Unscheduled Care

This paper was produced for the Coastal West Sussex (CWS) Clinical Commissioning Group’s Governing Body meeting on 18 September 2013. It provides an overview of unscheduled care within CWS local health economy. It highlights the national pressures on unscheduled care and demonstrates the impact and specific needs within our local population; as well as showing how we are addressing these and our expectations for the future. Current performance information for unscheduled care is included (system performance as well as specific service performance), and clear indications of risks to performance delivery are included to provide assurance that these risks have not only been clearly identified, but that we also have clear actions to mitigate against these.

1. Background

The pressures on unscheduled care nationally continue to grow, with the current system unaffordable and unsustainable and consuming NHS resources at a greater rate every year¹. Unscheduled care leads to at least 100 million NHS calls or visits each year, which represents about one third of overall NHS activity and more than half the costs². A&E attendances in England rose by 46% between 2003/04 and 2009/10, and emergency admissions to hospital increased by 37% during the last ten years. Of the rise in emergency admissions, nationally, 40% can be explained by an ageing population and the growing numbers of frail elderly patients.

Older people are admitted to hospital more frequently, have longer lengths of stay and occupy more bed days in acute hospitals compared to other patient groups, exacerbated for those patients with frailty and comorbidities. People aged 85+ are nearly 10 times more likely to have an emergency admission than those aged 20-40³. If admitted for inpatient hospital care patients in the 85+ age range have the highest readmission rates and highest rate of long term care use after discharge⁴.

This is particularly relevant for our local population as Coastal West Sussex has one of the oldest populations in England, over 30% of our population are aged over 65 (compared to the England average of around 22%) and by 2016 there will be 11% more people aged over 85 living in Coastal West Sussex⁵.

However, the pressures on the Unscheduled Care system are not solely an “elderly” issue, and we need to ensure that the work encompasses all ages and aspects of the patient population. These include;

- Those who are at risk or chronically unwell, such as mental health, elderly care, end of life and long term conditions

¹ Fernandes, A (2011) Guidance for commissioning integrated urgent and emergency care; RCGP Centre for Commissioning
² NHS Alliance (2012) A practical way forward for clinical commissioners
⁴ Woodard J, Gladman J, Conroy S. Frail older people at the interface. Age Ageing 2010;39(S1):i36
⁵ 2011 ONS data from the CCG Outcomes Tool (NHS England)
• Those who are unwell or have minor injuries, such as stomach pain, chest infection or minor cuts
• Those who require emergency care, such as sufferers of a major trauma, heart attack and stroke

The specific areas of work undertaken to improve the local situation are detailed later in this paper. However it should be noted that, whilst continuing to drive system change and ensure delivery of outcomes, we must ensure that it is aligned to our guiding principles for unscheduled care:

• Be easy to navigate for patients and clinicians, with a single points of access, single assessment processes and supported by specialist advice and services when needed
• Share patient information effectively across the system, ensuring the right care is provided encompassing the patients preference and choice, whilst profiling those at the risk of rapid deterioration
• Empower healthcare clinicians to support patients and avoid admissions, whilst maximising the number of patients who self-manage through more systematic implementation of care planning and shared decision making
• Will work seamlessly with Proactive Care services to support patients out of hospital and back to maximum independence as soon as possible
• Reflect evidence based whole-system pathways.

2. Local Need
We know that the pressures on the system observed nationally are replicated at a local level. We have seen, as shown above, that locally there are specific pressures with regards to a higher than average elderly population, and therefore proportionately high levels of complex frail elderly with a disproportionate impact on healthcare services and use of resources per patient.

Although Coastal West Sussex is seen as a generally affluent area, it also contains the most deprived areas within West Sussex, including some wards (River and Ham ward in Littlehampton) which are within the 10% most deprived in the country.

In terms of long term conditions we see the highest proportion of emergency admissions from cardiovascular disease (CHD, Heart Failure, Stroke) and COPD, and these are also the patients most likely to be readmitted to hospital. Indeed, responses in the GP patient survey 2011-12 indicate only 61% of CWS patients say they have had enough support from local services or organisations to help manage long-term conditions.

It is also understood that local services have been fragmented and patients are confused where to go for the right treatment, often defaulting to attendance at A&E due to lack of knowledge/understanding of services, or because alternatives have proved difficult to access (opening times, distance, referral criteria).

We know from discussions with clinical colleagues that standards of care in Sussex are good but there are still variations in the quality of care and clinical outcomes for patients. There is significant opportunity to improve the experience of patients by integrating care, closing gaps and removing duplication. Some patients are still admitted to hospital when they could have stayed in their own homes and benefitted from timely access to out-of-hospital care (community services and social care support). Within hospital

---

6 Joint Strategic Needs Assessment (2012) CWS CCG data pack
the way in which patients are assessed, diagnosed and treated could be improved to support better clinical outcomes, and reduce lengths of stay. Clinical outcomes, including survival rates, have been shown to vary by admission day of the week and, in addition, timely and more consistent accesses to senior clinical staff have also been shown to improve survival.  

