A GUIDE TO GOOD PRACTICE

Unscheduled and Emergency Care Services

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The National Leadership and Innovation Agency for Healthcare (NLIAH) established a team to review unscheduled care services across local health and social care communities with a view to:

• identifying duplication and gaps in service to improve current services
• improving current patient experience
• ensuring patients are treated in the right place by the most appropriate staff
• helping define the future of unscheduled care services for patients and their carers
• helping determine the service model for unscheduled care services
• developing a plan for the implementation of planned changes

Reviews of unscheduled care services have now been completed in three care communities and some common themes have emerged indicating areas for improvement. The knowledge gained from the reviews in Wales has been used to produce this guidance but the lessons are universally applicable across the UK.

1. Background

The Delivering Emergency Care Service (DECS) document published in February 2008 is designed to provide a framework within which the most appropriate care is made available, at the right time for patients to ease the pressure on vital parts of the unscheduled care system and to modernise the delivery of unscheduled care services.

The key elements of the strategy include:

• pioneering new Urgent Care Centres to provide care for patients who currently access A&E with non-life-threatening conditions. Urgent Care Centres developed as part of hospitals will mean, by definition, a whole systems change approach for the hospitals where they are established;
• using new technology to link rural and remote Minor Injury Units with major A&E departments, to provide better; safer clinical decision-making and to provide on-line clinical advice;
• more care and support provided closer to people’s homes where it is appropriate - including further roll-out of schemes to allow people to self-manage long-term conditions and more provision of telemedicine;
• staff working differently to ensure that patients are seen by the most appropriate available health professional at the right time - such as patients being seen by a more senior clinician upon arrival rather than more junior staff, to ensure they get the most appropriate treatment;
• better sharing of information to allow more seamless transition of care - sharing data electronically across unscheduled care providers to tackle patients’ concerns about having to repeat information to different providers, including the use of the IHR;
• to deliver effective change, services will have to work with a clearly defined clinical model, operating on a seven day per week basis, which is signed up to by all stakeholders in a coordinated way; and
• the reduction of unnecessary admissions by accelerating the process of diagnosis and supporting people with health and/or social care problems more effectively in the community.

2. Delivering Emergency Care Services
3. Definition of Unscheduled Care

Unscheduled care can be defined as; health and/or social care which cannot reasonably be foreseen or planned in advance of contact with the relevant professional. It follows that such demand can occur any time and that services to meet this demand must be available 24 hours a day seven days a week.

Unscheduled care, by definition, is urgent with the need to take action at the time of contact with services. Unscheduled care does NOT imply the delivery of routine or non-urgent services on an as required and uncontrolled basis 24 hours a day.

4. Levels of Care

Unscheduled care services are organised through the five levels of need, detailed below. These levels of need follow the same triangular framework as that identified within other strategies and initiatives, including the “Management of Chronic Conditions” and “Fulfilled Lives, Supportive Communities”; effective collaborative working is therefore an essential prerequisite for improving the quality of patient care.

Local Care Groups will deliver care up to Level 4 and access to Level 5 should be through agreed networks.

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1 Delivering Emergency Care Services: An Integrated Approach for Delivering Unscheduled Care in Wales February 2008
5. Drivers for Change

There is evidence across the whole of the health care community of increasing demand on hospital, community and primary care services. The Public have increased expectations of easy access and better care. The Welsh Assembly Government has responded to this with the production of the DECS strategy which sets out a vision for unscheduled care services in Wales. The vision will be achieved through a variety of enablers, which ensure that unscheduled care becomes better planned and understood by the people of Wales.

A sustained patient involvement and education programme is required to ensure services are developed to meet local community needs and inform people which services to use depending on their circumstances.

Change is required to meet the urgent care needs of patients with significant illness or injury, which arise regardless of the day of the week. Emergency and urgent care demand is remarkably predictable during the course of a week. However, the majority of current services for diagnosing, treating, managing and transporting patients are concentrated within the traditional Monday to Friday 9am - 5pm period.

