What's gone wrong in urgent care, and what should we do about it?

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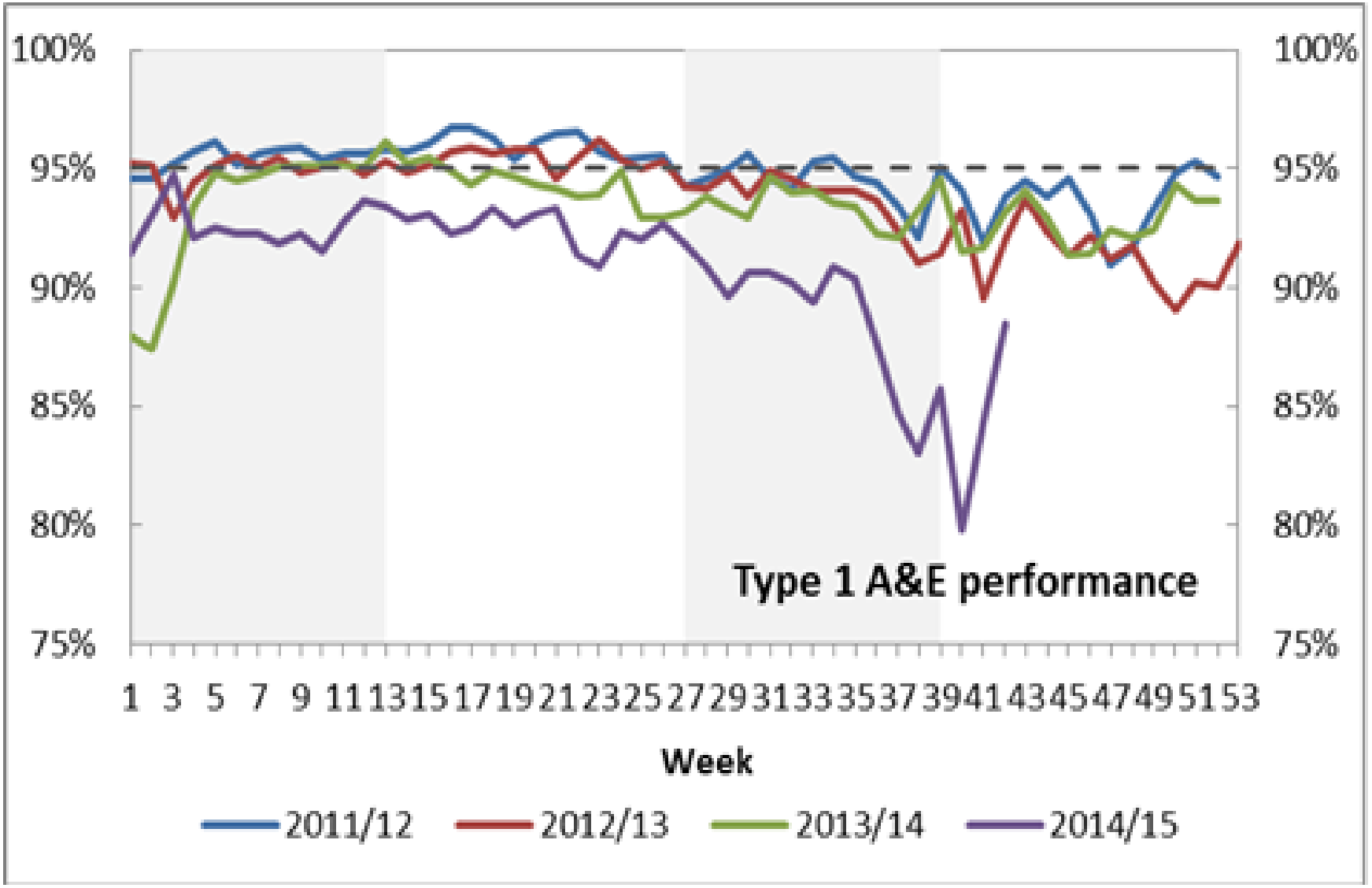
What does experience and data tell us about this winter?

