NHS England

Urgent and Emergency Care
Developing the vision for London

BUILDING THE NHS OF THE FIVE YEAR FORWARD VIEW

The NHS England Business Plan 2015-2016

THE NHS CONSTITUTION

Redesigning Urgent and Emergency Care Services …. the new offer

Keith Willett
Director of Acute Care


THIRD WORLD A&E
10 hospitals in crisis
Worst wait in 10yrs
Car park care tent
By NICK McDERMOTT
NHS
Emergency Department
Ultimate 5:2 diet for her – and HIM
Daily Mail
Most inspiring Fast Diet success stories ever
A&E CRISIS WORST FOR TEN YEARS
AMBULANCE
EMERGENCY AMBULANCE
KEEP CLEAR 3.5 METRES

What does the experience and data from recent winters tell us?

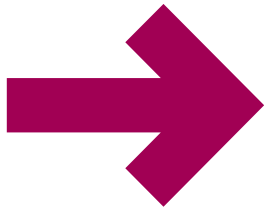
- Surge in demand exacerbated the **problems in a system** we knew was already under strain (4-6% per annum)

- **In hospitals** the surge “problem” is **emergency admissions** (admissions 2.7%, attendances 1.1% per year, cost £12bn)

- Strong **upward trend in all contacts** especially to NHS111

- **Resilience and availability of community-based services** and the important relationship with community and social care services compound difficulties in the acute hospital sector leading to ……..

unnecessary admissions and delayed discharges



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

What we also know:

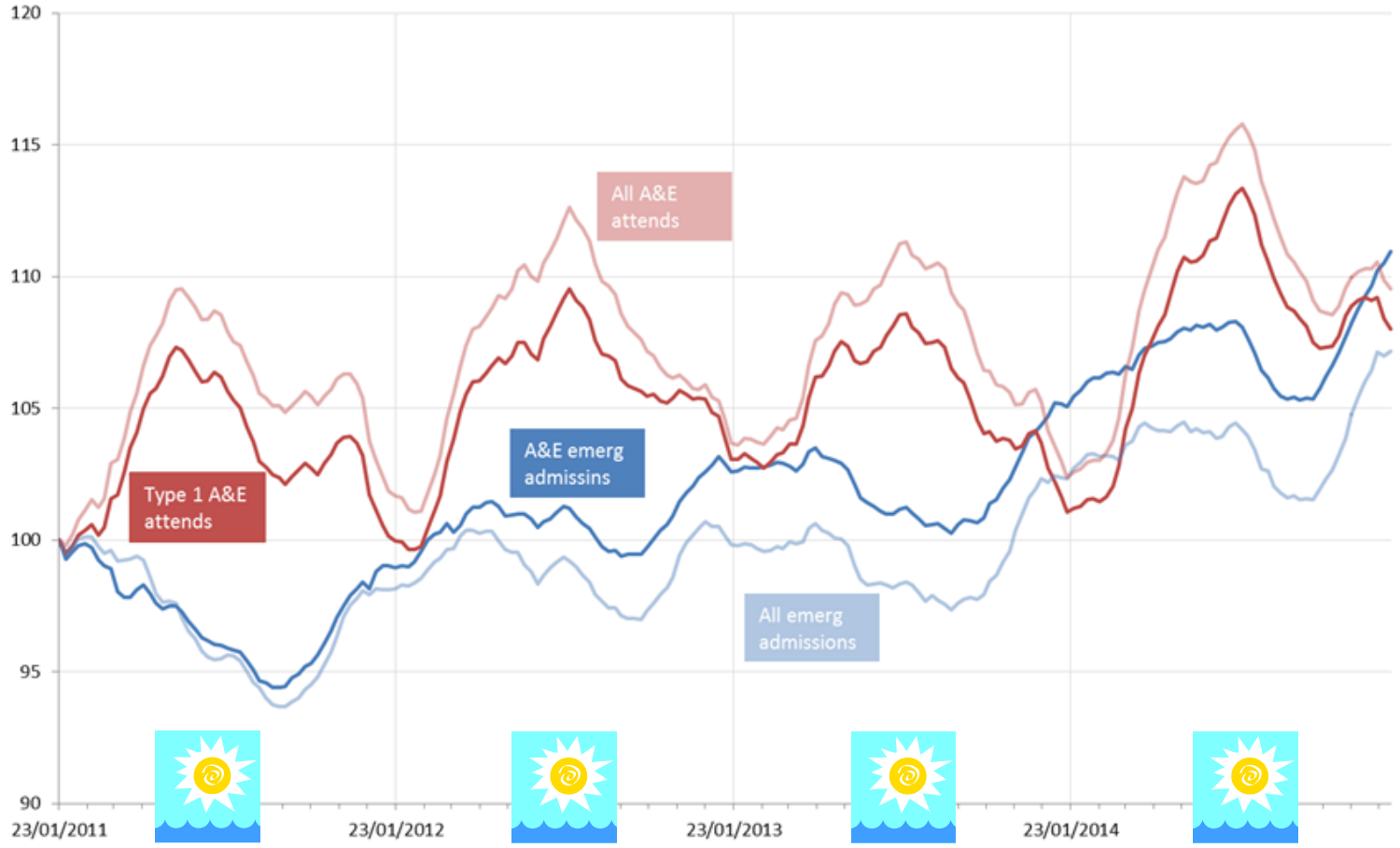
- a 1% increase in the population that **failed to access a GP** within 2 days predicts a 0.7% increase in self-referred A&E visits.
- 1 in 4 people state they would **use A&E for a recognised non-urgent** problem if couldn't access their GP
- 1 in 4 people have **not heard of Out-of-Hours GPs**
- 75% 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; but **7 fold increase** in 2 years
- higher A&E use; populations **urban** 15% and **deprived** 42%

