Care By Design 

North East Ambulance Service and Health and Social Care System Partners

Review of Alternative Pathways to A+E For Urgent Care Conditions that do not Require Acute Hospital Care

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Introduction

Winter 2012/13 saw unprecedented pressure on A+E and the Ambulance service across the whole of England, and the North East was no exception. Ambulances faced queuing outside A+E departments and patients delayed in transfer of care to hospital staff. Other people faced long waits for ambulance crews to arrive at an urgent scene, with in some cases a further deterioration of their condition and impact on other agencies such as the Police and Fire services. These situations are symptoms of a 'system' out of control and in need of gaining insight into how behaviors of all parts of the system impact on the problem and work collectively to seek solutions.

The North East Ambulance Service (NEAS) Chief Executive, Simon Featherstone, called all system partners to come together and take action as a 'System' to ensure plans are in place to prevent a similar crisis in winter 2013/14. A North East whole system Summit was held in February 2013 when the issues were discussed and a range of short term and long term actions were identified. One of the long term actions was a piece of work to understand the barriers to the use of urgent care pathways outside of A+E and hospital. To this end the author of this report was commissioned to:

- Provide consultancy to explore the barriers to the use of alternative pathways in place of acute admissions
- Work across the health community including Primary Care, Acute Trusts, North East Ambulance Service and Social Services to understand barriers and blockages in patient flow.
- Recommend remedial changes to any processes managed by Primary Care, NE Ambulance Service, acute trusts and social services that will redirect and prevent emergency admissions.

Methodology

A Steering Group was established in April to support both this work and the work reviewing ambulance handover and turnaround at A+E. Membership includes

Simon Featherstone - Chair
Caroline Thurlbeck – representing the N E Local Area Teams
Russell Patton – Mental Health Foundation Trust representative
David Gallagher – CCGs in Cumbria, Northumberland, Tyne and Wear Local Area
Gillian Findley – CCG representative, Durham, Darlington and Tees Local Area
Paul Fell – NEAS Acting Director of Clinical Care & Patient Safety
Yvonne Ormston – Acute Foundation Trust representative
Gary Collier – North East Commissioning Support representative
Ann Workman – Association of Directors of Social Care representative
Angie Nisbet – Project Consultant
Jeremy Pease – Project Consultant (ambulance handover and turnaround)

Discussions have been held with many stakeholders across the North East system including NEAS staff, management and operational. Discussions will be ongoing until close of the project at the Summit scheduled for September 3rd 2013.

At the commencement of the project there were some challenges in establishing contacts with the closure of PCTs and the SHA and the establishment of NHS England North; the North East Commissioning Support Unit; Clinical Commissioning Groups (CCGs) and the two Local Area Teams (LATs).

The author has attended meetings; workshops and forums related to urgent care pathway discussions and this will include for the remainder of this project the recently established or reconstituted urgent care boards/ networks.

Discussions have been held with the Emergency Care Intensive Support Team (ECIST) and NHS England to consider current best practice. A review of publications and literature available on the topic of urgent care has been undertaken including the Blue Rivers Report commissioned by Durham Dales, Easington and Sedgefield CCG.

Summary of Content

System Context

It is accepted across the health and social care system that the delays in ambulance handover of patients at A+E; crews' ability to respond to urgent calls and ability of hospitals to meet the 4 hour waiting time target are symptoms of system wide problems. If there is a lack of joined up 'integrated' working in preventing avoidable urgency and managing the 'flow' of services for the public, so that alternative care outside of hospital is properly available, then hospital attendance is usually the default position, often accompanied by an admission to an acute bed. The same integrated working is required to enable timely discharge when an attendance or admission has taken place.

Supporting CCGs in the management of this problem has become the primary focus for the newly established NHS England. Their recent publication: ***Improving A&E Performance Gateway ref: 00062*** makes reference to a number of factors that are **assumed** to have played a part in system deterioration. These are:

- Increased numbers of patients arriving at A&E. There is a general rising tide with 5.9% more attendances in 2012/13, than in 2009/10. However, the total numbers attending in Q4 of 2012-13 (which is when the significant deterioration began) was 1.7% lower than the previous Q4.
- Increased number of acute admissions putting pressure on beds. There were 10.6% more emergency admissions in 2012/13 than in 2009/10. There is general consensus (though it is hard to identify the evidence) that patients presenting are more ill and hence more likely to need admission and have longer stays.
- Hospitals being less proactive in process management which plays a very significant part in their ability to admit patients. Patients who require admission are the ones who are most likely to wait over 4 hours.
- A lower threshold in hospitals for admitting or discharging patients to ensure safety standards. In some cases, this is perceived to be linked to the seniority of the workforce in A&E.
- A lack of specific services available to acute trusts in a timely fashion for certain specific patient groups, such as those with mental health, alcohol or drug abuse problems.
- More delayed discharges because primary, community or social care services are not place.

There are also many assumptions as to why these factors have played a greater part than in previous years:

- Perceived lack of availability of primary care and community services, especially out of hours.
- Reduction in bed numbers and staff as hospitals try to deliver cost improvement plans.
- The Francis report and its impact on clinical decision making thresholds.
- Lack of focus during transition for commissioners and uncertainty about changing roles in the new system.

- Pressure on social care budgets.
- Introduction of NHS 111.

The Foundation Trust Network in their recent publication ***Emergency Care and Emergency Services****: A View from the Frontline* state as a 'Key Message'

'The wider NHS urgent and emergency care pathway is not working effectively. Our research indicates that at least 25% of patients currently attending A+ E departments could and should be treated by other parts of the NHS. Therefore a ***whole system approach is needed to tackle these issues longer term.*** *This requires fundamental re-design of the whole pathway, including appropriate investment in primary, community and social care services and much better patient signposting.'*

NHS England CCG Outcomes Benchmarking Support Pack Data	
	Emergency admissions for acute conditions that should not usually require hospital admission (Adults) *Age/sex standardised rate per 100,000 population*
Durham Dales, Easington and Sedgefield	1,387
North Durham	1,267
Darlington	1,230
Gateshead	1,554
Newcastle North and East	851
Newcastle West	1,055
Hartlepool and Stockton on Tees (2 LAs)	1,353
Northumberland	1,295
South Tees (2 LAs)	1,522
South Tyneside	1,674
Sunderland	1,392
North Tyneside	1,489
Cumbria	859

Table 1

Table 1 above shows the number of emergency admissions per 100,000 populations that have taken place for conditions that should not usually require hospital admission. This information is taken from the ***NHS England Outcome Benchmarking Support Packs*** available for each Clinical Commissioning Group (CCG). Other data contained in these packs include the rate of readmission within 28 days of discharge; hospitalisation for chronic conditions; GP referral rates etc.

There is currently no agreed definition for 'urgent' care and no shared vision across the North East for the future model of 'urgent' care. This has not always been the case, work was undertaken in 2004 to develop a shared vision and create an implementation plan. It is probable, that failure to bring this vision to fruition was as a result of the continual instability of commissioning organisations and community services. To deliver a vision requires constancy of purpose and system relationships.

The above data would indicate that some 'urgency' is created by what is known as *failure demand,* demand created because the overall delivery system is not working in synchronicity to manage the predictable daily patient demand, be this Primary Care; Social Care; Community support. Provision of urgent care is also variable across the area – different centres do different things and at different times. Out of hours services vary too. This is challenging for crews who work across the area so a consistent North East approach to urgent care would be helpful.