High cost services such as these, need to be spread throughout the seven day demand period to make them more effective. Consequently, staff in the NHS will need to change their work patterns to work seven days per week, potentially for longer hours, as a result of changes in working hours. NHS staff will have to adopt a team approach to care delivery using whole system care pathways.

Utilisation of capital resources will be increased as a result of changes in working hours. NHS staff will have to adopt a team approach to care delivery using whole system care pathways.

As populations age, demand on the NHS will rise as patients have increasingly complex multi-system health and social care problems.

Each critical event that a patient survives results in further presentation to the health service. Care systems therefore need to agree the management for end of life care and to focus more services for end of life management in the community, avoiding clinically inappropriate care delivery and expenditure when the outcome is inevitable. Codiﬁcaton should not be used for long term care nor end of life management. If the NHS is to modernise effectively and improve resource utilisation, care planning for end of life unscheduled care will need to be put in place, to ensure that it is delivered in an appropriate environment.

There are a range of factors causing a consistent increase in the demand on services:

- an increase in the number of patients attending major A&E units which may be due in part to people attending with minor ailments;
- increasing levels of inappropriate emergency or unnecessary admissions;
- increasing demand for emergency ambulances, with a significant number of patients who arrive in ambulances being discharged within a few hours of arrival, suggesting that there may be some inappropriate use of the 999 emergency services;
- increasing rise in demand for GP OOH services, often to deliver routine care in the period when surgeries are closed, frequently due to poor planning by patients (such as failing to plan repeat prescription requests or present early). Access to routine services may be inconvenient, therefore encouraging people to use OOH services by default; and
- risk aversion and fear of being sued may be driving an increased referral rate, as practitioners and Nursing Homes refer patients to hospital rather than make end of life decisions.

2 Delivering Emergency Care Services An Integrated Approach for Delivering Unscheduled Care in Wales February 2008

6. Key Principles

To deliver more effective healthcare the following principles should be adhered to:

1. Treat the sickest patients first, no matter how they enter the system.
2. Deliver care within an agreed clinical model using evidence based care, through ‘whole system care pathways’.
4. Avoid passing the baton of care more than necessary.
5. Maximise the use of available resources, staff, materials, equipment and buildings
6. Manage patients at home in the community wherever possible with full engagement of Local Authority services and community teams.
7. Integrate and coordinate service delivery through the use of Care Coordination systems to effectively manage and govern the delivery of unscheduled care on a 7 day a week basis.

7. Implementation

Change can only be delivered if each care community has an unscheduled care improvement plan and Implementation Team in place, with a mandate to deliver change to an agreed time scale. Short, medium and long term objectives must be clearly defined to deliver the agreed model of care for a community. The Model should be based on a ‘Local Care Group’ approach where all stakeholders collectively agree the objectives and jointly share resources to achieve them.

Measures of success can be defined by whether the changes improve clinical care delivery in terms of minimising time to diagnosis, treatment and problem resolution, as well as the current performance measures.

Clarity is needed in defining what elements of care each of the services is tasked to provide. The word ‘urgent care’ excludes the delivery of routine care even though this may occur in the out of hours period. Planned care is the opposite of unscheduled care and includes elective investigations, surgical procedures and out patient activity. Many GP appointments within surgery hours are for unscheduled or urgent cases so GPs are both providers of unscheduled and planned care.

2 Delivering Emergency Care Services An Integrated Approach for Delivering Unscheduled Care in Wales February 2008
8. Suggestions/Recommendations

A. Unscheduled Care Model

**RATIONALE**

Services should be integrated and work in a convergent and consistent way with partners sharing resources and common objectives. Services should be organised to meet the seven day demand with a seven day response.

While there are pockets of good practice in Wales, services at the present time are generally disjointed. Services are delivered by disparate providers with separate budgets, diverse organisational and ‘tribal’ cultures and behaviours. Performance measures often conflict and create perverse incentives.