3. Current Performance of Coastal West Sussex

Summary of main Unscheduled Care indicators:

- **A&E 4 hour** waits have **consistently** been **achieved** for April-June.
- **A&E attendances** peaked in May, came down through June then rose again through July. The last couple of weeks have dropped a small amount but it still reflects an **overall trend of increased attendances**.
- **Emergency admissions** have **fluctuated around planned levels** and are currently **1.3% below plan**.
- **Emergency bed days** started out incredibly **high in April** but then started to **fall steadily** and are **at expected levels** for August.
- **Delayed Transfers of Care** were high in the first couple of months, mainly due to therapy capacity in community, but have **reduced to predicted levels** of around 3%.
- **Average length of stay** for emergency admissions has **remained fairly consistent**, but reducing slightly from early April.
- **Ambulance See & Convey** activity remains at a **constant 48%** against a 40% target. SECAmb will need to produce action plan to address performance down to planned levels.

Moving forward, the CCG is contributing to the NHS Benchmark Network with regard to benchmarking urgent care. The results will be published in November 2013 and will allow us to test the balance of care across our local health system, as well as compare demand and capacity arrangements and commissioned services across different health economies.

4. Current Plans

The diagram below shows the main elements of the unscheduled care system and the impact areas we are focusing on (and at which point in the service pathway) in order to influence them.

---

Each of the impact areas contains work-streams focussed on change and improvement as follows:

**Proactive Care**
- These work-streams are taken forward by the CWS CCG commissioning team for Proactive Care working closely with the Unscheduled Care team, due to the overlapping nature of the services, to ensure joined-up pathway impacts are understood across the system. Areas of work include; multi-disciplinary team (MDT) working, Risk Profiling, Self-Care and Peer Support, End of Life Care, Prevention and Public Health.

**Avoiding Admissions**
- **One Call One Team** is our flagship service. It was developed through local discussions with clinicians and managers, across provider and commissioner organisations, as a vision for what local integrated unscheduled care services should look like. Elements of the service have been operational since April 2011, however the design and operational arrangements have continued to evolve in that time.

  *The aim of One Call One Team (OCOT) is to facilitate the treatment and management of patients, at the right time, in the right place, ensuring services are wrapped around patients’ need and choice. It is a single point of access for urgent care referrals by clinicians which facilitates access to urgent care management options across the health economy, and provides rapid assessment of patients and access to short term community packages of care, including medical, therapy and personal care. (see Appendix 1 for service components)*

In order to drive through the challenge of integration we have appointed Western Sussex Hospitals NHS Foundation Trust as Lead Provider for the service. Under this arrangement they will have responsibility for the management of the service as a whole, ensuring leadership for sub-contracted parties.

A snapshot for August of the activity areas influenced by OCOT, which highlights the year-to-date changes from 2012 to 2013, is shown below to show the impact that the service is having.

**One Call One Team Performance Dashboard:**
Summary & Highlights from August 2013

Data for Patients aged 65 or over:
- A&E attendance = 3,179 August, 15,622 YTD = **4% increase** from 2012/13
- Emergency Admissions = 2,027 August, 9,921 YTD = **5% reduction** from 2012/13
- Nursing Home Admissions = 67 August, 322 YTD = **13% reduction** from 2012/13
- A&E Conversions = 48.7% August, 49.3% YTD = **2.1% reduction** from 2012/13
- Seen by GP in A&E = 138 August, 678 YTD = **42% increase** from 2012/13
- RACE attendances = 49 August, 260 YTD = **9% increase** from 2012/13
- One Call urgent line calls = 2,581 August, 12,382 YTD = **7% reduction** from 2012/13
- Urgent Line Ave Wait = 2.3mins August, 2.1mins YTD = **22% reduction** from 2012/13
- % calls answered <2mins = 66.5% August, 70.3% YTD = **14% increase** from 2012/13
- Call abandonments = 5.2% August, 5.1% YTD = **3% reduction** from 2012/13
It can be seen that the areas that OCOT has a direct influence on have improved from last year. Further validation of the number of urgent calls received is being carried out as the assumption is that the efficiency of the service has improved and therefore clinicians are no longer having to hang-up and dial in again for the same patient. Therefore the reduction can be seen as a positive impact.

- **Out of Hours**
  - New Out of Hours contract to be in place from April 2014 with newly developed service specification for CWS. Will enable greater flexibility in dealing with patients requiring urgent treatment outside of working hours.

