Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Delivering Urgent & Emergency Care

A Vision and Strategy for Bristol, North Somerset & South Gloucestershire

Delivering Urgent & Emergency Care

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Overview

This strategy sets out how we will transform our urgent and emergency care system to manage the actual and predicted increase in demand from an ageing and increasingly complex population.

It is an opportunity to offer a vastly simplified; more resilient and connected urgent and emergency care system. It does not represent the conclusion, but the beginning of a journey towards a shared vision of the future.

Our focus starts and ends with the population we are here to serve, and the services that they and the people caring for them – professionals and support network – need in place to be able to resolve issues or re-set care plans to take account of changing circumstances.

A service built around patients – we have at least fifteen different ways a member of the public can step in to our urgent and emergency care system, and a vast array of opening times and service offers. As well as being confusing for people who can attempt to navigate to the right place, this is disadvantageous to groups who are not in a position to exercise choice – the frail and elderly, the socially deprived, people with disabilities or learning difficulties, people struggling with addiction, anxiety or depression or the burden of multiple diseases, the homeless, the housebound, or anyone who does not understand the English language or the English care 'system'.

Although these groups may appear to be 'minority' groups, in our urgent and emergency system their needs are key drivers for demand – be it in multiple contacts to 111, 999, GP practices, A&E and other services, in high rates of admission and readmission, or simply no contact at all, borne out in the stark statistics on the huge variation in life expectancy between our most and least deprived citizens. Designing our services needs to start with an understanding of the people who need them most. In the case of urgent and emergency care, this means prioritising the groups whose burden of disease, social or lifestyle factors makes them most likely to need us.

Integrated locality-based targeting of groups most likely to need urgent and emergency care: Localities (integrated locally-based working between primary, community, and social and voluntary care organisations) are best placed to understand the populations they serve. Managing urgent care demand starts here, with definition of priority target groups who would most benefit from intervention – from communication, to care planning, to specific services or pathways. In many cases, the solutions will be as much about prevention and early intervention as about urgent and emergency care. The Urgent Care System must enable General Practice to focus on providing continuity of care for the most complex patients by effectively dealing with urgent minor injury through the Integrated Urgent Care Service and Urgent Treatment Centre's.

Dramatically simplifying access points: recommissioning Integrated Urgent Care in BNSSG gives us the chance to offer a much simpler way of accessing the right urgent care service. Our future NHS111 service will offer more clinical assessment and the ability to book in to appropriate access points for our system. Even at front doors of walk-in services we want the same access to resources as 111 clinicians have, so that our response is consistent.

This strategy does not suggest spending time on diversion or global behavior management initiatives designed to reduce ED attendances or divert them elsewhere. We will make the easy

thing the right thing to do. However, we do need to ensure that urgent care walk-in services can deal with the vast majority of patients then and there without the need for redirection. We must therefore address the variety of walk-in offers in our system – what they are called, what they do, and when they do it to support more consistent services across the system.

Integrated and networked assessment function – throughout our engagement activities for this strategy, clinicians have said again and again that they want to be able to access each other more for information and advice. It will be a priority to make this interaction between health and social care professionals work seamlessly and consistently, particularly when further assessment is needed to understand the right course of action for a patient. Ultimately whatever face-to-face (or virtual) service the patient is directed to will benefit from integration with the full range of relevant teams, pathways, information, tests and results to make the most appropriate decision for the patient at that time, including a decision to admit to an acute hospital bed. Urgent Treatment Centres may play a key role in providing the alternative setting for much of this diagnostic and assessment activity.

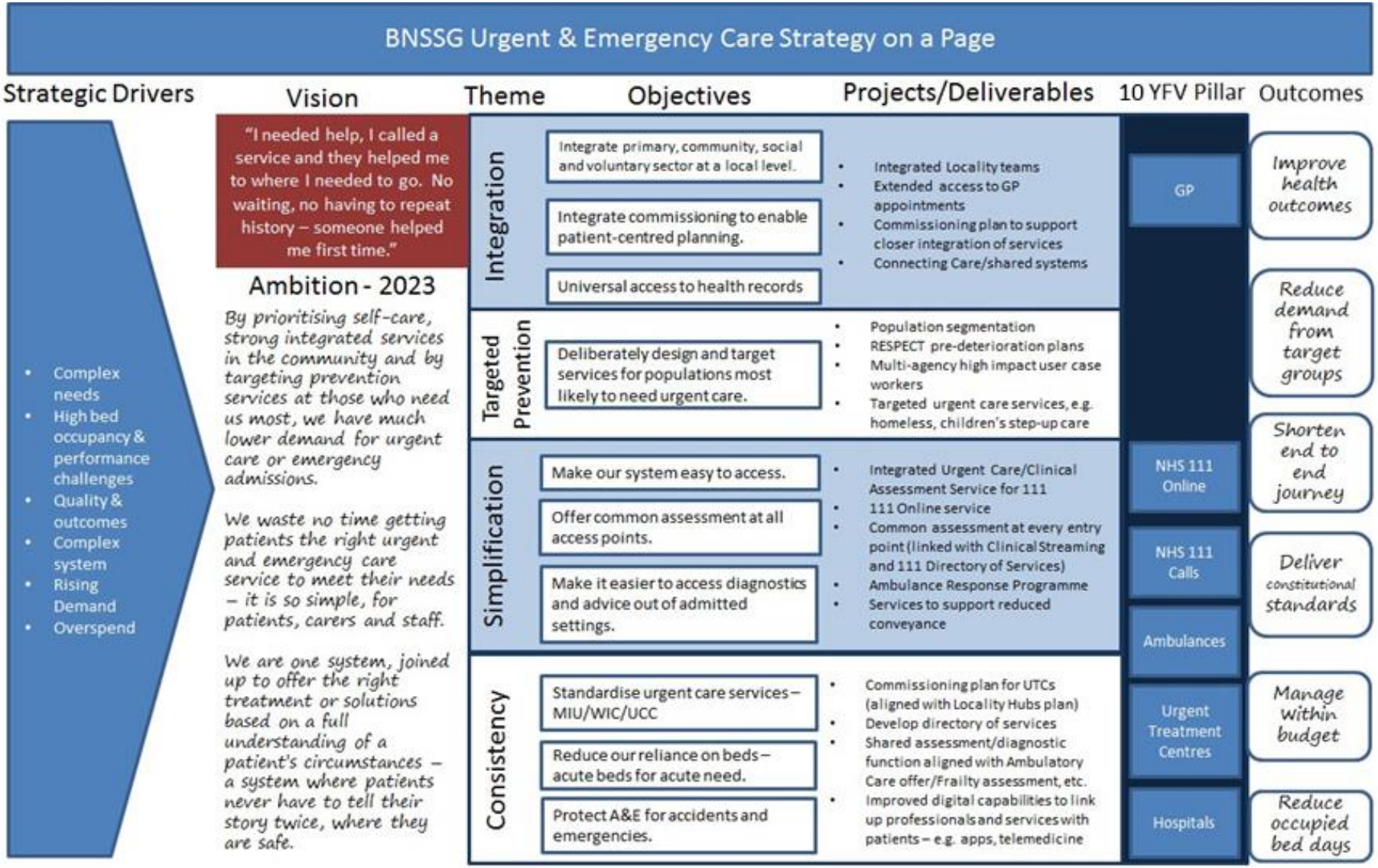
Accident and Emergency: part of this vision is that the Accident & Emergency Department is truly a department that specialises in serious accidents and emergency medicine. On this basis it should not be the first point of contact for the public; neither should it provide a processing function as a front door to the hospital. There are other services and other professionals better placed to do this so that A&E can do what it says over the door. For the public, that door may still look the same – but their first point of contact will be the common first assessment outlined above, which rapidly indicates whether they need an A&E or not, and gets them to the right service.

Acute beds for acute need: 75% of our acute beds are currently occupied by non-elective patients, we have a 95% average bed occupancy rate, and predict an increase of anywhere between 270 and 400 beds just for non-elective care over the next ten years if we do nothing. We therefore need to ensure that people are only in an acute hospital bed when it is offering real value to their treatment, care management and recovery. This means being a system that prevents the need for admission, and makes it easier not to admit whenever that would be a better option. In many cases the rapid solutions we need may not be a health response at all, and we must work seamlessly with social care and the voluntary sector to provide timely intermediate/step-up care options that are more appropriate than an acute admission.

A positive experience in a single system – so many of us are tired of the language associated with urgent and emergency care: inappropriate attendances, frequent flyers, avoidable admissions, bed blockers/‘stranded’ and ‘super stranded’ patients, delayed transfers of care. They imply a fault or inadequacy in the patient themselves or in another part of the system. We are one system. We are all doing our best to help patients at a time of illness and high anxiety. We commit to carefully consider the language that we use as we transform our system to focus on teamwork, shared purpose and common interest in value for the patient.

The BNSSG Urgent Care Strategy on a Page is set out overleaf and explained in the remainder of this document.

Strategy on a Page



Introduction

Purpose

This document has been produced with patients, professionals and carers from across the Bristol, North Somerset & South Gloucestershire health and social care system. It is our description of what we want our urgent and emergency care system to be like, and the important things we need to do to get there.

Who we are

The Bristol, North Somerset and South Gloucestershire (BNSSG) 'system' is made up of the three interconnected unitary authority areas. Our Sustainability and Transformation Partnership, *Healthier Together*, is a designated third wave aspirant ICS system and is made up of thirteen organisations, employing over 48,000 people and serving a population of just under 1 million residents. The thirteen organisations in *Healthier Together* are:

1. Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
2. Bristol City Council
3. North Somerset Council
4. South Gloucestershire Council
5. University Hospitals Bristol NHS Foundation Trust
6. Weston Area Health NHS Trust
7. North Bristol NHS Trust
8. South Western Ambulance Service NHS Foundation Trust
9. Avon & Wiltshire Mental Health Partnership NHS Trust
10. Bristol Community Health Community Interest Partnership *
11. North Somerset Community Partnership *
12. Sirona Health and Care Community Interest Partnership *
13. One Care Consortium

* (note: A BNSSG procurement during 2018/19 – 2019/20 will reduce the number of Community Service providers from three to one)

Brisdoc and Care UK are also significant partners in our urgent care system, providing the GP Out of Hours and NHS 111 services across BNSSG.

