Sussex Health&Care

Urgent and Emergency Care

Brighton & Hove HOSC

July 2024

Improving Lives Together

Introduction

We know that patients attending the emergency department at Royal Sussex County Hospital do not always receive timely care. The departments faces challenges in meeting the 4 hr A&E standard, and more patients experience ambulance handover delays, wait for more than 12 hours, and experience long waits for admission than at other Emergency Departments across Sussex. The long term plan to improve the flow of patients through the Emergency Department is through a rebuild of the department which is expected to progress over the next 3 years. Alongside this are a series of shorter term improvement actions which we have summarised in the following slides.

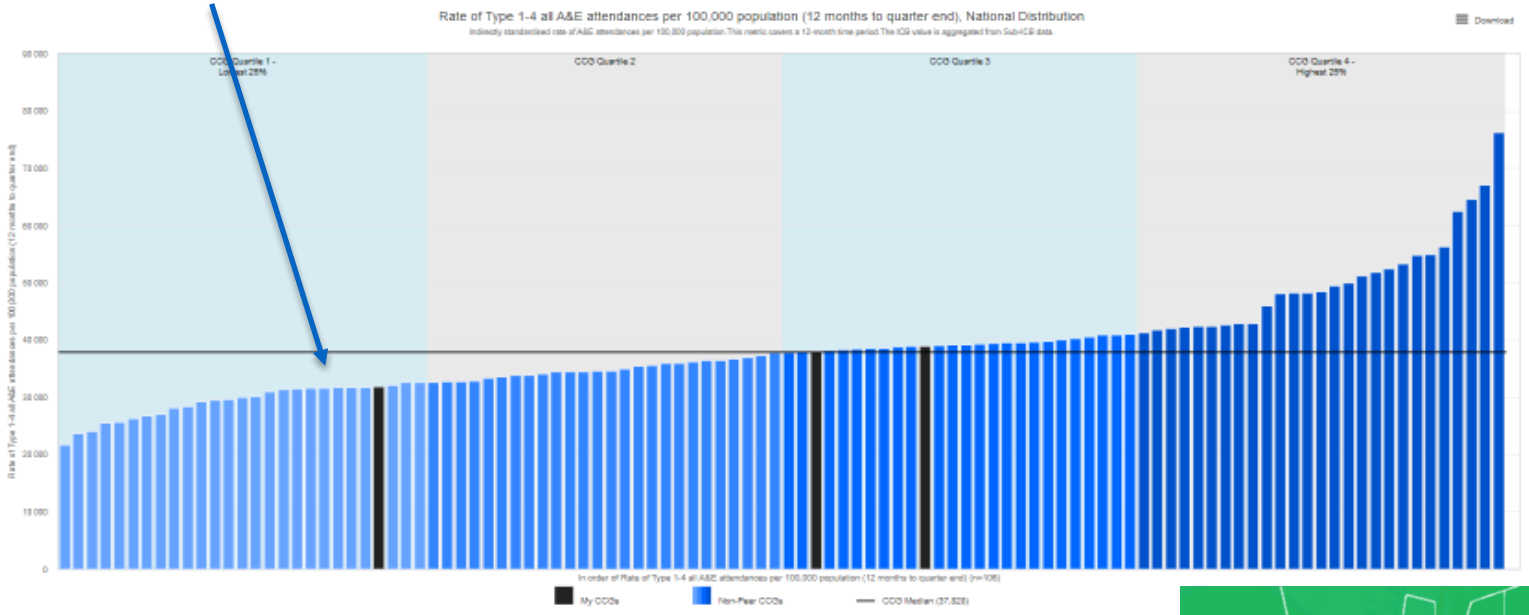
Key points to note include:

- Partners including the local authority and the Voluntary, Community and Social Enterprise (VCSE) sector continue to work with the NHS to provide services in the community to reduce attendances and ensure patients are seen in the right settings.
- The use of Virtual Wards and Community Urgent Community Response services, along with enhanced primary care is being expanded to reduce the number of emergency attendances and admissions.
- Several commissioned services are provided at the front door of the Emergency Department to support same day discharge.
- NHS partners and the City Council are working in acute, community and mental health settings to ensure that patients are discharged in a timely manner with the aim of improving flow through the hospital. More work is being done by the City Council to improve assessment times for care across all settings working within a multi-disciplinary team co-located in the same room at the hospital as part of the Transfer of Care Hub.
- The ICB is also working with Health and Care partners to deliver the Improving Lives Together strategy through the development of Integrated Community Teams working at neighbourhood level. The initial focus will be on delivering proactive care to the most complex and vulnerable patients with the aim of reducing avoidable exacerbations of ill-health and improving the quality of care for older people. This includes the delivery of proactive support for people living in care homes.

