NHS England

Urgent & Emergency Care (UEC)

South West Clinical Senate

Dr Phil Yates

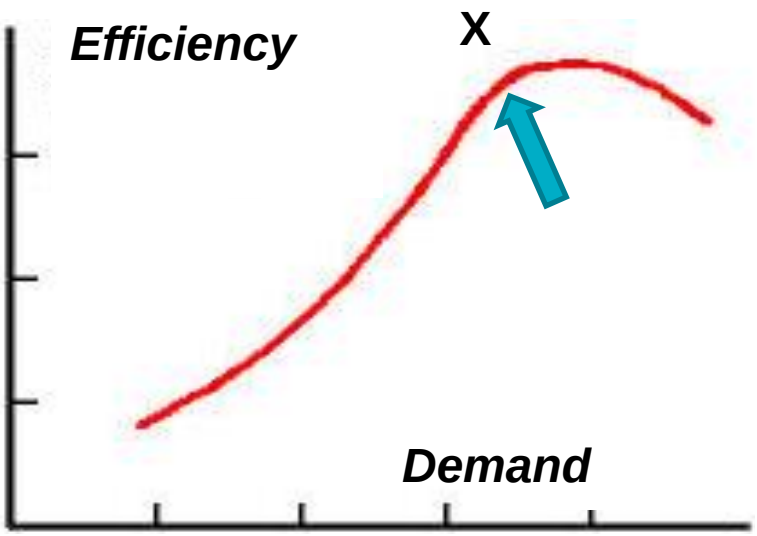
September 2015

Confusing & piecemeal current options

Some stats:

- **Over 10 years:**
  - **Patient attendance to ED risen by >2m /annum**
  - **Emergency admissions to hospital risen by 31% / annum**
  - **999 calls have increased from 4.9m to 9.0m calls / annum**
- **Attendance to WICs and MIUs is increasing by 12% / annum**
- **Costs of admissions that could be dealt with by ambulatory care approx. £1,420m representing 15.9% of all admissions**
- **Access to patient data could reduce need for transfer to hospital by 20%**
- **In the NW 11,000/18,000 COPD who accessed UEC could have been looked after in the community**
- **5% ED attendances Mental Health related: 150,000 DSH / annum**
- **10% ED attendances alcohol related**
- **Limited data on primary care UEC workload change exists**

Congestive Hospital Failure



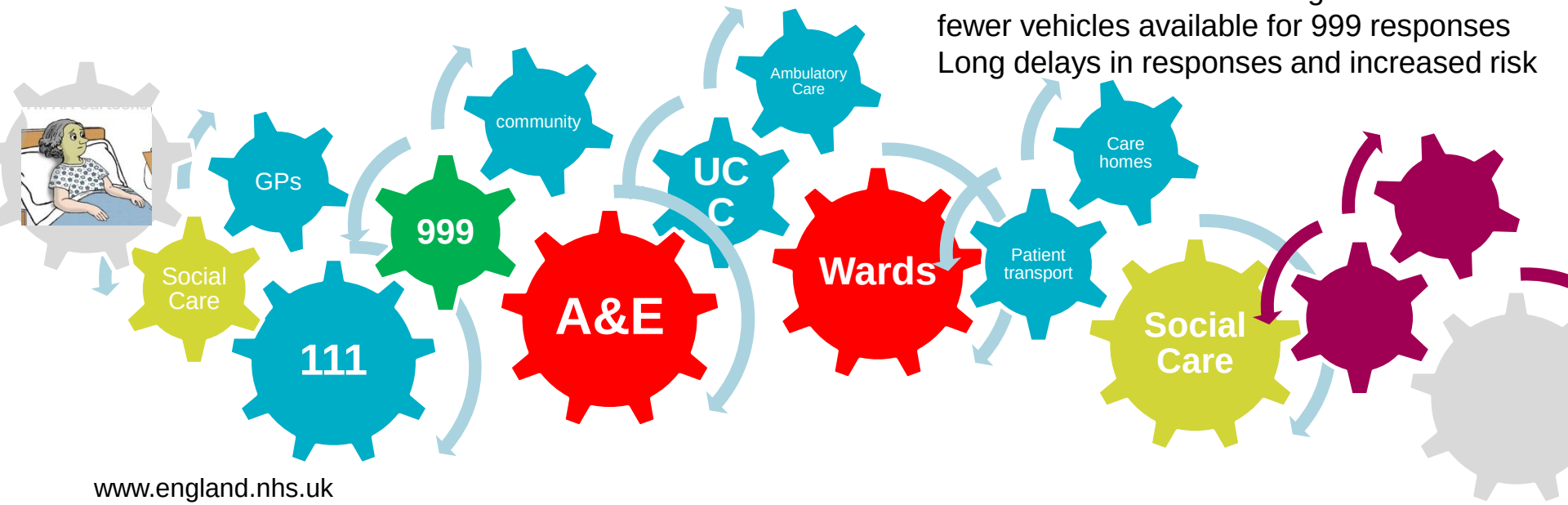
What happens at point "x"?

