUs are specialised units providing more advanced monitoring and organ support than can be provided on an ordinary ward (meeting Level 2 need as defined by the Intensive Care Society[2]). The HDU has a vital role to play in acute hospitals in enabling the sickest patients to be cared for in the most appropriate place, in offering appropriate support for the other clinical services in the hospital and in improving the efficiency of patient flow in the hospital. A High Dependency Unit is essential in a district general hospital such as Daisy Hill with a fully functioning Emergency Department. Major non elective surgery is regularly undertaken and medical patients requiring a higher level of care are routinely admitted. The absence of a properly resourced HDU can also be an impediment to attracting medical staff to apply for consultant posts.

6.3 A proposal developed by the Trust in 2015/16 suggested how the existing HDU could be enhanced to meet the core standards published by the Intensive Care Society. The service model in this proposal has been reviewed in the context of refreshed demand, including a snapshot audit in the HDU; benchmarking against standards; staffing guidelines and availability of key disciplines.

- An analysis of activity identified an increase in level 2 admissions over the past 2 years and demonstrates a clear demand for HDU services at DHH. A snapshot audit of admissions to the HDU for a one month period in 2017 showed that:
    - There were 47 level 2 admissions – 31 medical (66%) and 16 surgical (34%).

[2] *Levels of Critical Care for Adults:* Intensive Care Society © 2009

- There were on average 5.3 level 2 patients in the ward per day with a range of between 3 and 8 patients.
- There was a 13% increase in level 2 admissions from a previous audit 2 years ago.

- Proposals have been developed to enhance the current 7-bedded area to provide an intensivist-led 4-bedded 'closed unit' which complies with the ICS standards (as they apply to the HDU beds). These will be co-located with 4 augmented care beds which will provide care for patients requiring interventions such as non-invasive ventilation (NIV) and stroke lysis.
- The enhancement of the HDU will improve decision making and management of critically ill patients. It will enable the early identification of the deteriorating patient allowing earlier transfer off-site to level 3 care (ICU) if necessary and in other instances may prevent further deterioration, negating the need for transfer.
- Access to a HDU service is also an important factor in recruitment and retention of consultant medical staff.
- The proposed service model will require investment to provide an appropriate level of medical, nursing, allied health professional and pharmacy staffing to achieve required standards. The staffing requirements are as follows:

Post	Baseline Staffing Level wte	Interim 2 Year Target Staffing Requirements	5 Year Target Staffing Requirements
Medical			
Consultant Anaesthetists/ Consultant Intensivists	0	2	**2**
Specialist Doctor	1	1.5	**1.5**
Nursing			
Nursing	17.27	22-25	**22-25**
AHP			
Physio & OT	0.5	3.6	**3.6**
Dietitian	0.12	0.38	**0.38**

Post	Baseline Staffing Level wte	Interim 2 Year Target Staffing Requirements	5 Year Target Staffing Requirements
Speech & Language	0.05	0.34	**0.34**
Pharmacy			
Pharmacy	0	0.5	**0.5**
Non Clinical Support			
Admin	0	1	**1**

- The programme for implementation will be phased to take into account the likely availability of staff with consideration of interim measures until full requirements can be delivered.

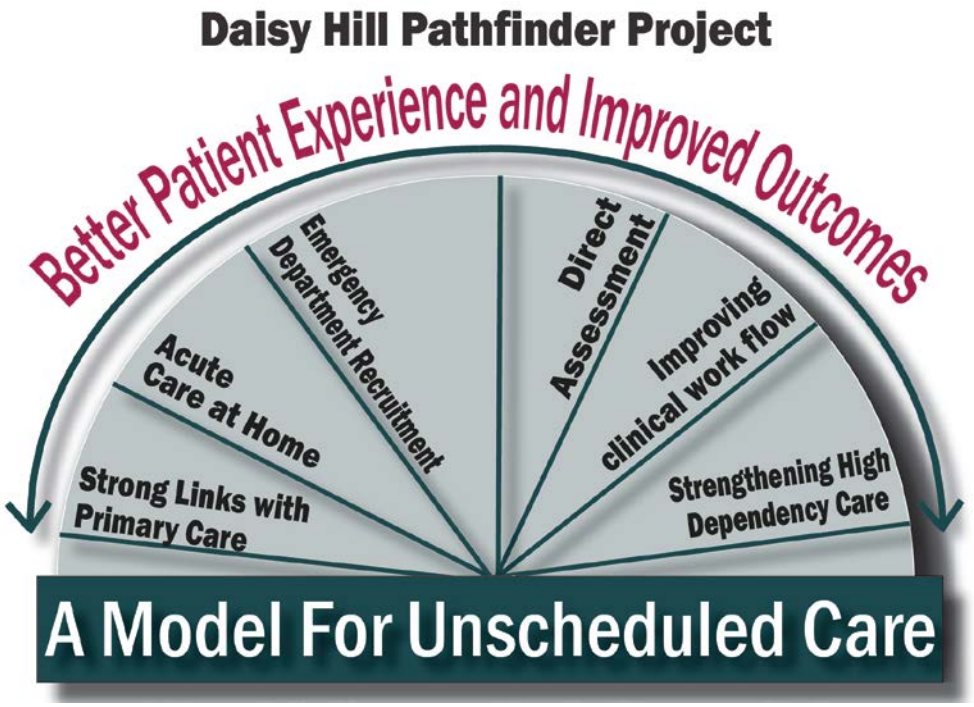
7.0 Summary of Proposed new Model to meet the Unscheduled Care Needs of the Newry & Mourne Population