Community Care: Preventing A&E attendances and hospital admissions

Attendances

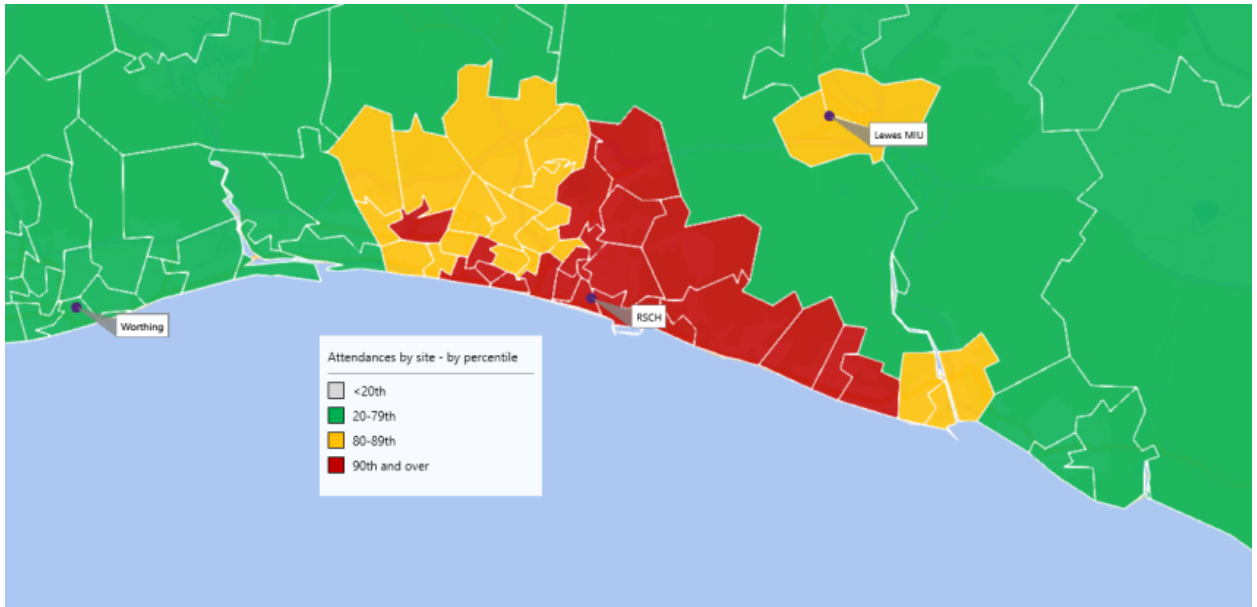
In 2023/24 people in Brighton and Hove were less likely to attend the Emergency Department than elsewhere in the country (in the lowest quartile nationally).



Some of the main reasons the people who do chose this service over others includes:

- Proximity to hospital
- Living in areas with high rates of deprivation
- Being of working age and/or student population
- Homelessness
- Complexity of need

The table (right) shows A&E attendances by percentile at RSCH between March 2023 and April 2024 by Middle Layer Super Output Areas (MSOA). Super Output Areas (SOAs) are a set of geographical areas developed following the 2001 census. They are used to give a set of areas of consistent size, whose boundaries would not change (unlike electoral wards). Middle Layer Super Output Areas (MSOAs) on average have a population of 7,200.



Actions Supporting People Away from ED

A key area of system focus is developing schemes to better support our people outside of having to attend ED. These include:

- Enhancing Primary Care
- High Intensity User Services
- Urgent Community Response Teams
- Virtual Wards
- Teams at the Urgent Treatment Centre and Front Door of ED to get people to the right place in the right time

Primary Care

- **General service provision:** 1319 Enhanced Access GP appointments are offered in Brighton per week*. This is in addition to the average 139000 appointments per month (up from 117,766 per month pre pandemic). Additional services are in place to offer alternatives to GP care where appropriate, including Pharmacy First, Walk in Centre, Enhanced Care in nursing homes; use of 111 and the walk in centre. The safe space works in the nighttime economy to offer care for patients *in situ* and prevent conveyance to hospital wherever possible. A number of initiatives including the staying well service, VCSE and open access services, and the Havens support flow and alternatives to inpatient admission for patients with mental health issues. To support this work further the relationship between the Havens and Mental Health Liaison Team based at RSCH is being strengthened to ensure a proactive pull of these patients from the acute Trust where appropriate.

- **Targeted service provision:** Several services have been commissioned to address the needs of specific patient groups and reduce the chance of accessing acute care. For example, a dedicated GP practice for the homeless ensures they have access to the same primary medical care as any other Brighton resident. Falls prevention services are offered to those at risk; VCSE support is targeted at High intense users of acute services (case study on subsequent slide); the VCSE offers proactive support to the most vulnerable by connecting them to health and care services across the city, empowering them to identify early health and social care needs; and finally, our Brighton place based transformation partnership programme, led by the City Council, supports adults experiencing multiple disadvantages.

Future actions

As part of our strategy *Improving Lives Together* we will roll out Integrated Community Teams across Health and Care at neighbourhood level to:

- Provide more proactive, personalised care with support from a multidisciplinary team of professionals for patients who may have more complex needs in the community to reduce admissions or in hospital to facilitate timely discharge.
- Build on our assets, and social capital by mobilising our communities working with our partners including the VCSE to enhance prevention including improving immunisation and vaccinations and enable self-management where appropriate.

* 19785 minutes calculated at 15 min per appointment according to British Medical association Guidelines. However, slots should be tailored to meet local population needs and will vary depending on the type of appointment being offered

High Intensity Users

Research has shown a clear link between high intensity use (HIU) of emergency services and wider inequalities. High intensity use is greatest in areas of deprivation, and across all age groups it is associated with issues such as homelessness, being out of work, mental health conditions, drug and alcohol problems, criminality, and loneliness and social isolation. Based on NHS England HIU principles, HIU services offer people with high attendance at ED, psychosocial support, crisis planning, and signposting within their own community.

In Brighton and Hove we commission a HIU service provided by the British Red Cross. To date the service has provided support to 47 clients who had been identified as frequent users of services. 33% of clients reside in Core20 areas (the most deprived 20% of the national population as identified by the national index of multiple deprivation (IMD)). The table to the right shows the impact of working with these clients both before and after intervention, showing significant reduction on ED attendances, admissions into hospital, and ambulance conveyances.

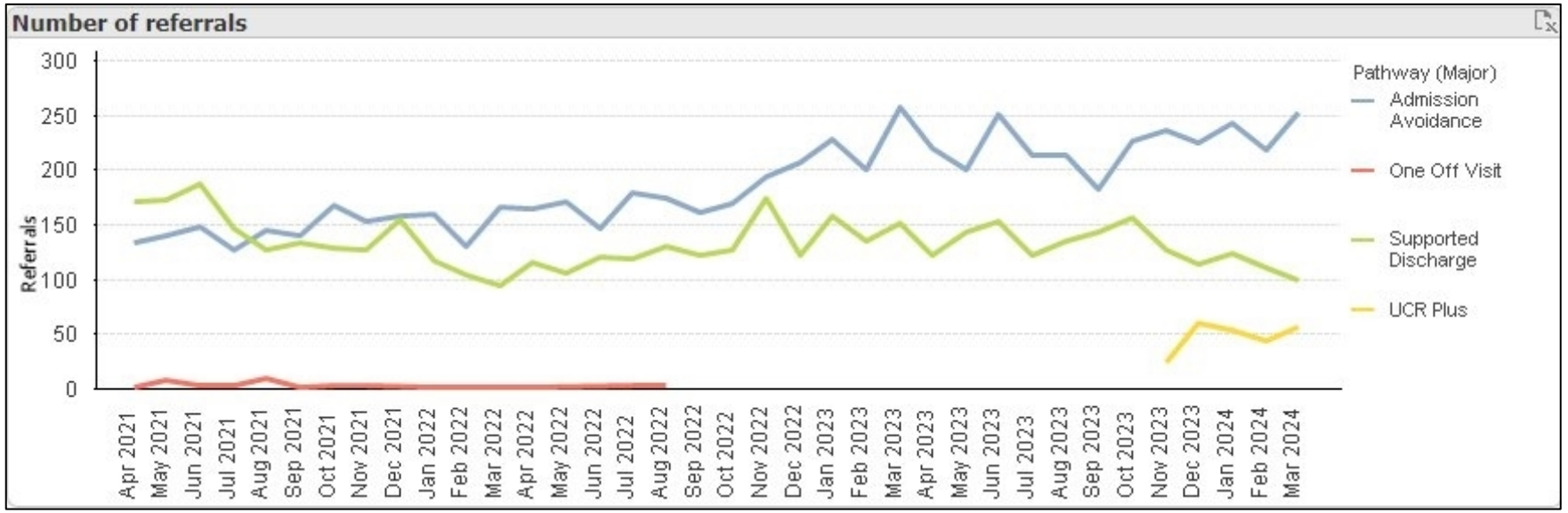
	A&E Attendances	Hospital Admissions	Ambulance Conveyances
Comparable time frame pre support	403	86	177
Comparable time frame post support	258	64	80
Total reductions	-145	-22	-97
% Variance	-36%	-26%	-55%

Urgent Community Response

Sussex Community NHS Foundation Trust (SCFT) provides a comprehensive Admission Avoidance service for patients across Brighton & Hove. The pathway is delivered via the Urgent Community Response (UCR) service which is a multi-disciplinary team including a GP, nurses, therapists, pharmacist and health and care workers.

