Urgent Care Pathways in Solihull

HASC Scrutiny Board update
March 2019
Overview

• Effective services, based at Solihull hospital site that are tailored to the needs of the population to provide a fast response and support appropriate admission avoidance

• 24/7 minor injuries unit with co-located GP service to treat illness and injury

• Separate Urgent Treatment Centre (UTC) with booked primary care facilities run by Badger

• Emergency admissions through the Medical Assessment Unit (MAU) with the ability to take more serious conditions via ambulance through the resus facilities at Solihull Hospital
Success stories

• Ambulatory Emergency Care (AEC) – A facility to support admission avoidance. Appropriate patients whose condition/diagnosis falls within the agreed clinical pathways are re-directed to AEC, from either the Minor Injuries Unit (MIU) or MAU, to receive prompt diagnostics and treatment, sent home where appropriate and come back to review clinics, rather than have an unnecessary overnight stay.

• UTC – Opened in October 2016, this was the first of its kind in Solihull. Commissioned by BSol CCG to deliver booked primary care and walk in services for minor illness and injury through a GP-led approach. Advantages of being co-located with MIU and MAU for more serious conditions.

• Clear pathways for patients requiring increased support and intervention for ease of transfer to Birmingham Heartlands Hospital if required
Performance in Solihull

Solihull Urgent Care - 4 hour target 2018

Solihull consistently performing above the 95% target
Challenges and Opportunities

- Increasing attendances to MIU – up 2% in the 12 months from Dec 2017
- Urgent ambulance attendances to MAU up 20% - same period as above
- MAU activity up 16% in the 12 months from Oct 2017
- Despite pressures, Solihull has still been able to maintain planned activity
- Further develop links with community services to better manage people in their own homes and prevent unnecessary attendances to hospital where possible
- Working with community services to promptly discharge people and support their ongoing recovery at home
Key priorities and next steps

- Due to the initial success, exploring how AEC can support a wider range of patients and conditions that could utilise this resource further to prevent unnecessary admissions.

- Increase use of review clinics to reduce admissions – key areas Cardiology and Respiratory.

- UTC – continue to develop the newly formed UTC with ability to provide booked appointments directly from NHS 111 service.

- Improve understanding of service planning for urgent and emergency services by increasing use of data and digital technology. An example of this is telemedicine in supported living environments - reduce conveyance of people living in nursing and residential homes to hospital by the provision of enhanced primary care or specialist care using telemedicine.
Case Studies:

Community Services input into admission avoidance

Impact of Older Persons Assessment and Liaison (OPAL) at Solihull Hospital
The Rapid Response Team in Solihull are responsible for providing support to people at a moment of crisis when they may need some urgent health care at home.

The team can go to a person's home and give them the care that they require and potentially prevent that person from having to go to hospital.
Activity and Impact

• The Rapid Response team received a total of 149 referrals to the service in January 2019

• Of these, 122 patients did not require an admission to hospital due to the support provided by the team

• 82% of referrals led to avoidance of an unnecessary admission to hospital
Community Matrons

• There are currently five community matrons working across Solihull

• Supporting people with complex needs and multiple health conditions in their own homes and working with them to stay as well as possible at home

• Proactive in working with people to make informed decisions about the healthcare they receive, particularly where interventions carry both benefits and risks and balancing these with people’s wishes at the end of their lives
District Nursing Teams

• Provide nursing care to keep people as well as possible in their own homes, and to avoid admission or dependency on hospital services

• Whilst there is no specific data to determine how many potential admissions may have been avoided, arguably without the care of the community nurses many more people would require admission or urgent care attendance
Community teams – Referrals and Active patients

- Over a six month period, all of the community teams combined receive around 6,700 referrals (approx. 1,120 per month)

- All of the community teams combined have a caseload of approx. 6,200 people being supported by the services at any one time

- This is a valuable resource that is working to keep patients as well as possible in their own homes and only attending hospital when absolutely necessary
Impact of OPAL at Solihull Hospital

- The team is achieving the targets set and has excellent patient and carer feedback, but what does this mean for the Solihull Hospital site? The graph below shows a picture of increasing discharges from the MAU department and the improvement starts at the same time as the OPAL team were recruited. The Solihull site has experienced a 16% increase in activity this winter but has not opened any extra capacity.
SupportUHome

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What is SupportUHome?

• It’s about people returning to independence after a crisis or hospital stay. Support may be provided for anyone over 18, although people 65+ are most likely to access.
• It’s is a range of short-term health and care services that enable the individual to regain or maintain as much health and independence as possible.
• Some of our services are rehabilitative and some provide short-term intensive health and care support. Services are time-limited, only for the period needed.
• It’s our way of bringing everyone’s ideas together, as part of the Solihull Together programme.
SupportUHome ambitions

We will:

• make sure people have been supported to maintain or regain as much independence as possible, before decisions are made about the need for long-term services
• aim to arrange support for hospital discharges within 24 hours of referral
• respond to a community crisis within two hours of referral, whenever necessary
• arrange for as few different people to provide care as possible, to provide continuity and personalised care.
What have people said about SUH supported services?