This document will refer to 'Localities' as the local building blocks for system design and delivery. There are six localities in BNSSG:

Locality	Local Authority
South Gloucestershire	South Gloucestershire Council
Bristol North & West	Bristol City Council
Bristol Inner City & East	Bristol City Council
Bristol South	Bristol City Council
Woodspring and the villages	North Somerset Council
Weston and Worle	North Somerset Council

Vision and Ambition

We came together as a system in April 2018 and identified on the most important principles for delivering Urgent and Emergency Care, and our personal visions for how the future will look. These have formed the basis for the development of this Strategy, in particular the vision, ambition, and four priority themes.

We have used the personal vision stories in this document to illustrate how this ambition will translate into reality for individuals. It is best summed up in the following testimonial from a future patient:

> "I needed help, I called a service and they helped me to where I needed to go. No waiting, no having to repeat my story – someone helped me first time."

Our top Principles are listed below, showing how they have informed the four Key Themes.

Principles	Change Suggestion	Key Theme
Prevent and empower	• Reduce profiled demand for urgent and emergency care	
Integrated	• Patients will tell their full story only once • Services will work seamlessly together to deliver what is needed	Integration
Connected	• We will have universal access to live care records	
Help those most in need	• Deliberately design and target services for populations most likely to use urgent care services	Targeted prevention
Simple	• Make our system easy to access	Simplification
Affordable	• Reduce our reliance on acute hospital beds • Integrate budgets to enable patient-centered decisions	
Consistent – no waste	• Offer common assessment at all access points • Build and maintain a common directory of services • No waiting, no duplication	Consistency

Finally, we used people's feedback to develop the following ambition for our future system:

"By prioritising self-care, strong integrated services in the community and by targeting prevention services at those who need us most, we have much lower demand for urgent care or emergency admissions.

When people need urgent or emergency care we waste no time getting them the right service to meet their needs – it is so simple, for patients, carers and staff.

We can do this because we are one system, joined up to offer the right treatment or solutions based on a full understanding of a patient's circumstances – a system where patients never have to tell their whole story twice, where they are safe".

Strategic Context

National

In 2014 the NHS in England published the *Five Year Forward View* (5YFV) describing the key strategic challenges for the NHS and priorities for delivery. In 2017 this was followed by *Next Steps on the Five Year Forward View* which provided more detail on exactly what local health and care system needed to do to deliver the 5YFV vision. In 2018 this was followed by the NHS 10 Year Plan which built upon the existing themes and deliverables required from an efficient and effective urgent care system.

This led to the definition of the 'Seven Pillars' of Urgent and Emergency Care:

1. NHS 111 Online
2. NHS 111 Calls
3. GP access
4. Urgent Treatment Centres
5. Ambulance services
6. Hospital services
7. Hospital to home

These national requirements for local urgent care systems are described below.

NHS 111 Online

This will offer online triage services, enabling patients to enter their symptoms and received tailored advice or a call back from a healthcare professional. As it develops, the online service can be increasingly tailored to individuals' needs and personal care plans.

NHS111 Calls

Development of NHS111 is already underway in BNSSG. Our recent procurement will enable us to increase the percentage of people who speak to a clinician and can therefore be offered improved self-care advice, or booked directly into an appointment with an appropriate service (e.g. their own GP or the local Urgent Treatment Centre). We can also provide dedicated lines for certain groups and individuals, e.g. Care Homes, so that they get straight through to the 111 clinical advisors.

GP Improved Access

General Practices are already offering extended access appointments over the weekend and in the evening. Other investment is supporting improved use of technology, and better integration of services in the community.

Urgent Treatment Centres

The direction is to move away from the confusing range of Minor Injuries Units, Walk-In Centres and Urgent Care Centres to more consistent Urgent Treatment Centres. These will be open at least 12 hours a day and staffed by doctors and nurses. As well as seeing walk-in patients they will be able to offer booked appointments via the 111 service and will be able to carry out x-rays and issue prescriptions.

Ambulances

Improvements in ambulance service provision will ensure that life-threatening conditions are recognised quickly and the right resources dispatched to deal with them. There will be

increased focus on offering telephone advice and treatment on the scene, with more local clinical services linked up with the ambulance service to be able to provide care closer to home.

The Urgent Care priorities were refreshed in the 2019/20 planning guidance and NHS 10 Year Plan as summerised below:

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National priorities for urgent care*

- 33% of acute admissions to be SDEC, delivered at least 12 hours a day, 7 days a week by Sept 2019
- A 24/7 integrated urgent care service accessible through NHS 111 & online, with 50% of callers offered clinical assessment & 40% of those requiring F2F appointment directly booked
- Provide an acute frailty service for at least 70 hours / week with an aim to deliver clinical frailty assessment within 30 minutes of arrival (no deadline)
- Further reduce delayed transfers of care
- Reduce >21 day (super stranded) inpatients by 40% from 17/18 baseline
- Record 100% of patient activity in A&E, urgent treatment centres and SDEC via the emergency care dataset
- UTC designation for most by Dec 2019, for all by Autumn 2020
- Test and begin implementing the new emergency and urgent care standards arising from the national Clinical Standards Review
- Ensure DoS 'A&E by default' dispositions <1%
- Achieve ambulance handover trajectories, zero tolerance of >30 minutes

Targets

- Deliver ARP, A&E 4 hour standard and zero tolerance of >30 minute handovers

* From 19/20 operational planning guidance & long term plan

Hospitals

There will be a greater focus on ensuring emergency departments are focused on providing the right highly skilled workforce to deliver life-saving care for the sickest patients. Patients arriving at a hospital will be streamed by a highly trained clinician to the most appropriate service, and there will be rapid, intensive support to those patients at highest risk of admission. Use of ambulatory care services will become much more widespread, enabling patients to return home with the right care plan and support in place.

Hospital to Home

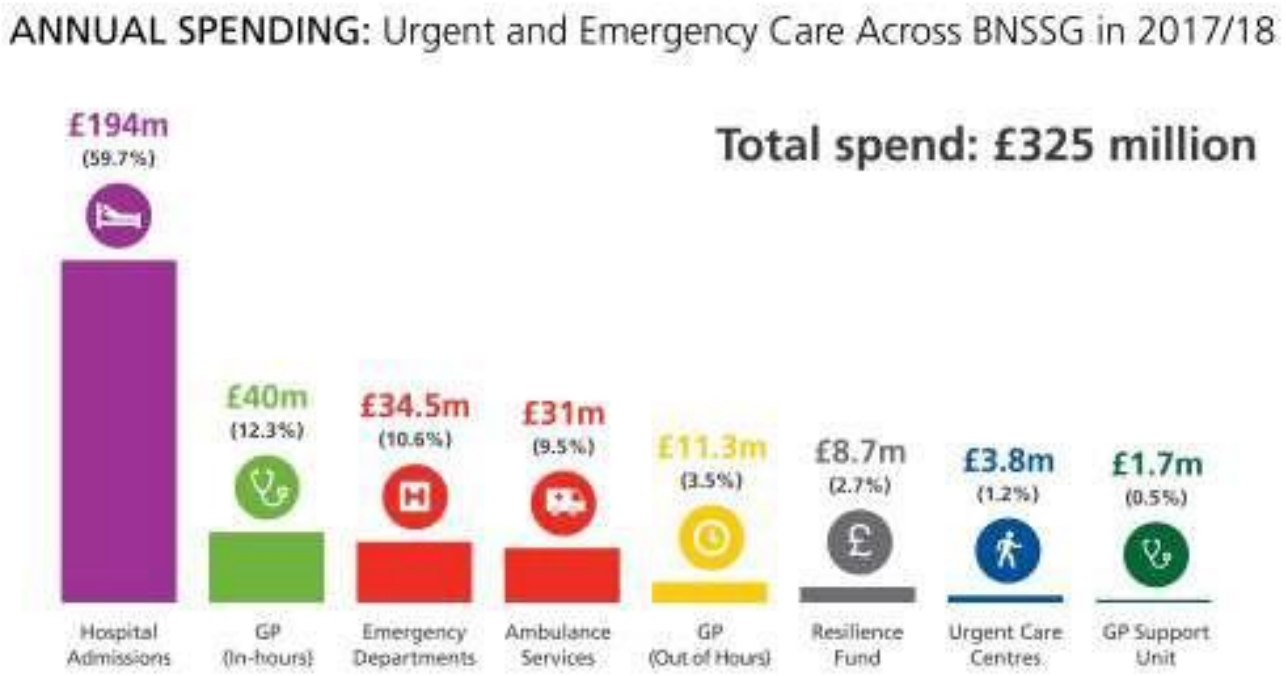
This pillar was not included in the scope for this strategy. However, we are already improving the way we plan and arrange discharge from hospital. The national drive is to ensure that patients' long-term care needs are assessed out of hospital as soon as they no longer require acute hospital treatment. For example, one aim is that fewer than 3 in 20 assessments for NHS Continuing Healthcare (CHC) will take place in an acute hospital. Comprehensive packages of health and social care should be available, and there should be coordinated and timely transfer of care from hospital to the most appropriate setting.

Whilst the BNSSG system is progressing delivery of the national imperatives, this will be driven by our own local population needs and system priorities. The following section describes the challenges we face locally. The subsequent section will bring together how we are going to respond to the local challenges in the way we deliver the national requirements.

