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

Designing Unscheduled Care Services for the Future

Clinical & Non-Clinical Staff Engagement– Outcome Report

23rd August 2017

1.0 INTRODUCTION

1.1 Background

1.1.1 The Southern Health & Social Care Trust (Southern Trust) is fully committed to delivering safe, sustainable 24/7 emergency services at Daisy Hill Hospital (DHH).

1.1.2 A recent regional summit, convened by the Department of Health (DOH) on Tuesday 2nd May 2017, secured system-wide support to enable the Southern Trust to address immediate pressures and to stabilise the provision of Emergency Department (ED) services at DHH.

1.1.3 On the 16th June 2017 the DOH issued a Project Initiation Document (PID) 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 model for the Newry and Mourne area with identification of regional learning".

The PID outlines the scope of work required, the project objectives and the timescales for completion.

1.1.4 The DHH ED Pathfinder Project provides a valuable opportunity to draw on the collective expertise of multidisciplinary health professionals from across Northern Ireland, alongside the experience and views of the local community, to develop proposals for the delivery of safe and sustainable emergency care services that will meet the needs of people in the Newry & Mourne area.

1.1.5 The key project milestones are identified in a letter from the Permanent Secretary issued 23rd June 2017 to the Trust's Acting Chief Executive and reflected in the PID. These are listed below and are based on a 20 week programme of work, which commenced following Trust Board approval on 27th June 2017.

- Report and recommendations on population health needs assessment (end of Week 8) – 23rd August 2017

- Interim report and recommendations on all other Objectives (end of Week 16) – 18th October 2017
- Final report (end of Week 20) – 15th November 2017

1.2 Project Reporting Structure and Governance Arrangements

1.2.1 The project structure and governance arrangements for the project are summarised below:

The Department of Health (DOH) **Transformation Implementation Group (TIG)** has overall oversight of the project. This group, chaired by Richard Pengelly, Permanent Secretary, provides the strategic leadership to oversee and make decisions on the design, development and implementation of the Minister of Health's *'Delivering Together'* Transformation Programme.

The **Emergency Care Regional Collaborative (ECRC)**, chaired by Dr Michael McBride, Chief Medical Officer for Northern Ireland as Senior Responsible Officer (SRO) is the main decision making body for overseeing the project and reporting progress to the Transformation Implementation Group. It will endorse recommendations and share learning with the HSC.

The Trust's Interim Chief Executive is the Senior Responsible Officer for the DHHPG and is working with the **Trust's Senior Management Team (SMT)** to ensure that the project group adheres to the Trust's established principles, policies and working practices in delivering the project outcomes and timescales and will provide progress reports over the duration of the project and identify any issues which may need Trust Board consideration and/or approval.

The **Trust Board** will be provided with timely, relevant and reliable information by the Trust's Interim Chief Executive and SMT. The End of Project Report, following approval of the ECRC, will be presented to Trust Board for endorsement. Special Trust Board meetings will be convened if necessary by the Board Chair.

The **Daisy Hill Pathfinder Group (DHHPG),** led and Chaired by Dr Anne Marie Telford, Project Director, is responsible for the direction and planning of the project and for overseeing the day to day/operational running of the Project. The corporate values and the priorities of the Trust guide its work.

Members of the DHHPG were selected to reflect the range of knowledge, skills and experience considered necessary to support the successful delivery of the project and work streams. Membership of the group (see Appendix 1) includes representation from:

- Southern Health & Social Care Trust (Southern Trust)
- Public Health Agency (PHA)
- Health & Social Care Board (HSCB)
- Southern Local Commissioning Group (Southern LCG)
- General Practitioners (GPs)
- Northern Ireland Ambulance Service (NIAS)
- Trade Union Representation
- Local Community Nominees

The DHHPG's remit includes:

- Agreeing the workstreams, their membership and remits;
- Setting timescales to meet PID requirements;
- Developing recommendations.

The DHHPG reports to the Southern Trust Interim Chief Executive who is the SRO of the Project.

