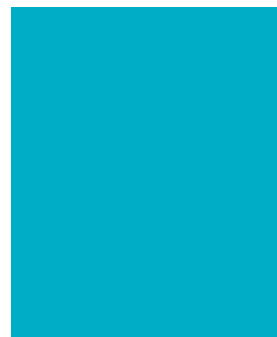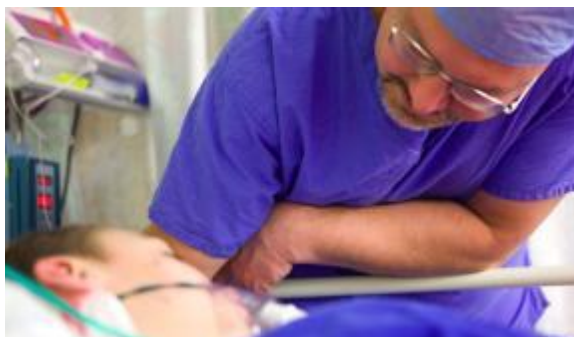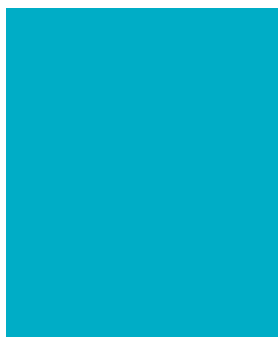# Urgent & Emergency Care Review

Health & Voluntary Sector Strategic Partnership Programme

Professor Keith Willett

Director for Acute Episodes of Care
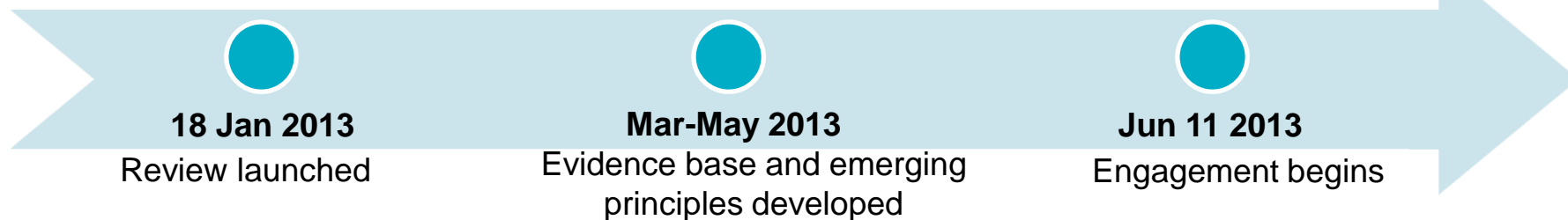
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Urgent & Emergency Care Review

- Professor Sir Bruce Keogh announced January 2013
- Steering Group chaired by Professor Keith Willett (Director of Domain 3 Acute Care) representation from patient and public organisation, provider and commissioning organisations and the wider clinical body.

- The review uses a **very transparent and engaged approach** which aims to:

  - Determine **patients' priorities** when accessing care
  - Determine **clinical principles** by which urgent and emergency care should be organised
  - Build the **evidence base** for principles and seek further evidence
  - Build *in public*, by contribution, consensus on the key components and the **system design objectives**
  - Develop **commissioning framework** for future proposed model options

Timelines for Review

Phase 1 – Evidence gathering and Principles development

18 Jan 2013
Review launched

Mar-May 2013
Evidence base and emerging principles developed

Jun 11 2013
Engagement begins

Engagement

NOW

Jun – Jul 2013
Workstream design & setup

Aug 2013
Close of Engagement (11 Aug) & Analysis

Sep 2013
Develop Clinical Models, Publish Engagement Outcomes & Mobilise Working Groups (**VOPP**, MH, CYP)

Phase 2 - Delivery

Mar – May 2014
Working Group outputs

May – Nov 2014
Tariff Amendments & Commissioning Guidance

2015 / 2016
Implementation for Contracting Round

3

Evidence base - overview

Growing demand is unsustainable and unaffordable
- 100 million NHS calls or visits in England each year:
    - Attendances rose by >50% between 2001 and 2012
    - Admissions are increasing at a rate of 2.7% a year (£83 million a year)
- More frail, elderly, with increasing complex and multi-morbidities
- More treatable illnesses
- Increased public expectations