B&H UCR receives an average of 300 admission avoidance referrals per month from a wide range of sources including primary care, 111, South East Coast Ambulance Service (SECAmb) and nursing and residential care homes (see table below) . The service aims to see all urgent patients within 2 hours, achieving 88% in May 2024 against a target of 75%. Most referrals within UCR require admission avoidance support, with a significant increase in referrals since 2022. The recently implemented UCR Plus supports patients with a higher acuity on a Virtual Ward pathway - referrals for this service are all admission avoidance. UCR also supports patients coming out of hospital on a supported discharge pathway.

Since March 2024, SCFT has been working with SECAmb on a pilot for UCR staff to have direct access to the SECAmb portal, which enables staff attend to lower category call patients directly and support the wider urgent care system. A total of 83 patients have been seen and treated by UCR, enabling patients to stay in their own home and avoid unnecessary admissions to hospital.



Plans are in place to expand the number of patients UCR can treat each day via the Virtual Ward model which enables patients to be under the care of a UCR GP and receive treatment and care they would ordinarily receive in hospital.

Virtual Wards

A Virtual Ward is a safe and efficient alternative to NHS bedded care. Virtual wards support patients who would otherwise be in hospital to receive the acute care and treatment they need in their own home. This includes either preventing avoidable admissions into hospital or supporting early discharge out of hospital.

In Brighton and Hove, Sussex Community NHS Foundation Trust (SCFT) operates the virtual ward. Table one shows the referrals in recent months. This year there has been a significant focus on increasing from supported discharge to admissions avoidance, as demonstrated in table two.

The SCFT Virtual Ward team consists of a dedicated General Practitioner, Nursing and Therapy and a wider support team of Pharmacy/ administrative staff. All face-to-face care is provided by the Virtual Ward team including medical interventions such as prescribing, TTOs and communication. Going forward, the intention is for the acute hospital to provide advice and guidance for the patients under the care of the General Virtual ward GP and will be part of the Multi-Disciplinary Team where necessary.

Table one: Referrals into Virtual Wards (Brighton)

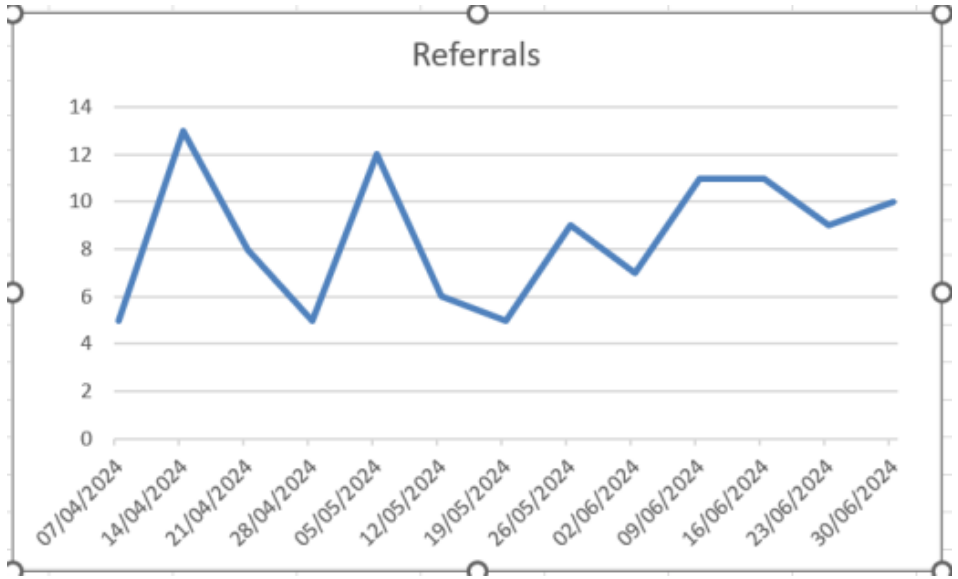
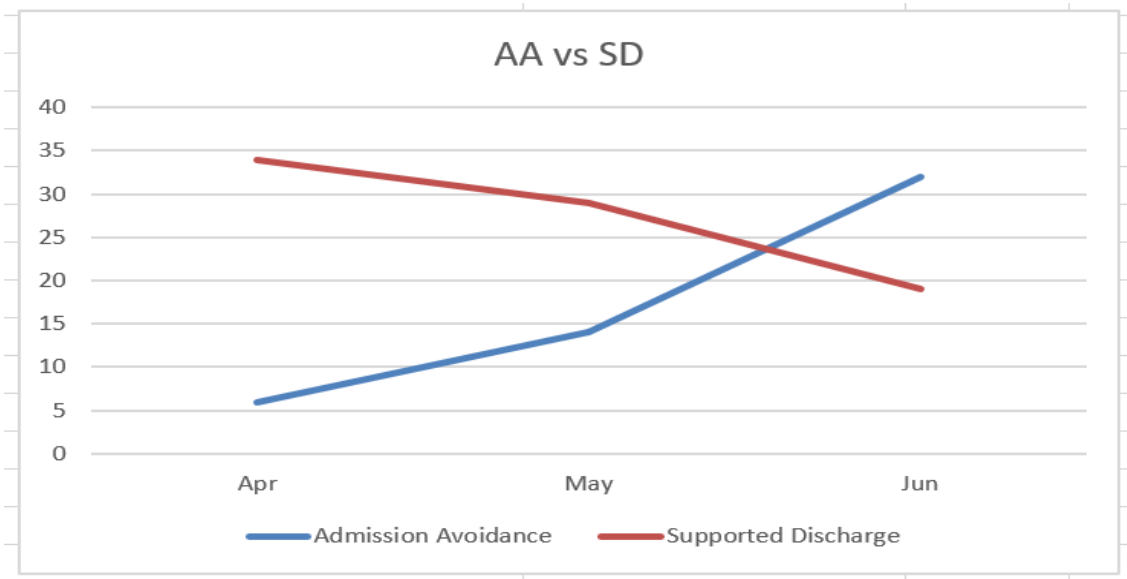