Where are we now?

The majority of healthcare in our system happens in a primary care setting, as illustrated below:

However, our funding is distributed according to organisation and setting of care, with the most money being spent in the setting where patients' care needs are the most acute.



Furthermore, our system financial deficit is around £93m. Since urgent care constitutes at least 25% of our expenditure, **our share of the 'overspend' is £23m.**

Complex system design

There are currently over fifteen potential access points into our Urgent & Emergency Care system for any single resident of BNSSG.

The points of access for an individual at any one time include:

1. Local GP surgery
2. Local dental practice
3. Pharmacy
4. NHS111 (includes access to GP Out of Hours services)
5. 999

   Walk-in/minor injuries services
6. Yate Minor Injuries Unit
7. Clevedon Minor Injuries Unit
8. South Bristol Urgent Care Centre
9. Broadmead Walk-in Centre
10. Minor injuries service in South Gloucestershire – accessed via booked appointment

    Accident & Emergency Departments
11. Weston General A&E
12. Bristol Royal Infirmary A&E
13. Bristol Children's Hospital A&E
14. Southmead A&E
15. RUH Bath A&E

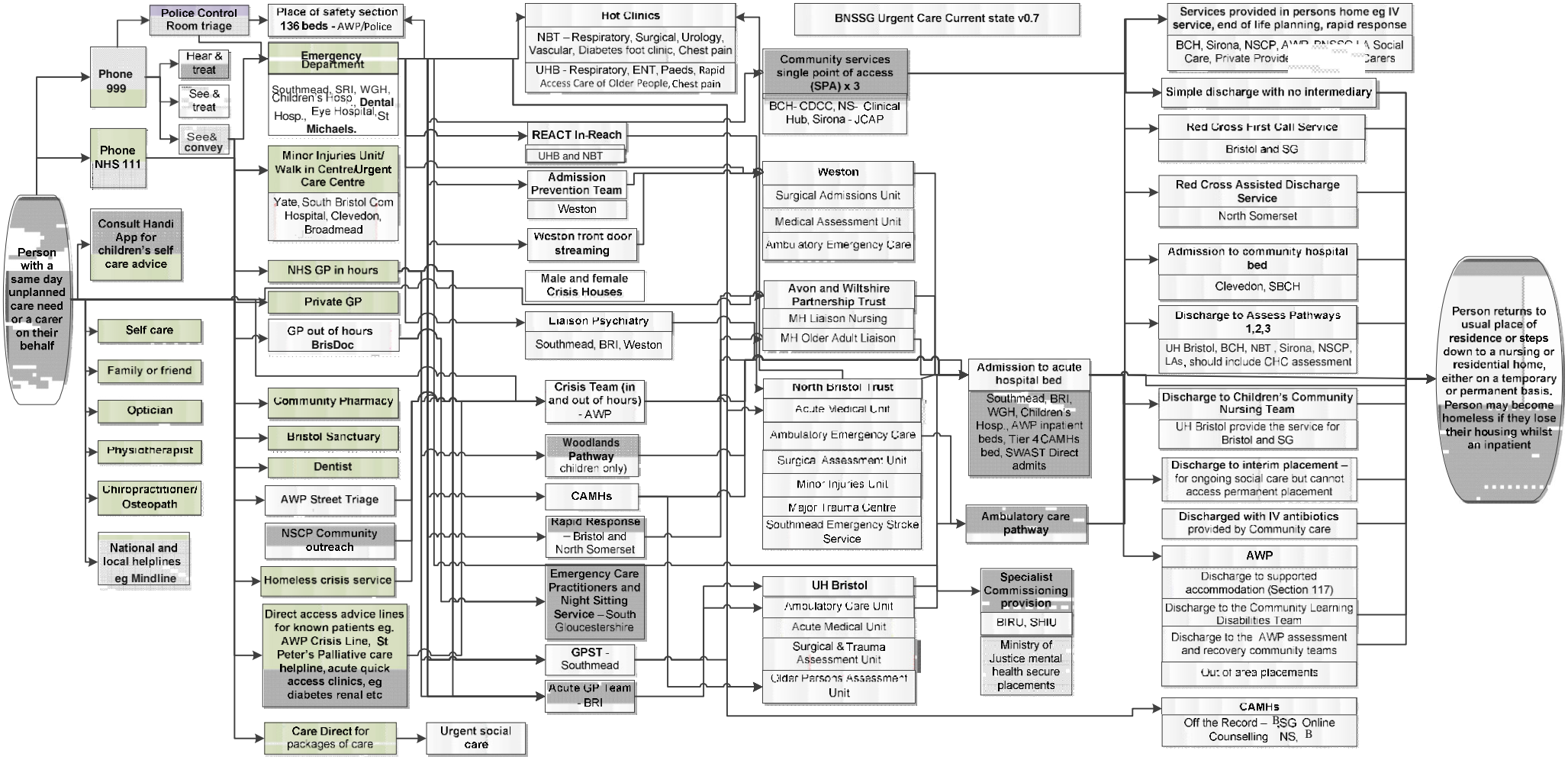
Patients already known to the system can get direct access to the services they need via targeted support lines, e.g.

16. Bristol Sanctuary, palliative care home support lines, AWP crisis line)

There are also some limited assessment functions available to healthcare professionals for diagnostic and decision support, e.g.

17. GP Support Unit/Team and the Woodlands Pathway for children

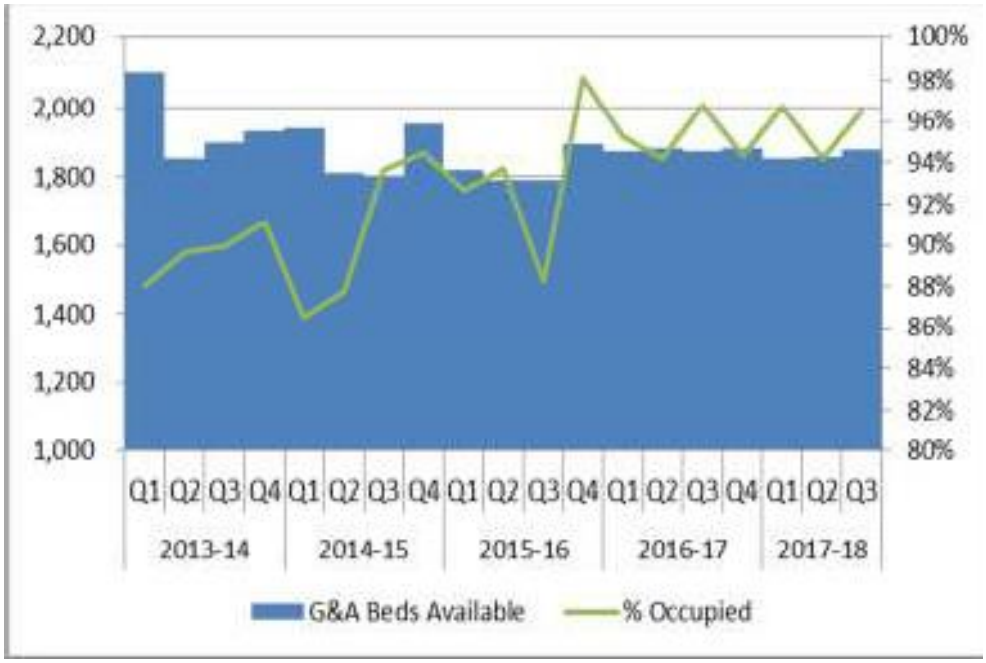
The diagram overleaf shows the scale and complexity of our 'current state' urgent and emergency care system.


BNSSG Urgent Care Current state v0.7
Person with a same day unplanned care need or a carer on their behalf
Phone 999
Phone NHS 111
Hear & treat
See & treat
See& convey
Police Control Room triage
Place of safety section 136 beds - AWP/Police
Emergency Department
Southmead, SRI, WGH, Children's Hosp., Dental Hosp., Eye Hospital, St Michaels.
Minor Injuries Unit/ Walk in Centre/Urgent Care Centre
Yate, South Bristol Com Hospital, Clevedon, Broadmead
Consult Handi App for children's self care advice
NHS GP in hours
Private GP
GP out of hours BrisDoc
Self care
Family or friend
Optician
Physiotherapist
Chiropractitioner/ Osteopath
National and local helplines eg Mindline
Community Pharmacy
Bristol Sanctuary
Dentist
AWP Street Triage
NSCP Community outreach
Homeless crisis service
Direct access advice lines for known patients eg. AWP Crisis Line, St Peter's Palliative care helpline, acute quick access clinics, eg diabetes renal etc
Care Direct for packages of care
Urgent social care
Hot Clinics
NBT – Respiratory, Surgical, Urology, Vascular, Diabetes foot clinic, Chest pain
UHB - Respiratory, ENT, Paeds, Rapid Access Care of Older People, Chest pain
REACT In-Reach
UHB and NBT
Admission Prevention Team
Weston
Weston front door streaming
Male and female Crisis Houses
Liaison Psychiatry
Southmead, BRI, Weston
Crisis Team (in and out of hours) - AWP
Woodlands Pathway children only)
CAMHs
Rapid Response – Bristol and North Somerset
Emergency Care Practitioners and Night Sitting Service – South Gloucestershire
GPST - Southmead
Acute GP Team - BRI
Community services single point of access (SPA) x 3
BCH- CDCC, NS- Clinical Hub, Sirona - JCAP
Weston
Surgical Admissions Unit
Medical Assessment Unit
Ambulatory Emergency Care
Avon and Wiltshire Partnership Trust
MH Liaison Nursing
MH Older Adult Liaison
North Bristol Trust
Acute Medical Unit
Ambulatory Emergency Care
Surgical Assessment Unit
Minor Injuries Unit
Major Trauma Centre
Southmead Emergency Stroke Service
UH Bristol
Ambulatory Care Unit
Acute Medical Unit
Surgical & Trauma Assessment Unit
Older Persons Assessment Unit
Admission to acute hospital bed
Southmead, BRI, WGH, Children's Hosp., AWP inpatient beds, Tier 4 CAMHs bed, SWAST Direct admits
Ambulatory care pathway
Specialist Commissioning provision
BIRU, SHIU
Ministry of Justice mental health secure placements
Services provided in persons home eg IV service, end of life planning, rapid response
BCH, Sirona, NSCP, AWP, BNSSG LA Social Care, Private Provide Carers
Simple discharge with no intermediary
Red Cross First Call Service
Bristol and SG
Red Cross Assisted Discharge Service
North Somerset
Admission to community hospital bed
Clevedon, SBCH
Discharge to Assess Pathways 1,2,3
UH Bristol, BCH, NBT , Sirona, NSCP, LAs, should include CHC assessment
Discharge to Children's Community Nursing Team
UH Bristol provide the service for Bristol and SG
Discharge to interim placement – for ongoing social care but cannot access permanent placement
Discharged with IV antibiotics provided by Community care
AWP
Discharge to supported accommodation (Section 117)
Discharge to the Community Learning Disabilities Team
Discharge to the AWP assessment and recovery community teams
Out of area placements
CAMHs
Off the Record – BSG Online Counselling NS, B
Person returns to usual place of residence or steps down to a nursing or residential home, either on a temporary or permanent basis. Person may become homeless if they lose their housing whilst an inpatient