**RECOMMENDATION**

Establish a Community wide Unscheduled Care Development Team/Local Care Group with responsibility for the delivery of an Unscheduled Care Service Model, which draws upon current best practice and which ensures joint working with neighbouring hospitals, LHBs, Specialist Care Networks and Local Authorities. Appoint a chair with the skills and drive to support the changes.

This will require changes in the way services are delivered.

Only services which are part of the agreed clinical model should be provided; there should be disinvestment in ineffective services.

This will result in launching systems to synergise change; accepting that all changes are evolutionary and that change in any part of a complex system will impact on other parts of the system.

**OUTCOME MEASURE**

Appropriate, safe and effective care delivered on the basis of need, in minimum time, within budget.

B. 24 hour, seven day a week services

**RATIONALE**

Demand for emergency and unscheduled care is spread throughout the seven day week, is consistent and predictable.

Hospital systems are focussed around the needs of patient care rather than staff. Patients need to be actively managed throughout their admission, diagnosis must not be delayed and treatment should be started without delay. Therefore the process of diagnosis must be 7/7 activity supported by staff and resources.

To be able to manage necessary admissions patients must be discharged at the same rate. Seven day discharge policies require staff and the resources in place to care for and support patients at home after discharge.

Ambulance and transport services will need to be in place to return patients home throughout the week.

**RECOMMENDATION**

The current practice of inactivity for patients at weekends is not sustainable if all resources are to be fully utilised therefore services need to move to seven day working and abolishing the “In Hours” – “Out of Hours” culture.

In addition all areas need wide ranging comprehensive community based services, to provide adequate safe care for patients within their own homes. Intensive support teams should be in place to prevent avoidable admissions and to expedite discharge to home.

**OUTCOME MEASURE**

Reduction in length of stay (LoS), greater throughput, more patients cared for within their own homes and improved patient satisfaction.
8. Suggestions/Recommendations (continued)

C. Community based services

**RATIONALE**
With greater pressure on in-patient beds, patients need to be cared for closer to home and in the most appropriate setting; service redesign is needed to achieve this.

**RECOMMENDATION**
To deliver more care and support closer to people’s homes, where it is appropriate, the resources and skills need to be based within the community. These services need to focus on chronic conditions, admission avoidance (a rapid response team) and facilitated discharge. Social services, Local Authority and Voluntary agencies must be fully integrated into unscheduled care delivery.

**OUTCOME MEASURE**
Fewer inappropriate admissions, reduced attendances and more people cared for within their homes.

8. Suggestions/Recommendations (continued)

D. Public and staff engagement

**RATIONALE**
The engagement of users, both patients and clinicians will allow ‘ownership’ of the new services and ‘responsibility’ for the outcomes achieved. Participants will understand the resources available to them and understand the need to maximise the use of resources to achieve maximum benefit. Capital resources are only part of the cost of a service, the utilisation of the revenue available is a key factor in achieving a cost effective service.

**RECOMMENDATION**
The staff, patients and carers in the community need to be engaged and consulted for their views on the development of a new system, aimed at improved emergency and unscheduled care and to manage more patients at home. Clinical staff need to play a key part in the designing of the clinical model, buildings and pathways of care.

**OUTCOME MEASURE**
Efficient services able to operate in conjunction with all other services and clearly managed by both clinicians and managers alike. Improved resource utilisation, greater throughput and decreased cost per case.

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8. Suggestions/Recommendations (continued)

E. Community Hospitals

RATIONALE
The Community Hospital beds are often used for long stay patients as the medical focus is reduced. To ensure patient care close to home and, in settings where minimal medical intervention is needed, admitting rights should be open to hospital doctors and local GPs, both of whom should be responsible for inpatient care. Prompt assessment on arrival, as per an acute unit, and agreement of care plans focusing on progression to discharge will enable patients to return home as quickly as possible.

