APPENDIX 1

HEALTH AND SOCIAL CARE

DAISY HILL HOSPITAL EMERGENCY DEPARTMENT PATHFINDER PROJECT WITH IDENTIFICATION OF REGIONAL LEARNING

PROJECT INITIATION DOCUMENT

June 2017

PROJECT NAME	Daisy Hill Hospital Emergency Department Pathfinder Project With Identification of Regional Learning
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PROJECT SRO	Dr Michael McBride
DOCUMENT OWNER	Alastair Campbell

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Version	Key Changes	Date	Author
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Document approvals

Name	Signature	Title	Date	Version
Dr Michael McBride		**CMO**	**16/06/17**	**V6**

Document distribution

Name	Date	Version

Daisy Hill Hospital Emergency Department Pathfinder Project with Identification of Regional Learning

Project Initiation Document

This document covers the following areas:

Purpose

1. The purpose of the Project Initiation Document (PID) is to define the project, to form the basis for its management and the assessment of overall success. The PID has two primary uses:

    - To ensure that the project has a sound basis before asking the Southern Health and Social Care Trust (SHSCT) and the Department of Health (DoH) to commit to make any major commitment to the project; and,
    - To act as a base document, against which the SHSCT and DoH can assess progress, risks, issues, change and ongoing viability questions.

Introduction

2. On 27 April 2017 Stephen McNally, Acting Chief Executive of the SHSCT, wrote to Richard Pengelly, Permanent Secretary (DOH), asking the Permanent Secretary to sponsor a summit that would bring together the collective expertise of the wider Health and Social Care (HSC) family and other stakeholders to fully pursue actions to stabilise and sustain the Emergency Department (ED) service provision at Daisy Hill Hospital. The Permanent Secretary replied to Mr McNally on 27 April welcoming the approach that he had outlined, and agreeing to convene a summit of colleagues from organisations across the HSC. The summit would involve departmental colleagues, the Health and Social Care Board (HSCB), Public Health Agency (PHA), Belfast Trust, Northern Ireland Ambulance Service, Northern Ireland Medical and Dental Training Agency and the Regulation and Quality Improvement Authority. The summit would provide an opportunity for all stakeholders to collectively support the SHSCT in fully exploring all possible options to support a safe and sustainable ED service at Daisy Hill Hospital. Furthermore, the Department welcomed Mr McNally's comments, in his letter, that the Southern Trust is fully committed to Daisy Hill Hospital and wants to find a mitigation that allows the ED service to remain in place. The Permanent Secretary confirmed the Department's commitment to meeting both the immediate and long term population health needs for the people of Newry and Mourne.

3. The summit was held on 2 May 2017 chaired by the Chief Medical Officer (CMO). It was agreed that DOH would provide guidance to SHSCT 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 pathfinder model is to include public engagement in line with PPI/co-production informed by local and regional PPI fora.

Background

4. The SHSCT has concerns about the sustainability of Emergency Department services at both Craigavon Area Hospital (CAH) & Daisy Hill Hospital (DHH). This concern reflects ongoing difficulties in the recruitment and retention of suitably qualified and competent staff. Despite best efforts the Trust has not been successful in securing a sustainable solution to this difficulty. The Trust believes therefore that in the absence of appropriate cover in DHH between the hours of 8pm and 8am the service has the potential to be unsafe.

5. DHH Emergency Department has a long history of delivering high quality emergency care to Newry and the surrounding areas and the department is held in high regard by the local population. The number of patients attending the Emergency Department at DHH has continued to increase over recent years, now exceeding over 50,000 per year. The complexity of illness has also increased as an increasing proportion of patients reach an older age.

6. For over two years, the delivery of a 24 hour ED service in DHH has become increasingly challenging. Emergency Department services are delivered by senior doctors and the number of trained ED doctors at a middle and senior grade within the UK, Ireland and beyond has been insufficient to keep up with demand.

7. A number of significant measures have been introduced over the last two years to strengthen the department. These included recruitment of a large number of locums at both middle (Tier 3 & 4) and consultant (Tier 5) grade, additional senior nurses (Band 6) and the expansion of the Emergency Nurse Practitioner service. Support from in-house medical and surgical teams was also enhanced. These measures

were put in place to support the service and to allow the Trust to undertake a full and comprehensive recruitment programme, but this has not been successful.

