Urgent and emergency care recent winters …

and the future

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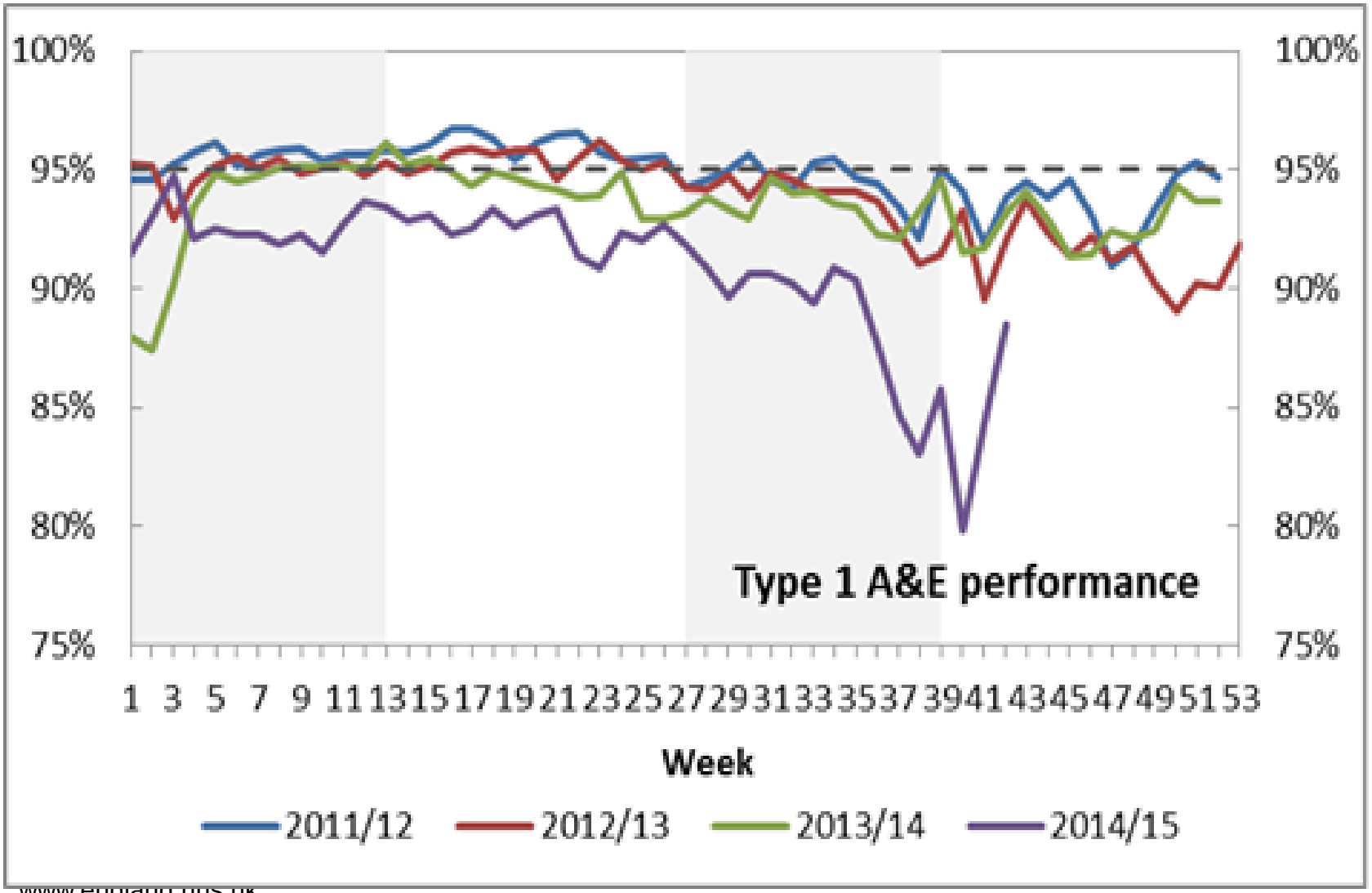
Director of Acute Care

April 2015

What does the experience and data for this winter tell us?

- Surge in demand exacerbated the **problems in a system** we knew was already under strain
- The surge “problem” is **emergency hospital admissions**
- Strong **upward trend in contacts** especially to NHS111
- **Resilience, and availability, of community-based services** and the important relationship with social care services compounds difficulties in the acute hospital sector – leading to **unnecessary admissions and delayed discharges**

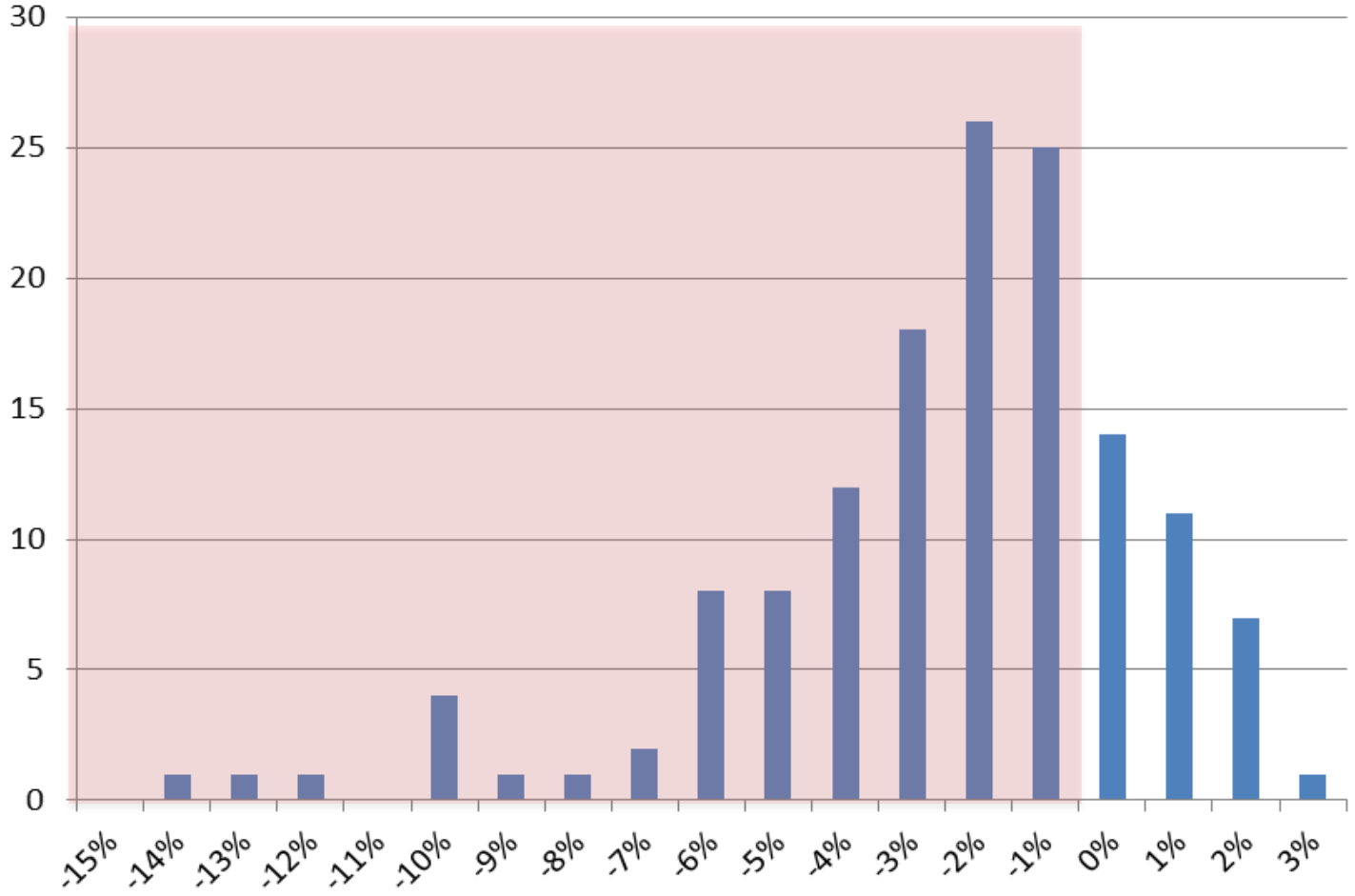
Weak 4-hour performance through 2014/15



Problems are systemic rather than localised

NHS England

Number of Trusts by change in A&E performance (Oct-Dec 14 vs Oct-Dec 13)



What behind what we are all experiencing?

- There are demand and supply issues – complex
- Major **recruitment issues** nationally in GPs, paramedics, nurses and Acute and Emergency Medicine
- Lowest number of beds per capita in western healthcare
- **Most efficient healthcare system in the world**
- **We have been set the highest operational performance targets anywhere in the world – A&E, 999 response etc.**
- Wherever you put the thermometer it will read hot!

Paramedics, doctors, nurses are staying focussed on the patients in their care ….. it is the clinical staff that save and maintain the reputation of the NHS

Current provision of urgent and emergency care services

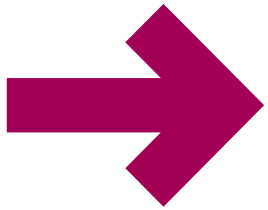
>100 million calls or visits to urgent and emergency services annually:

Self-care and self management	• **438 million** health-related visits to **pharmacies** (2008/09)
Telephone care	• **24 million calls to NHS** • **urgent and emergency care telephone services**
Face to face care	• **300 million** consultations **in general practice** (20010/11)
999 services	• **7 million emergency ambulance journeys**
A&E departments	• **15 million attendances at major / specialty A&E** • **5 million attendances at Minor Injury Units, Walk in Centres etc.**
Emergency admissions	• **5.4 million emergency admissions to England's hospitals**

What we knew before?

