Dr Maria O’Kane
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Southern College of Nursing
Craigavon Area Hospital
Portadown
BT63 5QQ

31st March 2023

Dear Dr O’Kane

**Re: SECURING SERVICES AT DAISY HILL**

Following on from our visit to the Southern Health and Social Care Trust to review services I am writing to summarise our key findings and suggestions for building a sustainable model of care.

**STRENGTHS**

- The turnaround of the Emergency Department has been impressive.
- Track record of attracting, retaining and stepping up range of professional staff.
- Many areas have no issues with attracting and retaining staff.
- Shared education and governance across site for certain specialties.
- Pathfinder model has been useful in facilitating change.
- Other services functioning well, e.g., Maternity, Nephrology.
- Transfers for sickest and surgical patients appears to be working well. Relatively high numbers of transfers, but this does not appear to be a burden on the system.

**ANALYSIS OF PROBLEMS**

**Initial Remarks**

We were primarily commissioned to look at how care might be improved at the Daisy Hill (DH) site. However, we found that not only were both sites experiencing similar problems (sometimes to an even greater extent at the Craigavon Area Hospital (CAH) site), but that solving the problems at CAH might provide additional capacity and expertise that would then unlock some of the problems at DH.

The problems currently confronting both sites are not unique to either DH or CAH. Rather, they are currently being experienced by many hospitals across the NHS in all four devolved nations. What is unique are the relative sizes of the two sites. The smallest acute hospital in England is the Weston General (261 beds) which is still substantially larger than DH. CAH is itself a ‘smaller hospital’, the closest comparators being Raigmore (Inverness) in Scotland or Ysbyty Gwynedd (Bangor) in Wales. Most towns in England have hospitals of well over 500 beds. Models of care and certain other organisational solutions are not scalable – what works in a larger District General Hospital or a teaching hospital is very unlikely to be successfully implementable at either site. This is particularly the case with solutions that are predicated on more staff delivering services for narrow patient segments.

In smaller hospitals, this instead tends to stretch staff more thinly across more areas and increases, rather than reduces cost.

There are clearly some issues with capacity, especially at the CAH site. However, the closure of surgical services at DH markedly increased the number of beds available for Medicine and yet this did not solve the problems with flow in the hospital. This implies that **process** is a much more substantial problem than capacity.

**Systemic Problems (at both sites)**

- Lack of whole-systems approach with a focus on somewhat over-engineered complexity, rather than ensuring that processes are aligned and efficient. As a result, there is duplication and over-complication of processes.
- Services are not well tailored to patient need.
- Hospitals basically run Mon-Fri, with services scanty or non-existent over the weekend. This represents both a clinical risk and a major source of dysfunction (every Monday a disaster).
- Lack of alignment across sites – not remotely necessary that services should be identical (we would argue they should NOT), but they don't dovetail for either patients or staff.
- Insufficient diagnostic capacity – urgent need for MRI and 2nd CT on the DH site; along with 2nd MRI and a 2nd cath lab at CAH.
- Specialty input is too far back in the patient pathways; access is inequitable across the sites.
- Insufficient middle and junior grade staff, leading to unstable and occasionally unsatisfactory out of hours cover.
- Lack of formal Standard Operating Procedures and a lack of clarity about expectations.