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

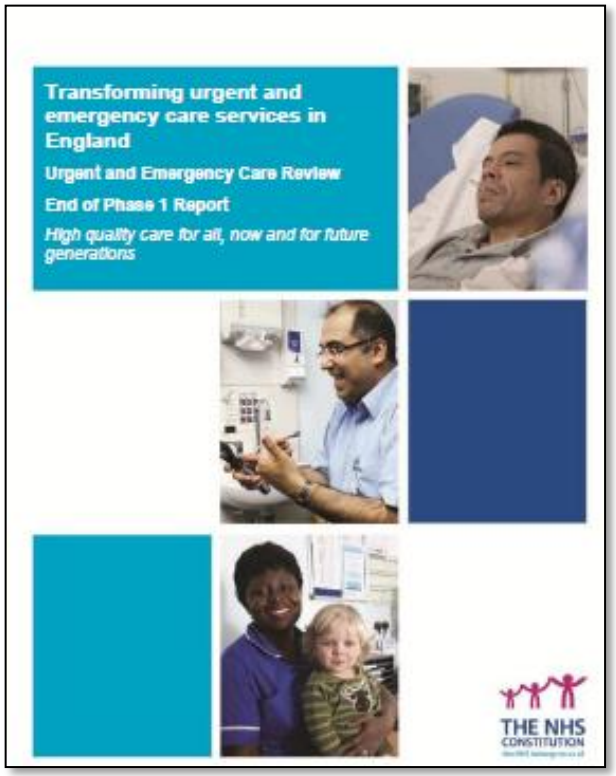
2) Increase beds numbers
- "isolated" escalation wards
- unfamiliar temporary / agency staff

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



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; reducing attendances and admissions**

