Ambition 6: Improving Urgent and Emergency Care

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"The aim is to ensure that the population we serve receive the right care, in the right place, at the right time. Everyone should receive the best care that meets their needs whether they access that care through their GP, 111, 999 or by walking into an Emergency Department (ED)"

Dr Lindy-Lee Folscher,
ICB specialty advisor for UEC

Our objectives

a) Improve emergency ambulance response times

b) Expand virtual ward services

c) Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals

What would you like to see in our five-year plan for health and care services? What matters most to you?

Recent JFP consultation feedback: "Involve other services such as the ambulance service when making your 5-year plan as when all the other services fail it's always the ambulance service picking up the pieces". "Next best thing is more rehab beds for step down patients who do not require an acute bed but are simply not well enough to be at home independently. "Really investing in digital health is crucial to ensure joined up, continuity of care". "Easier access to Primary Care services closer to home services in the community to prevent hospital admission or facilitate early discharge home from hospital."

Why we chose these objectives

We want our population to be confident that when an emergency happens the local NHS is there to rapidly respond, we will continuously improve our emergency and urgent care services and adapt to our population's changing needs, take advantage of new technologies and develop trusted relationships across all health and care organisations in Norfolk and Waveney.

We know our population wants to receive care at home and avoid stays in hospital where it is safe to do so and the evidence tells us this is best for people too, avoiding deterioration in mobility through bed-based care or hospital acquired infections. Two of our priorities focus on keeping more people at home through enhancing joint working and collaboration between community teams and ambulance services as well as expanding our virtual ward that has technology at the heart of it. Our third priority is making sure that where hospital is the best place for people to be cared for, there are quick, integrated processes to get people home with the support they need to recover.
The COVID-19 pandemic response enabled lots of our teams to integrate and work closer together however, we still have more to do. The Life Course Infographic in section 3.3 illustrates that for our older people who have a heart attack or stroke and our younger children, further work is required to improve admission to hospital where this is clinically necessary.

Pre-pandemic, Boston Consulting Group worked with the Norfolk and Waveney system to analyse demand and capacity across health and care. The report identified mismatches in demand and capacity, which if not addressed would result in a bed deficit position. The recommendations highlighted that these challenges could not be overcome by a single provider but only by the entire health and care system working collectively behind a single vision for urgent and emergency care services and going further with integration. Our three priorities for urgent and emergency care take the next step in collaborative working across organisations to respond to patients when a need arises.

Objective 6a Improve emergency ambulance response times

What are we going to do?
We will work with the ambulance service and community teams to improve how quickly emergency ambulances can respond to our most unwell patients. To do this, we will support community teams to respond to urgent care needs which are not life threatening but cannot wait, thereby allowing the ambulance service to better respond to serious issues that are a threat to life or limb and are emergencies.

This will result in more 999 calls being safely and appropriately transferred to community services, where the community is best resourced to respond the patient will be visited from a member of the local NHS team. This could be from a community nurse or therapist as part of the 2-hour urgent community response team (UCRT), virtual ward or pharmacy. Community teams will work with senior medical specialists who will advise on treatments and can access rapid-access clinics and same day appointments at hospital.

For patients with an urgent same day care need this will mean an increasing number of patients able to safely stay at home, supported by local health and social care teams to remain safe.

How are we going to do it?
Appropriate urgent 999 calls will be digitally transferred to community unscheduled care hubs which will bring together existing community services into a single point of access.

We will work collaboratively with clinicians in the ambulance service, the community, primary care and others to develop the framework and digital capability to identify and transfer patients from emergency services to urgent community services.

Our community response teams will be integrated working across organisations to share skills and make a greater impact by jointly responding and coordinating care and sharing resources.

Leaders from partner organisations will determine how this will be modelled and delivered to meet the needs of the local population. This may mean local variation in how services are set up across Norfolk and Waveney but the outcome will be the same – a rapid response from a clinician suitably skilled to assess and treat the patient.

