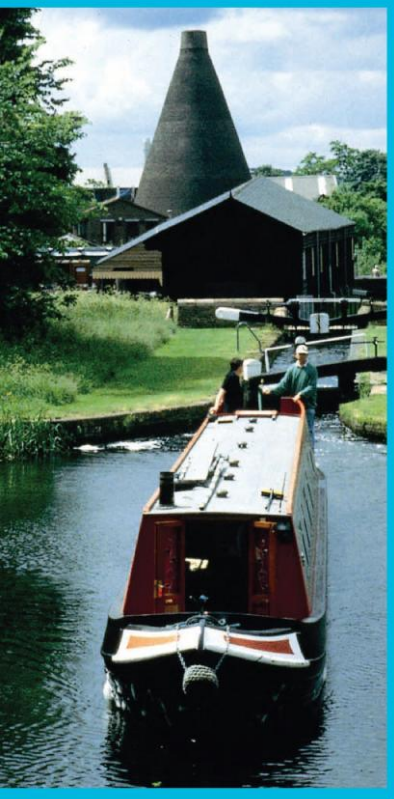
NHS Dudley

heart of local health



Urgent Care Strategy

November 2010

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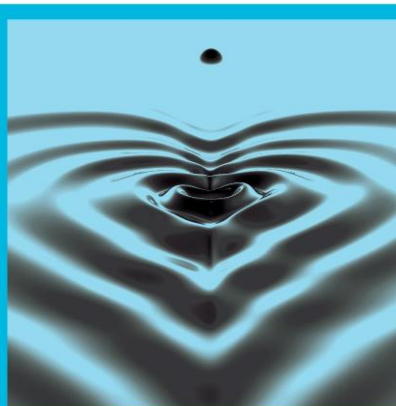


Contents

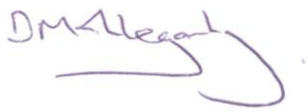
1. FORWARD

This urgent care strategy represents the efforts of clinicians, other colleagues and key stakeholders to pull together a vision for integrated urgent care services for the people of Dudley. This strategy outlines what we will do to achieve our vision. I believe that what we are doing will make a real difference to the people of Dudley who need urgent care support.

This strategy compliments our long term and planned care strategies and is designed to ensure that the health and social care system in Dudley operates in such a way that admission to acute hospital is seen as an option of last resort and that once patients have been treated they return to their normal setting with appropriate support as soon as possible.

An effective urgent care system requires partners across health and social care to work effectively together and this strategy is designed to achieve this. I would like to thank all the staff involved in delivering urgent care for their continued hard work under difficult circumstances and doing it in a way that still meets targets in these challenging times.

I am delighted to be chairing the Urgent Care Programme Board and look forward to working with colleagues to make this vision a reality.