The North East health and social care system held an Urgent and Emergency Care Summit on February 5th 2013 and a number of short term improvement ideas were discussed as well as acknowledgement that the whole system needs to be transformed at CCG level. These are as follows

Outputs/objectives from discussions

Short-term

- Ambulance influencing decision to divert (have overview of health economy)
- Provider (A&E) to audit source of patients through A&E and ambulance admissions
- Concept of GPs dedicated for home visits to stop batching of hospital admissions
- Re-profiling surgery hours
- Ensuring face-to-face contacts before ambulance request except in life-threatening emergencies
- Multi-patient management by paramedic at A&E
- Feedback from consultants to GPs in relation to inappropriate admissions
- All providers signed up to zero-tolerance over delays >60 mins
- Communication of what exists already in the Directory of Services (DoS) and what is outside the DoS
- Collect, collate and share information at GP practices on hospital admissions and discharges
- Admission and discharge support- communicate what is already available

- Ambulance review of thresholds for conveyance (999 calls)
- Undertake a quick mapping exercise across all organisations to understand what best practice is already in place and where gaps are
- Have a 'myth' amnesty e.g.: declaring which UC centres will not take ambulance patients
- Impact of 111 on ED attendances. Evidence of any impact?
- Is it worth doing an exercise in each area to try to understand what is different this year from previous?
- Targeted Communications for GP practices
- Strategy to reduce inappropriate use of transport (urgent/PTS)
- GP direct access to assessment units
- Developing feedback mechanisms for inappropriate use of transport to CCGs
- Match capacity with demand
- Small ideas/issues now will make a difference-look for 'quick wins' and make them happen
- Dispersal points-multiple-in hospital and out of hospital, and availability to ambulance crews
- Communication and cooperation between providers and commissioners-understanding service configuration
- OOH GP buddy system
- Risk-averse nature of ambulance service needs to be managed- more hear and treat and see and treat.
- Serious Incidents' to be investigated by the receiving hospital Trust

Long-term

- Taking demand out of the system through keeping frail elderly at home (proactive management in the community)
- Appointment based system for A&E
- Experience and autonomy of paramedics to non-convey
- Standardise contracts so paramedics can convey to UC centres
- Create capacity for more home visits and focus on quality premium (April)
- Practice triage system such as the 111 algorithms
- Admission and discharge support-what else is needed to manage safely?
- Development of a 7-day service
- Improve mental health pathways
- Social care-access and impact of cuts
- Can we use predictive modelling to manage demand better?
- Developing a strategy to address inappropriate use of OOH in areas of high poverty
- Redesign GP practice response- grouping practices geographically
- Early-day GP telephone triage
- Aligning contractual mechanisms
- Fines vs. system design- rising demand/static capacity
- Nursing homes and ceilings of care
- LTC- 'what's normal' passport for patient
- Multi-issue complex patients

Jennifer Walker ECIST South West agreed to provide two checklists of expected aspects of a well-developed system for urgent and emergency care, based upon national best practice. These are included as Appendices 2 and 3

Urgent Care has been established as an early critical role for NHS England North and both of the North East Local Area Teams (LATs) in supporting the CCG's leadership of the local improvement programme for their urgent care systems. The LATs have additional support from the ECIST team and NHS Improving Quality (NHSIQ) and CCGs from the North East Commissioning Support Service (NECS).

All CCGs submitted their A+E turnaround or improvement plans to NHS England for May 31st 2013 and are in the process of establishing their Urgent Care Boards/ Networks constituting the membership; meeting dates and early terms of reference. Some CCGs already have well established Boards e.g. Gateshead CCG. All CCGs need a similar model if not already in place that links the Urgent Care Board/ Network into the wider system governance structure of the Health and Wellbeing Board (see Appendix 4).

NHS England North held an urgent care summit on June 13th for CCGs and have pledged a range of development support over the coming months depending on CCG requirement to help make improvements a reality. Some initial guidance was given to CCGs regarding areas for their short term improvement focus for urgent care based on evidence of success elsewhere were presented. See Table 2

Admission avoidance & early discharge	
Stronger evidence	**Weaker evidence**
Admission prevention from nursing homes Ambulatory emergency care (e.g. 60-90% reduction in overnight stays for Pulmonary Embolism) Improve urgent access to primary care Intermediate care in-reach to ED and assessment units Assertive case management of frail patients with dementia Continuity of care with a GP Hospital at home as an alternative to admission Assertive case management in mental health Early senior review in A&E Multidisciplinary interventions and tele-monitoring in heart failure Integration of primary and secondary care 'Front-end' integration in acute hospitals	GPs in ED WICs and UCCs (unless co-located with EDs with integrated governance) Public education Pharmacist home-based medication review (Unfocussed) intermediate care Community-based case management (generic conditions) Early discharge to hospital at home on readmissions Nurse-led interventions pre- and post-discharge for patients with chronic obstructive pulmonary disease (COPD) Telemedicine (except for heart failure)

Table 2

The areas in Table 2 identified as having weaker evidence of success may be due to implementation rather than the scheme itself. How a scheme is designed around each patient's specific needs and staff involved in the design and implementation will impact the outcome and therefore the success.

Full roll out of 111 across the North East was completed April 2nd 2013. NEAS managing the 111 system and the emergency response pathway is a great opportunity for the whole North East system. Any early teething problems within 111 following the transfer from NHS Direct are being addressed.

In January Sir Bruce Keogh launched a review of Urgent and Emergency Care to be led by Professor Keith Willett. Keith and the review steering group are developing the evidence base for improving urgent and emergency care and have identified four emerging principles for an improved urgent and emergency care system in England. From these principles 12 'system design objectives' have been outlined – these are the suggested outcomes which should be delivered by any future urgent and emergency care system.

The Urgent and Emergency Care Review Steering Group has also identified illustrative implementation options to show the types of solutions that Phase 2 of the Review may develop. These are not agreed solutions at this stage, but have been presented to help explain what any future urgent and emergency care system might look like to stimulate debate. The emerging principles for urgent and emergency care in England outline a system that:

- Provides consistently high quality and safe care, across all seven days of the week;
- Is simple and guides good choices by patients and clinicians;
- Provides the right care in the right place, by those with the right skills, the first time;
- Is efficient in the delivery of care and services

The 12 'system design objectives' are

1. Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice.

2. Increase my or my family/carer's awareness of early detection and options for self-care and support me to manage my acute or long term physical or mental condition.

3. Increase my or my family/carer's awareness of and publicise the benefits of 'phone before you go'.

4. If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.

5. Improve my care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway.

6. Wherever appropriate, manage me where I present (including at home and over the telephone).

7. If it's not appropriate to manage me where I present (including at home and over the telephone), take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to a highly specialist centre if needed.

8. Ensure all urgent and emergency care facilities are capable of transferring me urgently and that the mode of transport is capable, appropriate and authorised.

9. Information, critical for my care, is available to all those treating me.

10. Where I need wider support for my mental, physical and social needs ensure it is available.

11. Each of my clinical experiences should be part of programme to develop and train the clinical staff and ensure their competence and the future quality of the service is constantly developed.

12. The quality of my care should be measured in a way that reflects the urgency and complexity of my illness.

The review team is seeking comments to ensure that the evidence base and principles are scrutinised and clinically sound. Feedback will be used to develop a national framework for commissioning of urgent and emergency care. CCGs will then be able to use this framework to commission local urgent and emergency care services. The feedback period will take place between 17 June and 11 August 2013.

In addition to this national review, NHS England has launched a review of Personal Medical Services (PMS). Each LAT is required to nominate a lead representative to coordinate local input into this review. The aim is to create proposals and options for how PMS resources are used from 2014/15 onwards

It is essential that these two reviews complement each other to facilitate the implementation of the developing commissioning framework for urgent and emergency care.

The Local Authorities across the North East are an essential partner in managing care in the community and are themselves facing challenges with a 28% funding cut

in 2011-15 and an additional 10% funding cut planned for 2015/16 from the recent Spending Review.

The possible impact of the recent welfare reforms is as yet unknown in terms of people's wellbeing. However a paper presented to the Tees Valley Health and Social Care Strategic Forum has identified early signs to suggest that, for example, rent arrears are increasing; a greater use of foodbanks; increased pressure on some of the Local Authority advice and information services; and some customers showing signs of anxiety and worry when seeking advice and support.

Positive news from the Spending Review is the NHS budget is set to rise by 0.1% nationally to £110 bn and there will be a joint £3bn commissioning plan between the NHS and councils for social care. However, the recently announced £30bn deficit in NHS funding will require an even greater emphasis to spend available money at the right points in the system to reduce urgency and pooling of resources and integration across the health and social care system.

Population changes in the North East taken from the 2011 Census (non weighted for deprivation)

North East	**2011 population**	**2001 population**	**Change 2001-2011 (per cent)**
County Durham	513,200	493,800	3.9
Northumberland	316,000	307,400	2.8
Newcastle upon Tyne	280,200	266,200	5.3
Sunderland	275,500	284,600	-3.2
North Tyneside	200,800	192,000	4.6
Gateshead	200,200	191,200	4.7
Stockton-on-Tees	191,600	183,800	4.2
South Tyneside	148,100	152,800	-3.1
Middlesbrough	138,400	141,200	-2
Redcar and Cleveland	135,200	139,200	-2.9
Darlington	105,600	97,900	7.9
Hartlepool	92,000	90,200	2

Overall the population in the North East has risen over the 10 years from 2001 – 2011 by 100,000; so from a total of 2.5 million to 2.6 million. Four local authorities saw a decrease in population: Sunderland (3.2 per cent), South Tyneside (3.1 per cent), Redcar and Cleveland (2.9 per cent), and Middlesbrough (2.0 per cent).