7.1 Summary of Service Model

The key elements of the proposed Model to meet the unscheduled care needs of the Newry & Mourne population are interrelated and interdependent. In summary, these are:

- **An appropriately staffed ED** at DHH achieved through a 5 year workforce plan.
- The implementation of alternatives to admission to hospital, including direct GP access and the development of a new **Direct Assessment** Unit in DHH to provide 'same day' ambulatory emergency/urgent care services and telephone advice to GPs and NIAS.
- **Strengthened High Dependency Care** that will improve the management of the sickest patients in the hospital and enhance senior decision-making for those receiving inpatient care to improve patient flow and clinical outcomes.
- The **expansion of Acute Care at Home** services across Newry & Mourne along with the introduction of rapid assessment clinics in DHH and a 'Discharge to Assess' model to improve the management of frail elderly patients.
- The **introduction of measures to improve patient flow including** those identified through a commissioned audit undertaken by the HSCB's senior nurse review team in August/September 2017, the 100% Challenge undertaken in November 2017 and new 'Discharge to Assess' processes across the Southern Trust.
- **Strong collaboration with primary care services**.

7.2 The following visual image has been developed to represent the model:



7.3 Endorsement of the Service Model

7.3.1 The Model has the full support of the senior clinical staff in DHH, staffside representatives, community representatives, the Trust Senior Management Team, NIAS, the Southern Integrated Care Partnership and the Health & Social Care Board Unscheduled Care Group.

7.3.2 In addition, the work of the DHH Pathfinder Project has been endorsed at regional level at each phase of the project, including:

- The First Phase Report and Population Needs Assessment Report were endorsed by the ECRC at its meeting on 5th October 2017.
- The Second Phase Interim Report and the Report of the ED Workforce Group were endorsed by the TIG on 1st November 2017.

8.0 Equality, Human Rights & Rural Needs Assessments

8.1 Equality & Human Rights Considerations

8.1.1 The Trust's Senior Management Team supports this new service model as the optimum way to meet the unscheduled care needs of the Newry & Mourne population and the wider DHH catchment population. The model is in line with strategy and policy and represents significant service improvement.

8.1.2 The development of a new Direct Assessment Unit has the potential to impact on existing staff on the DHH site who will need to move their base to accommodate the extension of clinical services in the main DHH building, however this is expected to be minimal considering that the identified estates solution will mean that all staff can remain on the DHH site.

8.1.3 An initial equality screening of the proposed model has indicated that a full equality impact assessment would not be required. There would only be a minor adverse impact on staff with the development of the new Direct Assessment Unit and the change proposed will be managed through the Trust's Management of Change Framework through a partnership approach in consultation with staff and trade unions.

8.1.4 The Trust will continue to ensure that equality of opportunity and good relations, disability duties and human rights are inherent within its implementation plans, including the development of operational policies and procedures for the new Direct Assessment Unit.

8.2 Rural Proofing

8.2.1 The Department of Agriculture and Rural Development has published guidelines for rural proofing in the development of new policies or policy proposals. The Trust remains committed to the principles set out in these guidelines and routinely considers the impact of any of its service change proposals on staff, patients and the wider public.