Dr David Hegarty
Chair Urgent Care Programme Board

URGENT CARE EXECUTIVE SUMMARY

Vision	Values	Strategic Objectives	2010/11 Goals	Prioritised Initiatives	Performance Measures
To design and implement a network of service that provides advice, care, support and emergency treatment at the right time and in the right way	We will work continuously to improve services for urgent care We will strive to secure seamless services that best meet the health needs of our community We will value our patients as equal partners in care We will embrace partnership working We will aim to improve the value and cost effectiveness of services	**To ensure that patients flow better through the urgent care system** **To support the long term conditions programme to manage patients better in the community** **To shift clinically appropriate patients into community setting.** **To make better use of information**	Managing urgent and emergency care differently at the front door	To implement recommendations following the clinically led service review To commission a new model of care for acute hospital "front end" services if appropriate	Performance v 95/98% target Reduced short stay admissions Improved capacity to deal with appropriate patients (including referring patients to community alternatives)
			Acute Psychiatric Liaison Services	To establish the newly developed team for acute service liaison	Reduced length of stay for patients with mental health Reduced admissions Appropriate and timely referrals to mental health services
			Long Term Conditions Management	To secure sign up of GP practices and role out of BUPA Risk tool To use the BUPA tool to better target health needs for the population To support the implementation and role out of the Virtual Ward Project	Reduce number of long term conditions patients presenting in urgent care settings via improved care pathways Reduced attendance at hospital for those patients seen by the virtual ward Reduced risk score for patients
			Community Based Intermediate Care	Establishment of a joint community Intermediate care service Establishment of community (in preference to the current hospital) based continuing HC Assessments Development of community bed-based Rehabilitation for patients Intensive support	Improved bed utilization Better identification of appropriate patients for appropriate beds Fewer delayed discharges at DGOH
			End of Life Care	To support additionally commissioned services to support End of Life Care and build on the success of this workstream	Percentage of people dying at home increasing to 25% in 2014/15
			Ambulance Services	To implement alternative pathways of care to reduce ambulance conveyance rate to hospital	To reduce the ambulance conveyance rate from 72% to 68%
			Walk in Centre	To maximise the potential of the WIC in its contribution to the efficient delivery of urgent care services and strengthening partnership working with the ambulance service	Integration of the service with the urgent care redesign programme
			Out of Hours Services	To review the OOH service in line with the urgent care programme pathway service redesign to exploit the potential provision minor injury and illness services in a community setting	Integration of the service with the urgent care redesign programme and implementation of the minor injury pathway
			Directory of Services	To commission an electronic resources for everyone providing healthcare in Dudley	Implementation of Directory of Service tool Improved access to community services

Critical Success Factors

Ownership by clinicians across primary, community and secondary care to the programmes and issues described in this strategy

The integration of Planned, Urgent and Long term condition programmes, in terms of their scope, implementation and delivery

Effective and mutually supportive relationships between clinicians and managers within and outside of the PCT to secure effective design and delivery of a coordinated commissioning strategy

The ability and flexibility of providers to adapt to the changing environment both clinically and under harsher economic conditions

Effective communication within organisations and at the interface

Clinical leadership of pathway redesign programmes
A robust performance management framework with measures of success and KPIs

The right information and other forms of intelligence, both quantitative and qualitative, to support decision making both for investment and dis-investment

Effective integration of community services as part of the TCS transfer to Dudley Group of Hospitals

A workforce development strategy and staff recruitment to support new models

Improving IT systems and accuracy of coding across care settings

3. VISION

People using services (patients, families and carers) '*should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need*' Direction of Travel for Urgent Care DH 2006

The vision of health and social care professionals in Dudley is that the people we serve experience urgent care services in the way envisaged in this document.

At a time when demand for services is rising at unprecedented levels we aim to design a network of services that offer advice, care, support and emergency treatment at the right time and in the right way. We know that many people who attend Accident and Emergency Departments do so because they are not getting the support they need to prevent their need for urgent care arising. We know that we do not have enough alternative services available out in the community or at the front door of our hospital through which more appropriately to sign-post people who need urgent care. Even where alternative services are available, we know we must do more to ensure those services are understood and well used.

Many people who attend hospital emergency care departments have an urgent need, but that need is often for advice, support, or care that does not require the skills of highly specialized hospital staff. Our vision is that we release our hospital colleagues from the excessive burden of responding to 'all comers' and introduce new, more effective ways to look after people who have an urgent need for support.

This strategy recognizes the impact on front end emergency services of 'blockages' further down the line. Our vision is of an integrated model of care that maximizes the potential for people to be seen, assessed, sign-posted and treated in the most cost effective, high quality and efficient way.

We will:-

- design services to assess and treat people by the right professional with access to the right interventions first time,
- establish services to deliver as much as possible of people's urgent care needs out of hospital if they do not need the expertise of hospital clinicians,
- ensure that primary care services are accessible and of high quality in order to reduce demand on hospital services,
- work closely with social care colleagues to commission and deliver services in a collaborative way in order that as many people as possible can be cared for out of hospital and to facilitate people's discharge from secondary care more effectively than is currently the case,
- improve co-ordination of care for patients living with long term conditions in order to reduce their need for urgent care services, and we will,
- empower patients to take control of and responsibility for their own health and well being through self care and self management programmes.