8. The RQIA carried out an unannounced inspection of DHH from 5 to 7 December 2016 which included an inspection of the ED. The RQIA's report of the inspection was published in March 2017. While the report identified areas for improvement its overall findings indicated that the ED was well-led and provided a safe service.

9. Despite the positive RQIA Report, there remained three reasons for concern cited by the Trust, which are:

i) <u>Recruitment and retention of medical staff.</u>

10. The Royal College of Emergency Medicine suggests recommended staffing levels for a safe Emergency Department in a key paper from 2015. For a department with the activity of DHH ED at least 10 consultants are required with an appropriate middle grade support. DHH ED has only 1.8 WTE permanent ED consultants in post and only 2 middle grade doctors. The multiple attempts at recruitment are outlined in Table 1 at Annex 1 and Table 2 at Annex 2, almost all of which have been unsuccessful. The Trust has spent considerable time and effort marketing Newry and Daisy Hill as a location and good working environment as illustrated by the Trust's recruitment brochure. The Trust has used extensive advertising techniques both digital on line and in print but to no avail.

11. In acknowledgement of the challenges, uniquely in Northern Ireland, the Trust secured permission from DOH to offer an enhanced recruitment and retention package for the DHH post but also without success.

12. The Southern Trust working with a coordinated regional project implemented an international recruitment campaign both in Eastern Europe and Asia. The Trust has made conditional offers to 3 specialty doctors (Emergency Medicine) from this process although none have commenced yet. Unfortunately none of the offers are at consultant level.

13. Currently the ED department permanent staffing is 1.8 WTE Consultants (tier 5), 2 Specialty doctors and 5 Junior doctors in training (3 Foundation Year 2 doctors and 2

GP Trainees) (tier 2). This means that many evenings and nights have to be covered by locum middle grade and consultant doctors. Locum doctors do not necessarily have the same experience or qualifications required for substantive positions. Because of their temporary nature they may be unsuitable to fulfill the necessary supervisory requirements and can leave at short notice creating instability in the system.

14. The ED consultants in Craigavon have provided support to the Daisy Hill rota, however they are working on a 1:8 rota, instead of the recommended 1:10, and can only offer limited further support out of hours without destabilising the Craigavon ED rota.

ii) Supervision of training

15. The ED in DHH depends on a significant number of training grade doctors, many at a relatively early stage in their training. FY2 or General Practice trainees must have their training supervised appropriately to meet GMC requirements as overseen and assured by the Northern Ireland Medical and Dental Training Agency (NIMDTA). This supervision must be delivered by permanent grade staff.

16. The DHH Emergency Department was inspected by NIMDTA in Spring 2016 and was given a 'red' rating for sustainability (see scoring system at Annex 3). A further update was provided to NIMDTA in October 2016. In November 2016 the actions taken by the Trust to ensure appropriate supervision for trainees was noted. This resulted in a re-RAG assessment as Amber, to be monitored via the Local Education Provider (Trust) Quality Report. A further report has been requested by NIMDTA which the Trust will submit in summer 2017.

17. Extract from GMC/NIMDTA report 2015 with Sep 2016 update (further update now pending): "*Patient Care - The Department is heavily dependent on locums. A lack of sustainable, adequate senior supervision could call into question the sustainability of the Department for F2 and GPST training."* The department has been given a 'Red' rating for patient care which as outlined above, means "*Unsatisfactory-unsafe training environment-Immediate action"*

iii) Intensity of workload

18. The number of patient attendances has been steadily increasing over the last few years. Last year (2016) attendances increased to greater than 50,000; the largest percentage increase of any ED department in Northern Ireland. The workload in the 8pm-8am period has increased by at least 8% over the year with an overall increase of more than 10%. This increases significantly the risk for an inexperienced doctor working with relatively little support in the out-of-hours period. The comparison figures from DOH figures for the last quarter of 2016 are given in Annex 4 as compared to the same period in 2015 as an example.

In Summary

19. There are three main reasons for concern:
    a) Recruitment and retention
    b) Supervision of doctors in training
    c) Increased activity

20. Action is required to remove the Trust's increasing dependence on the availability of locums, enhance the supervision of junior doctors and most importantly provide a consistent, safe and sustainable model of care for Southern Trust patients.