**PROBLEMS – DAISY HILL**

**Medical Admissions**

- Emergency Department (ED) is experiencing major exit block. 'Corridor Medicine' has been normalised, both during the day and overnight.
- The adjacent ambulatory unit next door is also used for overflow – bedded patients overnight and over the weekend. Unit is then unable to function as normal during the day (although some patients able to be seen out of small consulting cubicles). This leads to an increased number of admissions presenting to the ED and acts as a deterrence to discussion with GPs.
- There is no unified medical clerking process for admitted patients. Patients are double-clerked by ED and the medical team (despite Medicine being effectively embedded in the ED).
- Some mechanisms put in place to help manage the front door seem questionable in terms of return for effort. It is appreciated that some of these are nationally directed, but these should be reviewed.
- Afternoon ward rounds by consultants are inconsistently conducted, not least in terms of starting and finishing time.
- There is usually no consultant presence after 6pm on weekdays or after 2pm on the weekend. There is a mismatch between consultant presence and when patients actually arrive. This adds additional delays to patient care.
- Review of patients the following morning is relatively haphazard and relies on a degree of good will from consultants. We heard that the meeting is not consistently attended and can often be fractious.
- Obtaining a specialist opinion or intervention is often difficult and relies on personal knowledge ('phone a friend') which is problematic when the majority of consultant staff currently are locums.
- It was difficult to discern what was actually happening in **Cardiology**, with regards to consultant management of the ward. However, it is apparent that delays for transfer for secondary PCI are

marked and due to lack of a 2nd cath lab on the CAH site.  There may also be a need for clearer policies to ensure more rapid movement of patients as it is not clear whether patients at DH have equality of access to this service.
- Quite complex services for **Geriatrics** in place, especially for size of the hospital.
- Hyperacute stroke, Acute Frailty Ward, Older People's Assessment Unit (in development), Rehabilitation, Hospital at Home (Do DH consultants contribute to this?).
- Ongoing tensions around whether there should one or two hyperacute stroke services limiting development and stability.
- Highly complex discharges are often problematic, although able to facilitate simpler discharges seemingly faster than other wards.
- The lack of reliable mechanisms for follow-up (virtual or physical) means that patients are often kept for 1-2 extra days for consultants 'to be sure' or for other information, such as final diagnostic reports or outpatient treatment dates.
- Processes for discharge, such as discharge summaries and TTOs, are cumbersome and 'sticky'. Addressing these keeps being pushed back, as a new Electronic Patient Record (EPR) system is in the pipeline (albeit repeatedly delayed).
- Across both sites there was a feeling that clinical leadership was being left to a few individuals. Not surprisingly these individuals reported feeling overwhelmed and despondent about their ability to effect necessary change.

**HDU**
- This currently poses a genuine clinical risk.
- Open unit – patients are cared for by the consultant they are under. Especially problematic given that most consultants are locum.
- No named clinical lead.
- Good assistance from Anaesthetics, out of hours (OOH) especially with regard to provision of technical expertise. Reluctance, however, to provide decision-making support to middle grade staff.
- Although the numbers of patients being transferred has fallen since the cessation of surgical services, the overall consensus is that tolerance for risk has fallen.

**CRAIGAVON MEDICAL ADMISSIONS**

The logical solution to many of the problems at DH would be to use the skills, capacity and experience of the CAH consultants to support services so they can be stabilised. However, we found that many of the same problems were replicated at the CAH site and were often more problematic than at DH.

**Medical Admissions**
- Exit block and poor flow are also problems, if not worse than the DH site. It is possible that patient stays are increased by 4-5 days because of this.
- Lack of side rooms is especially difficult – patients have been known to stay in ED for as long as 7-10 days.
- Corridor medicine also normalised.
- Same day emergency care (SDEC) area is entirely made of trolley spaces and hence is routinely used to bed patients overnight. There often NO space for any SDEC services to be run. The space is also expected to host Cardio and Elderly Care clinics, causing competition for space.
- Patients are reviewed by Acute Physicians until 8pm 3 nights per week. Weekend cover is provided only until 12.30 (time variable) by specialist physicians on 1 in 14 basis. Two additional consultants doing ad hoc weekend locums.

- Review of patients in the morning appears complex – two Acute Physicians round on the AMU, while other available Acute Physicians (variable in number, can include consultant assigned to SDEC) are dispatched to the ED. Lack of continuity is the norm.
- Flow for medical admissions is almost all 2-step – ED, Acute Medical Unit and then to the wards.
- Specialists have almost entirely retreated from the Acute Take. Paper referrals are required for most specialties. Often delays to reviewing, especially if the patient remains in the ED. Will only make recommendations, rather than take over care (even if obvious that the patient needs their care e.g. NSTEMI). Hence, often very substantial delays to specialist input/care and concerns were raised about safety.
- Appears to be difficulty in tracking patients and especially in determining which patients ought to go to which ward.
- No direct communication between teams at point of transfer of care.
- The comments about Cardiology services are identical to those above.
- We did not get a good feel for Care of the Elderly services, although Hospital at Home services appear to be developing with some success.