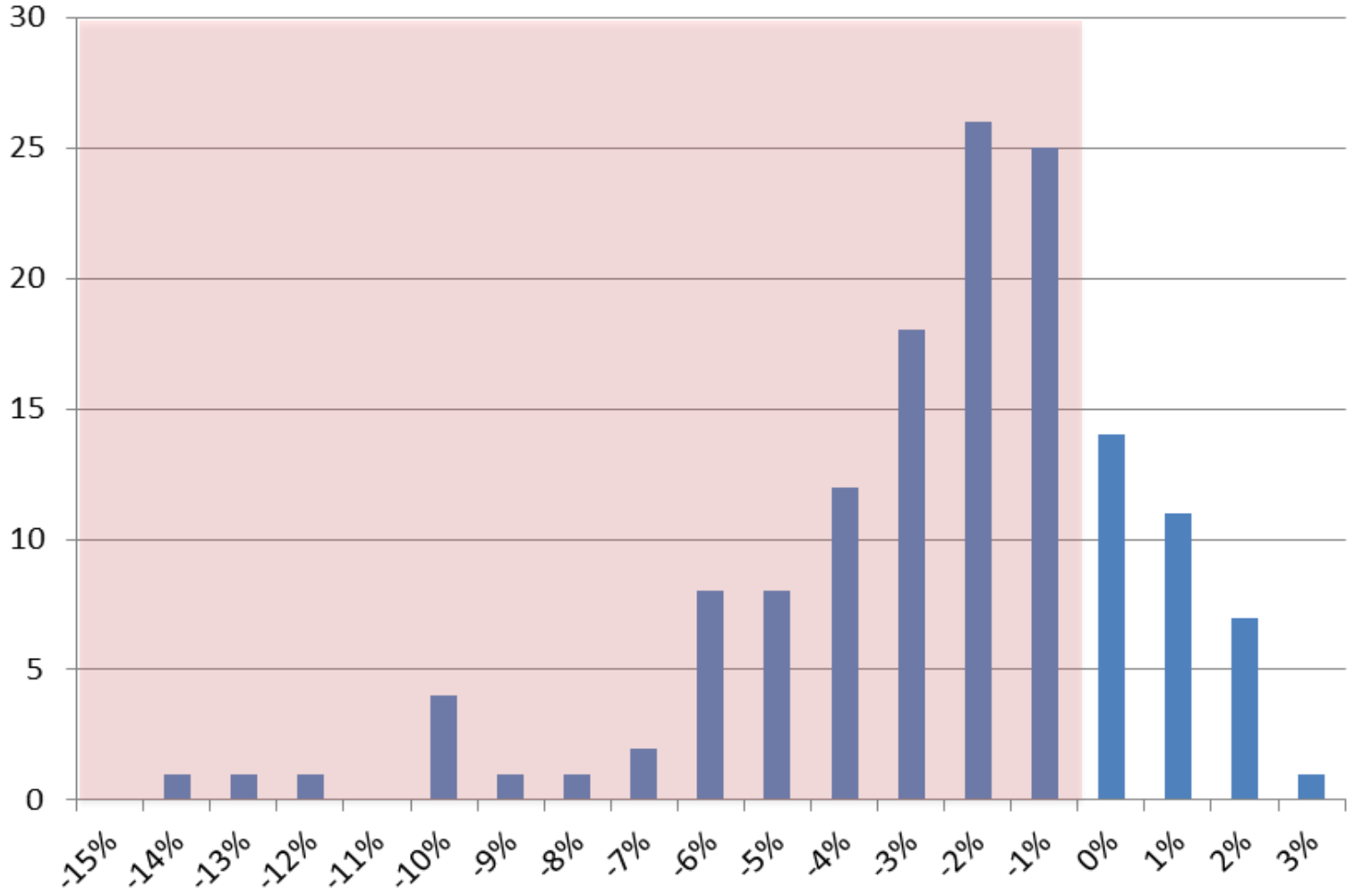
- Surge in demand exacerbated the **problems in a system** we knew was already under strain
- The surge “problem” is **emergency hospital admissions**
- Strong **upward trend in contacts,** especially to NHS111
- **Resilience, and availability, of community-based services** and the important relationship 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

Number of Trusts by change in A&E performance (Oct-Dec 2014 vs. Oct-Dec 2013)