The current system is consuming NHS resources at a greater rate each year

Patient experience indicates fragmented and complex system leading to confusion about where and when to access care and what to expect
- Too often the urgent and emergency care system fails to communicate and share information effectively, putting patients' care at risk
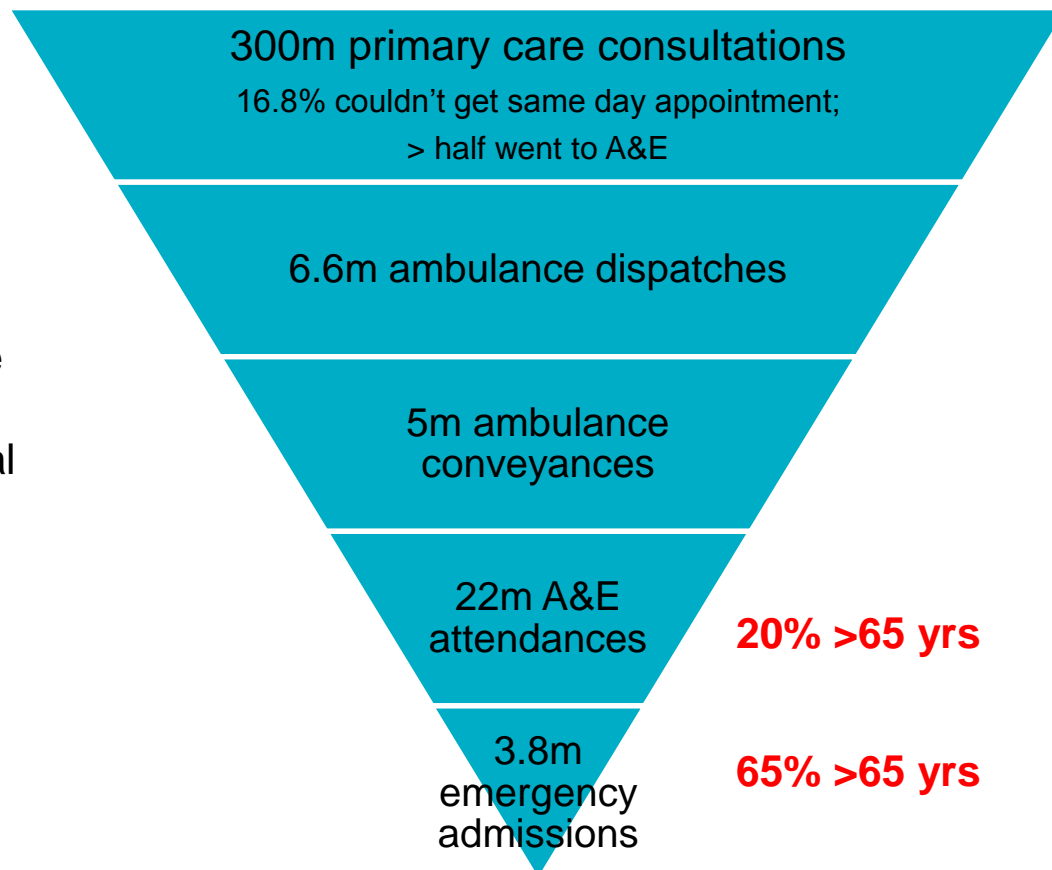
What are we engaging on and why?

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WHAT

Evidence Base for change
- 70+ pages
- 300+ references supporting the Clinical Evidence Base
- End to End review of the clinical pathways

Emerging Principles for change
- 4 key principles
- **12 system design objectives**
- Possible implementation options

300m primary care consultations
16.8% couldn't get same day appointment;
> half went to A&E

6.6m ambulance dispatches

5m ambulance conveyances

22m A&E attendances

20% >65 yrs

3.8m emergency admissions

65% >65 yrs

WHY

Evidence Base for Change

- 70+ pages
- 300+ references supporting the Clinical Evidence Base
- End to End review of the clinical pathways
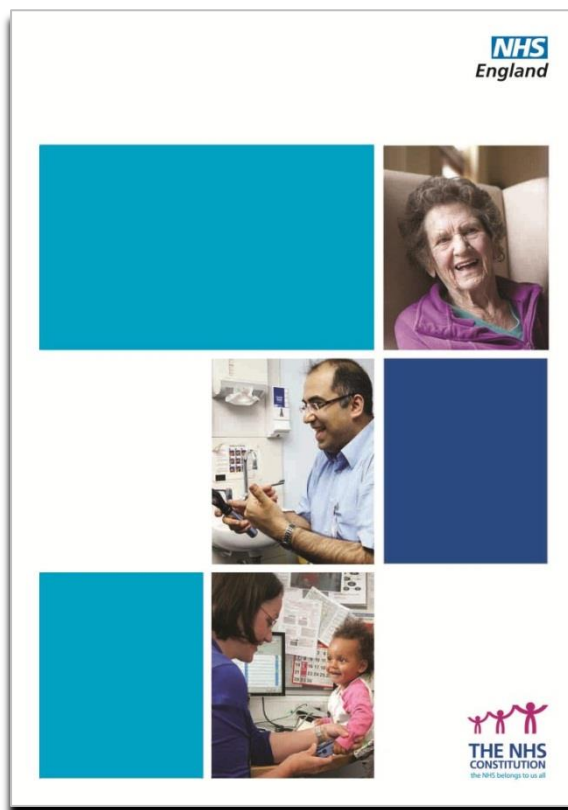- Test and improve through engagement

Evidence base - overview

- **Self care** – is strongly linked to better health outcomes and proven to reduce A&E attendances and admissions for people with long term conditions.

