Emergency Care Intensive Support Team Review

Urgent and emergency care in South West Hampshire

Context

The emergency care intensive support team (ECIST) is a national team set up to provide support to health and social care communities in reviewing their system for urgent and emergency care.

This team was invited to review the patient journey through urgent and emergency care services in South West Hampshire in September 2012. This followed the team's review of hospital based arrangements within University Hospitals Southampton NHS Foundation Trust (UHS) in July 2012.

Representatives from SHIP and all key providers including acute, community health and social care and ambulance were involved in providing information and views to the team. The ECIST also visited several community sites.

The draft recommendations were shared in advance of the final review and so SHIP and providers have already begun to deliver these.

Delivery plans are being updated to include the recommendations as a priority and the health and social care community has welcomed the opportunity to review the system and to develop a collaborative approach to delivering further improvements.

Overall conclusions

i) The South West Hampshire health and social care community faces significant service pressures within its emergency care pathway, with potential impact on patient care. The health community recognises the need to refresh some elements of partnership working locally.

ii) A stronger focus on hospital discharge and timeliness of post-acute transfer is needed as a short term priority. This is required in addition to ongoing work to reduce avoidable

admissions, from closer working across community, primary care and ambulance services. A large number of patients are staying too long in acute and community hospital beds, which may compromise their physical health as a result.

iii) There is a need to develop a 'pull' rather than a 'push' system of discharge, with community services able to identify early and support discharge for their residents. This needs to be supported by timely discharge planning and information sharing initiated early during acute care.

iv) Within community services there has been a strong focus on integrated care to avoid hospital admissions, but this risks being at the expense of early facilitated discharge. A greater focus here would help address some of the severest pressures in the system. There is also scope for more systematic clinical processes in community hospital beds to both reduce length of stay and improve the flow of patients.

v) Work on redesigning patient pathways and joint work between acute and community/primary care services is needed to build on successes to date. This requires further clinical engagement and leadership and a greater pace of change.

vi) Whole-system capacity planning and a formal system-wide escalation planning have an important role locally, yet both require further work as a key priority to mitigate current service pressures.

Recommendations

The recommendations were presented under the headings outlined below:

Governance - i.e. how the system is held to account and how each organisation within the health and social care community delivers what is needed to provide efficient and effective care.

The arrangements for overseeing and planning urgent and emergency care were clear and the team encouraged further involvement of clinicians in development of these.

Commissioning - the team suggested further engagement of clinicians in developing the vision for urgent and emergency care and in wrk on pathways of care across organisations.

Information – to develop a new way of presenting a range of indicators, such as:

- numbers of people admitted to hospital
- numbers of ambulances called and;
- four hour wait times.

These will provide on-going monitoring of services including a daily set of indicators developed especially for GPs.

Primary care (care in GP surgeries) – the team recognised that work was underway to make sure that urgent primary care is organised as well as possible. They recommended that this should include, as a priority, the provision of timely and appropriate home visits or care in a medical day unit to prevent unnecessary emergency admission to hospital where appropriate.

Community services –

In visiting across two NHS provider services, the team were interested in several themes: the respective focus on admission avoidance activity as against facilitating discharge, the responsiveness of community teams, and processes within inpatient facilities.

The team were clear that this required a continuation of the work underway, but also recommended further and increased work on:

- Considering how community services could make more defined offer to acute services, by introducing a guaranteed minimum number of daily supported discharges for acute trust inpatients

- Idnetifying how to increase community team “pull” of inpatients out from community hospitals to virtual wards, or to be supported at home.

- Working with local GPs to both increase the uptake and range of ambulatory care provision at Lymington, and promote professional development links with UHS services.

- Develop more standardised clinical processes, such as Expected Dates of Discharge and clinical criteria for discharge, to improve care co-ordination and decision-making on discharge across community hospital beds.

District General Hospital (Acute) services –
Priorities from the team's July cover the following key areas:

- Pathways and senior decision-making processes in ED within the first two hours, including any capacity constraints that inhibit senior decision-making.

- Inpatient ward processes to improve co-ordination and decision-making, including opportunities to strengthen the impact of a divisional project on reducing internal waits.

- Bed management and patient flow including the functioning of the Operations Centre, and interactions and system escalation plans with other partners.

Capacity management & escalation

The team saw evidence of good whole system working on system resilience, and positive progress over the last 12 months. The team were clear that this required a continuation of the work underway, but also recommended further and increased work on:

- Developing the remit of the System Resilience Group to take on whole system capacity planning, with a role to share information and inform Unscheduled Care Board, and health and social care commissioners on capacity constraints, via an initial short term baseline assessment.

- As a short term priority, developing a system-wide escalation plan, with clearly defined triggers for escalation and named executive leads from each organisation.

Discharge Planning: acute and post-acute beds

The report highlights that bottlenecks at the 'back-end' of the acute pathway are delaying discharge for a large group of inpatients at UHS, and some patients in community hospitals. The team felt these are one of the main problems for the SW Hampshire system. The whole system needs to be actively concerned about the full range of delays to discharge (matching a focus on internal delays within individual organisations).

Recommendations include:

- Establish a short-life group to look at an agreed list of issues of mutual benefit, aiming to reduce 'medically fit' list to a defined threshold over a short period.

- Commit to a short-life project to strengthen 'pull' arrangements for discharge by building stronger relationships and systems for sharing information between acute and community nursing staff.

- Undertake regular, whole-morning multi-agency bed surveys looking at the reasons behind patient delays for stays over 7 days. These would be undertaken by senior nurse and therapy practitioners from community and acute settings, plus social workers.

Onward process and progress

The recommendations made as a result of the review have been accepted by the Unscheduled Care Board, which comprises Executives and senior clinicians from each organisation.

They are being adopted as a priority within the work plan for the whole health and social care community as well as individual Trust delivery programmes.

The details will be agreed by those clinicians and managers involved in the planning for emergency care.