…. but its not about attendances …….

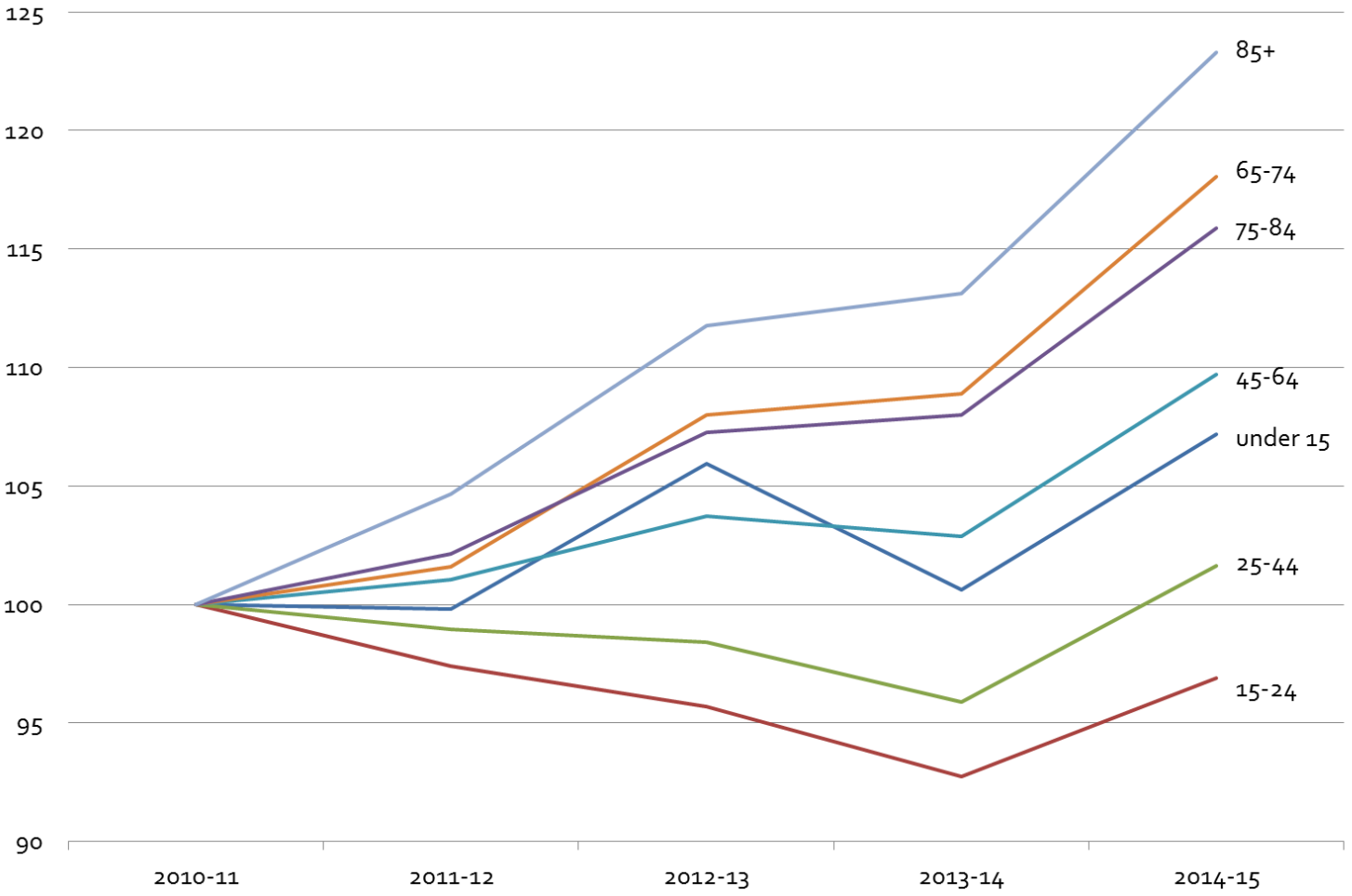
It’s not attendances, it’s admissions stupid!

