Nottingham and Nottinghamshire ICS

Urgent Care

Clinical and Community Services Strategy

March 2021

This information has been placed in the public domain in order to benefit patients across the country as we believe the experience and approach may be useful for others, however we request that acknowledgement to the work in Nottinghamshire is made and referenced in all materials. This helps us to understand the wider impact benefits of our programme. Please cite 'this work has been informed by the Nottingham and Nottinghamshire ICS' when referencing.

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1. Executive Summary

The Integrated Care System (ICS) ambition across Nottinghamshire is to both increase the duration of people's lives and to improve the quality of those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The aim of the Clinical and Community Services Strategy (CCSS) is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate with a long term view of beyond 5 years. Where there is a need for urgent care, this needs to be accessible in a timely fashion in the most appropriate setting.

Urgent care services are provided by a whole host of organisations, generalists and specialists ranging from primary care clinicians to emergency department (ED) consultants in acute hospitals; from mental health services to ambulance crews and paramedics; from community pharmacists to social care providers. It is an area of care that is truly crosscutting for both roles and organisations, which can make it difficult to deliver safely and effectively, unless true partnership working is coordinated. It requires cooperation between and within these organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do.

The NHS responds to more than 110 million urgent calls or visits every year and so it is essential that patients receive the right care, by the right person as quickly as possible. The NHS Long Term Plan (LTP) distinguishes between urgent and emergency care as follows:

- *Emergency: Life threatening illnesses or accidents which require immediate, intensive treatment. Services that should access in an emergency include ambulance (via 999) and emergency departments (ED).*
- *Urgent: An illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC). If unsure what service is needed, NHS111 can help to assess and direct to the appropriate service/s.*

In order to align to the LTP and to the introduction of a new clinical assessment service (111 First), it is imperative to develop new models of care in the redesign of urgent and emergency care services. These need to incorporate access to the multitude of professionals and organisations in a coordinated and effective manner to ensure the patients do receive the right care, by the right person in a timescale that reflects clinical need but also is acceptable to patients.

This urgent care service review has been undertaken as part of the ICS CCSS work stream. It has been supported by clinical experts and stakeholders in the development of place based service models for the future, to support the long term needs of our existing citizens. The review also focuses on embedding prevention in our population over the next 5-10 years, by shifting our culture from one of illness to one of healthier lifestyles and self-care.

The strategy identifies major stages in the urgent care patient's journey and stresses a need to reorganise the way in which this care is delivered, from prevention through to longer term support for those at highest risk that require access to urgent care. A whole pathway approach in the provision of urgent care is crucial in order to maximise the clinical outcome for patients, their quality of life and their experience of urgent care.

Key themes have been identified along with key transformational opportunities and potential impacts have been developed which include: prevention strategies to promote healthy living and independence; improved self-management; improved access & shared communication about patients' past medical history from acute care settings to community specialists; appropriate levels of workforce skill mix across the ICS; standardised but appropriate access to services and support such as appropriate mental health access.

A transformational 'Bridge to the Future' highlights current service offers across the ICS and identifies some potential long term next steps that can be taken to achieve the identified opportunities with proposed timelines and the expected outcome for our citizens of Nottinghamshire.

The recommended next steps are vital in keeping the momentum of change in the future offer of improved prevention and self-care resulting in better health for our citizens; providing the right tools for our population to support their wellbeing; providing strong communication links for our staff is vital to enable them to provide the best care for our citizens; the most appropriate models of care in acute settings, neighbourhood and home need to be provided equitably across the ICS and be provided using best evidence, flexibly and in a patient centred way for them to fulfil their maximum potential throughout their lifetime.

2. Introduction

Background and Purpose	In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. However, our health and care system faces change and this will impact on our services, for example, the growing prevalence of long-term health conditions places new strains on our system. There is inequality evident in both the location of services and in access to services. In some areas, it is easier to access a GP than in others, or to find things to do to enable citizens to stay active and fit. The ICS ambition across Nottinghamshire is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The requirement for a CCSS came from the recognition that to achieve this ambition the system has to change as a whole, rather than just in its individual acute, primary care, community and social care elements. It is recognised that only by working together to describe changes in how care is provided across the system, rather than through individual organisations, will we deliver the scale of change required.
The ICS Clinical and Community Services Strategy	The aim of the CCSS is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention. This should be delivered closer to people's homes or in community locations where this enables better prevention, more supported self-care and earlier intervention to support citizens. The Strategy recognises that achieving this change is a long term programme that will be delivered over the next 5 years and beyond. This is also to enable a necessary long term investment in the health and care buildings and infrastructure in the system. An overall CCSS whole life model framework has been developed to focus on the need to support people through their lives from living healthy, supporting people with illness and urgent and emergency care through to end of life care. Citizens can experience different parts of the system at different stages in their lives. With the development of the overall Strategy framework the next phase of work is to review the 20 areas of service across the ICS that collectively form approximately 80% of the volume of clinical work in the ICS. This will ensure that overall the Strategy is described as a coherent whole and generates a programme of change for the whole ICS. This evaluation of Urgent Care is one such review and is part of the second phase of work.
NHS Long Term Plan	The NHS LTP is clear that to meet the challenges that face the NHS it will increasingly need to be more joined up and coordinated in its care; More proactive in the services it provides; More differentiated in its support offer to its individuals. The ICS has focused on describing 5 areas of focus for the delivery of the NHS LTP. These requirements are reflected in each of the service reviews that collectively will describe the CCSS **1. Prevention and the wider determinants of health -** More action on and improvements in the upstream prevention of avoidable illness and its exacerbations **2. Proactive care, self management and personalisation -** Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation **3. Urgent and emergency care -** Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting **4. Mental health** - Re-shape and transform services and other interventions so they better respond to the mental health and care needs of our population **5. Value, resilience and sustainability -** Deliver increased value, resilience and sustainability across the system (including estates)