4. CONTEXT

4.1 Population Demographics

In common with other health systems across the country, Dudley is experiencing significant growth in demand for urgent care services. A&E attendances have risen by 3% over the period September 2009 to August 2010; non-elective admissions have risen by 3% over the same period. This rate of rise in activity is not sustainable, especially since it comes at a time when pressures on elective throughput, impacted by the constraints on local authority residential care budgets, are also growing making whole system performance difficult to maintain at optimum levels.

Demographic changes are going to bring added pressure. by 2020 the overall population of Dudley is predicted to rise by 2.6% (8000). There is however a disproportionate rise expected in the 65+ and 85+ age ranges to 2020 of 24% and 52% respectively.

4.2 Urgent Care System Review

In October 20009 a comprehensive review of Dudley's urgent care system got underway, supported by ATOS Origin.

- Dudley was failing to hit the A&E 4 hour target
- Delayed transfers of care were severely hampering patient flow through and out of Dudley Group of Hospital impacting on the effectiveness and efficiency of A&E
- Multi-agency teams together responsible for operations within the hospital were not working effectively together to achieve optimum performance
- Ambulances were backing up at the front door of A&E
- The economy was not coping well with Winter Pressures; it did not understand its own urgent care system nor which parts of it required improvement
- Hence, there was no clear plan for system recovery

Ten service improvement projects were identified:-

- Nursing Home Attendances – to reduce demand by better supporting homes
- Ambulance Attendances – to reduce attendances by utilizing alternative pathways
- Service Integration – to achieve whole system improvement
- Frequent Service Users – to discern reasons and better case manage
- Patient Flow – to improve systems and processes to smooth flow
- Patient Discharge – to improve multiagency discharge practice
- New Models of Care – to determine what model fits best
- Mental Health – to improve access to psychiatric liaison
- Readmissions – to consider scope for reducing readmissions

Much of what is in this strategy are the agreed priorities for service improvement arising as a result of what was learned through these projects.

4.3 Patient, Carer and Public Engagement

This strategy is designed to deliver the aims and objectives outlined in Dudley's Strategic Plan *At the Heart of Local Health*. Consultation events with local people informed that strategy. They told us that they want:-

- an increased say in how and where they are cared for,
- to be helped to make informed choices through the provision of better more easily accessible information,
- more care closer to home, and
- improved access to diagnostic and other services where and when they need them

Patient and public expectations of health services are at their highest. Patients are more aware of the choices available to them, more understanding of the NHS's obligation to deliver those choices, and more able to challenge when things go wrong. We welcome this increased 'patient power'.

In respect of urgent care:-

- In March 2008 and then again in 2010, focus groups were run with A&E patients to determine their views of the service.
- In November 2009, social marketing was undertaken with A&E patients to identify issues relating to patient experience and expectations that could be directly addressed as part of the urgent care review described above
- In 2010 this intelligence was underpinned by telephone surveys with patients to help us gain an understanding of the issues of particular groups i.e. parents of children under 5, young people and carers.
- The information from this has been shared widely within the health economy and has helped inform the development of this strategy.
- The PCT's Healthcare Forum is regularly used as a reference group. In particular in detailed consultation about the new models of care described later in this strategy.
- The same is true of the Emergency Care Network Patient Group which meets on a monthly basis to discuss urgent care issues.

5. FINANCE & ACTIVITY

The PCT is facing significant financial challenges and needs to make savings in order to achieve its financial targets. The savings targets up to and including 2013/14, which need to be cash releasing, are shown in Table 1 as follows:-

Table 1 - PCT Savings Targets

	PCT Savings Targets
2010/11	5,739,000
2011/12	13,488,000
2012/13	8,787,000
2013/14	6,240,000
TOTAL	**34,254,000**

5.1 Activity and Spend Analysis for Urgent Care

Table 2 below demonstrates the impact of projected increases in demand for urgent care by attendance type.

