Share your Fab Stuff! #FabAwards23

Title of innovation / initiative

Community Based Unscheduled Care Coordination - Preventing unnecessary hospital attendance and admission for sub-acute patients requiring unscheduled care.

Problem

There are very few services available in real time to help community-based clinicians access the most appropriate part of the health and care system whilst they are with their patient. As a result, this leads to them working in a clinical silo, with a proportion of their patients attending hospital unnecessarily.

Community-based clinicians such as GPs, paramedics, care home and nursing home teams should not be expected to access clinical services directly. The process is too time consuming and too complex. A more realistic option, from a time constraints perspective, is 999 and hospital attendance.

Aim

In cases where the patient is not seriously ill or injured, Integrated Care Systems (ICSs) should take responsibility for coordination the most appropriate response. This needs to happen ‘as the need arises’ whilst the referring clinician is with their patient.

Plan

We worked with health systems to provide access to unscheduled care coordinators via a ‘genuine single point’ of access, that provides the means to respond rapidly and appropriately. Advanced clinical practitioners based in care coordination hubs take clinical responsibility at the point of call. They arrange for multidisciplinary teams to respond, providing care by default, in the patients’ home unless clinically indicated otherwise.

Systems set up care coordination hubs, to sit above all unscheduled care services. These are not a replacement or duplication of planned care access points such, as community neighbourhood teams. They operate at ICS or County level providing a ‘catch all’ service for referring clinicians.

We helped systems to develop and operate a clinical exclusion criterion, as opposed to an inclusion criterion. The was designed to accept any patient with an unscheduled care need if they are over 18 years of age, not pregnant and not seriously ill or injured. Basically, any patient without a clinical ‘red flag’.

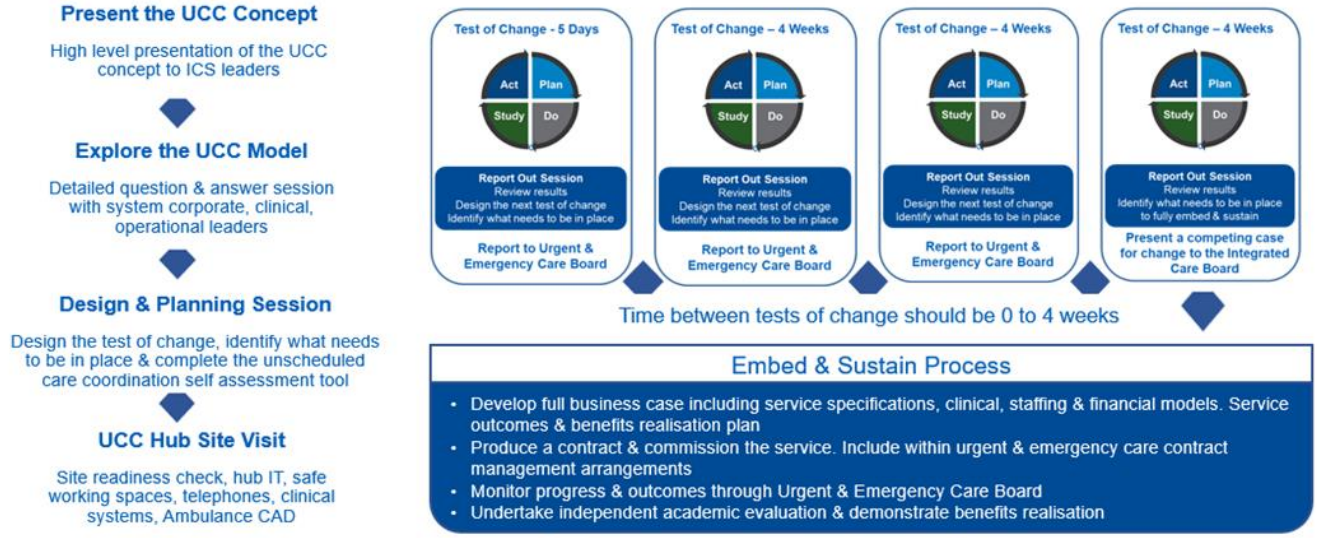
We introduced trusted assessor status for Paramedics, GPs, community-based clinicians, and nursing home staff. Meaning that they are not subjected to further assessment and triage processes. Once the clinician has assessed their patient, the care coordinator simply asks them ‘what do they think their patient needs clinically and within what timeframe’. The care coordinator discusses the case with the referring clinician, and they jointly decide if the

patients' needs can be met by community services. The assessment and transfer of care process takes fifteen munities, with a single phone call. Meaning that it isa viable operational alternative for GP's and Ambulance Crews.