2.0 Engaging Clinical & Non-Clinical Staff

2.1.1 A range of methods are being used to meet and engage with clinicians and non-clinical staff on both CAH and DHH sites considering that many staff provide services across Trust facilities.

2.1.2 A Clinical & Non-Clinical Staff Engagement event was facilitated by the Leadership Centre and held on Wednesday 9th August in the Canal Court Hotel, Newry. There were 85 stakeholders in attendance which ensured the involvement and participation of Trust Executive Directors, Public Health Agency, Associate Medical Directors, Clinical Directors, Consultants, Specialty Doctors, Senior Nurses, Allied Health Professional Leads, Social Work Leads, Diagnostics, Community staff, GP Out of Hours, local GPs, Pharmacy, Labs, non-clinical staff representation and the Patient Client Council.

2.1.3 The objective of the event was to ensure a common understanding of the remit of the DHH Pathfinder project and to provide an opportunity for staff to get involved in proposing and developing new ways of working to improve acute unscheduled care services. Discussion areas were designed to be broad enough so as to get as many ideas as possible from the groups represented. Following testing of initial thoughts with medical and nursing staff, the agreed discussion areas included:

Discussion 1: Shaping the future model – what do you want?

A - Share your ideas for new ways of working to meet the unscheduled care needs of people in the Newry & Mourne area – what would make a real difference?

B - What supports would need to be in place to make these happen and to ensure they are sustainable in the future?

Discussion 2: The future model – how will we get there?

How can we best ensure your involvement and maintain partnership working in the longer term as we develop and implement our proposals?

It was important to make the Engagement Event as productive as possible and to ensure that all the delegates were able to contribute their views and ideas.

The Health and Care Leadership Centre provided support and expertise in designing and preparing for the event and also facilitating the smooth running on the day. Delegates were divided into eight groups for the group discussions and were in a different group for the first and second discussion sessions. The 'Nearpod' interactive tool was used in the discussion groups to enable all of the ideas and views to be captured in real time and shared with the wider group during the feedback session. This proved to be a really successful tool for harnessing all of the energy and enthusiasm in the room.

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The key themes from Discussion 1 are summarised under the following seven headings:

- **Emergency Department**
- **Improving Patient Flow in the Hospital**
- **Alternative pathways**
- **Interface with Primary Care**
- **Supporting our Staff / Workforce issues**
- **Public Education & Communication**
- **Improving access through Technology**

Emergency Department

- Potential for presence in/access to other services in ED. This may be an advice service or rapid access to referral for assessment to a core service rather than hands on treatment. Adult mental health services in ED was cited as a good example of this which ties in with the psycho-social model.
- Need for a direct access frailty service for referral from ED triage.
- Outcome of the '100% challenge day' planned to take place in DHH will need to be considered.
- Improve configuration and enhance space in ED to improve patient flows.
- Explore opportunities for referral from ED to community pharmacy.

Improving Patient Flow in the Hospital

There was recognition of the great track record of innovation in the Trust and the need to build on what we know is working well.

- Development of ambulatory care services for medical and surgical services – small number of beds with interface with primary care/advice line - could be 'hot' clinics from ED, GP access and from wards. Also, potential for expansion of ambulatory Paediatrics to a 24/7 service (currently 12 hours).
- Review and enhance existing Surgical Assessment Unit to improve use. This will require some additional space to support development.
- Development of dedicated rapid access services for investigations and results to avoid admission.
- Further development of near patient testing to support clinical teams to reach timely decisions.
- Need to enhance laboratory turnaround time.
- Restructuring of diagnostics to provide protected ultrasound time for emergency care. Also, an MRI scanner at DHH would reduce the number of people needing to be transferred to CAH and would to help with investigation of acute trauma e.g. fracture pathways, hip fractures.
- Introduction of daily ward rounds in DHH (currently Monday, Wednesday and Friday).
- Development of a 'step down' unit & discharge lounge to facilitate patient flows and free up ward space.
- Develop a Level 2 Critical Care Unit for DHH.
- Enhancement of early pregnancy clinics over 5 day week which would avoid ED attendances.
- Patients with chronic diseases, such as inflammatory bowel disease, need better access to outpatient clinics to prevent attendances at ED (pathways should be developed in line with guidance to move this forward).
- Improve support to junior doctors to facilitate smoother discharge.