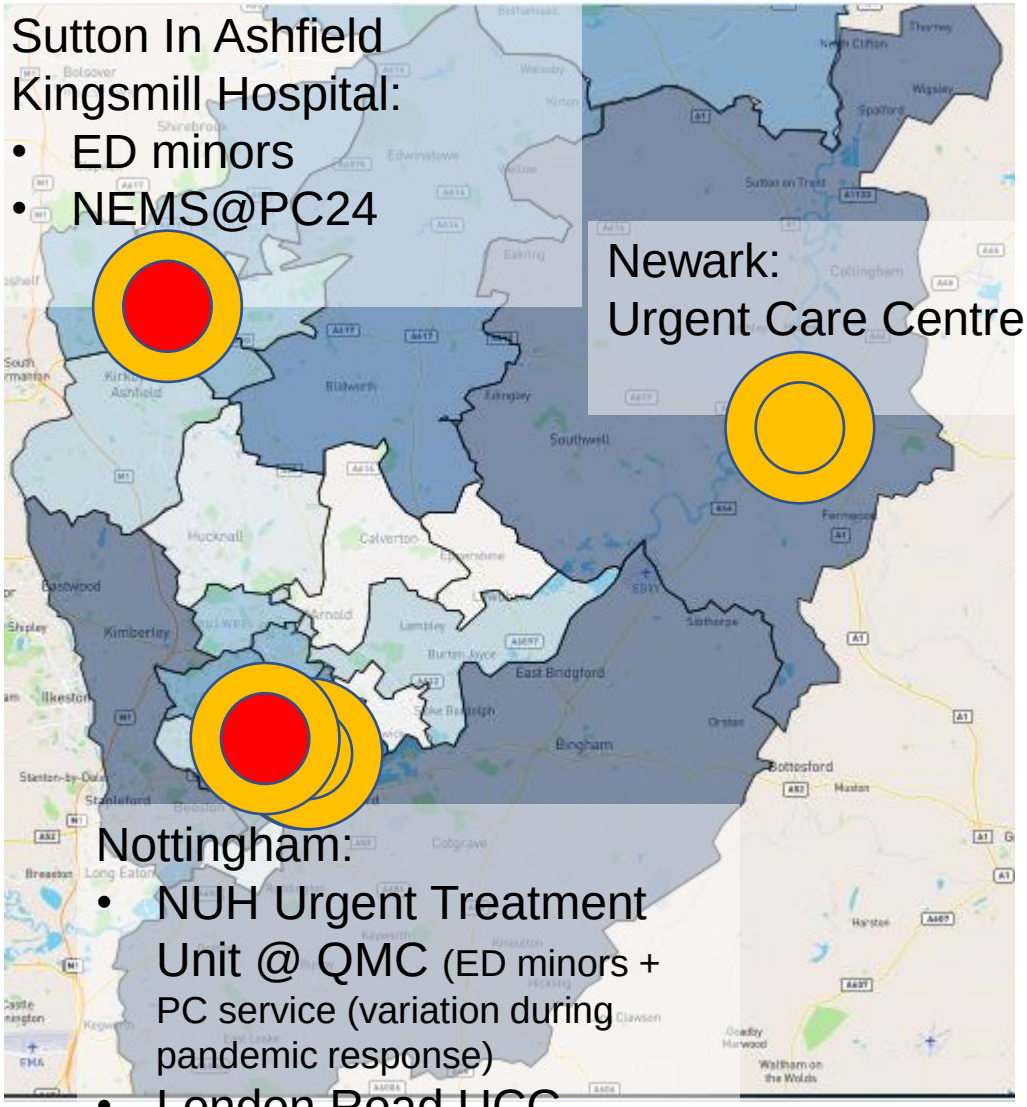
3. Approach and Scope

Approach	This strategy has been developed through an open and inclusive process which weaves together the expertise of clinicians and care experts with commissioners and citizens in determining the future shape of services across the system. There have been a variety of stakeholder and service user events to develop a clinical and community services model. An extensive system wide piece of work is taking place across a minimum of 20 services. The CCSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the second phase of six service reviews. These include; Diabetes; Eye Health; Skin Health; Women's Health; Heart Health and Urgent Care. Due to lockdown following the outbreak of the pandemic, Corona Virus Disease 2019 (COVID19), it was decided to postpone Heart Health and Urgent Care, in-line with clinical commitments in response to the pandemic. Urgent Care was resumed in July 2020. This document discusses the approach, scope, the key issues and potential transformational opportunities within Urgent Care services across the ICS. Health, social care, public health and the voluntary sectors have all been considered through reviewing the current service offer across the ICS. The service review included a number of steering group meetings that were held and wider stakeholder workshops conducted remotely via MS Teams. An evidence review pack was developed which considered national and local best practice to inform the development of potential themes and new models of care where transformational change may take place across the ICS in the future.
Scope	In the NHS LTP Urgent Care is defined as an illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC). This review has been framed to consider the range of services accessed by patients falling into one of the following categories: • Accidents (falls, cuts, collision, etc.) • Exacerbation of an existing condition • New condition developed • Mental Health related (substance abuse, alcohol abuse, self-harm) The scope of the work was drawn to represent the needs of undifferentiated patients rather than those already known to services including consideration of • Community pharmacy • GP Same Day or Out of Hours provision • Ambulance service • ED urgent care • UTC urgent care **Not in scope:** Dental services and Eye Casualty were agreed to sit outside the scope of this review, although it was agreed recommendations could be fed through this process. The specific requirements of Maternity services were also not covered in the review. Eye Casualty is considered in the Eye Health review.
Engagement	The urgent care review has been supported by an Urgent Care Steering Group including stakeholders and clinical experts from across the ICS. They have provided expert advice, guided, confirmed and challenged assumptions throughout the period of review and connected to other workstreams. This group has formed part of the governance process along with the CCSS Programme Board. Nine workshop type events were held remotely, enabling a wide breadth of stakeholders (Clinicians, Allied Health Professional (AHP), Nurses, Pharmacists, Heads of Service, Social Care, Public Health, Commissioners and others) to be proactively involved in re-evaluating current service offers across the ICS, in developing potential themes and agreeing transformational change for the future Clinical and Community Services Strategy. Due to restrictions imposed as a result of the COVID19 pandemic, it was not possible to include full engagement from patients. Although patient focus groups were planned, due to the COVID19 lockdown and restrictions these have not been held, but would still be beneficial when social distancing rules allow this to be organised.

4. Contents

Strategy Development	This Strategy Document consists of five key elements. These have been developed through a process of design and iteration at the steering groups. The strategy has been developed with reference to the Evidence Review document and alignment to the NHS LTP linked to urgent care specifically, but also in some of the generic principles.
Urgent Care in the ICS	What does the provision of urgent care look like in our ICS? Undifferentiated urgent care is delivered in many settings across the ICS and involves over 7,000 face to face patient contacts a day with in the region of a further 1,000 calls to 111. Considering the whole picture of urgent care in the ICS helps give the context for future service change.
Priorities for Change	The work of the Steering Group identified four key areas of focus that need to change in the ICS for urgent care. These were based on a review of the current issues facing the ICS and the views of the Steering Group members.
Proposed Future Care System	Following the evidence review at subsequent stakeholder sessions, delegates developed the urgent care model based on 4 care steps agreed: • Pre-care • Connect and Triage • Diagnosis, Treatment and Care • Post Care This enabled key changes required to be identified for the future care system for urgent care to address the Priorities for Change. This future care system was described against three location settings • Home – the usual place of residence for the patient/ citizen (including care homes) • Neighbourhood – Care in all locations outside of the home and acute hospital - includes non-medical step down, primary care, community hospitals, ambulatory care, community pharmacy • Acute Hospital – a setting with 24/7 medical presence
Transformation Proposal	The Transformation proposal describes the key initiatives or programmes that are required to deliver this new model. Namely, • **Priority** – What is the priority of the initiative in the view of the steering group and workshop attendees • **Alignment** – At what level of the system should we aim for a consistent approach for each initiative? In most instances this is ICS level where with the greater value is perceived to be in an overall consistent approach. However there are some instances where the recommendation is for delivery to be at Integrated Care Provider (ICP) level where. Alternatively, it is at Primary Care Network (PCN) level where differential delivery would benefit the needs of very local populations • **Enabling Requirements** – What is required to enable each Programme to deliver? This includes workforce, technology, estate or service configuration. There are also requirements of culture or finance and commissioning to allow the system to work together differently • **Benefits and Costs** – Where available, the key benefits of the initiative at system level are summarised
Service Vision	The 'Bridge to the Future' was generated at a further virtual steering group meeting. It summarises the current challenges for the urgent care system in the ICS now (Priorities for Change), what the ambition is and the outline steps to get there. Progress with the 'Bridge to the Future' and the partnering vision can be returned to with stakeholders as the work develops to review progress.

5. Context: Urgent and Emergency Care in our ICS



In addition to same day appointments at GPs and community pharmacy there are 5 main locations for undifferentiated urgent care provision

Home

111
EMAS
Call 4 Care

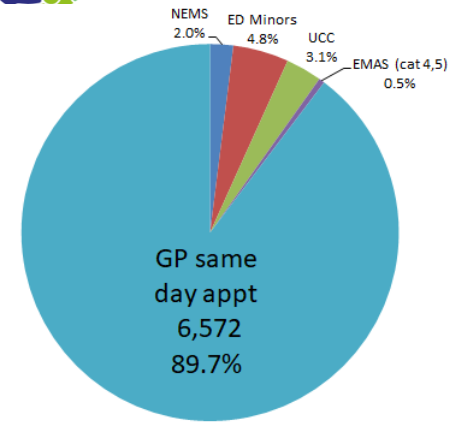
Neighbourhood

- GP Same Day Appointments
- Community Pharmacy
- UCC / UTU
- PC in hours
- PC OOH (NEMS)

Acute Hospital

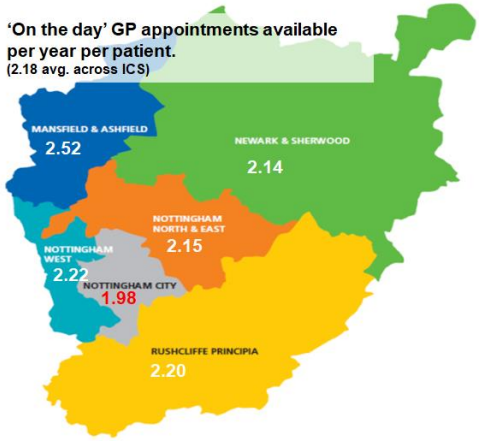
- ED
- PC 24
- NEMS

5. Context: Urgent and Emergency Care in our ICS



Urgent Care is largely the work of primary care….