For health and care professionals working in urgent and emergency care services this will result in consistent and standardised access points, a single access route for alternatives to emergency care and easier referral mechanisms to transfer patients between services, which will further support workforce satisfaction and retention.

How are we going to afford to do this?
We are working together as a system with all our partners, to make sure our resources are used to support transformation and deliver the care our patients need in the right place at the right time.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023
- Existing programme of improvement.

Year 1 Oct 2023 – March 2024
- Deliver Category 2 30-minute mean response time by the end of March 2024.
- Maintain consistent 70% 2-hour UCR performance throughout 2023/24.
- Identify appropriate urgent calls for transfer to community response.
- Establish the unplanned care hubs and access routes
- Consolidate community urgent care service access points under the unplanned care hub.

Year 2 April 2024 – March 2025
- Further review and expansion of the type of urgent calls suitable for transfer from 999.
- Review how community capacity can be expanded through continued integration at place level.

Year 3 April 2025 –Year 5 March 2028
- Continued integration of urgent and emergency care provision, further collaboration across system partners, including VCSE to increase the support available.

How will we know we are achieving our objective?

- Confirm a Category 2 30-minute mean response time by the end of March 2024

National description of C2:
C2 - Emergency. These calls will be responded to in an average (mean) time of 18 minutes, and within 40 minutes at least nine out of 10 times (90th percentile)

Objective 6b Expand virtual ward services

What are we going to do?
Virtual Wards allow patients to get the care they need at home safely and conveniently, rather than being in a hospital setting. Support can include remote monitoring using digital technology, wearable medical devices such as pulse oximeters and face to face care provided by multi-disciplinary teams in the community.

Where patients can leave hospital earlier with remote monitoring support, we refer to this as step down. All three of our hospitals have a Step-Down Virtual Ward in place.

Step up virtual wards are an alternative to admission in a hospital setting, where patients can safely receive the same level of clinical care at home.

We will do this by:

- Building a new ICS collaborative partnership to promote joint working, innovation and new ways of working, instead of more traditional approaches of specifying and buying services
- Ensuring strong clinical leadership is in place to support collaboration. This will move towards an integrated model of care that uses resources across the system rather than in individual organisations.
- Developing a common digital solution with one dashboard for clinical teams to access.
- Expanding the conditions that a virtual ward can support to include respiratory, frailty and heart failure provision, as well as pioneering new, locally driven models of care.
- Develop a system wide step-up model which will play a key role in managing urgent care demand and building capability in the community to safely support people at home outside of a hospital setting.
- We will work with the whole provider community -Primary, Community and Acute care, 999 and 111 (CAS) all need to be part of developing, supporting and using the additional capability that the virtual ward creates, to deliver better outcomes for patients
- Integrate and embed virtual ward in the care system. As well as pioneering new ways of working, there is a huge opportunity to link all pre-hospital initiatives into one overall integrated urgent care 'pre-hospital' model with enhanced clinical oversight that allows the community teams to do more to safely support patients outside of hospital.

How are we going to do it?
Virtual Ward will work across the whole health and care system. We will identify referral routes in and out of virtual ward for equal service provision across Norfolk and Waveney. We will make sure there are automated, digital referral routes and the ability to transfer patient details electronically, so patients only have to tell their story once.

Local teams will design the new models of care and supporting processes that will form the Virtual Ward face to face response. These need to be joined up with existing services and offer staff opportunities to work across different organisations to enable better integration and use of skills.

How are we going to afford to do this?
Virtual Ward has an allocation of national funding that is to be used to maintain and expand services. In the longer term it is expected that local areas will need to fund virtual ward services.

As virtual ward expands, we anticipate there will be corresponding changes in where urgent care activity is managed – increasingly outside of hospital settings.

What are the key dates for delivery?