NHS England

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



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

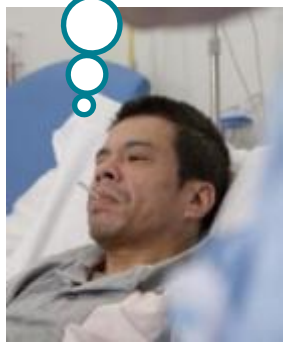
What does the transformation of our Urgent and Emergency Care services look like?

Urgent and Emergency Care Review
- the new offer

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

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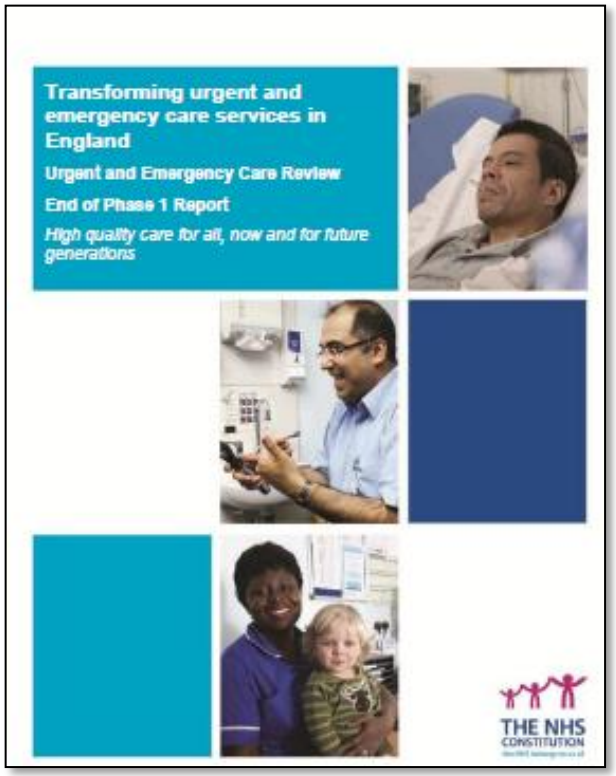
THE NHS CONSTITUTION
the NHS belongs to us all

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**

Mental and physical health

UEC Review: arriving here

- Three phases to the programme 2013-15:

Phase 1
DESIGN
Jan – Oct 2013

- **Examined the challenges the UEC system faces, and what principles and objectives a new system should be based on COMPLETED**

Phase 2
PRODUCT DELIVERY
Nov 13 – Dec 14

- **Translation of 'what' needs to happen into 'how' these ideas can be operationalised COMPLETED**

Phase 3
IMPLEMENTATION
Jan 15 – now

- **NOW the final phase is focused on implementing those new models of care and ways of working**

Helping people help themselves

Self care:

- Better and easily accessible information about **self-treatment options** – patient and specialist groups, **NHS111 on a digital platform as part of NHS Choices (nhs.uk). Promote pharmacy access**

- Accelerated development of **advance care planning,** end of life care

- **Right advice or treatment first time - enhanced NHS111 - the "smart call" to make**:
  - **Improve patient information** for call responders (ESCR, care plan)
  - **Comprehensive Directory of Services** (mobile application)
  - **Greater levels of clinical input** (mental health, dental heath, paramedic, pharmacist**,** GP)
  - **Booking systems** for GPs, into UCCs, dentists, pharmacy

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

- **Faster, convenient, enhanced service:**
  - **Same day, every day access** to general practice, primary care and community services advice
  - Harness the skills of **community pharmacy,** minor ailment service
  - **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,
  - Develop 999 ambulances so they become **mobile urgent community treatment services,** not just urgent transport services
  - **Single Point of Access** with Community and Social Care