- a 1% increase in the population that **failed to access a GP** within 2 days predicts a 0.7% increase in self-referred A&E visits.
- 1 in 4 people state they would **use A&E for a recognised non-urgent** problem if couldn't access their GP
- 1 in 4 people have **not heard of Out-of-Hours GPs**
- 75% of those who had intended to go to A&E, but phoned **NHS111**, were managed without needing to go; and 30% who would have dialled 999
- **Urban** 15% and **deprived** 42% populations higher A&E use

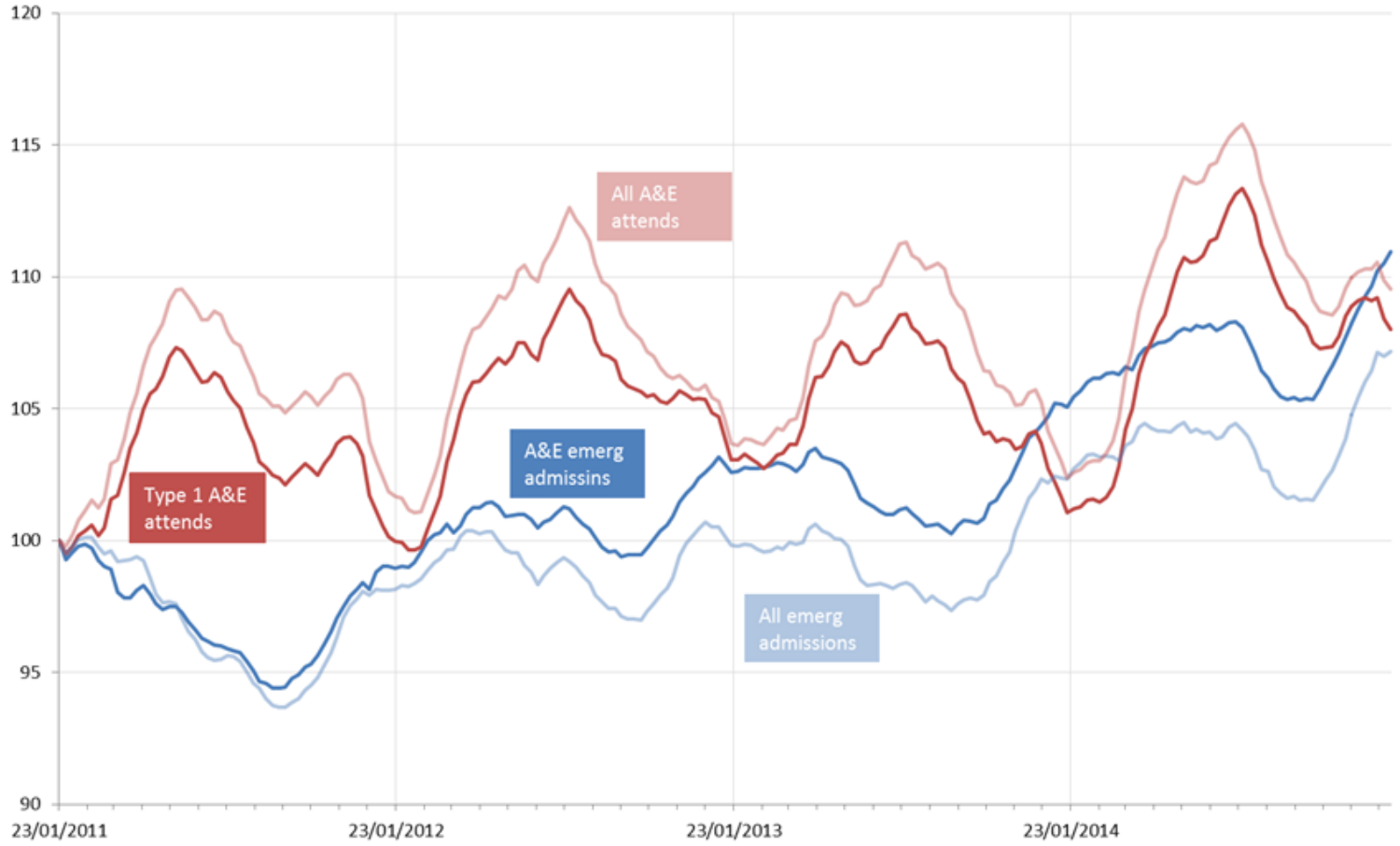
…. but its not about attendances…….



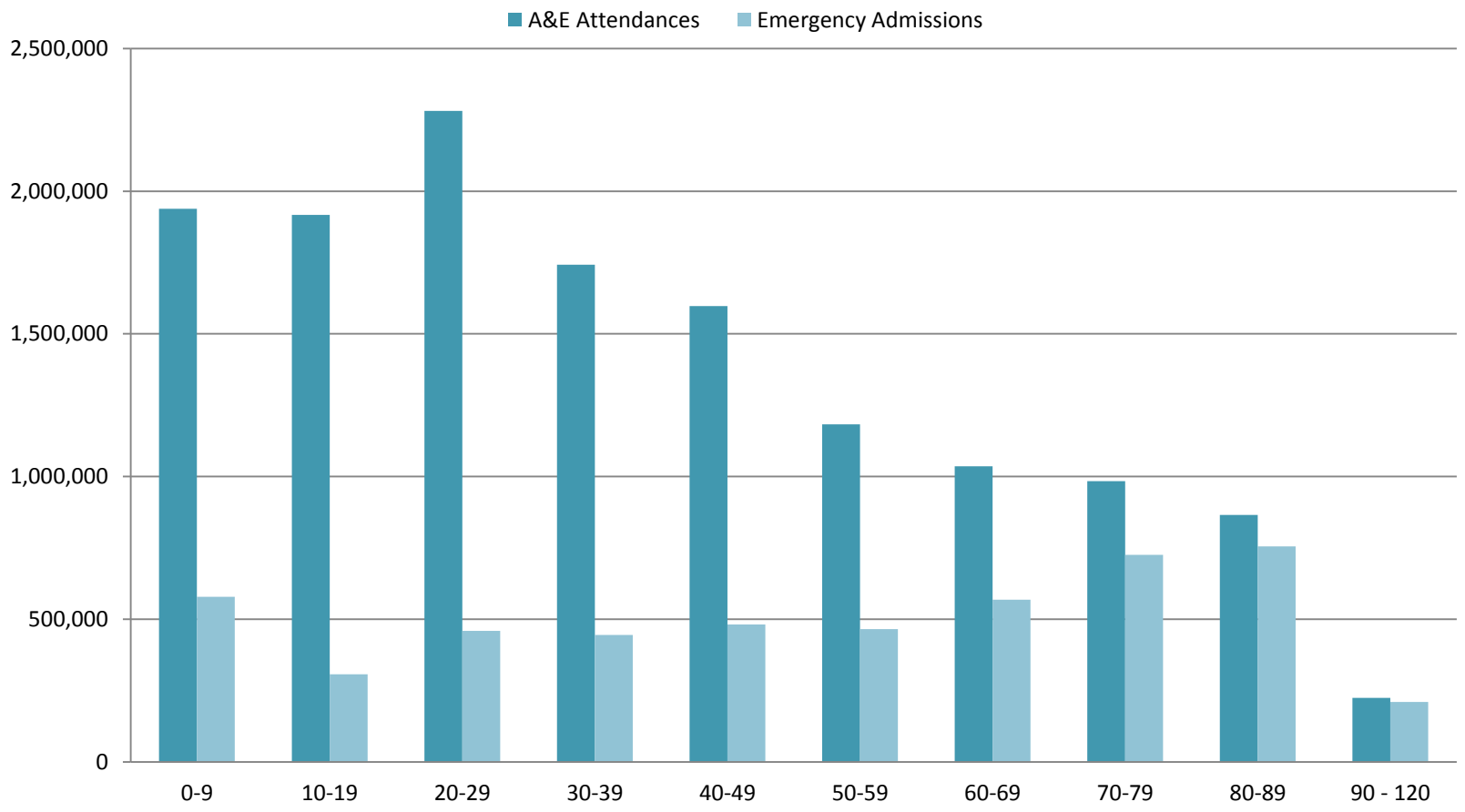
It’s not attendances, it’s admissions stupid!

NHS England

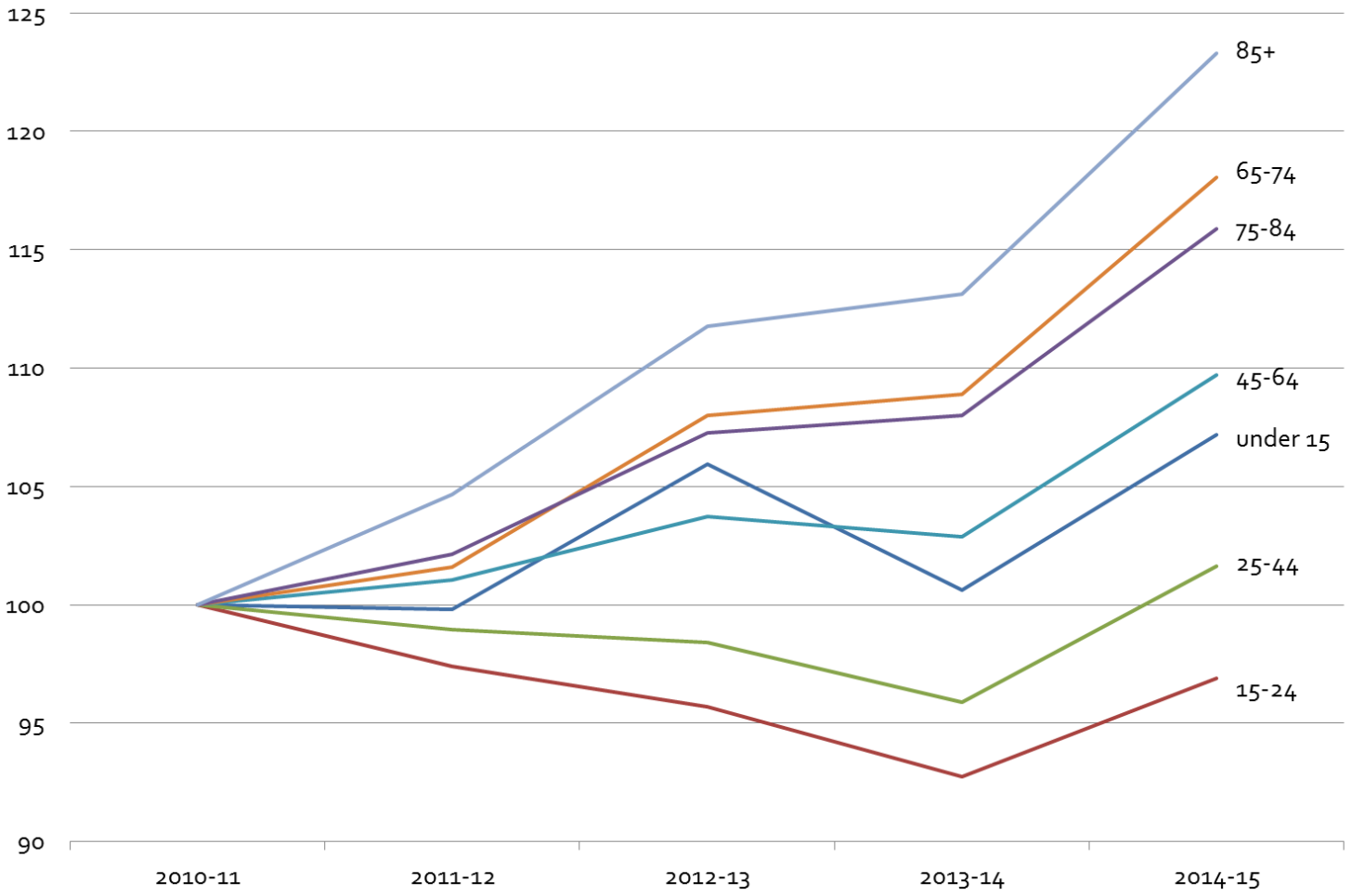
A&E attendances and emergency admissions, 13-week rolling average (indexed)



Who are these emergency admissions?