We found that working alongside systems to facilitate real-time tests of change was particularly key to our project success. This approach was based on generating ideas for how they could test our each of the six principles within the model. Then using the model for improvement, including plan, do, study, act cycles to test the ideas out.

This process allowed systems to test out and develop the unscheduled care coordination model, using their existing urgent care service provision. It also helped them to produce local data to use in a compelling case for change.

The following visual describes the test of change process used with systems to implement the unscheduled care coordination model:



Benefits

Tests of change led by NHS England's Emergency Care Improvement Support Team (ECIST) have shown, that talking to ambulance crews on scene and offering care at the patients' home can reduce conveyance. Between 30% and 50% of crews intending to convey their patient to hospital, used unscheduled care coordination, following a clinical conversation with an advanced practitioner.

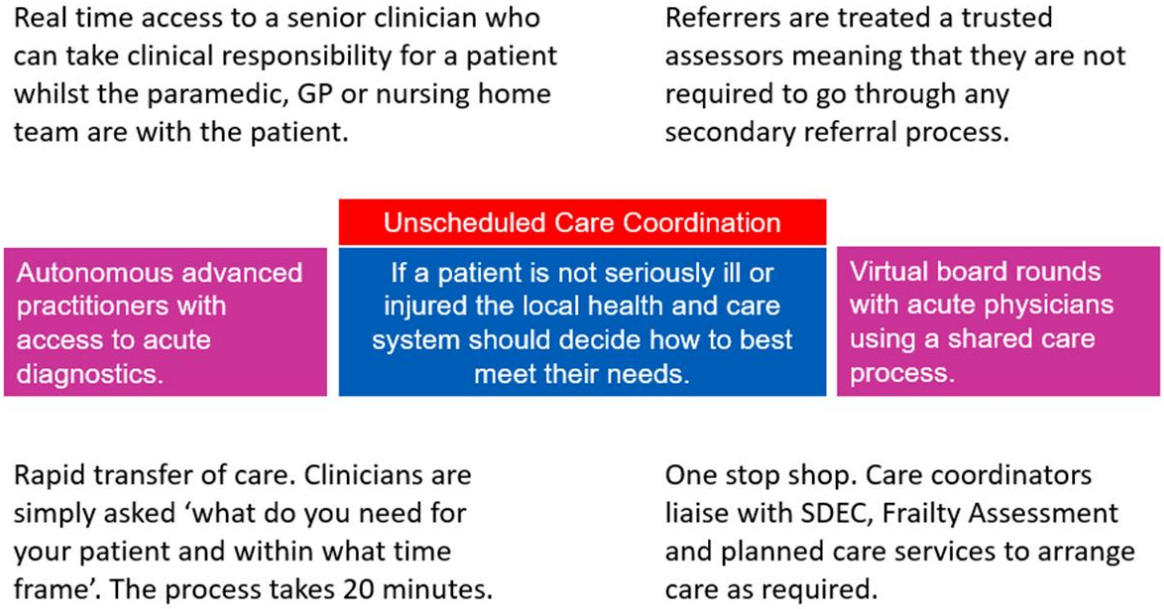
Care coordination hubs provide the health and care system with the ability to respond to patients who are at 'immediate risk' of receiving an emergency ambulance or attending hospital unnecessarily. Even though they are not seriously ill or injured.

Colleagues working in care coordination hubs have the time to make the appropriate arrangements to treat patients at home or close to home. As a catch all service, this might involve liaising with local neighbourhood teams and arranging an aspect of planned care. The key aim is that referring clinicians make a single call to the hub and do not need to phone multiple teams.

Care coordination hubs, linked to community based planned and un-planned services, showed that it is possible to reduce unnecessary emergency ambulance dispatches, ambulance conveyance, attendance at Emergency Departments and hospital admissions.

Unscheduled Care Coordination Model:

The following visual presents the unscheduled care coordination clinical model. This was distilled from the six key principles, developed whilst working with systems during their tests of change.



Patient and Staff Experience:

Patient and staff experience improved as a result of our project. Staff reported that they could reduce duplication of clinical response in approximately 20% of cases. As planned care services had already been scheduled and would meet the unscheduled care need.