**THINGS TO WORK ON**

The problems of the front door of hospitals are not fixed by adding complexity at the front. Exit block and lack of flow are **whole hospital problems** and require whole hospital, joined-up solutions. While we acknowledge that the social care does contribute substantially to delayed transfers of care, nonetheless, around 30% of delays in discharge are due to issues that fall within the control of the hospital.

**1. Public commitment to the DH Site**

- There is an urgent need for the Executive Team to commit to the DH site and to a long-term plan for the two sites to be developed.
- We appreciate that national planning in NI is 'stuck' due to the current political situation. However, the Trust does need to fill the void left by this. Staff will not be attracted to nor will stay in hospitals in uncertain circumstances, especially when the new pay deal in ROI is comparatively very generous.
- There needs to be quid pro quo in any redistribution of services – the DH site must gain as well as lose.
- Resurrecting the Pathfinder project should be considered.

**2. Make Southern Trust (especially Daisy Hill) a great place to work**

- Define the Trust's **mission** (to serve the local community). Embed this at every level of the organisation. Some trusts find that short-term programmes help to get this kick-started, but it MUST be a long-term commitment that guides the Trust in the very long term.
- Address hygiene factors – offices, IT, onboarding/induction, the canteen, consultants' mess, parking etc. These are less important when it comes to recruitment, but are critical for retention.
- Bolstering of the DH site through provision of some hyper-specialist services (e.g., stroke), as well as regular outpatient clinics in each specialty on site.
- Consider whether revisiting the 'Pathfinder' project might be helpful.

**3. Reduce the pressure on the DH site**

- Is it possible to get help from elsewhere to bolster the general medicine service?
- The obvious place is Craigavon. Addressing some of the issues at Craigavon might reduce pressures there sufficiently to allow some staff capacity to being able to help.

- In the meantime, alternative sources of doctors at consultant, SAS and middle-grade levels should be explored e.g. Target international recruitment, creation of fellowship posts (more below), Medical Training Initiative Scheme (MTI) etc.

**4. Realism Around Models of Care**

- Hospitals of DH size could usually expect only 1-2 consultants in each of even the major specialities.
- Hospital of CAH size, would usually only have 3-4 consultants in the major specialties.
- Moreover, for a pop of ~350K, in which most of the sub-specialist stuff goes to Belfast anyway, there isn't remotely enough outpatient work for 10-12 consultants in each spec (which seems to be the minimum number touted to cover both sites).
- Generalist models of care are well-suited to the smaller hospitals, such as DH. The issue is easy access to consultation.
- CAH could run with a generalist model or with a 'blended' model, which would be most common in a hospital of this size (specialists deliver BOTH acute and specialist care), instead of aspiring to run a model of care suited to a large tertiary teaching hospital. By comparison, Chelwest, when it had 60K ED presentations, ran with 16 physicians TOTAL for standard Medical services.

