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Rethinking Unscheduled Care: Strategic Planning Considerations

Insights summary

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This summary report

During 2021-22, Healthcare Improvement Scotland, Scottish Government, NHS 24, Police Scotland, and the Scottish Ambulance Service conducted a design investigation validated by user research on people's experiences and journey through unscheduled care. Rethinking Unscheduled Care: A design investigation into people's experiences and journey through unscheduled care adds to the evidence base of how people experience the existing system. This companion piece considers these findings through a strategic planning lens and identifies actionable learning insights for the design and delivery of unscheduled care services.

The design investigation identified three reasons why people seek unscheduled care (see Figure 1). Each of these demands has potential failure demand that occurs in unscheduled care.

Figure 1: Potential failure demand that occurs in unscheduled care

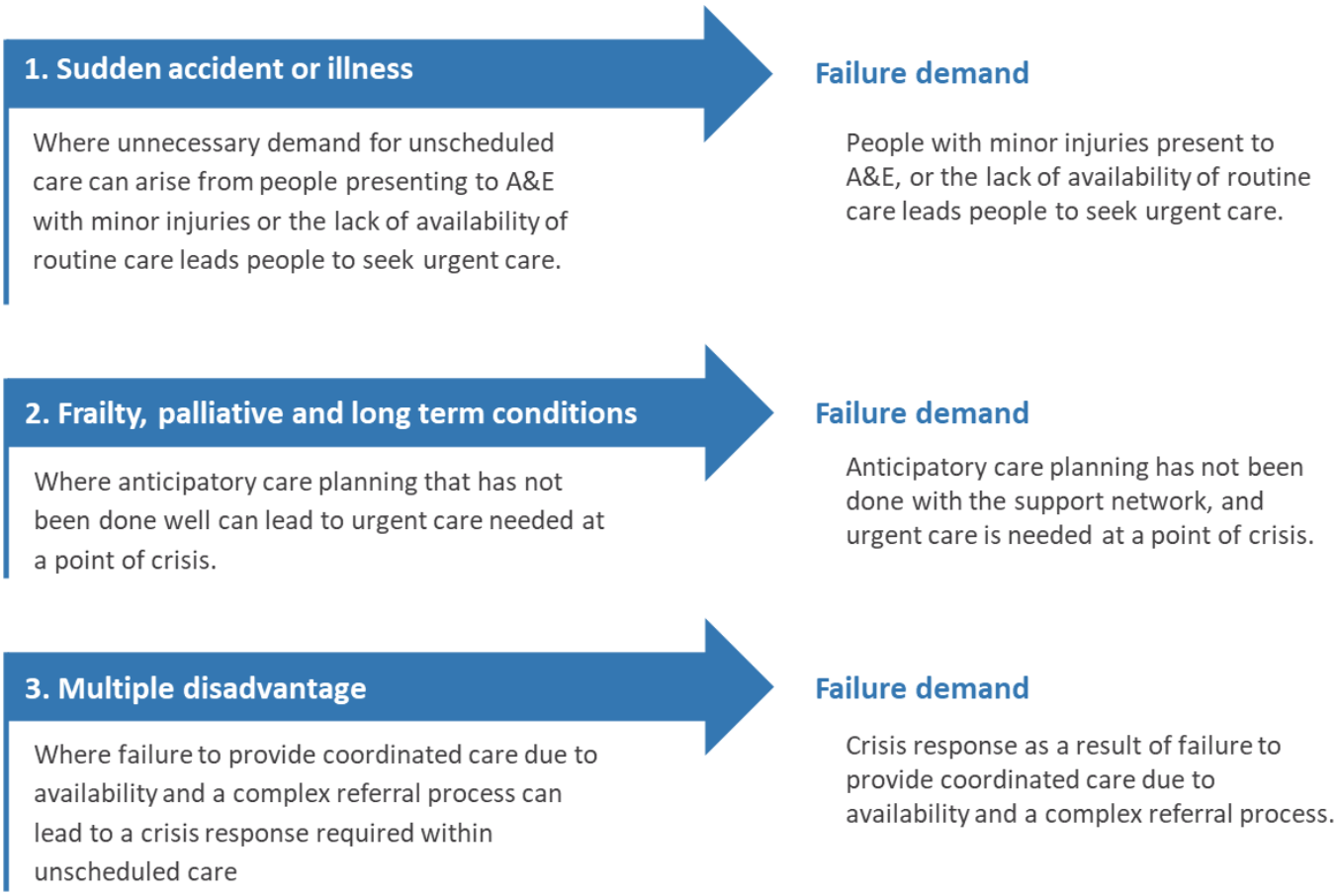


Figure 2 outlines what is clear from both the design investigation user research and our strategic planning analysis.