- **Paediatric Urgent Care Pathways**
  - Have developed and are implementing care pathways for Diarrhoea and Vomiting, Fever, Head Injury, Bronchiolitis to be used across primary and secondary care

- **Home Oxygen Service**
  - Prevent unnecessary admissions by using home oxygen assessor to review use of home oxygen and to recommend prescription changes accordingly.

- **Community Beds – Step Up Model Review**
  - As part of the community bed review we will be commissioning community step-up beds to ensure that patients at risk of admission are managed in a proactive manner

- **Nursing Homes (Hospital Admissions)**
  - SBAR (situation background assessment recommendation) protocol piloted and now being rolled-out across nursing homes. Enables ambulance crews to challenge whether nursing home patients need to be conveyed to hospital. Reduces unnecessary conveyances.

- **Ambulatory Care**
  - Developing Ambulatory Care Areas within the hospital enabling patients to be managed safely and efficiently on the same day thereby avoiding admission to a hospital bed.

**Improving Inpatient Care**

- **Ambulatory Care**
  - Seven ambulatory care pathways designed and implemented (inc DVT, Heart Failure, Lower limb cellulitis, exacerbation of COPD), one pathway designed and due to be implemented October (Pulmonary Embolism).

- **Paediatric Urgent Care**
  - Paediatric Advanced Nurse Practitioner role being developed. Currently exists in other health economies and has helped to reduce lengths of stay and provide link between community and acute care.

**Facilitating Discharge**

- **One Call One Team**
  - RAIT will help to facilitate discharges from A&E / AMU and inpatient beds for those patients who will require additional community support but who do not need to remain in an acute setting.
Patient Flow Team will help to identify community bed availability and coordinate discharges to these beds

- **Community Beds – Step Down Model**
  - As part of the community bed review we will be commissioning community step-down beds to enable timely discharge from acute with the ability to manage patients for a short time with the necessary clinical inputs (therapies etc) to reduce readmissions.

**Local Health Economy Improvement**

- **NHS 111**
  - Local input into wider Surrey/Sussex system and link down into OoH and A&E provider. We also ensure that we are clear on any impacts on the LHE resulting from 111. For example, currently evaluating, with main acute provider, impact on A&E to give assurance on current 111 dispositions.

- **Ambulance Services**
  - Urgent & Emergency – link into wider performance management via contractual leads. Translate performance regarding See & Convey, See & Treat and Hear & Treat into local impacts and actions
  - Patient Transport Services - link into wider performance management via contractual leads and liaise with local stakeholders re issues.

**5. Future Plans**

In order to achieve our goal of providing an excellent standard of integrated Unscheduled Care to our patient population we want to enhance the focus on preventative care and care that manages people’s illnesses, whilst providing strong, clinically effective care for urgent or emergency care when needed.

We will need to ensure that we commission the services during 14/15 to ensure that;

- **Patients and relatives are helped to manage their care**
- **Patients are better informed**
- **Services are aware of what each other are doing**
- **Patients looked after at home or as near to home**
- **The A&E service is responsive and has senior clinician decision-making**

We will do this by:

- Ensuring AMU service has a consultant physician always available “on call” and present for at least 12 hours a day, seven days a week, with no concurrent duties except the delivery of care to acute admissions.
- Ambulatory Care Areas are delivering a consistent service across both sites
- Delivering a step-up, step-down community bed model
- Working with our Lead Provider to commission outcomes, potentially within a capitated weighted budget, and holding them to account for delivery of the programme.
- Liasing with Primary Care Development Team to ensure access to General Practice reflects patients’ needs for urgent care
- Working with Patient & Public Engagement teams to ensure two-way patient feedback for services (will start via the “Let’s Talk” campaign), and undertaking strategic work identifying public behaviours regarding A&E.
- Setting-up, along with Pro-active Care, the ability for “expert patients” to support peer groups
6. **Operational & System Issues**

As a health economy we are making significant progress to delivery of our unscheduled care plans, however we are mindful that a number of risks exist which will need to be mitigated against. The main risk areas are shown below.

- **System Risks**
  - **Winter Pressures**
    As we approach the winter period we are working with our provider colleagues to ensure that we have plans in place to help cope with the increased demand that is typically seen. We have started this process earlier than in the past to ensure a proactive approach rather than a reactive one when we are already in crisis.