**5. Restore flow (at both sites)**

- Stop overnighting patients in the DAU and SDEC areas immediately.
- Rethink the current DAU model at DH and have ED 'lean into' the care it provides. One option would be to consider the ED and DAU as a single team providing extended scope Same Day Emergency Care services 7 days a week. The absence of a full suite of on-site specialty support services on site at DH make this a more appealing option, rather than concentrating on simply acute medical presentations in the DAU. The DAU space might lend itself to management of patients that would prefer not to travel to Craigavon, pending specialty review if possible, eg when attending clinics at DH (or Emergency Physician review, if not). It is increasingly recognised that Same Day Emergency Care (Ambulatory Care) services can be delivered effectively by Acute Medicine *or* Emergency Medicine teams, and the proximity of the DAU to the ED appears to provide an opportunity to combine the two on the DH site. Increasing the hours of DAU and the cessation of patient boarding in the physical DAU space would significantly reduce the pressure on the ED, improve patient experience and likely improve outcomes.
- At CAH, need to consider whether the current area used for SDEC might be better repurposed as an ED CDU and/or whether they should lead services, with support from Medicine. If a Medical SDEC was considered to also be useful, this should be moved to a clinic-type area that cannot be bedded.
- For both sites, the purpose of any SDEC style services needs to be carefully considered. Service-created demand and scope-creep are a problem with these models. Are they for admission avoidance, rapid access for consultant opinion, supported discharge etc?
- On both sites, SDEC/ambulatory services need to be available 7 days per week.
- Both hospitals need to urgently rethink consultant medical presence in the evening and on weekends. Increasing cover in the evenings would reduce the burden on staff during the day AND reduce length of stay, thereby relieving pressure in the system.
- Given the high numbers of locum staff at DH, consideration should be given to whether Saturday mornings should become part of the standard working week (alternat Saturdays on their own + one other ward in return for afternoons off during the week).
- DH is sufficiently small that a 'firm' model, where consultants keep their take patients, should be considered.
- Both hospitals should move to a model of single clerking for medical admissions, where whoever does the initial assessment (regardless of team) is responsible for organising the initial investigation and care (drug charts, other pt orders etc).
- Grow the home care model.

- Improve access to imaging and diagnostics, particularly, MRI, CT and PCI. There may be novel solutions to the problem of an MRI scanner at DH, such as a mobile unit offsite, but close to the hospital.
- Systems and processes for discharge need to be urgently examined – these cannot wait several years for a new EPR system. This includes a review of the provision of pharmacy services OOH and might include ward-based dispensing and/or use of an Omnicell. Need to review, with social care, where replication and duplication of assessments and paperwork can be eliminated – a unified approach would substantially reduce friction across the system.
- Need to develop either hot clinics and/or virtual reviews to facilitate earlier discharge. The latter can be seen as an extension of current ward-based care.

**6. Specialty Input**

- On both sites, specialty input needs to be brought much further forward into the patient journey, with first contact being within 12-24 hours.
- The purpose of the AMU on the CAH site needs to be clarified and it is not clear what value it is adding to patients with specialty need. The focus should be on patients with undifferentiated illness and short-stay patients.
- Patients who are tagged as 'specialist' should be able to bypass the AMU, especially those who have already spent long periods in the ED. Ideally, wards should be supported to 'pull' the right patients to them.
- For the DH site, thought needs to be given as to how to facilitate and sign-post tele-support.
- For the CAH site, introduction of a morning 'triage' meeting, similar to that being held at DH, should be considered. All patients tagged as needing specialist input should be seen by the relevant teams that morning. This would also remove the need for cumbersome paper referrals.
- Pathways and points of contact need to be clear.
- Attention needs to be paid to interfaces of care.
- Consideration, especially at the DH, needs to be given to how to manage patients in need of semi-urgent investigation i.e. need imaging and review within 5-7 days. Often the alternatives for these non-cancer patients is either admission or review in 3-6 months.
- Other mechanisms for the provision and payment of OOH services by specialists, particularly the delivery of interventions overnight (eg. endoscopy for GI bleeds) need to be considered.
- Avoid further fragmentation of care at CAH through the development of specialist rotas.
- More outpatients on the DH site. This would also facilitate review of ward patients (many of whom could actually be seen in clinic).

**7. HDU at DH**

- Needs to have a Clinical Director with an appropriate skillset appointed as quickly as possible, in order to oversee the safety of the care provided in the unit.
- It is possible to safely run a small 'closed' HDU with 2-4 consultants, who provide care Mon-Fri, with cover OOH provided by other hospital staff already on call (Med Reg, Anaes), with additional decision making support provided remotely (e-ICU model). The ideal partner for the e-ICU support would be CAH, but alternatives should be considered. These is no evidence that these models of care produce poorer outcomes.