Over-dependence on bed-based care

Over the last four years the volume of emergency admissions in BNSSG has been higher than forecast based on population growth. What this means is that the population in BNSSG has grown by around 4% since 2013/14, but the volume of emergency admissions has risen by around 25% across the same period. Our analysis suggests this growth relates to a similar cohort of patients using more resources, rather than overall increases in demand. Comparatively, across England, Emergency admissions have increased by 13%.

We are admitting patients to a general and acute bed base that has remained static over this time. Our bed occupancy is rate is frequently at 95% or above, as illustrated below:



Benchmarked against other systems, BNSSG ranks as the worst in the country for high general and acute bed occupancy.

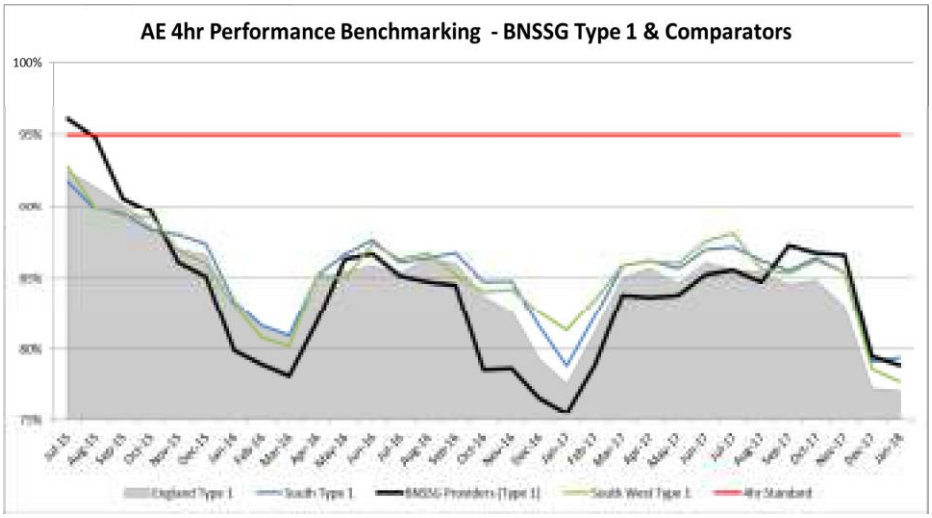
The recommended safe operating bed occupancy level is around 85%.

When bed occupancy exceeds 85% we lose the ability to safely manage flow through our system.

There are several consequences:

Failure to deliver constitutional standards

The operational standard for A&E waiting times is that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department. As would be expected for a system operating under significant pressure, BNSSG consistently fails to deliver the four hour A&E standard:



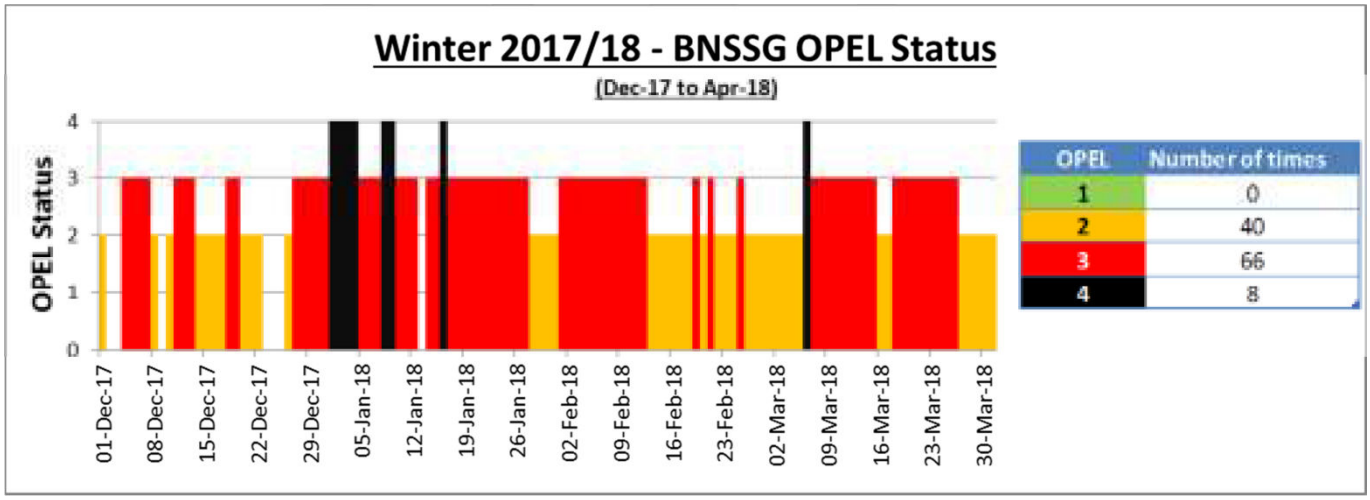
Harm as a consequence of pressure

There is evidence that patient safety and outcomes are compromised by pressure in the system:

- For patients who are seen and discharged from an A&E, the longer they have waited to be seen, the higher the chance they will die during the following 7 days (Guttmann et al, 2013)
- The longer a patient spends in A&E, the longer they stay in the hospital (Liew et al, 2003)
- Delays in transfer from A&E to higher dependency units increase mortality and length of stay (Chalfin et al, 2007)
- Once a hospital is over 90% bed occupancy it reaches a tipping point in its resilience (Forster et al, 2003)
- Lowering levels of bed occupancy is associated with decreased in-hospital mortality and improved performance on the 4-hour target (Boden et al, 2015)
- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Gill et al 2004)
- One week of bedrest equates to 10% loss in strength, and for an older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, a 10% loss of strength may make the difference between dependence and independence (Hoenig & Rubenstein, 1991)

Pressure as a frequent factor

We measure relative pressure in our system by calculating a daily Operational Pressures Escalation Level (OPEL). The chart below shows the BNSSG system OPEL rating during the winter of 2017/18. Amber is OPEL 2, red OPEL 3, and black OPEL 4.



Our Urgent and Emergency care system commonly runs ‘hot’, putting clinicians under significant pressure to maintain responsive, safe and integrated services and putting patients at risk of harm or poor outcomes.

Understanding demand in our population

Deprivation and life expectancy

There are stark inequalities in life expectancy across BNSSG. People living in more deprived areas experience comparatively poor health, with a lower life expectancy than those living in the least deprived. The table below shows the life expectancy gap between the most and least deprived areas, by local authority area.

Area	Difference in life expectancy at birth	
	Males	Females
Bristol	9.6	7.0
North Somerset	9.1	6.9
South Gloucestershire	6.5	4.8
BNSSG	8.6	6.3

Source: Public Health Outcomes Framework / ONS death extracts, IMD 2015 deprivation deciles, 2013-15

As well as life expectancy, we know that deprivation itself is a predictor for higher levels of urgent and emergency care need[1]. It is also associated with higher levels of morbidity and frailty, which themselves are also predictive of higher urgent care demand[2].

Multiple Morbidities

We know that "the burden of multimorbidity is the strongest clinical predictor of ED attendance" (BJGP, 2018). Multimorbidities are also the most significant driver for emergency admissions in our system. 58% of the population in BNSSG has two or more 'multimorbidities'. A third of people aged over 75 have three or more multiple conditions.

People with 2 or more conditions make up nearly **70%** of the total emergency hospital admissions in BNSSG, but they stay in beds for longer and therefore account for **80% of unplanned occupied bed days** in our system. **Three quarters of the money spent** on emergency hospital admissions relates to people with multiple conditions.

Mental Health

Improved mental health is associated with a range of positive outcomes including better physical health and life expectancy. We know that prevalence of depression in BNSSG is slightly higher than the England average (8.98% compared with 8.26% nationally), with over 10% of adults in North Somerset diagnosed with depression.

Our analysis suggests that **just over half** (54%) of all acute hospitals admissions in BNSSG include a mental health or substance misuse diagnosis code.

The emergency hospital admissions rate for intentional self-harm is high in BNSSG, higher than the national average. This is particularly evident when comparing rates for female admissions. The age standardised rate per 100,000 for females in BNSSG is 317 and 247.8 for England. The admission rates for Bristol are also higher than the rate for the South West region.

