

NHS Kent and Medway - update report to Kent HOSC on their recommendations in the review of A&E attendance in March 2012: 'Not the default option'

Work to develop the urgent care system in Kent and Medway is led by the CCGs through the Urgent Care boards (or equivalent) in each area. This update is therefore a summary of progress from their plans, for each of the recommendations:

1. The patient journey should be seamless, with no duplication of diagnostic tests, or better communication with patients of why tests are being carried out. We ask the commissioners and providers to report back to the Committee with details of what work is being undertaken to assess the scale of the problem and achieve this.

The majority of diagnostic tests are undertaken by the local acute provider and therefore it is highly unlikely for the same test to be repeated. The order system for tests will normally flag the recent requests and the results that the patient has had, to minimise duplication. Patients going via either A&E or the assessment unit will have their results available.

Diagnostics are considered as pathways are developed. For example, in Ashford a new community geriatrician role is being developed to provide specialist support for management of the pathway. This will include diagnostics at initial assessment within primary care.

2. Lack of awareness or confusion around the alternatives to accident and emergency mean turning to A&E is often the simplest and most rational choice, even where it is not the most appropriate one. Commissioners and providers should produce a joint communication plan to simplify the choice of GP out-of-hours services, minor injuries units, walk-in-centres and other alternatives and improve public understanding.

Integrated communications plans in each area have been developed. These have a level of consistency across Kent, but include locally appropriate messages and targeting of specific groups of people. They build on information gathered through the urgent care needs assessment as well as through local surveys (e.g. surveys carried out in Medway by the LINK and in Darent Valley Hospital by commissioners), regional questionnaires and focus groups.

This public engagement identified, for instance, that many people, particularly teenagers and young adults, and also the working population, are not aware of the range of services provided by pharmacies, out of hours GPs or even their own GP practice.

The communications plans aim to help these people find out what their options are. Some people have heard of the alternatives to A&E but do not think of them when they are worried - the campaign therefore aims to bring them to mind for this group.

The plans set out a framework for a wider and deeper level of communication than in previous years, to enable local people to find out about local services, through communications targeted at specific groups, wider communications, news releases, innovative use of social media and the creation of a web and smartphone app. We are grateful for the support offered by Kent County Council with this communication.

An example of the poster tailored to Ashford is attached. Ashford CCG is developing magnets and leaflets documenting which services patients can use as an alternative. The team has met with local groups such as children's centres to discuss service provision. In addition the magnets and posters were distributed within supermarkets, libraries, schools and other local public areas, as well as to GP practices and health service locations. The poster for Ashford has also been translated into Nepalese and Ashford CCG has also established a forum with volunteers and care homes.

Once NHS 111 is available in the area from March 2013, this will allow a 'phone before you go' message which will help patients to access the best service for their needs, and will be sensitive to actual opening hours and availability of the right skills for the condition. Marketing of the NHS 111 service will be linked to the national campaign as well as having a local flavour.

3. Following from the above recommendation, the Committee asks that commissioners and providers explore the appropriateness and viability of introducing standardised opening hours around a clearly understood set of services across all the minor injury units in Kent.

Each urgent care system is considering the future arrangements for the tapestry of urgent care services that are currently available. The HOSC has rightly identified that the current picture of minor injuries units, walk in centres, urgent care centres is confusing for patients. Other urgent services are also available – including the GP out of hours services (in Kent, the contract is due for review from April 2014) and urgent access community nursing (especially when the integrated teams and single points of access have been implemented).

A review of MIU/WIC services in the eastern and coastal Kent area (now the area covered by the East Kent Federation of CCGs and Swale CCG) is currently on-going. This review is currently in draft form and with MIU/WIC providers to comment. The review examines the disparate nature of MIU/WIC services including the different services offered and opening hours. Standardisation in these areas will be

considered as part of the review recommendations phase. The outcome of review will then inform the broader redesign of urgent care which includes the GP out of hours service.

In west Kent, the CCG is looking at the issues facing the whole of the urgent care system. The Emergency Care Intensive Support Team has recently visited and a plan to review the system is being developed.

In Dartford, Gravesham and Swanley, community services and out of hours services are both due to be reviewed. In Swale the review is underway and the CCG is working on some quick wins as well as the longer term strategy to ensure care delivered in the community is meeting the needs of our population in an integrated way.

In each area, the reviews are at an early stage and partners will be involved in the design.

The other route to tackling this complexity is by using NHS 111 to help patients access the most appropriate service. NHS 111 service will provide detailed information on the type of services required by patients and will not only support patients to reach the best service in the current arrangements but will also help to inform the future requirements.