County Durham was the largest local authority in the North East by population with 513,200 people an increase of 19,440 (3.9 per cent) between 2001 and 2011. The

greatest population growth was in Darlington UA, which saw a 7.9 per cent increase (7,700) in its population between 2001 and 2011.

The authority with the largest proportion of people aged 65 and over was Northumberland, with 20 per cent; the smallest proportion in this age group was in Newcastle (14 per cent). Northumberland also has the smallest proportion of people aged 19 and under with 22 per cent, and Middlesbrough the largest with (26 per cent).

This demonstrates that the overall population numbers have increased but not in a proportionate way across all geographical areas. This increase is also well below the national population growth average figure of 16/17%.

Since July 1st the Health and Social Care Information Centre (HSCIC) has published more accurate General Practice registered patient counts data, both at Practice level and CCG aggregated patient counts. Going forward, patient registered counts will be extracted on the first day of each financial quarter and published on the HSCIC website.

Dementia care has been cited as an area of increasing need and an area for service improvement. It is known that there are circa 700,000 people in England with a Dementia in 2013 and this is set to rise year on year. In 2007 The Alzheimer's Society published guidance for commissioners on delivering the National Dementia Strategy for England. This publication contains specific locality projections (by previous PCT localities) on the incidence of Dementia that CCGs can use for reference.

The BlueRiver consulting report was written specifically to provide an external perspective on the position around urgent care across County Durham and Darlington. The report highlighted areas that the system already knows:

The North Durham Management Executive Report (December 2012) summarised the key headlines for urgent care. These were that:

• There are multiple points of access – not regarded as a major problem if there is integration between providers.
• There is a variance in tariffs from £54 to £89 per attendance.
• Rates of lower A&E tariff activity compared to elsewhere in the country.
• 111 provides a platform for triage and signposting.
• There is confusion around how the current system integrates with primary care.
• Demand and cost for urgent care is growing and unaffordable if growth continues.
• There are a high number of frequent attenders in the system.
• Data suggests that the trend for A&E has been steady growth in activity year on year.

The report highlighted that data reviewed in 2008 as part of the compendium of information that supported the development of the then PCT urgent care strategy identified that:

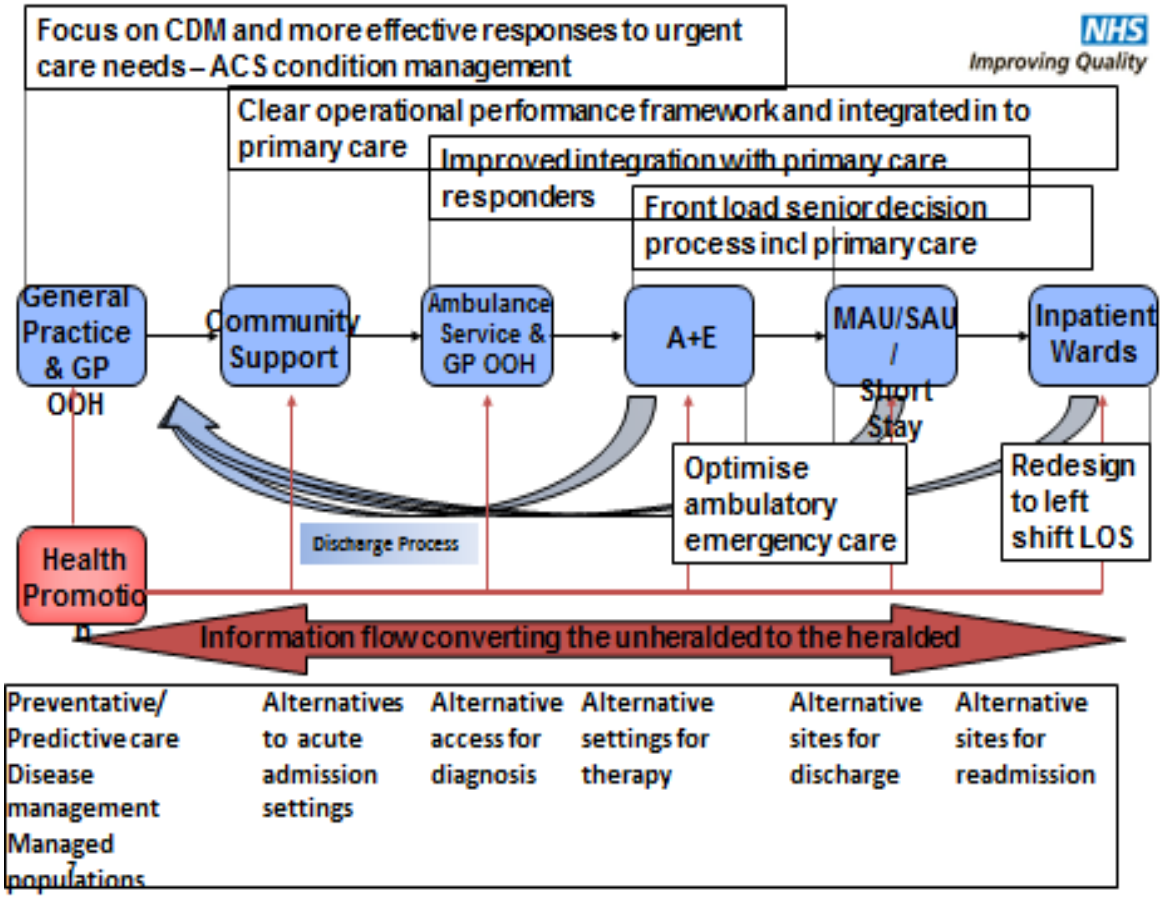
- Emergency and urgent care for many residents is provided at Sunderland, Hartlepool and Stockton;
- Emergency and urgent care services of all kinds show peaks in activity at breakfast time and 4.30pm-6.00pm;
- Urgent care services are used to a higher than expected level by young people (aged 19) and also pre-school children;
- Older people use urgent care services less often than expected, and
- Current urgent care service activity shows a small number of patients using services on a frequent basis.

The data compendium reviewed by the project team as part of this review identified that these key challenges within the system remain prevalent. The full report is at Appendix 1.

All CCGs must use information available from PCTs to support understanding the urgent care problem baseline

Leading Development of the Future Urgent and Emergency Care System

NHS Improving Quality presented the model below for managing urgent and emergency care at the June Leeds Summit. This model is not new and has been used by ECIST as an example of how the health part of the system should work together to reduce pressure on acute care. Other partners need to be included in this model – Social Care; Housing; the Voluntary Sector.



As of April 1st 2013 CCGs have responsibility for the local configuration of urgent and emergency care services (including GP OOH services) to deliver a coherent 24/7 urgent care service. LATs have responsibility for Primary Care contracts and so CCGs and LATs will need to work closely together in the development of services and responses to manage urgent care.

All CCGs have written draft plans that include short term deliverables (early wins) and longer term system transformation deliverables. Making these plans a reality will require a new mind set and collaborative approach across the local systems.

Each locality across the North East has a range of work underway to start to address the pressure on urgent care. This report cannot cover these entirely but as one example that has evidence of impact the partnership work between Newcastle

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Hospitals NHS Foundation Trust (NUTH) and Newcastle City Council (NCC) Adult Services

November 2012 saw the colocation of a number of Community Health teams and Adult Social Services at NCC Allendale Road offices. From the date of their co-location the community health and adult social care services have been working through a structured 90 day integration programme to enable them to settle in and establish their new pathway/processes. This joint work has enabled new streamlined pathways and processes between the teams resulting in a more comprehensive, efficient and effective range of service options to meet service user needs.

Over the 90 days from November 2012 to January 2013 the integrated team received 426 referrals (32%) cases (all urgent and some initially classed as non-urgent) that resulted in an avoided hospital admission (a case that without intervention would have resulted in a hospital admission). Evaluation of cases during January 2013 (where the predominant clinical diagnosis was matched against an indicative hospital cost/tariff code Health Resource Group HRG) suggests that these avoided admissions equated to a £144,156 saving. Empowering front line staff to work together to meet the needs of patients is essential and managers need to work with the multi-agency teams to remove the barriers to making this happen.