RECOMMENDATION
Review all inpatient community hospital beds, their use, supporting therapies and medical cover. Need to consider a ‘Merged Matrix’ concept where patients are seen as belonging to a Local Care Group, wherever they are in the system, sharing the care and support instead of the current ‘silo’ model.

OUTCOME MEASURE
Increased bed days but reduced length of stay (LoS) in community hospital beds. More patients cared for closer to their homes.

8. Suggestions/Recommendations (continued)

F. Directory of services

RATIONALE
A directory of services, when they are available and how to access them, is essential for the delivery of integrated services. Often staff seem unaware of services outside their immediate working area therefore limiting referral options and ultimately best patient care. Information on how to access Social Services, voluntary agencies and other Local Authority services is not easily accessible nor integrated with health services.

RECOMMENDATION
A directory of services, their role and access criteria should be available for staff/departments. The development of a Single Point of Access for Health Professionals could act as a reference point both for information of services and as a central control point for admissions/community care package creation. Care Coordination systems are essential for the delivery of integrated comprehensive care packages.

OUTCOME MEASURE
Swift access to appropriate services resulting in reduction in admissions and improved care delivery, more patients managed in the community and a decrease in hospital costs.
8. Suggestions/Recommendations (continued)

G. Clinical referral documentation

Rationale
To improve patient care and safety, all participants in a care system should have a common records platform including access to previous history and investigations as outlined in the IHR (IHC-Welsh Clinical Portal).

At present discharge letters can be indecipherable and GP referral letters offer neither history nor reason for referral.

Recommendation
Use Common Transaction documents (CTDs) for all care handovers between system providers. Ensure that they are comprehensive, legible and sent with the patient.

Utilise the Individual Health Record (IHR) as part of all transactions in unscheduled care.

The Welsh Ambulance Service Trust (WAST) should leave a patient report form with every patient not conveyed to hospital, to be passed to the general practitioner at the earliest opportunity or send the report directly to GP practices.

Outcome measure
Improved communication, greater patient safety and improved quality of care.

8. Suggestions/Recommendations (continued)

H. Ambulance services

Rationale
Patients should be attended on the basis of need and diagnosis. They should be treated in minimum time appropriate to their condition, focussing on minimum time to definitive care, not the arrival of the first ambulance resource on scene.

The WAST operates on AMPDS, a system which generates a response. It does not reliably differentiate out non-urgent cases.

WAST targets are time based, not clinically based and are not based on minimum time to definitive care.

GP urgent cases have less of a priority than ‘minor’ emergencies.

GP urgent cases are frequently delayed and remain at risk, they arrive late at the hospital and often in batches.

Recommendation
The ambulance service should, on the basis of a clinical assessment, refer patients directly to specialist units e.g. coronary care unit, an adult CDU or Paediatric CDU, thus bypassing A&E.

Ensure that patients who are deemed to require admission are actually seen by their GP ‘face to face’ prior to admission and are then given appropriate priority in ambulance allocation/response. (This is not applicable to emergency admissions)

Outcome measure
Clinical targets of minimum time to definitive care will drive improved WAST care and improve patient outcome.

GP urgent cases will arrive at hospital much earlier in the day improving time to senior doctor contact.
8. Suggestions/Recommendations (continued)

I. Primary Care services

**RATIONALE**

Many patients appear to bypass their GP surgery and opt for the open access of A&E units. Comprehensive primary care services as first point of call for patients are able to deliver a wide range of services including prevention of illness, diagnostics, investigations, minor illness/injury care, chronic condition maintenance and act as a gate-keeper to acute services.

The GP practice is the only place with comprehensive patient record – all other services inform GP practices of patient interventions and outcomes.

**RECOMMENDATION**

Ensure that there are Enhanced Services contracts in primary care to deliver services aimed at admission avoidance and A&E attendance reduction. LHBs should commission minor injury services in general practice, where appropriate.