Emergency admissions from A&E have grown for all age groups, especially oldest



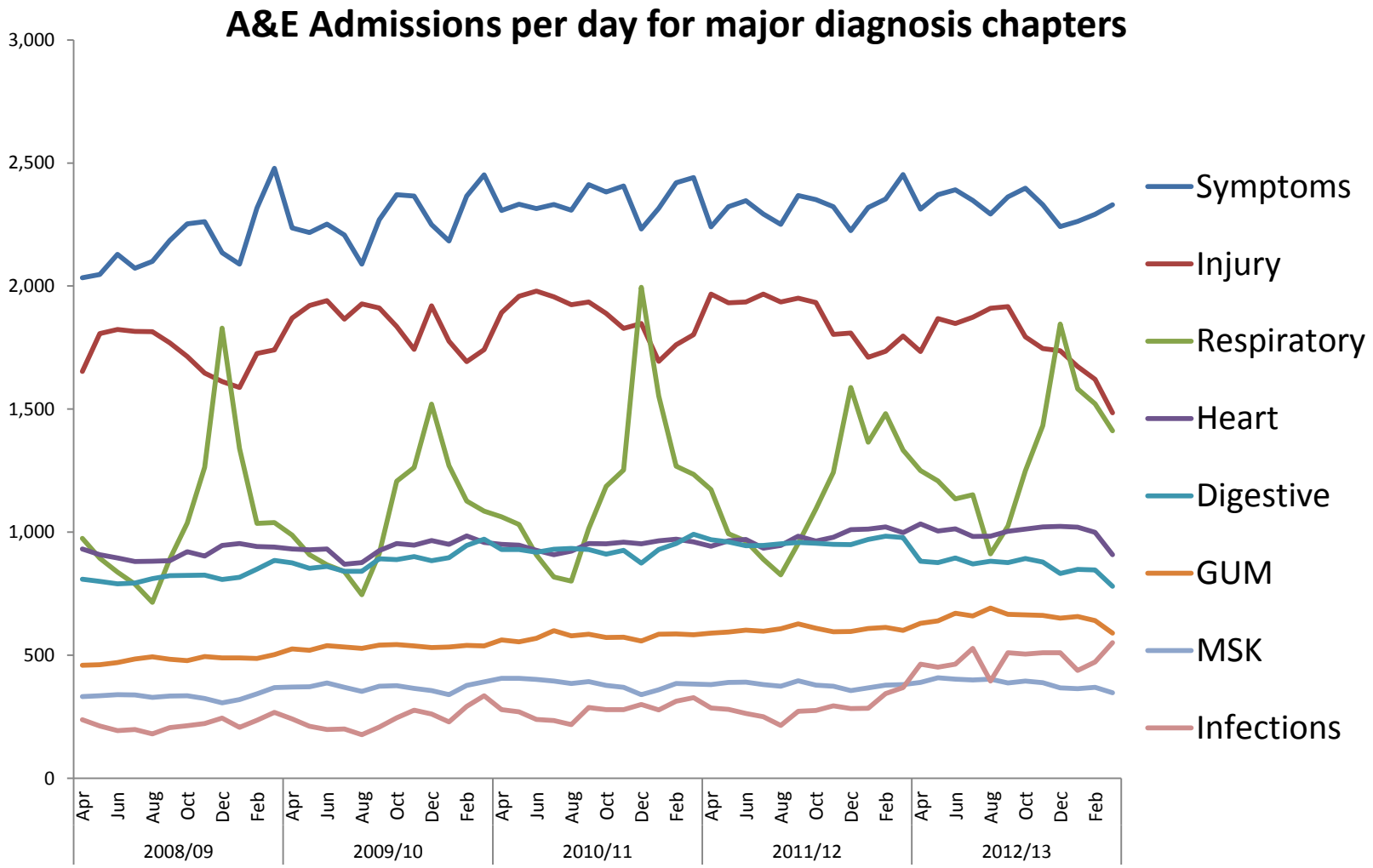
Source: HES data, Apr-Sep, each year

Most studies suggest that admissions can be avoided in 20-30% of >75 year old frail persons

"Avoiding admissions in this group of older people depended on high quality decision making around the time of admission, either by GPs or hospital doctors. Crucially it also depended on sufficient appropriate capacity in alternative community services (notably intermediate care) so that a person's needs can be met outside hospital, so avoiding 'defaulting' into acute beds as the only solution to problems in the community".

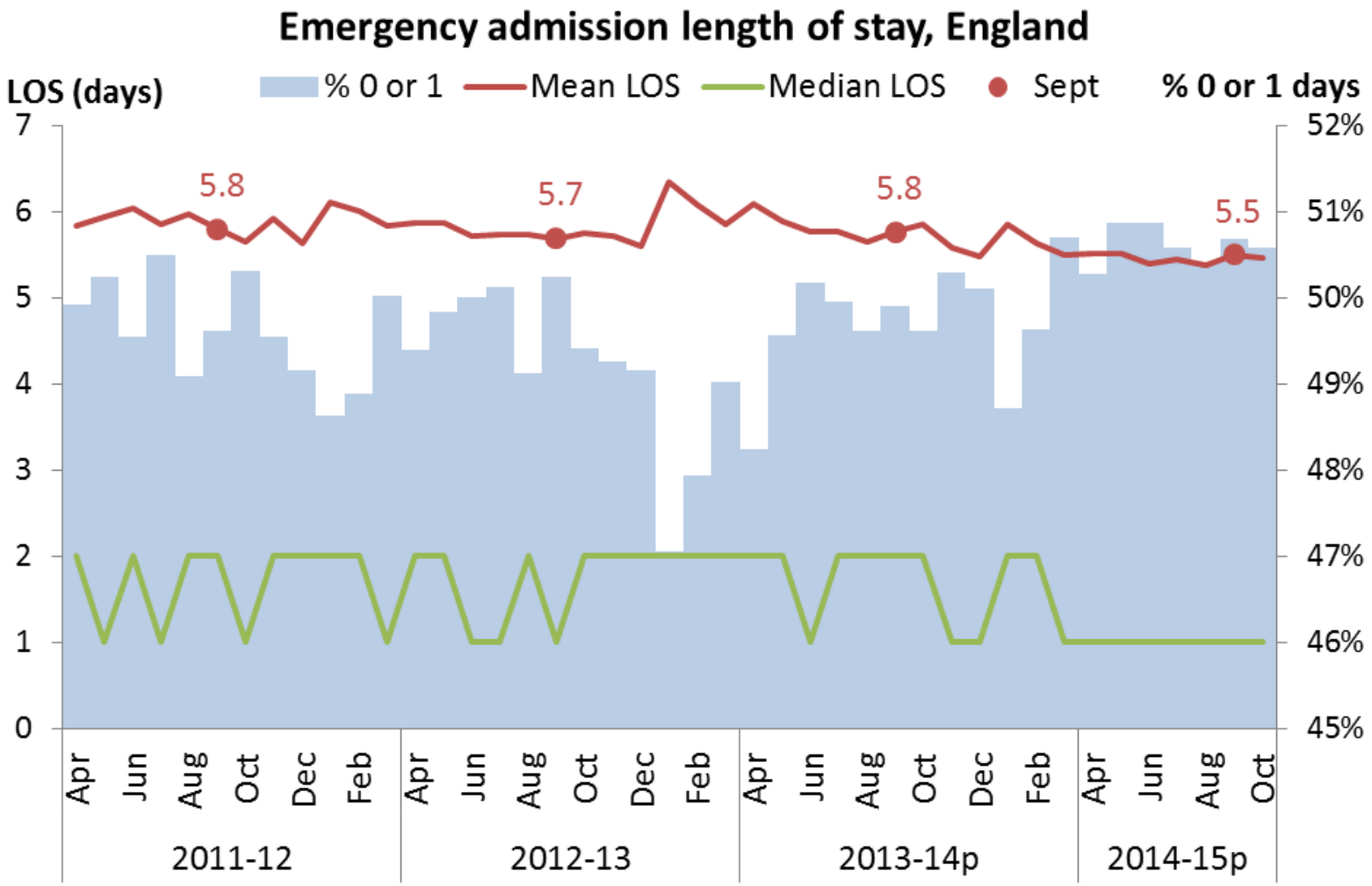
Mytton et al. British Journal of Healthcare Management 2012 Vol. 18 No 11

And with what?