What's 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**

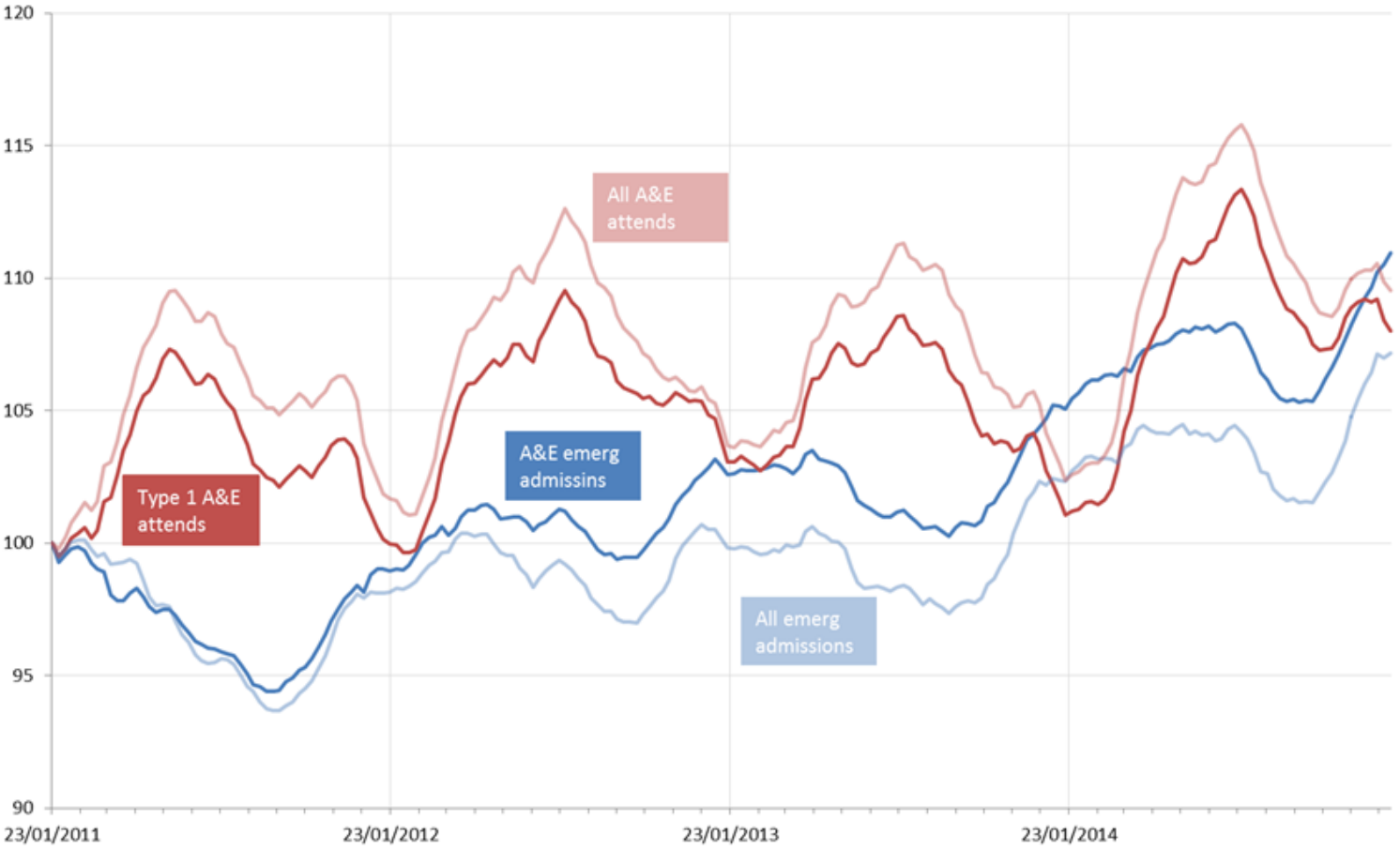
What we already know

- a 1% increase in the population that **fails 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 they couldn't access their GP
- 1 in 4 people have **not heard of OOHs 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
- Higher A&E use in **urban** (15%) and **deprived** (42%) populations

…. but its not about attendances…….

It’s about admissions!