GP practices should be open for the whole of their core hours i.e. all day every weekday to allow easy access for appointments etc. Unscheduled care must be delivered without delay during core hours and patients requiring urgent care should not default to A&E or other services within or outside normal surgery hours.

Improved access to, and a wider range of, diagnostics would allow more patients to be managed in the community. OOH services should be able to access recent results in order to ensure that there is continuity in patient care and not a hiatus when practices are closed.

GP OOH services could be co-located in Urgent Care Centres.

Dental, pharmaceutical and ophthalmic services play a major role in overall health care and need to be included in plans.

**OUTCOME MEASURE**

Patients access their GP practice as a first point of contact and see this as the source of advice, investigation and treatment or referral thereby reducing unnecessary A&E attendances.

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9. Model of Care

Agreement needs to be achieved between the Welsh Ambulance Service, NHS Direct Wales, and General Practitioner “in” and “out of hours” services, the hospital emergency services and the LHBs on a common unified clinical prioritisation pathway to ensure that the sickest patients are treated first with the objective of delivering definitive care, if available, in minimum time. Consideration should be given to the best available model and adapting it to the provision of care for each care community. Unified clinical prioritisation clearly identifies who is responsible for delivering care and in what circumstances.

This schematic diagram identifies the key elements required to commission a model delivering care for the Critically Ill and Injured together with Unscheduled Care and a service to deliver Elective and Scheduled Care. Key partnerships are identified with WAST/NHSDW and Primary Care. The emphasis needs to be on ‘diagnose and decide’, ‘decide to admit’, ‘right first time’, ‘minimum time to definitive treatment’. This has to be done by senior clinical decision makers as soon as practicable, for the purposes of rapid diagnosis and early initiation of treatment and the removal of potential for referral from junior to junior, often also from place to place within the hospital.

Full engagement and participation of Social Care, Local Authorities and voluntary agencies is essential for the successful delivery of unscheduled care.

Providing effective unscheduled care will require a whole systems change by all participants, changing the service for unscheduled care means changing the way NHS and Social Care staff work and the way systems are organised.

The 1948 model of the NHS is now outdated and ineffective and no longer meets the demands, needs and expectations of users in a changing world with an ageing and changing population. Delivering change will require a stepwise approach to an agreed end point with clearly defined ‘waypoints’ to deliver a new model of care fit for the people of the 21st Century in Wales, delivered safely, effectively and within budget.

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Examples of Urgent Care Centre Models

Attendances to Acute Trust Emergency Departments have been steadily increasing as members of the public bypass the GP gate-keeping system. At present, patients have open access to Emergency Departments. In future, Urgent Care services should provide a triage service at every physical point of access for Emergency and Urgent Care. Patients should not directly access acute emergency departments without initial triage and correct signposting.

Two key benefits of the UCC system will be:

- Early triage: patients are signposted to most appropriate service quickly.
- Single triage: one universally agreed triage process so that patients are triaged once and then treated, not triaged in each part of the service as they move around.
The UCC Model would be replicated in both the 24 hours and day Unscheduled Care Centres and is indicated in the blue flow chart, the main difference being with the 24/7 UCC is the collocation with ED.

### 10. Case Studies

#### SCENARIO 1

**Common Scenario**

Dorothy Long aged 85 lives in her own home with no family support. She has a fall, and the attending ambulance crew decide that although there is no sign of injury, to take her to the local Emergency Department.

The Emergency Department diagnose that Dorothy has a sprained ankle but with support could be discharged back home. On investigation, it becomes apparent that there are no community services available to support Dorothy’s return to her own home.

Dorothy is moved to a MAU whilst attempts are made to get her home. However she is finally admitted to a general medical ward while she recovers.

During her stay on the ward, Dorothy contracts a chest infection, which affects her confidence in walking as she is coughing so often this makes her more unsteady on her feet, added to the problem caused by her tender ankle. Dorothy gradually become less mobile and has to stay in hospital for three weeks before she is medically fit. Her condition is such that her assessment determines, and Dorothy agrees, that she is not fit to return home; she spends a further 6 weeks in hospital until a vacancy arises in a suitable care home. Dorothy’s health does not improve enough for her ever to return to her own home.