“I am writing to express my gratitude and congratulate your team on providing an excellent service”

“Excellent service. You have improved my independence at home”

“Enabled many of my patients to discharged home safely and in a timely fashion”

“You have all gone above and beyond and are wonderful caring people”

“Professionalism and kindness was second to none”

“I can’t say thank you enough to the Social Worker”

“Lucky to have the support of such a nice team”

“You have been very helpful and a credit to your profession in helping my dad”

“Showed great patience, compassion and understanding”
Structure

• Four work streams
• Senior Responsible Officer and leads for each work-stream
• Programme Manager working across all work streams
• SUH Board – effective decision making forum
• Representatives from many partnership organisations SMBC, UHB, BSol CCG, BSMHFT – joined-up approach
• All work streams have clearly defined plans outlining objectives and milestones with comprehensive project plans in place
## Work streams

1. **Effective discharge planning**
   - Aim: To ensure a standardised system wide approach to safe/quality, effective, timely discharge planning for patients during an acute stay, focused on ensuring people don’t spend longer than necessary and are not delayed.

2. **Straight home/Stay home**
   - Aim: To support a direct return home (or to stay at home) and minimise patient time in hospital, via a responsive, integrated service experience for users.

3. **Independent Care Sector**
   - Aim: To work with the independent care sector as system partners, to develop independent care services to be responsive, high quality and provide person-centred care.

4. **Intermediate Care Beds**
   - Aim: To ensure Solihull residents/registrants have access to high quality intermediate care beds, which achieve good outcomes.

[www.solihulltogether.co.uk](http://www.solihulltogether.co.uk)
Key achievements

- Refined intermediate care model, with agreed criteria and good outcomes for people receiving this support – occupancy rate of Intermediate Care (IC) beds 92% and 68% of people were able to go home after a period of support in IC (Jan 2019)
- Implemented an extended hours service (including weekends) working within hospital social work team to improve flow of discharges and reduce delayed discharges of care
- Increased capacity in the brokerage team to include a hospital focussed broker. Service has also been extended to cover weekends
- Reablement – Length of stay for people using the service reflects effective use of resources. Currently 4.2, weeks but there is rigorous review of the service planned to reduce this to around two weeks
- Proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation services, is 82% (Jan 2019)
Hospital Attendances and admissions 2018

Admissions vs home - Urgent care attendances for Solihull residents aged 65 and over (Heartlands and Solihull Hospitals)

*Other refers to patients transferred elsewhere or RIP
Average Length of Stay
2018

Average Length of Stay for Solihull registrants aged 65 and over following urgent admission (all providers)
Performance – Readmissions 2018

Readmissions for Solihull registrants aged 65 and over (all providers)

Solihull patients aged 65+ who have an emergency readmission within 30 days of discharge based on national PBR guidance
Performance – Delayed Transfer of Care 2018

Total Delayed Days

0 100 200 300 400 500 600 700 800 900 1000


Plan Actual

905 631 623 768 586 668 700 629
Key successes

Admissions vs Discharge from urgent care:
Throughout 2018, the percentage of people aged 65 and over admitted to hospital following presentation to urgent care services fell whilst the percentage of people going home increased

Length of Stay:
LOS for people aged 65 and over in 2018 decreased overall from just under 7 days to just over 5 days

DTOC:
Since April 2018 total delayed days has decreased from 905 days in April to 629 days in Nov - 30% reduction

Emergency re-admissions within 30 days:
Throughout 2018, the numbers of emergency re-admissions within 30 days for Solihull patients aged 65 and over has decreased
Key challenges

• Red bag scheme – Has been implemented. Difficulties in evaluation nationally and locally and more work is being undertaken to understand if it can become an effective model.

• DTOC figures remain higher than we would like, however, there has been a significant drop since April 2018 where these peaked at 905 days.
Key future priorities

• Further development of a system focussed performance dashboard which links work stream improvements with Solihull Together outcomes

• Review of communication materials to improve the information provided for people leaving hospital who may need ongoing support

• Straight Home work stream will be taking forward the ambitions of the NHS long term plan for integrated working between Health and Social Care

• Review of Rapid Response service will identify further opportunities for cross system working

• Bringing physical and mental health services closer together with the effective use of “step down beds” at Saxon Court and Alexandra House to reduce delays in hospital and also support carers
Summary

Recently published NHS long term plan outlines intentions for increased funding to support further development of community services.

There has been some good progress in both Urgent Care in Solihull and SUH, and we will continue to work towards the best possible care for the people of Solihull.

All partnership organisations that come together as part of SUH are committed to providing effective integrated care as well as high quality services in the community to ensure that people in Solihull receive the right care in the right place.

This will help to relieve pressure on hospital based services so that those that do require admission/attendance to hospital again get excellent care delivered in the right place.

www.solihulltogether.co.uk