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

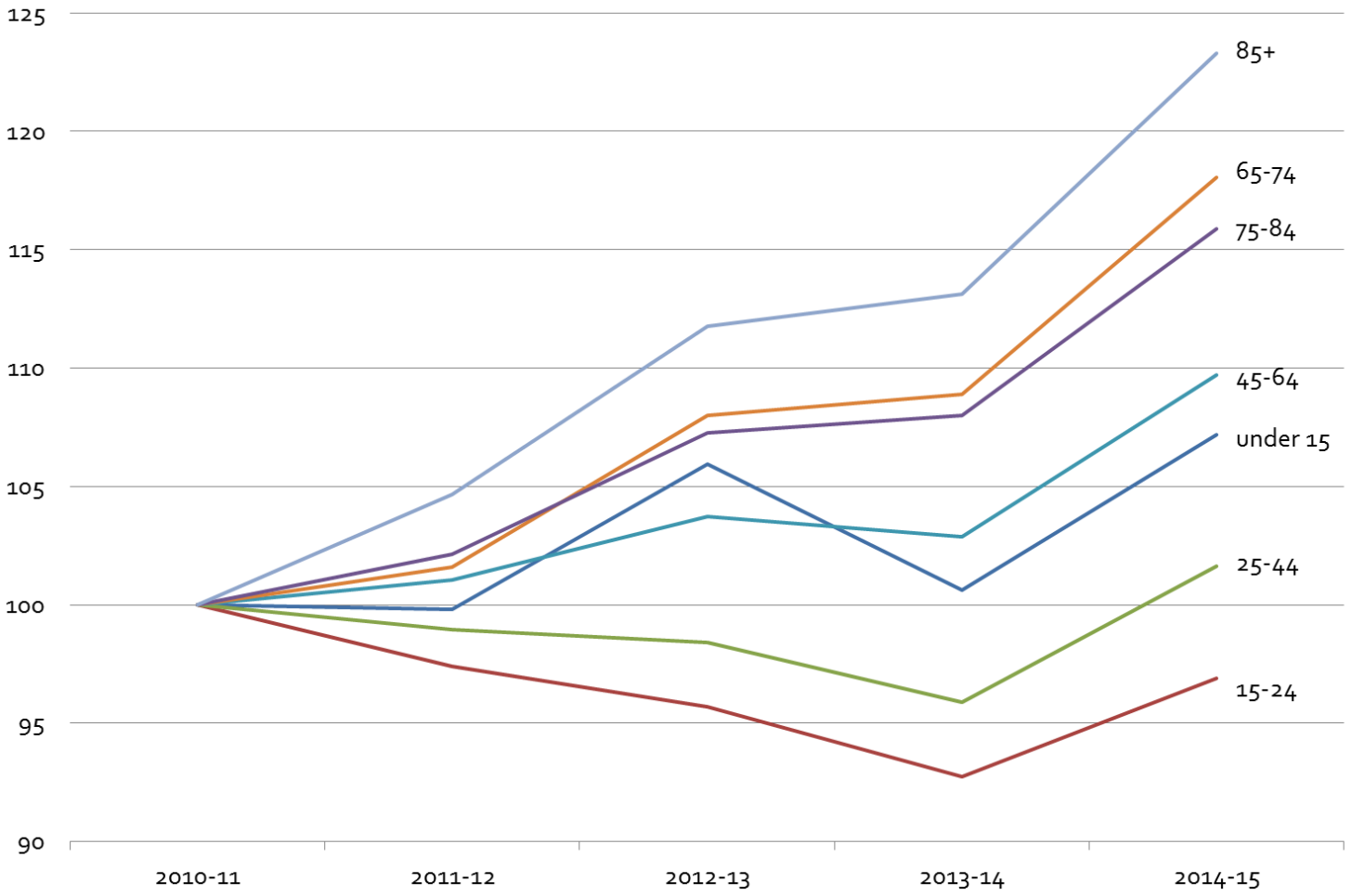


Admissions have surged in the past year

A&E attendances and emergency admissions, 13 week rolling average, change on previous year

Data source: weekly sitreps
www.england.nhs.uk

Admissions from A&E have grown for all in the past year, especially in the oldest