**8. Grow the workforce**

- Actively recruit and upskill doctors who wish to practice outside of conventional training (F3, fellowship, SAS). Invest in programmes that offer additional skills, e.g., education, Chief Registrar, quality improvement.
- Expand the 'advanced' practitioner model across professions and clinical spaces e.g. Nurse endoscopists.
- Consider whether a cross-professional 'academy' approach might be useful.

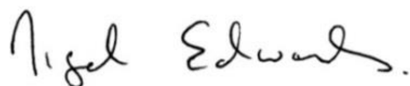
- Expand support for consultants practising without middle or junior grade doctors e.g. ward clerks, PAs, scribes.
- Should consider whether a partnership with one of the new rural medical schools in England is feasible.
- Schemes for encouraging local school children to consider careers in healthcare have been successful in parts of rural Scotland.

**9. Leadership and Standards**

- The relative lack of clinical engagement, particularly medical clinical engagement (with notable exceptions), coupled with a single relatively new Medical Director across both sites represents a clear opportunity.
- There could be benefit from creating and actively supporting a triumvirate structure for Clinical Specialties/Directorates consisting of Medical, Nursing and Managerial Leads.
- These positions would require support development and above all *time* to devote to the task of accepting responsibility and accountability for the delivery of services across both sites.
- Urgent need for SOPs (Standard Operating Procedures) and clear expectations that they are adhered to.
- Implementing something like the GSTT-Dartford buddying model might be useful (https://pubmed.ncbi.nlm.nih.gov/31098590/).
- Need to strengthen systems of care and governance mechanisms that promote clinical responsibility eg. 'firm' rather than 'ward-based' models of care, circulation of performance statistics (LoS, adverse incidents, investigation ordering etc).
- Introduction of cross-site governance and education (including Morbidity and Mortality meetings) could be key to breaking down inter-hospital professional barriers (similar to what ED has implemented).
- Is there a role for population approaches to certain conditions?
- Change in approach to consultant recruitment – a strategy for the whole of Medicine needs to be developed, based on the needs of the local population and what is required to support services (generalist/specialist, emergency/elective, inpatient/outpatient) across both sites. Approaches that have been flexible in recruitment both in terms of advertising and appointment are often successful e.g. if there is only one post in a particular specialty, but two excellent applicants, appoint both regardless.
- Consideration should be given to investing a trust-wide quality improvement programme. We would advise against this being separate from routine work. But rather managers and clinicians should be trained and given tools to support daily work using a QI (or better still, system engineering) approach. (Virginia Mason approach).
- Consideration needs to be given to other IT support systems that can be implemented without waiting for EPR. There are web-based systems, such as Vidimo, that can help substantially with a range of functions, including bed management and scheduling.