Table two: Split between Admissions Avoidance (AA) and Supported discharge (SD)



Front door at the Emergency Department and Hospital Journey

Front Door at the Emergency Department (ED)

These are the teams we work with to support people who present at ED but could be better supported in a different way:

Urgent Treatment Centre at the Front door of the ED: Care navigators work in partnership with adult social care to identify social care needs and other need such as housing. This includes engaging with the ambulance service during handover.

Admission Prevention Team: A multidisciplinary front door admission prevention team led by the City Council works with the NHS to support patients to facilitate same day discharge by providing care, social prescribing, emergency care packages as required. In April 2024, 160 patients were discharged from the front door with 83% of patients screened return home; 6% of patients were referred to short term beds to get the support they needed before going home; and 11% of patients had complex health needs and were admitted.

Housing Team and Duty to refer: The City Council housing officer is linked to the front door and co-located within the hospital to respond to those who are homeless or vulnerable from a housing perspective. Sussex homeless data highlighted that the largest proportion of homeless attendances (approximatley 40%) is for ‘Psychosocial / Behavioural Change’, and the effects of alcohol and/or drug use

Additional primary care appointments at the front door: Face to face and virtual primary care appointments are available 7 days a week to support those patients who present at the hospital with conditions which are more appropriately managed in primary care.

RSCH Emergency Department Challenges

- Maintaining and delivering the 4 hour Standard of Care - In June 2024 – 55% of patients seen and left within 4 hours, against a national operating target plan for 2024/25 of 78%.
- Supporting Timely Ambulance Handovers - 10% of patients arriving by ambulance waited over 60 minutes for handover in June 2024.
- High numbers of patients waiting in ED for longer than12 hours:
- Whilst between May 22 and April 2024, attendances in ED remained stable, we have seen a 16% increase in admissions from ED into the hospital itself in the last quarter.
- Constrained estate housing our emergency department which results in corridor care.

Internal Actions to Improve UEC at RSCH

- Continuous Flow Model: transfer patients from ED to wards at planned interval times to ensure early movement from ED each morning.
- Ambulatory Clinical Decision Unit (ACDU) utilisation: improvement cycles based on Plan Do Study Act (PDSA) are ongoing to improve utilisation.
- Emergency Ambulatory Care Unit (EACU) utilisation: to create capacity and increase flow from ED to assessment areas.
- Opening Surgical Assessment Unit LA6: which will reduce the surgical demand in ED.
- Pharmacy First: redirection of patients to pharmacy services.
- Implementation of regular huddles: huddle agendas in place, occurring daily at 09:00 and 15:30 to enable patients to be streamed to the right service.
- Reducing the time at which ‘Wardable’ patients are discharged from Critical Care: Early identification of potential ‘wardable’ patients to enable planning and transfer within hours.

Timely and effective discharge from hospital

Enabling Discharge

There are a range of schemes in place to support effective discharge:

- **Home to settle services:** NHS Sussex commissions VCSE to provide transport and practical support for those going home.

- **Carer hub:** the hub is co-located at the hospital with link workers to facilitate discharge and support for carers.

- **Multidisciplinary Transfer of Care Hub:** Adult social care workers are physically co-located in the same workspace as NHS staff at the hospital to facilitate a multi-disciplinary team (MDT) approach to discharge.

- **Discharge to Recovery back home:** An MDT team supports patients to go home as soon as they are ready. This includes therapist, nurses and social care workers who provide support and assess patients level of need.

- **Optimising all available community capacity and ensuring timely flow out of the capacity**: The City Council has commissioned a number of reablement beds; 5 beds for people who are homeless, 7 Mental Health beds and 8 physical health discharge to assess beds. NHS Sussex commissions 58 beds and commissions Urgent Community Response from the SCFT. UCR enables patients to go back home on a HomeFirst pathway while waiting for adult social care to assess and source packages of care.