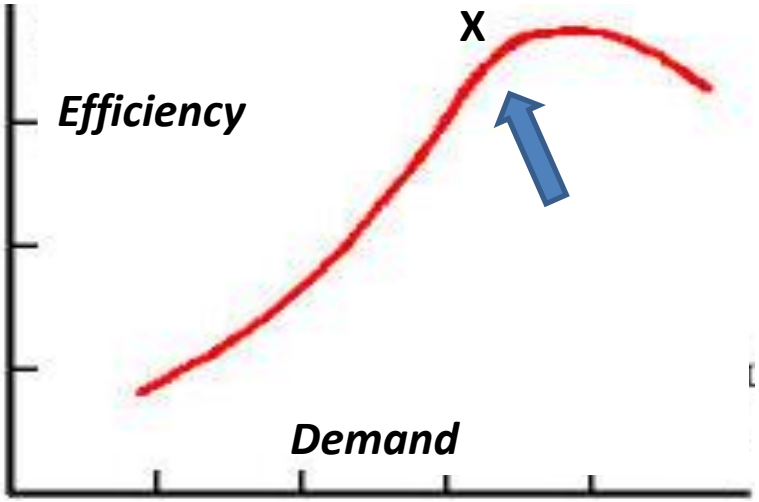


Mental health primary problem in 4% of A&E attendances, implicated in 15-20%

Despite pressure - average length of stay for emergency admissions has fallen



Congestive Hospital Failure



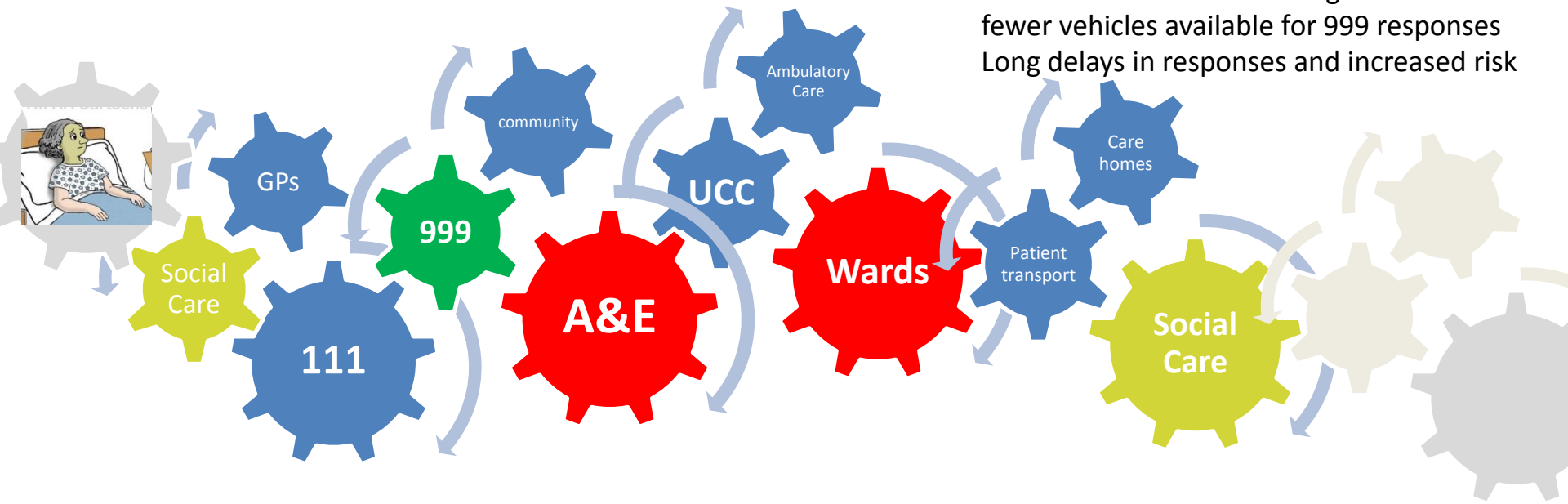
What happens at point "x"?

1) Patients outlying: (mortality ↑)
- inappropriate nursing
- inefficient ward round / treatment
- less senior input and DTOC

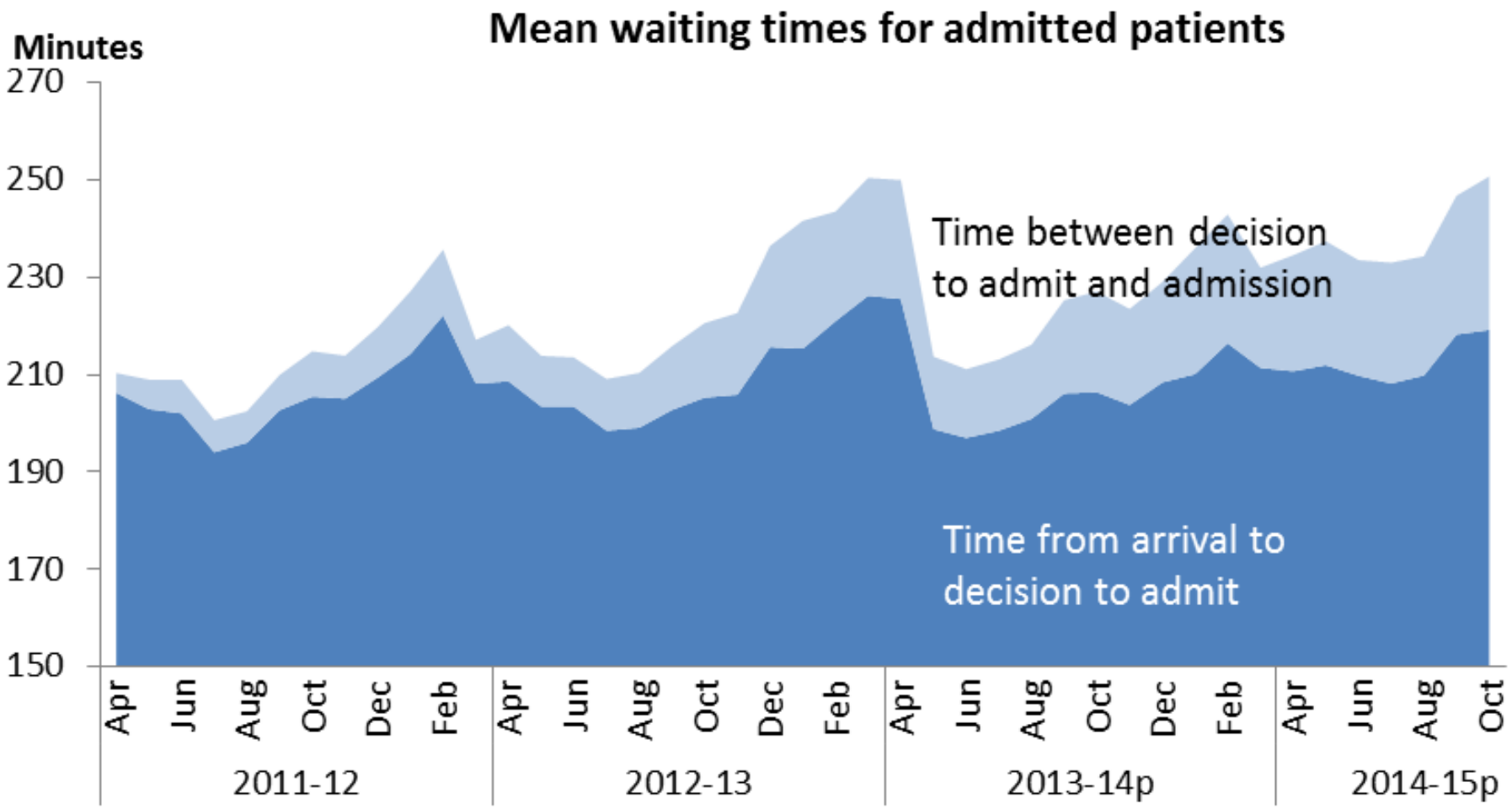
2) Increase beds numbers
- "isolated" escalation wards
- unfamiliar temporary / agency staff

3) Patients backing up in A&E
- majors cubicles and trolleys occupied
- overflow to other holding areas
- observation and care compromised
- ↑ focus on A&E at expense of wards
- congestion – diminished flow all patients

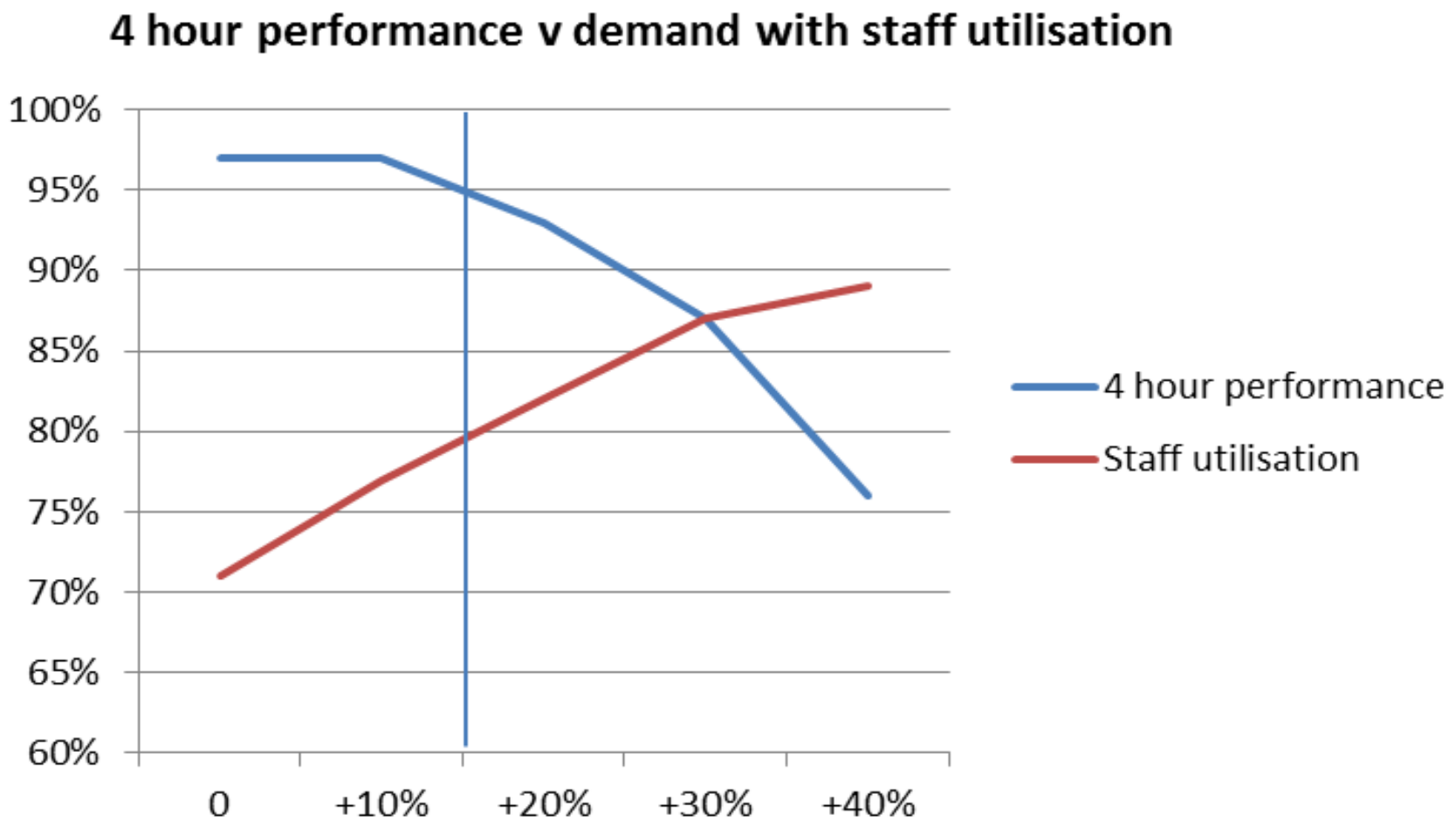
4) Ambulances queue to offload
- vehicle and crew utilisation goes down
- fewer vehicles available for 999 responses
- Long delays in responses and increased risk