For some years there has been a great deal of emphasis on trying to educate patients about the different options for urgent care instead of the system working as a 'system', rather than independent parts, to respond rationally to where patients present and what they class as urgent – design the system around what the patient understands and drives flow. Patients understand 111; GP in and out of hours and 999. This has been evidenced in work undertaken by Sir John Oldham the National Integration Tsar and Professor Matthew Cooke; Warwick University.

Newcastle's integration pilot shows the benefits of managing the need where the patient presents and the opportunity to preempt urgency through integrated multiagency work processes and communication.

Essential to the long term management of urgent care out of hospital will be for CCGs to work with all system partners to understand the makeup of their constituent populations. Commencing with registered General Practice populations is a good place to start and understanding the Practice capacity to meet both routine and urgent demand. Also understanding how services integrate at a Practice level to jointly manage patients at the various levels of risk stratification. Only when this level of sophistication in care planning is in place is it possible to disinvest in Acute Care.

Southern Health in Hampshire have single community care teams that focus on population clusters of approximately 30,000, these teams then have sub teams that serve populations of 10,000. The teams work with General Practice and Social Care and Acute clinicians to support the frail and vulnerable in the Community. South Devon and Torbay CCG use the same model and saw a fall in emergency admissions in 2012 by 25.75 percent.

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Services must become designed around the person and anticipating potential risks and problems so minimising urgency and managing conditions out of hospital. In particular with the increasing incidence of Dementia working with people with a diagnosis and their families in both the early stages – when there is a sense of loss and grief that can affect mental health too; and in the latter stages where short term memory loss becomes significant and creates challenges not just in orientation to day and time, but also to activities of daily living including eating and drinking. Often, because of the latter, people with a Dementia are more at risk of infection and if they get an infection any associated delirium can be taken as a worsening of their dementia as opposed to needing urgent medical attention. All organisations need to look at staff development in understanding Dementia which is a neurological condition caused by brain damage.

The Ambulatory Emergency Care Directory was published in 2007 by the NHS Institute for Innovation and Improvement, identifying 49 emergency conditions and clinical scenarios that have the potential to be managed on an ambulatory basis i.e. not requiring A+E attendance or admission.

The resident populations and natural communities of each differ considerably and this may impact upon the demands placed upon each urgent care service. Therefore CCGs need to understand the benefits to be had in working collaboratively for certain services. For example the need for Mental Health crisis support may be greater in CCGs with greater deprivation.

Key Recommendations

- Urgent Care Board/ Networks scope their current plans against the NE February 2013 Summit Outcomes; the Urgent and Emergency Care Review principles and design objectives and the Kings Fund NHS England South Report Checklist referenced in Improving A+E Gateway 00062
- Urgent Care Boards/ Networks consider the ECIST Checklists for the whole system and for hospitals and look at how they can evidence achievement so not just a tick box exercise
- CCGs, Local Authorities and LATs must design an engagement and communication plan for all stakeholders to help create a shared and cohesive vision for urgent and emergency care so all staff are on board and understand their role in shaping the future of managing urgency for patients.
- If community services have been put 'out to tender' the CCGs responsible must commence a population planning exercise focused on general practice populations to understand risk stratification and design of service required.
- Planning multi agency services around Practice populations is essential for reducing avoidable urgency and establishing virtual ward teams that include all agencies, with outreach support from acute physicians to manage those most at risk.

- Provider service managers must listen to and empower front line staff across the system to remove the barriers to managing patient care in an integrated way
- NEAS are to be considered in the pool of community practitioners as per the award winning Northumberland Community Paramedic approach and have the opportunity to work with local health and social care communities to design their response services and develop commissioning plans.
- Social Care and Voluntary Sector partners must be included in scoping service design at the practice population level supporting the road to true service integration around the needs of patients.
- Early engagement and involvement of Local Medical Committees (LMCs) in designing local health and social care service models is essential as they need to be accountable, as all partner agencies are, for enabling its successful delivery.
- Urgent Care Boards in improving services for the frail elderly must identify the knowledge level of Dementia in all partner organisations and consider how workforce development resources can be used to develop multi agency staff in working with people with Dementia and their families/ carers.
- Urgent Care Boards should work to understand their current management of the 49 conditions/ scenarios in the Ambulatory Care Directory and if not in place already design an ambulatory care process to manage them without the need of A+E attendance.
- Partner agencies must work together to consider the potential impact of welfare reforms and understand how they work collectively to identify members of their communities at risk and in need of support. Involving the voluntary sector and private sector in creating the support required.
- All CCGs are to share the work on the development of their urgent care models and negotiate any possible cross boundary support that would make sense to patients and the public in terms of access to certain services.

Primary Care Access

There is rhetoric about high numbers of patients presenting at A+E out of hours yet there is evidence to show that demand is often high in Practice hours and just before they open and after they close. When ambulances arrive at A+E in 'batches' it is usually mid to late afternoon and often on a Monday. Access to primary care for patients can be improved using a model called **Advanced Access**

Advanced Access focuses on the following areas to achieve the greatest improvements

- Understanding demand
- Shaping the handling of demand
- Matching capacity to meet shaped demand
- Developing contingency plans to sustain the system
- Communicating effectively with the team and with patients

Using **Advanced Access**, Practices have demonstrated that:

- Telephone follow-up consultations reduce face to face consultations by up to 20% and are more convenient for patients and the practice.
- Telephone management of same-day appointment requests reduces face to face consultation by 30-50%
- Email and websites can be successfully used for repeat prescribing requests, health queries, and self-help materials and programmes.
- DNAs are dramatically reduced.

Practices that are using advanced access keep daily capacity and demand in equilibrium, and are able to offer patients a choice of ways to gain access to appropriate health care. Improvements in their ways of working using this system can level out, or even reduce, demand for home visits, out of hour's consultations and face to face consultations. In addition, patient, staff and clinician satisfaction increases.

The ability of patients to access information and share information has to be the way forward for the long term in helping to prevent avoidable admissions. Also ease for patients in booking an appointment getting repeat prescriptions etc. will help access to Primary Care. The Thornley House Medical Centre in Hyde Cheshire has implemented this access and patients can actually view their medical record as can Nursing Homes/ other professionals if patients give permission.

The lead for this work is Dr Amir Hannan a senior partner at the Practice http://www.htmc.co.uk/.

The North East contact/lead is Annette Chambers of the Health and Social Care Information Centre

Key Recommendations

- Revisit the Primary Care Collaborative principles of no delays through doing todays work today especially managing urgent requests on a Monday and not booking routine appointments
- A Demand and Capacity Gap analysis is undertaken for General Practice exploring the ' never full practice' concept as a possible future model
- As a priority consider the impact of current management of requests for a same day home visit and pilot mainstreaming into a 'doctor of the day' and schedule as per Practice appointments
- Learn from the success of Thornley House Medical Centre in Hyde Cheshire in enabling patients and other healthcare professionals to access patients' medical records.

111 and the Directory of Services

111 continues to receive some bad press across the country. Implementation in the North East appears to be the most successful to date. There have been some early teething problems and these are being addressed. As with any service continual improvement and refinement is essential through feedback/ dialogue. NEAS has been hosting a number of sessions where stakeholders have been attending the 111 centre to see the service in action and undertake this improvement/ relationship dialogue.

For 111 to work successfully, it is reliant on an up to date locality Directory of Services (DoS) that has accurate data on the availability and capacity of alternative services. This was set as an imperative in the 2011 Department of Health/ National Audit Office report ***Transforming Ambulance Services*** .

The DoS should include mental health; social care and voluntary sector services.

The 'Green Man' decision tool for ambulance crews has proved successful in Sunderland and Durham Dales and Darlington in the use of urgent care pathways outside of hospital but again its success is dependent on a comprehensive, regularly updated DoS. With these in place the Green Man concept can be rolled out across the whole of the North East.

