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NHS England

Going further for winter: Care homes ambulance conveyance avoidance

Outcome Specification

18 October 2022

Contents

1. Summary

1.1 There are approximately 360,000 people living in a care home in England most of whom are over 85 years old, female and in their last years of life. The majority will be living with a form of dementia, be in receipt of seven or more medications and a significant proportion live with depression, mobility problems, incontinence, and pain. Their health needs are likely to be complex in nature, and they have worse outcomes associated with hospital admissions.

1.2 Frailty, multi-morbidity, polypharmacy, and dementia are all known to increase the likelihood of unplanned hospital admissions and increase length of stay[1] and as such, care home residents are at an increased risk of conveyance and admission to hospital. Many of these admissions may be necessary and warranted, however, there is evidence to suggest that a significant proportion are treatable in the community. The Health Foundation[2] national study of emergency hospital use by care home residents demonstrated that 41% of emergency admissions to hospital were for potentially avoidable conditions such as chest infections, urinary tract infections and pressure sores, and that care home residents account for 7.9% of all emergency admissions.

1.3 Between 4 January and 28 February 2022 there were on average 772* A&E presentations per day by care home residents over 70 years. 15,915 care home residents (aged 70+) presented to A&E and were discharged same day (89% of these were ambulance conveyances)**. On weekdays, 65% of presentations occurred during business hours (8am to 8pm) in which alternative services (e.g. Urgent Community Response) are operational. Avoiding these presentations represents a maximum reduction of 519 presentations per weekday.

*(*Data presented here is derived from a snapshot of the Emergency Care Data Set from 4th January to 28 February 2022, ongoing reporting of these measures requires up-to-date care home resident data to flow to NHSE in a*

[1] Age UK (2019) *Later life in the United Kingdom 2019* [Available at: www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf
[2] Wolters A, Santos F, Lloyd T, Lilburne C, Steventon A (2019) *Emergency admissions to hospital from care homes: how often and what for?*, Health Foundation; [Available at www.health.org.uk/publications/reports/emergency-admissions-to-hospital-from-care-homes]

timely manner.
***From Chief Complaints data)*

1.4 When a resident's condition(s) or health and care needs change or deteriorate, there are many excellent models of community based urgent care and treatment services which reach into care homes and offer an optimal response, maintaining the resident in their home and avoiding unnecessary admission to hospital. Navigating a way through to these services is not always as easy as it could be and can result in people being conveyed to hospital if an appropriate alternative community-based service cannot be found to meet their immediate health and care needs. Regular communication and updates about the type and availability of such services to all key stakeholders locally are essential to the success of reducing avoidable conveyances from care homes, and ideally this will be in a digital format. Urgent Community Response (UCR) should always be considered as a first response where it has been determined that a 999 response is not appropriate to meet the person's needs.

1.5 Workforce issues affecting social care can also impact on the way care home staff might utilise urgent and emergency healthcare services. Where there is an absence of a registered manager, or a newer manager in post there can understandably be a greater degree of risk aversion in decision making, particularly if they are unfamiliar with what services might be locally available to support the care of the resident. The same may be true for care homes where use of agency staff is higher, and the worker may not be as familiar with the resident as regular care home staff or staff from wider support services.

1.6 By working collaboratively with care homes where ambulance conveyances are higher, local systems can determine what alternative appropriate responses might be required to support more residents to remain in their care home when it is clinically safe to do so.

2. Principles of reducing care homes unplanned ambulance conveyances

2.1 The Health Foundation and the Care Quality Commission[3] (CQC) have highlighted that older people are experiencing emergency admissions to hospital with conditions that are potentially avoidable. Although first identified some time ago, the trajectory remains largely unchanged, in particular for people living in a care home with dementia. Up to 43%[4] of people with dementia in hospital were admitted with either a urinary tract infection (UTI) or chest infection, conditions which are treatable in the community.

2.2 Often people in a care home with dementia and/or mental ill health who develop a physical illness do not receive the optimum health care response, because physical and mental health services have not collaborated in their treatment of the person. Actions should be taken locally so that services work together to ensure a person's whole health needs are considered by including their dementia and mental health needs alongside their physical health concern.

2.3 The complexity of care for people living in a care home may also mean that although the person's emergency admission could potentially be avoided, when their condition becomes acute, admission becomes necessary. Understanding local context for the person and the services around them is critical when deciding upon the right course of action for an individual.

2.4 Combining analysis of ambulance data and SUS data with local "soft intelligence" will enable ICSs to determine priorities for prevention of avoidable ambulance conveyances from care homes and understand where there may be gaps in service provision, such as access to advanced clinical practitioners, that could support this.