8.2.2 A rural needs assessment has been completed on the proposed service model and no adverse impact has been identified for people living in rural areas. The service development will enhance services at DHH providing for improvement in access to services, quality of care and experience.

8.2.3 The Trust will continue to monitor its achievement against the agreed project objectives.

9.0 High Level Implementation & Investment Plan

9.1 The Transformational Model will involve:

- Strengthening primary care and links between primary and secondary care; and
- Transforming and modernising processes for patient assessment, diagnostics, discharge and care in the community.

9.2 The Project Initiation Document indicates that the Implementation Phase should:

- Involve the delivery of the agreed Implementation and Investment Plan (week 19 to week 80); and,
- Be dependent upon the DHHPG recommendations in respect of the aspects for regional learning and/or regional implications arising from the Implementation and Investment Plan. Both the regional learning aspects and regional implementation implications will be brought to the attention of the HSC Transformation Implementation Group to consider next steps in relation to implementation at regional level.

9.3 An implementation and investment plan has been developed to support the recommended model to meet the acute unscheduled care needs for the Newry and Mourne population. The development of short, medium and long term plans have been fully aligned with the principles and recommendations within Systems not Structures and Delivering Together and gives consideration to opportunities for recycling of existing and additional resources for consideration by the Emergency Care Regional Collaborative (ECRC).

9.4 Whilst the delivery of the service model has been planned over a 5 year investment period, it was recognised that the model should be subject to ongoing review and it would only be realistic to set out the key actions to be progressed for the first 2 years of the programme at this stage.

9.5 The following high level implementation plan provides a summary of the key milestones, actions and timescales for Year 1 and Year 2 of the Plan.

9.6 High Level Implementation Plan for Year 1 & 2

Milestones	Actions	Action Owner	Timescales
Endorsement of Service Model	• SMT to endorse proposals and high level implementation and investment plan • ECRC endorsement • TIG endorsement	SHSCT/ECRC/TIG	19th December 17 5th January 18 Mid-January 18
Establish Implementation Plan & associated Project Structure	• Develop high level project implementation plan • Project Initiation Document to be developed for project implementation phase • Agreement on project structure and resource to support implementation	SHSCT	December 17 – January 18
Delivery of Workforce Plan	• Agree operational staffing model/opportunities for rotation of staff which will optimise flexibility, consider skill mix and improve retention • Agree job descriptions and specifications, job plans and banding of posts • Recruitment & Selection Process: o Recruitment of medical and practitioner staff to enhance staffing levels in ED and HDU in line with regional standards and to develop new Direct Assessment Unit o Recruitment of nursing & other professional staff to enhance staffing levels in ED and HDU in line with regional standards and to develop new Direct Assessment Unit • Induction & training, including training on operational policies & procedures	SHSCT with regional support for recruitment, retention, new roles & new ways of working	January 18 – December 19

Milestones	Actions	Action Owner	Timescales
Estates/Infrastructure requirements to deliver a new Direct Assessment Unit	• Agree project execution plan • Engagement with staff affected by moves to deliver agreed estates solution • Business case and procurement approvals • Design Works • Estates works and decant of staff • Commissioning • New Direct Assessment Unit complete	SHSCT with regional support for funding of infrastructure costs	January 18 – End Oct 18
Pathway Transformation	• Implement measures to improve patient flow in DHH o Communicate outcome of Patient Flow Audit & 100% Challenge Day to staff at DHH o Agree key actions to improve patient flow in line with recommendations of patient flow audit & 100% challenge day	SHSCT	Dec 17 – Jan 18
	• Explore further opportunities through pilots with GPs to improve interface across primary, community and hospital services	SHSCT with regional support to introduce new ways of working	Jan 18 onwards
	• Establishment of Direct Assessment Unit Model o Process mapping of current and future patient pathways o Develop operational policies and procedures for new pathway and use in training of staff o Communicate access and referral pathways with GPs, NIAS, ED, specialist nursing, community services o Develop protocols/simple flow chart to assist staff in	SHSCT	January – October 2018 with monitoring processes to commence on

