Emergency Care Improvement Support Team

Safer, faster, better care for patients

NHS England

Unscheduled Care Coordination

Implementation Guide for Integrated Care Systems & Boards

An innovative approach to delivering timely, accessible, and sustainable community based unscheduled care.

Emergency Care Improvement Support Team

Introduction & Context

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.

GPs, paramedics, care home and nursing home teams have minutes to decide what should happen next for their patients.

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.

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.

Why Care Coordination?

Real time access to unscheduled care coordinators via a ‘genuine single point’ of access 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.

A care coordination hub sits above all unscheduled care services.

It is not a replacement or duplication of planned care access points such as community neighbourhood teams.

It operates at ICS or County level providing a ‘catch all’ service for referring clinicians.

Hubs operate a clinical exclusion criteria, as opposed to an inclusion criteria. They will 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’.

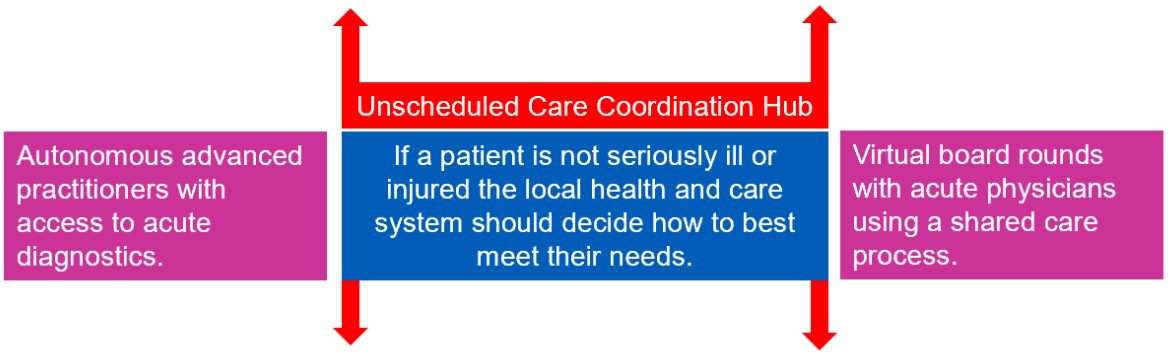
Care coordination hubs provide the health and care system with the ability to respond to patients who are at ‘immediate risk’ of attending hospital. Even though they are not seriously ill or injured. Colleagues working in the care coordination hub have the time to make the appropriate arrangements to 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.

Unscheduled Care Coordination Model

1. Real time access to a senior clinician who can take clinical responsibility for a patient whilst the paramedic, GP or nursing home team are with the patient.

2. Referrers are treated a trusted assessors meaning that they are not required to go through any secondary referral process.



4. One stop shop catch all service with minimal exclusions. Care coordination hub arranges unscheduled and planned care services as required.

3. Rapid transfer of care. Clinicians are simply asked 'what do you need for your patient and within what time frame'. The process takes 20 minutes.

Referring Clinicians Decision Making Process

GPs, paramedics & care homes do not always understand what community services can offer clinically.

50% of ambulance crews with a plan to take their patient to hospital could avoid the conveyance if they had real time access to care coordinators.

Is your patient seriously unwell? Yes = Hospital

No = Do you think your patients should attend hospital? Yes = Call care coordination hub.

Advance practitioner based in care coordination hub asks what does your patient need clinically and within what time frame?

Referrer describes clinical need and response time needed. They have trusted assessor status so no secondary referral process required.

Care coordinator offers a service to referring clinician whilst they are with their patient. Takes responsibility for arranging the care required.

Transfer of care takes place within 20 minutes.

Trusted Assessor Status

Paramedics, GPs, community-based clinicians, and nursing home staff have trusted assessor status. 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.

Due to the lack of variation across community services, it is incredibly difficult for paramedics, GPs, care home and nursing home teams to understand what level of care can be delivered in the community. This is another key reason for avoidable hospital attendance and the under-referral into community-based unscheduled care services.

The care coordination hub addresses this in a couple of ways. Firstly, by liaising with community-based clinicians to raise awareness of the genuine single point of access and care coordination service. Secondly, by senior clinicians in the hub monitoring the ambulance service case management system and proactively identifying appropriate patients for treatment at home. Whilst the crew are on scene.

Tests of change led by 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.

