Letters

Of the 75 IAs, 59 (79%) were in individuals who had self-presented. This included 22 patients at the RVH (5% of all RVH attendances) and 37 at the MIH (16% of MIH attendances). 16 IAs (21%) were in patients referred by a GP, who did not require ED care. This included 5 attendances at RVH and 11 at MIH.

Very few IAs were assigned a Manchester Triage Category of 5 (non-urgent) (Figure 1). 6 patients were categorised as Category 2 (very urgent) and 43 as Category 3 (urgent).

This study identified that most attendances were appropriate. The MIH had a greater proportion of IAs with larger numbers of both inappropriate self-presenterations and GP referrals. This may reflect accessibility to primary care or a greater prevalence of chronic illness in the catchment area.

The proportion of IAs was 11.6% overall. This is similar to the findings of an analysis of attendances captured in a national ED dataset over one year, which identified 11.7% as inappropriate. Other studies estimate a greater proportion of attendances to be avoidable. A systematic review suggested that 20–40% of attendances were inappropriate. Analysis of the Royal College of Emergency Medicine Sentinel Site Survey, conducted in March 2014, identified around 15% avoidable attendances. This variation may be due in part to the lack of a standardised definition of ‘inappropriate’ attendances.

Some patients may be being triaged into higher categories than their clinical condition would necessitate. A recent systematic review identified that the Manchester Triage System had both potential to under- and over-triage patients, impacting on safety in the ED and waiting times for patients.

A limitation of this review is its small size. As it was carried out through retrospective note review, it is limited by the amount of information recorded on the notes. It may be possible that some presentations were wrongly categorised as inappropriate or appropriate.

This analysis has provided information on the proportions of patients attending ED in the Belfast Trust who have potential to be seen safely in an alternative setting. This may help to inform future investment decisions for those working in unscheduled care in Northern Ireland.

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DO THE PUBLIC GET WHAT THE PUBLIC WANTS IN NORTHERN IRELAND HEALTH AND SOCIAL CARE?

Editor,

Healthcare systems in Northern Ireland have undergone some degree of transformation over the last decade. Within the hospital sector, some services have relocated from smaller “local hospitals” to larger units. However, reorganisation of services has proven difficult, with evidence based proposals ignored and service alterations overturned by Government or judicial review, often as a consequence of “Save our hospital” campaigns by local community groups and political representatives. It is nonetheless unclear if these voices are representative of the population.

The recently published Donaldson Report recommends a major service reconfiguration to provide the Northern Ireland population with optimal secondary healthcare. The subsequently appointed Northern Ireland Health and Social Care (HSC) Review Panel aims to determine the needs of the Northern Ireland population and describe a configuration of health and social care to best serve these.

Over recent years, increasing emphasis has been placed on empowering patients by offering more choice on treatment location and methods, similar to other consumer choices. In this context, do patients employ a similar decision making process when contemplating healthcare decisions to that employed when purchasing other consumer commodities? We compared Northern Ireland public attitudes to healthcare with that of traditional consumer goods.

Methods

Questionnaires to assess public attitudes were distributed over a two-week period (18th-31st July 2014) in two locations–Belfast and Newcastle, County Down. Participants living

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within the Greater Belfast area were considered to be urban dwellers, all others were considered rural dwellers. Data were analysed using SPSS (Version 21.0 Armonk, NY).

Results

One hundred questionnaires were completed. The participants rated accessibility of healthcare as more important than accessibility for traditional consumer products (Table 1). Participants would travel further for healthcare treatments than a variety of consumer products. Notably, participants would travel further for high quality products including healthcare treatments than for products of average quality (Table 2).

\[\text{Table 1.}\]

| The importance of accessibility to healthcare and consumer items | Importance of accessibility* |
|---------------------------------------------------------------|------------------------------|
| Sick children                                                 | 4.63                         |
| Cancer treatment                                              | 4.63                         |
| Accident and Emergency                                        | 4.39                         |
| Cardiac surgery                                               | 4.16                         |
| Outpatient clinic                                             | 4.09                         |
| Bread                                                         | 4.09                         |
| Everyday essentials e.g. shampoo                              | 4.04                         |
| Large household appliances                                    | 2.78                         |
| Clothes for a special occasion                                | 2.55                         |
| Television                                                    | 2.51                         |

*Accessibility was measured on a Likert scale from 1-5 with 5 being highest importance

Discussion

Consumers have similar attitudes to healthcare as they do to other consumer commodities. Consumers are willing to travel further for what they perceive to be specialised products or large one off purchases such as a fridge or television. Similarly, consumers are willing to travel further for traditionally perceived specialised treatments such as cardiac surgery, in comparison with GP or outpatient attendance. The public do want community based services such as their general practitioner to be nearby, similarly to frequently purchased consumer items such as bread. However, consumers are willing to travel on average more than one hour for secondary healthcare such as cancer treatment, particularly when the healthcare provided is of high quality. No longer should pressure be applied to maintain all local healthcare services at the expense of providing regional services of high quality. We encourage the HSC review panel to focus on the provision of high quality health and social care regardless of vocal opposition and suggest that implementation of a quality focussed system would meet the approval of the Northern Ireland population.

\[\text{Table 2.}\]

Acceptable travel time for healthcare and consumer items of varying quality.

| Average quality | High quality |
|-----------------|--------------|
| Item            | Travel time* | Travel time* |
| Cardiac surgery | 3.29         | 3.60         |
| Clothes for a special occasion | 3.05 | 3.20 |
| Cancer treatment | 2.98        | 3.56         |
| Large household appliance | 2.72 | 3.05 |
| Television      | 2.67         | 2.96         |
| Outpatient clinic | 2.45        | 2.99         |
| Accident and Emergency | 2.38 | 2.96 |
| Sick children   | 2.21         | 3.19         |
| GP              | 1.92         | 2.59         |
| Bread           | 1.16         | 1.48         |

Travel time was assessed using a Likert scale from 1-4 corresponding to the travel times below

1 2 3 4
0-15 minutes 15-30 minutes 30-60 minutes more than 60 minutes

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ASSEMBLY OF SUCTION APPARATUS. AN ACQUIRED SKILL?

Editor,

Suction is an important aid in airway management. Correct assembly of the suction particulate trap apparatus is a prerequisite for obtaining sufficient vacuum. We sought to determine if the assembly of suction apparatus is an acquired