Urgent and Emergency Care Review
Progress Update

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If its really serious I want specialist care

Help me to help myself and not bother the NHS

Treat me as close to my home as possible please

If only they could talk to my GP?
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
### Current provision of urgent and emergency care services

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Statistics</th>
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</thead>
<tbody>
<tr>
<td>Self-care and self management</td>
<td>• 438 million health-related visits to pharmacies (2008/09)</td>
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<td>Telephone care</td>
<td>• 24 million calls to NHS</td>
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<td></td>
<td>• urgent and emergency care telephone services</td>
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<tr>
<td>Face to face care</td>
<td>• 300 million consultations in general practice (2010/11)</td>
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<td>999 services</td>
<td>• 7 million emergency ambulance journeys</td>
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<td>A&amp;E departments</td>
<td>• 14.9 million attendances at major / specialty A&amp;E departments (2012/13)</td>
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<td></td>
<td>• 6.9 million attendances at Minor Injury Units, Walk in Centres etc (2013/13)</td>
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<tr>
<td>Emergency admissions</td>
<td>• 5.3 million emergency admissions to England’s hospitals (2012/13)</td>
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</table>
A new urgent and emergency care system needs to shift more people from right to left, delivering as much care as close to home as possible.

- 438 million health-related visits to a pharmacy
- 340 million GP consultations
- 24 million calls to NHS urgent and emergency care telephone services
- 21.7 million attendances at A&E, minor injury units and urgent care centres
- 7 million Emergency ambulance journeys
- 5.2 million emergency hospital admissions

324 million visits to NHS Choices

- 20% of GP consultations relate to minor ailments which could largely be dealt with by self care and support from community pharmacy
- Only 4% of emergency calls are currently resolved and closed on the phone
- 40% of patients who attend A&E are discharged having needed no treatment at all
- 50% of 999 ambulance calls could be managed at the scene
- Over 1 million emergency admissions in 2012/13 considered avoidable
Helping people help themselves

Self care:

- Better and easily accessible information about self-treatment options – patient and specialist groups, NHS Choices, pharmacies
- Accelerated development of advance care planning
- Right advice or treatment first time - enhanced NHS 111 - the “smart call” to make:
  - Improve patient information for call responders (SCR, care plan)
  - Comprehensive Directory of Services
  - Improve levels of clinical input (mental and dental health, pharmacy)
  - Booking systems for GPs, into UCC or A&E, dentist, pharmacy
NHS 111 Call Volume – front end to urgent care
Patients are predominantly referred to lower urgency settings

Dispositions callers
(where callers are referred to)

- 111
- 999 Ambulance 11%
- A&E / UCC 7%
- GP OOH 62%
- GP in hours 1%
- Community service 1%
- Dental 7%
- Pharmacy 14%

www.england.nhs.uk
• **Enhanced 111 service:** Smart call to make, helping people get the right advice or treatment in the right place, first time. This service will:

  • Be an *integral part of the Urgent Care Network*
  
  • Have *knowledge about you and your medical problems*, so the staff advising you can help you make the best decisions; *PILOT*

  • Allow you to *speak directly to a wider range of professionals* (e.g. nurse, doctor, paramedic, mental health team, pharmacist); *PILOT (GP)*

  • If needed, *directly book you an appointment* at whichever urgent care service can deal with your problem, as close to home as possible;

  • Still provide you with an *immediate emergency response* if your problem is more serious, with direct links to the 999 ambulance service, and the enhanced ability to book appointments at Emergency Centres.
Highly responsive urgent care service close to home, outside of hospital

• **Faster, convenient, enhanced service:**

  • **Same day, every day access** to general practitioners, primary care and community services

  • Harness the skills and accessibility of **community pharmacy**

  • **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 centres.

  • Develop 999 **ambulances** so they become **mobile urgent community treatment services**, not just urgent transport services
Ambulance Services

• **Transport → Treatment**: Community-based provider of mobile urgent and emergency healthcare, **fully integrated within Urgent Care Networks**. Principles to underpin this transformation would include:

  - Emphasis on **supported treatment in community settings**
  - **Single consistent triage system, DoS and universal referral rights**
  - Successful “**hear and treat**” - closer integration with 111, timely access to relevant patient information and care plans, **support of interdisciplinary clinical hub**
  - “**see and treat**, inter-disciplinary working” across traditional organisational and professional boundaries, with guaranteed timely access to primary care, mental health provision, social care and **specialist clinical advice 24/7**
  - **Development of the ambulance workforce, education programmes** coupled with changes to organisational culture, will be essential to long-term success
Serious and life threatening conditions – expertise and facilities

- **Two levels of hospital based emergency centres**
  - **Emergency Centres** - capable of assessing and initiating treatment for all patients
  - **Specialist (Major) Emergency Centres** - 40-70 larger units, capable of assessing and initiating treatment for all patients, and providing a range of specialist services (direct, transfer or bypass).