Milestones	Actions	Action Owner	Timescales
	dealing with queries and identifying risks/emergency situations o Agree communication materials for patients o Agree baselines, datasets & KPIs o Establish information systems and telephony systems to support agreed dataset o Agree weekly review/monitoring to identify and action improvements o Prepare Benefits Realisation Plan/Post Project Evaluation & processes for continual review of key data to inform any service change necessary		opening of DAU
	• Agree operational service model for HDU, including use of telepresence robot, who will use it/when and opportunities to improve access to CAH Consultant Intensivists	SHSCT	Jan – March 18
Funding Approval	• Submission of IPTs for service proposals to HSCB for approval • Confirmation of funding approval • Establishment of budgets	SHSCT/PHA/HSCB PHA/HSCB/DOH/SLCG SHSCT	January 18 January 18 February 18
Communications	• Proactive plan to be developed to raise awareness of new/enhanced services and pathways – internal and external audiences, including update of e-zine etc	SHSCT/DOH	January 18 onwards
Project Evaluation	• Agree KPIs for project as a whole • Agree baselines • Develop mechanism for ongoing monitoring and review	SHSCT	January – March 18

9.7 Implementation

The Trust SMT has prepared a Project Initiation Document for the Implementation Phase. This will include:

- The establishment of a Pathfinder Strategic Implementation Group reporting to SMT;
- Mirrored workstreams of the 'Task and Finish' groups that developed the plans; and
- Membership that will reflect a co-production approach.

9.8 The Pathfinder Project has identified issues requiring regional support to the proposed Investment and Implementation Plan (**Appendix 6**), specifically:

- Most importantly, there are several significant workforce areas which require regional consideration in relation to the funding process for additional trainees. These include medical, nursing and AHP staff. Training numbers both at undergraduate and post-graduate levels appear not to be generating sufficient numbers in medicine and nursing to fill existing posts, nor those needed in future to meet population-based guidance. This affects both primary and secondary care. It is leading to increasing reliance on temporary staff and high service costs.
- Of particular importance in the DHH setting is the ability to recruit to vacant ED Consultant posts. Over the next 3 years, 33 doctors currently in the NI training system will become eligible to apply for ED consultant posts, having completed their training. The Southern Trust will seek regional support, working in co-operation with the other 4 Trusts, to achieve its interim target as set out in its workforce plan of appointing an additional 2-3wte ED Consultants by 2019 (an increase from 2.6wte to 5wte). This will require regional agreement on phasing of Consultant job advertisements.
- Regional support may also be needed to achieve additional medical, nursing and radiography staff required to develop the new Direct Assessment Unit and strengthen high dependency care.

9.9 The **Investment Plan** identifies the costs associated with the development of this new service model, including staffing and infrastructure costs.

9.9.1 The total additional cost of the service model is approximately £6m (total cost less budget).

9.9.2 The Trust will work to ensure that £1.9m demography funding which is currently being used to support locum costs is made available to DHH ED. Therefore, approval will be sought to the remaining funding requirement of £4.1m (total additional funding less £1.9m) to fund the overall service model.

10.0 Project Evaluation

10.1 In order to evaluate the planning phase of the project, feedback was sought from members at the final meeting of the DHH Pathfinder Group on 13th December 2017. All comments (included in **Appendix 7**) were very positive with recognition of the benefits of good leadership and a co-production approach to engagement having been fundamental in the success of the project.

10.2 It is envisaged that the implementation phase will commence in early 2018. A 5 Year workforce plan and high level implementation plan details the actions to be progressed in the first 2 years of the investment programme to deliver on the model.

10.3 The progress made in delivering the implementation plan will continue to be monitored and reviewed on an ongoing basis and may require Year 3-5 plans to be revised over time.

- KPIs for the overall Pathfinder Project will be developed.
- A post project evaluation will be undertaken in 2019, 1 year after the commencement of implementation, and will be led by a senior member of the Trust who is independent of the project. It will involve a review of the achievements against the project objectives and KPIs. It will assess the impact of the model and the views of stakeholders, including community representatives and clinical and non-clinical staff as well as GPs and Commissioners.
- Work undertaken through the DHH Pathfinder project seeks to identify regional learning. Any lessons learned from this proposal will continue to be shared with other Trusts in Northern Ireland by the Trust Chief Executive through the Transformation Implementation Group which is chaired by the Permanent Secretary.

11.0 Next Steps

11.1 Next Steps

- ECRC to meet to consider the Final Report on 5th January 2018.
- Pathfinder Strategic Implementation Group reporting to SMT will be established.
- Membership of the Pathfinder Strategic Implementation Group and Subgroups will reflect a co-production approach.
- The implementation process will begin immediately upon receipt of endorsement of proposals by DoH.