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**

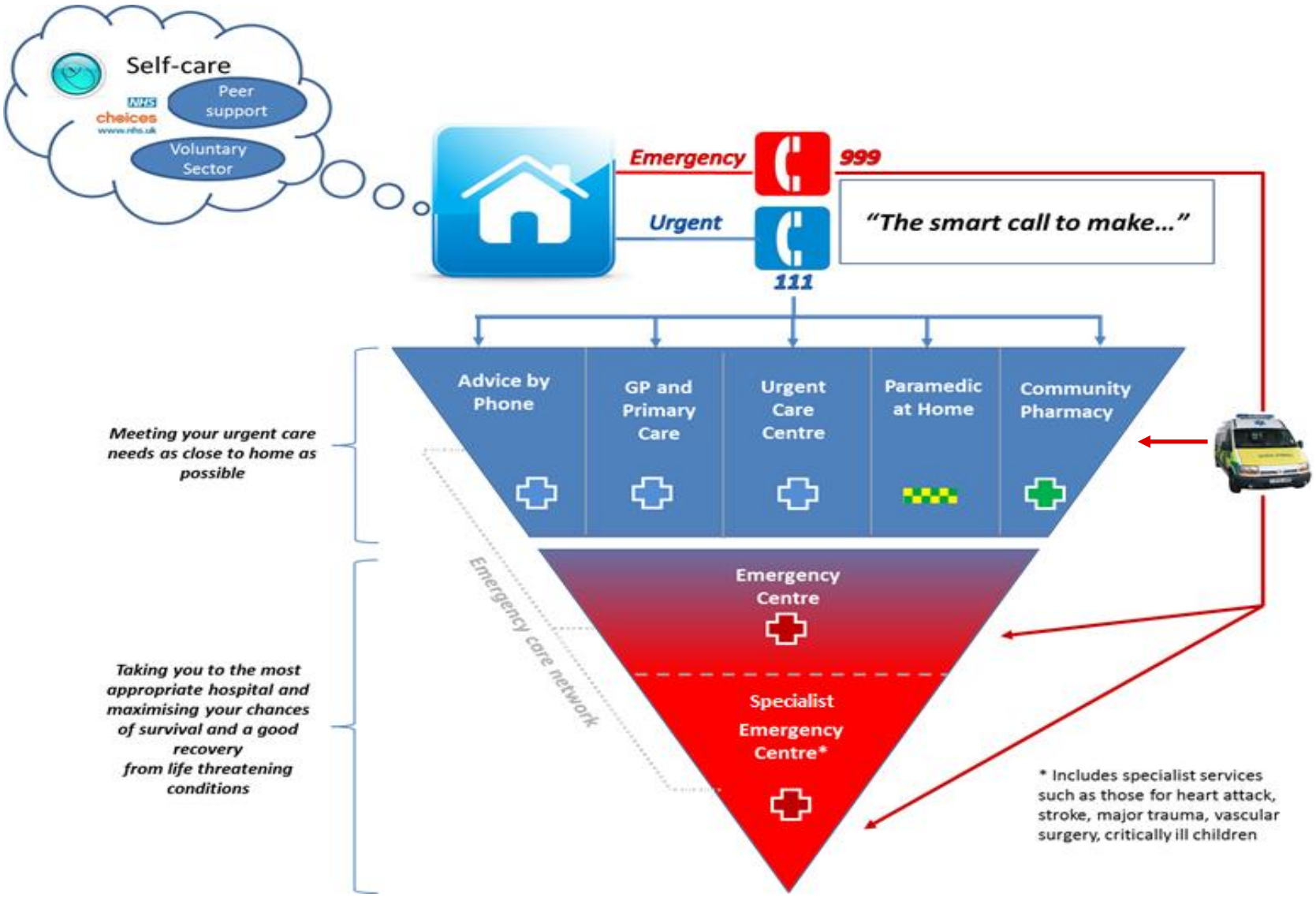
Mental and physical health

Current provision of urgent and emergency care services

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

Self-care and self management	• **450 million** health-related visits to **pharmacies**
Telephone care	• **24 million calls to NHS** • **urgent and emergency care telephone services**
Face to face care	• **340 million** consultations **in general practice** (2013/14)
999 services	• **7 million emergency ambulance journeys**
A&E departments	• **16 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

New offer: no consult in isolation



Specific nomenclature …

1. **Urgent Care Centres - UCCs (incorporate current WICs, GP-lead Health Centres, MIUs / Type 3 A&E and similar): -**

    a. **community facilities open ≥16 hours/day 365 days/annum with access to EPR;**

    b. **networked to EC or ECSS (linking to 111, GP OOH, ambulances *et al* if closed);**

    c. **include physical, mental health and injury (b/test & plain X-ray);**

    d. **UCCs may be collocated with EDs;**

    e. **Staffed by Multispecialty Teams.**

2. **Emergency Centres EC with Emergency Departments (EDs)* within them;**

3. **Emergency Centres with Specialist Services ECSS with EDs* within them but also with a range of relevant tertiary facilities.**

***The term A&E is now to be obsolete**

Specific nomenclature … cont.