4. We ask the commissioners to provide further information on the costs per case for those patients seen at a walk in centre or minor injuries unit compared to those seen at A&E departments.

The current pricing for MIU and walk in centres is complex and for most, is not separately priced on a cost per case basis. The review work in east Kent will help to identify the amount paid to each unit, but within a broader service contract. Where the national 'Payment by Results' pricing applies to Minor Injury Units, the national tariff of £54 applies, whatever investigations are provided. In the Emergency Departments, the tariff is also £54 if no investigations are carried out, but ranges from £81 to £235 dependant on the category of treatment and investigation.

5. The Committee congratulates the work done so far in developing Liaison Psychiatry services and asks that commissioners and providers work together to ensure the successes are consolidated and the service fully rolled out across the county.

Implementation of the psychiatric liaison services across Kent and Medway is underway with Kent and Medway NHS and Social Care Partnership Trust (KMPT) collaborating with both West Kent Acute trusts, Dartford and Gravesham NHS Trust and Maidstone and Tunbridge Wells NHS Trust, as part of the QIPP Programme. The aim is to integrate the delivery of mental and physical health services in the acute setting and improve performance.

Progress to date has included increasing the mental health staff establishment at each hospital.

- At Darent Valley Hospital the mental health clinical staff numbers have increased from 2.8 whole time equivalent (wte) band 6 mental health clinicians to 3.8 wte and the appointment of 0.5 wte consultant psychiatrist.
- At Maidstone and Tunbridge Wells Hospitals mental health clinical staff have increased from 4.8 wte band 6 mental health clinicians to 6.8 wte and the appointment of 1.0 wte consultant psychiatrist.

At Medway NHS Foundation Trust the dedicated Liaison Psychiatry Team has been operational since November 2011 and was nurse led with 4.6 wte mental health clinicians. At the beginning of September a 0.5wte Consultant Psychiatrist was appointed. A single point of access has been in place for almost one year as has a self-harm and Mental Health Act Pathway. The team is available 7 days a week from 9am to midnight and provides mental health assessment, advice and awareness training to the Emergency Department. Standards have been negotiated with the crisis team and psychiatric on call Doctors so that there is consistency across the 24 hour period including timely and safe transfer to the mental health unit when psychiatric admission is required. An average of 150 people each month (including both Medway and Swale populations) are assessed with the majority seen in the Emergency Department. Medway Foundation NHS Trust has noticed that an increased number of patients are being seen sooner in the Emergency Department with fewer admissions.

In addition new processes have been put in place including:

- a single point of access which is open 24 hours a day, 7 days a week which has been introduced at all hospitals,
- a new pathway covering self-harm,
- a new Mental Health Act pathway

A training programme has been prepared and delivery initiated to key acute trust staff.

The three NHS Trusts are currently collating data in order to monitor the impact of the additional resource and the impact on meeting the CQUIN targets. This includes looking at A&E response times, admission avoidance, reduced lengths of stay, increased awareness of nursing someone whose behaviour is impacting on their care and treatment (cognitive impairment, depression, psychosis), with informed care planning, effective risk management and reduced incidents.

6. The role of GPs in ensuring the goal of each person receiving the most appropriate treatment at the right time is achieved cannot be underestimated. We ask NHS Kent and Medway to provide assurances that all of the emerging Clinical Commissioning Groups are leading on the work to develop the urgent and emergency care pathway.

As described above, each Clinical Commissioning Group is working to redesign the model for urgent services, utilising the opportunity for NHS 111 to help guide the patient to the right service first time. Each area has an Urgent Care Board that is clinically led by the CCGs and is driving change.

Medway and Swale have a joint Whole System Urgent Care Programme Management Group that is committed to on-going implementation of system redesign through the delivery of actions in the Urgent Care Plan. The group membership includes representation from all key Providers across Medway and Swale. The main focus of the redesign is to ensure that many more patients are diverted away from the Emergency Department to a range of effective community treatment and prevention services that deliver the right care in the right place at the right time.

The whole systems group is led by GPs, and key projects on the delivery plan have GP leadership and engagement as appropriate. Similarly, an urgent care delivery group in Dartford, Gravesham and Swanley is in place and across the north area (Medway, Swale and DGS), a Transformation Board supports the integration and development of services across the whole area.

In west Kent, the Urgent Care Board is chaired by the Clinical Commissioner for urgent care and supported by clinicians and managers from all the main partners. There is an action plan to improve the capacity and work flow within Maidstone and Tunbridge Wells Hospitals, following the report from the Emergency Care Intensive Support team. It focuses on the flow through the hospitals; admissions management and length of stay and discharge management.