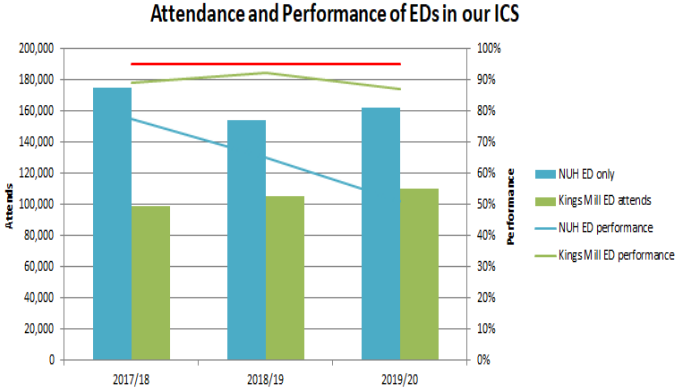
Urgent Care provision as framed by GP out of hours (NEMS/PC24), Same Day GP appointments, EMAS See and Treat and ED Minors attendances is dominated by the role of primary care with 90% of face to face contact provided by primary care. Urgent Care, as distinct from Emergency Care, is mainly a Primary Care activity. This can be forgotten when faced with intense pressure in emergency department hospital based services. Further detail on urgent care activity in the ICS can be seen at Appendix 1.



There is significant variation across the ICS in GP/PC same day appointment availability…

There is relatively good availability of GP same day appointments in the ICS compared to the rest of England.

The England Average is 2.05 'on the day' GP appointments per year per person.
Our ICS has a higher average at 2.18 'on the day' GP appointments per year per person.
Nottingham City CCG area is the only area where patients have less on the day appointments available to them per head of population than the England average.
Prior to COVID 40% of all GP appointments in the ICS are same day appointments. This increased to 56% during April 2020.
NHS Digital 'On the day' GP appointments data is experimental data, but is the best/only data available. It is inline with the national data where it is known that those in more deprived areas have less on the day access to GP/PC appointments. It is expected that this picture is mirrored locally in the ICS.



Demand on Emergency Departments, outside of the COVID-19 response, continues to increase…

Waiting time performance in ED is on its own a very limited measure of urgent care access. However across the ICS attendances have broadly continued to increase in Emergency Departments, although offset by ongoing performance improvement work, and as they have done so there has been a reduction in waiting time performance as measured by the 4 hour access standard. Access has historically been better at Kingsmill than QMC in Nottingham but the trends are similar.

Only 51% of ED attends on the QMC site were discharged or admitted within 4 hours in 2019/20 (this increases to 69% when the NEMS and Urgent Treatment figures are included).

5. Context: Urgent and Emergency Care in our ICS

EMAS undertake a significant contribution to the delivery of urgent, as opposed to emergency, care…

There are 243,000 calls annually to East Midlands Ambulance Services Nottinghamshire (EMAS Nottinghamshire) converting to 189,000 incidents. The majority of these incidents are assessed as life threatening or emergency (93% Category 1,2 and 3).

Of the remaining 13,000 incidents 90% do not result in conveyance to an Emergency Department, 79% (10,000 incidents) are treated over the phone (hear and treat - including self-care advice or refer to other service); and 14% treated on scene (1,800).

Category	Definition
Cat 1 - Life Threatening	This is defined as a time critical life-threatening event requiring immediate intervention or resuscitation. These calls should be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes.
Cat 2 - Emergency	This is defined as potentially serious conditions that may require rapid assessment and intervention. These calls should be responded to in a mean average time of 18 minutes, and at least 9 out of 10 times before 40 minutes.
Cat 3 - Urgent	This is defined as urgent problems that needs treatment to relieve suffering but are not immediately life threatening. These calls should be responded to at least 9 out of 10 times before 120 minutes.
Cat 4 - Less Urgent	This is defined as problems that are not urgent but require assessment. These less urgent calls should be responded to at least 9 out of 10 times before 180 minutes.

NHS 111 makes a growing contribution to the delivery of Urgent Care…

Prior to the COVID pandemic (which saw NHS111 online traffic increased 5 fold to 20,000 hits per month), the site was visited 3,000-4,000 a month steadily increasing over time. In Nottinghamshire 25,000-30,000 calls are answered each month with the exception of 35,000 in March 2020 due to COVID.

Community Pharmacies have nearly half as many urgent care contacts daily as GPs in the ICS…

There are approximately 200 community pharmacists across Nottingham and Nottinghamshire ICS. The PSNC Pharmacy Advice Audit (Pharmacy-Selected Audit 2020/21) reports approximately 15 patient consultations per day per community pharmacy. This equates to 3,000 appointments per day (1,095,000 appointments per year).

6. Priorities for Change – Urgent Care Key Themes

Prevention & Self Care

- Self Care Models and Awareness
- Education and Preventative Care
- Early Intervention

Navigation & Access Model

- Navigation & Diversion
- Simplify Offer
- Urgent Primary Care Offer
- 24 hour access

Connecting the Urgent Care System

- Mental & Physical Health & Social Care
- 24/7 Social Care
- Partnership working and IT

System Working Day

- Integration of systems
- Avoid elderly overnight stays

6. Priorities for Change – Infographic

Integrated Care System
Nottingham & Nottinghamshire

www.healthandcarenotts.co.uk @NHSNottingham

7 in 10 people lack the knowledge & confidence to act if someone was bleeding heavily.
British Red Cross

Only 5% of people are confident to respond in an emergency
British Red Cross

1 in 7 emergency admissions are avoidable through improved self-care.
NHS England

7 in 10 adults lack the knowledge and confidence to act if someone collapsed and was unresponsive and breathing.
British Red Cross

47% 'Common Approach To Children's Health' app users chose self-care instead of attending A&E since downloading the app NHS England

1 in 5 non-urgent cases arrived by ambulance, largely out of hours Lord Carter Ambulance Review 2018

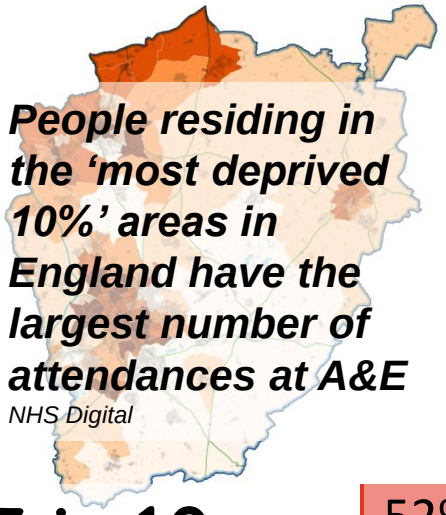
Calls for **life threatening emergencies** now only make up **10%** of ambulance demand.
Lord Carter Ambulance Review 2018

RoSPA 'Safe At Home' scheme (2008-2011), educated, informed and provided safety equipment to targeted **vulnerable families reducing hospital admissions** for under 5s year olds by **52%**.

1 in 4 older people admissions could be avoided if there is an early review by a suitably qualified clinical decision maker supported by responsive intermediate care services British Journal of Health Care Management Avoidable acute hospital admissions in older people

Reducing avoidable conveyance (especially elderly) could save **£300M** across the wider health system by treating patients at home or directing them to more appropriate health services.
Lord Carter Ambulance Review 2018

6. Priorities for Change – Infographic



People residing in the 'most deprived 10%' areas in England have the largest number of attendances at A&E

NHS Digital

Patients were asked about their awareness of alternatives to A&E. Patients on the whole are very much aware of the community-based alternatives

Royal College of Emergency Medicine (2015)

1 in 4 patients **contacted their GP** surgery prior to presenting to A&E. Of these, **45%** could have been seen within **3 hours**

Royal College of Emergency Medicine

7 in 10 people attended A&E without seeing any other healthcare provider.