Figure 2: Findings from design investigation and strategic planning analysis

Our system design has failure built into it – when we fail to meet people's needs right then we see a high demand for unscheduled care as people reach crisis point.

If we considered unscheduled care from a person-centred perspective we would spend **more time thinking about it in the broader system** and not as an isolated system in itself.

Insights from the design investigation challenge us to **set a new strategic direction** for future improvement, redesign and transformation future work.

It is clear that the system is failing to meet people's needs in the right place, at the right time and with the right support. This is driving high demand for unscheduled care leading to greater pressure on our services and workforce, as well as poorer outcomes for people. Many of the current challenges unscheduled care is facing is driven by two particular failures of our system.

System failure 1: unavailability of more suitable care

People are faced with the need to access care not designed for their needs due to the unavailability of more suitable care.

For example, someone attending the ED at night when a minor injury unit is closed or delayed discharge following an inpatient admission.

System failure 2: preventable escalation in care need

People are seeing an escalation in care need that is preventable due to insufficient access to routine care and anticipatory care planning.

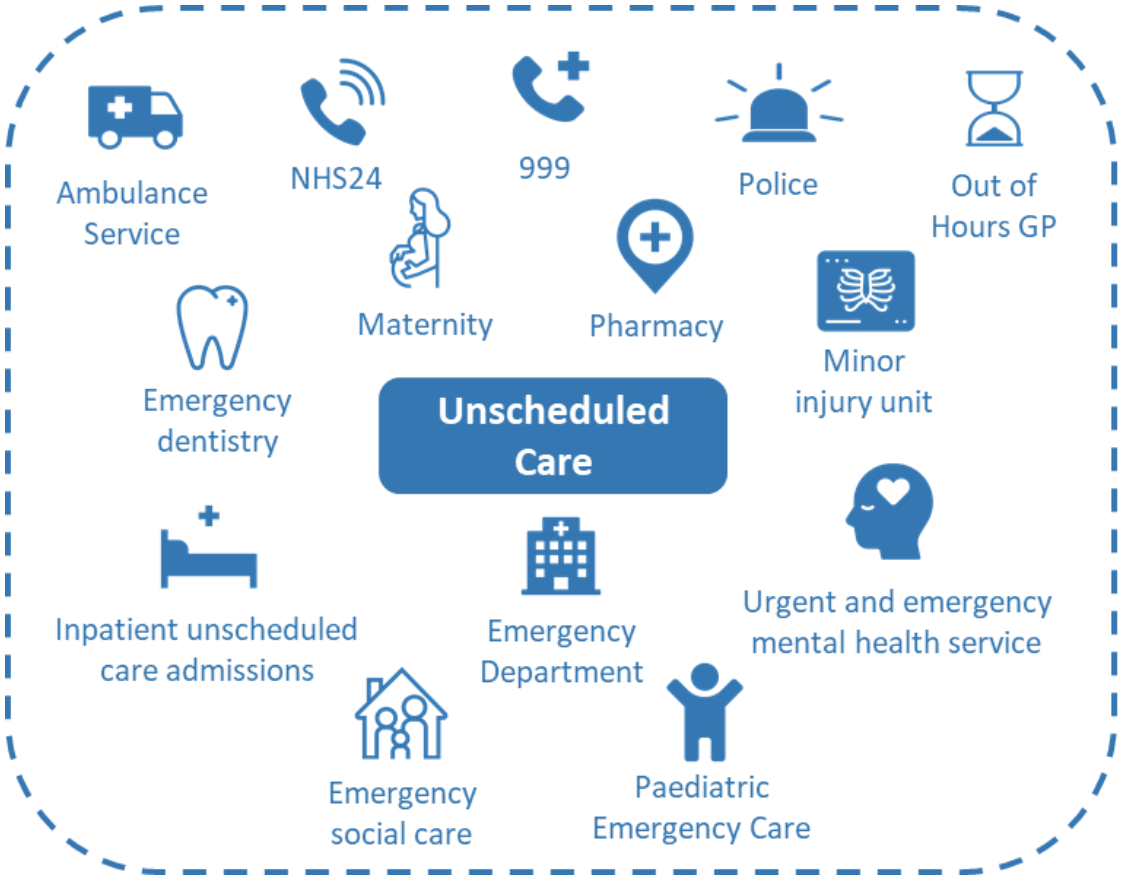
For example, where someone is admitted due to a polypharmacy reaction due to a lack of availability of care at home services that can support the safe administration of complex medication combinations.