Table 2 – Activity and Spend Analysis for Urgent Care

Point of Delivery	October 09 - September 10		2013/2014 (projected)		Increase	Increase
	Activity	Cost	Activity	Cost		%
Non Electives	22,297	£43,245,773	24,365	£47,255,824	£4,010,051	9%
Non Elective Short Stay	8,688	£5,225,254	9,494	£5,709,777	£484,522	9%
Non Elective Non Emergency	13,368	£12,901,379	14,608	£14,097,685	£1,196,306	9%
A&E	83,048	£7,160,704	83,048	£7,160,704	£0	0%
Total	**127,401**	**£68,533,111**	**131,514**	**£74,223,990**	**£5,690,879**	8%

5.2 QIPP Plans

NHS organisations at regional and local level have QIPP plans in place to address the quality and productivity challenge. Supporting these are national work streams designed to help NHS staff successfully deliver these changes. The urgent care strategy's contribution to the PCT's savings targets is shown in Table 3:-

Table 3 – Urgent Care QIPP Plans

Plans	Forecast 2010/11 £	2011/12 £	2012/13 £	2013/14 £	Cumulative Total £
Virtual Ward (Pilot)	0	0	0	0	0
Virtual Ward Roll out	261,000	365,305	0	0	626,305
Intermediate Care	260,000	441,000	0	0	701,000
ATOS Nursing Home Attendances	0	843,000	0	0	843000
ATOS Ambulance Attendances	38,107	0	0	0	38107
ATOS New models of care	100,000	0	0	0	100000
Total	**659,107**	**1,649,305**	**0**	**0**	**2,308,412**

6. GOALS

6.1 Our Overarching Objectives are:-

- To better plan and deliver care and support to people with long-term conditions in order to minimize their need for urgent care. Where a need does present, to prevent as much urgent care as possible hitting the front door of our acute hospital
- To design an urgent care system that delivers integrated services outside of hospital for people whose need for urgent care might be for advice, support or treatment
- To ensure that the use existing commissioned services that make a contribution to urgent care delivery are optimised
- To ensure that end to end pathways in and out of hospital, including planned care, run smoothly such that a steady flow of patients through the 'whole system' allows for efficient emergency service operations in our hospital's urgent care departments

6.2 Aspirant Service Model

The goals outlined below go a significant way to delivering better urgent care services for the people of Dudley.

We will build on those goals to deliver a truly integrated model of urgent care services that is clear about the most appropriate modes of access, assessment and care delivery for people whose needs are for advice, support and treatment. The model will:-

- ensure patients have the right information to inform how and when they access services
- present opportunities and support for people to 'self care'
- open up access to primary and community based urgent care available 24/7
- open up telephone access for urgent advice, support and sign-posting
- improve the urgent care pathway through the 'see, assess, sign-post and treat' stages of care

We will aim to have a proposal for this aspirant model of care ready for consultation by late Spring 2011.

6.3 Our Current Goals are as follows:-

6.3.1 Managing Urgent and Emergency Care differently at the 'front door'

National evidence suggests that 25% of A&E patients may be more appropriately treated by Primary Care and therefore do not need the services of a full accident and emergency department. The Dudley Group of Hospitals serves a Dudley resident population of 305,000 and captures patients from across the borders chiefly into Sandwell and Worcester. A&E attendances between September 2009 and August 2010 demonstrated an average weekly level of 1832 patients with normal variation expected to be in the range of 1600 – 2000. This translates into daily attendances in the range 200 – 320.

- 52% of attendees spend less than 2 hours in the A&E department
- 78% of GP referrals who spend 2 hours or less in A&E are discharged home
- 27% of West Midlands Ambulance Service (WMAS) arrivals at the hospital spend 2 hours or less in the A&E department
- 61% of referrals into EAU are from the A&E department (Apr 2010 – Sept 2010)
- 14% of referrals into EAU spend 2 hours or less in EAU (Apr 2010 – Sept 2010)

Our recent urgent care system review identified this pattern of activity as potentially impeding the delivery of efficient A&E services for those with a major need for specialist emergency care. The review also identified the need to improve the performance of the time spent in A&E prior to a decision to admit or be discharged.