In east Kent, the four CCGs work together in a Federation, and have an Integrated Urgent Care Programme, supported by an operational delivery group. They recognise that in east Kent an effective integrated system will ultimately ensure that the local health economy works within a planned budget and to high standards of safety and quality. A successfully delivered integrated urgent care system will incorporate elements of acute care, community services, social care and out of hours provision. For example a neighbourhood care team that is actively striving to deliver the Long Term Conditions agenda but is not intimately aligned with the step down / step up / ambulatory care / hospital at home alternatives to acute admission will not deliver an integrated service.

Therefore the aim in east Kent is to integrate all of these services together, and take a huge step forward in developing and integrating the primary and secondary care interface.

As well as these structures to ensure commissioning is clinically led and co-ordinated, the key role of GPs is well recognised.

There are examples from across Kent and Medway including the Quality and Outcomes Framework for general practice which includes an element where GPs are asked to review A&E attendances and admissions for their population and consider what actions they can take locally. One example in Dartford, Gravesham and Swanley CCG involved a practice discussing urgent care services with their patient participation groups, gaining feedback on a number of issues and testing posters with patients to ensure the communications were appropriate.

All east Kent CCGs have signed up to the Professional Standards for urgent care. This has been about ensuring:

1. All practices will have a nominated GP Urgent Care lead and adopt a multidisciplinary approach to access that involves clinicians and reception staff.
2. For telephone appointment requests, practices should either offer an appointment (either phone, home or surgery) **or** ring patient back.
3. Practices should record all urgent care referrals, generated by the practice (e.g. 999, MIU, A&E), in the same way as elective referrals.
4. All patients requesting a home visit will be offered the next available visit **or** 'triage' slot by the reception team.

The intention of these "standards" is to begin the process of applying the "Best Practice" findings from the Primary Care Foundation report - "Urgent Care: A practical guide to transforming same-day care in general practice". This allowed practices to identify current performance against the PCF standards for urgent care, and more importantly the areas requiring improvement to allow future demand to be met. All practices have completed an action plan which outline the steps required to improve same day access to primary care services, and the practices overall response to patients who are high users of urgent care services.

They are currently working through how they can implement these standards and report back to the CCGs quarterly. They are also looking at providing a direct line for paramedics, and working with EKHUFT for better contact with consultants.

The second element of the scheme focuses on the validation of A&E attendance data. Practices have been asked to implement a system whereby A&E data is clinically validated, with further agreed steps then taken to manage patients who had a primary care need in the practice. All practices have implemented systems for monitoring patient use of A&E on at least a monthly basis, with action plans in place outlining the steps taken by the practice e.g. providing communication material for alternative services, calling patients into the practice for a clinical review, arranging appointment with other professionals best suited to meet patient needs.

Ashford CCG has also implemented a project to determine the impact of using a GP within the A/E department so that for patients who present themselves they are seen by a GP in the first instance.

A Medway GP project is raising further awareness of differences in A & E attendance ratios and working practices across GP practices. Sharing information and best practice is enabling and supporting practices to review their own patterns of A & E attendances and develop action plans to make improvements. This project has helped to identify that there are still a high numbers of patients that frequently attend A & E. Further work is planned as part of this project to review reasons for this and then address them.

All CCGs are working with GP practices to improve the identification of patients at risk of hospitalisation through the strategy for Long Term Conditions (LTC). A validated decision support tool identifies those who have had frequent admissions and other factors to enable GPs to predict patients at risk of admission and then provide more co-ordinated care to support them. The work on the strategy includes arrangements for sharing information, integrated health and social care teams and support for self-care and self-management.

Having the right information about a patient when they need urgent care is a crucial element, to enabling management of patients without requiring A&E. GP practices are working on this through a number of routes. Part of the LTC programme involves better arrangements for sharing information with patients consent, and Swale are piloting a system called 'Patients Know Best' which facilitates the sharing of information. GPs are already well advance in some parts of Kent in populating the Summary Care Record which contains information on allergies and medication. The 'Special Patient Notes' arrangements that are already in place from GPs with Out of Hours providers are being considered to ensure that appropriate clinical information can be available to clinicians within the NHS 111 service. The ambulance service are developing their 'IBIS' system to allow special notes to be flagged to the 999 service and help identify if for example, a patient has requested they follow a particular care plan.

7. The rollout of 111 is a great opportunity accompanied by great risks. There is only one chance to introduce it properly. The Committee requests that the commissioners of the service and relevant providers involve the HOSC and other key stakeholders early on in the development of the communication and implementation strategies.