Key Recommendations

- Local Urgent Care Boards must take ownership of their geographical Directory of Service (DoS) and work with NEAS on an ongoing basis to ensure it is constantly updated.
- The 49 clinical conditions/ scenarios for ambulatory care must be included in the DoS when clear pathway established.
- Providers must be held to account through the commissioning process to supply up to date information on alternative pathways for urgent care and their available capacity
- Investment in technology to enable frontline crews to have information literally at their fingertips of services available and key contact details will be essential in directing patients to the right service or practitioner as opposed to A+E where acute care is not indicated.

Nursing Homes Support and End of Life Care

The CCGs across the North East commenced discussion at the June Summit on areas to focus for 'early wins' in managing avoidable urgency. All have identified projects working with Nursing Homes and End of Life care as two areas of work. Currently 70-80% of people die in hospital and some of these are people from Nursing Homes. It has been identified that the relationship between General Practice and Community Services with Nursing Homes must be strengthened. General Practice is also pivotal in End of Life care, as it is general practice that registers people on the Gold Standard Framework (GSF), which should commence the end of

life care planning. It will be important for these projects to be discussed and planned early on in the local urgent care board/ networks meetings.

Specifically in respect of **Nursing Homes**, CCGs need to work with Social Care colleagues and NHS community providers to understand the number and type of homes in their constituent population. How many beds they have; which GP surgeries have registered residents, what is the current level of support from health and social care; what care and support is required for the residents; are there staff training needs to be addressed.

The acute hospitals will have valuable information on attendances from nursing homes. Newcastle Hospitals has a spreadsheet to capture this information and use it to develop and give in reach support targeting the homes with highest attendances.

The incidence of people in Nursing Homes having a Dementia is likely to be high and therefore understanding the training and development of staff in these homes to help them understand how to care for these residents is essential.

Key Recommendations

- Work with nursing homes to establish plans for Norovirus/ D+V; prevention and management of other infections (especially urinary tract infections) and planning ahead for end of life care.
- Ensure nursing home residents receive appropriate Primary and Community service support to prevent avoidable admission.
- Work with Nursing Homes to develop good person centred end of life care.
- Local authorities to work with Nursing Homes to ensure the homes have a dementia friendly environment and staff are skilled in dementia care.

Specifically for **End of Life Care,** the End of Life Care Strategy document on Quality Markers and Measures recommended that PCTs develop Patient Related Outcome Measures (PROMS) for end of life care; suggestions from consultation on the strategy were that:

- pain and other symptoms should be controlled effectively
- the individual, carers and family should feel well supported
- the individual, carers and family should feel confident in the skills and knowledge of their health and social care professionals
- the individual, carers and family should know who to contact in an emergency
- the individual should be able to die in their place of choice.

It seems sensible that any work commenced in PCTs is revisited by CCGs if available. It will be essential as part of the developing end of life care work to

understand General Practice populations and how, going forward, integrated teams identify those people who may have a predictable death in the next 6 -12 months, and agree how they will support the person and their carers/family in deciding how and where they would like to die.

If individuals and families feel supported to die in a place of their choice then the ratio of people dying in hospital should shift from the current 70% / 30% in other settings to 70% in other settings and 30% in hospitals.

Key Recommendations

- As the population modeling and risk stratification work develops, provider teams should identify people who can be anticipated to die in the next 6-12 mths and commence end of life planning with them and their family/ carers.
- Ensure services are tailored to deliver the suggested end of life care patient related outcome measures and seek feedback from families/ carers of their experience of the death of their loved one to ensure these outcomes are delivered.

Planning for Periods of Surges in Urgent Care Demand

There is a perception that surges in demand are happening throughout the year now and not just at the usual 'winter pressures' stage. However winter can pose particular problems in terms of increased health issues for some members of the population. August can also be an intensive month as it's a main annual holiday month with schools closed and the impact in acute settings of the doctors in training rotations during its first week. Surges in demand at other times of the year may be due to specific events in certain localities and predictable so needing to be built into forecasting and planning.

The term ' consuming their own' smoke has become synonymous with the view on how local plans should enable communities to manage unless extreme situations arise where there needs to be clear criteria for what these may be and how neighbouring localities will assist. Diverting patients to a neighbouring hospital may seem like a good solution but it is not a good experience for the patient and their family/ carers and can further complicate discharge arrangements. Diverts should be a last resort option, the first option must be to bring the system for dealing with urgency into alignment and match demand with capacity to respond where it needs to be.

Winter

The Office for National Statistics has produced evidence that there are more deaths over the winter months December – March as a result of cold weather. The number of extra deaths occurring in winter depends on temperatures, the level of disease (particularly influenza) in the population and other factors such as predisposing long term conditions; frailty etc.

Although excess winter deaths occur in both warm and cold homes, it is evident that there is a higher risk of death in the latter. In their report, The Health Impacts of Cold

Homes and Fuel Poverty, the Marmot review team estimated that 'EWDs [excess winter deaths] in the coldest quarter of housing are almost three times as high as in the warmest quarter'.

The impact of cold weather on health is predictable and mostly preventable. Cold causes blood pressure to rise and blood to thicken hence increased risk of heart attacks; strokes and pulmonary thrombosis. The lungs' resistance to infection is lowered so increased levels of chest infection.

Direct effects of winter weather include an increase in incidence of:

- Heart attack and stroke (accountable for 40% of increased winter deaths)
- Respiratory disease (GP visits for respiratory illnesses increase by up to 19% for every 1°C drop below 5°C of the mean temperature)
- Influenza
- Falls and injuries related to snow/ icy conditions
- Winter vomiting disease/ Norovirus
- Hypothermia

Indirect effects of cold include an increase in incidence of:

- Mental health illnesses such as depression
- Carbon monoxide poisoning from poorly maintained or poorly ventilated boilers, cooking and heating appliances.

The Cold Weather Plan for England Protecting health and reducing harm from severe cold was established in 2011 to predict cold weather and help agencies minimise and manage its impact. The cold weather alerts are an essential enabler for local planning.

Cold weather ***alerts*** are issued by the Met Office on the basis of either of two measures: low temperatures or widespread ice/heavy snow. Often low temperature criteria are met at the same time as the ice and snow. However, sometimes one may occur without the other. There are 4 alert levels

Level 1: Long Term Planning and winter preparedness – Level 1 is in force throughout the year and also emphasized in the winter from 1 November to 31 March, with the seasonal flu vaccination programme starting on 1 October.

Level 2: Alert and readiness – Level 2 is declared when the Met Office forecasts a 60% risk of severe winter weather in one or more defined geographical areas in the days that follow. This usually occurs two to three days ahead of the event. A Level 2 alert would be issued when a mean temperature of 2°C is predicted for at least 48 hours, with 60% confidence, and/or widespread ice and heavy snow is forecast, with the same confidence.

Level 3: Severe weather action – a Level 3 alert is issued when the weather described in Level 2 above actually happens. It indicates that severe winter weather is now occurring, and is expected to impact on people's health and on health services.

Level 4: Major incident – a Level 4 alert indicates that many parts of the country are experiencing exceptionally severe winter weather and the conditions are affecting critical services. Such weather conditions are likely to have significant impacts not only on health, but also on other sectors and critical infrastructure. A cross-governmental response may be required.

Alert Trigger Level 1 is about **ALL YEAR**, long term planning. The actions for Health; Social Care and Local Authorities organisations and their staff are to work with partner agencies to

- develop a shared understanding of excess winter deaths and what partners can do to reduce them
- identify those most at risk from seasonal variations
- improve winter resilience of those at risk
- ensure that a local, joined-up programme is in place to support

Alert Trigger Level 1 has an enhanced phase from *1 November - 31 March called winter preparedness* when Health Social Care and Local Authorities Organisations:

- Work with partner agencies to co-ordinate cold weather plans programme
- Work with partners and staff on risk reduction awareness (e.g. flu jabs– for staff), information and education
- Support communities to help those at risk from freezing
- Plan for a winter surge in demand for services
- Professional Staff must be working collectively to identify those at risk of the impact of cold weather and work together to minimise the potential impact.

England has not seen a severe episode of I**nfluenza** for a few years and winter 2013 may be more challenging for flu than 2012. The flu immunisation programme for 2013 has been announced and CCGs will be working with the Screening and Immunisation Team in each LAT to plan implementation. This year there will be

some immunisation of children and also immunization for Shingles. To ensure minimal effect of flu on staff capacity it will be essential that staff immunisation is maximised.