Objectives of the Project/Terms of Reference

21. The project objectives are:

Objective 1

To develop an exemplar Model to meet the acute unscheduled care needs for the Newry and Mourne population, fully aligned with the principles and recommendations within *Systems not Structures* and *Delivering Together*. The Model should take account of the evidence base for modern timely care, ehealth/IT solutions, the science of efficient flow, the professional advice of clinicians in Daisy Hill and across the Southern Trust, General Practitioners and the people in the Daisy Hill catchment area, including other stakeholders, in keeping with the principles within *Delivering Together* and its commitment to coproduction. This will require:

- Completion of a population health needs assessment for unscheduled care, taking into account access and travel times as appropriate.
- Assessment of alternative care pathways across the continuum of community, primary and secondary care that might effectively meet some of the emergency care health needs.
- Development of comprehensive community engagement and involvement proposals aligned with extant statutory PPI requirements, PPI framework and the commitment in *Delivering Together* to co-production.
- Development of outline proposals for a service model for emergency care, taking account of the principles set out in *Delivering Together*.

If broad agreement cannot be reached within the timescales outlined, the DHHPG will escalate to the Departmental Regional Emergency Care Regional Collaborative and Department of Health.

Objective 2

Co-produce plans with the relevant stakeholders to strengthen local community based care, OOH primary care, ED, ambulatory and inpatient care.

Objective 3

Develop a workforce proposal for the Model including: innovative nursing, AHP, diagnostic, social and medical workforce recruitment, training and development plans to be developed in conjunction with HSC partner organisations (NIPEC, NIMDTA and other HSC Trusts). Proposals to improve recruitment and retention of medical staff should be developed; for example, job plans that include sessions or roles in other services or sites which maintain their skills in specialist care. This will include working with HSC Trusts to ensure that the development of the long-term Model includes devising short to medium-term interim arrangements to secure a sustainable workforce during transformation and transition.

Objective 4

To develop a high level Implementation and Investment Plan for the recommended Model, giving consideration to opportunities for recycling of existing and additional resources for consideration by the Emergency Care Regional Collaborative (ECRC).

Timescales

22. The report and recommendations on Objective 1 to be completed by the end of week 8.

23. An interim report and recommendations on all other Objectives to be completed by the end of week 16, with a final report by the end of week 20.

Authority for the Project

24. The authority for the project is provided by the Permanent Secretary, Department of Health.

25. Dr Michael McBride, Chief Medical Officer for Northern Ireland, is the Senior Responsible Officer for the Project.

Project Definition

Key Deliverables

26. The following **key products** will be delivered throughout the life of the project:

i. Project Initiation Document;
ii. Overall project plan;
iii. Workstream Plans;
iv. Risk Register;
v. Interim reports;
vi. Final report; and,
vii. Post Project Evaluation.

Project Scope

27. The **scope** will cover the work necessary to explore the medium and long-term acute unscheduled care needs of the Newry and Mourne population, including the role of Acute and Emergency Department Services in Daisy Hill Hospital (DHH), in light of recognised clinical need, population size and projected growth. In addition the project will provide general principles and approach to assessing the population needs of other relevant rural peripheral areas in Northern Ireland (NI). In-hours GP services and specialist mental health services are outside the scope of this project.

Constraints

28. The constraints on this project are:

    i. Medical workforce resources within the SHSCT and related HSC and stakeholder organisations to take forward this project and implement the resulting long-term Acute and Emergency Services Plan ("the Plan") for DHH;
    ii. Securing buy-in from stakeholders, particularly the wider Newry & Mourne community. The constraint concerns the ability to: demonstrate meaningful engagement; and, how best to ensure a representative group for all through PPI and coproduction), within the time available;
    iii. Timescales for completion of the 18 week programme of work set out in the terms of reference;
    iv. Timescales to make significant progress in implementation of the Plan within 15 to 18 months (by December 2018); and,
    v. Resources, both capital and recurrent.

Assumptions

29. The main assumption at this stage is that resources will be made available, in each of the stakeholder organisations, to take forward the work required to develop and complete implementation of the Plan.

30. Extant accountability arrangements remain and the Department will continue to look primarily to the SHSCT and the HSCB/PHA other Trusts and relevant HSC

organisations to ensure that a safe ED service is provided at DHH until a more permanent solution is put in place.

External Dependencies

31. The project is externally dependant on the following:

    i. The co-operation and understanding of Senior Management and Staff of the relevant HSC and stakeholder organisations; and,
    ii. Timely decision making.