[1] Gray, D.P. et al BMJ http://bmjopen.bmj.com/content/7/2/e014045; Reid, FDA et al (1999) BMJ http://dx.doi.org/10.1136/bmj.319.7202.98; Conway, R et al (2016) QJM 2016;109:675–80

[2] Charlton, J et al (2013) in Journal of Health Services Research & Policy 2013;18:215–23

Alcohol and Substance Misuse

The rate of hospital admissions attributable to alcohol is high for BNSSG and particularly high for Bristol. Across BNSSG the rate of admissions is 708.5 per 100,000 compared to a national average of 646.6 per 100,000. In Bristol the rate is 801.8 per 100,000 whilst North Somerset and South Gloucestershire have estimate much lower than the national average. The rates are higher for males in all areas, reaching a rate of 975.3 per 100,000 in Bristol. The BNSSG estimated rate is 859.9 per 100,000 compared to a rate of 573.7 per 100,000 for females.

Binge drinking usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk. In BNSSG nearly a quarter of the adult population (22.7%) report binge drinking, which is higher than the average nationally (20%).

Opiates, including heroin, and crack have historically been the most prominent drugs used by people seeking specialist drug treatment and are closely linked to poor health. People who inject drugs are particularly vulnerable to a wide range of viral and bacterial infections and experience elevated risk of overdose. The estimated rate of opiate and crack use in Bristol is significantly higher than the national average, compared to a lower than average use in South Gloucestershire. North Somerset has a comparable level of use to the national average.

Homelessness

Although our system needs assessment identified that the homeless rate for BNSSG was lower than the England average, a more recent needs assessment by NHS England[3] highlights Bristol as having one of the highest numbers of rough sleepers in England's core cities[4]. More recently Bristol's annual rough sleepers count has shown a 14% increase since 2016, which is recognised as a large underestimate of the real problem[5].

Studies suggest that people who are homeless attend A&E six times more than the housed population; are admitted four times as often; and stay three times as long[6]. Outcomes for the homeless population are significantly worse than for those of the housed population. The average age of death of homeless people is 47 and 43 years for men and women respectively compared to 77 years of age in the general population.

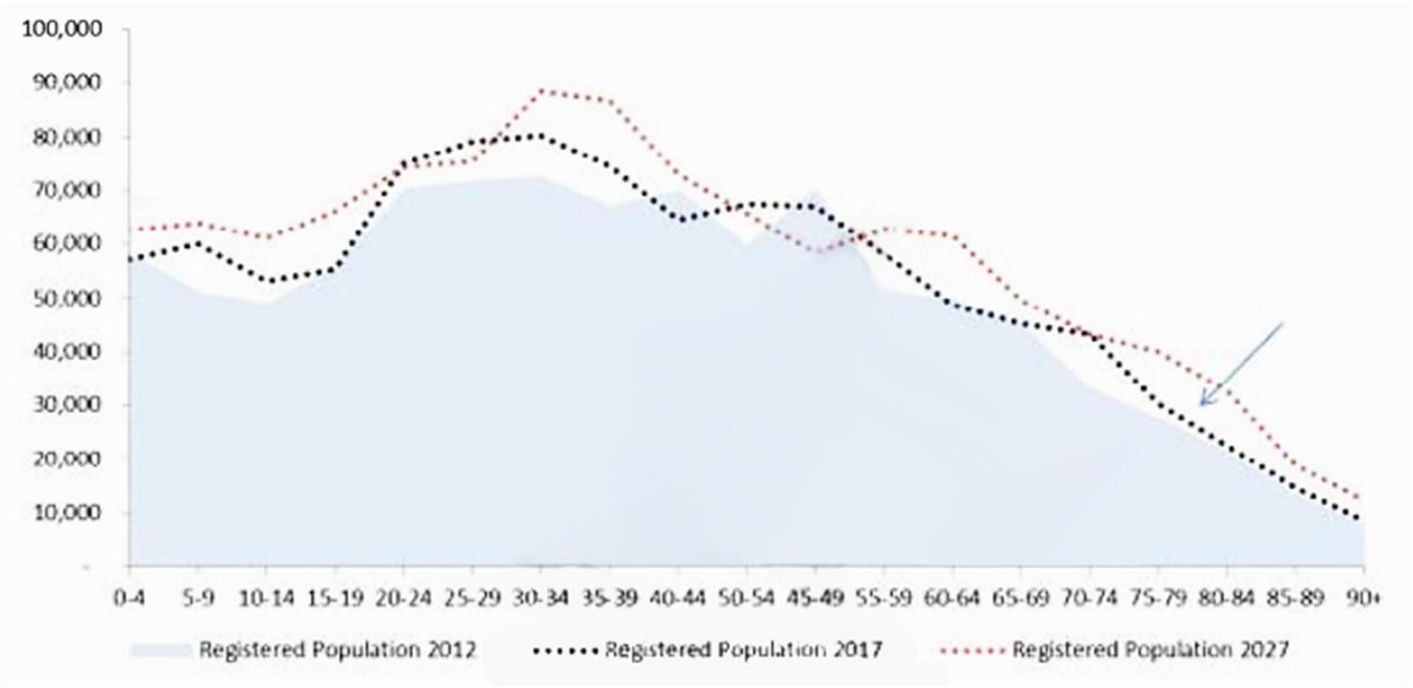
Children and Young People

The Emergency hospital admission rate for the age group 0 to 4 years is higher in BNSSG than the national rate, at 134.8 per 10,000. Similarly, in young people aged 15 to 24 years, the injury rate is 144.1 per 10,000 in BNSSG compared to 134.1 per 10,000 in England. It is notable that, despite having a specialist Children's Hospital in our region, the rate of A&E attendances for the under 4s in BNSSG is lower than the national average with 466 per 1,000 young children attending A&E locally compared to 533.6 per 1,000 attending nationally.

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/692140/NHSE_Mandate__2017-18_revised.pdf
[4] https://www.bristolpost.co.uk/news/bristol-news/number-rough-sleepers-bristol-revealed-916343
[5] http://news.bristol.gov.uk/annual_rough_sleeping_count_figure_revealed
[6] https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

Rising demand

Over the next ten years our overall population growth slows from the 1.2% per annum experienced in the last 5 years to around 0.9% per annum. However, this hides a huge increase in the population aged over 75. This age group accelerates sharply over the next 10 years, with a projected 28,000 (37%) increase, as shown below:



Note: Population projections based on ONS projections applied to registered population Dec 2017

With this population growth comes greater demand for services. The table below shows the projected impact on acute hospital beds and cost if nothing changes:

	2017/18	2027
Population growth		0.9%
>75 population growth		37%
Total Admissions	88,000	14,198 (16%)
Total Occupied Beds	1158	+278 (24%)
Total Cost	£168 million*	+£34.4 million (20%)

The projected growth in our population over 75 is driving:

- 75% of the projected increase in admissions,
- 92% of the projected increase in demand for beds and
- 85% of the projected cost increase

Summary of Strategic Drivers for Urgent & Emergency Care

The drivers for change and associated strategic objectives are summarised below:

1. **Complex needs:** prioritise population-based targeted approaches to better meet need, demand for urgent care, and respond appropriately to urgent need for:
    - people living in deprived areas, and/or
    - people with multi-morbidities;
    - people with mental health issues;
    - people with alcohol and substance misuse issues;
    - the homeless; and
    - children and young people who would benefit from alternatives to admission.
2. **High bed occupancy and performance challenges:** Reduce our reliance on acute hospital beds, de-escalate our system and manage performance
2. **Quality and Outcomes**: improve outcomes and avoid delays or treatments that are not in line with the patient's own goals
3. **Complex System:** Dramatically simplify access to the system and ensure services across the system are consistent
4. **Rising Demand:** integrate and streamline the way we offer services to get the best value and impact.
5. **Overspend:** ensure best and most effective use of resource and contribute to our system being in financial balance

Where do we want to be?

In order to deliver our vision we have identified four key delivery themes:

- Integration
- Simplification
- Consistency
- Targeted Prevention

These are explored in more detail in the following sections.

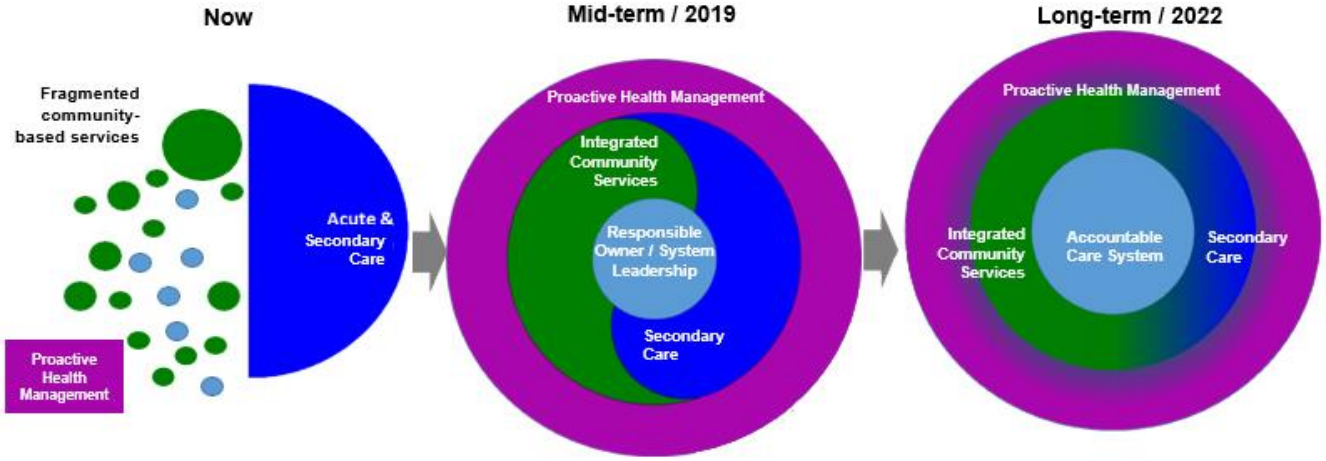
Integration

The BNSSG health and care system is currently on a journey: from a more fragmented and dis-jointed out-of-hospital provider environment, with insufficient focus on proactive health management, to a model where the out-of-hospital system and the secondary care system are more in-balance and working together in a more integrated and cohesive way, with strong central leadership and a focus on proactive health management across the entire system. This is illustrated in the diagram overleaf:

Integrated Primary & Community Services

We are already working on how primary care and community, social care and the voluntary sector can work more closely in the six BNSSG Localities. The cornerstone of our model is of General Practice and General Practice working at scale. The vision is for a resilient and thriving primary care sector and a future model of care in which groups of practices collaborate with other community provider organisations to provide integrated care and services for a defined population and geography, as illustrated below:

We're on a journey to shift the balance



1

The immediate focus is on the creation of an organised, coordinated and effective out-of-hospital provider environment that is seen as the main conduit for meeting a person's health and care needs. This new out-of-hospital environment sees primary care, out of hours, community services, mental health, the ambulance service, the local authority and the third sector working much more collaboratively around a single, person centered care plan.
In the longer term, a more integrated model which supports an integrated, care system is envisaged but the priority now is to bring together the currently fragmented community model, including general practice.