These system failures mean that we need to **think about the system beyond unscheduled care and consider the upstream drivers for unscheduled care**. These are described in the next sections.

We need to think about the system beyond unscheduled care

When we think of unscheduled care we often think of this system of services working together with various routes in and triage points (see Figure 3).

Figure 3: Unscheduled care services



In reality the factors that influence the need and demand for unscheduled care are a much broader system of services (see Figure 4). Provided by a combination of the public sector, private sector, community organisations, and the independent sector. For someone with frailty, palliative and long-term conditions, their system of need to reduce demand for unscheduled care might include the effective and timely provision the services in pink (see Figure 4).

Figure 4: Service need for people with frailty, palliative and long-term conditions

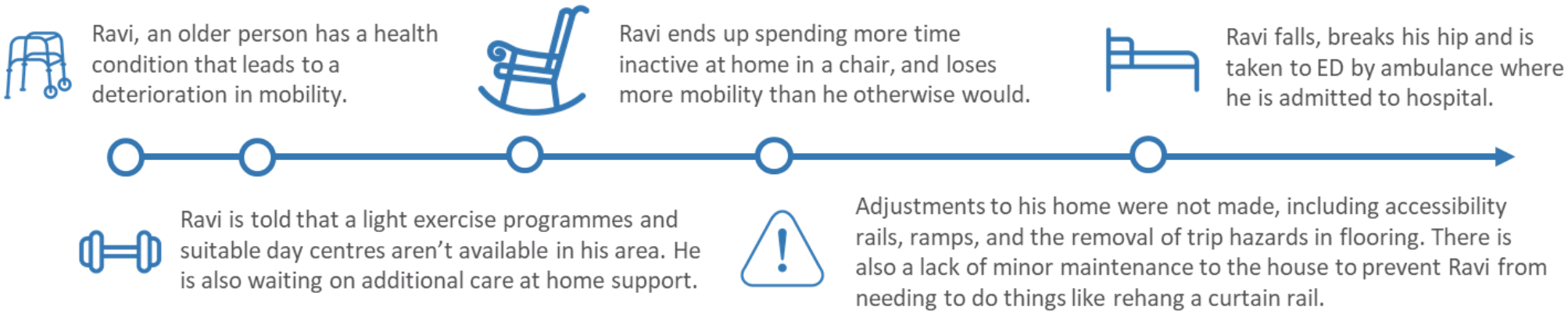
For someone from multiple disadvantage, their system of need to reduce demand for unscheduled care might include the effective and timely provision of the services in green (see Figure 5).

Figure 5: Service need for people with multiple disadvantage

We need to consider the upstream drivers for unscheduled care

The persona “Ravi” (see Figure 6) is an example of a preventable escalation of frailty that results in additional demand for unscheduled care.

Figure 6. Example of preventable escalation of frailty

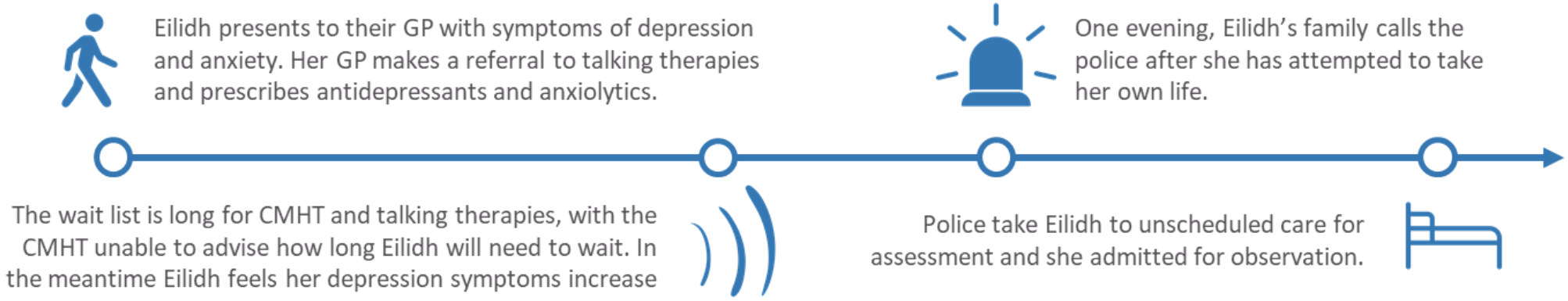


Did you know…

30% of people aged 65 and over and 50% of people aged 80 and over fall about once a year.[1]	Repair and equipment fitting service in Dumfries and Galloway estimated to have prevented hundreds of falls within first year with an estimated service cost of circa £150,000 a year.[2]
5% of falls lead to fracture and hospitalisation.[3]	As at February 2023, a total of 4,445 were waiting on a care at home package.[4]
Moderate exercise reduces risk of falls by 23% - 32%.[5] [6] [7]	Fall related emergency hospital admissions cost £7,843 per admission.[8]

The persona “Eilidh” (see Figure 7) is an example of a preventable escalation in mental health acuity that results in additional demand for unscheduled care.

Figure 7. Example of preventable escalation in mental health



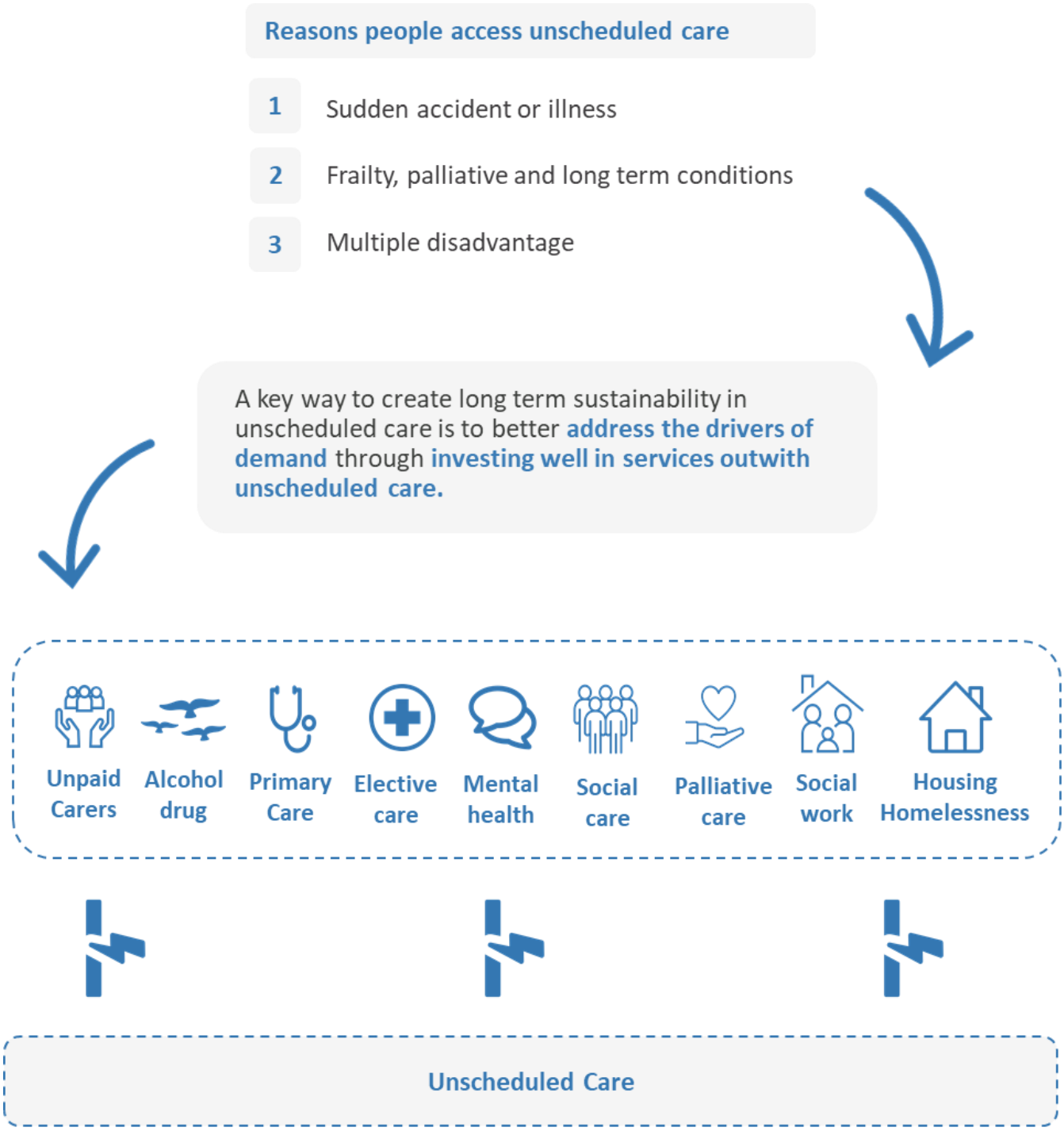
Did you know…

19.3% of the Scottish population were prescribed drugs for anxiety / depression / psychosis in 2020-21; this equates to 1,054,374 individuals.[9]	Prevalence of attempted suicide was highest in individuals living in most deprived areas (15% - most deprived vs. 4% - least deprived).[10]	Evidence illustrates links between suicide and deprivation; suicide rates are over 3 times higher in most deprived areas, compared to least deprived areas (23.4 per 100,000 compared to 6.8 per 100,000).[11]
9% (680) of children and young people on the CAMHS waiting list were waiting over 35weeks to begin treatment as at Dec 2022.[12]	22.5% (330) older adults were waiting over 18weeks to begin psychological treatment as at Dec 2022.[13]	13,186 unplanned admissions had a recorded diagnosis of self-harm in 2019/20. On average, each admission costs approximately £1,582; equating to £866 per bed day.[14]

We need a new strategic direction

We need to **shift the way that we see demand for unscheduled care**. Instead of looking at how to divert demand away from unscheduled care once someone has reached out for support, we need to think about how the services that surround unscheduled care can be seen as assets in reducing the need and demand for unscheduled care – as outlined in Figure 8.

Figure 8: How to create long-term sustainability in unscheduled care



When considering how to put these into practice, we have developed the following **Actionable Learning Insights** for policy maker and planners.

1. Have a shared understanding amongst stakeholders of the definition of unscheduled care and the wider system that it sits within including a shared understanding of what unscheduled care is and isn't suitable for.

2. Understand why people are accessing unscheduled care and develop a shared understanding of what successfully supporting them further upstream looks like

3. Ensure that data and intelligence used to inform decisions includes both data and intelligence from within unscheduled care and data from the broader system to give a more balanced evidence base to make decisions from.

4. Proactively identify the assets within primary and community settings and within planned/elective care that help to address and ensure they are clearly linked into unscheduled care demand management approaches.