    Unlike in past years we have not received any additional “winter funding” for 2013/14, however we see this as an opportunity to break the cycle of relying on extra non-recurrent funding and ensure that we have robust systems in place to cope with surges in demand. We, along with our partners, have identified four main areas which will be addressed within existing resources available to us:

    - We will be increasing the seniority level of staffing in A&E in order to ensure that timely clinical decisions are made. This will ensure that patients start on the right pathway of care as soon as possible and should help to avoid admissions.
    - We will ensure that community step-down beds are available in both East and West areas with the model (on hospital sites, community hospitals or in nursing homes) to be finalised.
    - We will ensure that care hours are available for intermediate care teams to access in order to continue to provide personal care rehabilitation support
    - We will ensure that the Rapid Assessment Intervention Team is at the optimum level of capacity, particularly regarding therapy support, in order to deliver interventions for the increased demand levels

  - **South East Coast Ambulance**
    We have seen a number of performance issues with the Ambulance contracts which will have an impact on local delivery. These include the Urgent & Emergency contract, Patient Transport Services and 111.

    - **PTS Contract**
      Patient transport is not always provided in a timely manner, either through lack of capacity at time of request, or delays to the pick-up times previously agreed.
      - At a contracting level they are now working to a remedial action plan to improve performance.
      - New Intermediate Tier Vehicles introduced to cover GP urgent requests
      - For 14/15 we will seek to recover costs from the provider for any hospital admissions as a result of PTS not being available

    - **Urgent & Emergency Contract**
      There is a large risk in terms of lack of local engagement due to how the service is contracted for at a Kent/Surrey/Sussex level.
Agenda Item No. 6
Appendix G

- We have set-up regular meetings with local SECAmb operational leads in order to progress improvements which will have a subsequent positive impact on the wider contracted performance (for example the SBAR process with Nursing Homes to reduce conveyance)

  - **111 contract**
    It has been well documented this year, not least in the national media, that the 111 service saw a number of operational issues, particularly around staffing capacity, which meant there were significant risks in their ability to deliver the service. However there has been a major improvement with the service locally and we are now focussed on two specific risk areas

    - Anecdotally it is believed that 111 advice given to patients has resulted in higher numbers attending A&E locally. An audit is taking place at the end of September, in partnership with the acute trust, to review the patients sent to A&E via 111 and ascertain whether these were appropriate or not. The outcomes, if warranted, will then be fed back to SECamb for action
    - There is a current risk with the length of time it is taking for clinician call-back to 111 callers who require it. A programme board has been set-up by the host commissioner (which CWS will input into) to drive through and monitor the rectification plans to ensure that performance is in line with the contract.

  - **Public Engagement**
    It has been highlighted that patients are often unsure, or unaware, of alternative services within the unscheduled care system and that A&E therefore becomes the default place of care. Indeed, we have seen from the activity performance that there is an overall trend of increased A&E attendances. This places a large risk on the system, not only on achieving national targets (i.e A&E 4 hour waits) but on the increased pressures and flows through the system post-A&E.

    - In order to inform and mitigate this risk we will be gathering evidence, utilising a company specialising in research, to understand how and why our patient population use the services they do. This will then inform a tailored CWS CCG communication strategy to explain our system and promote alternatives.
    - We will also be ensuring, via the “Let’s Talk” campaign, that case studies are utilised which highlight the good work being done in primary and community care to prevent emergency admissions to hospital.

Definitions:

What is Unscheduled Care?

- Unscheduled Care refers to both urgent and emergency care and covers healthcare activity that is unplanned.
- **Definition of Urgent Care**: A condition that requires an assessment and planned intervention within seven days, or which is likely to lead to an emergency within four weeks.
- **Definition of Emergency Care**: Not always life threatening, but needs prompt assessment and a planned intervention within 24 hours.

Dr Susanna Petche, Clinical Lead – Unscheduled Care and Paul Goddard, Head of Unscheduled Care
September 2013
Appendix 1 - One Call One Team System

- **GPs/community referrers**
- **111**
- **one call**
- **NHS 111 service**

**one team**

**AMU/A&E**
- Hospital for immediate admission - patient requires constant clinical care and immediate treatment

**Paramedic Practitioners**
- Patient needs urgent assessment at home to avoid ringing 999. If treatment initiated in community and supported by RAIT an admission may be avoided

**Rapid Assessment & Intervention Team (RAIT)**
- Up to 14 days rapid support to manage a crisis - including night/day sitter

**Community Geriatricians**

**RAIT**
- Support to A&E and AMU to help patients home - includes social care

**Domiciliary visits**
- Needs an urgent consultant opinion within 24 hours

**One Team GP**
- Patient needs urgent investigations with results reviewed immediately to inform ongoing care. Generally these patients do not need admission

**Rapid access clinics for elderly**
- Not clear what is wrong, not urgent today but needs consultant advice within days, supported by community team in the meantime.

**Nursing home support**
- Support to nursing and care homes to prevent avoidable admissions

**proactive care and community services**