Proposed Approach

32. To ensure that the defined outcomes are achieved the project will be managed and controlled in broad compliance with PRINCE methodologies with the priority being progress on agreed and recommended outcomes rather than process management.

33. The implementation of the Project to be informed and underpinned by improvement methodology to ensure wider regional system learning, scale and spread.

Phase One: Establishment of the Project

34. This will involve the establishment of the: Emergency Care Regional Collaborative chaired by the CMO as SRO; the SHSCT Task and Finish Group, known as the DHH Pathfinder Group; drafting the Project Initiation Document (PID); and, obtaining the SHSCT and DoH approval to proceed.

35. This phase will also involve establishment and population of any workstreams as necessary and development of high level timescales.

Phase Two: Plan and Design

36. This phase will 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.

Phase Three: Plan Implementation

37. This phase will:

- Involve the delivery of the agreed Implementation and Investment Plan (week 19 to week 78); 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.

Project Structure

38. The Project Structure will encompass: an Emergency Care Regional Collaborative (ECRC) chaired by CMO as SRO; the SHSCT Task and Finish Group, known as the DHH Pathfinder Group (DHHPG) which will be accountable to the SHSCT's Interim Chief Executive as SRO.

39. The ECRC is supported by a Secretariat. Workstreams will be established to deliver the Project's objectives as required.

40. Each workstream will require leadership, resources and, where necessary, a working group structure in accordance with the nature of the work they are leading.

Emergency Care Regional Collaborative (ECRC)

41. The Department's Transformation Implementation Group (TIG) has overall oversight of the Project. The ECRC is the main decision making body for overseeing the Project. It will agree the workstreams, timescales, facilitate progress on solutions for DH and endorse recommendations and share learning with the HSC. The Chief Medical Officer is the Senior Responsible Owner (SRO) and will report progress to the Transformation Implementation Group.

Membership of the ECRC:

42. Membership will be kept under review and will evolve and will draw on relevant experience across the HSC as required as the work proceeds.

- Dr Michael McBride, CMO, chair
- Charlotte McArdle, CNO
- Jackie Johnston, Deputy Secretary, DOH
- Dr Paddy Woods, DCMO
- Chris Matthews, Director of Social Services Policy Group, DoH
- Dr Anne Kilgallen, Chief Executive, WHSCT
- Dr Carolyn Harper, PHA
- HSCB Commissioner Representative
- Dr Sean McGovern, RCEM
- Dr Seamus O'Reilly, Medical Director, Northern Trust
- Dr Charlie Martyn, Medical Director, South Eastern Trust
- Dr John Maxwell, Clinical Director, Emergency Medicine, Belfast Trust
- Dr Grainne Doran, RCGP
- Margaret Moorhead, Assistant Director Allied Health Professions, SEHSCT
- Eileen McEneaney, Interim Director of Nursing, NHSCT

43. ECRC members have been selected to reflect a range of knowledge, skills and experience of the HSC which will be necessary to support successful delivery of the Project. Members will be responsible for supporting the SRO to achieve the aims of the Project. Membership of the ECRC will be reviewed on an ongoing basis.

44. It is expected that other stakeholders will be invited to attend ECRC workstream meetings as appropriate. In addition, expertise may be sought from critical friends or advisers.

ECRC Project Secretariat

45. The ECRC Project Director is Alastair Campbell assisted by Aaron Thompson. The Secretariat is responsible for supporting the ECRC, its Chair and SRO by managing the finance, liaising with external bodies, overarching management of administration, and by providing regular performance reports/stocktakes on workstreams against targets and work plans. The Secretariat will manage the project on a daily basis, monitor the outputs of the various workstreams, monitor progress against timetable and ensure deadlines are being met. During the course of the project, the Project Director may identify the requirement for further resourcing to support the project. Where this is required, and is not currently available, this shall be communicated to the Acting Deputy Secretary Healthcare Policy, ECRC and SRO in advance for approval and resource allocation.

DHH Pathfinder Group (DHHPG)

46. The DHHPG is the group 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 SHSCT will guide the work. Led by the Project Director, it will agree the workstreams their membership and remits, set timescales to meet PID requirements and develop recommendations, reporting to the SHSCT's Interim Chief Executive who will be the SRO for the Project. He will be accountable to the SHSCT's Board, reporting alongside the Chief Medical Officer to the Minister for the delivery of the Project.