Year 1 April 2023 – Sep 2023
- Current virtual ward provision

Year 1 Oct 2023 – March 2024
- Put in place a single platform across the ICS to ensure consistent ways of working, reporting and viewing capacity are available.
- Launch of the community step up virtual wards across Norfolk and Waveney
- Establish consistent tracking against targets to inform the Partnership and aid decision making and risk mitigation
- Evaluate virtual wards and use the findings to be at the centre of service transformation.

Year 2 April 2024 – March 2025
- Use findings from the evaluation to refine and improve the service.
- Agree an ICS wide approach to medicine administration and point of care testing, based on two trials currently under consideration.
- Continue to expand the specialties Virtual Ward can support.

Year 3 April 2025 – March 2026
- Use outcomes from the evaluation report to further develop virtual wards.
- Continue integration of virtual wards with urgent and emergency care services
- Extend Virtual Ward service to enhance multiple long term condition management to reduce inpatient demand and improve outcomes.

Year 4 and 5 April 2026 –March 2028
- Further evaluation and monitoring to continuously improve the service.

How will we know we are achieving our objective?

Trajectories

- By April 2024 we will have 368 virtual ward beds.

Objective 6c: Delivery of the Improving Lives Together Programme to reduce length of stay (LOS) in hospitals

What are we going to do?
We want to improve discharge planning and processes, so that you can take the next step in your recovery and rehabilitation after a period of illness, quickly and safely, in a place where you can be as active and independent as possible and stay connected with the people and activities that matter most to you.

The 'home first' principle is important to us when we start your discharge planning. We want to make sure that you can return to your home, if this is the right place for you, and meets your needs. If things have changed while you have been in hospital, and home is no longer the right place for you to live, then we can work together to plan what that will look like.

The date and time for your discharge home will be agreed with you in advance, to allow you to make plans with carers, loved ones and/or family members and we will make sure you have a supply of medication and a discharge letter to share with your GP so that they know what help and support you may need once you arrive home.

Better discharge planning helps to reduce your length of stay in hospital, and reduces deconditioning and the need for readmission, which also helps us to bring people into hospital more quickly when they need emergency or planned care because we have more space and resources. It's about getting you to the right place, for the right care and support, at the right time.

How are we going to do it?
The Improving Lives Together Programme will bring system partners together to lead and deliver improved discharge planning and reduced hospital length of stay, across Norfolk & Waveney. There are two timelines for the delivery of discharge improvement, which will happen alongside each other. We will focus on process-based improvement to be delivered in the first 6 months and a programme of wider transformational improvement with a longer term 18-month timescale. The immediate priorities over the next 3 months will be:

1. Mobilise a digital solution (Optica) for managing patients through their discharge pathway more efficiently.
2. Focus on early discharge planning, embed the SAFER flow care bundle, and increase the number of Pathway 0 discharges and weekend discharges for people who do not need additional care and support to go home.
3. Build an Integrated Transfer of Care (ITOC) Team at each Place, which will bring together hospital, community, voluntary, therapy, transport and pharmacy resources around the patient and deliver more seamless support.
4. Continue to develop collaborative leadership, with a clear and consistent governance structure to support delivery. Include the needs of people who are being discharged from Mental Health settings into the improvement journey.

The ICS Discharge Board has agreed these priorities and will oversee improvement and delivery of metrics. Principles and outcomes agreed at system level will help ensure consistency while delivery will be driven at Place-level with support from the NHSE improvement team. In the longer term, the system will create a stable and sustainable model of care for discharge support across the board, but particularly for discharge Pathways 1 to 3, which are pathways for patients who require support following a hospital stay.

Data and Digital
Data is a significant issue and risk for all partners due to the digital immaturity of the Norfolk and Waveney system, however, this highlights the importance of a digital solution to help us monitor, track and report on the discharge position and impact of our interventions and improvements. New national guidance will be issued in 2023 and NHSE will report more discharge data publicly; this will be addressed with current workarounds until Optica is fully operational.