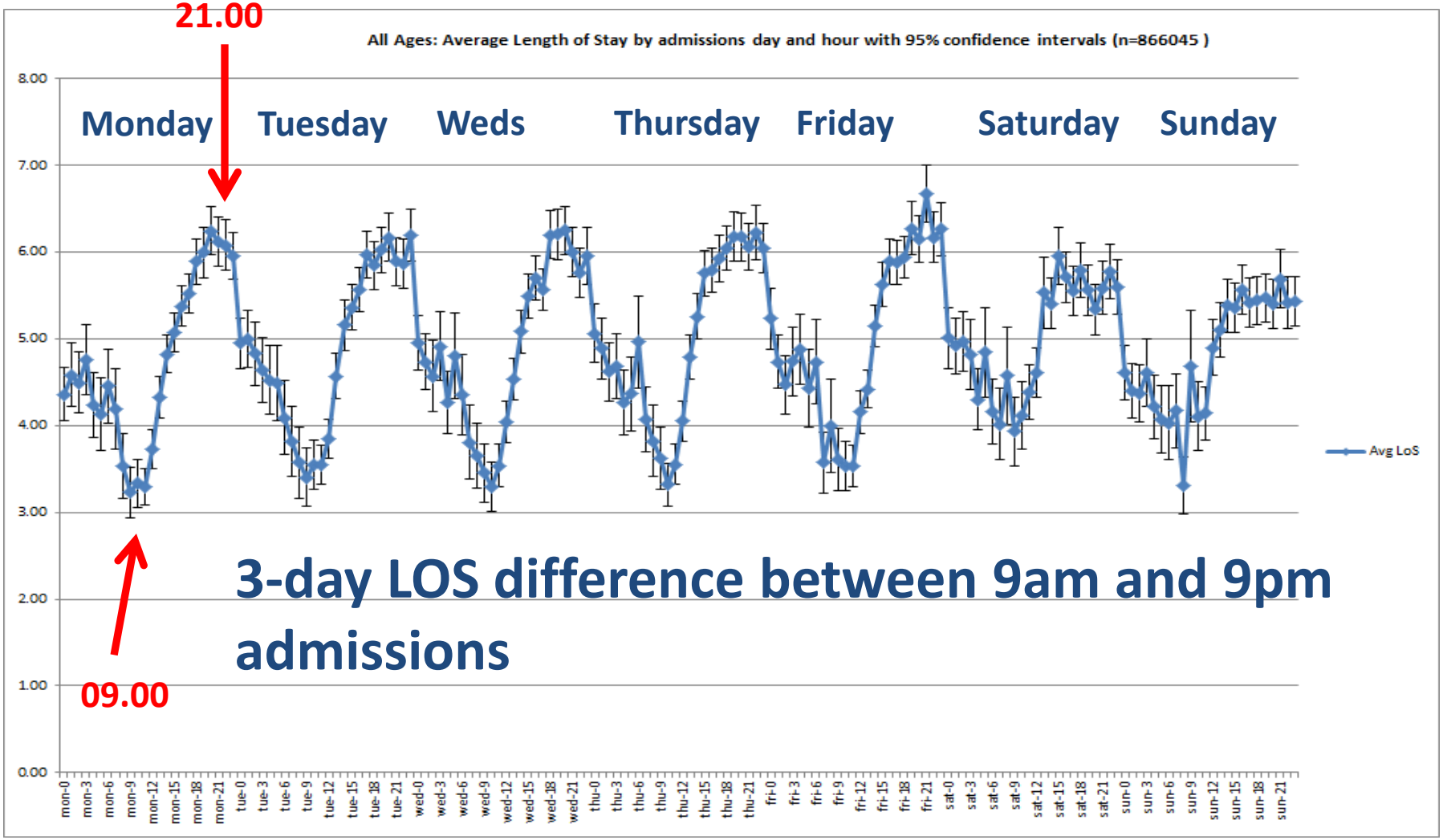


For admitted patients, increase in waiting times mainly driven by increased time waiting for a bed



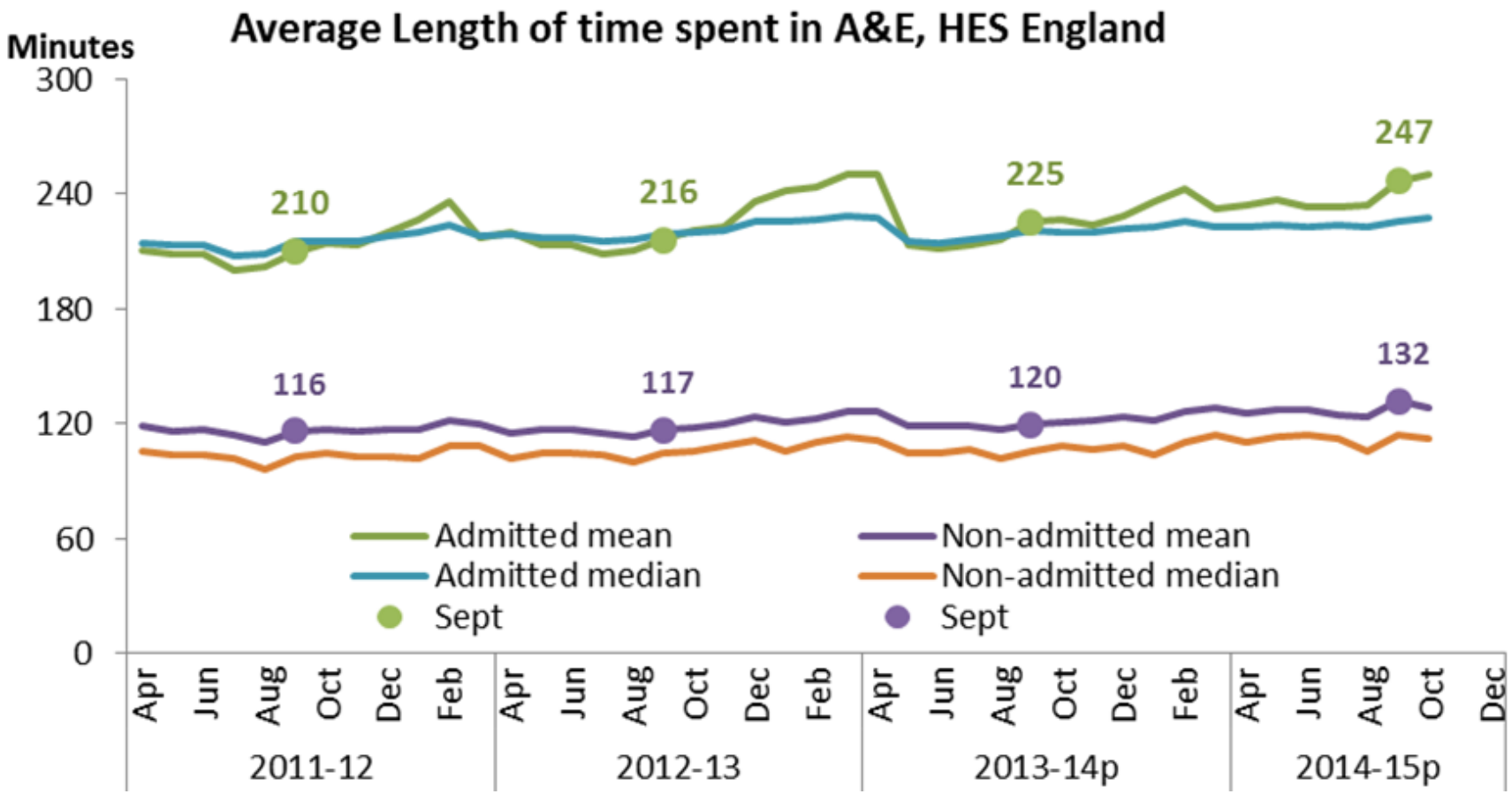
A&E performance is the result of interaction of demand and supply in a complex system





Why? Late admissions less likely to have a consultant review; more likely to 'board'; more likely to have a care plan from junior doctor; more likely to be admitted from a crowded A&E

Average waiting times have increased for both admitted and non-admitted patients

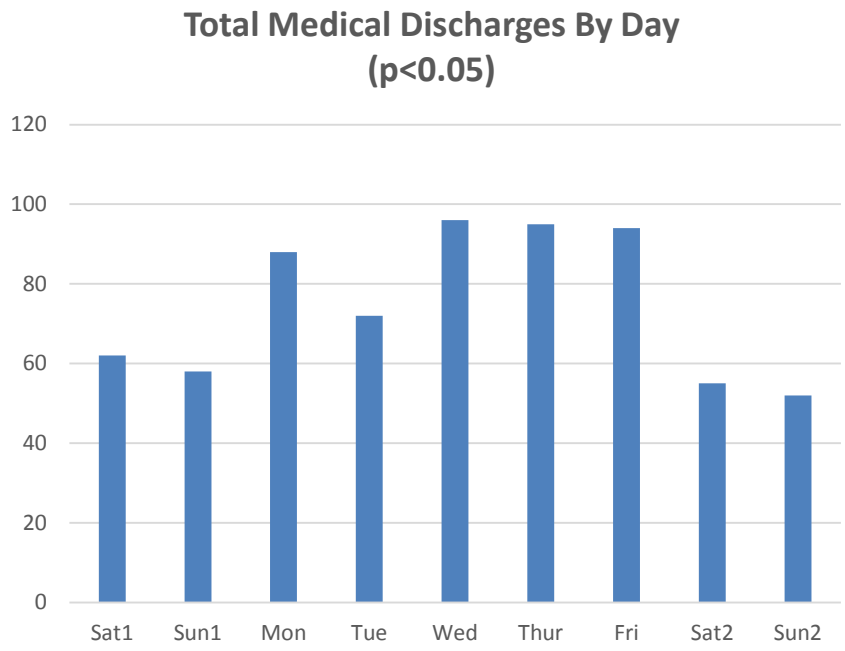


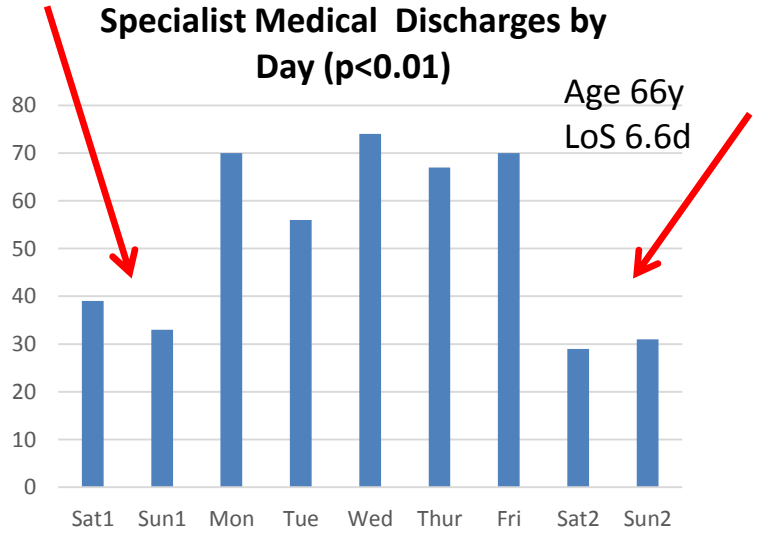
Boarding/Outlying:
50% higher mortality; adds 2 days to length of stay