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. Integrated Care Systems should provide a physical multidisciplinary unscheduled care coordination hub that covers their geographic footprint. 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.

Key Features of 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

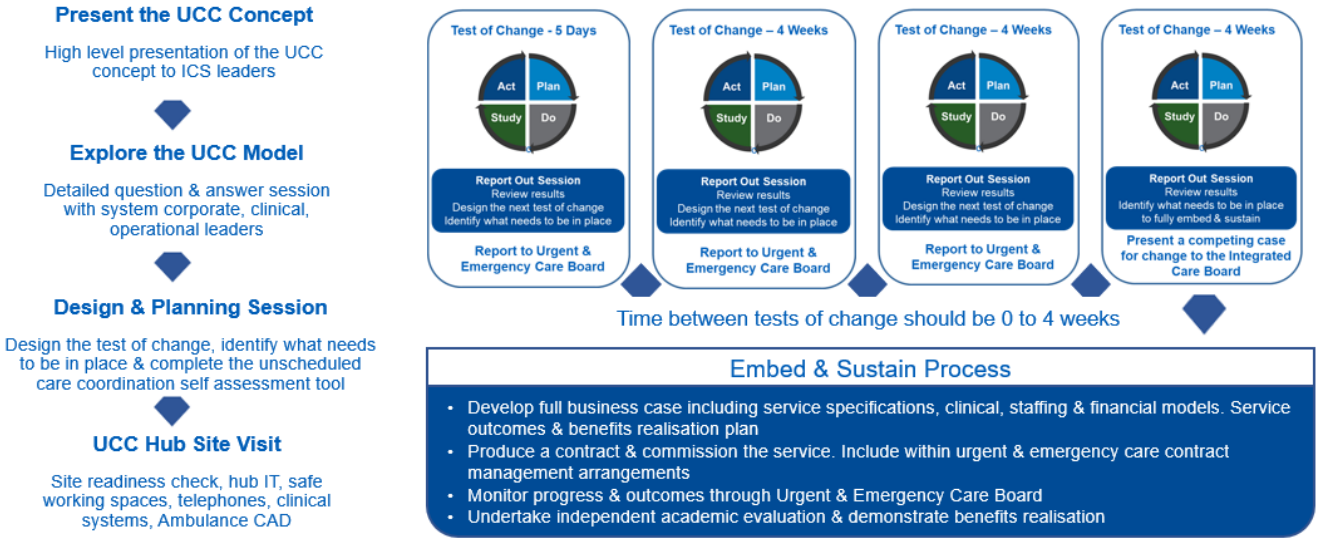
3. The multidisciplinary unscheduled care team decide how best to respond to meet the patients the needs. Based on the clinical requirement and urgency agreed with the referring clinician.

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.

ECIST Test of Change Process

ECIST provide a fully supported test of change and facilitated implementation process to all Integrated Care Systems. This process allows systems to test out and develop the unscheduled care coordination model, using their existing urgent care service provision.



Critical Factors to Successful Implementation:

Using a test of change methodology to adapt the model locally for each Integrated Care System. Ensuring that no system partner is compromised, because of adopting the unscheduled care coordination model.

Test of Change Planning Checklist

The following checklist is used by the system prior to commencing their first test of change. It contains the most critical elements required to test the unscheduled care coordination concept.

Test of Change Planning Checklist	Test of Change Planning Checklist
1. Clinical, operational, commissioning and executive leads	10. Clinical support worker to arrange services required and track patient progress
2. ECIST care coordination lead scheduled to facilitate test of change	11. Patient tracking list in hub for case management
3. Initial concept briefing for stakeholder team	12. Virtual board rounds with geriatricians/ acute physicians daily or twice daily
4. Test of change planning session	13. Advanced practitioners available in the community to respond and deliver unscheduled care to patients at home, nursing/ care homes
5. Location and set up of care coordination hub	14. Data collection and project support colleague
6. Hours of availability 7 days per week	15. Communications lead for GPs, Ambulance Service, nursing and care homes
7. Admin and/ or support worker call takers	16. Access to Ambulance Service case management system within care coordination hub
8. Senior clinicians in hub having clinical conversations with referrers who call in, taking clinical responsibility for patients in real time	17. Daily and weekly touch point sessions
9. Senior clinicians in hub monitoring the ambulance service case management system, proactively identifying appropriate patients for treatment at home whilst the crew are on scene	18. Link to and reporting into system urgent care board

Expected Benefits of Unscheduled Care Coordination

- Reduction in ambulance dispatches
- More patients can be treated at home or in a community setting
- Faster more tailored care and improved patient experience
- Reduction in ambulance conveyances
- Less crowded Emergency Departments
- Reduction in ambulance on scene times (care coordination)
- Saved transport time and hospital turnaround time
- Increase in available ambulance unit hours
- Improvement in ambulance response times
- Increase in right work for ambulance crews

Common Questions & Answers

What is the best geographical area for care coordination?