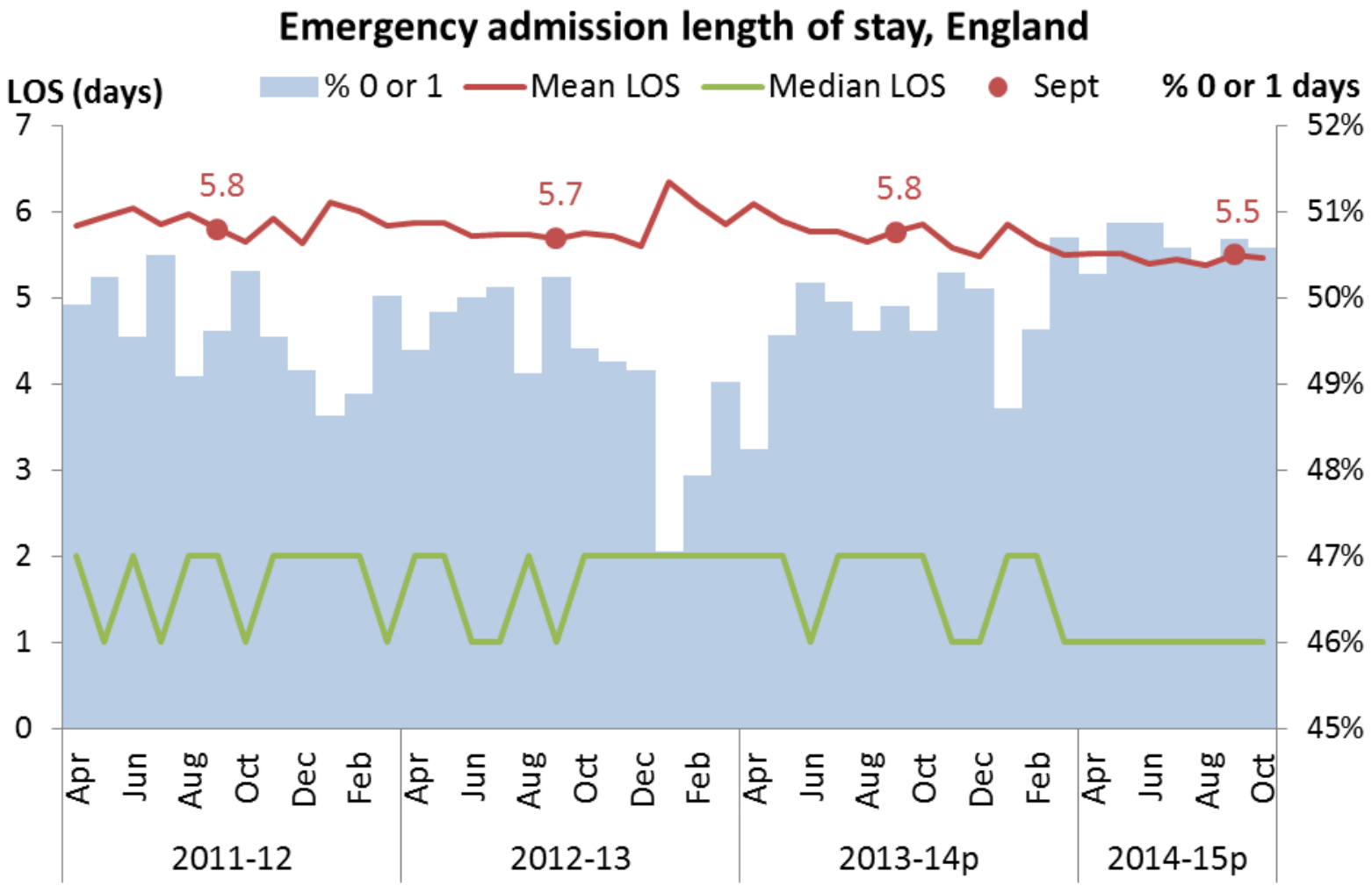
Source: HES data, Apr-Sep, each year

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

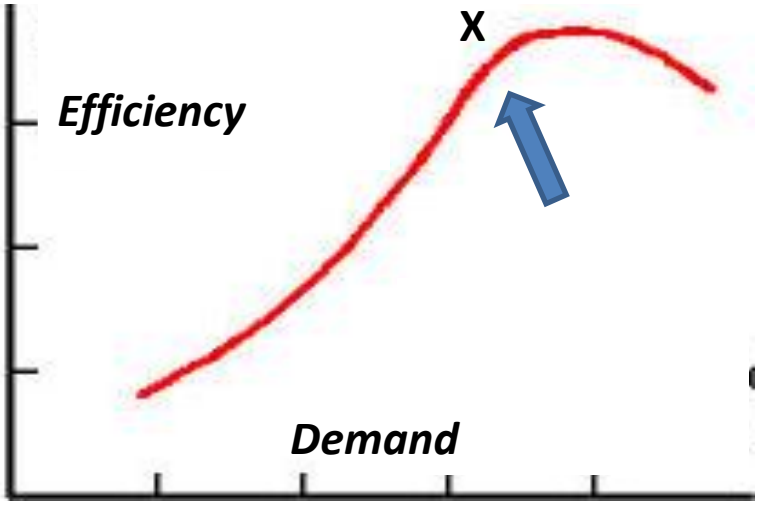
"Avoiding admissions in this group of older people depended on high quality decision making around the time of admission, either by GPs or hospital doctors. Crucially it also depended on sufficient appropriate capacity in alternative community services (notably intermediate care) so that a person's needs 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

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



Congestive Hospital Failure



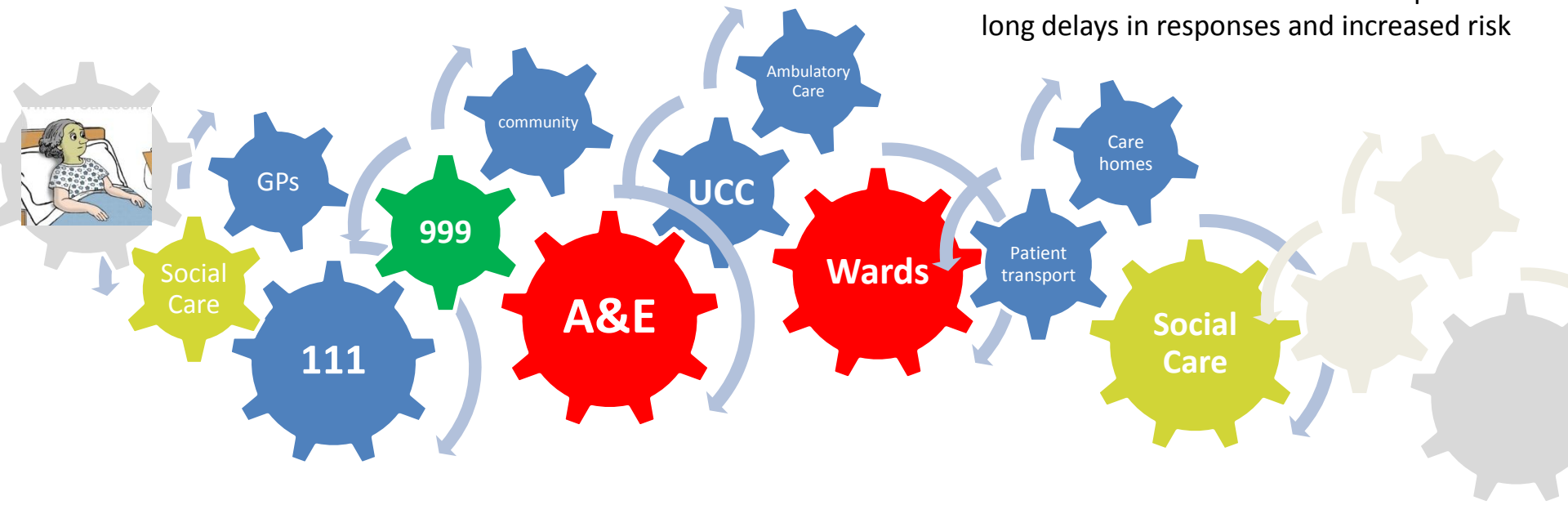
What happens at point "x"?