Royal College of Emergency Medicine (2015)

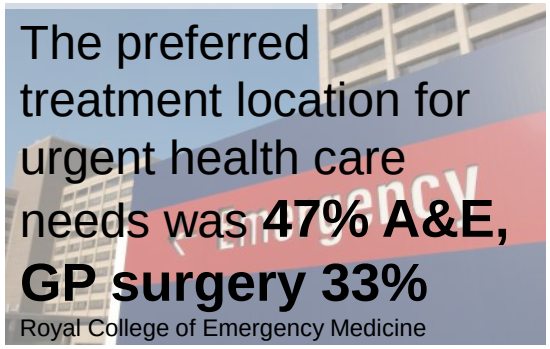
52% people in ED were seen by a doctor or a nurse in fewer than 30 minutes.

Royal College of Emergency Medicine

72% of survey respondents received a specific diagnosis for their condition.

The average community pharmacy does 15 consultations per day. Preventing each GP practice having 65 additional appointments a week.

PSNC PHARMACY ADVICE AUDIT Pharmacy-Selected Audit 2020/21



The preferred treatment location for urgent health care needs was **47% A&E, GP surgery 33%**

Royal College of Emergency Medicine

26% of ED attendees had been **symptomatic** for more than 24 hours

Royal College of Emergency Medicine

In Denmark GPs or nurses at the urgent care hotline book appointments for patients at the nearest ED. Patients are only seen with a referral unless it's a clear emergency.

Emergency and Urgent Care Systems in Australia, Denmark, England, France, Germany and the Netherlands

Urgent Care Benchmarking – Midlands Hospitals

A&E attendances - Apr 2019 - Mar 2020

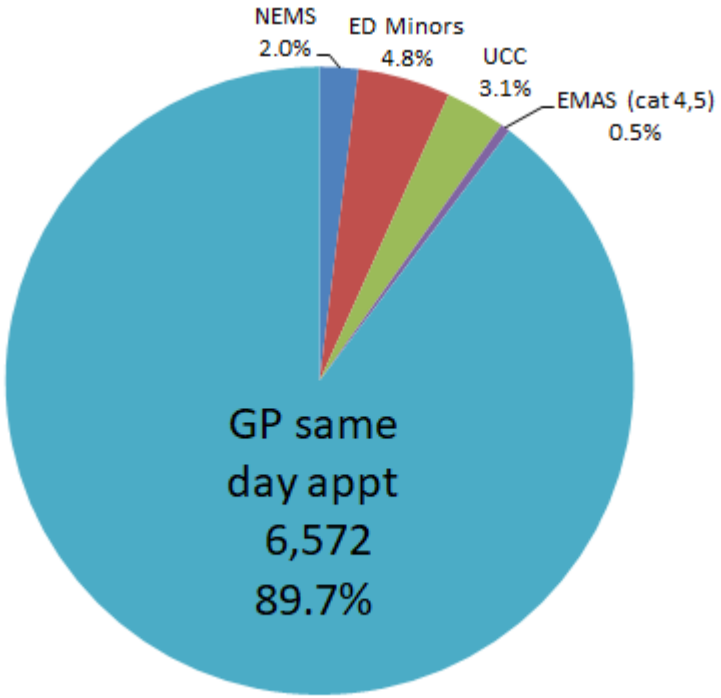
Data source - UEC daily sitrep (Note: unvalidated daily data)

	A&E Attendances				Type 1 attends (ED)				% Type 1 (ED) attends				ED Minors as % of ED Minors & UCC attends
Trusts	Type 1 (ED)	Type 2 (Eye Casualty)	Type 3 (UCC)	Total A&E Attends	Major	Minor	Paeds	Resus	Major	Minor	Paeds	Resus	
The Royal Wolverhampton NHS Trust	144,028	-	101,534	**245,795**	41,793	77,322	20,955	4,037	29%	54%	15%	3%	43%
George Eliot Hospital NHS Trust	74,747	-	13,746	**88,390**	23,554	34,065	16,014	1,084	32%	46%	21%	1%	71%
Nottingham University Hospitals NHS Trust	188,275	20,246	61,596	**270,387**	59,816	84,410	41,519	2,445	32%	45%	22%	1%	58%
University Hospitals of Leicester NHS Trust	234,238	19,391	116,524	**369,828**	81,127	84,670	58,546	9,605	35%	36%	25%	4%	42%
Northampton General Hospital NHS Trust	103,385	12,761	17,509	**133,682**	46,528	36,213	20,644	-	45%	35%	20%	0%	67%
University Hospitals Birmingham NHS Foundation Trust	364,502	56,110	258,407	**679,003**	163,618	127,641	55,932	17,079	45%	35%	15%	5%	33%
Wye Valley NHS Trust	63,630	-	2,299	**65,782**	37,034	22,050	3,095	1,399	58%	35%	5%	2%	91%
Kettering General Hospital NHS Foundation Trust	93,171	-	82,878	**176,107**	40,314	32,211	16,441	4,149	43%	35%	18%	4%	28%
Sherwood Forest Hospitals NHS Foundation Trust	109,299	-	53,064	**162,337**	49,884	35,443	17,527	6,463	46%	32%	16%	6%	40%
Sandwell and West Birmingham Hospitals NHS Trust	166,484	13,389	34,030	**213,782**	89,378	52,965	22,303	1,707	54%	32%	13%	1%	61%
Walsall Healthcare NHS Trust	82,445	-	50,185	**132,708**	33,884	23,594	16,550	8,482	41%	29%	20%	10%	32%
South Warwickshire NHS Foundation Trust	72,511	-	7,766	**80,185**	36,663	20,105	13,803	1,940	51%	28%	19%	3%	72%
University Hospitals Derby & Burton NHS Foundation Trust	208,911	-	191,228	**400,196**	97,605	54,019	45,314	11,944	47%	26%	22%	6%	22%
University Hospitals Coventry and Warwickshire NHS Trust	146,897	23,361	73,742	**244,099**	71,440	36,582	33,849	5,081	49%	25%	23%	3%	33%
University Hospitals of North Midlands NHS Trust	178,670	5,227	82,022	**265,789**	93,545	44,368	33,980	6,640	52%	25%	19%	4%	35%
Worcestershire Acute Hospitals NHS Trust	129,772	-	53,818	**183,525**	61,732	32,205	19,840	15,960	48%	25%	15%	12%	37%
Shrewsbury and Telford Hospital NHS Trust	117,567	-	54,154	**171,811**	65,099	27,736	21,656	3,166	55%	24%	18%	3%	34%
United Lincolnshire Hospitals NHS Trust	148,097	-	132,934	**281,259**	93,296	31,205	19,866	3,842	63%	21%	13%	3%	19%
Chesterfield Royal Hospital NHS Foundation Trust	74,108	-	55,866	**129,718**	50,355	12,666	8,982	2,072	68%	17%	12%	3%	18%
The Dudley Group NHS Foundation Trust	106,949	-	66,912	**173,861**	68,340	17,037	21,164	275	64%	16%	20%	0%	20%

NUH ED attendances: 45% are for minors (84,410) – which appears relatively high compared to other midlands hospitals. Although major and minor streams in different settings are not always comparable most hospital EDs now have alongside primary care services which is a main cause of difference.

Type 3 attends (Urgent Care Centre (UCC) or equivalent) make up a relatively small proportion of A&E classified activity in Nottingham compared to other systems. Partly this can be explained by history and geography with some systems having a greater make up of Minor Injury Units in more rural locations but it also reflects a systemic preference for minor injury/minor illness provision outside of primary care to be delivered through ED in Nottingham. Historically the closure of underutilised Walk in Centres has not resulted in proportionate increases in ED activity suggesting patients have found alternative to Type 1 or Type 3 A&E attendances.