- **Emergency Care Networks**
  - Connecting all services together into a cohesive network so the overall system becomes more than just the sum of its parts
  - **Strategic and Operational**
Urgent Care Networks

Networks would focus on:

- effective, pathways of care across boundaries for physical and mental health irrespective of entry portal
- all patients managed to agreed pathways mutual trust in system
- no clinical decision made in isolation

Networks would function at two levels:

1. Strategic Urgent Care Networks would operate over large populations encompassing specialist provision, all severity and complexity, all relevant stakeholders to plan, oversee and monitor network performance

2. Operational Urgent Care Networks would describe local communities of clinicians (System Resilience Group) who work together to achieve the best outcomes for patients within the urgent care system
Shape and structure of the new system and key constituent parts...

Self-care
- Peer support
- Voluntary Sector

Meeting your urgent care needs as close to home as possible

Taking you to the most appropriate hospital and maximising your chances of survival and a good recovery from life threatening conditions

“The smart call to make...”

* Includes specialist services such as those for heart attack, stroke, major trauma, vascular surgery, critically ill children
Progress update

• **Implementation phase of the Review**: Aims to convert the work done so far into a national framework to guide commissioning of UEC services: Update report

• **Delivery Group** own and describe the **key national products** from the Stage 1 Report – *primacy to out-of-hospital*

  • Regional roadshows June-Sept 2014

  • Working with **System Resilience Groups, CCG and NHSE Ops Teams** as they develop 2 and 5 year operational and strategic plans

  • Working through the **NHS Commissioning Assembly** to co-produce commissioning guidance and specifications (throughout 2014/15)

• **Release guidance, standards and outcome metrics** for Commissioners regarding UEC Networks, centres, and clinical models and for Ambulance Services (after 5 year Forward View)
Progress update

- Continue to “build in public”

- 8 Work Programmes:
  - WHOLE SYSTEM PLANNING AND PAYMENT, COMMISSIONING AND ACCOUNTABILITY
  - PRIMARY CARE ACCESS – NHSE strategy
  - 111 service specification and standards
  - DATA, INFORMATION AND CARE PLANNING
  - COMMUNITY PHARMACIES – Call for Action
  - EMERGENCY DEPARTMENTS and EMERGENCY CARE NETWORKS
  - AMBULANCE TREATMENT SERVICE
  - WORKFORCE (HEE)
UECR: What – Big Tickets

**Programme Vision:**
- For those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital.
- 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 reduce risk and maximise their chances of survival and a good recovery.

**Programme Objectives:**
1. Provide better support for people to self-care
2. Help people with urgent care needs to get the right advice in the right place, first time
3. Provide highly responsive urgent care services outside of hospital
4. Ensure those with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise survival and recovery
5. Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts

**Big Tickets’ and Products:**

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<tr>
<th>Product</th>
<th>Description</th>
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<tbody>
<tr>
<td>Promote effective self-care and self management</td>
<td>1.1 Develop self-care resources 1.2 The Earlier The Better Marketing Campaign</td>
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<td>Integrate pharmacy into the UEC system</td>
<td>2.1 Support for CCOs to introduce minor ailments services 2.2 Pharmacist Competency Framework 2.3 Explore the role of Pharmacists in Emergency Departments</td>
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<td>Integrate system by improving appointment booking through UEC system</td>
<td>3.1 Commissioning standards and procurement strategy support the development of appointment booking across the UEC system 3.2 Develop guidance on improving referral pathways across the UEC system</td>
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<td>Develop ambulance service model to offer more treatment on the scene</td>
<td>4.1 Guide on clinical models for treatment on scene by ambulance services 4.2 Develop a new single accredited curriculum for Paramedics 4.3 Best practice case studies on how GP advice beat admission add value to ambulance and A&amp;E</td>
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<td>Successful models of care for improved primary care</td>
<td>5.1 Principles for Primary Care Access and Inclusion of service models to inform local service design and improvement 5.2 Develop local health care capacity and organisational structure 5.3 Improving dental care and Public Health response to call to Action 5.4 District and General Practice recommendations and single commissioning framework 5.5 Competency Framework for Advanced Clinical Practitioners and national standards for the role of Advanced Practitioners</td>
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<td>Access to hospital specialist advice 7/7 to advise PC and key OOH services</td>
<td>6.1 Provision of specialist hospital advice to other parts of the system 6.2 Develop appropriate tools to understand flows around the UEC system for use locally 6.3 Workforce Planning</td>
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<td>Matching hospital resources to patient capacity &amp; complexity; tools and guidance on flow</td>
<td>7.1 Develop summary care record (SCR) 7.2 Review and enrich SCR content 7.3 Identify data sharing and architectural requirements into urgent care settings 7.4 Proof of concept primary care information into community pharmacy</td>
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<td>Timely Access to relevant patient clinical data across the system</td>
<td>8.1 Develop a footprint tool 8.2 Integrating general practice and community health services report 8.3 Payment system redesign 8.4 Assess at a national level the non-financial incentives and benefits of the future UEC system</td>
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<td>Unified quality measurement system: Develop metrics to measure whole system performance</td>
<td>9.1 Outcome measures and other metrics for the UEC system</td>
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<td>Introduction and roll-out of personalised care planning</td>
<td>10.1 Develop guidelines on Personal Care Planning</td>
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<td>Improve clinical input to NHS 11</td>
<td>11.1 Development of NHS 11 Commissioning standards to include recommended clinical input</td>
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<td>Enhance the DOS to be a real time and accurate commissioning tool</td>
<td>12.1 DOS development work 12.2 Principles for extended pharmacy offer, backed up by contractual changes</td>
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<tr>
<td>Develop pharmacy services to offer wider range of services</td>
<td>13.1 Principles for improved community services (in and out of hours) accompanied by necessary national contractual incentives</td>
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<tr>
<td>Successful models of care for improved community services</td>
<td>14.1 Guidelines for community care and local service models 14.2 Support process for accreditation and designation of facilities</td>
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<td>Designation of Major Emergency Centre and Emergency Centre</td>
<td>15.1 Develop guidance on commissioning of emergency care networks Inc. 15.2 Promoting General Practice and Community Health Services Report 15.3 Payment system redesign 15.4 Assess at a national level the non-financial incentives and benefits of the future UEC system</td>
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<td>Improved system of commissioning, finance, and payment</td>
<td>16.1 Develop a “Footprint” tool 16.2 Integrating General Practice and Community Health Services Report 16.3 Payment system redesign 16.4 Assess at a national level the non-financial incentives and benefits of the future UEC system</td>
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<td>Establishment of effective emergency networks</td>
<td>17.1 Develop guidance on commissioning of emergency care networks 17.2 Promoting General Practice and Community Health Services Report 17.3 Payment system redesign 17.4 Assess at a national level the non-financial incentives and benefits of the future UEC system</td>
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<td>Identifying what good looks like, including test sites and demonstration of benefits</td>
<td>18.1 Design, set up, and manage test beds: assess the impact of all elements of the UEC vision on local health economies, and identify what good looks like</td>
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Consulting and testing

• Design to Delivery:
  • NHSIQ mapping support/pilots testing ideas and models (Integration Pioneers, PM Challenge, 111 pilots and 7DS early adopters)
  • NHS England/Monitor proposal for a redesign of the payment system “all” urgent care - test in 2015/16

• New Commissioning Standards for NHS 111:
  • Clinician access to relevant patient’s medical and care information
  • Access and treat to specific care plan where available
  • Increased clinical advice to support call handlers
  • to book appointments with urgent or emergency care providers
Urgent and Emergency Care Review

I’m alive cos I had specialist care really fast

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

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

DEFINITELY . . . . BUT ONLY THROUGH YOU

It’s like everyone knows all about me
Network Aim = Quality and Consistency

AHSN

Primary Care Clinician

Clinical Advisory Group

Secondary Care Clinician(s)

Provider(s)

Operational UC Networks SRGs

Network Configuration

Strategic Urgent Care Network: CCGs / NHS England / UCWG / Health and Well-Being Board / Local Authority / Public Health / Healthwatch

Assurance Process

Clinical Senate

Key

Network Structure
Accountability
Clinical Governance
Evaluation

Pathway Evaluation: PROMS, PREMS and F&F

Assurance Process

Host (Lead) Commissioner

Provider feedback

Pathway review

Consider other models: e.g. Alliance Commissioning, Partnership or Single Lead

Public-Friendly Version of This Necessary: What Can You Expect? Where Should You Go?
Emergency Centres (hospital)

- Hospital based facilities able to receive a full range of emergency patients, of all ages, and provide for the reception, resus, diagnosis and onward referral.

- Would include an Emergency Department, which is under the continuous supervision of one or more consultants in Emergency Medicine, who are not necessarily continuously present, but have clinical accountability for the care delivered in that ED.

- ECs would contain some inpatient facilities (hospital beds), as well as a range of supporting services and outpatients.

- In rural areas ECs would be the initial receiving destination for almost all emergency and ambulance patients.

- In more urban environments, ambulance staff may bypass ECs in favour of Specialist (Major) Emergency Centres when the patient has identified specialist needs, and the increase in journey time is clinically justified.
Specialist (Major) Emergency Centres

• Would have all the features of an Emergency Centre, but also include specialist facilities that receive patients from ECs, or directly from an ambulance which has bypassed an EC.

• Concentration of specialist expertise and services - likely to fall within the remit of specialist commissioning. Provide support and coordination to Network partners to ensure access to specialist care in a timely way.

• EDs, integral to SECs, would provide consultant presence over extended hours, immediate access to enhanced diagnostics, such as MRI scanning and interventional radiology, and a wider range of facilities.