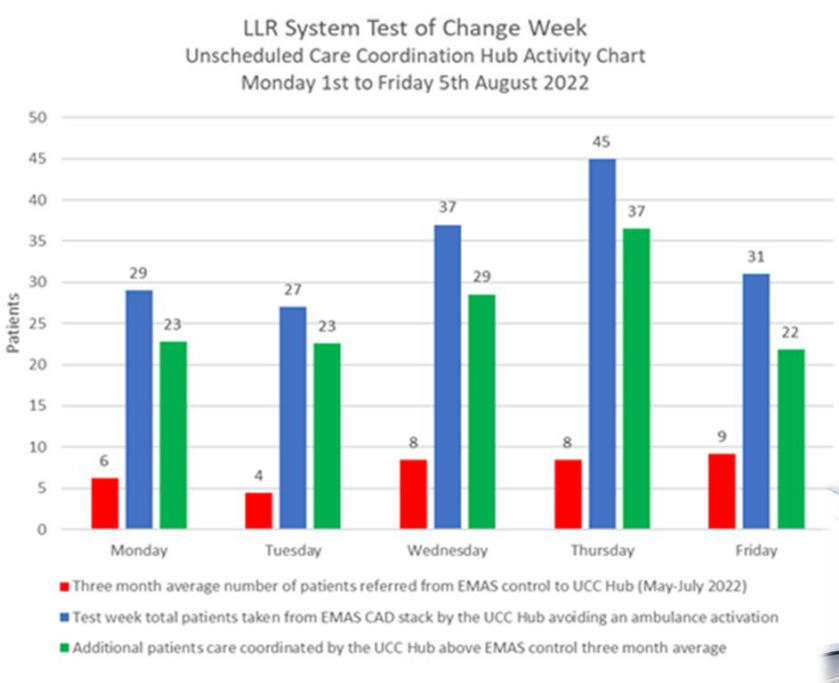
Staff also noted that using the care coordination principles helped to streamline care pathways and processes. Making it easier to provide case management services.

Patients commented most notably on a reduction in fear and anxiety. This was associated with the prospect of having to attend hospital. Without a clear plan of what would happen, or when they would return home.

Measures

.

A key measure for our project related to the reduction in avoidable emergency ambulance dispatches following a 999 call. The green column in the visual below, shows the number of patients who care coordinated safely into community services, as opposed to receiving an emergency ambulance. The red column shows the average number of referrals into the Leicester City care coordination hub from East Midlands Ambulance Service by day of the week.



Leicester City care coordination test of change.

Avoiding emergency ambulances from being dispatched following a 999 call.

Including patients presenting by 999 category 2 calls.

For further information please contact: paul.devlin@nhs.net

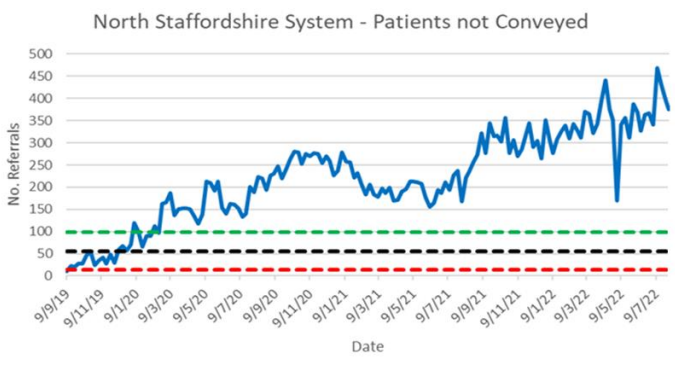
A second key measure for our project was the number of patients who avoided unnecessary hospital attendance following a call to 111 or 999.

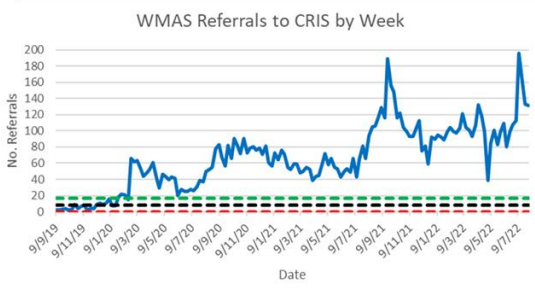
The North Staffordshire care coordination hub has supported a reduction in unnecessary hospital attendance. Moving from an average avoidable attendance of 50 patients per week in 2018, to 450 patients in 2023.

North Staffordshire unscheduled care coordination service.

Avoiding unnecessary hospital attendance for GP's, care homes, nursing homes & emergency ambulance crews.