A clinically led service review has been established to consider the optimum model of care for services at the hospital 'front end'. We will look to commission a new model of care for acute hospital 'front end' services should a better alternative to the existing model emerge

6.3.2 Acute Psychiatric Liaison Services

Poor access to acute psychiatric liaison services is resulting in sub-optimal care being provided to patients with mental health problems. It also creates bottlenecks in acute urgent care departments. A new service model for psychiatric liaison is almost agreed and new services will be commissioned in time for the start of 2011/2012.

6.3.3 Long Term Conditions Management

The BUPA risk management tool is being rolled out across Dudley and our aim is to have complete coverage by January 2011. This tool uses predictive modeling based on primary and secondary care activity data to predict the risk of the need for acute care in the long-term conditions population. The tool identifies the people on a continuum from those most at risk to those at minimum risk and as such will be used to target community team support across the population. This tool will promote equitable service provision and access based purely on need and complexity of condition. Care will be delivered on a 'virtual ward' made of up of a multi-disciplinary team led by a GP and Case Manager.

We aim to reduce urgent care activity by 15% for A&E and 20% for admissions as a result of this programme for those on the virtual ward.

6.3.4 Community Based Intermediate Care

We will establish a community based intermediate care service in favour of our existing exclusively bed based model. Community intermediate care teams have already been established and we will be caring for 75 people in domiciliary packages of intermediate care by the end of January 2011.

Patients are currently assessed for continuing healthcare during their inpatient stay. We will use the capacity freed up as a result of introducing community teams to assess all people for continuing healthcare in community based intermediate care beds from the beginning of January at the latest.

The third strand of our strategy to provide better intermediate care involves enhancing the skill mix of community and bed based intermediate care teams to enable patients to be discharged from hospital sooner than is currently possible. Patients will not stay in hospital longer than they need to if it is safe to discharge them into community based support. We aim to be doing this from 1 March 2011.

<u>Achieving better multi-agency integration in intermediate care services</u>

The model described above is being delivered in partnership with our adult social care colleagues from whom we have commissioned the required personal care support.

We will go further during 2011/2012 and will explore the potential to commission truly integrated services through the use of pooled budgets. Health and Social Care commissioners will develop options with our local acute trust for the provision of integrated rehabilitation and intermediate care that spans seamlessly through community – acute – community elements of the pathway. We aim to have an agreed totally integrated model worked up by the end of July 2011 at the latest.

6.3.5 End of Life Care

We are committed to helping people die at home if they want to and aim to increase the percentage of people dying at home from the current rate of 22% to 25% in 2014/15. This is another target that is less ambitious than we would like and we will review the target in light of the impact of the following additionally commissioned services:-

- appointment to a community palliative care consultant,
- enhancement of psychology services
- training in and establishment of advanced care planning and the Liverpool Care Pathway for health care professionals
- specialist nursing support to care homes to improve quality of care for residents in the end of life stage

6.3.6 Ambulance Services

We aim to reduce the ambulance conveyance rate to hospital from 72% (2009/10) to 68% (by March 2011). We are doing this by working closely with the West Midlands Ambulance Service to improve access to alternative pathways of care, including use of the Walk-in-Centre.

Our target reduction in the conveyance rate is less ambitious than we would wish. We will aim to agree a more challenging target as the virtual ward model matures.

6.3.7 Walk in Centre

For the financial year to the end of October 2010, the Walk-in Centre has seen 21,668 patients. Whilst the vast majority are presenting for primary care conditions they would not ordinarily have attended A&E for, a small but not insignificant number are using the Walk-in-Centre as an alternative to A&E. At times of pressure, the A&E department does redirect patients to the Walk-in Centre.

We will continue to exploit the potential of the Walk-in Centre to contribute to the efficient delivery of urgent care services. Consideration will be given to the benefits of including this service in the redesign of front of house services as described in 6.3.3 above. In addition, we will continue to work with the ambulance service to ensure as much activity as possible is conveyed to the Walk-in Centre in the future.

6.3.8 Out of Hours Services

We will consider the best way of providing out of hours services within a model of integrated 24/7 urgent care service provision. We will exploit the potential of out of hours services to support the provision of minor injury and illness services and to work within a network of strong clinical partnerships delivering timely high quality services. As with the Walk-in Centre, we will give consideration as to how out of hours services might fit best within any new model of care provided at the front door of our local hospital.