- **Telephone care** – Effective, but more risk averse less experienced staff may direct patients to higher acuity care. Inadequate advice results in duplication.

- **Face to face care** – Poor GP access can lead to patients accessing other urgent and emergency care

- **Confusing nomenclature and services** offered

- **999 emergency services and admission to hospital** – huge variation exists in access to high quality back up services between days of week and OOH

- **Specialist care requires critical mass of activity -** increasingly complex and specialised, requiring more patient activity to make them viable but demonstrable better survival and recovery.

Emerging principles

Emerging principles for urgent and emergency care in England outline a system that:

1. Provides **consistently** high **quality** and **safe** care, across all seven days of the week;

2. Is **simple** and guides good choices by patients and clinicians;

3. Provides the **right care** in the **right place**, by those with the **right skills,** the **first time;**

4. Is **efficient** in the delivery of care and services.

System design objectives (1):

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).

System design objectives (2):

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 are constantly developed.

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

1. Provides **consistently** high **quality** and **safe** care, across all seven days of the week (1)

System design objective	Possible implementation options:
(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.	• Same day, every-day telephone, web or email contact to a primary care team integrated with patient's own GP practice • A same-day, every-day appointment system for urgent care facilities • Direct access to community nurse specialists and hospital specialist teams for patients with long term conditions • GPs/Out-of-Hours teams to have easy direct access to same day opinion from hospital specialists 7/7
(5) Improve my care, experience and outcomes by ensuring early senior clinical input in the urgent and emergency care pathway.	• 111 (advice and triage) services with greater clinical input , such as senior clinical input in telephone triage where hospital transfer is recommended or for complex enquiries • Urgent Care Centres staffed with a multi-disciplinary team with support of at least one GP or other registered medical practitioner • Senior emergency physicians present in all 999 ambulance receiving Emergency departments to ensure presence until midnight, and beyond this where acuity and patient numbers justify this • Ensure working patterns/careers are sustainable - rested, alert and safe practitioners ready to provide high quality care • Utilise specialist nurses, paramedics and other allied health practitioners at key decision points in care to optimise patient outcomes and experience • Specify clinical service modules of care for different patient groups (e.g. ill child, mental health, limb injuries, etc.) that are capable of assessing and either treating or transferring. These could be combined to create bespoke local emergency facilities based on a community's needs

1. Provides **consistently** high **quality** and **safe** care, across all seven days of the week (2)

System design objective	Possible implementation options:
(6) Wherever appropriate, manage me where I present (including at home and over the telephone).	• Identify and commission joint primary and specialist care of complex patient groups in the community (e.g. diabetics) • Mobilisation of the appropriate level of decision making for the call/enquiry, and where appropriate, decision maker is sent to the home rather than taking the patient to the decision maker • Remote/rural areas to be supported by higher specification on-scene treatment options by paramedics, nurse specialists or doctors • Telemedicine support and on scene/home diagnostic testing • Direct referral of patients to responsive community support teams
(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.	• All urgent and emergency care facilities to be in formal networks • Each facility to have immediately available and capably skilled staff and plans for the safe care and/or transfer of all patient types • Bypass some Emergency facilities to specialist centres for stroke, heart attack, major trauma and specialist children's services; those centres to have consistent network pathways and concentrate expertise to improve patient outcomes and efficiency • Inpatient service support for Emergency facilities is always available • Remote and rural areas to have intermediate facilities capable of stabilisation prior to transfer if network journey times are too lengthy
(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.	• Establish a code of conduct for non-NHS urgent and emergency care operators to ensure alignment with NHS operational and clinical governance and provide clarity of corporate responsibilities • Commission appropriate transportation for those in mental health crisis, which is sensitive to their holistic needs