The NHS 111 service will be provided by South East Coast Ambulance Service NHS Foundation Trust, in partnership with Harmoni (now Care UK). They were selected following a competitive procurement process which included evaluation by a wide selection of stakeholders.

The NHS 111 service will provide a service which helps to manage patients urgent care needs with advice, but also helps to navigate them through the urgent care pathway. It is supported by a Directory of Services (DoS) which is locally owned and populated by the CCGs with the services available for their population. The clinical

assessment tool that the NHS 111 service uses links directly to this DoS and is sensitive to the skills patients are identified as needing and the timescale for the response so that patients will only be referred to services which can meet their needs. Over time, the service will be able to book appointments directly into some services.

Now that mobilisation is underway, each cluster is establishing local governance arrangements involving stakeholders to ensure the service is developed in conjunction with the other partners in urgent care, including the voluntary sector.

The NHS 111 service will also provide valuable management information about the services required but unavailable, or potentially where services are available but little used, or are duplicated. This will support the redesign work referred to in section 5.

KCC colleagues are working with the commissioners in this development, and the Directory of Service will include details on social care as well as the newly forming health and social care integrated teams. The marketing and communication plan for NHS 111 is linked to the nationally planned campaign. The plan is being developed with stakeholders.

8. The creation of the Health and Wellbeing Board and transfer of substantial public health responsibilities to local government provides a golden opportunity to develop integrated preventive health plans and we ask the Health and Wellbeing to prioritise work which will reduce the number of people entering the urgent and emergency care pathway in the first place.

Many of the areas in the draft strategy presented to HOSC in October will support this. In particular, the section in outcome three has a particular focus:

We want people with long term conditions to experience well-co-ordinated services which prevent them from being admitted to hospital unnecessarily or experiencing a crisis.

*If we do this in Kent the following will happen; more patients and their carers will be supported to manage their own care in order to reduce unplanned admissions to hospital and improve health outcomes; improve access to patient information; reduce number of times patients have to repeat information to professionals (Tell us Once); **see a 15% reduction in A&E admissions**; a 20% reduction in emergency admissions and a 14% reduction in elective admissions. More importantly this will lead to a 45% reduction in the rates of people dying earlier than expected.*

There are a number of local initiatives designed to develop more proactive models of care which will impact on A&E attendance and unplanned admissions. For example, Swale's Health Inequalities project is designed to address health inequalities in

relation to cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD). This is being undertaken through direct action in primary care to reduce variation in care and treatment and identify people with currently undiagnosed need. In addition, a public facing campaign raises awareness of these diseases with a view to disease avoidance and/or improved management.

9. The HOSC requests that NHS Kent and Medway produce a written report for the Committee by the end of the year detailing what success has been achieved in reducing attendance at A&E and what plans have been agreed with the NHS provider trusts in order to further meet the challenge.

As described above, each urgent care board has agreed plans with their providers to meet the challenge. These are locally led and owned, and examples of some of the initiatives include:

- Integrated teams between health and social care, with single points of access are due to be in place in Dartford, Gravesham and Swanley in November 2012. West Kent CCG has a similar approach with social care with the benefits expected early in 2013.
- A clinical audit was completed this month to identify whether patients conveyed to A&E at Medway NHS Foundation Trust by South East Coast Ambulance Foundation Trust (SECAMB) in response to a 999 call could have been managed by using an alternative pathway. Where alternatives to A&E may have been possible, the audit will identify areas for development to enable these alternatives to be used if available or considered for commissioning if not.
- In Maidstone, Swale and Dartford, Gravesham and Swanley, significant work with care homes is being undertaken to support clinical management in the home, to minimise unnecessary transfer to hospital.
- In Maidstone and Tunbridge Wells, urgent appointments are now available for GPs to refer elderly patients for consultant assessment, to avoid the need to go via A&E.
- Darent Valley Hospital has implemented a geriatrician led assessment unit which, in addition to providing specialist urgent care for older people attending the hospital, will provide telephone support for healthcare professionals. Enabling the provision of specialist advice and guidance to ensure patients are treated in their home if clinically appropriate to do so.
- In Maidstone and Tunbridge Wells, GPs are working in A&E to reduce short stay admissions and support management of non-registered patients.
- A clinical audit of GP out of hours referrals to A&E has been undertaken in west Kent, to help inform improved management.