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

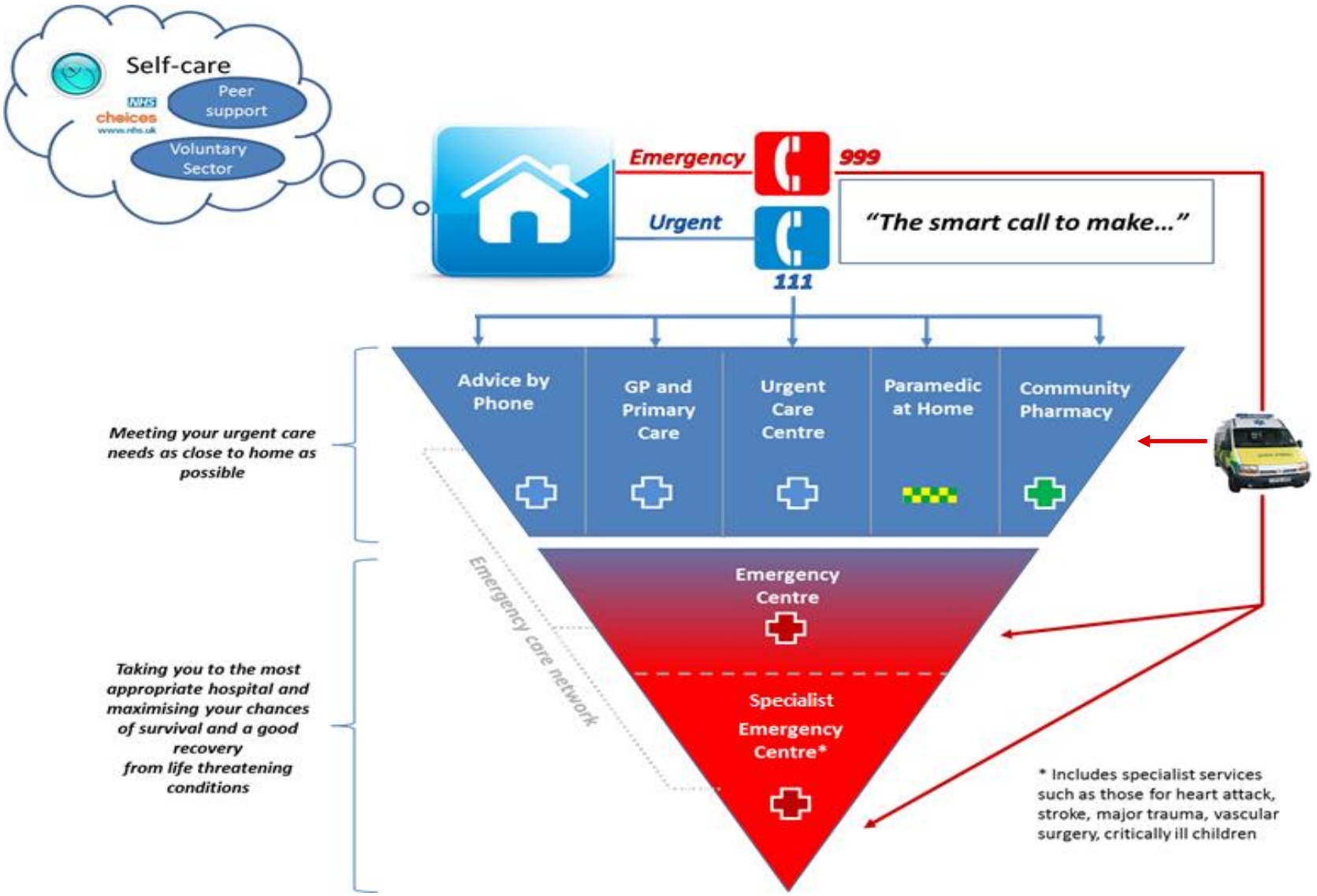
- **Identify and designate available services in hospital based emergency centres**

- **Urgent Care Centres** – primary care, consistent, access to network
- **Emergency Hospital Centres** - capable of assessing and initiating treatment for all patients
- **Emergency Hospital Centres with Specialist services** - capable of assessing and initiating treatment for all patients, **and** providing specialist services: transfer or bypass access, 24/7 specialist network support

- **Emergency Care Networks:**
  - **Connecting all services** together into a **cohesive network**