- Establish handover meetings/improve communications between teams through protected time for more structured meetings/learning between teams
- Considered why all services would need to be provided on both hospital sites – if there was the opportunity to replace both hospitals with one new hospital more ideally located this could make better use of resources, improve recruitment & retention and support more sustainable rotas.

Alternative pathways

We need to look at why people are attending ED and develop alternative pathways & services that would best meet patient need to avoid inappropriate attendances / use of ED services. Some potential ideas included:

- Further development of Acute Care at Home services as better for the patient (recognise the need for workforce planning to address recruitment issues). It is important that we change our message to the public by doing more assessment in the patient's home rather than in hospital. Respiratory infections could be treated at home to avoid ED attendance. Acute care at home could also be developed to include a single point of contact.
- Development of a new primary care service staffed by Senior Nurse Practitioner, Band 7 and doctor who triage, see and prescribe which could take pressure off GPs and ED (e.g. of this service in Liverpool).
- Upskilling of triage staff to provide increased awareness of alternative services available at ED triage and knowledge of when/how they should be used to ensure that patients avail of the most appropriate service to meet their need.
- Improved management plans and clear pathways for patients who are frail/elderly or have palliative care needs to avoid patients needing to attend ED.
- Development of Respiratory ICP (e.g. Belfast Trust).
- The need for more accessible community care services, e.g. 7 day working, to support an emergency ambulatory care model and to ease

pressure/help free up medical beds which will in turn ease pressure on ED and ambulance turnaround.

- Development of 7 day & out of hours enteral tube feeding service. This could be undertaken in the community setting by a multi-disciplinary team (nursing, AHP) rather than ED. Timely treatment for action to avoid deterioration of patient and need to understand skills of the team and when to call them in - patients can be seen in 20 mins rather than a 24 hour case.
- Enhancement of NIAS services with OT or other AHP services.
- Development of a community/primary care hub for services - to include a triage for initial point of contact for patients.
- Need for an alternative pathway for some fracture clinic patients.
- More proactive management of patients in nursing homes.
- Extending access to specialist advice at home/community e.g. mental health, cancer, long term conditions.
- Review the mental health assessment process and alternatives to admission and escalation processes

Interface with Primary Care

There was recognition of the significant pressures already placed on GP services both in-hours and out of hours and the challenge this will present, particularly considering the fundamental role that GPs have to play in supporting the development of any new and changing pathways.

- Improve communication/interfaces between Acute services and GPs, this should include protected time to access senior clinical advice via telephone/email (this would involve building in time in consultant job plans). This could include a single point of access for GPs and access to a Clinical Decision Unit with an ambulatory stream. Potential role for GPs working sessions in other services, e.g. Acute Care at Home.
- Better support for GPs to meet the needs of frail elderly patients in the community.
- Need to move to services that are multidisciplinary in design but wrapped around the patients and GPs.

Supporting our Staff / Workforce issues

- Need for an appropriate workforce plan with respectful sharing of roles and support.
- Recognition of staff.
- Examine new working patterns which cross traditional boundaries such as rotating between hospital and communities.
- Skill Mix - need to look at alternatives to the registered AHP/Nurse/Pharmacist and doctor.
- Opportunity to upskill nurses – we need more advanced nurse practitioners so they can assess and treat and enhanced access to specialist nurses after 5pm and weekends. We need to value these roles more.
- We need to build on the already positive working relationships.
- Improve sustainability of hospital
    - More senior clinical medical staff available at weekends to reduce admissions
    - Enhance the level of middle tier doctors (across all specs).
    - Seek NIMDTA support for increased numbers of trainees.
- Recognise AHP appetite to support system change - develop training programme for nursing homes to understand AHP roles e.g. podcasts or on-line training, and fully utilise skills to exploit the potential for extended roles.
- Need for workforce planning across professions and in partnership with service users and carers
- Need to better resource labs and radiography rotas

Public Education & Communication

It was suggested that people are not always using ED services appropriately. This was supported by the needs assessment work which showed high numbers and rates of attendances at DHH ED yet relatively low number of ED admissions.