Including patients presenting by 999 category 2 calls to West Midlands Ambulance Service (WMAS).





Resources / team

Testing out and implementing the unscheduled care coordination model was predominantly done with existing system resources. The tests of change involved re-organising how community services were delivered.

The following visual provides a high-level view of colleagues involved in the test of change process:

Key learning

Key learning from this project related to the change management and improvement approach taken. We resisted the pressure to produce directive guidance for systems to use. This is because each system had different urgent care priorities, starting points and resources.

Instead, we used learning gathered from system stock take sessions and our tests of change, to develop a set of six principles for the unscheduled care coordination model. The principles are below:

Unscheduled Care Coordination Principles:

1. Integrated Care Systems should take responsibility for managing the needs of sub-acute patients who present to the unscheduled care system. Who are not seriously ill but are at immediate risk of receiving an emergency ambulance or attending hospital unnecessarily.

2. Patients with no clinical red flags, who are well enough to be left on their own for 2 hours or more, should, by default, be treated in their normal place of residence.

3. Community based clinicians including ambulance crews and GPs should not be expected to access community service providers directly. The process is too timely and too complex.

4. Systems should provide a physical multidisciplinary unscheduled care coordination hub that covers a locality or ICS. Accessing community and non-ED hospital services.

5. Advanced unscheduled care practitioners (including therapists & local authority) should be available to respond in the community to same day needs. Non-medical prescribers with autonomous access to urgent bloods and X-ray.

6. Patients presenting via 999, with sub-acute unscheduled care needs, should only receive an ambulance, or be conveyed to hospital, following a clinical conversation between the ambulance crew on scene, and a senior clinician in the system unscheduled care coordination hub.

We also used a similar approach to help systems understand the differences between traditional single points of access for unscheduled care, and care coordination hubs. We described these in a list of key features below:

Key Functions of Unscheduled Care Coordination Hubs:

1. A genuine single point of access, catch all service. Infrastructure includes call taker management systems, voice logging and links to ambulance control with visibility of 999 demand.

2. Referring clinicians have trusted assessor status with no secondary triage or referral process. Transfer of care takes 15 minutes. #Handover@Home

3. The multidisciplinary unscheduled care team decide how best to respond to meet the patients the needs. Based on the clinical requirement and urgency agreed with the referring clinician.

4. Real time visibility of their emergency ambulance demand. And the ability to interact with ambulance dispatchers and crews on scene, to provide viable alternatives to attending hospital.

5. Pathways should include access to same day community unscheduled care, including advanced practitioners and 2-hour urgent response. Virtual consultant led ward rounds, community step up beds, UTCs, hot clinics, SDEC, frailty services, community mental health, local authority and outpatient diagnostics.

Doing Things Differently:

Going forward, I would spend more time ensuring that there is a political will to support this project from system leaders. The project requires unprecedented partnership working across system organisations. It also raises risks to the distribution of activity and income across the system.

Work needs to be done to improve patient level data collection within community services so we can understand the patient's journey. Multiple organisations can be involved in a single episode of care. This is key to evaluating the clinical effectives and operational efficiency of the model. We also need to adapt existing contracting and commissioning models to accommodate the transfer of activity, from ambulance services and hospital services to community services.

Tips for others

Critical Factors to Success:

Ensuring that system leaders have a politically will to test out an innovative approach to providing more sustainable unscheduled care.

Using a test of change methodology, model for improvement with PDSA cycles, to organically grow the model locally for each system.

Ensuring that no system partner is compromised, because of adopting the unscheduled care coordination model.

Future Application:

Systems reported through our test of change process, that that the way we supported rapid improvement events was highly effective in moving them forward. In our case it related to unscheduled care coordination, however, systems suggested that this approach had the potential to be equally effective to innovate and improve other service areas.

Further Information and Advice:

If any colleague would like to like to receive further information, or discuss arranging support for a test of change, please visit www.NHSCareCo.uk

Link to unscheduled care coordination video

Please also feel free to email Paul Devlin on the email address below.

Paul is a Fab Academy ambassador and can be contacted through the Fab WhatsApp group.

Contact name: Paul Devlin Emergency Care Improvement Support Team

Contact email address: paul.devlin@nhs.uk

Date of innovation / initiative: January 2023

Do you have any attachments?

- “A picture is worth a thousand words". Are there any photos or graphics that could help bring your story to life?
- Are there any supporting materials, documents, communications or other outputs that you used or produced that you could share to prevent others reinventing them?

If so, please upload them to the Fab site with this completed template.