overall system becomes ***more than just the sum of its parts***

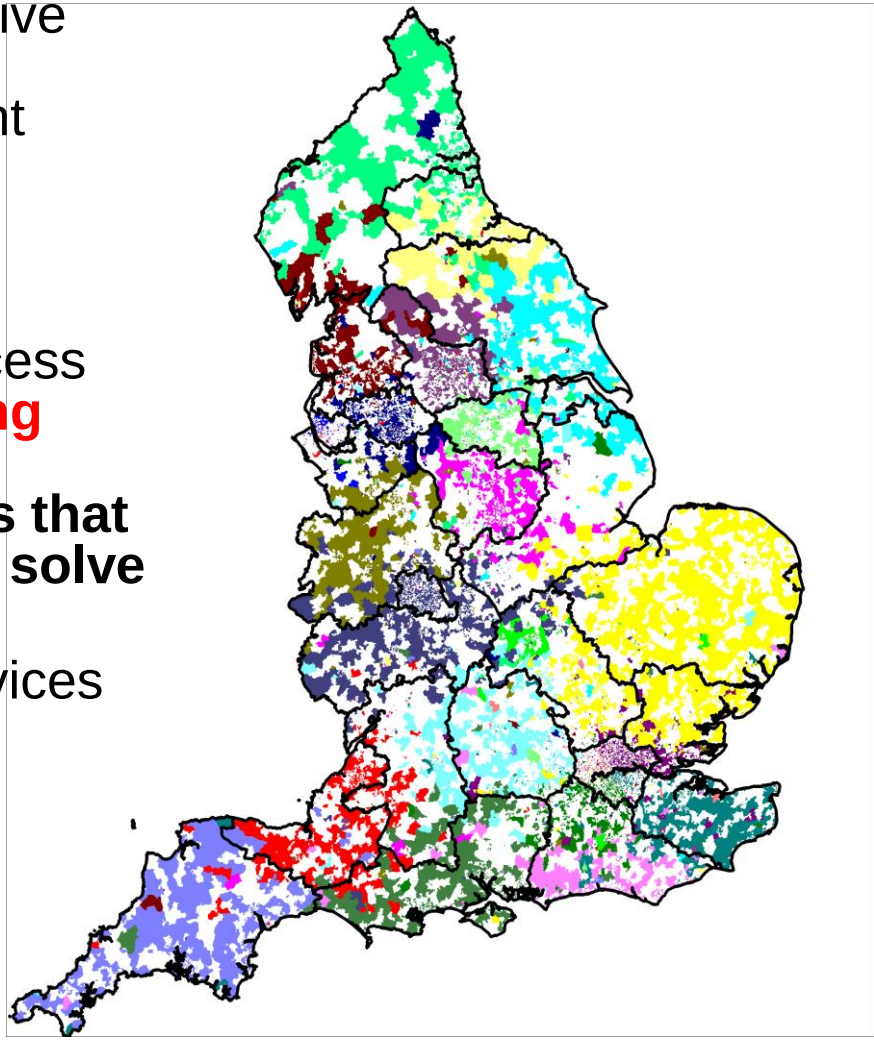
new offer; no consult in isolation



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 protocol
  - Clinical decision support hub
  - NHS 111 services
  - Single point of access



How do we do this as a modern NHS?

Establishing Networks – early actions

- **Early actions** to be undertaken by Networks include:
  - Developing a membership structure and terms of reference;
  - Fostering strong relationships and effective communication across the network, and building trust;
  - An immediate initial stocktake of UEC services within the boundary of the Network, and an assessment of access and equity of provision (by deprivation and rurality);
  - Agreeing the configuration of the Network and its structural components co-dependencies and critical pathways;
  - Beginning to define the consistent pathways of care and equitable access to diagnostics and services across large geographies, for physical and mental health and children

System Resilience Groups

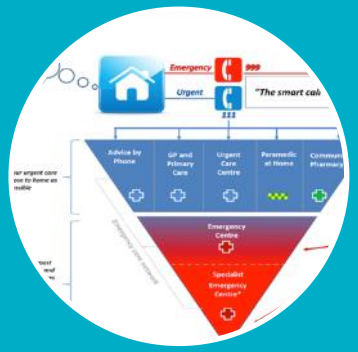
- Operational leadership of local health and care services
- Responsible for effective delivery of bespoke urgent care in their area in coordination with an overall urgent and emergency care strategy agreed through the regional Urgent and Emergency Care Network
- *Where's there is a problem that is common to SRG's there may be some sense in having uniformity in the solution across their UEC Network*

A “route map” for implementation

This will describe:

1. the anticipated changes by 2017 and beyond
2. a timeline for delivery of **national enablers**
3. the recommended **actions at urgent and emergency care network and SRG level**
4. an **assurance programme** for SRGs to support delivery of the objectives of UEC review and winter resilience plans
5. the **support offer** to SRGs and networks

Key areas of work to help you



UEC Review Big Tickets

Monitor
Making the health sector work for patients
NHS England
tda Trust Development Authority