Admission to hospital **for winter vomiting disease and Norovirus** has a major impact on acute bed capacity with the closure of ward bays and often whole wards to admission and decontamination processes. Also discharge of patients is challenging as homes refuse to take patients back from affected wards or refuse to attend affected wards to assess patients. Winter plans must include planning to manage as much of these infections in a community setting as possible, with joint agency plans for management in place and staff awareness/ training before winter 2013.

One of the biggest challenges with Norovirus is hydration/ rehydration.

- A local multi-agency plan should be developed to minimise the admission to hospital of patients with Norovirus
- Local surveillance and inter-agency communication systems should be set up to enable early warning of and timely response to increased Norovirus activity
- Triage of patients at hospital portals using designated clinical areas and effective medical assessment should be established
- Use should be made of outreach teams to prevent admissions through the management of dehydration in the community

NEAS have an established **Falls Pathway**. CCGs need to understand the impact of this pathway and response times of professionals involved and outcomes for the patients and the system in terms of preventing or managing further falls. In addition, what is the anticipated demand on the pathway for winter 2013/14 should we have another long bout of snow and ice as was the case in two recent winters.

Local Area teams are currently working with their respective CCGs in developing the plans for winter 2013/14 and these should be 'testable' in August for robustness. The ECIST team presented on winter planning at the Leeds CCG Summit in June and included details of what they suggest should be included in a good winter plan.

Doctors in training in the UK have historically started new six-monthly rotations in February and August, with the majority of junior doctors rotating to new training programmes during the first week of August. There is an increasing body of evidence to suggest that simultaneous trainee changeover is associated with higher mortality, reduced efficiency and lower satisfaction.

The Academy of Medical Royal Colleges (AoMRC) and NHS Employers have worked with partner organisations to develop simple, practical recommendations that can help mitigate the August trainee changeover problems.

The four key recommendations are recognised as best practice and could be implemented within the current arrangements:

1. Consultants must be appropriately available
2. Flexible and intelligent rota design
3. High quality clinical induction at all units
4. Reduction of elective work at changeover times

The AoMRC and NHS Employers believe these recommendations are applicable for use across the UK, whilst recognising that there will be local variation in how they might operate and be implemented.

The UK Medical Education Scrutiny Group has asked the AoMRC and Conference of Postgraduate Medical Deans (CoPMeD) to explore the wider issue of moving to a staggered transition by grade. The Safe Trainee Changeover Working Group has been established to examine options for long-term solutions to the problems for the UK Medical Education Scrutiny Group and relevant authorities in the four countries to consider. The group comprises representatives from all major stakeholders across the UK, and aims to report in July 2013.

Key Recommendations

- CCGs should understand the health impact of cold weather and work with providers to plan for management of infection and flu and preparing capacity plans for the potential increase in respiratory problems and heart attack and stroke
- Acute hospitals undertake shared learning and co development of a planning framework for internal capacity management and escalation so measuring and responding on a like for like basis and trusting each other's surge management process and escalation trigger points. Creating a collaborative approach at hospital level.
- The first phase of the Level 1 Cold Weather Plan Alert is in place between Community services and Local Authority services and structured around Practice populations so that people at risk are being identified and management plans tailored to their needs being developed
- Acute hospitals in preparing for the August rotation changes should ensure the four key recommendations to mitigate potential impact are being implemented.
- All agencies to learn from the impact of winter 2012/13 and undertake a capacity/ demand analysis and identify potential gaps in services that could have prevented A+E attendance during this period.

- Ensure plans are in place to enable 7 day support in the community (including homecare services, community nursing and equipment services) and to facilitate weekend hospital discharge.
- All local Surge plans are shared and a whole system level view is taken on their robustness and NEEP; REAP escalation is clearly defined so there is consistent escalation management across the system.
- Undertake a test of operationalising escalation plans to ensure they can work in practise.

Metrics for Urgent Care

General practices should be receiving real time data about the utilisation of their patients of any of the local urgent or emergency care facilities; a **GP Urgent Care Dashboard**. This information gives Practices the opportunity to understand where their patients are presenting and the opportunity to investigate why. This information should feed into the multi-agency work at a Practice level to manage patients pro-actively.

There will be two types of information required

1. Daily operational data that helps the whole local system manage the urgent and emergency care proactively – On the 'flight deck'
2. .Performance improvement data that can show the Urgent Care Boards and the whole system success in implementing agreed improvement plans – looking in the 'wing mirror'

The Kings Fund Report for NHS South of England recommended a whole system urgent care dashboard data set for Urgent Care Boards/ Networks to monitor the impact of their improvement work and manage system resilience and give the following example of a suite of whole system metrics

- A primary care access metric at general practice level.
- Ambulance turnaround times (30minute arrival to clear) and 'Red', 'Green' and 'GP Urgent' response time delivery.
- The four hour standard (underpinned by disposal profiles, showing the % of patients leaving the department after three hours forty five minutes has elapsed (for admitted patients, and two hours for non-admits)
- Adult non-elective bed occupancy rate using an agreed non-expanded bed number consistently as the denominator.
- Percentage of discharges from hospital before and after midday.
- Community service based performance metrics (e.g. Rate of delivery of a 4 hour standard for admission avoidance and a 12 hour standard for early supported discharge).
- Average time from referral to assessment for mental health patients with no physical illness.

- Social care response and performance metrics. Outcome and patient experience metrics (mortality, effectiveness of pain control, patient reported outcome measures etc.).

Daily SITREPs currently report

- A+E Diverts – how many and how long divert period
- Trolley Waits over 12 hours
- Urgent operations cancelled for the second or subsequent time in the previous 24 hours
- Urgent operations cancelled in the previous 24 hours
- Number of cancelled operations in the previous 24 hours: elective including day case
- Non clinical critical care transfers out of an approved group
- Number of non-clinical critical care transfers within approved critical care transfer group
- Paediatric/Neonatal Transfers
- Ambulance handover delays of over 30 minutes
- The total number of available adult critical care beds on day of reporting
- The total number of occupied adult critical care beds on day of reporting
- The total number of available paediatric intensive care (Level 2, Level 3 and Level 4) beds on day of reporting
- The total number of occupied paediatric intensive care (Level 2, Level 3 and Level 4) beds on day of reporting
- The total number of available neonatal intensive care cots (or beds) on day of reporting
- The total number of occupied neonatal intensive care cots (or beds) on day of reporting
- Number of general and acute bed stock available on day of reporting
- Number of general and acute escalation beds open on day of reporting.
- Of the total number of general and acute beds available, the number that are occupied.
- The number of beds closed due to D&V or norovirus like symptoms.
- Of the number of beds closed due to D&V or norovirus like symptoms, the number of beds that are unoccupied.
- The number of beds unavailable due to delayed transfers of care
- Any other relevant factors (e.g. staffing issues, adverse weather conditions), has the trust experienced serious operational problems during the past 24 hours?

The above information is very Acute focused and doesn't show the position across the whole system; such as capacity for homecare; community nursing; IV fluids at home capacity nursing and residential home capacity; reablement etc. So establishing a daily operational information dashboard for the whole system is essential for all localities. Agreeing the dashboard data set is one step, the next step

is to consider how this dashboard can be managed in real time to serve each locality and support daily system management.

The CCG Outcomes Indicator Set: General Practice registered patient counts is extracted on the first day of each financial quarter and published on the HSCIC website https://indicators.ic.nhs.uk. The first figures for the new Adult Social Care Outcomes Framework (ASCOF) are also available on the website. These include data for 14 measures which are designed to enable users to compare the effectiveness of care delivered by councils responsible for adult social care services. Local Basket of Inequalities Indicators (LBOI), a collection of 60 indicators to help organisations measure health and other factors which influence health inequalities such as unemployment, poverty, crime and education can also be found here.

These indicators were previously available on the London Health Observatory website.

A meeting took place on July 1st between the two NE LATs and NECS with representation from an Urgent Care Board and NEAS to commence work in understanding the metrics requirements for urgent and emergency. It was agreed that the NECS information team would start to shape a possible dashboard as a starter for ten. This will then support a dialogue with all Urgent Care Boards to design a whole system dashboard for urgent care. At the same time the NECS team will work with Urgent Care Boards to consider their performance improvement information needs.

Key Recommendations

- All Urgent Care Boards should begin a discussion to identify both their performance improvement information (to show progress of improvement plans) and daily operational dashboard information needs to manage the local urgent care system on a daily basis.
- All Urgent Care Boards to work with the NECS information team in creating a whole system operational dashboard so consistency across the whole of the North East.
- All Urgent Care Boards to consider funding a pilot of a 'managed' dashboard so information is available in a timely manner to help proactive daily management of the local urgent care system.