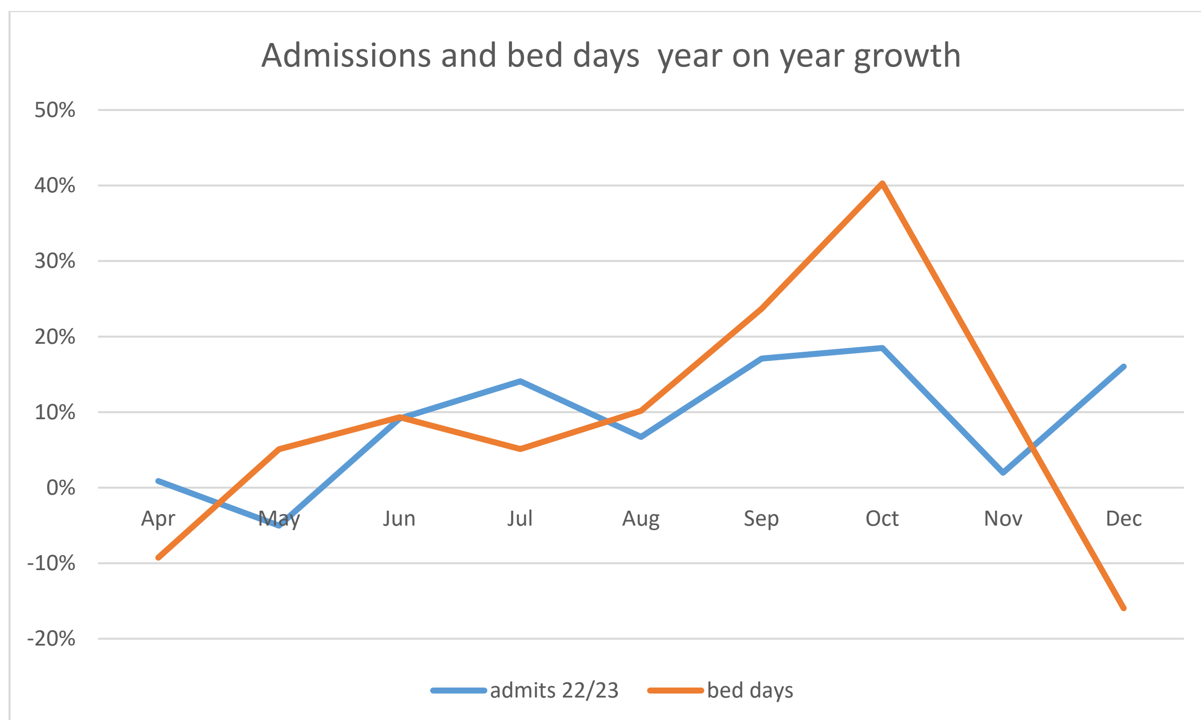
We do hope that you find our review helpful, but do get in touch if you have any queries about our findings.

With best wishes,



**Nigel Edwards**
**Chief Executive, Nuffield Trust**

**DATA**




| 3 | Row Labels | CRAIGAVON | DAISY HILL I | Grand Total |
|---|---|---|---|---|
| 4 | Emergency Use Of U07.1 | 956 | 325 | 1281 |
| 5 | Urinary Tract Infection, Site Not Specified | 428 | 278 | 706 |
| 6 | Mental And Behavioural Disorders Due To Use Of Alcohol | 411 | 291 | 702 |
| 7 | Lobar Pneumonia, Unspecified | 357 | 196 | 553 |
| 8 | Chest Pain, Unspecified | 291 | 257 | 548 |
| 9 | Syncope And Collapse | 258 | 184 | 442 |
| 10 | Chronic Obstruct Pulmonary Dis With Acute Lower Resp Infec | 291 | 150 | 441 |
| 11 | Acute Subendocardial Myocardial Infarction | 319 | 120 | 439 |
| 12 | Pneumonia, Unspecified | 262 | 154 | 416 |
| 13 | Congestive Heart Failure | 270 | 120 | 390 |
| 14 | Other And Unspecified Convulsions | 247 | 105 | 352 |
| 15 | Headache | 165 | 148 | 313 |
| 16 | Atrial Fibrillation And Atrial Flutter, Unspecified | 187 | 120 | 307 |
| 17 | Pneumonitis Due To Food And Vomit | 201 | 100 | 301 |
| 18 | Acute Renal Failure, Unspecified | 174 | 116 | 290 |
| 19 | Tendency To Fall, Not Elsewhere Classified | 148 | 86 | 234 |
| 20 | Sepsis, Unspecified | 147 | 80 | 227 |
| 21 | Cellulitis Of Other Parts Of Limb | 125 | 99 | 224 |
| 22 | Unspecified Acute Lower Respiratory Infection | 138 | 80 | 218 |
| 23 | Chron Obstruct Pulmonary Dis Wth Acute Exacerbation, Unspec | 113 | 97 | 210 |
| 24 | Cerebrl Infarct Due Unspec Occlusion Or Stenos Cerebrl Arts | 142 | 63 | 205 |
| 25 | Pulmonary Embolism Without Mention Of Acute Cor Pulmonale | 129 | 76 | 205 |