**Ideal Scenario**

Dorothy Long, aged 85, lives in her own home with no family support. She has a fall, and the attending ambulance crew decide that, as there is no sign of injury, it would be best to try to keep her at home. The Ambulance crew discuss this with Dorothy and she is keen to stay at home.

The Ambulance crew contact Dorothy’s GP practice and they arrange for an acute response team to visit within the next 4 hours. The Ambulance crew check that she is happy to be left and, as requested, ask the neighbour to pop in.

The ART attend that day and after assessment, contact their local authority colleagues who set up home care/support and the community physiotherapy service. The physiotherapy services explain some ankle exercises and teach Dorothy to use a Zimmer frame for interim period.

Daily visits from the home care team, and a second physiotherapy visit the end of the week see Dorothy pretty much back to normal with her mobility and independence.
SCENARIO 2

Common Scenario
Tom is 56 years old and lives alone at home. He has mental health problems and is an alcoholic with reduced mobility, spending most of his day in his wheelchair watching television. He has refused most support offered to him, though the community psychiatric nurse visits occasionally; therefore he leads a pretty lonely life. He is well known to the Ambulance Service as he is prone to call them a couple of times a week.

Tom knows that he uses the right words/phrases it will initiate an emergency response and the Ambulance Service has to respond. He has been seriously ill in the past, resulting in conveyance to hospital and subsequent admission.

Tom calls the Ambulance Service and complains of a “tightening in his chest” and difficulty breathing. An emergency ambulance is dispatched but on arrival finds him well though unable to reach the television remote which has slipped off the table. He states that he “had a turn” but is ok now and while they are there could just pass him the remote.

The ambulance crew leave knowing that although this is the 50th time in 3 months that the ambulance service has responded and the 45th time they have left without any clinical intervention, Tom will call again.

Ideal Scenario
Tom is 56 years old and lives alone at home. He has mental health problems and is an alcoholic with reduced mobility, spending most of his day in his wheelchair watching television. He has refused most support offered to him, though the community psychiatric nurse visits occasionally; therefore he leads a pretty lonely life. He is well known to the Ambulance Service as he is prone to call them a couple of times a week.

Tom knows that he uses the right words/phrases it will initiate an emergency response and the Ambulance Service has to respond.

He has been seriously ill in the past which has resulted in conveyance to hospital and subsequent admission. Tom knows that if he calls the Ambulance Service they will question whether he really is ill or just seeking attention. The last 3 times he called the ambulance service attended him but notified his GP of their attendance and the GP subsequently asked the CPN to visit.

Tom decides to call his CFPN and ask him to visit to talk about what other support might be available to him.

SCENARIO 3

Common Scenario
Peter is 19 years old and attending University away from his own home. On Friday afternoon he starts to experience dental pain and notices a slight swelling of his face. He is not registered with a local dental practice nor does he have any analgesia so attends the local Emergency Department for treatment. The Emergency Department triages his symptoms and he waits two and a half hours to be seen, as he is not urgent.

On examination by a doctor, Peter is advised that he probably has a dental abscess developing. He is prescribed some antibiotics and analgesia and told that he needs to go to a dentist. Peter does not know where to find help on a Friday evening so calls his Mum who drives over and collects him, brings him home and takes him to see her local OOH dental service the following morning.

Ideal Scenario
Peter is 19 years old and attending University away from his own home. On Friday afternoon he starts to experience dental pain and notices a slight swelling of his face. He is not registered with a local dental practice. Peter calls NHS Direct which provides the number of the local OOH dental service and advises him to take some analgesia in the meantime.

He phones the OOH Dental Service who after triaging his symptoms, arranges for an urgent dental appointment to be made at the OOH Dental Centre early the next morning.
11. Useful References

Useful references on unscheduled and emergency care services include:
