Response to NHS Chief Executive’s Open Call for Evidence and Ideas

Respondent ID: 220

Organisation name: Locala Community Partnership Yorkshire Ambulance Service and Mid Yorkshire Hospitals NHS Trust

Type of response: Online and case study
**Respondent ID:**

220

**Your name (completed by):**

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**Organisation name:**

Locala Community Partnership

**Please choose the description below that best fits your organisation’s main role:**

Social Enterprise.

**What can the NHS and NHS Commissioning Board learn from national and international best practice to accelerate the pace and scale of adoption of innovations throughout the NHS?**

Understanding of what works well - identifying standards of practice.  
Basic care - learning from leadership "ownership" of care  
Sharing of information - stop the "you can’t see my data mentality" understand the wider picture

**What specific actions do you think national NHS bodies, such as the NHS National Commissioning Board, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

Push for web resources  
share of data  
Single records community - secondary care push towards use of technology

Industry - costings of products  
Prescribing look at best evidence practice not just cost  
Push media the "right time right place"  
Social marketing Choose Well campaigns - start planning NOW winter with care homes, individuals, elderly etc.

**Do you have any further comments about accelerating the adoption and spread of innovation in healthcare?**

Use web- based tools  
Webex  
Teleconferencing  
Social networking sites.

**We would like to be able to follow up interesting comments and case studies. Can we contact you for this purpose?**
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<td><strong>Do you want to be kept in touch with the next steps in this process?</strong></td>
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<td><strong>Do you want to be included in a wider community of interest?</strong></td>
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**What specific actions do you think local NHS bodies, such as providers and Clinical Commissioning Groups, need to take to encourage and stimulate the successful and rapid adoption and spread of innovations throughout the NHS?**

Audit local systems, understand gaps in care such as dementia end of life care, and follow patient journeys through system. Understand clinical and professional gaps in care.
Introduction

Calls from nursing and residential homes can be a high proportion of the demand to the 999 system. This pilot aims to improve the availability of emergency ambulances and clinicians to respond to life-threatening emergencies, while aiming to reduce demand on emergency departments. Improving quality of care provided to the residents by ensuring the right care is provided at the right time in the right place, improve end of life planning and choice of place of death.

Background

Following early discussions it was found that many ambulance clinicians were unaware of the role of the community matron and how they play a part in case managing patients to reduce number of admissions improve management of long-term conditions and improve co-ordination of care.

Ambulance clinicians frequently attend patients who are being managed by a matron but they are not aware of this at the time of the call or there was no system in place at the homes before the ambulance crew attended to be made aware of the ongoing care plans and normal medical state of the patient.

Prior to commencement of the project no concrete pathway existed for nursing and residential home 999 calls to be referred to the ambulance service clinical hub for advice or triage. Minimal information was shared between staff to the homes and there was no shared approach to improve services. No easy way to identify how many calls could be prevented in geographical area. Without education of care home staff and documentation to what is the “normal” it would be difficult for clinicians’ to manage the patient safely at home.

Despite having an established ambulance service and recently expanded long-term conditions (LTC) team, communication and collaboration between these provider services regarding LTC patient management was limited. Government drivers for ambulance services identified the need to reduce unnecessary A&E attendances and modernise pathways of care to ensure patients receive the right care, first time, in time (Warner 2005).

Once identified, the specific aim of collaborative working between the ambulance service and community matrons was in line with the Strategic Health Authority target to reduce 999 calls by 10%.
Pilot objectives

This pilot aims to
- Improve the availability of emergency ambulances and clinicians to respond to life-threatening emergencies, while aiming to reduce demand on emergency departments.
- Improving quality of care provided to the residents and improve end of life planning.
- To reduce hospital attendances and acute admissions from nursing and residential homes.
- To reduce emergency department admissions and length of stay in hospital.
- Greater understanding of the role of the clinical hub and how it can improve service.
- Identify if there any other ways of reducing 999 calls such as alternative pathways emergency care practitioners. Mapping any gaps in services.
- Increase the calls to the Clinical Hub and identify processes within YAS to improve the management of frequent calling care homes.

Information on how YAS records data.
The care homes are assessed and targeted by volume of call alone. YAS has no knowledge regarding the client type or designated number of residents in the individual homes.
The focus is on identifying issues through trend analysis and alerting each PCT via reports.

Each month’s data is compared to the previous quarter as a baseline. E.g. Aug 10-Oct 10 17 calls in total……expect 5 call in November, 6 calls in December and 6 calls in January
Actual calls are then assessed against the baseline calls.

All intervention is performance managed via quarterly baseline comparison.
The data relating to these patients is captured on the Executive team reports monthly. Understanding that this data is not just 999 driven but can also affect the costs to inpatient bed days.
Prior to the project the data had changed and became PCT driven not YAS driven. The report is now accurate to the top 10 homes for each organisation in order to aim to reduce demand and improve service.