The Locality Transformation Scheme brought together GPs in localities with agreed ways of working. The current phase for this scheme is to deliver Improved Access at a locality level. Improved Access supports the move towards Primary Care at scale across 7 days, using a variety of skill mixes in an integrated way with partners in the community and the whole system, to meet the needs of the local population. Improved Access was designed to:

> *"test innovative ways of increasing access and delivering wider transformational change in general practice. The fund will also support GPs to play an even stronger role at the heart of more integrated out-of-hospital services that delivers better health outcomes, more personalised care, and excellent patient experience."* [7]

The newly formed Locality Provider Forums are now working on key priorities that build integrated working for key cohorts of the population, providing the foundation for a strong, cohesive and integrated system in the community which is required to support a sustainable model of urgent care.

[7] NHSE Improving Access to General Practice: Innovation Showcase series. Effective Leadership. July 2015

Integrated Digital Records

We have pioneered Connecting Care in BNSSG – particularly focusing on the urgent and emergency care system. By January 2018 3,500 registered clinicians were accessing 17,500 patient records a month. However, this represents an estimated 10% of total urgent care contacts per month so we have yet to realise its full potential. There is an overriding desire to link up records more seamlessly across providers and care settings, and we need to harness this to ensure that we optimise the capability we already have, and collectively address any further development needed to achieve full read/write access to records in compliance with data protection rules.

A Commissioning Approach to Integrated Service Delivery

One barrier to a truly patient-centered integrated system is the way that services are commissioned and paid for. Clinicians and managers alike are often frustrated in their efforts to improve care for patients by financial flows or payment mechanisms. We need to review the potential to streamline the way we commission and pay for services in a way that empowers staff. For example, we could look at personalised or capitated budgets focussed on the priority target groups, or we could harmonise commissioning and payment for assessment and diagnostic services.

Simplification

One person drew this 'vision' at our system event. It represents the barriers in place for patients and professionals to reach the 'goal' (the right setting of care or treatment plan). The future vision 'bends' those barriers out of the way so that the patient can reach the right point as quickly as possible.

111: Integrated Urgent Care/Clinical Assessment Service (IUC/CAS)
The new BNSSG Integrated Urgent Care service will be crucial for delivering a simplified urgent care system. This combines the current 111 service with much greater capability for a clinician to assess the caller's needs then and there. This Clinical Assessment Service (CAS) will also be able to book appointments for patients with the most appropriate service, for example appointments with their own GP, the Locality Hub, or an Urgent Treatment Centre. As a result of speaking to a clinician at the start of their urgent care experience, patients should be much less likely to be directed to settings such as A&E 'just in case'.

Similarly, a new 111 Online service will enable people to self-serve assessment and advice, directing them into services as appropriate. Over time this can be increasingly personalised to recognise existing care plans and history and offer tailored solutions.

Common first assessment
With the capability of the IUC/CAS comes the potential to offer common assessment support at all of our first access points in the system. This could work effectively with streaming services in A&E departments. For example, a patient who attends Weston A&E could be assessed on arrival by a clinician who had the same access to the Directory of Services as clinicians on the CAS. The result would be that they are offered the same end service as if they had dialed 111.

As well as being less complicated for the public ('call/click 111'), this would increase consistency in our system, ensuring all professionals have access to the range of available services.

Ambulance Response Programme
South Western Ambulance Service was the first to pilot the new ARP, so we are already benefitting from improved capability to assess and dispatch the most appropriate resource for each call.

Services to Support Reduced Conveyance
The Ambulance Trust and paramedic teams would still benefit from better access to – or provision of – services that would avoid the need to convey a patient to hospital. For example, SWAST has raised the challenge of consistent access to appropriate mental health support services in BNSSG, particularly out of hours.

Mobilisation of the Integrated Urgent Care Service/CAS needs should take account of data from SWAST demonstrating opportunities for further development of our Directory of Services.

Consistency

Although IUC/CAS is the main route to simplifying access for patients, we also need to address the wide range of urgent and emergency care services across our system. Variation is fine if it is warranted, for example if a particular locality has a much larger population of young families. In many cases however the variation in our system is due to historic factors and can be addressed by identifying common provision that should be available everywhere.

Urgent Treatment Centres

> *Well that was easy ☺ Popped in to the Urgent Care Centre today who had a physio on-site who sorted out my aching shoulder there and then. Also I had an appointment made with the same physio for a week's time in the same hospital. No need for a GP appointment or GP referral – straight to the UCC who sorted out my minor problem.*

Our services have different names and a range of different functions: Walk-in Centre, Minor Injuries Unit, Urgent Care Centre, and this is confusing. One suggestion from stakeholders who participated in the development of this strategy is to think about 'branding' of these centers in the same way we understand supermarkets. We all recognise a Tesco Extra and a Tesco Express as being the same brand. We understand that we are going to get similar products in each store – but we will recognise the range of products on offer at the Tesco Extra will be more limited and will choose which store we shop at according to our needs. In the same way, Chris Moulton, Vice President of the Royal College of Emergency Medicine, suggests that we optimise the A&E brand when we think about what we call our Urgent Treatment Centres"[8], perhaps referring to them as "A&E Local" or "Green A&E". Urgent Treatment Centre is used in this document because it aligns with the national programme.

In preparing this strategy, the system now has a rich dataset of population-based health needs, hospital admission data and projections of future demand. Coupled with travel time, it is now possible to model the critical mass and optimal locations for Urgent Treatment Centres in BNSSG, which should be commissioned according to a common specification. This will be done alongside assessment of appropriate settings of care for integrated Locality service provision (e.g. hubs/supra-hubs), and should take into account the specific needs of each Locality.

Given our strategic challenges, our Urgent Treatment Centres need to do more than see and treat minor injury and illness in the general population. On the one hand they should offer capacity that will free up Primary and Community Teams to focus on complex patients requiring continuity of care. On the other hand they will play a critical part in reducing our reliance on acute hospital beds, both by providing a hub for escalation/crisis services for the target population groups, and as a part of an Integrated Assessment Function.

[8] https://www.kingsfund.org.uk/audio-video/chris-moulton-urgent-emergency-care

Develop our Directory of Services
Part of mobilising the new Integrated Urgent Care (111) service will be reviewing our Directory of Services and ensuring that available services are consistent across the system (or that variation is explained by population need and not gaps in provision or commissioning).

Integrated assessment function
This is a function which allows a clinician looking after a patient presenting with undifferentiated illness, crisis or escalating care needs to carry out tests, examinations and diagnostics and initiate a management plan. A large proportion of this care is currently provided in A&E, acute assessment units and hot clinics and we often refer to it as Ambulatory Emergency Care.

However, we also have a range of other services which support assessment and appropriate care planning for patients, often preventing hospital admission. These include:

- Children's Woodlands pathway
- GP Support Unit/Team
- REACT (Rapid Emergency Assessment & Care Team)/Admission Prevent Team
- Rapid Response
- Frail Older People's Assessment & Liaison Teams
- Liaison Psychiatry Teams
- Ambulance see and treat

This strategy suggests we consider these services as a group – in terms of function, scope and cost – and develop a clinically-led plan to better integrate and network what they offer. There is also scope for a commissioning plan to support more integrated care delivery.

In our future system, the clinicians at the first point of contact with a patient (e.g. Primary Care Team, CAS, A&E Triage Nurse), should all have the same access to diagnostics, expert advice and assessment which would allow them to reach a management plan for a growing number of patients without the need for a hospital stay. Urgent Treatment Centres could offer a base for provision of these integrated assessment services.

Acute Capacity for Acute Need
Our proposed future state model is founded on the assumption that our hospitals are limited resources and there are no significant capital plans to build more beds in BNSSG. We therefore need to manage the increased demand within a similar bed base. This means all parts of the system working together to ensure that an acute bed is only ever used if the patient really needs to be there and could not be safely cared for elsewhere. Similarly, in line with the national strategy, Accident & Emergency Departments need to be protected to ensure they are able to safely perform their function without being the overflow point for a system under pressure.

Integrated Localities will work to prevent demand, IUC/CAS will work better to direct people to settings more appropriate to the acuity of need, Urgent Treatment Centres will offer that alternative setting, as well as greater capacity to assess and diagnose patients – with virtual support from acute specialists – rather than filling up Acute Assessment Units.