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

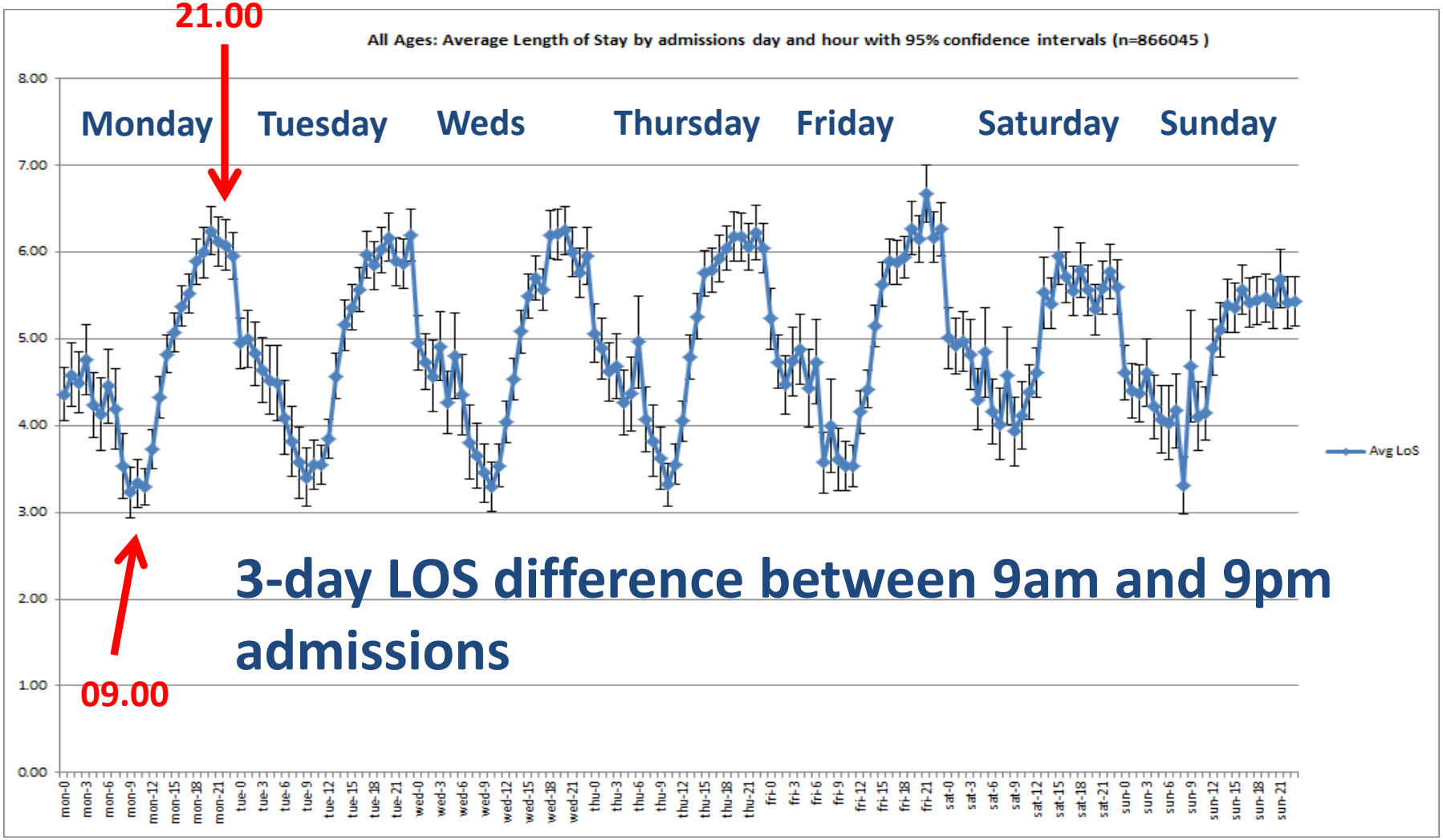
4) Ambulances queue to offload
- fewer vehicles available for 999 responses
- long delays in responses and increased risk



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

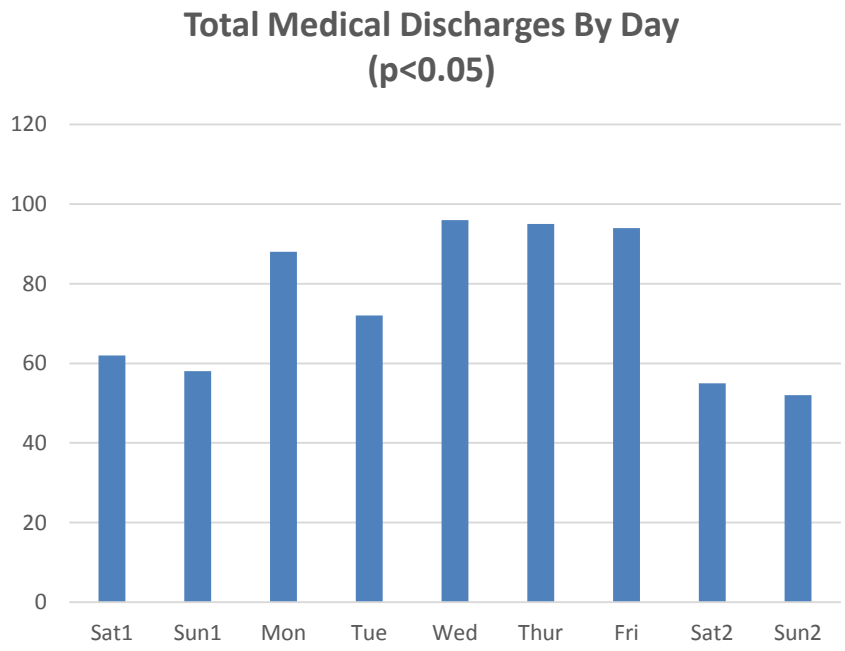
	Ave LoS	Readmissions		Mortality		Notes
		7 day	30 day	7 day	30 day	
Non-Boarded	2.3	4.6%	7.5%	1.4%	2.8%	
Boarded	6.5	7.5%	11.0%	2.0%	4.2%	
Wards boarding pts out	4.2	4.8%	10%	2.5%	3.7%	Highest no of patients