National Tripartite Work including **8 High Impact Interventions**

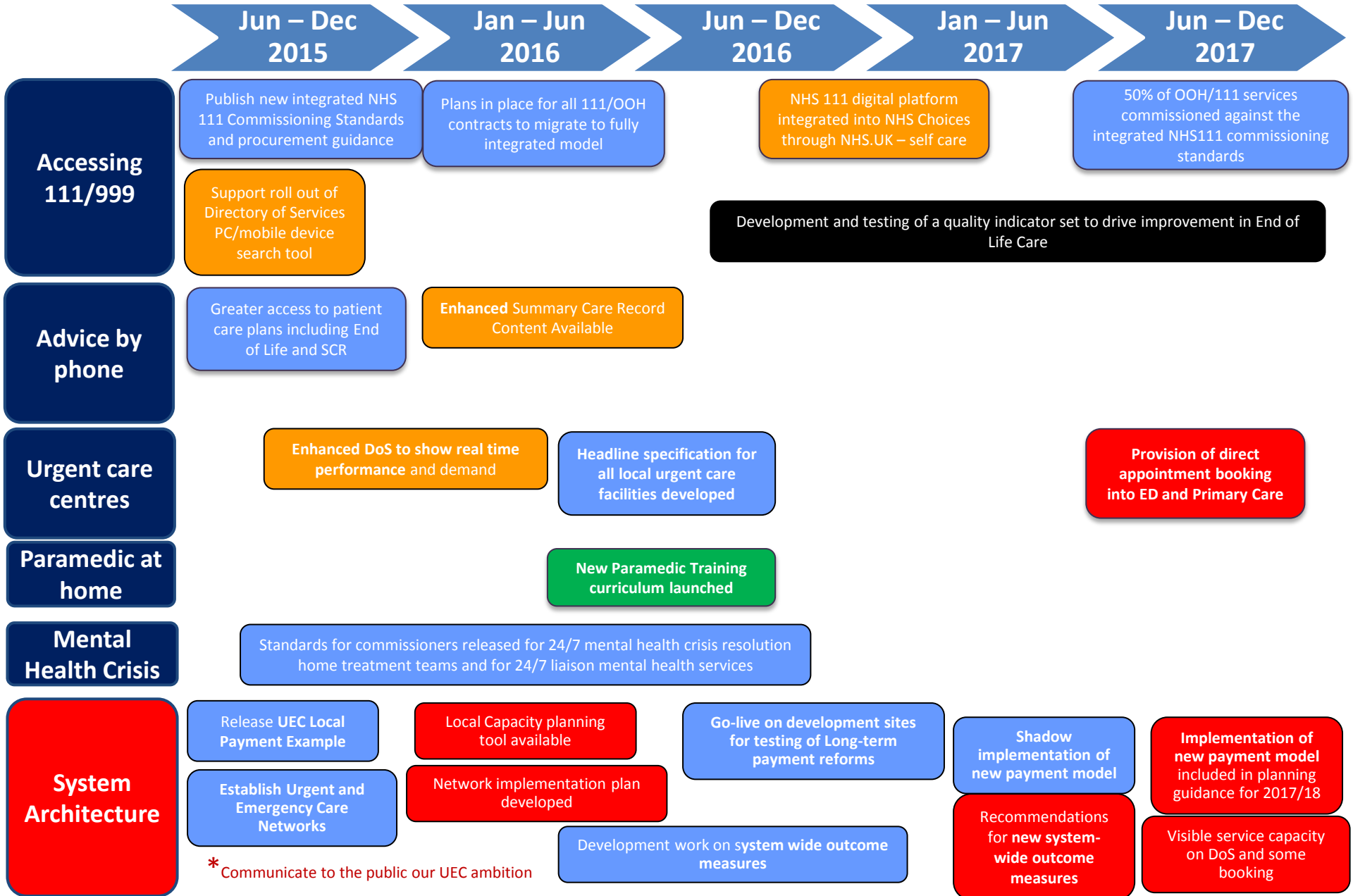
Implementation of key guidance

with Clinical Commissioning Groups

Alignment with **Out of Hospital** program and **Winter Resilience**

- Support SRG delivery of **8 High Impact Interventions**

Timeline for delivery or the new offer:



Key areas of work – national enablers

UEC Review Big Ticket Items including:

- Self-care initiatives e.g. realising the value
- Standards for acute receiving facilities
- 111 as portal to out-of-hours integrated service
- New system-wide indicators and measures
- Local capacity (demand) planning tool

Transforming urgent and emergency care in England

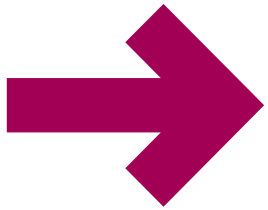
- **Role & establishment of UECNs, published.**
- **Safer, Faster Better published**
- **Clinical models for ambulance service**
- **Improving referral pathways between U&E services**
- **Financial modelling methodology for local use**
- **Commissioner guidance on Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services**
- **Access standards for mental health crises**