<u>Membership of the DHHPG</u>

- Dr Anne Marie Telford, Project Director and Chair
- Dr Richard Wright, SHSCT Medical Director
- Mrs Angela McVeigh, SHSCT Director of Primary & Community Care
- Mrs Aldrina Magwood, SHSCT Director of Planning
- Head of Communications, SHSCT
- Dr Brid Farrell, AD for Service Development, PHA

- Dr Diane Corrigan, Consultant, PHA
- Mrs Mary Hinds, Director of Nursing, PHA
- NIAS nominee
- SLCG Commissioning lead for acute services
- HSCB Commissioner Representative
- Staff side Representative
- Community Representative

47. DHHPG members have been selected to reflect a range of knowledge, skills and experience of the HSC which will be necessary to support successful delivery of the Project. Members will be responsible for supporting the Chair to achieve the aims of the Project. It is expected that other stakeholders will be invited to attend DHHPG workstream meetings as appropriate. Membership of the DHHPG and its workstreams will be reviewed on an ongoing basis to ensure compliance with co-production principles set out in Delivering Together. In addition, expertise may be sought from critical friends or advisers.

Partnering Arrangement with the Belfast Trust

48. The Southern and Belfast Trusts have agreed a partnering arrangement to share the Belfast Trust's experience of developing new approaches to delivering unscheduled care through its IMPACT programme.

DHH Pathfinder Group (DHHPG) Secretariat

49. The SHSCT will provide the secretariat for the DHHPG drawing upon support from other HSC organisations as required. The Secretariat is responsible for supporting the DHHPG Chair by overarching management of administration, and by providing regular performance reports/stocktakes on the work of workstreams against targets and work plans. The Secretariat will support the project on a daily basis, monitor the outputs of the various workstreams and monitor progress against timetable and facilitate achievement of deadlines. During the course of the project, the Project

Director or the Secretariat may identify the requirement for further resourcing to support the project. Where this is required, and is not currently available, this shall be communicated to the Acting Chief Executive as SRO in advance for approval and resource allocation.

Workstreams

50. Workstreams for the DHHPG will be established by the Project Director as required during the development of the Project.

Project Benefits

51. The new DHH Acute and Emergency Model of Care and underpinning initiatives will stabilise and secure long term service provision for the population of Newry and Mourne. The anticipated learning from the DHH pathfinder part of the Project is expected to inform wider regional system learning, scale and spread.

Communication and Stakeholders

Communication method

52. Regular progress reports will be provided by the workstreams to the DHHPG and ECRC via their respective Secretariats. Progress on the project will be reported, via CMO, to the Minister and Health Committee.

53. An internal communication plan will be developed to ensure all relevant stakeholders are kept informed.

Key Stakeholders

54. The key stakeholders for the project include but are not limited to:

- Minister
- NI Assembly Health Committee
- Local population
- Public Representatives
- Patient Representative Groups
- Trade Unions/Staff Representatives
- Department of Health

- Southern Health and Social Care Trust
- All other HSC Trusts
- Health and Social Care Board (HSCB)
- Public Health Agency (PHA)
- Southern Area Local Commissioning Group (SLCG)
- Northern Ireland Ambulance Service (NIAS)
- Northern Ireland Medical and Dental Training Agency (NIMDTA)
- Regulation and Quality Improvement Authority (RQIA)
- Newry, Mourne and Down District Council

55. As part of the mobilisation and establishment phase, a stakeholder mapping exercise will be undertaken, and communications approach and plan developed by the respective Secretariats.

Project Controls/Governance Arrangements

Project Initiation

56. The project will formally start when the SRO has approved this document following consideration by the Board of the Southern Trust.

Meetings

57. As a minimum ECRC meetings will be held in week 7, week 15 and week 19 to consider the outputs from DHHPG. DHHPG meetings will likely have high frequency but not less than weekly.

58. At their respective meetings, the ECRC and DHHPG will:
    - Receive brief verbal (and written) progress reports from DHHPG highlights on objectives, achievements, communication activity and forward objectives and any critical issues.
    - Raise any new risks that could impact the Project and determine any actions to militate against the risk and/or an approach to mitigate the risk. Discuss arising issues with a view to deciding how the item can be resolved; ensuring that

appropriate actions are put in place; not necessarily resolving the issues at the time.

- Maintain and monitor progress on actions arising from the meetings.
- Consider matters requiring approval and/or issues referred under escalation procedures.
- The ECRC will focus on those issues that have a major impact on the overall project and/or require resolution across workstreams or with operational services.
- Individual workstreams should deal with day-to-day issues affecting them.