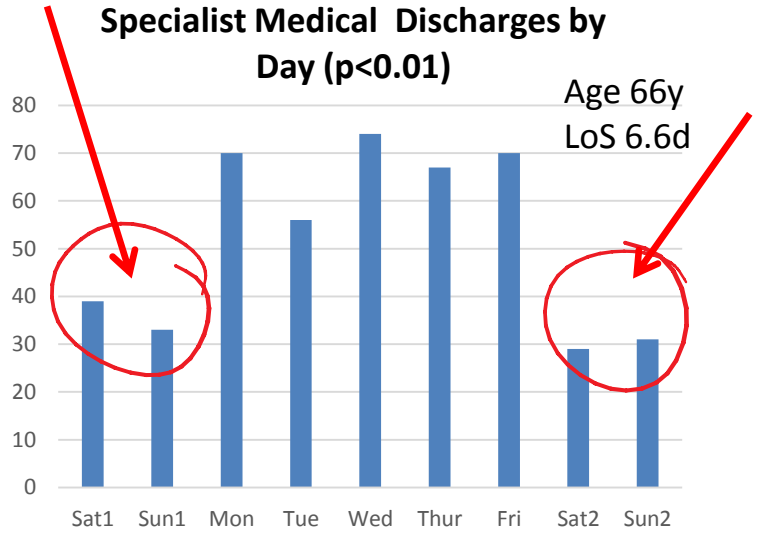
Mortality on wards that board patients out is 30% higher than on those that don't

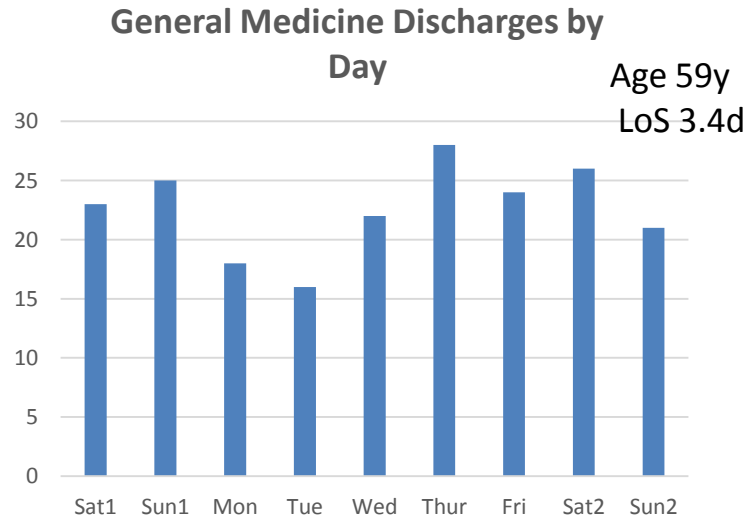


Why? Late admissions less likely to have a consultant review; more likely to 'board'; more likely to have a care plan from junior doctor; more likely to be admitted from a crowded A&E

Discharges by day: general vs specialist care





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What's should we do?

What could out-of-hospital best practice look like?