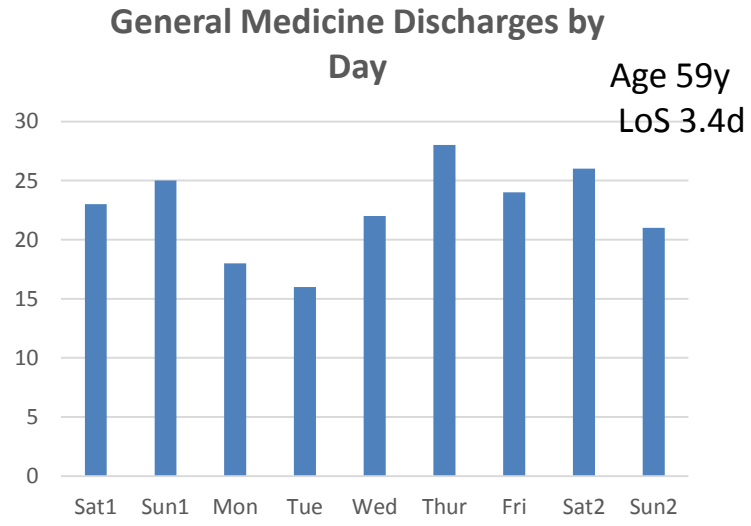
	Ave LoS	Readmissions		Mortality		Notes
		7 day	30 day	7 day	30 day	
Non-Boarded	2.3	4.6%	7.5%	1.4%	2.8%	
Boarded	6.5	7.5%	11.0%	2.0%	4.2%	
Wards boarding pts out	4.2	4.8%	10%	2.5%	3.7%	Highest no of patients

Mortality on wards that board patients out is 30% higher than on those that don't

Specialists to focus on ward patients and discharge



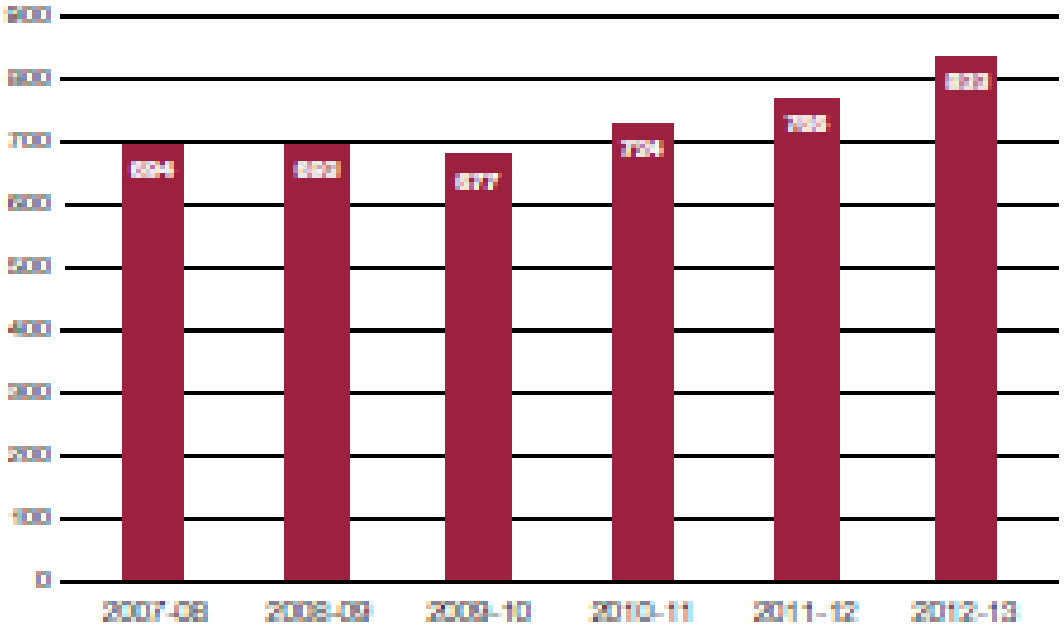




Delayed transfer of care

Number of acute bed days lost due to delayed discharges, 2007-08 to 2012-13

The number of acute bed days lost due to delayed discharges rose by 9 per cent between 2011-12 and 2012-13

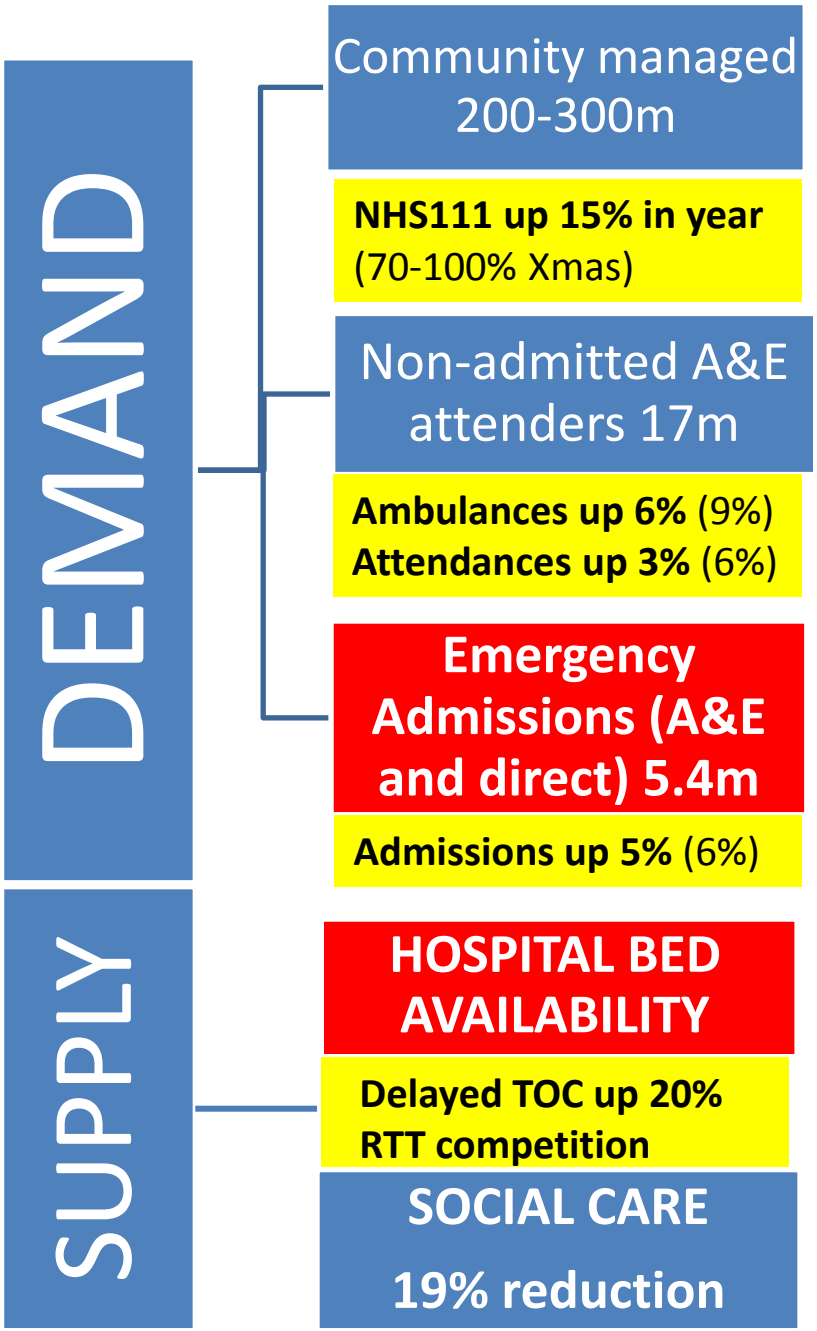


Note

1 Data on delayed discharges is only available from 2007-08.

Source: National Audit Office analysis of Department of Health data

Discussion



URGENT CARE DEMAND MANAGEMENT

Self–help: NHS Choices, community pharmacy, advance care plan, personal budgets

Telephone support: NHS 111, clinical advice (mental, dental, nursing, GP, social care, community, pharmacist)
999 "hear and treat" including above
universal booking rights into services

Out of Hospital F2F Response:
in and out of hours GP access
community team – packages of care
better supported care homes
community pharmacist – minor ailment service
ambulance "see and treat" - prescribing
999 ambulance utilisation pilots

Information sharing: Summary Care Record, EPR across all providers

Hospital admission avoidance and flow promotion
Senior medical input (RAT, RAID), 7 day services
GPs in A&E and alongside Urgent Care Centres
Ambulatory care services / Frailty pathways
Early board and prioritised regular ward rounds ,pull from AMU
Long stay patient >7 days MDT review meetings
Discharge to assess / GP and pharmacy review
Patient transport, community volunteers
Intermediate Care beds (community) and access to Care Homes
System resilience group (health and social care collaborating)
Urgent Care networks and special advice and support

Delivering the vision – what could Out-of-Hospital best practice look like?