Workstream Meetings

59. Workstream meetings will be held as deemed appropriate. The workstreams will provide performance reports/stocktakes on their work against targets and work plans agreed by the ECRC and DHHPG.

Exception Reporting

60. Exception reporting to the ECRC will be carried out by the Project Director as required.

Project Issues

61. Risks and Issues may be raised by anyone with an interest in the Project at any time. The respective Secretariats will manage the Risks and Issue Log.

Risk Management

62. A Risk Register will be maintained throughout the project by both the ECRC and DHHPG.

Cost/Financial Arrangements

63. Financial arrangements will be managed to normal governance procedures through the respective Secretariats. All expenses incurred by the ECRC will be approved by the Project Director. All expenses incurred by the DHHPG will be approved by the SHSCT's Interim Chief Executive or as delegated by him to the Secretariat. The main cost associated with the achievement of the overall objective of the Project will be staff time.

64. It should be recognised that this Project will need significant commitment from the workstreams. In some cases dedicated resources may be required for substantial periods, in all other cases appropriate resources will need to be provided in a timely manner regardless of other commitments if the project is to meet its deadlines and objectives. In so far as it is possible each of the workstreams will attempt to quantify these requirements in advance as part of the planning process. However, flexibility is required by all stakeholders to help deliver this project.

65. The expectation is that each workstream will be supported at various stages as required. The various project workstreams take day-to-day responsibility for ensuring that project deliverables are of appropriate quality and delivered in a timely manner and will provide written reports to the ECRC and DHHPG.

End Project Notification

66. The Project will be formally closed once an End of Project report has been considered by the TIG.

Annex 1

Table 1: Recruitment attempts for speciality doctor posts 2015 to present

Job File	POST ADVERTISED	LOCATION ADVERTISED	DATE ADVERTISED	MEDIA	NO. OF APPLICANTS	NAME OF APPOINTEE
73815019	Specialty Doctor	DHH	24/2/2015	BMJ (British Medical Journal), NHS jobs, ROI media	2	2 appointments
73815037	Specialty Doctor	DHH	21/04/2015	BMJ (British Medical Journal), NHS jobs, ROI media	1	no appointment
73815042	Specialty Doctor (2 or more posts)	DHH	05/05/2015	BMJ (British Medical Journal), NHS jobs, IMT (Irish Medical Times),	2	no one shortlisted
73815044	Specialty Doctor - 4 posts	DHH	19/05/2015	BMJ (British Medical Journal), NHS jobs, IMT (Irish Medical Times),	2	no one shortlisted
73815058	Specialty Doctor - Acute Medicine & Emergency Medicine	DHH	23/06/2015	BMJ (British Medical Journal), NHS jobs, JC (Job Centre)	0	no applicants
73815073	Specialty Doctor – Emergency Medicine (4	DHH	07/07/2015	BMJ (British Medical Journal),	1	1 appointment to DHH

	posts)			**NHS jobs, JC (Job Centre)**		
73815081	**Specialty Doctor - Acute Medicine & Emergency Medicine**	**DHH**	**21/07/2015**	**BMJ (British Medical Journal), NHS jobs, JC (Job Centre)**	**0**	**no applicants**
73815090	**Specialty Doctor (M3 website)**	**DHH**		**(M3 website)**	**1**	**no appointment**
73815114	**Specialty Doctor in Emergency Medicine (3 or more posts)**	**DHH**	**08/09/2015**	**BMJ (British Medical Journal), NHS Jobs**	**1**	**applicant withdrew**
73815118	**Specialty Doctor in Acute and Emergency Medicine**	**DHH**	**22/09/2015**	**BMJ (British Medical Journal), NHS Jobs, JC (Job Centre)**	**0**	**no applicants**
73816056	**Specialty Doctor**	**DHH**	**03/05/2016**	**BMJ (British Medical Journal), NHS jobs, JC (Job Centre)**	**0**	**No applicants**
73816084	**Specialty Doctor Emergency Medicine, DHH 1 or More posts**	**DHH**	**05/07/2016**	**BMJ (British Medical Journal), NHS Jobs, FB (Facebook)**	**1**	**1 appointment to CAH**