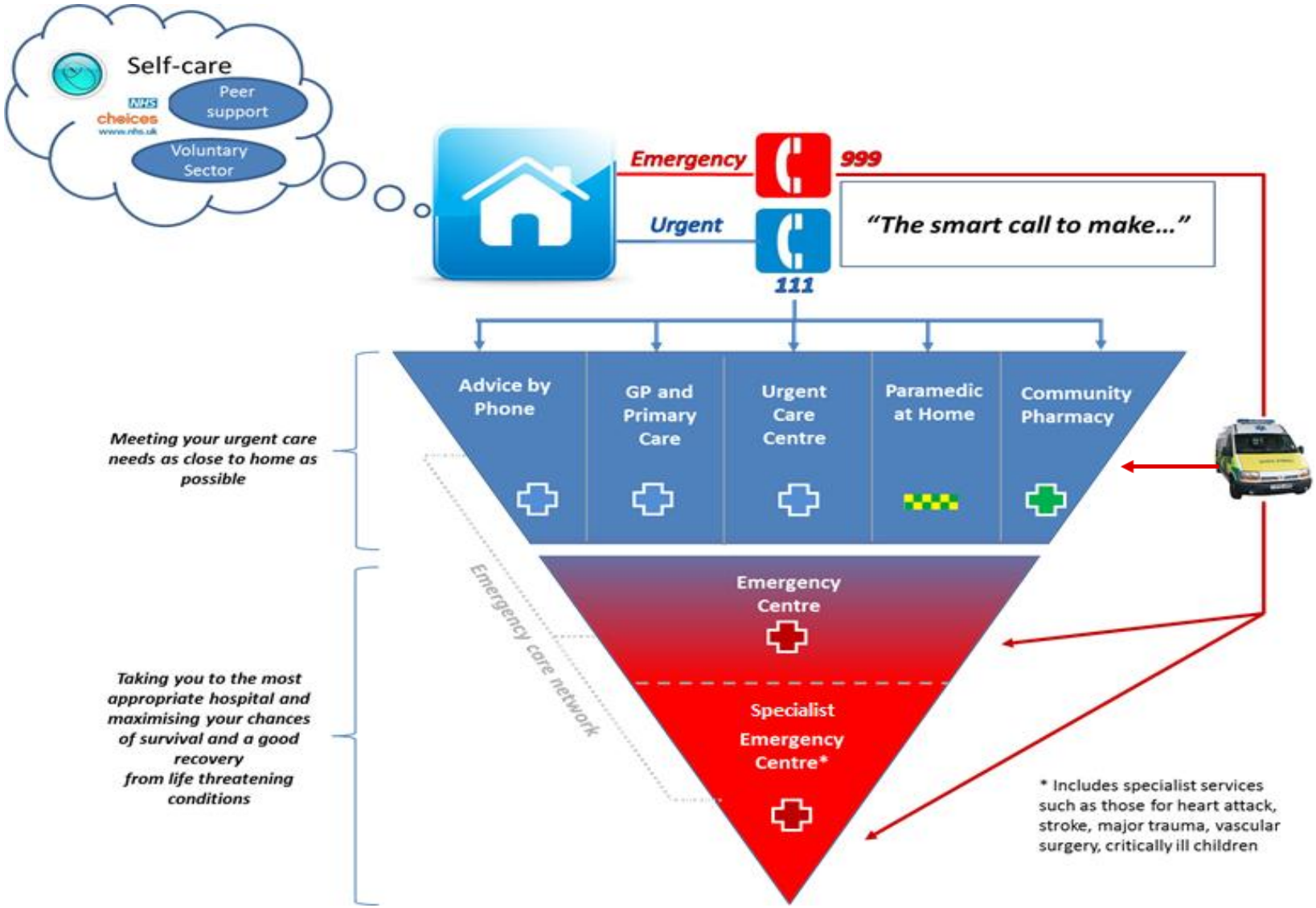
The current components that need to function as one and interface seamlessly are:

- **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;**
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;**
3. **All out-of-hospital services available 7/7 with same degree of 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 Urgent Care Review: time to do it



The Urgent and Emergency Care Review

- Three phases to the programme:

- Looked at the challenges the UEC system faces, and what principles a new system should be based on

- Translation of 'what' needs to happen into 'how' these ideas can be operationalised and delivered

- The final phase is focused on implementing the new models of care and ways of working developed by the Review

Programme update

October 2014: NHS Five Year Forward View published.

- UEC networks identified as one of first new models of care

November 2014:

- NHS England Chief Executive. Authority to move to implementation.
- Secretary of State Meeting. Positive response, approval for a higher profile and to be accelerated where possible

17 December 2014: NHS England Public Board Meeting –

Progress and implementation plans now agreed. This is significant because it will:

- Raise the profile of the work
- Marks a public commitment to deliver the products that will implement our vision of a new system

UEC Networks

The development of networks will be fundamental to delivering the new UEC system

- **System Resilience Group (SRG) members will retain responsibility for local delivery and enabling local innovation** through wider clinical involvement and membership (the 'operational' network).
  - *Also important to have all partner organisations involved at this level – i.e. wider health and social care economy & patients/Healthwatch, etc*.

- **SRGs will come together by agreement to form a wider Urgent and Emergency Care Network** to consider more strategic issues including the planning, oversight and governance of a regional or sub-regional urgent care system (the 'strategic' network).

Concept of designation

A key role for Urgent and Emergency Care Networks is set out as:

- **Designating the facilities that will operate within the Network** (more detailed guidance on this is to be released)

Concept of designation - a way of outlining principles for the whole system and its constituent components.

Principles describe where patients should be treated for best outcomes

- Networks should consider:
  - The architecture of urgent health and social care ***in their community***
  - The role of the network in describing and securing the pathways that are needed to provide a consistent offer of urgent and emergency care

Designation will be a process to determine the function of individual services within the overall system and core clinical pathways.

AGREE:

CORE SERVICE and AVAILABILITY, ACTIVITY and FLOW, QUALITY

Outcomes, standards and specifications

- **Shift in outcome measurement to whole system performance**

- Nationally, there is a need to develop standards and specifications to:
  - **Help describe the networked system**
  - **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
  - Whilst developing new specifications for community hospitals, Urgent Care Centres, Emergency Centres, Specialist Emergency Centres and other system components.

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

Questions and Discussion

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