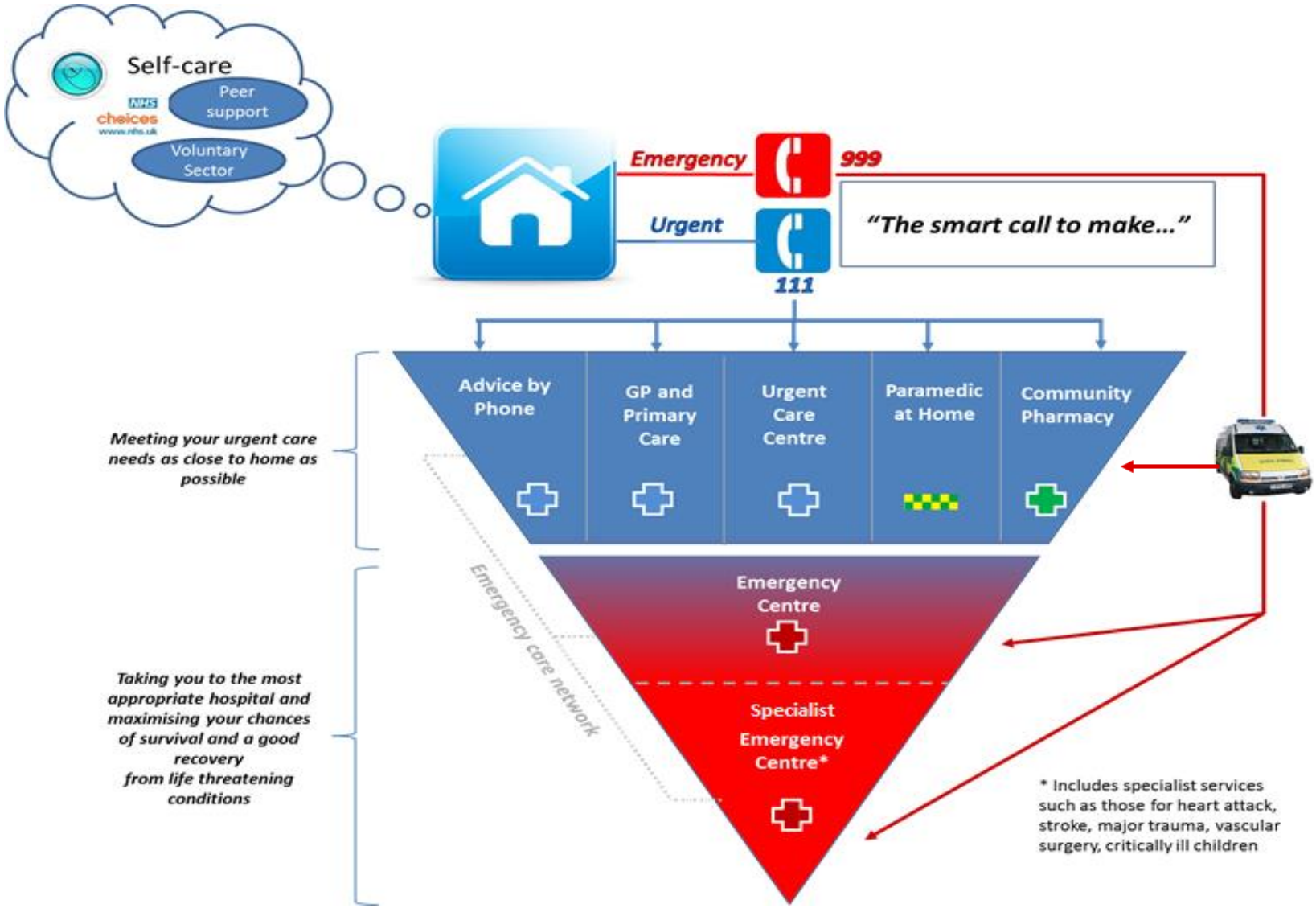
The current components that need to function as one and interface seamlessly are:

- **Self-care**
  - NHS Choices options and other web based NHS advice
  - Local Directory of Services
  - Voluntary patient support group information
  - advance care planned fast-track access to advice/care
- **Community pharmacy**
  - Walk-in and referral options
  - National minor ailment service / repeat prescription services
- **All hours General Practice (in-hours and out –of –hours)** including particularly
  - On line booking all practices
  - Advice and visiting service for care homes
  - End of life care
  - Hospital discharge reception (if required)
- **All hours telephone advice** (NHS 111) with clinical advice/decision-making support
- **All hours urgent Dentistry advice and treatment**
- **All hours community care response**– home healthcare support
- **All hours social care response** – home personal care support
- **All hours ambulance service paramedic care and conveyance to achieve care**
- **All hours expert/senior decision-support from hospital-based specialists** (networked)

… and if we were starting again we might want …

1. **A central clinical advice and decision support "hub" linked to all components** – there should be no consultations in isolation; expert advice available to optimise care quality and proximity for patients;
   - patient's care preferences and previous encounters
   - healthcare professionals to have access to core clinical patient information;
2. Although there would **be multiple entry portals, a single methodology for offering information, advice, and either direction to, or provision of, best treatment/care**;
   - Most applicable and local option to be the simplest choice for patients or system default
3. **All out-of-hospital services available 7 days a week with same degree of seamless coordination**;
4. **Sufficient health and personal care support in the community**
   - step down (intermediate care or home care)
   - maintain safe flow of patients being transferred back into the community from hospital.
   - flexible and equal to the admission demand
   - transfers of care should not be delayed by assessments or funding (state or self) resolutions; assessment, negotiation and selection should be in a limited state funded interval
5. **Surge in demand to be managed by a whole system response**, with the core of responsiveness being **upstream not downstream**;
6. **Contracts that ensure the above must secure interdependence, governance, efficiency and safety;**
7. **Financial payment and incentives should drive cohesion, risk sharing and patient flow** to most appropriate, convenient and local care settings.

The Future System

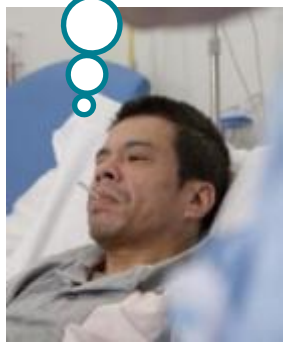


Urgent and Emergency Care Review
- *time to do it*

If it's really serious I want specialist care

Help me to help myself and not bother the NHS

If only they could talk to my GP?



Treat me as close to my home as possible please

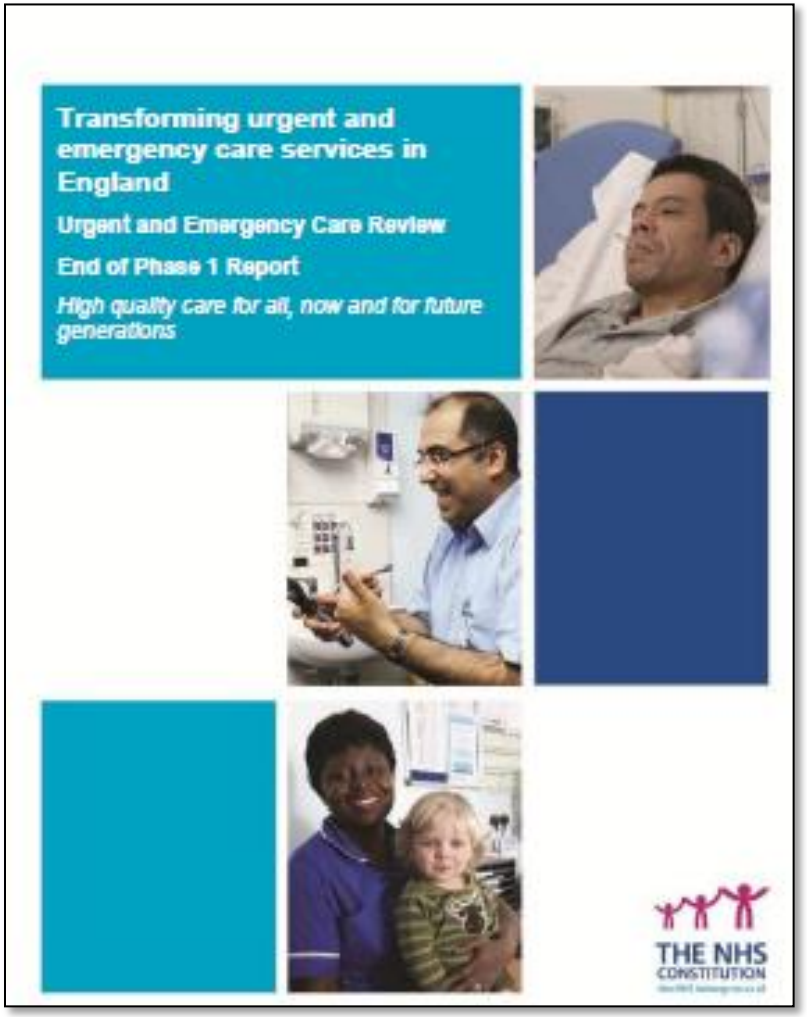
Keith Willett

2015

NHS England

THE NHS CONSTITUTION
the NHS belongs to us all

UEC Review Vision



For those people with **urgent but non-life threatening** needs:

- **We must provide highly responsive, effective and personalised services outside of hospital, and**
- **Deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families**

For those people with more **serious or life threatening** emergency needs:

- **We should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery**

UECR: The Why? – Care closer to home

NHS England

A new urgent and emergency care system needs to shift more people from right to left, delivering as much care as close to home as possible

324 million visits to NHS Choices

438 million health-related visits to a pharmacy

340 million GP consultations

20% of GP consultations relate to minor ailments which could largely be dealt with by self care and support from community pharmacy

24 million calls to NHS urgent and emergency care telephone services

Only 4% of emergency calls are currently resolved and closed on the phone

21.7 million attendances at A&E, minor injury units and urgent care centres

40% of patients who attend A&E are discharged having needed no treatment at all

7 million Emergency ambulance journeys

50% of 999 ambulance calls could be managed at the scene

5.2 million emergency hospital admissions

Over 1 million emergency admissions in 2012/13 considered avoidable

Helping people help themselves

Self care:

- Better and easily accessible information about **self-treatment options** – patient and specialist groups, **NHS Choices, pharmacies**

- Accelerated development of **advance care planning**

- **Right advice or treatment first time - enhanced NHS 111 - the "smart call" to make**:
  - **Improve patient information** for call responders (SCR, care plan)
  - Comprehensive Directory of Services
  - **Improve levels of clinical input** (mental health, dental heath, paramedic, pharmacist, GP)
  - **Booking systems** for GPs, into UCC or A&E, dentist, pharmacy

Highly responsive urgent care service close to home, **outside of hospital**

- **Faster, convenient, enhanced service:**
  - **Same day, every day access** to general practitioners, primary care and community services
  - Harness the skills and accessibility of **community pharmacy**
  - **24/7 clinical decision-support** for GPs, paramedics, community teams from (hospital) specialists ***– no decision in isolation***
  - Support the **co-location of community-based urgent care services** in Urgent Care Centres and Ambulatory Care centres.
  - Develop 999 ambulances so they become **mobile urgent community treatment services,** not just urgent transport services

From life threatening to local – where is the expertise and facilities?

- **Identify available services in hospital based emergency centres**

- **Urgent Care Centres** – primary care, consistent, access to network
- **Emergency hospital Centres** - capable of assessing and initiating treatment for all patients
- **Specialist Emergency hospital Centres** - capable of assessing and initiating treatment for all patients, **and** providing specialist services (direct, transfer or bypass) (- estimated 40-70 larger units)

- **Emergency Care Networks: Strategic and Operational**

- **Connecting all services** together into a **cohesive network** so the overall system becomes more than just the sum of its parts

How we built the model

- **Continue to "build in public"**
- **8 Work Programmes:**
  - WHOLE SYSTEM PLANNING AND PAYMENT, COMMISSIONING AND ACCOUNTABILITY
  - *PRIMARY CARE ACCESS – NHSE strategy*
  - *111 service specification and standards*
  - DATA, INFORMATION AND CARE PLANNING
  - *COMMUNITY PHARMACIES – Call for Action*
  - EMERGENCY DEPARTMENTS and EMERGENCY CARE NETWORKS
  - AMBULANCE TREATMENT SERVICE
  - *WORKFORCE (HEE)*

Progress: from design to delivery

- **Implementation phase of the Review**: Aims to convert the work done so far into a national framework to guide commissioning of UEC services:

Delivery Group own and describe the **key national products** from the Stage 1 Report **– gave *primacy to out-of-hospital***

- **Regional roadshows** June-Sept 2014**, update report** August 2014
- Working with **System Resilience Groups**, **CCG and NHSE Ops Teams** as they develop 2 and 5 year operational and strategic plans
- Working through the **NHS providers / CCGs and users** to co-produce **commissioning guidance and specifications**
- **Develop designation guidance, standards and outcome measures** for commissioners regarding UEC networks, centres, and clinical models and for Ambulance Services

UECR: What – Big Tickets

Programme Vision:

DRIVER

For those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital.