Good Practice in delivering UEC

- **Safer, Faster, Better: Good Practice in Delivering Urgent and Emergency Care:** published Summer 2015
- Guidance for front line providers and commissioners of urgent and emergency care
- A practical summary of the design principles that local health communities should adopt to deliver faster, better, safer care
- The guide draws on evidence of what currently works well in the urgent and emergency care system, setting out key design principles to help this good practice to be adopted locally

Clinical Advice Service 'hub'

- **Right advice or treatment first time** - enhanced NHS111 the "smart call"
  - on a digital platform as part of NHS Choices (nhs.uk)
- **Greater levels of clinical input** (mental health, dental heath, paramedic, pharmacist, GP, community nurse, hospital specialists)
- **Improved patient information** for call responders (enhanced SCR)
  - Accelerated development of **advance care planning,** end of life care
- **Comprehensive Directory of Services** (mobile app)
- **Single Point of Entry** for community and social care to support 111, ambulance, out-of-hours and in hours GP
- **Booking systems** for GPs, into UCCs, dentists, pharmacy

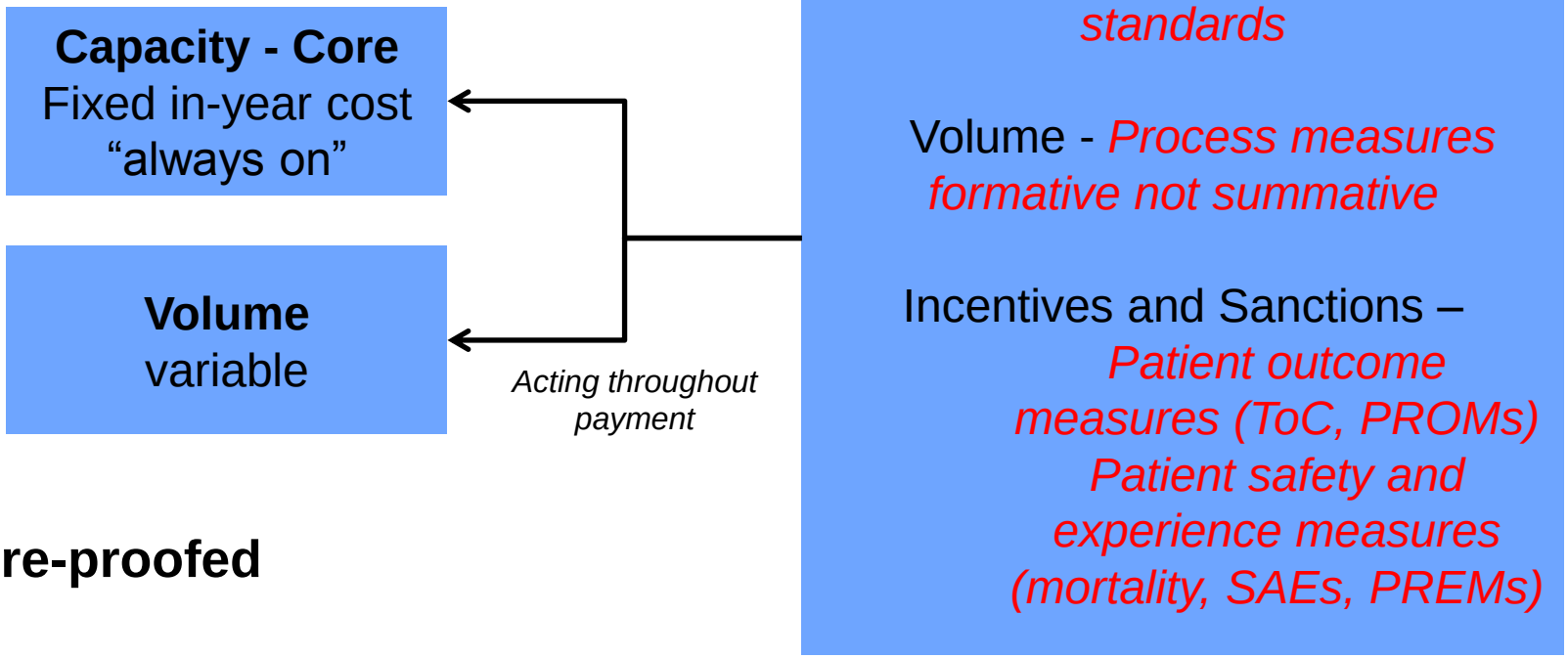


The 4 greatest challenges

1. **Payment system reform**
2. **Information sharing**
3. **System measures**
4. **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:**