How are we going to afford to do this?
Reducing length of stay for patients improves quality outcomes and offers opportunity for savings to be realised or re-invested. Maintaining people's independence will enable funding to be diverted toward reablement and care at home, reducing costs associated with long term complex care packages and residential care. Reduced length of stay will reduce the risk of patients deconditioning and needing a higher level of care and support, in the longer term.

As part of this ambition, we need to develop a sustainable financing model. To do this we will need system-wide partner financial and operational engagement, to determine how we can resource changes in activity across organisations and develop workforce models that allow organisations to create the right capacity to meet demand, while also ensuring we meet our system's financial targets.

How will we know we are making a difference?

- Reduction in length of stay is the key outcome metric of this programme.
- We can see a reduction in the average length of stay in acute and community beds and an overall reduction in use of intermediate care beds.
- See improved outcomes for patients following discharge, and better experiences for their carers. Deconditioning and readmission rates will fall.
- We can see an increase in our daily numbers of patients discharged.
- Can stop using surge and escalation beds to manage day to day pressures.

What are the key dates for delivery?

First 6 Months: April 2023 to September 2023

- Beginning of Optica phased rollout and real-time tracking of patients through discharge, reducing then eliminating manual Transfer of Care form. Early sight of patient by hubs to start planning complex discharge needs.
- Embed SAFER flow bundle and 'red to green' management system.
- Focus on early discharge planning for P0 patients and increase P0 discharges through criteria lead discharge and weekend discharge activity.
- Voluntary sector integration and utilisation by Wards and Discharge Teams.
- Agree ITOC system principles, aligning goals and purpose with Place-based delivery and improving communication.
- Increase Trusted assessor model.
- Improve multidisciplinary working to support complex discharge planning for service users awaiting discharge from mental health settings.
- Review the ICS Discharge Board and system-level governance. Set and monitor metrics, agreeing principles and outcomes at a system level to ensure consistency.
- Reduction of deconditioning so that patients can leave on the most appropriate pathway.

October 2023 to March 2024

- Continue to map and amend pathways and services to support discharge across the system. Develop and establish the ITOC process at each Place.
- Fully onboard Mental Health into the improvement journey with digital and collaborative leadership.
- Robust oversight of discharge plans to ensure that they are meeting patient needs.
- Reduction in the requirement for intermediate beds and complex long term care packages.

April 2024 to March 2025

- Fully embed Optica digital tool.
- Create comprehensive evidence-based Place-level Discharge Demand and Capacity Plans.
- Evaluation of the programme's effectiveness; review the evidence base and celebrate and share successes.
- Review and reset goals and metrics to measure effectiveness and to evidence continuous improvement.

April 2025 to March 2027

- Deliver a stable and sustainable model of care for discharge. Focus on discharge Pathways 1 to 3, for patients who require additional support following a hospital stay; ensuring there is better patient choice and communication with carers so that decisions can be made together.

April 2027 to March 2028

- Digital maturity fully embedded.
- A model of care that meets demand.

How will we know we are achieving our objective?

Achieving or exceeding the national target to reduce hospital occupancy to 92% or less.

Case Study

Lung health checks launched in a drive to save more lives

Past and current smokers in Great Yarmouth are being invited to an NHS lung health check in a drive to improve earlier diagnosis of lung cancer and save more lives.

With one of the highest mortality rates for lung cancer in England, Great Yarmouth is one of 43 places across the country to launch the Targeted Lung Health Check programme.

The initiative means around 13,750 past and current smokers aged 55 to 74 years of age in Great Yarmouth are being invited to a lung health check by their GP. This will identify lung cancer earlier than it would have been otherwise.

People diagnosed with lung cancer at the earliest stage are nearly 20 times more likely to survive for five years than those whose cancer is caught late.

A patient who has had a lung health check, said: *"This is an excellent scheme and I was so pleased to be invited to attend this check up. Prevention is always better than the cure and this is a great example of the NHS, working together to help identify cancer much earlier. I am so grateful."*