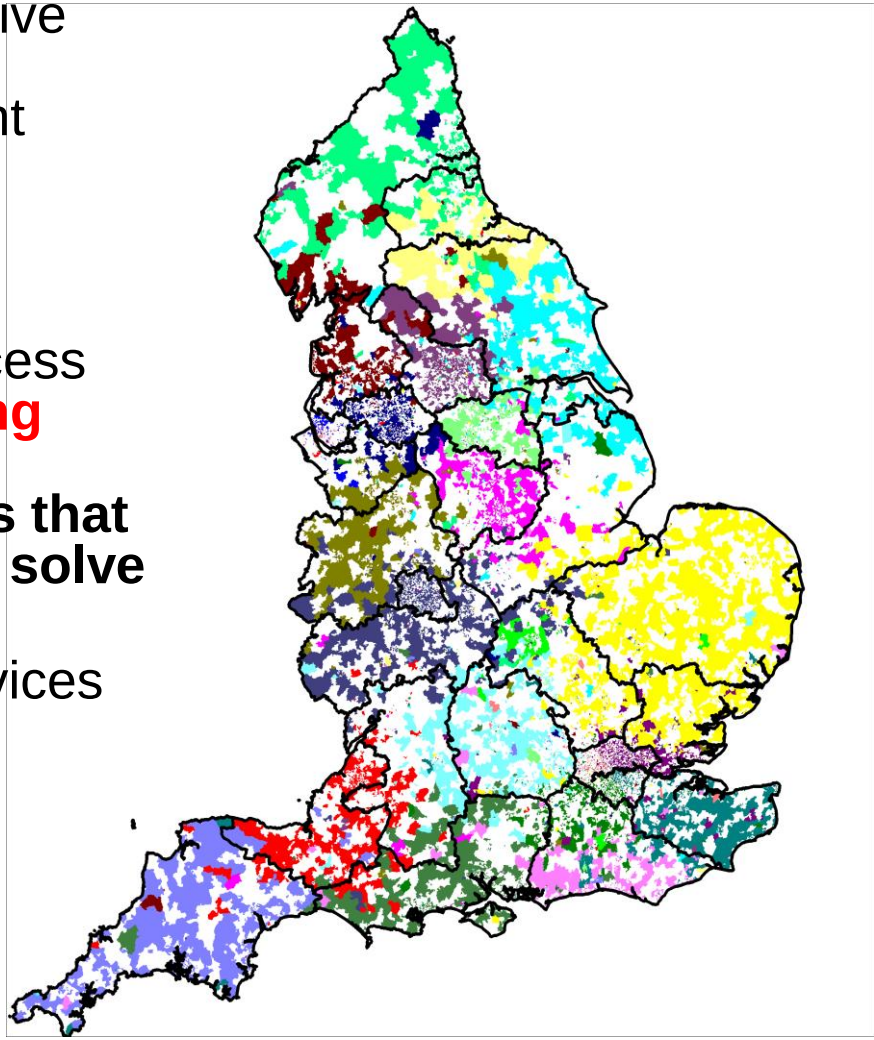
Notes:

- **All ECs' and ECSS' EDs have red signage 'H's as Emergency sites for patients;**
- **Current Type 3 A&E Depts. will be developed into UCCs**
- **Current Type 2 A&E Depts. will be developed into ECs or ECSS**
- **'Specialist Receiving Facilities' will take patients into specialist hospitals (e.g. eye, dental) & not be called A&E Depts.**
- **Specific issues for remote UCCs and ECs settings include:**
  - **Upskilling of staff;**
  - **Good on-site diagnostics & off-site support;**
  - **Stabilisation and transfer arrangements.**

Establishing Urgent and Emergency Care Networks – the purpose

- **Based on geographies** required to give **strategic oversight** of urgent and emergency care on a regional footprint
- **1 - 5million population** based on population rurality, local services

- To improve consistency of quality, access and set objectives for UEC by **bringing together SRG members and other stakeholders** **to address challenges that are greater than a single SRGs can solve** in isolation
  - Access protocols to specialist services
  - Ambulance protocols
  - Clinical decision support hub
  - NHS 111 services
  - Single point of access