The Impact of Managing Length of Stay and Discharge Planning on Bed Capacity and Flow through Acute Care

When A+E is under pressure flow through the hospital pathway is essential to move patients from A+E in a timely manner for their positive experience and wellbeing, not just to achieve the target. The report by Jeremy Pease on ambulance handovers and turnaround highlighted the need for flow through an acute hospital to be managed with everyone's eyes on minimising length of stay and ensuring timely discharge.

Care By Design

Not all patients who present at A+E are avoidable attendances or admissions, some patients are acutely ill and require an admission and treatment/ monitoring on the right ward for their condition.

Ensuring good management of length of stay and discharges on medical and elderly medicine wards also has the impact of reducing the need to 'board' patients in times of pressure. 'Boarding' is known to increase length of stay and also can have an additional negative impact on a person's recovery.

To manage length of stay all patients must have a realistic expected date of discharge (EDD) on admission and daily Board and Ward rounds used to manage the patients journey (timely tests/ treatment/ agreed multi-disciplinary objectives completed in a timely coordinated manner).

Nurses present on Board and ward rounds ensure continuity of care and achieving patient goals for recovery where this is possible or for care in a patient's place of choice where patients may be approaching the end of their life.

It is also known that frail older people deteriorate the longer they stay in hospital and can become very depressed. Also hospital settings are confusing and frightening for people who have a Dementia and depending on their specific type of neurological impairment; they are challenged in making sense of the ward environment and communicating with staff.

The Delayed Transfer of Care (DTC) Act 2003 was introduced to try and minimise delays in discharges although in some cases the process of issuing Section 2's (notification of assessment of care needs required) and Section 5's (notification of medically fit for discharge) has become a process and industry in itself that has not always been focussed around the needs of patients.

Delays in discharge can be for a number of reasons

- Delay in social care assessment
- Delay in therapy assessment
- Conflict in opinion on the term ' medically fit for discharge'
- Capacity for reablement
- Capacity for homecare
- Capacity for nursing or residential home placement
- Capacity for non weight bearing beds (post fracture treatment)
- Homes coming to assess
- Norovirus in a home
- Homes refusing to assess on contaminated wards

- Capacity for Continuing Healthcare Checklist completion
- Capacity for Continuing Healthcare assessments
- Community service capacity
- Equipment
- Availability of Rehab beds
- Housing needs
- Transfer out of area following divert
- Repartition post tertiary transfer
- Person has no recourse to Public funds
- Patients who will self fund care
- Family disputes
- Safeguarding issues

As part of the DTC process, local agencies have to agree on a weekly basis the reasons for delays and report these to the Department of Health. Acute hospitals can raise a charge for the agreed delayed discharge days against Local Authorities. Although mature systems rather than have this blame and shame approach work proactively to minimise delays.

As an example, Sunderland Health and Social Care Community have created 'The Hub' from pooled resources to facilitate more timely step down from hospital and a better environment to facilitate long term reablement or care decisions.

Again as part of the DTC SITREP process agencies come together to discuss the preceding week's SITREP position. The available information is good litmus for the hospitals and local partners to understand source of delay and plan for improvement/ escalation of the problem if out of management level span of control.

It has long been recognised that decisions about Continuing Healthcare (CHC) should not be made in hospital and so a step down facility for CHC assessment is essential. Since the revised guidance for CHC was issued in 2009 and the threshold for checklisting lowered there has been increasing pressure on capacity to undertake these and also full CHC assessments.

Key Recommendations

- Urgent Care Boards should initiate an audit of the delays in discharge for the winter period 2012/13 and identify the sources of delay and work with providers and local authority to plan improvements going forward in the year and especially for winter 2013/14
- Urgent Care Boards should consider using the Point Prevalence Audit of Discharges (attached as Appendix 5) designed by ECIST and available for use as a multi-agency team audit to understand any real time discharge issues.
- Acute hospitals must ensure daily Board and ward rounds and forward planning of actual discharges especially planning the appropriate level of transport (if any), equipment and to take home pharmacy items.
- Wards should have the ability to work with care providers in restarting simple packages of care directly with them.

- Continuing Healthcare assessments should not delay discharge from hospital and a step down facility for full Decision Support Tool (DST) assessment be available with an agreed pathway and decision timescales.

NEAS Internal Organisational Development Programme

NEAS has recognised the need to work differently and so has for some time been in the process of undertaking internal development and service redesign. NEAS divided into 3 departments - Emergency Care; Patient Transport Service (PTS) and the Contact Centre – calls are triaged and where appropriate undertake 'Hear and Treat'. NEAS is currently below average for levels of 'hear and treat' and 'see and treat', and work is being undertaken to understand/address this.

Operational Structure Changes have taken place within the service so that the emergency care team will have 3 divisions instead of 4 and coterminous with the Patient Transport Service. Three new operational managers have been appointed whose roles will be 75% outward focused to stakeholder organisations and 25% inward working together on service improvement.

Work has commenced to look at the interface of emergency transportation and PTS as there is a middle ground where a patient may not need a blue light for transport. The aim is to enable an 'intelligent dispatch' with the transport requirement rather than type of care.

Nine band 7 managers are being appointed, three per emergency care division. There will be 97 team leads (Band 6) of which 15 will be managerial leads (process focused; nuts and bolts of system working) and 82 clinical leads who are trained in Enhanced Care and managing minor illness.

There is a perception from the Paramedics' Band 5's in respect of the support they would receive from the organisation for clinical decisions and 'see and treat' or convey people to alternative sites for care to A+E if something went wrong (risk aversion). National job description limits this group to referring/ transporting to other units. Band 6 job descriptions allow more scope of clinical decisions so it could make economic sense to have band 6 staff, as opposed to band 5's, who are better able to avoid inappropriate hospital transport and attendance.

There is also a perception of contract limitations for other providers re diversion to alternative urgent care pathways. E.g. – can divert to District Nurses or out of hours service if a crew do not attend a patient but cannot do if on site with patient.

One area that needs discussion across the whole community are 'ceilings of care' for each urgent care pathway in the community and these need to be clearly stated in the DoS to enable appropriate signposting or conveyance of patients

Front line crews have a wealth of day to day experience and ideas for improvement and they need the opportunity to link with the dispatch team in planning responses and moving ambulances around the geographical area.

Care By Design

The ***Health Select Committees Report on Urgent and emergency services (HC 171)*** published on July 24th emphasised that the ambulance service has the potential to coordinate other elements of the emergency and urgent care system and lead integration of services.

Changing the staff mix, reforming tariffs and ensuring access to patient information are important elements of a process of developing ambulance services into care providers in their own right.

Key Recommendations

- Consider how the new Operational Managers interface with the wider system (75% outward focus role) and develop with system partners.
- Consider how the intelligence from the local urgent care networks/ boards is brought back into the organisation for service development/ refinement.
- Give support to the front line crews in decision making/ empowerment to use clinical judgment and work with the local health and social care systems.
- Consider the possibility of Clinical Team leaders available to crews to aid decision making and most appropriate response and how upskilling can be funded where required in line with the Health Select Committee recommendations.
- Continue work commenced looking at interface of PTS and emergency care response - the middle overlap ground where PTS transportation could be used as opposed to a blue light vehicle.
- Develop stronger team interface between on the road crews and dispatch. Front line staff have a wealth of knowledge and experience and ideas for improvement that need to be tested. Creating inclusive empowered cross functional teams.
- Commission for improvement and redesigned locality urgent care services ; the NEAS personnel who are the interface with Commissioners need Urgent Care Boards to consider upskilling of ambulance staff as appropriate to become part of local proactive urgent care responses/ services as care providers.
- Consideration must be given to workforce planning; if additional front-line paramedic resource is required the lead in time is 2 years or higher.

Financial Levers

Clinical Commissioning Groups are commencing their commissioning role within very tight financial limits. Therefore for the urgent care boards to facilitate service redesign it has to be from a position of how the money already in the system is used to create better value in delivering more coordinated urgent care and prevention of urgency occurring wherever possible. This will require all partners working together to place the available monies in the right place to ensure this happens – commissioning for whole system outcomes.