5. Widen the role that the third, community and independent sectors play in a system wide approach to bring them proactively around the table to discuss and address upstream drivers of unscheduled care

6. Focus improvement work on services in the wider system beyond unscheduled care that prevent demand for unscheduled care throughout the year as the primary driver for developing a resilient system that reduces winter pressures.

References

The two illustrative pathways on slides 8 and 9 are based on personas developed to represent example patient journeys that we know are likely to exist based on our interpretation of the data and evidence available as well as case studies from our national improvement programmes. Personas are fictional characters developed to help understand the needs, experiences, and behaviours of target populations.

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[1] Public Health England, 2017. Falls and fracture consensus statement: Supporting commissioning for prevention.

[2] DnG24 (2023). Elderly falls prevented through new project

[3] Public Health England, 2017. Falls and fracture consensus statement: Supporting commissioning for prevention.

[4] Public Health Scotland (2023). Dashboard - Social care - Demand for Care at Home Services 28 February 2023

[5] International Journal of Behavioural Nutrition and Physical Activity (2020). Evidence on physical activity and falls prevention for people aged 65+ years: systematic review to inform the WHO guidelines on physical activity and sedentary behaviour

[6] Cochrane (2019). Exercise for preventing falls in older people living in the community

[7] Public Health England (2019) A menu of interventions for productive healthy ageing, for pharmacy teams working in different settings

[8] Public Health England, 2017. Falls and fracture consensus statement: Supporting commissioning for prevention

[9] Public Health Scotland (2021). ScotPHO profiles (shinyapps.io)

[10] Scottish Government (2019). Chapter 2: Mental Wellbeing - Scottish Health Survey 2019 - volume 1: main report - gov.scot (www.gov.scot)

[11] Public Health Scotland (2021). Suicide statistics for Scotland - Update of trends for the year 2021 - Suicide statistics for Scotland

[12] Public Health Scotland (2023). Dashboard - Child and Adolescent Mental Health Services (CAMHS) waiting times - Quarter ending December 2022 - Child and Adolescent Mental Health Services (CAMHS) waiting times

[13] Public Health Scotland (2023). Dashboard - Child and Adolescent Mental Health Services (CAMHS) waiting times - Quarter ending December 2022 - Child and Adolescent Mental Health Services (CAMHS) waiting times

[14] Public Health Scotland (2023). Mental health inpatient costs and preventable admissions