6.3.9 Directory of Services

Access to services available to support urgent care service delivery is hampered by poor knowledge on the part of professionals about what services are available and by poor information systems to support sign-posting.

We will work in partnership with the West Midlands Ambulance Service to develop further our proposals in view of WMAS's role in developing a regional resource modeled on the North East of England's NHS

Pathways model. An added benefit of the WMAS work programme is that it will maximize the potential for WMAS to divert calls and ambulances from acute hospitals to other relevant services at times of pressure.

We have commissioned a service directory that will include a summary of the services provided by the PCT's provider arm and by Dudley and Walsall Mental Health Trust. We aim to extend the scope of the directory to cover primary care, Dudley Group of Hospitals, and Social Services during 2011/2012.

The service directory will

- improve patient experience and confidence to be maintained in the community
- provide information to support integration with other health care providers
- improve quality and care closer to patient residence by informing those making decisions about alternative pathways
- assist in the identification of gaps in service provision
- assist Health Professionals to reduce the number of admissions to secondary care by informing them of alternative pathways
- clarify working practices and roles and responsibilities
- assist to inform Health Professionals responsible for patient discharges
- improve user satisfaction ratings

7. MONITORING DELIVERY

The urgent care programme will be monitored via the economy's Urgent Care Programme Board and the QIPP performance monitoring processes both internally and via the Black Country Cluster framework. The work covered by this strategy will also be the subject of scrutiny via the newly formed health and social care CEO level strategy meetings.

Measures of success and Key Performance Indicators will be devised in order that success can be measured and reported upon.

Should any initiatives prove not be delivering their aims, or in need of amendment, they will be changed in real-time to ensure that only financially viable workstreams are progressed. Lessons learned will be shared widely between the three strategies and beyond via the PCT business case committee so that learning can be shared positively.

8. CRITICAL SUCCESS FACTORS

Critical to the success of this strategy are the following:-

- Ownership by clinicians across primary, community and secondary care to the programmes and issues described in this strategy
- The integration of Planned, Urgent and Long term condition programmes, in terms of their scope, implementation and delivery
- Effective and mutually supportive relationships between clinicians and managers within and outside of the PCT to secure effective design and delivery of a coordinated commissioning strategy
- The ability and flexibility of providers to adapt to the changing environment both clinically and under harsher economic conditions
- Effective communication within organisations and at the interface
- Clinical leadership of pathway redesign programmes
- A robust performance management framework with measures of success and KPIs
- The right information and other forms of intelligence, both quantitative and qualitative, to support decision making both for investment and dis-investment
- Effective integration of community services as part of the TCS transfer to Dudley Group of Hospitals
- A workforce development strategy and staff recruitment to support new models

Work programmes will be delivered to ensure these critical success factors are put in place.

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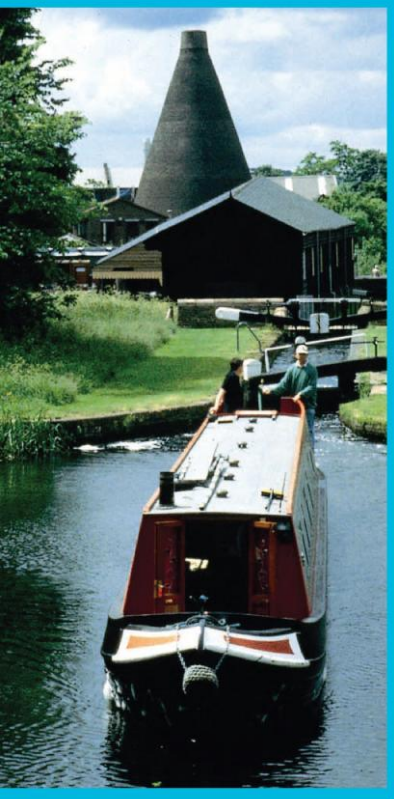

If you have any questions about this strategy please contact:

Derek Hunter – Commissioning Lead for Urgent Care

David Hegarty – Clinical Lead for Urgent Care

Tel: 01384 321758