- There is a need to change current public perception that all needs can be met in ED. This needs to be more than the 'Choose Well' campaign. Suggestions included:

- Honest conversations with the public - breaking down the reasons that people attend ED, be clear on what the correct service is to use and the right time to use it.
- Working in partnership to ensure proactive communication with those patients who are most frequent attenders/known to our service to provide them with advice on the best person to contact in time of illness, their role in self-management and reassurance, where appropriate, around their condition.
- Employers need to support employees to attend in hours GP.
- Educating children in schools, youth clubs, sports clubs etc about managing illness, what is normal and front line treatment.
- Educating the public about the added value that a range of practitioners can bring and other services available.
- Use of social media and internet e.g. use of pop ups of people speaking depending what has searched for.
- Communication via TV/screens in clinics, receptions areas etc.

Improving access through Technology

- Importance of access by professionals to patient clinical information to be aware of patient baseline information.
- Development of telemonitoring for remote monitoring of patient condition in their own home.
- Making better use of the IT systems that we currently have/shared records e.g. PARIS community aspect -true electronic record of patient care.
- On-call systems for access to certain services say to 11.00pm - may be more cost effective to have staff on call to provide a service.
- Potential for mobile units to provide service at events to avoid people attending going to ED.
- Primary/Secondary care - Patient records that follow them (e.g. maternity regional notes).
- Satellite clinics e.g. dermatology currently working well.

- Use of technology for video advice and to its maximum (including the robot).
- Technology to help teams to be more mobile, such as hand held devices to allow staff to move with the patient.

Discussion 2: The future model – how will we get there?

How can we best ensure your involvement and maintain partnership working in the longer term as we develop and implement our proposals?

There were 2 key themes arising from Discussion 2. These are summarised as follows:

- **The need for full engagement and involvement of all stakeholders in the development and implementation of plans**
- **Effective communication**

Fully Inclusive Engagement and Participation

The need to have buy-in and involvement from all groups was widely recognised.

- Multi professional working across primary, community and secondary care will be essential to enable proposals to be developed and taken forward. This approach will ultimately benefit all our patients.
- Strong relationships between acute and community staff need to be fostered and strengthened.
- All groups need to be engaged in the project and communicated with:
    - From primary, secondary and community care services, the voluntary sector, patients and the wider public
    - All groups of staff not forgetting non clinical staff such as porters, drivers, call handlers and admin staff need to be included
- Working groups need to be truly multi-disciplinary and should include junior staff.
- Staff should be given dedicated time to work on important proposals
    - Backfill may be required for staff
    - Use of SPA time may be appropriate for medical staff as workstreams will provide a professional development opportunity
- We need to ensure that all staff feel comfortable and supported to bring ideas to the table.

Communication

It was felt that, despite the communication to date, there is still a lack of clarity about the project across the Trust and within the wider community. This could be resolved with a communication strategy which results in information being widely disseminated and easily available to all stakeholders.

- A clear, concise communication strategy is required.
- The establishment of a specific communication workstream for the Pathfinder Project would be beneficial.
- The project management structure including membership of the various groups should be widely communicated.
- Information about key dates such as the dates for particular reports to be completed and disseminated should be communicated.
- Clear and understandable language should be used in all communications.
- The strategy should clarify how all the different groups of stakeholders will be kept informed and what methods of communication will be employed.
- Communication must be timely, concise and focused.
- All stakeholders should be aware of where they can access minutes, reports etc from the various groups and sub groups.
- It will be essential for delegates to receive feedback on the outputs from today's workshop.

Methods of Communication

It was recognised that it is difficult to reach everyone who has an interest in the Daisy Hill Pathfinder project and that no single method of communication will suit everyone who needs to be informed.