- **future-proofed**

Summary Care Record: Creating the records

- **SCRs are an electronic record of key information from the patient's GP practice**
- As a minimum contain **medication, allergies and adverse reactions**
- **Enhanced Record** option available now for 85% GP practices
  GPs will need to consent

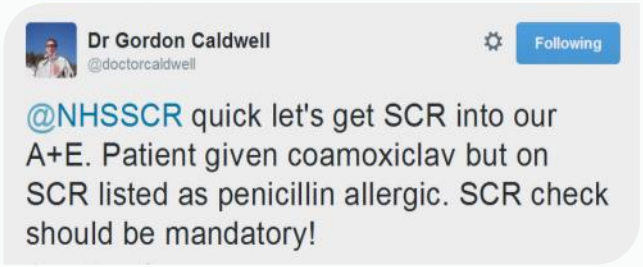
55m
SCRs created
(>96%)

> 2.5m
contacts in last year
12 secs

To find out more or enable SCR: scr.comms@hscic.gov.uk **or** @NHSSCR

Summary Care Record: Benefits

Summary Care Records



Safety: **one out of every five patients on MAU had improved prescribing**

Efficiency: **30 minutes time saved per patient in hospital pharmacy** establishing drug history

Effectiveness: **fewer OOH patients asked to contact their own GP practice** for a follow up if SCR available

By the end of 2015 all 111, 999 and EDs will have access

To find out more or enable SCR: scr.comms@hscic.gov.uk **or** @NHSSCR

hscic Health & Social Care Information Centre

NHS

Mobile Access to the Directory of Services

Outcomes, standards and specifications

- **Shift to outcome measurement for whole system**

Nationally there is a need for standards and specifications to:

- **help describe the networked system**
- **to enable commissioners to have the information to commission for system-wide outcomes**
- **monitor and improve performance**

Will build upon existing standards and clinical quality indicators:
– i) clinical pathways ii) patient experience iii) staff experience

testing in UEC Vanguards in early 2016

Post-CCT (EM) Fellowship

A 12 month, programme; aimed at providing urgent, emergency and acute care training for **GPs**.
Objective: To remove the "safety net" from the ED, back into the community.

Advanced Practitioners

Launch of a regionally standardised training course pilot. **Objective:** To inform regional planning. 15-strong cohort – 3 from each of 5 disciplines: nursing, pharmacy, podiatry, physiotherapy, paramedic.

NHS
Health Education England

GPs

Advanced Practice

SAS (EM) Doctors

EM Fellowships

1) A bespoke 12 month portfolio of practical skills-based **SAS EM** Training.
2) An pilot for SAS Doctors.

PROJECTS:
Medical *and* Non-Medical

Physician Associate

Physician Associate

1) Supporting the West Midlands re-launch of the role from January 2014.
2) Supporting the national plan for statutory registration.
3) Sharing learning across regional LETBs.

Non-Medical Prescribing

Independent Prescriber Pharmacists

Non-Medical Prescribing

Launch of a bespoke **course** – to up-skill Pharmacists to Independent Prescriber level, with additional skills training in clinical diagnosis / minor injuries & minor ailments.
Also for AHPs; physios, paramedics, radiographers, optometrists

Independent Prescriber Pharmacists

A UK-first pilot study, investigating the role of clinically-focussed in the ED, across three regional Trusts. Now scaled up to national project, with 53 trusts across 12 LETB areas nationally

WM EM Taskforce:

To **develop innovative workforce solutions** to:

1) Meet Emergency Medicine workforce demands within the **Emergency Department.**
2) Improve **Admissions avoidance**, through primary-care / community pathway strategies.

www.hee.nhs.uk

UEC Vanguards

- Focus on i) local health systems with strongest network progress and ii) addressing greatest operational challenges
- **Accelerate pace of change**
- Drive **new ways of working across organisation boundaries**
- Tripartite support for implementation, help remove barriers
- **Test beds for new UEC initiatives** (relationships, workforce, clinical decision support hubs, payment model, new indicators)
- Meet explicit requirements on implementing best practice and national policy expectations

A new strong consumer offer to the public:

NHS urgent care starts to look like what the patients tell us they want, not what we have historically offered

- **A single number – NHS 111 – for all your urgent health needs**
- **Be able to speak to a clinician if needed**
- **That your health records are always available to clinicians treating you wherever you are** (111, 999, community, hospital)
- **To be booked into right service for you when convenient to you**
- **Care close to home** (at home) **unless need a specialist service**
- **Provide specialist decision support and care through a network**

…….. we will change patient and staff behaviour through experiential learning

Urgent and Emergency Care Review

the new offer

It's great to share and learn so much with this group

It's like everyone knows all about me

I'm alive cos I had specialist care really fast

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