Unscheduled care coordination hubs work best when covering an Integrated Care System footprint. County wide hubs can operate above this level. This is advantageous to service providers such as Local Authorities and the Ambulance Service.

How is the unscheduled care coordination hub different to any other single point of access?

Unscheduled care coordination hubs provide a genuine single point of access to services for each Integrated Care System. This greatly simplifies access to healthcare professionals. They use a principle of trusted assessor, based on the referrer's clinical impression. Avoiding lengthy secondary referral processes. Hubs also provide the means to accept patients at the point of call, within 20 minutes. Including a clinical conversation with the referring healthcare professional. Making access to the hubs a viable operational alternative to ambulance services. The hubs then take on clinical responsibility for each patient. They physically coordinate the most appropriate response for the patient. They provide a genuine one stop shop, single front door into unscheduled care. They also run twice daily virtual wards for patients stepping up or stepping down in acuity.

Who should we be receiving referrals from?

Unscheduled care coordination hubs accept referrals from community-based clinicians, Local Authority Duty Teams, GPs, ambulance crews, care homes and nursing homes.

How will we know if our unscheduled care coordination approach is the right one for our system?

ECIST support each Integrated Care System to customise their own approach to testing out, and adopting the six unscheduled care coordination principles, contained within the model. Virtually all systems worked with to date, have the component parts already in place. ECIST help them to identify which principles would add most value to their system, in order of priority. Then to identify what needs to be put in place, to do a test of change. ECIST facilitate tests of change during the first three-month period. At this time, the system will have local data to demonstrate a compelling case for change. Along with key enablers that would be required to adopt the model sustainably.

Don't we just need 24/7 urgent community response?

24/7 access to 2-hour urgent community response is a key element of the unscheduled care coordination model. It should be noted though, that 80% of patients presenting to same day urgent care services do not need a 2-hour response. 50% of patients can be converted into a next day response. And approximately 20% to 30% of patients do not need any unscheduled care response at all. This may be due to planned care services already scheduled. Or the presenting problem nature being resolved by a virtual consultation.

Is this about balancing risk?

Yes. Balancing, but also reducing risk to patients and system providers. The aim of care coordination is to ensure that patients who do not have a clinical reason for needing to attend a hospital facility, are cared for in their normal place of residence. This results in reduced harm through unnecessary hospital attendance, treatment delays, admission, and physical deconditioning. Also reducing the risk of requiring nursing or residential care services following an unnecessary hospital admission.

Data for Evaluation & Case Study

The aim of testing out the unscheduled care coordination concept, if for Integrated Care Systems and Boards to build a compelling case for change. This is done by collecting a standard set of data throughout the test of change process. ECIST ask systems to collect the following data.

Lead Measures

- Number of clinical conversations between referrers and care coordination clinicians by week.

Call & Case Management Measures

- Agents logged in
- Voice logger active
- Calls answered within 20 seconds ring pick up
- Calls abandoned
- Calls in progress
- Status at a glance patient tracking (active caseload)

Demand & Activity Measures

- Referrals into community same day services by week over time
- Break down by category, ambulance, GP, Care Home, Nursing Home & other
- Number referrals accepted by all categories

Outcome Measures

- Number of ambulance dispatches saved by week
- Number or hospital conveyances saved by week
- Destination outcome for patients by category (which service did they go into)
- Number of ambulance patients attending ED majors with NEWS of 0 to 1 & 2 to 4

Balancing Measures

- Number of patients representing with the same problem nature within four weeks

Experience Measures

- Experience of using the service and overall rating
- Referring clinicians experience of using the service
- Unscheduled care coordination hub staff experience of working in the service
- Responding clinicians experience of working in the service
- Patients experience of receiving the service

Further Information

For further information about the unscheduled care coordination model, or to discuss a test of change, please contact paul.devlin@nhs.net