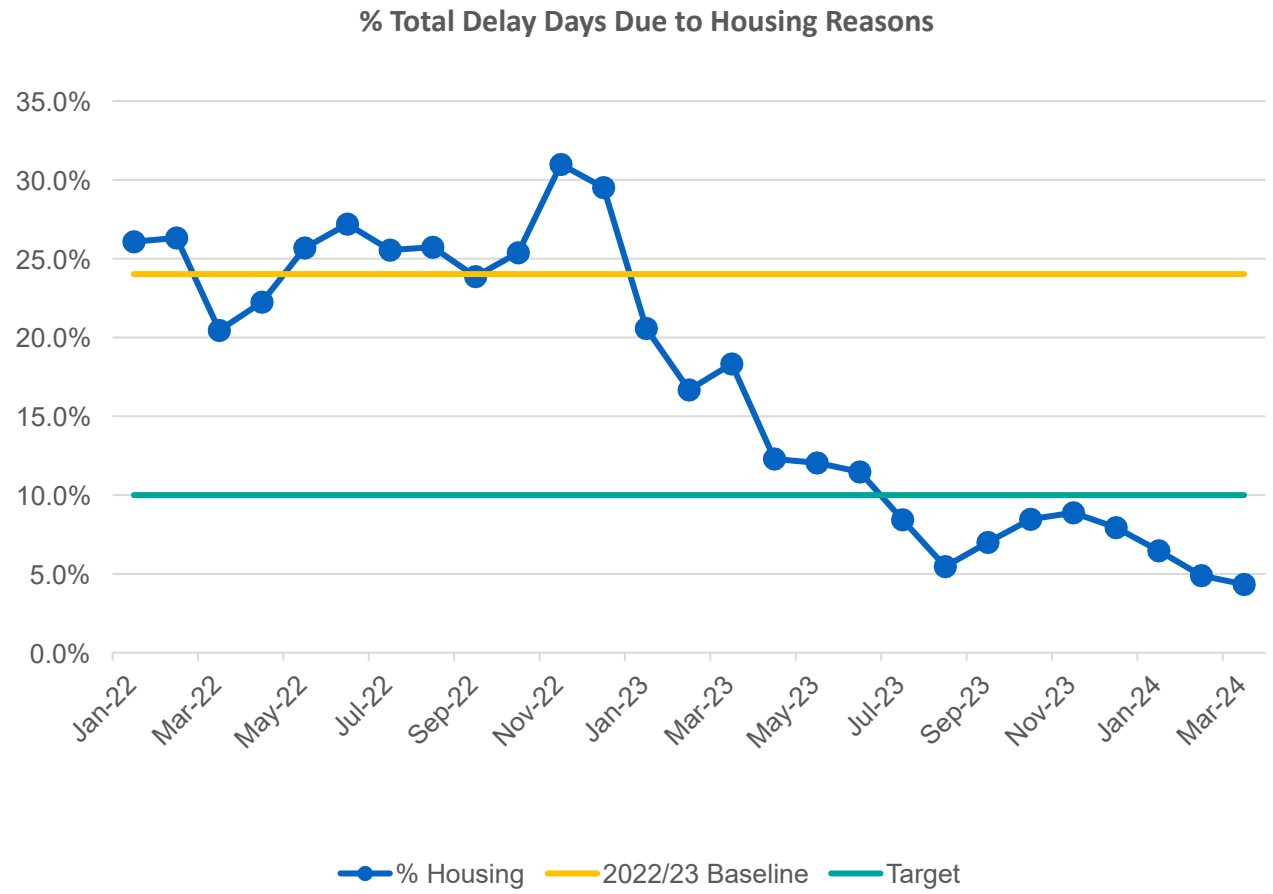
- **Responding to delays related to Housing and Mental health**– see next slide

Sussex Mental Health Housing Programme

Poor housing is associated with poorer physical and mental health outcomes. With this in mind, Sussex Partnership NHS Foundation Trust has committed to delivering the Sussex Mental Health Housing Strategy. This strategy is underpinned by evidence of the impact on mental health of poor-quality housing. NICE recommend that housing interventions are made accessible within health settings as part of a holistic treatment offer.

What SPFT are doing:

- Expanding the integrated housing workforce (11 Housing Specialists) within SPFT which has successfully reduced housing related delays to discharge from 30% to less than 10%. This integration of a housing workforce to enable colocation of staff with Local Authority (LA) housing departments allows direct access to statutory housing functions (social housing allocations, homelessness duties etc). This includes the development of MoU with all District and Boroughs & the City Council.
- Expand the Trust's Supported Tenancies scheme in 25/26 by a further six tenancies- building on the outputs from the two Mental Health Quality Summits.
- Developing a case for change to repurpose inpatient rehabilitation beds as supported housing model- underway.