A range of different methods were suggested including:

- Establishing a dedicated webpage on the Trust internet site with a section on what is happening currently
- Generic e-mail updates (though it is accepted that not everyone has access to these nor the time to read them all)
- Twitter feeds and other social media, 'Whats App' groups

- Using GP Federations to disseminate information
- Open Trust Board meetings (that can be attended by members of the public, public representatives, GPs, staff etc)
- A Pathfinder email address that people can email queries to
- Establish an 'ideas innovation hub'
- Use of PC screensavers
- Information boards in departments
- Staff newsletters
- Nursing white board meetings
- Dissemination of information to staff via Staff Side representatives
- A standing agenda item for staff meetings
- Road shows in a variety of (public) locations
- GP and hospital consultant fora
- Use of teleconference to facilitate easier participation on workstream/sub groups
- Use of the Nearpod software (used at today's workshop)
- Video streaming meetings
- Use of existing groups eg medical education sessions (Friday afternoons)
- Further workshops like the one today

Reducing Negative Publicity

It was noted that there has been a degree of negative publicity about Daisy Hill Hospital. This affects public confidence and staff morale and can impact on the ability to attract and retain staff. It is important to communicate positive messages.

- Communication about this project to the wider community
- Hold 'roadshows' using locally recognised champions.
- Communicate a clear vision for SHSCT unscheduled care – in particular the Emergency Departments.
- Focus initially on developments that will produce early wins and publicise these. Revisit projects that have been developed but shelved due to lack of funding in the past.
- Be seen to implement quickly.

- Clearly communicate the short, medium and longer term actions that are proposed.
- Use of local newspapers to present a more positive image.

3.0 Next Steps

- The ideas and views within this paper will be shared with the DHH Pathfinder Group for inclusion in its report back to the ECRC on 23rd August 17.

- Your views on potential alternative care pathways/models of care will be brought together with ideas and suggestions raised through community engagement events, our work on needs assessment and other work ongoing in the Trust, including the recent Ambulatory Care Workshop, to inform a long list of potential proposals.

- By the end of August we will be coming back to you in regards to our plans for the prioritisation of this long list of proposals.

- Once we have agreed a recommended list of proposals we will be establishing 'Task and Finish' groups that will look at these proposals in more detail and work up implementation and investment plans for consideration by the ECRC and the Southern Trust.

Professional Group <u>SHSCT Medical/Management</u>			
Dr Bassam Aljarad,	AMD Children & Young People's Services	Mr Ronan McKeown	Consultant T&O Surgeon
Dr James Crockett	Specialty Doctor Anaesthetics	Mrs Anne McVey	AD, Acute Services
Dr Donal Duffin	Consultant Physician	Dr David Mawhinney	Consultant in Emergency Medicine
Mrs Esther Gishkori	Director of Acute Services	Dr Shane Moan	Consultant Physician
Mr Simon Gibson	AD Medical Directorate	Dr Seamus Murphy	Consultant Physician
Dr David Gracey	Consultant Radiologist	Dr Neville Rutherford-Jones	Consultant Anaesthetist
Mr David Gilpin	Consultant Surgeon	Dr Damian Scullion	Acting AMD for Anaesthetics, Theatres & ICU
Dr Gareth Hampton	Clinical Director, Emergency Medicine	Mr David Sim	Consultant in Obstetrics & Gynaecology
Dr John Harty	Consultant Nephrologist	Dr Ruth Spedding	Consultant in Emergency Medicine
Dr Martina Hogan	Associate Medical Director, Maternity & Women's Health	Dr Shahid Tariq	Consultant Anaesthetist
Dr Paul Hughes	Associate Specialist General Surgery	Mrs Heather Trouton	AD, Acute Services
Dr Sanjeev Kamath	Consultant in Obstetrics & Gynaecology	Mr Colin Weir	Consultant Surgeon