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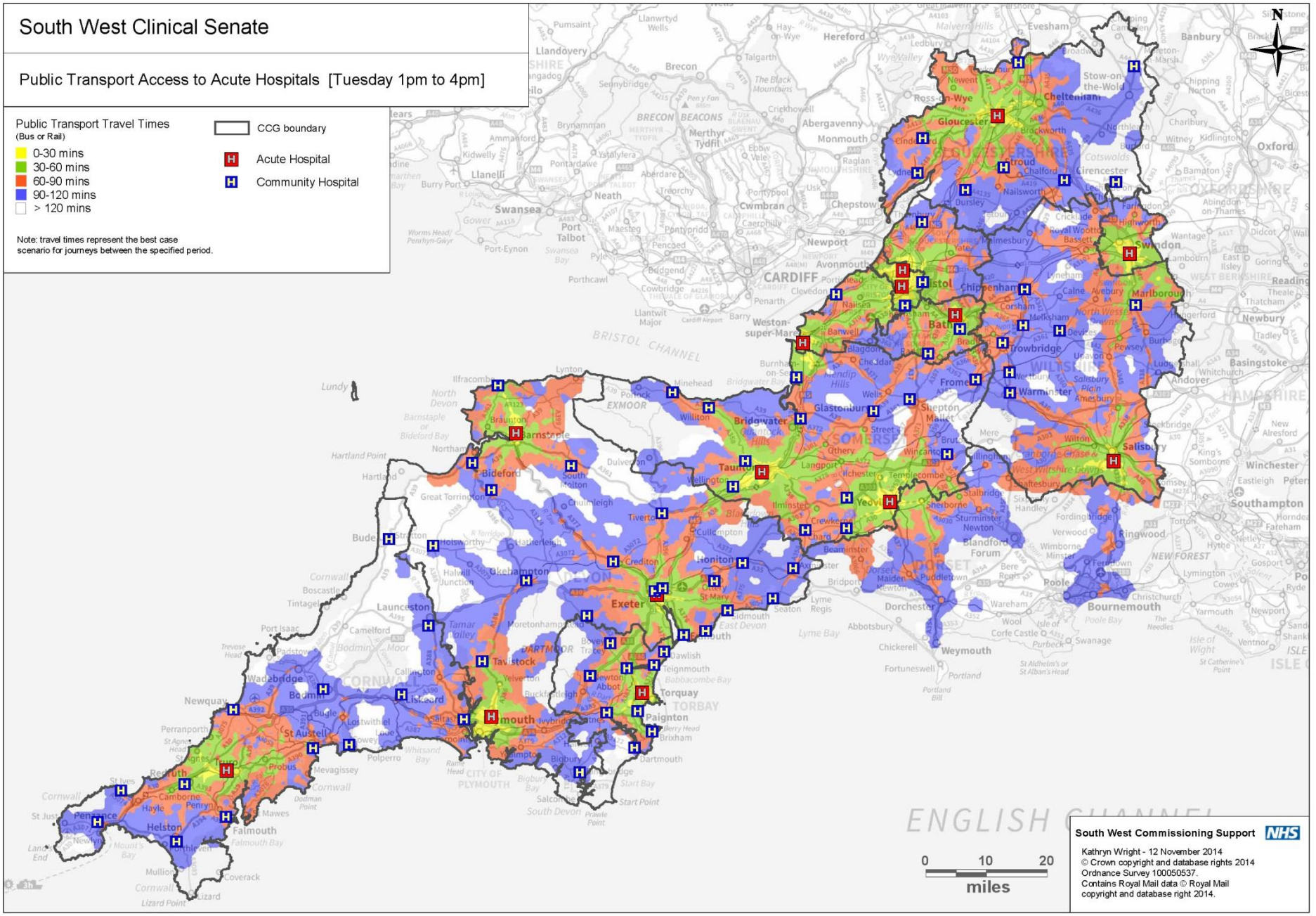
Public Transport Access to Acute Hospitals [Tuesday 1pm to 4pm]



South West Commissioning Support NHS

Kathryn Wright - 12 November 2014

Key areas of work

- **UEC Review Big Ticket Items** including:
  - Standards for acute receiving facilities
  - NHS 111 and out-of-hours integrated service
  - Ambulance service: new clinical models
  - Improved referral pathways
  - New system-wide indicators and measures
  - Local capacity planning tool
  - Self-care initiatives
- Alignment with **Out of Hospital** programme and **Winter Resilience**
  - Support SRG delivery of **8 High Impact Interventions**

We want to work towards …

1. **A central clinical advice and decision support "hub"**, linked to all components of urgent care

2. **Although multiple entry portals** will remain**, a single methodology for offering information, advice, and either direction to, or provision of, best treatment/care**

3. **All out-of-hospital services available 7/7** with same degree of coordination

4. **Sufficient health and personal care support in the community**

We want to work towards …

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