2. Is **simple** and guides good choices by patients and clinicians

System design objective	Possible implementation options:
(1) Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice.	• Simplified and standardised access points to the urgent and emergency care network and facilities • A single urgent and emergency care system for the public, but with a supporting, responsive, tiered clinical structure behind • Decision support from a patient's own GP practice and hospital specialist nurse/team, seven days a week
(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.	• Increased patient, family/carer education to self-care and self-manage • 7 day continuity of care from a patient's GP practice • 7 day access to community, mental health and hospital nurse specialists • 111 service fosters communication and co-ordination between different elements of the urgent care community, whilst developing an effective and expanding directory of services in every locality • 111 website and NHS Choices better linked to charity and other support groups and their information • Improve status and use of pharmacists
(3) Increase my or my family/carer's awareness of and publicise the benefits of 'phone before you go'.	• 111 service to have greater medical input - senior clinical input in telephone triage and advice • GP telephone consultations both in and out-of-hours
(12) The quality of my care should be measured in a way that reflects the urgency and complexity of my illness.	• Process and outcome measures and commissioning requirements should be sensitive to, and appropriate for the casemix, linked to the outcome and relate to the episode of care

3. Provides the **right care** in the **right place**, by those with the **right skills,** the **first time** (1)

System design objective	Possible implementation options:
(5) Improve my care, experience and outcomes by ensuring early senior clinical input in the urgent and emergency care pathway.	• 111 (advice and triage) services with greater clinical input , such as senior clinical input in telephone triage where hospital transfer is recommended or for complex enquiries • Urgent Care Centres staffed with a multi-disciplinary team with support of at least one GP or other registered medical practitioner • Senior emergency physicians present in all 999 ambulance receiving Emergency departments to ensure presence until midnight, and beyond this where acuity and patient numbers justify this • Ensure working patterns/careers are sustainable - rested, alert and safe practitioners ready to provide high quality care • Utilise specialist nurses, paramedics and other allied health practitioners at key decision points in care to optimise patient outcomes and experience • Specify clinical service modules of care for different patient groups (e.g. ill child, mental health, limb injuries, etc.) that are capable of assessing and either treating or transferring. These could be combined to create bespoke local emergency facilities based on a community's needs
(6) Wherever appropriate, treat me where I present – at home, on scene or over the telephone.	• Identify and commission joint primary and specialist care of complex patient groups in the community (e.g. diabetics) • Mobilisation of the appropriate level of decision making for the call/enquiry and, where appropriate, decision maker is sent to the home rather than taking the patient to the decision maker • Remote/rural areas to be supported by higher specification on-scene treatment options by paramedics, nurse specialists or doctors • Telemedicine support and on scene/home diagnostic testing • Direct referral of patients to responsive community support teams

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3. Provides the **right care** in the **right place**, by those with the **right skills,** the **first time** (2)

System design objective	Possible implementation options:
(7) If it's not appropriate to treat me where I present (home, on scene or 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.	• All urgent and emergency care facilities to be in formal networks • Each facility to have immediately available and capably skilled staff and plans for the safe care and/or transfer of all patient types • Bypass some Emergency facilities to specialist centres for stroke, heart attack, major trauma and specialist children's services; those centres to have consistent network pathways and concentrate expertise to improve patient outcomes and efficiency • Inpatient service support for Emergency facilities is always available • Remote and rural areas to have intermediate facilities capable of stabilisation prior to transfer if network journey times are too lengthy
(10) Where I need wider support for my mental, physical and social needs ensure it is available.	• A directory of community and acute services available to all clinicians in the urgent and emergency care pathway, encompassing health and social care services • Rapid access to social care assessment and mental health liaison services
(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 are constantly developed.	• Regular integrated clinical governance meetings involving all contributors to the urgent and emergency care pathway with a focus on final outcomes • Ensure training is delivered effectively and that services are not over-reliant on trainees • Appropriate senior supervision of trainees

4. Is **efficient** in the delivery of care and services

System design objective	Possible implementation options:
(1) Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice.	• Simplified and standardised access points to the urgent and emergency care network and facilities • A single urgent and emergency care system for the public, but with a supporting, responsive, tiered clinical structure behind • Decision support from a patient's own GP practice and hospital specialist nurse/team, seven days a week
(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.	• Establish a code of conduct for non-NHS urgent and emergency care operators to ensure alignment with NHS clinical governance and provide clarity of corporate responsibilities
(9) Information, critical for my care, is to be available to all those treating me.	• All patient records are to be accessible and shared amongst all urgent and emergency care providers

Engagement: 17 June to 11 August 2013

- Online engagement tool http://www.england.nhs.uk/uec-england/ to seek contributions and qualitative feedback on the evidence base, principles and system design objectives

- **6 August 2013:** stakeholder engagement event Thistle Marble Arch, London W1A 4UR – 9.30am to 1.30pm http://urgentandemergencycare.eventbrite.co.uk/

- **September 2013:** consolidation and review of engagement feedback – publication of final evidence and principles

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