Hospital data
Within the last year data pulled from performance management information using Mid Yorkshire Hospitals data has identified that 997 patients were admitted to Dewsbury District Hospital and the average length of stay was 13 days.
This was a significant cost once it included the admission, 999 transfer and tariff for ED.

Process mapping occurred to review the current pathway for patients who were frequent callers to emergency services specifically from care homes.
Discussions across the group led to an initial draft of a revised pathway of care for these patients. The key homes were quickly identified the “top 10” and 4 that were exceptionally high callers for a small bed base so these were perceived as quick wins. Several of the 14 calls in the pilot are not ringing OOH but calling 999 first.
Education was required for the homes to follow pathway
Results
Audit of the last 6 months of internal YAS data looked at specifics of calls –and aimed to identify if these patients were reviewed by medical staff prior to admission.

Gaps in service that have been identified were mainly around management of admissions, patients with dehydration, falls, dementia and also several > 90 year olds with cardiac respiratory arrest this may suggest that end-of-life planning and managing patients appropriately is essential.

Clinical Hub/ CCT
The ambulance service clinical hub is a dedicated team of experienced clinicians and support staff. It provides a single point of contact for patients who present to the 999 service with non life threatening conditions in line with “Right Care, Right Time, and Right Place”

Utilising the clinical hub will also be a driver for Locala Community Partnership in the developments of community care team as bringing the healthcare to the patient and the patient being the centre of all care provided. Information sharing of community care team concept—a team approach incorporating health and social care putting the patient at the centre of all care provided.

Understanding Data
Understanding the homes that are the highest callers will identify those which require further support and education in order to improve service. This will ultimately will reduce duplication of services and ensure the most appropriate person is providing care required for that patient ensuring patient-centred care.

Audit
- Audit of 70 calls from one local area specifically from nursing and care homes identified that 3 should have been a 999 cat A (life-threatening) call.
- A qualified nurse from homes may have very varying skill set as some may be more efficient than others and some may not be general nurse trained.
- Listening into a further 40 calls identified that 1-2 should have been a cat A (red) response. The rest should have been c or other pathways district nurses or hospice etc.
- Filtering out those calls required a 999 response. The timing of calls interestingly showed approx> 80% were in day time.

Actions from Audit
A meeting with Julie Williams (end of life facilitator for care homes) identified homes that had “signed up” to gold standards and understood those that were not using the education and practices they have been taught. Macmillan nurse specialists will link with homes identified and understand any issues or possible reasons for this forward planning not being achieved by homes, escalating to home management where appropriate.

Interestingly expected calls from intermediate care homes have increased this suggested that staff within ICT may need further understanding of when to call 999
and processes to follow include early planning before a bank holiday etc. Or due to pressure on the acute hospital patients may not be applicable for those beds.

A review was undertaken to understand if the specific patients admitted may not be suitable for ICT beds or if pressure from secondary care has pushed potential inappropriate admissions to these beds.

Review in one month to identify any further actions required
Meeting arranged with area home manager for Nursing homes to look at processes throughout the home not just intermediate care beds.

**YAS PROCESS**

From the audit of calls it has been identified that in a very small audit more than 80% of 999 calls from the target group could have had an alternative response- than a category A(red ) response

The author has a limited experience in using medical priority dispatch systems so may be not 100% accurate in suggestions – however clinical experience in triage and advanced clinical skills suggest ideas on how calls could be managed differently

YAS internal review of processes identifies those emergency medical dispatchers (EMDs) who could potentially use the priority dispatch system of questions and answers. This may reduce the incidence of emergencies HCP (health care professional Red) and may offer alternative pathways at source for these calls

**Mental Health support**

Following the TCS challenge we were awarded funding for a CPN to look at the frequent callers.

This project will give us the opportunity to pull in resources to identify by looking at what the current questions are and triage tools used by YAS. This may identify training needs or specialist case reviews for mental health patients who are frequent callers. This may in turn lead to the planning or influencing of these patients plans of care at home and in the community.

The Mental Capacity Act will come into play as this is a difficult line to negotiate for clinicians. It might need me to look at some specific cases with the clinicians to understand the dilemmas and issues and may highlight training needs.

Training could give be provided by the expert CPN or where best to signpost for timely treatment and care; ultimately in order to manage more efficiently patients in their home environment.

Funding is in place Dr David Macklin will enable a CPN in post short term to aid in achieving these goals.

**Further Suggestions**

Trial of nursing homes being “flagged” and having to use AMTS or Q&A – to a health care professional. This may improve the appropriateness of 999 calls.
Information for care home managers

Letter to each care home informing them of the plan of project to improve services and identify which matron would potentially linked if not doing already. With the development of the community care team this may be easier as will have a team including district nurses who may already have patients within the specific care home and relationships may also be in place.

In order to work better with our partners it is essential to ensure the directory of services is accurate with key numbers for clinical hub to contact palliative care and single point of access district nurses. The author is pulling together an updated list of contact numbers.