A typical Urgent Care day in the ICS



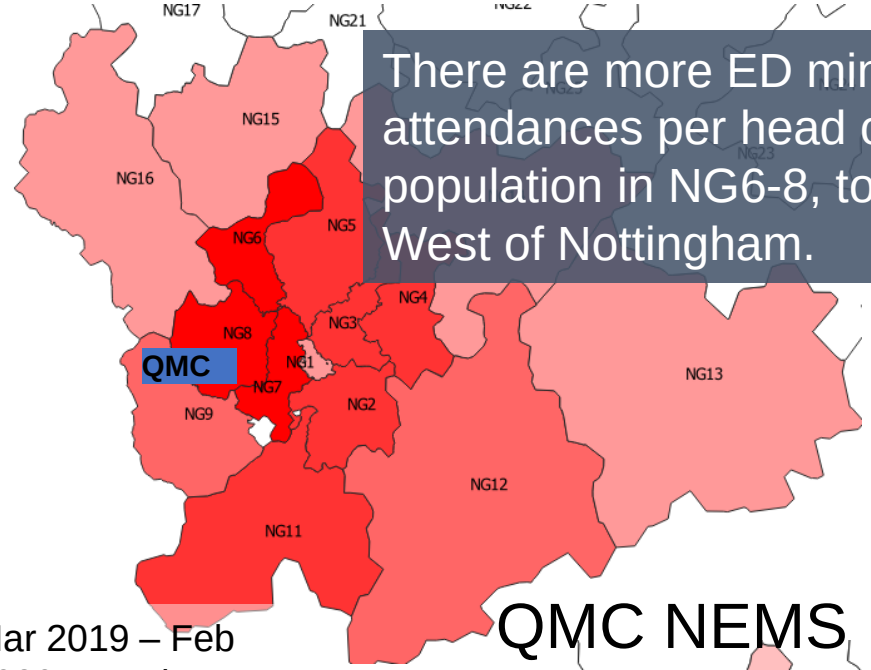
The Urgent Care system in Nottingham and Nottinghamshire ICS is dominated by GP on the day appointments (6,572) which reflect 90% of the face to face activity.

There are up to 1,000 calls a day to 111 in the Nottinghamshire ICS which can result in face to face appointments

Community Pharmacists are also key providers of urgent care with approximately 3,000 patient consultations per day.

What UC setting do our patients use - geography

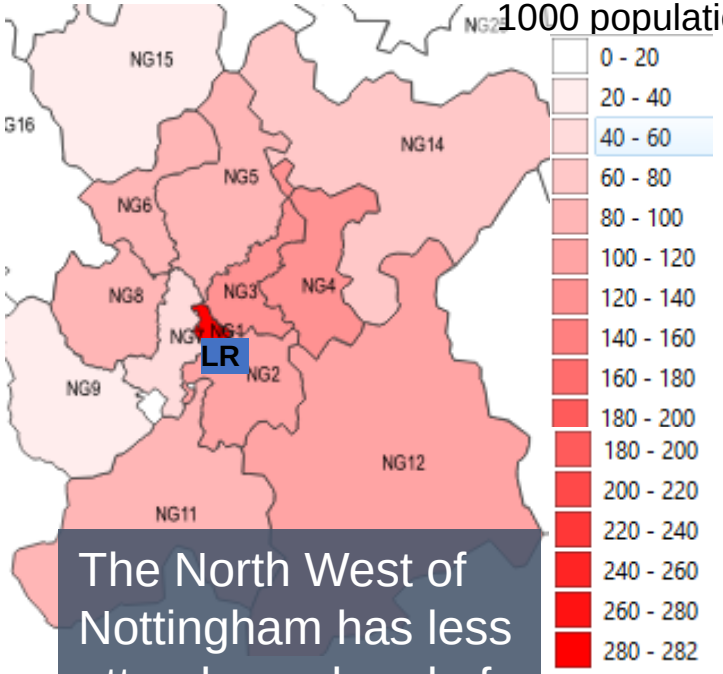
QMC ED minors



There are more ED minors attendances per head of population in NG6-8, to the West of Nottingham.

London Road UTC

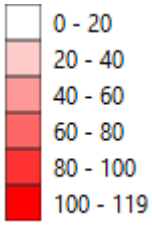
Mar 19- Feb 20 attends per 1000 population

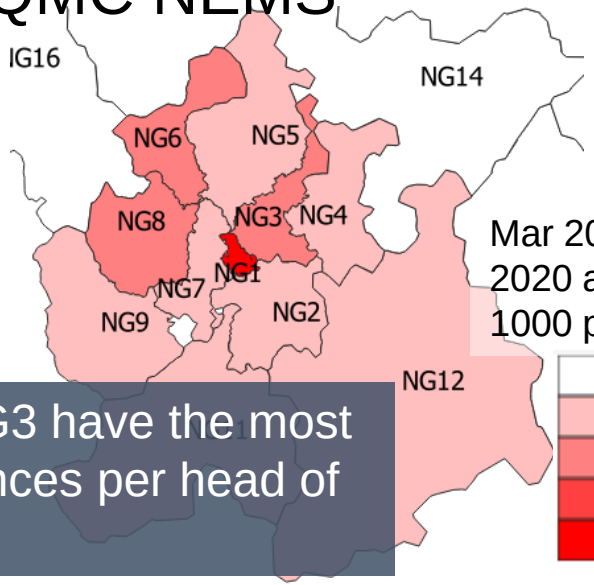


The North West of Nottingham has less attends per head of population.

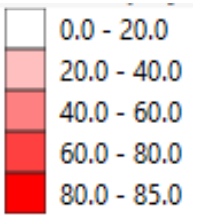
QMC NEMS

Mar 2019 – Feb 2020 attends per 1000 population



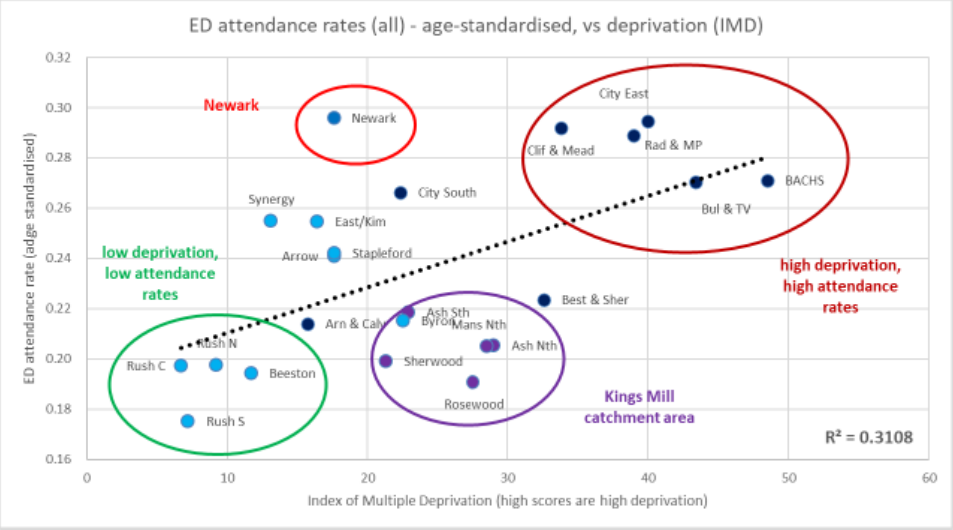


Mar 2019 – Feb 2020 attends per 1000 population

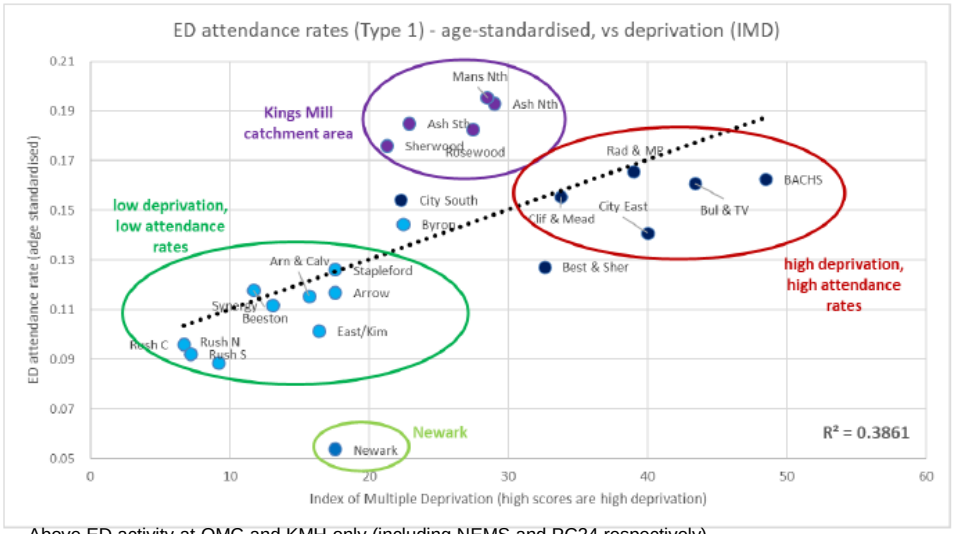


NG1, NG6, NG8 and NG3 have the most NEMS @ QMC attendances per head of population

6. Priorities for Change – PHM Review



Above includes London Road, Newark and QMC Eye Casualty activity



Above ED activity at QMC and KMH only (including NEMS and PC24 respectively)

The ICS Population Health Management (PHM) team have undertaken a review of the usage of Urgent Care services that identifies a number of key features

- There are greater levels of walk-in ED attendance with no admission from areas of higher deprivation in Nottingham
- Walk-in ED attendances with no admissions are characterised by young children, teenagers and young adults
- Walk-in ED attendances with no admission from areas of higher deprivation have higher numbers of outcomes of 'no investigation or no significant treatment'
- Overall the PHM work identified 3 main groups for Walk—in ED Attendance with no admission

(1) Nottingham City PCNs, most South Notts PCNs -> QMC (59%) and London Road UTC (26%). But note:
i. 33% of Byron patients attend Kings Mill, compared with 43% QMC and 13% London Road
ii. A notable proportion of Eastwood/Kimberly and Stapleford patients, and some Ashfield South patients, attend the Ilkeston and Ripley UTCs
iii. 20% of Rushcliffe North patients attend Newark
iv. 14% of Unity patients attend out-of-area ED departments
v. Quite a few Rushcliffe South patients attend the Loughborough Urgent Care centre
(2) Mid Notts patients, except Newark -> Kings Mill (84%)
(3) Newark patient -> Newark Hospital UTC (76%)

These charts show the strong relationship between Walk-in ED attendance and no admission and areas of higher deprivation (in Nottingham in particular) but also that the London Road UCC plays a significant role in meeting Walk-in demand from all areas. Newark UCC is very effective in meeting this demand in Newark.

6. Priorities for Change

The review identified 4 key areas of focus highlighting potential areas of change which include:

- Prevention and Self-Care (with emphasis on self-care models and awareness with improved education and preventative care with early intervention);
- Navigation and Access Model (efficient navigation and diversion in a simplified offer, including an urgent primary care offer and reviewing 24 hours access for urgent care);
- Connecting the Urgent Care System (encompassing mental and physical health, including appropriate social care 24/7 with much improved information technology (IT) to enable much broader partnership working);
- System Working day (enabling equitable and universal access supporting the patient's journey with integrated systems; transforming the urgent care service to reduce avoidable overnight stays for the elderly in acute hospitals).

Prevention and Self-Care	A crucial element in considering the strategy for urgent care services is developing knowledge and capacity for alternatives to the provision of services. Some provision of urgent care is avoidable through confidence and knowledge in how to self care, knowledge of children's health, and by accident avoidance. The CCSS has prevention and self care at its heart and this applies to Urgent Care as for other services. Around 80% of all care in the UK is self-care and many people feel comfortable managing everyday minor ailments themselves. However, there are still 57 million general practice (GP) consultations for minor ailments each year, while one in seven emergency admissions is preventable through improved self care. In the Nottinghamshire ICS approximately 30-40% of attendances result in no significant treatment. A free self-care app developed by the CCG and local council in Cheshire, demonstrated a reduction in emergency attendances, where 47% of the app users said they had chosen self-care instead of attending A&E since downloading the app, while 35% said it had helped them feel more confident in self-caring for their child and in knowing where to find the best treatment. Local data shows that some of the diagnoses of urgent care patients, are linked to long term conditions (LTC). Improved understanding and patient education can vastly improve self-management to reduce the urgent or even emergency care needs of some of these patients, helping to reduce exacerbations and avoidable admissions. Through supporting people to better manage LTCs, this can help with reductions in the demand for urgent and emergency care. Self-care has been considered in completed reviews, including Frailty, Respiratory, CYP, Maternity and Neonatal, Stroke, Skin Health, Eye Health, Diabetes and Women's Health. Risk factors play an important role in determining whether a person becomes ill, at which age, and the associated effect on quality of life. The Global Burden of Disease (GBD) divides risk factors into 3 main groups: behavioural, metabolic environmental and occupational. GBD does not include the broader social and economic factors that shape people's lives, such as education, income, work and social capital. Therefore it may not fully reflect the risk and protective factors associated with health, particularly mental health. Top behavioural risk factors were smoking, drug and alcohol abuse and aspects of diet and nutrition, with obesity being the top metabolic risk factor (high body mass index (BMI)), high blood-glucose levels, high blood pressure and high cholesterol. Accidents and injuries are a major cause of death and disability. Around 14,000 people die in the UK, most of them in England and more than 700,000 will be seriously injured in England alone. They cost the UK an estimated £150 billion every year. For children and young people, accidents are the greatest threat to life. Concept in accident prevention allow risk reduction for primary prevention, secondary prevention tertiary prevention. There is a role for HCPs in accident prevention through advice to patients, identifying and treating accident causing conditions or identifying unacceptable risks and intervening, (such as child protection concerns). There are key areas of accident prevention, such as specific medical conditions, falls choking/ suffocation in children, burns, drowning, poisoning, falls for elderly, accidents in the home (which make up around 2.7M ED attendances each year in the UK), road accidents, sports and leisure accidents, workplace safety. The Royal College of Emergency Medicine (RCEM) and Royal Society for the Prevention of Accidents (RoSPA) highlighted the disproportionate number of injuries resulting in the highest attendance rates at ED tend to be linked to 3 main age groups – under 5 year olds at home, over 75 year olds at home and leisure accidents in15-24 year olds. Of these, injury prevention programmes for the under 5s in the home presents the best opportunity to reduce harm and ED attendances, with 72% of unintentional injuries occurring at home. First aid is identified as an essential life skill and should be part of everyone's basic education and integral to public health strategies, with opportunities to learn throughout one's lifetime, particularly for those most at risk of experiencing a crisis.

Navigation and Access Model	Moving beyond prevention and self care when there is a need for urgent care delivery there are a number of key questions in how to access the urgent care system. For the public, location, speed of access and confidence in having an issue resolved are important. For services in turn there is an imperative in the face of increasing demand of matching patient need with the right level of professional skill in the most efficient and effective way. Balancing these demands is at the heart of providing coherent UC services. If the balance is wrong in terms of • Location – not enough local options • Time – Opening hours do not meet patient need • Confidence – Not being sure a location will resolve the issue the patient has It will affect how the local population access services with ED services seen as the default. Repeated surveys have shown that patients are often aware of alternatives to ED but not always what they could offer or would have to be sure that the alternative location would be able to deal with their issue without them needed to go to ED. Attendance is driven by perception of urgency with many minor injury and illness complaints having existed for more than 24 hours. 111 is a well known access point for urgent care and it is well used in Nottinghamshire with over 25,000 calls per month. Nationally, both before in the LTP and during the pandemic response, the focus has been on encouraging the use of 111 services before attendance at ED or other physical urgent care locations and the use of booked appointments in these settings. This helps services match clinical urgency and condition with the most effective level of professional input but it if is not responsive enough in meeting how patients perceive their needs then it may have limited success. Whilst the NHS 111 First service offers a different approach to the way patients access and receive urgent and emergency healthcare, there are many practical challenges to overcome. As access to urgent care is driven by perception of urgency rather than a clinical definition of urgency how can the use of 111 be encouraged while 'walk up and wait' services remain a key part of the NHS service offer? Attached to this challenge is the question of what is the most effective model of provision. Some health systems focus urgent care provision through emergency departments while others have a balance with more urgent care/walk in centre availability. Compared to most other Urgent and Emergency care settings in the Midlands areas Nottingham has a relatively high proportion of delivery of it's non-primary care urgent care services centred on the Emergency Department. 45% of Nottingham ED attendances are for the minors stream and in Nottingham 58% of minors activity is delivered through ED. While direct comparisons are difficult due to different geography and possibly patient classification these proportions are high compared to most other Midlands hospitals and raises the question as to whether the balance is the right one in Nottingham. When faced with needing treatment for a minor injury the options outside self care are limited to ED and the Urgent Care Centre at London Road although the provision of minor injury care is an element of the current primary care Enhanced Services Delivery Scheme. However public awareness of this is unclear and activity information is not reported. As this is a new development availability will have been impacted by the pandemic response. Alongside these overall observations there is a clear geographical difference in where patients choose to go to access urgent care. In Nottingham citizens to the North and North West of Nottingham are more likely to use ED for Urgent Care. Perhaps unsurprisingly greater proportions use London Road to the East and South of Nottingham. In this analysis patients access the local offer. Alongside this picture is the evidence that citizens access ED for urgent care more often from areas of higher deprivation. The questions of the balance of physical service offer in terms of location, opening hours and range of service alongside the question of how to provide access to services in terms of the balance of 'walk up and wait' provision in the traditional sense with the new model of 'connect, triage, appoint' best expressed by 111First are key for the strategic direction of service development.

