Winter improvement collaborative

Urgent and emergency care improvement guide to contact hubs for primary care, ambulance and clinical calls

NHS IMPACT
Improving Patient Care Together

Introduction

A series of 'Urgent and emergency care improvement guides' have been designed for providers and systems to consider embedding as good practice to reduce ambulance handover delays.

The contents have been drawn from the Winter Improvement Collaborative which was set up to identify solutions to the problems facing the system over the winter period. Members of the collaborative were asked to co-design a series of plans and potential improvement measures, to be adapted and trialled at local level.

Throughout the process there were opportunities to understand what is working and what is proving challenging, and to iterate the approach to ensure it has maximum benefit.

The learnings from the programme cover a range of areas including the flow of patients within hospitals from emergency services to wards, streaming patients into the most appropriate services, and standardising operational processes to be as efficient as possible.

The example trust used in this document has been anonymised.

Each trust is different and will need its own bespoke approach; examples are provided to inform local decision-making and action.

Key principles of contact hubs

Most organisations have a slightly different approach to their contact hub, however the overarching principles are the same – that patients receive the right care/advice, by the right clinician at the most appropriate time.

Some key principles for good contact hubs are likely to be:

1. They support the direction of patients to the most clinically appropriate service and only to the emergency department when this is truly required

2. They can also support in the provision of advice/support/redirection to alternative pathways to avoid secondary care attendance

3. Internal and external stakeholders are widely engaged in the process

4. The service is easy to use and efficient for the referrer and pathways are consistent

5. The service is not exclusive to one referral group (i.e. includes primary care, ambulance services, urgent community response)

6. Operational times of the contact hub (and the services referred to) should meet the demand and capacity modelling

Contact hubs

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Examples of already embedded contact hub models include:

1. A single point of access for referrals from primary care and ambulance services, which triages and links the caller with the most appropriate clinician to give telephone advice, appropriate redirection to a community service or a referral to an alternative pathway such as same day emergency care (SDEC), direct ward admission or outpatient 'hot clinic'.
2. Call before you convey for all medical conditions direct to an acute medical consultant for triage to the appropriate acute or community pathway.
3. A single point of access for 111, ambulance, primary care and rapid response referrals to an emergency medicine physician for triage/remote consultation and as a trusted assessor referral to all onward services such as SDEC, direct admission and community service.

Benefits reported:

- Reduction in ambulance conveyances to emergency departments and ambulance delays.
- Patients are treated in the most appropriate setting, including their own home.
- Increased appropriate use of alternative pathways.
- Reduced hospital crowding and improved patient satisfaction.
- Empowering confidence in community service delivery.
- Environmental benefits associated with reduced transportation.

Advice for those wanting to implement or improve contact hubs:

- Think big, but start small. Consistency is key so that stakeholders have the confidence to use the service.
- Be clear on your improvement metrics, these will be quantitative and qualitative.
- Staff engagement is key to getting people on board. This will involve all stakeholders and system partners.
- You will need to consider if the redirection services have the right capacity to meet the demand and review this regularly. Clinicians leading this will need PMO/improvement/comms support to help deliver this effectively.
- ICS and trust board sponsorship is key to getting buy in from all services.
- Ensure there is effective system wide governance/learning processes. This will help monitor any unintended risks but also share success and increase confidence in the service being delivered.
- Consider the feedback loop to improve services – ensure ambulance / clinician involved can learn from their interaction and use the pathways they've been guided to and supported to make different decisions next time.

Enablers
Project management team resource inclusive of data analytical support and clinical leads
Executive sponsorship and system buy-in.
Telephony/IT system/equipment to support the delivery of the service effectively
Strict adherence to scientific improvement methodology (PDSA)
Parallel multi disciplinary team working across the whole system

Barriers	Cause	How the barrier could be addressed
Trust	Service teams wanting to control access to their service	Extensive engagement with specialty and service colleagues and co-design of the pathways
Lack of uptake/impact	Potentially due to lack of communication, or delays in response from services not being available	Extensive communication is key, alongside robust demand and capacity modelling / reviews and appropriate metrics to measure
Interoperability	Different booking systems, EPR's, access to patient records	Map these clearly as part of the design process. As the service becomes more successful, it may add to the case for changes.

Supporting documents which may be key to use/develop:

- Clear comms for stakeholders and patients.
- Up to date internal and external directory of service.
- Standard operating procedures for the service.
- Governance terms of reference.
- Improvement metrics / KPI's dashboard.
- Information / data sharing agreements across organisations (if applicable).
- Safety netting advice for services referred to.

Contact hubs cont.

Roles and responsibilities that will enable intervention delivery:

Role	Responsibility
Acute trust executive triumvirate (COO, MD, CN)	All engaged with one nominated senior responsible owner to maintain triumvirate oversight. COO to provide operational leadership, MD to provide clinical oversight and sign off any clinical risk and CN to oversee quality and patient experience. These may of course be delegated, but ownership should remain with executive.
System leadership	Executive sponsorship from the integrated care board is essential for system buy in. Each individual stakeholder should have a nominated executive sponsor, for example ambulance trust, primary care network, community trust
Roles critical in implementation	PMO (clinical area liaison and staff engagement, GANTT chart oversight / performance oversight / reporting), communications (staff engagement, patient engagement and stakeholder engagement), data analysis (performance), divisional triumvirates (engagement and SOP design), patient representatives (PALS)

Critical implementation path:

	Critical action	Timeframe	Lead
Process	Organisational assessment of what is already in place. Internal engagement to identify scope for improvement.	Week 1	Exec sponsorship, PMO/Clinical delivery
	External stakeholder engagement to identify wider system opportunities (such as community service redirection) and what stakeholders would need to make process work.	Week 1 – 2	PMO Lead / SROs
Policy	Collaboratively create a standard operating procedure (SOP) and metrics to be monitored.	Week 2-4	PMO Lead / SROs
	Significant staff engagement exercises.	Week 2-4	PMO Lead / SROs
Comms	Coordination of engagement events and range of mixed media staff comms encouraging collaboration and feedback.	Week 2- ongoing	PMO Lead / SROs / Comms
	Daily group meetings and weekly PMO / SRO project meetings.	Implementation – ongoing	PMO Lead / SROs / Comms
Data/ BI	Metric check list to include qualitative and quantitative measures chosen collaboratively.	Week 2-4	PMO Lead / SROs / Stakeholders
	Daily and weekly metric monitoring and reporting	Implementation – ongoing	PMO Lead / SROs / Stakeholders

Data for improvement:

Flow Area	Possible Metric
Ambulance	Cat 2 Performance
	Ambulance Handovers >15/30/60m
In Hospital	No. of patients directed to assessment areas/SDEC/hot clinics
	No. of patients directed to ED for ED/ Speciality review
	No. of patients redirected to community services or attendance avoided
	Call answering performance/ abandonment for the contact hub

Potential impact

Some organisations that have introduced successful contact hubs have found the following:

✓ One hospital saw 65% of calls which went to the single point of access, avoided conveyance to the acute trust, 13 of which were seen by a virtual ward team

✓ Another organisation who set up a primary care advice line saw a reduction of abandonment from 10.1% to 3.0% over 3 years and 70-75% of calls were directed to an assessment area.

✓ One hospital identified a potential reduction of 4,800 conveyances to emergency departments since the implementation of their REACH model and saved 156 metric tonnes of carbon dioxide emissions from transport.

✓ The BARTS REACH model receives positive staff and patient feedback and has had zero reportable serious incidents identified since commencing.

Metrics

The level of data availability, completeness, quality and ability to extract these items varies significantly from organisation to organisation and therefore the final decision about the most useful indicators of success sits at a trust level

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Top 6 metrics: Flow Area	Possible Metric	Locally collected / already reported	Level of visibility	Type of measure
Ambulance	Cat 2 performance	Collected through ambulance daily collection – trusts may require ambulance service to share	Ambulance service	Outcome
	Ambulance handovers >15/30/60m	Collected on UEC daily SitRep for 30/60, 15m is collected in daily ambulance collection – trusts may require ambulance service to share	Trust, region	Outcome
In hospital	No. of patients directed to assessment areas/SDEC/hot clinics	Locally collected	Trust	Process
	No. of patients directed to ED for ED/ Speciality review	Locally collected	Trust	Process
	No. of patients redirected to community services or attendance avoided	Locally collected	Trust	Process
	Call answering performance/ abandonment for the contact hub	Locally collected	Trust	Process

Flow Area	Possible Metric	Locally collected / already reported	Level of visibility	Type of measure
Ambulance	Ambulance arrivals direct to SDEC	Locally collected		
In ED	No. of patients in ED by hour	Locally collected	Trust	Process
In ED	Type 1 patients seen within 60m	Collected on UEC daily SitRep	Trust	Process
In ED	Type 1 patients seen by senior decision maker within 60m	Locally collected	Trust	Process
In ED	4h A&E Performance	Collected on UEC daily SitRep	Trust, region	Process
In ED	12h waits from Decision to Admit	Collected on UEC daily SitRep	Trust, region	Balancing
In ED	12h waits from arrival to ED	Collected on UEC daily SitRep	Trust, region	Balancing
In ED	Clinically Ready to Proceed	Should be collected on ECDS – data quality may be poor	Trust, region	Balancing
In ED	Number of emergency admissions from ED	Collected on UEC daily SitRep	Trust, region	Process
In ED	Number of admissions by hour	Locally collected	Trust	Process
In ED	Reattendance rate (within 72 hrs)	Locally collected	Trust	Balancing
In ED	Mean time in ED by chief complaint / age	ECDS	Trust	Balancing
In ED	Comprehensive geriatric assessment (CGA) within 30 mins of arrival			

Supporting roles and responsibilities: national, regional and system

The following table represents a list of 'responsibilities' that were shared by members of the collaborative on subjects that were barriers/ enablers to implementing this intervention. These have been allocated against suggested roles that could provide support on these items. The collaborative has worked with subject matter experts in the national UEC team who have developed suggested actions that regulatory /national / regional / system / local teams may wish to consider in supporting solutions to those asks and, ultimately, would be at their discretion

Role	Responsibilities	What action could be taken?
Regional	Support to identify workforce with the right skill set to staff the hub	Establish a collaborative working group to audit current service provision and perform a demand and capacity review. This should then inform the creation of a strategic regional and ICS improvement plan.
	Ensure hub is on the directory of service (DOS) and promoted across the ambulance service/ CAS	Request the working group (as described above) to review the DOS against the demand and capacity review. The group should also proactively and regularly audit activity on all known pathways in order to identify improvement requirement.
System	Support to build multiple alternative pathways for the hub to utilise and cross- system access to patient records	System to appoint project lead to reconcile full alternative pathway offers. Lead to perform gap analysis. Alternative pathway use audit to be performed monthly. Lead to use all of this information to create a system improvement action plan on the creation of a wide selection of alternative pathways and the growth in their usage.
Local	Availability of a ED/ acute medicine clinician (or appropriate skill set) via a single point of access to have a clinical conversation with either the patient or healthcare professional	Trust to assign a project lead to support a designated clinical lead in the creation and growth of a single point of access for external HCPs to contact. This will invariably mean the creation of an improvement action plan, audit and executive oversight.