DRIVER

For those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.

Key:
Green = Product complete or in development
Amber = Product planned but needs further clarity
Red = product undeveloped

Programme Objectives:

OBJECTIVE

1. Provide better support for people to self- care

OBJECTIVE

2. Help people with urgent care needs to get the right advice in the right place, first time

OBJECTIVE

3. Provide highly responsive urgent care services outside of hospital

OBJECTIVE

4. Ensure those with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise survival and recovery

OBJECTIVE

5. Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts

'Big Tickets' and Products:

PRODUCT

Promote effective self-care and self management

1.1.1 Develop self-care resources

1.1.2 The Earlier The Better Marketing Campaign

PRODUCT

Integrate pharmacy into the UEC system

2.1.1 Support for CCGs to introduce minor ailments Services

2.1.2 Pharmacist Competency Framework

2.1.3 Explore the role of Pharmacists in Emergency Departments

PRODUCT

Integrate system by improving appointment booking through UEC system

2.3.1 Commissioning Standards and procurement strategy support the development of appointment booking across the UEC system

2.3.2 Develop guidance on improving referral rights across UEC system

PRODUCT

Develop ambulance service model to offer more treatment on the scene

3.1.1 Guidance on clinical models for treatment on scene by ambulance services

3.1.2 Develop a new single accredited curriculum for Paramedics

3.1.3 Best practice/case studies on how GP advice best accessed/can add value to ambulance and A&E

PRODUCT

Successful models of care for improved primary care

3.3.1 Principles for Improved Primary Care Access and a compendium of service models to inform local innovation and improvement

3.3.2 Headline specification for local urgent care facilities

3.3.3 Improving dental care and oral health: response to Call to Action

3.3.4 District and General Practice Nursing: recommendations and single competency framework

3.3.5 Competency Framework for Advanced Clinical Practitioners and national standards for the role of Physician Associates

PRODUCT

Access to hospital specialist advice 7/7 to advise PC and key OOH services

3.5.1 Provision of specialist hospital advice to other parts of the system

PRODUCT

Matching hospital resources to patient acuity & complexity: tools and guidance on flow

4.2.1. Develop appropriate tools to understand flows around the UEC system for use locally

4.2.2 Workforce Baselining.

PRODUCT

Timely Access to relevant patient clinical data across the system

5.2.1 Deploy Summary Care Record (SCR)

5.2.2 Review and enrich existing SCR content

5.2.3 Identify data sharing and architectural requirements into urgent care settings

5.2.4 Proof of concept primary care information into community pharmacy

PRODUCT

Unified quality measurement system:Develop metrics to measure whole system performance

5.4.1 Outcome measures and other metrics for the UEC system

PRODUCT

Introduction and roll-out of personalised care planning

1.2.1 Develop Guidance on Personal Care Planning

PRODUCT

Improve clinical input to NHS 11

2.2.1 Development of NHS 111 Commissioning Standards to include recommended clinical input

PRODUCT

Enhance the DOS to be a real time and accurate commissioning tool

2.4.1 DOS development work

PRODUCT

Develop pharmacy facilities to offer wider range of services

3.2.1 Principles for extended pharmacy offer, backed up by contractual changes

PRODUCT

Successful models of care for improved community services (in and out of hours)

3.4.1 Principles for improved community services (in and out of hours) accompanied by necessary national contractual incentives.

PARKED

PRODUCT

Designation of Major Emergency Centre and Emergency Centre

4.1.1 Headline specifications for Emergency Centres and Specialist Emergency Centres

4.1.2 Support process for accreditation and designation of facilities

PRODUCT

Improved system of commissioning, finance, and payment

5.1.1. Develop a 'Footprint Tool'

5.1.2 Integrating General Practice and Community Health Services Report

5.1.3 Payment system redesign

5.1.4 Assess at a national level the non-financial impacts & benefits of the future UEC system

5.1.5 National financial modelling

PRODUCT

Establishment of effective emergency networks

5.3.1 Develop guidance on constitution of emergency care networks Inc. Headline specifications for Urgent Care Centres, Emergency Centres and Specialist Emergency Centres

5.3.2 Urgent and Emergency Care Networks Accountability and Governance Paper

PRODUCT

Identifying what good looks like, including test sites and demonstration of benefits

5.5.1 Design, set up, and manage test beds: analyse the impact of all elements of the UEC vision on local health economies, and identify what good looks like

Programme Update

December 2014:

- **Planning Guidance and 5 Year Forward View published**
- **NHS England Public Board approval**
  - set out our expectations of commissioners and providers in relation to urgent and emergency care, including the formation and operation of networks.

Spring 2015 NOW:

- **Establish Urgent and Emergency Care Networks**
  - outlines formation / operation of networks, role of SRGs
- **Advice for Clinical Models for Ambulance Services**
  - how ambulance services could deliver enhanced rates of hear and treat, see and treat, avoiding unnecessary admissions
- **Safer, Faster, Better: Good practice in delivering UEC**

UECR Phase 2: Product Design & Delivery

UECR Phase 3: Implementation

NHS England

PLANNING GUIDANCE RELEASED

	July – Dec 2014	Jan –June 2015	July – Dec 2015	2016
OBJECTIVE 1. Provide better support for people to self- care	Self-Care Knowledge Portal Released NHS England's contribution to Self-Care Week Delivered 'Feeling under the Weather' Campaign	Integrated H&SC Personal Commissioning Programme Commences Final Draft Self Management Guide for Frailty Released Personal Care Planning Guidance Released Continuation of Age UK and British Red Cross Pilots with National Tripartite around supported discharge from A&E	'Realising the Value' self-care programme Patient Activation Programme Pilots and Evaluation Development work on extension of Personal Health Budgets	
OBJECTIVE 2. Help people with urgent care needs to get the right advice in the right place, first time	NHS 111 Futures Phase 1 Pilots Learning and Development Evaluation Complete Revised NHS 111 Commissioning Standards (with UECR enhancements) Released Revised Pharmacy Training courses (aligned to new Competency Framework) procured by HEE	'Pharmacist in Emergency Departments' Pilots (West Midlands) DoS Search Tool Developed (subject to agreement with HSCIC) NHS 111 Futures Phase 2 Pilots Guidance on Referral Rights across the UEC system released	UPDATED NHS 111 Commissioning Standards Reprocurement window for new NHS111 Services	
OBJECTIVE 3. Provide highly responsive urgent care services outside of hospital	Engagement on Clinical Models for Ambulance Services Advice (through UECR Regional Roadshows) Five Year Forward View published, including new models of care Position statement on provision of hospital specialist advice to other parts of the UEC system agreed ECR input (via Primary Care Strategies) into GP Contract Enhanced Service: GP Advice to Ambulance Services and A&E	New Paramedic Training Curriculum Modelled and Costed by HEE Clinical Models for Ambulance Services Advice Released Advanced Clinical Practitioner Competency Framework Published Educational Framework for General Practice Nurses and District Nurses developed	Guidance/case studies on provision of hospital specialist advice published New Paramedic Training Curriculum developed by HEE Advice for networks to identify hospitals that have network roles in providing specialist services Physician Associate Role marketed by LETBs Release of guidance for Urgent Care Centres	Go-live for new configuration of UEC Network facilities (2016/17)
OBJECTIVE 4. Ensure those with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise survival and recovery	Engagement on UEC Networks Advice (through UECR Regional Roadshows)	UEC Networks Establishment Advice Released	Best practice models and guidance produced with ECIST on management of patient flow through Emergency Departments Development / Implementation of UEC Networks Advice/toolkit on UEC Networks Governance Released Release of guidance for Emergency Centres and Specialist Emergency Centres	
OBJECTIVE 5. Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts	Monitor Engagement on 15/16 Tariff System Publication of engagement document on Long-Term reforms to pricing system Flow model developed to assess growth in demand for key services developed to assist in UEC Review costings work Publication of review UEC financial incentives for 15/16 (options to align financial incentives relating to Quality Premium and CQUIN) UEC Review Financial Cost Review & Baselining Complete UEC Review Non-Financial Benefits Review Complete	Payment system examples for testing in 15/16 released Go-live on co-development sites for testing of Long-Term payment reforms Summary Care Record Pharmacy Access Project Established Patient Flow Footprint Tool Lessons Learned Report from London Interoperability Pilot Published	Enhanced Summary Care Record Content Available Testing period for Long-Term payment reforms Development work on revised Outcomes Measures and other Metrics for UEC System	New Long-Term payment Regime commences (2016/17)

KEY
- Product Released
- Product Development
- Pilots /Engagement
- Finance and Benefits work
- Planned/anticipated future work

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The greatest challenges

1. **Payment system reform**

1. **Information sharing**

2. **Workforce and skills shift**

Proposed new payment model

- **A coordinated and consistent payment approach across all parts of the UEC network**
- **Making use of three elements:**

Capacity - Core
Fixed in-year cost
"always on"

Volume
variable

Acting throughout payment

Quality

Core – *Facilities and service standards*

Volume - *Process measures formative not summative*

Incentives and Sanctions – *Patient outcome measures (ToC, PROMs) Patient safety and experience measures (mortality, SAEs, PREMs)*

- **future-proofed**

Outcomes, standards and specifications

- **Shift in outcome measurement to whole system performance**
  - Process, outcome and equality measures / indicators

- Nationally, a need to develop standards and specifications to:
  - **help describe the networked system**
  - **to enable commissioners to have the information and support to commission for system-wide outcomes**

  - This will **build upon and align existing resources, standards and clinical quality indicators**: NHS 111, ambulance services, out of hours primary care, A&E

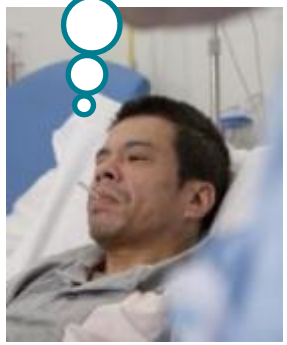
- These will then **be linked to ongoing work to design, develop, test and implement system-wide outcome measures.**

Urgent and Emergency Care Review

I'm alive cos I had specialist care really fast

Its great to share and learn so much with this group

It's like everyone knows all about me



Ready to go?

DEFINITELY . . . . BUT ONLY THROUGH YOU

I feel so much better for not having to go all the way to hospital

NHS England

THE NHS CONSTITUTION
the NHS belongs to us all