Connecting the Urgent Care System	Capacity in the system requires review, as simply diverting UC patient away from ED (when they do not require ED), may see blockages quickly develop in the UC or primary care services in the system. The balance needs to carefully considered particularly in aligning to nationally driven developments such as NHS 111 First. The UC offer in the system needs to be simplified with the initial triage being key to ensuring the right service is accessed, removing any confusion patients may experience and to ensure a positive experience rather than unnecessary referral onwards. Services available should aim to prevent avoidable admissions and maximise community and ambulatory care and to expedite discharge. Connecting patients to the right urgent care service for their needs, can have a huge impact on their outcome. The health and care system across the ICS consists of different organisations responsible for the mental health, physical health and social care of the citizens. Understanding a citizens needs, their existing conditions and treatment is essential for the safe functioning of patient pathways and a good experience for patients that means they do not have to repeat their circumstances to multiple professionals. Changes in one area of the system have a knock on effect on other parts of the system, so partnership working is crucial to having a system that works effectively and is coordinated. Findings in the Lord Carter review into Ambulance Services, showed that providers of community services and mental health trusts, could manage to do more to prevent admissions if the healthcare system was more joined up. The nature of call data set identifies mental health as the primary cause of around 2% or 340,000 calls every year to the ambulance service. Analysis showed there is significant variation in the conveyance rates from 27% to 54% across England. Conveyance rates are likely to be associated with the extent to which paramedics can access 24/7 crisis services and NHS England were committed to making sure these services were available across England by April 2019. To reduce avoidable conveyance, ambulance staff need to know the other services that are available to the patient. A vital aspect of effectively providing a multi provider urgent care system that avoids inappropriate attendance, unnecessary onward referral and care as close to home as possible is excellent information as to the availability, coverage and accessibility of services. This requires the effective use of existing aids such as the Directory of Services (DoS), which contains information for a wide range of health and care services across England. It is a core part of the urgent and emergency care system workflow and is responsible for directing patients to appropriate services. If effectively used, the DoS should serve two important functions; • Supporting Integrated Urgent Care (IUC) colleagues with navigating and triaging patients correctly, and • Protecting ED front door capacity, with an emphasis on same day emergency care (SDEC) Locally, some urgent care services report not having access to the DoS and/or that it needs to be more useable and reliable. With widespread understanding and effective use of the DoS, its functionality and content, it can aid with triage and navigation of patients to help with getting the patient to the right place first time. All paramedics should have access to an easily navigable electronic DoS that provides up to date information. However, in some trusts it is only available as a paper resource and updated infrequently, often with the quality of information in the DoS being variable. The Five Year Forward View for Mental Health set out plans for expanding mental health services so at least 1.5 million people can access Improving Access to Psychological Therapies (IAPT) services each year. The LTP made a renewed commitment to expand access to IAPT services for adults with common mental health problems, with a focus on those with long term conditions. Studies have shown that a quarter of admissions of frail older people could be avoided if there is an early review by a suitably qualified clinical decision maker supported by responsive intermediate care services. Early expert intervention with multiagency support to manage older people may be more promising than other interventions that have been attempted. This is supported by the view that building community capacity is required to ensure a timely response. Teams need to be able to respond rapidly, seven days a week and into the late evenings, and engage wider personalised community support. Access to equipment and short term care packages is essential.

System Working Day	Integrated urgent care is underpinned by the availability of integrated technology solutions to deliver robust, resilient solutions. The LTP has highlighted the importance of delivering a functionally integrated urgent care service and sets out the standards against which technology must be procured and emphasises the importance of robust resilient solutions: • Telephony: The function of the national 111 platform and how providers receive 111 calls. • Service Directory: The importance of maintaining an accurate service directory and how to access and use it. • Interoperability: The challenges associated with referral of encounters into and out of the service, access to records and appointment booking. • Future Technology: The emergence of alternative access channels such as on-line and the replacement / onwards development of existing technologies such as service directories and triage tools. Interoperability between IUC services is a fundamental enabler ensuring that service providers can facilitate a consistent and integrated journey for patients. NHS Digital's Urgent and Emergency Care Digital Integration (UECDI) programme is helping people get the right care, first time by improving the flow of information through the urgent and emergency care system. This is in light of the challenge that patients travelling through the urgent and emergency care system do not always have a seamless journey. Information about their condition may pass through multiple data systems which don't always connect to each other, and patients may have to see different clinicians, go to multiple places or repeat the same information before receiving the care they need. By improving the flow of digital information and accelerating the use of new technology, systems and standards, the chances of urgent and emergency care patients to be seen in the right place, at the right time, by the right clinician can be improved, resulting in a better patient experience and help to relieve pressure on frontline services. An integrated IT system is in operation in the Danish urgent care model, which supports a single record, providing visibility of information across settings to aid decision-making and navigation across the pathway. An increasing number of older people are accessing emergency departments. This is related to the increasing number of older people, but may also be due to lower thresholds for accessing urgent care. Over the next 20 years, the number of people aged 85 and over is set to increase by two-thirds and will put an increasing strain on the urgent care system. Multi-dimensional assessment and multiagency management of older people leads to better outcomes. To be effective this must be delivered in an integrated manner across primary and secondary care, and health and social care interface. The underlying factors giving rise to urgent and emergency care needs of frail older people include physical illnesses, mental health problems, and the end of life. This group may also be carers themselves to similarly predisposed relatives, which means that 24/7 urgent care response has to consider the needs of dependents as well if the carer becomes seriously unwell. In managing older people with urgent care needs in the community, the first 24 hours of timely, effective health and social care support is crucial. Home care and provision of equipment are often the essentials, yet overall contact hours of home care provided appeared to have declined. In a case study undertaken by the Health Foundation, they found two-thirds of frail older patients 'arrived' on the Medical Assessment Unit (MAU) after 6pm. This resulted in many frail older people staying in hospital overnight. In addition, 20% of these patients had their diagnosis or care fundamentally change when seen be a specialist if seen at an early stage compared to 20 hours after admission. It was recognised that the key problem in the emergency system for older people is the time taken from patients presenting to being assessed and given a care plan by a specialist. Through fundamental changes, this resulted in a 37% increase in patients that can be discharged on their day of admission or the following day, but importantly without an increase in re-admissions, resulting in a cost saving/ avoidance of circa £3.2M. In South Nottinghamshire, Call for Care, a care navigation service, for health and social care professionals was launched in October 2019. The new service supports health and social care teams in Nottingham West, Nottingham North and East and Rushcliffe to access urgent, same day community alternatives to hospital admission, except for patients with clear life-threatening conditions. Call for Care offers clinical triage and a two-hour response for those patients with complex physical health and care needs who are at risk of hospital attendance. The service also has access to a range of other community services to support ongoing care. In Mid-Notts a Community Urgent Response and Rehab Team provides care navigation, urgent response and short term intensive rehabilitation to support timely discharge from hospital and prevent unnecessary hospital admission. The service provides a 2 hour urgent response to prevent admission offering a face to face assessment and initiation of most appropriate community service and or signposting to other health and social care providers. It also provides a hospital at home service, for treatment and review of medically unwell patients.