2.5 ICSs should work collaboratively with care homes where ambulance conveyance rates are higher to understand the key factors driving these figures. Using quality improvement approaches for this work will enable development of strong and trusted relationships and a 'no blame' attitude to collaboration for improvement. The Enhanced Health in Care Homes

[3] Care Quality Commission (2013) *CQC publishes fourth State of Care report*
[4] Sampson, E., Blanchard, M., Jones, L., Tookman, A., & King, M. (2009). Dementia in the acute hospital: Prospective cohort study of prevalence and mortality. *British Journal of Psychiatry, 195*(1), 61-66. doi:10.1192/bjp.bp.108.055335

framework is an ideal model for collaboration across health and social care for care home residents, with delivery supported by contractual elements in the Network Contract Directed Enhanced Service 2022/23 .

2.6 ICSs will need to work with care homes to ensure care home residents have access to Urgent Community Response, Acute Respiratory Infections hubs, virtual wards, specialist palliative care advice and other avoidable admissions initiatives and that care home staff are informed about what services are available locally and how to access them.

2.7 The community-based falls response service equally applies to people living in a care home. Section 4.0 of the document specifically details the management of falls in care homes.

Case study: Weston-super-Mare (WSM)

WSM have a high number of small to medium sized care homes and 1800 beds. They have created a care home hub response, staffed by a GP clinical lead and advanced clinical practitioners who support care homes and their residents to plan proactively for their potential future care needs. They also respond to more urgent health care needs, meaning residents can be treated at home quickly, often avoiding the need to utilise emergency services. They began by working in collaboration with the care homes that were receiving greater input from emergency services and had higher emergency admission rates, utilising a quality improvement approach to determine their focus.

3. Minimum requirements for reducing unplanned care homes ambulance conveyance

	Minimum requirements for all ICBs:	Timings
1.	**Work collaboratively with the care homes in their system to support those with the highest 20% rates of unplanned ambulance conveyances to consider alternatives to 111/999 calls where appropriate.** Utilise data from local ambulance trust(s), SUS data and local intelligence including workforce turnover and vacancy rates in identified homes.	**By Nov 2022**

2.	**<u>Analyse the data from 111/999 in relation to care homes to determine:</u>** • Time and day of call • Reason for call determined by ambulance data • Main reason for conveyance determined by ambulance data	**By Nov 2022**
3.	**Map the provision of advanced clinical decision-making services available to care homes after 8pm and before 8am.** (Does not include 111/999 or District Nursing services, and assumes a full UCR service 08:00 – 20:00 is in place) *Note: An advanced clinical decision maker is likely to be an Advanced Clinical Practitioner (ACP), Geriatrician or similar*	**By Nov 2022**
4.	**<u>Map provision of the following EHCH contractual requirement to all care homes:</u>** Every care home aligned to a named PCN? Does every care home have an assigned clinical lead from the PCN? Is every care home in receipt of a weekly home round supported by an MDT?	**By Nov 2022**
5.	**<u>Ensure all 111 and 999 call handlers are aware of and know how to refer to local UCR services</u>**	**By Nov 2022**

	Going Further – next steps	**Timings**
1.	It is recommended all systems put in place access to advanced clinical decision-making support for care homes. This could be within a clinical hub that already exists. This would include UCR service provision, as well as access to advanced clinical decision makers such as ACPs, who can lead and deploy appropriate clinical support to ensure the resident receives treatment and care in the right setting e.g. virtual ward/remote monitoring in the care home/community hospital/other, to enable clinical risk sharing across the system, and therefore preventing avoidable conveyances and reducing clinical variation in practice.	tba

	For example: Weston-Super-Mare developed an integrated MDT response to meet local population health needs (1389) One Weston Care Home Hub - Moving Towards An Integrated MDT Walsall introduced a Care Navigation Centre actively supporting reduction in conveyances and avoidable admissions Model of Health, Care and Well-Being : Walsall Together	

4. Governance and risk management

4.1 Each ICS should ensure local governance processes are determined to safeguard residents when implementing local plans to reduce ambulance conveyances from care homes, ensuring appropriate clinical leadership and clear clinical oversight is agreed to manage risk and deliver safe and effective care.

4.2 Admission avoidance through focusing on reducing unnecessary ambulance conveyances from care homes should not result in sub optimal care for residents. If ambulance conveyance and admission to hospital is deemed clinically necessary for an individual, this should continue to happen.

4.3 Due consideration must be given to the response times of local service provision, and mitigations put in place to ensure deterioration in a person's condition is not missed while they are waiting for an identified service to start. This should include an escalation of care pathway.

5. Measurements and metrics to support implementation

5.1 The overall aim of this service is to reduce unnecessary ambulance conveyances for care home residents where alternative support services are available. Local systems may choose to use the following metrics to measure the impact of quality improvement approaches:

- Rates of ambulance conveyances to emergency departments for care home residents
- A&E attendances via ambulances broken down by time of arrival

- Number of UCR contacts
- Analysis of NHS 111 and 999 call data for calls from care homes

5.2 It may also be helpful to collect softer intelligence from care home staff about their knowledge of available support services locally, and how this is informing decision-making.

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