Acute foundation Trusts have taken a significant financial hit in only receiving 30% marginal tariff for admissions. The Trusts have had to deal with the high number of cases presenting at their doors (opening extra beds; increase staffing etc.) when the wider system was not working in a way that admissions were reducing. The money saved from the reduced funding for hospital A&E admissions is meant to be invested in other services that would stop people coming to hospital. It could be that the problem of increased urgency was ill defined and the wrong solutions were commissioned or implementation of solutions poorly executed.

Baseline budgets have been reset as Trusts have implemented ambulatory care pathways. All Trusts have seen an overall net reduction of -1.3% on tariff as required by NHS England.

The DoH requires every Ambulance Trust each year to complete a costing exercise to nationally determined criteria to determine the cost of their Emergency Ambulance Service. The Reference Costs calculated for each service in this manner are then indexed where Reference Cost 100 is the average cost of Emergency Ambulance Services. NEAS had the lowest Reference Cost Index of 85 for 2011/12, the latest data available, and has had the lowest cost index for a number of years.

NHS England is expecting use of the 70% tariff to link to the local turnaround or improvement plans submitted in May. Local Area Teams have allocated the 70% tariff to CCGs.

A range of financial levers have been in place to reward commissioning of better patient outcomes. These include:

1) CQUIN payments available to providers who meet the minimum requirements concerning the high impact innovations as set out in ***Innovation, Health and Wealth***. CCGs in South of Tyne have committed 50% of this tariff to support increase of 'hear and treat' and 'see and treat' by the ambulance teams. Other CCGs in the North East have allocated between 30-50% to achieve an increase in activity in these areas.

2) Quality Premiums payable to CCGs for

- Achieving A reduction of potential years of life lost from amenable mortality (12.5% of payment).
- Reducing avoidable emergency admissions (25% of payment)
- Improving patient experience of hospital services (12.5% of payment)
- Preventing healthcare acquired infections 12.5% of payment)
- 3 locally agreed measures (each accounting for 12.5 % of payment – 37.5% in total)

However the payment will be reduced for failure in meeting the NHS Constitution requirements of (25% reduction for each target failed)

- 18 weeks elective referral to treatment – achieved for 92% of patients over year 2013/14

- A+E 4 hour maximum wait – achieved for 95% of patients over year 2013/14
- Category A Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes – achieved for 75% of patients
- Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer

The LATs have already agreed the local measures with the CCGs for 2013/14. These premiums if achieved will have no additional finance impact for winter 2013/14 as the monies will only become available late 2014.

3) Support for CCGs to define their local QIPP challenge and milestones

During this financial year these incentives (rewards and sanctions) will be reviewed. So the Urgent Care Boards have the opportunity to consider, in tandem with their improvement plan how these should work for the future if at all.

CCGs have also assumed responsibility for the management and administration of monies available for reablement provision. They are required to work with local authorities to agree the allocation of the monies to benefit local populations.

The Technology Fund became operational on 1 July and NHS providers are invited to submit Expressions of Interest by the end of July.

Winter pressures monies were released late in 2012 to try and ease the burden of the then increased use of A+E however there was no joint health and social care community plan for how these monies should be allocated. The latter meant the monies were in provider baselines and did not on the whole provide service to meet the presenting urgent care problems. If these monies are available for 2013/14 then they need to be released earlier and also the urgent care board needs joint agreement of where the monies should be spent.

The PMS Review announced in June gives an opportunity to plan for redesign in Primary Care and work with LATs and NHS ENGLAND in establishing new contracts going forward for 2014/15

Key Recommendations

- All stakeholders to understand that the financial position is tight and that money currently in the system will need to be used more innovatively.
- All local urgent care stakeholders need to work collaboratively in designing the ideal local urgent and emergency care system and to ensure the financial flows act as an enabler
- If winter pressures monies become available for 2013/14 that a whole system plan for using these for the purpose of reducing pressure based on lessons from 2012/13 is created and implemented.

- CCGs to work with all providers to develop a joint expression of interest for the Technology Fund that can support development of electronic information flows to enable better patient care.
- To ensure reablement investment supports timely discharge from hospital and where possible prevention of admission.
- LATs to work with CCGs as they review Primary Care Access to inform the PMS Review and creation of potential finance framework for 2014 onwards.

Media

The media can be a useful positive tool for health and social care. Winter plans should include working with the media to prepare campaigns on managing flu; winter vomiting and norovirus keeping hydrated etc.

The North East Health and Social care System should also consider engaging the media proactively in the work being undertaken to design services to better manage urgency and therefore allow true emergency the smooth pathway to A+E.

Whole System Summit September 2013

The follow up Summit to the February 2013 Summit that saw the commission of the Handover/ Turnaround and Alternatives Pathway projects will take place as agreed on September 3rd 2013.

The Summit will be attended by Professor Keith Willett, the lead for the National Urgent and Emergency Care Review announced in January 2013.

This is a great opportunity for the NE health and social care community to hear directly from Keith his thoughts and the progress of the review as of September, and also to influence the review and show how the North East have grasped proactively, as a System, the problems of urgent and emergency care.

The session is to be an opportunity for local urgent care boards/ networks to attend as a multi-agency team (CCG; Acute; Social Care; Community; General Practice; NEAS; Mental Health) and have the opportunity to give a 15 minute update on progress over the Summer with turnaround and improvement plans and discuss as a whole system any further immediate work required going into winter 2013/14.

Development Support from NHS England; ECIST and NHSIQ

At the Leeds June Summit for CCGs NHS England; the Emergency Care Intensive Support Team (ECIST) and NHS Improving Quality (NHSIQ) pledged development support to the NE System. Learning from each other and other sites through the use of Webinars through the next few months would enable sharing of good practice and ideas. The webex technology means that hour long sessions can be diarised and people can take part without having to leave their desks.

As an initial range of suggested topics the report author would recommend:

- Primary Care Access: Never Full Practice - Dr James Kingsland

- Patient Electronic Appointment Access; Information and Access to GP Records – Dr Amir Hannan
- Impact of Welfare Reforms – Led by Tees Valley Health and Social Care Partners
- South Devon and Torbay Virtual Wards – South Devon and Torbay CCG
- Southern Health population modeling and service design – Southern Health
- Community Paramedic – Steve Jones NEAS

This is not an exhaustive list and localities may wish to share more of their local developments as well as learn from other paradigm leaders.

NHSIQ have requested to 'case study' the North East whole system approach to solving the current urgent and emergency care problem. NHSIQ have also made a National pledge to support local health systems deliver 7 day working.

Summary

'Every system is perfectly designed to achieve exactly the results it delivers' Paul B Batalden introduced this quote widely used now by Don Berwick and the author and repeated several times in the Blue Rivers Consulting report for Durham Dales, Easington and Sedgefield.

The term 'design' implies creating something to meet a need and so in respect of the urgent and emergency care system all localities need to design services to work interdependently to meet today's needs. This includes matching capacity to meet demand at the right point in the system; failure to do this pushes demand upstream and results in avoidable attendances at A+E and demand on the ambulance service.

The health and social care system has seen an unremitting number of changes over the last 14 years, especially in Primary and Community services. These changes have constantly tampered with the system and probably brought us to the crisis point we are at today. Change and especially constant organisational restructure does not imply improvement, more over it creates an illusion of bringing improvement.

Improvement however does bring about the need to change and in terms of today's urgent and emergency care system that is where we stand. All organisations have to take a shared responsibility and accountability for redesigning the system to bring about the required improvements.

Integrating services around natural local populations (General Practice) and understanding what these populations require is the cornerstone to reducing avoidable urgency and bringing the system into realignment. Staff must be empowered to work collectively to design proactive support.

Avoidable urgency is any call on the system in a crisis way that could have been predicted/ preempted. As an example, the Author's mother in the last months of her life with terminal Cancer had every service under the sun going into her home but

none were managing her pain or nausea. The Author finding her mother in great distress knew the system and did not call 999 but called a McMillan nurse she knew and her mother was admitted to a hospice for 2 weeks to stabilise her pain and nausea situation. A less knowledgeable person would have called an ambulance and a journey via A+E. This situation was predictable and had the services been truly integrated and person centred managed in the community.

The various national reviews on the subject of urgent and emergency care; Primary Medical Services and tariff are acknowledgment that there are some fundamental design errors. Now is a great opportunity for the North East health and social care system to own the service redesign required and influence constructively future national service direction.

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