Improved Digital Capability
We tend to use digital capability more in planned than urgent care. However, there is great potential for digital solutions, including telemedicine, to help with our ambition to offer more consistent services and faster access to the 'right' opinion wherever the patient has presented.

As well as giving patients greater insight into their own care plans and choices, digital solutions can support greater use of telemedicine, e.g. an Urgent Treatment Centre could link with the duty Psychiatric Liaison Team to organise urgent assessment for someone experiencing mental health crisis.

Targeted prevention

The Integrated Locality Teams will take charge of ensuring that at-risk population groups are appropriately targeted and supported with the right services. The primary aim of targeting at-risk groups is, of course, prevention (of crisis, exacerbation, ill health, admission).

However people will still need urgent and emergency care services – albeit hopefully less often – and our aim is that they will be known in the system and as a result will experience a straightforward, seamless service to initiate their care plan swiftly.

RESPECT – Pre-deterioration Planning
The West of England Academic Health Science Network is launching the RESPECT (Recommended Summary Plan for Emergency Care and Treatment) in June 2018. This is part of the Patient Safety Collaborative's focus on the deteriorating patient, and follows on from successful roll-out of National Early Warning Scores (NEWS) in BNSSG. A review of 3,000 patients who died in hospital identified that around a third did not benefit from the escalated acute care provision that NEWS initiates, because they were already in an advanced stage of illness or had irreversible pathology.

RESPECT is a programme which seeks to identify people whose condition makes them likely to deteriorate, and agree their preferences for how this should be managed: a pre-deterioration plan. This is not just about end of life care planning, it encompasses any patient where there is a risk of deterioration, (e.g. frailty, severe advanced dementia, severe COPD). It is also not just about Do Not Attempt Resuscitation protocols, since it includes other interventions which the patient may prefer to forgo given their circumstances, e.g. IV antibiotics, diagnostic scans.

The aim of RESPECT is that a significant proportion of our high-risk population groups have a pre-deterioration plan in place, which sets out their preferences for non-acute options. It is likely to entail an increase in demand for step-up/intermediate care and/or social/voluntary care to support deteriorating patients in an out of hospital setting.

The remainder of this section offers some stories from patients and staff in the system about what we can do to improve the system in the future.

Multi-morbidities/Complex/Frail

> *"I have just put down the phone to a community nurse who has sent an elderly patient in to the emergency department who has fallen. She briefed me before her arrival, as everyone is aware of the services available. The electronic records are complete and I am fully aware of*

her needs – I triage her and there is no fracture. Although she has vast comorbidities I can see on the system that they have all been addressed and so she is not admitted. I instantly update the GP via the system."

By and large these patients will be known to the system and should have care plans agreed already. This is an example of a where a Pre-Deterioration Plan would be in place, but practical steps to manage a possible fracture might still be taken. Better access to care records will ensure that these plans are available to provide context to decision-makers in the urgent care system. Given the large increase in this population group, we need to ensure that there is sufficient expertise available in the right place to support assessment and decisions, e.g. Frail Older People's Assessment and Liaison, accessible to paramedics and community teams as part of the Integrated Assessment Function. Social care and the voluntary sector will also play a key part in ensuring that non-health care needs, including Carer needs, can also be assessed and met as part of our urgent care response.

Mental Health

"As a patent I have only had to tell my story once, accessing seamless mental health care that supports me even if I have turned up in the wrong place (A&E). Relevant skill and expertise is available, leaving me feeling supported and free of being judged, not going through a revolving door every few months".

At every part of our urgent care system we need to work with specialist and general mental health services to ensure mental health assessment and services are integrated and readily available. As well as addressing any gaps in our Directory of Services, this will entail delivery of appropriate environments and services in our Urgent Treatment Centres and A&Es. If people in mental health crisis have accessed our Urgent Care System, they should never be made to feel they have come to the 'wrong place'.

Homelessness and Drug/Alcohol Services

A homeless man with a personality disorder, multiple addictions and multiple physical problems including COPD and hepatitis-C, thought about taking an overdose and going to A&E. But something made him ring his health-link worker – but it was the middle of the night and the call went through to a Clinical Assessment Service, which managed to find all his details on the 'system', including his latest psychiatric assessment. As a result they connected him automatically to the Crisis Service who connected with the Street Triage Team who assessed him in a public park. He was taken to a sanctuary in the City, who offered a place to sleep and people to talk to for the rest of the night.

Increasingly we need to widen our scope of urgent care provision to include the Police, Drug and Alcohol support services, Street Triage and Homeless support services. As for other services for priority groups, these need to be available via our Directory of Services and

provision should be developed to ensure that our response is in the right place when it is needed.

Children

> *Bristol is a leader in the field of Urgent and Emergency Care for children. People travel to come and work in our system to learn primary care for children. Our system allows users access to the level of care they need in the time they need in a non-judgemental way. The healthcare system for children in Bristol is cited as one of the reasons to live in or near Bristol. All GPs and ENP workers in the city feel comfortable with children and treatment them, and know when to ask for help. The children's hospital tertiary care also flourishes.*

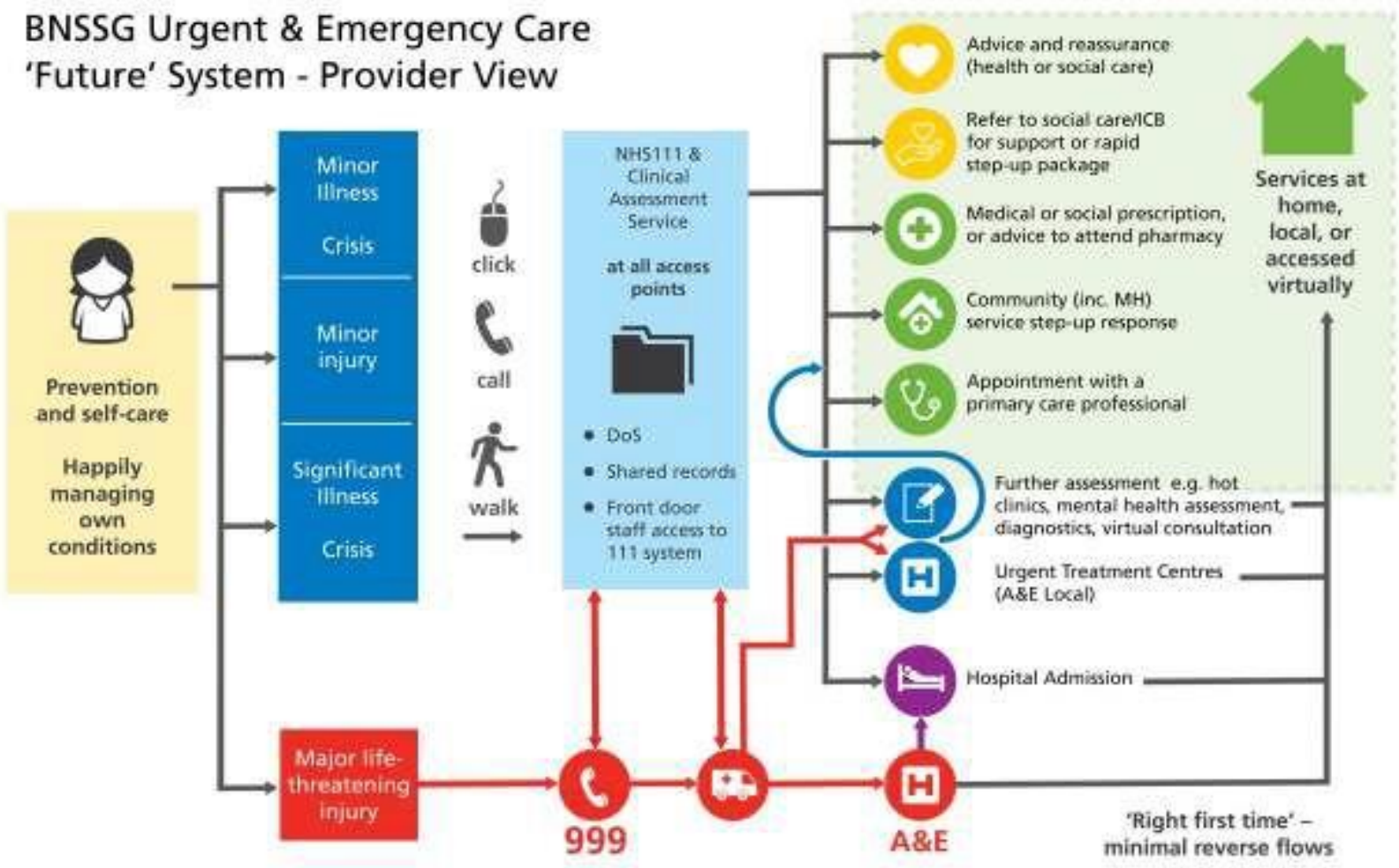
As an urgent care system we will focus on developing pathways for out of hospital treatment of illness and conditions which currently require an emergency admission. In doing this, we will also support better paediatric education and training for primary and community teams.

Future state model

The view from the future is much simpler from the patient's perspective. Although we still need a whole range of services available depending on your need, all you need to do is 'call, click or walk'. For simplicity's sake, the public message would be "Talk before you Walk".

You will not need to weigh up options beyond life threatening (999/A&E) or not (111/UTC). A common First Assessment will ensure that the right service is identified and arranged with you. If you are known already, this will initiate a pre-agreed care plan.

You will trust that services are working behind the scenes to access appropriate records and advice. The proof that this works will primarily be that you get to the right service first time. Secondary proof will be that, if you do have to speak to more than one clinician on that journey, you never find you need to repeat your story from the start.



The service delivery future state has slightly more detail – but not a lot. It shows that we deliver the same first assessment function through 111/CAS. It also shows that services will rapidly stream major life-threatening injury through the emergency route.