Further SPFT initiatives planned and underway to support the Mental Health UEC pathway

1. THE HAVEN	A review has made a series of recommendations which will be implemented to optimise the work of Havens to support flow and alternatives to inpatient admission. This will include developing a strengthened relationship between the Haven and MHLT and proactive pull of patients from RSCH.	By March 25
2. HIGH INTENSITY USERS	Approach to HIU in Brighton will be developed as part of the emerging system plan for HIU, building on audit work already undertaken.	By March 25
3. CERN PATHWAY	Programme of work to develop the Complex Emotional Needs (CEN) pathway to support different outcomes for patients with complex emotional needs, including work to maximise use and effectiveness of the Lighthouse.	Dec 2024
4. BLUE LIGHT SERVICES	Reimagining of the offer to police, other partners (and the public) in light of RCRP. Coproducing a new model based on the positive impact of the BLT service in NWS to support rapid advice and guidance and hear/see and treat (including community based mental health assessments undertaken 24/7).	Phase 1 March 2024 Phase 2 Oct 2024
5. MH VEHICLES	Phased procurement and roll out of the nationally funded mental health response vehicles (MHRV). The vehicles will be staffed by SPFT Blue Light Services Staff (qualified staff and support worker with additional physical health training) and provide 24/7 assessment and triage in the community.	Phase 1 - March 2024 Go live Phase 2- Sept 2024-March 2025
6. SMHL/ NHS 111 PRESS 2 FOR MH	Continued review of the SMHL NHS111 press for mental health service to optimise as far as possible including development of a SPoA within the current contracted envelope. Potential to include Compassionate calls within this initiative and combine existing resources providing telephone based clinical advice and guidance.	March 2024
7. CRHTT	Working with the CRHTs to establish a new clinical model, supporting rapid assessment, facilitated discharges and therapeutic home treatment, reducing unwarranted variation and the potential for access inequity.	Phased steps to be defined. Full implementation planned for Sept 2024

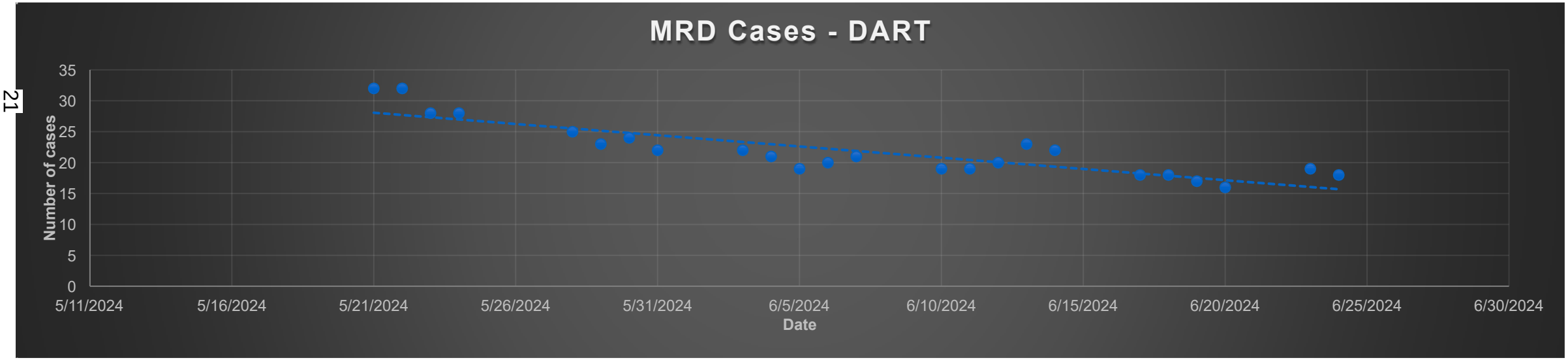
Further SPFT initiatives planned and underway to support the Mental Health UEC pathway

10. WINDING DOWN EOU	SPFT to work alongside UHSx to wind down the EOU and aim to reduce attendance.	October 2024
11. ADMISSION AVOIDANCE	Clinical Complex Case Review (CCR) MDT of patients waiting for informal admission in the Haven and in ED to be established and review trusted assessor approach / role of the CRHT in gatekeeping admission.	July 2024
12. PRIOTISATION FOR ADMISSION	Ambition to gradually reduce the amount of time people wait for admission whilst waiting in the EOU where possible. Currently the approach has been a risk-based, clinically prioritised approach, working across the Sussex mental health system to manage the demand for inpatient care based on patient need.	By July 24
13. LOS QI – MILL VIEW	Quality Improvement work is being rolled out to Caburn ward and will be extended to wider Mill View Hospital wards in the coming months to support a reduction in LOS and improve flow.	Q1-2