Annex 2

Table 2: Recruitment attempts for Consultant ED posts 2015 to present

POST ADVERTISED	LOCATION ADVERTISED	DATE ADVERTISED	MEDIA USED	NO. OF APPLICANTS	NAME OF APPOINTEE	COMMENTS
Consultant in Emergency Medicine (2 posts)	DHH	05/05/2015	BMJ (British Medical Journal), NHS jobs, IMT (Irish Medical Times),	0	**no applicants**	
Consultant in Emergency Medicine (2 posts)	DHH	07/07/2015	BMJ (British Medical Journal), NHS jobs, JC (Job Centre online)	0	no applicants	
Consultant in Emergency Medicine (2 or more posts)	CAH & DHH	1/9/2015	BMJ (British Medical Journal), NHS jobs,	0	No applicants	
Consultant Emergency Medicine (5 posts)	CAH & DHH	12/01/2016	BMJ (British Medical Journal) full page ad, IMT (Irish Medical Times), NHS Jobs, JC (Job Centre online)	3	**3 appointees (2 for CAH and 1 for CAH & DHH)**	
Consultant in Emergency Medicine (3 posts)	CAH/DHH	31/05/2016	BMJ (British Medical Journal) Display, NHS Jobs, FB (Facebook)	0	no applicants	
Consultant in Emergency Medicine (3 posts)	CAH/DHH	05/07/2016	BMJ Display, NHS Jobs, FB (Facebook)	0	**No applicants**	
Consultant in Emergency Medicine (3 posts)	CAH/DHH	12/10/2016	HSCRecruit	1	applicant declined post in Feb 17	
Consultant Emergency Medicine	DHH	06/12/2016	BMJ (British Medical Journal)/EMJ (Emergency Medical Journal) /NHSjobs/IMT (Irish Medical Times)/FB (Facebook) /HSC Recruit	0	no applicants	Recruitment Premium may be payable
Consultant in Emergency Medicine **(Readvertised)**	DHH	14/03/2017 ***)***	BMJ (British Medical Journal)/EMJ (Emergency Medical Journal) /NHSjobs/IMT (Irish Medical Times)/FB (Facebook) /HSC Recruit	0	No applicants	Recruitment Premium may be payable

Annex 3

NIMDTA scoring system. This department has been already given a RED rating before the most recent departures.

	Grading Outcome	Description
A1	**Excellent**	**Exceeds expectations for a significant number of GMC domains**
A2	**Good**	**Meets expectations under all GMC domains**
B1	**Satisfactory**	**Areas for improvement identified, but no areas of significant concern**
B2	**Satisfactory (with conditions)**	**Areas for improvement identified. Specific concern to be addressed**
C	**Borderline**	**Areas of concern to be addressed**
D	**Unsatisfactory-Not able to assess**	**Unable to assess due to lack of trainee and/or trainer engagement with visit**
E	**Unsatisfactory-Urgent action**	**Urgent action required on areas of significant concern**
F	**Unsatisfactory-Unsafe Training Environment – Immediate Action**	**Immediate action to be taken by notification to nominated Trust representative. Possible withdrawal of trainees**

Annex 4

Attendances at Emergency Care Departments (December 2015 and December 2016) Department	**New Attendances**		**Unplanned Review Attendances**		**Total Attendances**	
	Dec15	**Dec16**	**Dec15**	**Dec16**	**Dec15**	**Dec16**
Mater	3,425	3,671	102	130	3,527	3,801
Royal Victoria	7,028	7,357	233	194	7,261	7,551
RBHSC	2,894	3,002	269	333	3,163	3,335
Antrim Area	6,037	6,416	298	346	6,335	6,762
Causeway	3,212	3,198	225	259	3,437	3,457
Ulster	7,046	7,572	167	168	7,213	7,740
Craigavon Area	6,345	6,578	358	405	6,703	6,983
Daisy Hill	3,787	4,325	187	240	3,974	4,565
Altnagelvin Area	4,788	4,716	250	246	5,038	4,962
South West Acute	2,510	2,688	160	121	2,670	2,809
Type 1	**47,072**	**49,523**	**2,249**	**2,442**	**49,321**	**51,965**
Type 2	**3,104**	**3,343**	**105**	**146**	**4,388**	**4,790**
Type 3	**4,827**	**5,119**	**198**	**220**	**5,025**	**5,339**
Northern Ireland	**55,003**	**57,985**	**2,552**	**2,808**	**58,734**	**62,094**

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