Services that can be delivered in or near to people's homes are differentiated from services they must travel to. The assessment function sits on the threshold, indicating there will be access to virtual advice (e.g. telehealth) without always having to make an extra appointment or journey.

There are hardly any reverse flows, on the assumption that our initial assessment will get it right first time.

How are we going to get there?

Programme Governance

Urgent and Emergency care is part of the *Healthier Together* system transformation programme, which incorporates several delivery subgroups. The governance structure for *Healthier Together* is shown overleaf.

The Urgent Care Oversight Board (UCOB) will be responsible for overseeing the delivery programme for the Vision and Strategy set out in this document. Reporting in to this, the A&E Delivery Board will manage programme delivery. There is currently an Urgent Care Programme Board/Control Centre which focuses on implementation and interdependencies with other programmes, although this function may be incorporated over time into the A&E Delivery Board.

The key areas of interdependency with Urgent & Emergency Care are:

- North Somerset Sustainability Board (Healthy Weston)
- Acute Care Collaboration
- Integrated Care
- Digital Transformation (including Connecting Care)
- Mental Health

Programme of Work

The Summary Programme on a Page at the end of this document shows which specific projects or capabilities will be delivered through other groups. The remaining key priorities for Urgent and Emergency Care to deliver are:

- Commissioning plan to support closer integration of services (e.g. integrated commissioning/integrated budgets)
- Demand/capacity plan (in partnership with Integrated Care) for step-up/intermediate care services, e.g. as a result of implementation of RESPECT/pre-deterioration plans and liaison with the Ambulance Trust
- Working across agencies and settings to design consistent urgent care services and solutions for the priority population groups (e.g. mental health, social care, children's services, drug/alcohol services)
- Mobilise new Integrated Urgent Care/Clinical Assessment Service (111)
- Commission 111 Online
- (Subject to Integrated Urgent Care/Clinical Assessment Service capability) develop design and plan for Common First Assessment at every point of access
- Develop and implement the commissioning plan for Urgent Treatment Centres
- Develop a comprehensive Directory of Services
- Scope and design an Integrated Assessment Function for BNSSG

As shown on the Summary Programme on a Page, these projects are at different stages of definition and delivery. Where necessary, the UCOB will mandate new work to be delivered through the A&E Delivery Board/Urgent Care Programme Board or other delivery group as appropriate.

In December 2018 senior strategic representatives of all organisations within the BNSSG STP/ICS responsible to deliver Urgent Care, came together for an event designed to “stress test” this strategy and refocus combined system wide efforts towards achieving its aims. The following are two of the slides that were produced as a result of the event, to represent the agreed system “refocus” and way forwards:

Agreed system priorities for urgent care

- ICB continuation & digitisation (capital requirement)
- Rapid / REACT
- Primary / secondary care interface medicine (future model for current GPSU/T & ED streaming)
- Acute frailty units & community frailty
- 7 day services particularly therapies
- UTCs (locality hubs)

- Same day emergency care (Ambulatory care extended hours)
- Integrated urgent care & the CAS

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Position Update

Following the two day UEC Accelerated Design Event held on 11th and 12th December, the transformation roadmap (developed at the end of the two day event) has been organised into seven groups of deliverables:

- Triage and Routing
- Developing Locality Hubs to Manage Urgent Need
- Digital and Data
- Training and Communities of Practice
- Social Marketing and Communications
- Implementation of New Payment Structures and Financial Risk Approach
- Clinical Governance and Risk Management

At the same time, as part of the single system planning process, all the change initiatives proposed in 2019/20 have been collated by the system planners, for review, oversight and prioritisation by the relevant programme groups (for urgent care this is the A&E Delivery Board)

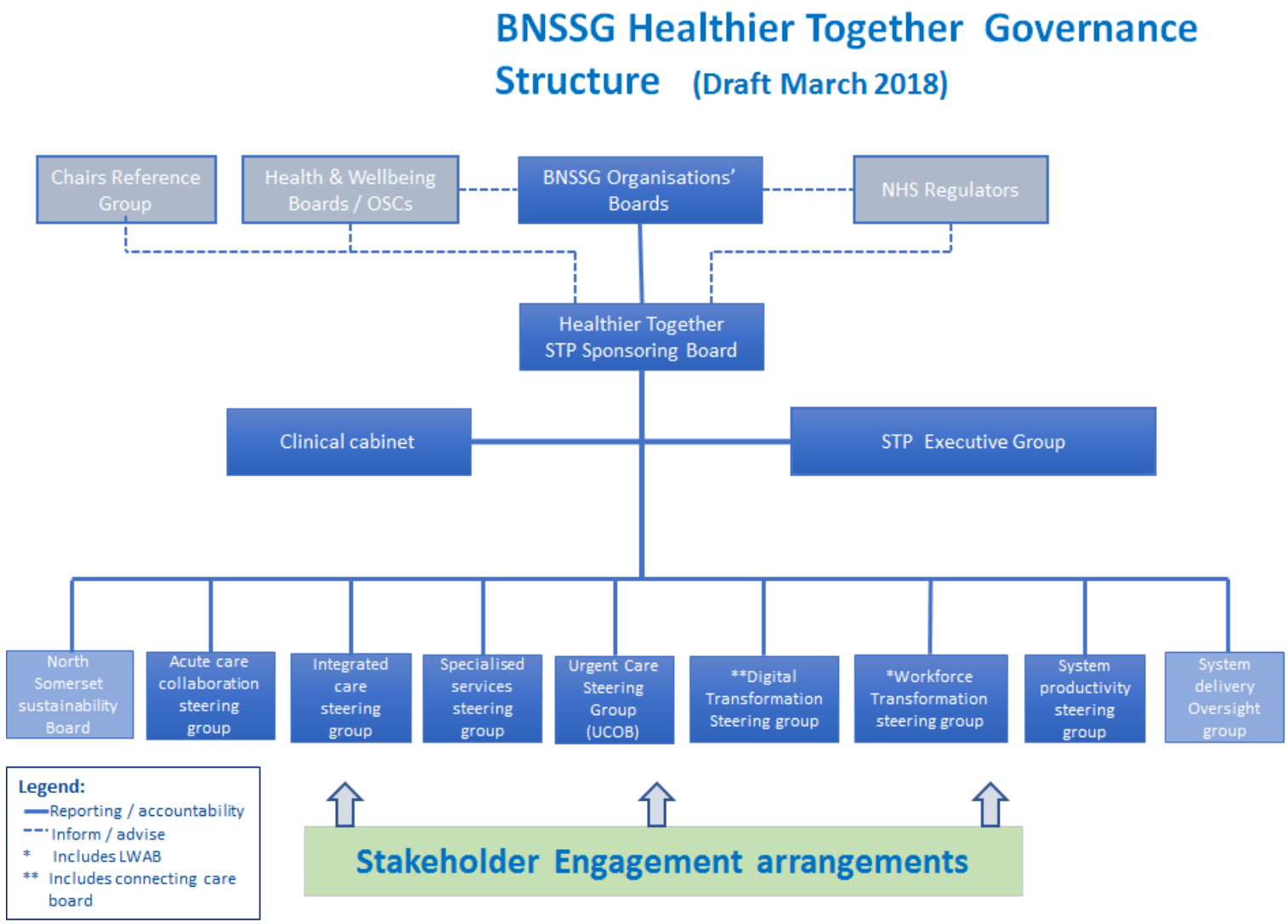
Delivery Methodology

Work will be delivered using standard project methodologies. In addition, we will continue to use the participative approach adopted to develop this strategy to ensure whole system input to the ideas, and involvement in implementation and evaluation. For example, wider stakeholder engagement may be used for:

- Joint design sessions, e.g. with Integrated Primary & Community stakeholders
- Regular topic-focused rapid improvement events focused on implementation
- Creating a virtual community of practice for communication and innovation via an urgent care 'microsite'
- Communication and update sessions
- Delivering training in service transformation skills and techniques, for example in partnership with West of England Academic Health Science Network
- Innovation sessions - more 'open space' collaborative sessions to ensure the strategy remains fresh and relevant through implementation
- Evaluation/peer review of changes implemented – either in pilot or in full
- Public feedback on experience and services offered (e.g. through surveys)

Next Steps

High level next steps	Timescale
1. Agree Vision and Strategy for Urgent and Emergency Care through the Urgent Care Oversight Board, and adopt it through the *Healthier Together* Sponsoring Board	**By August 2018**
2. Quantify and assess the impact of each intervention on each part of the system	**End July 2018**
3. Prioritise proposed projects (Urgent Care Oversight Board)	**End August 2018**
4. Agree Project Delivery and Reporting process, and delivery plan	**End August 2018**
5. Strategy Launch and public communication.	**September 2018**
6. Mandate new Project areas through the appropriate steering group and allocate delivery resource.	**July to September 2018**
7. Deliver Projects with continued engagement from system stakeholders	**Current to June 2020**
8. Review progress and impact; adapt plans according to innovations, new evidence, etc.	**Ongoing**
9. Capture and review benefits	**Ongoing**
10. Evaluate	**By December 2020**


BNSSG Healthier Together Governance Structure (Draft March 2018)
Chairs Reference Group
Health & Wellbeing Boards / OSCs
BNSSG Organisations' Boards
NHS Regulators
Healthier Together STP Sponsoring Board
Clinical cabinet
STP Executive Group
North Somerset sustainability Board
Acute care collaboration steering group
Integrated care steering group
Specialised services steering group
Urgent Care Steering Group (UCOB)
**Digital Transformation Steering group
*Workforce Transformation steering group
System productivity steering group
System delivery Oversight group
Legend:
Reporting / accountability
Inform / advise
* Includes LWAB
** Includes connecting care board
Stakeholder Engagement arrangements

Urgent Care Delivery 'Roadmap'