- A GP to work in SECAmb emergency operations centre has been agreed to support the use of alternative pathways across Kent and Medway and to identify where healthcare professional referrals could be managed differently.
- Work has been undertaken to strengthen further the Medway on Call Care (MedOCC) and South East Coast Ambulance (SECAmb) alternative treatment pathway to enable more patients, with specific conditions, to be treated by either MedOCC or SECAmb ambulance crews. This diverts more patients away from A & E. During November 2012 SECAmb crews are also attending training sessions with MedOCC to improve awareness and knowledge of the pathway which will be a key action to increasing referrals.
- Opening hours at the MedOCC@ Medway base have been extended this year to enable more patients with primary care treatable conditions arriving at A&E to be treated by MedOCC. The plan is for an additional 2500 Medway and Swale patients to be seen by MedOCC rather than A & E, and results to date show that projected numbers are approximately 2700.
- Disease specific pathways have been developed in most areas to improve care for patients with diabetes, heart failure, those at risk of falls, DVT, cellulitis and respiratory disease.
- Swale CCG as part of its intermediate care review is working towards putting in place community geriatrician service to support the work with care homes, to support the Multi-Disciplinary Teams (MDTs) in primary care in relation to our risk stratified patients with highest need, to support advice and guidance to GPs.
- Ashford CCG are implementing care systems for patients with long term care needs to ensure that they are supported to manage at home through education and development of support systems. They will be working with volunteers to establish care networks. Community matron hours have been extended to include on call so that they can assist both care homes and the out of hours teams to manage patients within their homes.
- South Kent Coast CCG has developed a Rural Minor Injury Service. They identified that poor transport links exist between certain areas and the nearest out of hours (OOH) base, minor injury service (MIU) or A&E, with patients travelling 30 minutes to an hour using public transport. There are also significant seasonal changes in populations which has had an impact on local services providing general medical services. The service commenced in August 2012, operating 8am-8pm, 7 days a week. There has been enormous local support for this pilot service and the service has been well used to date. The CCG will begin evaluating the pilot early 2013; the outcome will inform their commissioning intentions for 2013/14.

Current Accident and Emergency Department activity

Each urgent care board monitors activity at A&E, ambulance incidents and in emergency admissions. Further work is underway to enable routine monitoring of Minor Injury Unit and Walk in Centre data. Out of hours data has recently been significantly improved and will start to provide information about the outcome for patients. The minimum dataset for NHS 111 provides patient level data that will enable clinical audit across the patient journey, and reporting is being developed as part of the service mobilisation.

Activity so far this year shows a continued increase in A&E attendances, although the numbers of ambulance incidents shows a greater increase than the numbers taken to hospital or seen in A&E, suggesting that alternatives are beginning to be used.

A&E Attendances-2012-2013 April- August:

Kent and Medway commissioner activity

<u>April - August</u>	% change on 11-12
RN7-Dartford & Gravesham NHS Trust	3%
RPA-Medway Hospitals	1%
RVV-East Kent University Hospitals Trust	0%
RWF-Maidstone & Tunbridge Wells Hospital	2%

Ambulance activity, to Sept 2012

<u>PCT</u>	% increase on 11/12 total	% increase on 11/12 conveyed
West Kent	6%	2%
Medway	5%	0%
Eastern & Coastal Kent	6%	1%
Total	6%	1%

Provisional data published nationally by Hospital Episode Statistics Online for April to July 2012 show a 5% increase compared to the same period last year. The increases in Kent and Medway are therefore lower in comparison.

Summary

There has been progress on many areas to support appropriate A&E attendance; however this will continue to be a priority. CCG plans are being developed for 2013/14 and longer term strategies for urgent care are also being worked up in each area. Urgent care and management of long term conditions continues to be a very high priority on all their agendas.

Example of poster developed as part of the integrated communications plan for use in the Ashford area:

URGENT HELP WHEN YOU NEED IT

Call your GP surgery first
or the out-of-hours GP on
03000 24 24 24

Late night and Sunday pharmacies

- Asda (Kimberley Way) **01233 655000**
- Boots (Barrey Road) **01233 503670**
- Sainsbury's (Simone Weil Avenue) **01233 662819**
- Tesco (Kingsnorth) **01233 207349**

Minor injuries (*small wounds, burns or sprains*)

- Charing (8am to 5.30pm) **01233 714490**
- Hamstreet (8am to 6pm) **08444 773989**
- Ivy Court (8am to 6pm) **01580 763666**
- Kingsnorth (8am to 6pm) **01233 610140**
- Woodchurch (8am to 6pm) **01233 860236**
- Wye (8.30am to 6pm) **08443 878419**

Dental emergency?

Contact your dentist. No dentist? **0808 238 9797**
Evenings and weekends DentaLine **01634 890300**

Confidential emotional support

Mental Health Matters helpline **0800 107 0160**

Walk-in service available to everyone – even if you're registered with another GP

Find all your local services at www.nhs.uk or call **0845 46 47**