The role of Adult social care in supporting flow

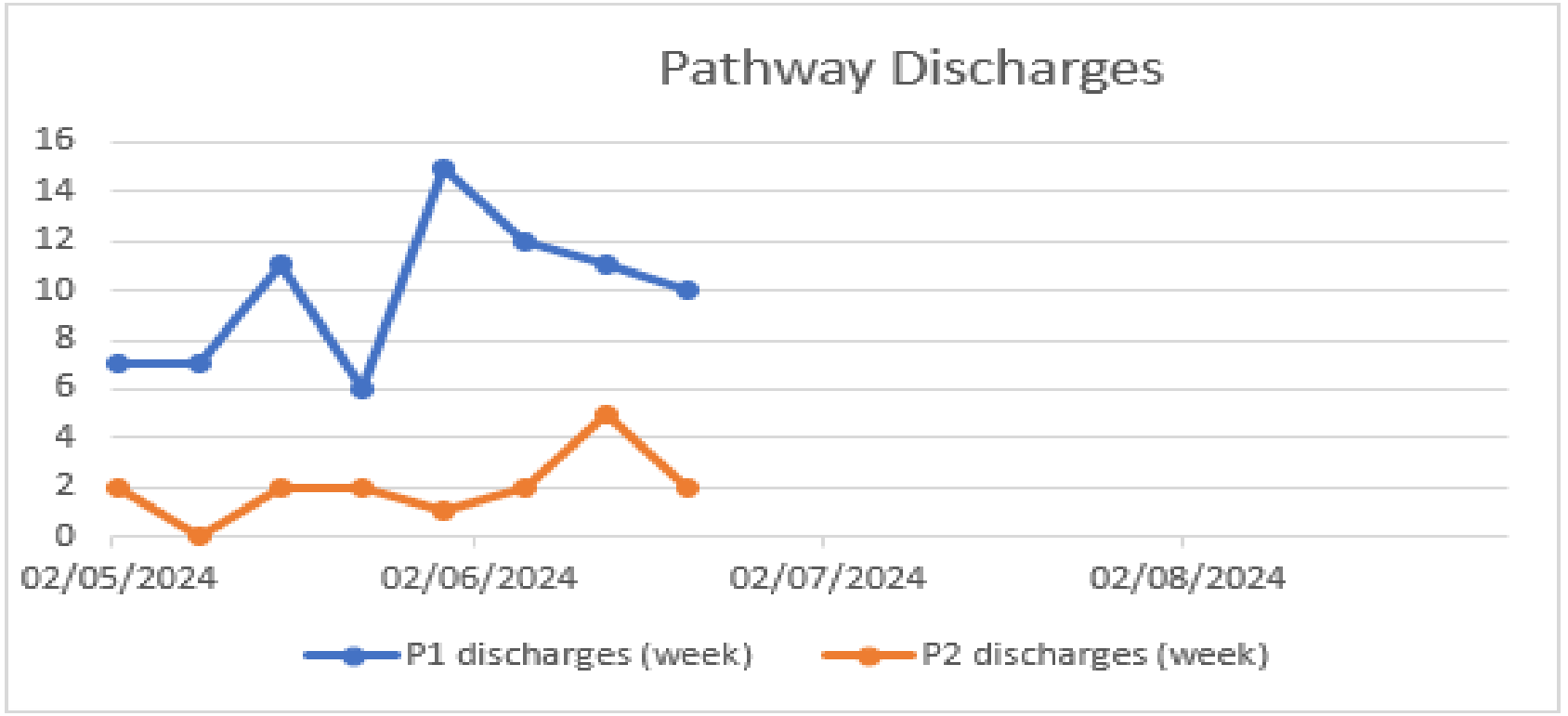
Brighton and Hove City Council (BHCC) are currently managing on average 180 active cases across two teams. These are the Acute Hospital Social Work Team and Community Team covering Pathway 1 (Discharge to Assess) and Pathway 2 (step down/rehabilitation beds).

BHCC have a recent average of 20 service users being NCTR (delayed).



B&H Hospital Discharge pathways

There has been recent good flow from Pathway 1 (Discharge to Assess via Urgent Community Response) & Pathway 2 (step down/rehab beds).



B&H Adult Social Care – Improvement actions undertaken

Our improved position can be related to a number of actions being put into place such as:

- Short term redeployment of Care Managers and Social workers from other parts of Adult Social Care.
- A locum Social Worker to support to work both in the hospital setting and community to reduce waiting times for assessment.
- Development of a Trusted Assessor Pilot in conjunction with Sussex Community NHS Foundation Trust which has commenced. This enables clinical staff based in our partner organisation to undertake Care Act assessments on behalf of BHCC, to improve outcomes and reduce delays on post hospital pathways.
- Increase in the Craven Vale reablement beds from 8-12 (end of May 2024). This service is fully utilised with an average length of stay of 27 days, after which the individual returns home with low level support or independently.

Admission Prevention Team (APT), which has been operational for 1 year and this team has been based in Patient Handover area and corridor in A&E (RSCH). The APT focuses on same day discharge and admission avoidance and recent data showed:

- Over 1500 patients screened.
- 6% of patients screened are supported to step down beds (new pathway).
- 54% of patients screened are discharged (over 700 patients).