Professional Group <u>SHSCT Nursing</u>			
Mrs Mary Burke	Head of Service – Acute Medicine & Unscheduled Care	Mrs Anne Harris	Sister – Stroke Ward (DHH)
Mrs Alison Campbell	Sister – Elective Admission Ward (DHH)	Ms Laura McAuliffe	Department Manager – Emergency Medicine & Minor Injuries
Mrs Wendy Clarke	Lead Midwife - CAH	Mrs Joanne McGlade	Lead Midwife - DHH
Ms Natasha Cummins	Clinical Sister – Endoscopy (DHH)	Ms Noelle McGarvey	Staff Nurse – General Outpatients (DHH)
Ms Margaret Donnelly	Clinical Sister – High Dependency Unit (DHH)	Mrs Fiona Reddick	Head of Cancer Services
Ms Lynn Fee	AD – Nursing (Workforce Development Training)	Mrs Siobhan Rooney	Sister Coronary Care (DHH)
Ms Dawn Ferguson	Nursing, Education & Workforce		

Professional Group <u>SHSCT Allied Health Professionals</u>			
Ms Lynn Allen	Speech & Language Therapy (CAH)	Mrs Teresa Ross	Head of Physiotherapy Services
Ms Emma Givan	Dietetics	Mrs Denise Russell	Head of Podiatry
Mrs Carmel Harney	Assistant Director of AHP, WFD and Training	Ms Joanne Tilley	Physiotherapy (DHH)
Ms Lis O'Connor	Dietetics		

Professional Group <u>SHSCT Other Services</u>			
Ms Carolyn Agnew	Head of Promoting Wellbeing	Ms Catherine Farrell	Trade Union Representative - UNISON
Mr Brian Beattie	AD – Primary Care	Dr Richard Hamilton	General Practitioner
Mrs Tracey Boyce	Director of Pharmacy	Ms Shirley Henning	Social Work Team Manager
Mrs Anita Carroll	AD – Acute Services	Dr Maeve Lambe	General Practitioner
Mr Adrian Corrigan	AD – Mental Health	Dr Arnie McDowell	General Practitioner
Mr Loughlinn Duffy	Trade Union Representative – NIPSA	Mr Brian Magee	Head of Pathology Services
Dr Sandra Elliott	GP Out-of-Hours	Ms Suzanne Martin	Patient & Client Council
Dr Alan Evans	Clinical Lead – GP Out-of-Hours	Ms Yvonne Murphy	Team Leader – Integrated Care Services & Stroke
Dr Derval O'Reilly	General Practitioner	Mrs Catherine Sheeran	Head of Non-Acute Hospital, Integrated Care Services & Stroke
Mrs Jeanette Robinson	Head of Diagnostic Services	Dr John Shannon	General Practitioner
Dr David Rogers	Associate Medical Director – Primary Care	Ms Fiona Waldron	Lead Social Worker
Dr Petrina Ryan	General Practitioner	Mrs Catherine Weaver	Head of ITS Programme Management

Facilitators/Support			
Dr Anne Marie Telford	Project Director		
Mr Barry Conway	Assistant Director – Acute Services	Ms Charlene Stoops	Assistant Director of Corporate Planning – Project Manager of DHH Pathfinder Project
Dr Diane Corrigan	Consultant in Public Health Medicine, Public Health Agency	Ms Michelle Tennyson	Assistant Director of Allied Health Professionals – Public Health Agency
Dr Brid Farrell	Assistant Director Service Development, Safety & Quality, Public Health Agency	Mrs Vivienne Toal	Director of Human Resources & Organisational Development
Ms Claire Fordyce	Public Health Agency	Mrs Roisin Toner	Assistant Director - Enhanced Services
Mrs Mary Hinds	Director of Nursing and AHPs, Public Health Agency	Mrs Sandra Waddell	Head of Acute Planning
Ms Joanne McCloskey	HSC Leadership Centre	Dr Richard Wright	Medical Director
Ms Rose McHugh	Nursing, Public Health Agency	Ms Elaine Orr	Public Health Agency
Mrs Angela McVeigh	Director of Older People & Primary Care		

Mrs Heather Mallagh-Cassells	PA to Director of Human Resources & Organisational Development		

HSC Leadership Centre			
Christine McGowan	Principal Consultant, HSC Leadership Centre	Paula Taylor	ICT Programme System Training Support Officer, HSC Leadership Centre