Aside of this primary focus, this whole process has facilitated improved communication and networking across healthcare boundaries which has proved extremely valuable for the community matron teams, as a recently expanded service, at a time when the value of the role in co-ordinating complex case management is high on both local and national healthcare service specifications.

Despite appearing a simple solution to the problem, the partnership working and effective transformation of traditional services has been vital to the early success of this initiative. Reviewing existing pathways, evolving services and therefore better ways of working across healthcare boundaries has facilitated a significantly improved service for both patients and healthcare professionals, whilst achieving local and national healthcare service specifications.

Monthly report of demand may identify what other interventions or processes would need to occur to achieve the goals of the project.

Management of nursing and residential home patients appropriately allows the urgent care system to respond more timely to life-threatening emergencies and enables patients to receive appropriate care closer to home with their place of death being considered and adhered to.

Financial benefits

Frequent callers cost the local health economy 11 million a year (better for less 2010).
By improving service can ultimately reduce costs, improve quality and subsequently improve the patient experience.

Frequent callers cost the NHS almost £800,000 per pct. Reducing these could save the PCTS approx £400,000. (York’s and Humber better for less 2010)

Innovation and sustainability

Early evidence demonstrates the benefits of well planned and co-ordinated partnership working, benefiting both patients and healthcare professionals.
The strategic health authority has identified a benefit of this partnership working by agreeing to fund a part-time data analyst to help pull results together in order to enable this process to be shared across Yorkshire and the Humber regional health authority.
Next step

Monthly review of the care homes activity identifying trends
Monthly review of OOH activity linking into the OOH individual patient data on the 14 homes chosen.
Monthly feedback to all stakeholders re development of the project
In three months time it is anticipated that we would see a further improvement in reduction of 999 call activity. It would also be expected that if a 999 response was sent then it would appropriate to that specific call.

To date, we have seen a 20% reduction of activity from 14 specific homes however we are keen to formally evaluate this. We now have administrative support that will continue to monitor each home activity and identify overall demand so that we can achieve our aims. - Data will be provided by graphs in final report.

Feedback – Flowchart / clinical Hub

“It takes the responsibility off us if we not sure it’s another port of call – knowing when to call district nurses and matron improves things for our residents!”
(Deputy Manager Care home West Yorkshire)
This has now been removed from the list as it has gone from being a frequent caller 12-14 calls a month to now 2 calls last month which were appropriate.
Acknowledgements

- Dr David Macklin Associate Medical Director YAS
- Dr Jeremy Till Consultant ED Dewsbury district hospital.
- Long term conditions team Locala community partnership.
- Robert Flack CEO Locala Community Partnership
- Annette Strickland Frequent caller case manager Yorkshire Ambulance service.
- Julie Williams EOL Facilitator for care homes Locala Community Partnership
15/06/11

Dear Home Manager,

I am writing to update you that Locala Community Partnership in partnership with Yorkshire Ambulance Service is commencing a project within nursing and care homes to try to identify how we can support you in providing care to your residents in the most appropriate place at the right time.

We are reviewing calls to 999 in order to identify if we can provide any assistance or training to reduce the incidence of calls and improve planning for your often vulnerable patients. We aim to develop better pathways for you to use in place of a 999 ambulance.

Please feel free to advise us of any issues or difficulties you may have come across relating to this pilot, and identify any specific training needs that you feel you or your staff may have.

Please see feedback form enclosed

We are keen to work with you, district nurses, community matrons, Macmillan nurse specialists and GPs.

We are hoping to ensure that patients are receiving a high class service and encouraging gold standards in end of life care and improve in the management of their long term conditions.

We are hoping that you can utilise our new service as a pilot by calling

0xxxxxxxxxxxx (current number) FROM 5TH JULY 2011

For Non life threatening emergencies please see flowchart enclosed.

Do not hesitate to contact us if you have any ideas or suggestions for the development of this project.

Kind regards

Angela

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angela.harris@yas.nhs.uk

Annette Strickland YAS  
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### Patient details

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<tr>
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<tr>
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<td>Care First/ social service ……</td>
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#### ACTION PLAN (self management)/ signs of deterioration

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**INFORMATION FOR EMERGENCY SERVICES**

**Allergies**

**Medications (correct as of ...)**

**Past medical history**

**Normal Baseline observations**

**Professional network**

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<th>Name</th>
<th>Address</th>
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If you use this form can you please leave a message on office phone number in order to audit its effectiveness in order to improve patient care

*“All healthcare information is collected, held, shared and used for the benefit of patients. Everyone working for the NHS has a duty to keep the information we hold about you confidentially. If the purpose for using your information is not for your direct healthcare we would ask your permission before doing so.”*
Developed by Angela Harris, in consultation with Sandra Gott, Louise Thornton, Janet Walshaw, community Matrons and Ken Lowe & Cathryn James (YAS)