7. Proposed future care system

Pre-Care

Home

- Apps for awareness - NHS App/ PKB - self-help mindfulness, sleep advice, exercise to improve wellbeing
- Education - Programmes of education to enable patients to manage families better; anti-natal classes, mother and toddler groups - opportunities to educate; awareness of 3rd sector groups, e.g. Breathe Easy - need to understand what is available and what health and social care is able to provide
- Charitable organisations and training for self-management - Red Cross - CPR training, St. Johns, ROSPA - enabling the population to gain confidence in self-care
- MECC and brief interventions to raise awareness on smoking, obesity, alcohol, etc.
- GP Practices to host group consultations on topics such as childhood eczema, asthma etc., encourage networks, promote groups support 'good' advice such as Diabetes UK
- Scoping exercise to establish what support networks are out there to be recommended to provide best advice and help create networks
- Alcohol, substance abuse, self-harm mental health teams. Being more proactive with these cohorts of patients - psychological services are all self-referral
- AI systems, Careline alarms for elderly, living alone
- Culture - make it a norm for first aid training and awareness to be seen in everyday lives – influenced where possible by the ICS.
- COVID Volunteers in community - currently available as most are furloughed, how can this be sustained - helping with chores, reducing loneliness, etc.
- Social prescribers/ link workers' activities to engage people. Peer support and community based - link workers need to understand available services and their pathways (or have access to a directory that explains it), especially for those with more complex needs such as deteriorating mental health, equitable access
- LTCs information and education needs to be robust to enable self-management and clear support structures that are available in each of the settings need to be identified – needs to be a joint up approach to ensure the best opportunity is taken to help with this
- Single point of access for home healthcare visitors - numerous visitors to the home for a multitude of services - people need to know who they are and what they can help with - so need a single point of access
- COVID has forced people to increase the use of online support groups – where technology exists and people are happy using it, this needs to be instilled into the behaviours and culture of healthcare.

Sustainable by:

- Improved support and understanding of risks allows early prevention
- Promotes awareness to support self-care and independence
- Improved outcomes - reduced urgent care need and improved management by lowering prevalence and improving awareness

Neighbourhood

- More support needed in Care Homes – focus on PCN physio support provision into care homes – prevention
- Multidisciplinary support from PCNs to care homes in their communities
- PCN responses to support Urgent Care in local communities.
- Culture 'Know your numbers' – improving accessibility and understanding of individual health (e.g. do you know your blood pressure, weight etc and what is means?)
- GPs check BP, can patients do this at home instead? AF test in pharmacy. Get the public to want to know their numbers as a routine once a year activity. Change in behaviours for patients to want to know and what to do with it once they have it.
- Tele-health – diabetes for weight – i.e. Blood Sugar monitor. Access and integration of this technology. Integration across settings. Pulmonary Rehab – monitor improvement/decline
- Social care reablement – undertake some health-checks, BP, temperature etc to check for infection or other issues – with training potential admission prevention
- Improving awareness generally for all professionals through a 'live' DoS to provide access for all HCPs to be able to pass on information – this can ensure people are able to get the correct and most up-to-date information

Sustainable by:

- Improved GP support for care homes to avoid ED attendance and admissions

Acute Hospital

- Redirection from ED with signposting as to where to go prior to clinical assessment for agreed presentations – system ownership of risk
- Frequent attender specific response
- Better understanding of what will work for different groups of patients. OB calling – rapport with HCP. Smoking in pregnancy by phone has worked better with this cohort than F2F. Research need.
- Personalised Care Plans - How best to communicate – different formats for messages to be available and relevant for that individual. Written for professionals currently, needs to be written for the citizen.
- 20% patients in SFH ED streamed to PC, this can be developed further to help the process, by making availability of PC services readily accessible through the day rather than a focus on early morning booking
- Support for people presenting with mental health issues that need crisis management, need to avoid this with early intervention available at home or locally. This access point needs to be simplified to make it a clear pathway for this cohort.
- Brief conversation to understand patients – who they are why did they attend, what options are/ were available to them – collect as ongoing feedback to evolve service offer
- Providing advice on other support and services available including 3rd sector support groups, e.g. Breathe easy for respiratory
- Education of clinical teams to raise awareness to be able to signpost.
- Generic letters need to include information on the patient's specific condition

Sustainable by:

- Prevents admissions, speeds up home support as appropriate

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

7. Proposed future care system

Connect and Triage

Home

- IT – need a single patient record so patient history etc. can be viewed and/or edited by the appropriate person.
- Need to be able to track people through the system – do they go where they are directed – capture through ongoing feedback systems
- Continued use of phone triage systems post COVID
- Use this window of opportunity of COVID to get used to new way of working
- ROBUST DoS – accurate, 'live' and comprehensive. Consistent. All services need access to this in a very user friendly form.
- Range of services that call handlers will need to be aware of and know about is great in theory but practically may not work – the level of advertising to make this work needs to resemble the COVID media coverage. The 111 First needs to robustly be in touch with, and understand the available and appropriate services very well.
- The real opportunity from COVID is to help maintain the change in behaviour
- NHS app downloaded more, still <10%. Frail - target high users. NHS app lots of options – can use NHS app to find out where to go. Encourage for younger people. Direct access to GPs, Directory of what is available.
- Culture: Patients decision to come to ED. 20-39 year olds use like PC, accessing for children's health needs. Target a message to this group. NHS app ideal.
- Social Care – Notts CC – MyApp – links between NHS App and the Social Care App – how well are these connected? – this could be stronger
- Culture – trust and clinical decision making, risk averse culture – person centred and shared decision-making – system visibly supporting balanced risk decisions
- Technology – visibility of information – interoperability record and data sharing – consistent and approved, governance, DoS – what can see and when
- Workforce – education and training who is involved, advanced practitioner with EMAS role
- Pharmacy put their details on DoS, but don't have access to it. Word of mouth referrals just based on what individuals in the Pharmacy are aware of – DOS coverage vital
- Need single point of access for mental health care.
- Patients don't always do what we envisage and won't always do what we want or expect. Just because we prefer it doesn't mean patients will. Hard to change behaviour of generations. Look at services we have to reinforce that we want patients to call 111. Consistency is important – need services embedded over time without unnecessary change to imbed range of service offers in public consciousness
- One number would assist. 999 response wouldn't result in Call for Care coming out. 0300 numbers harder to find/remember. Host of contact points in the DOS.
- How is the DoS accessed – make is as user friendly as possible

Sustainable by:

- Reduce demand on acute hospitals supporting reduced waiting times and access locally improves satisfaction

Neighbourhood

- HCP access to medical records and info to provide clinical expertise. Community pharmacies don't have access to GP systems – only prescription info. – pharmacists providing advice through consultations can be formalised to reduce attendance at GP, UCC and ED.
- Appointments at appropriate times – doesn't have to be 24/7. Not saying no, giving an alternative.
- HCP helpline with acute. A&G Offer to HCP.
- Community services do run 24/7 and there is access to step up when required so this needs to allow us to improve the appropriate connections needed (e.g. Lings Bar). Community nursing services are available 24/7 - this is more about hearts and minds and culture – effective training and culture change to ensure that this option is selected more often than admissions
- Continue with telephone triage offer for UCC. London Road UCC trial showed this model to be effective during the initial COVID response
- Need to celebrate more of the cases that go well, not creating the fear through focusing on the cases that don't go well. Need to use this to become a learning ICS by feedback into the system of these cases and by visible ICS support for balanced risk decision making between professionals and patients.
- Need to ensure we support people that are EoL to support the advanced care planning of these people – comprehensive EOL planning that is updated in partnership with patients/carers and can be relied upon for decision making
- General ICS support for all the positive decisions clinicians are making every day.
- Consistency of provision across the ICS to support simple , consistent messages for citizens
- Seamless IT solution, if not a single system, then well-connected systems
- DoS needs to be correctly used to provide real-time status of services to allow (e.g. 111) to appropriate (re)direct – not left on red all along
- 111 workforce capacity to be reviewed and managed to prevent going back to where we are
- Professional and system awareness of distorted perceptions in supporting neighbourhood care. Tendency to remember the 1 case where the re was a problem was rather than the vast majority where there were no issues.
- Ensure that the back up plan is good where the plan is not successful and have confidence in decisions with visible ICS support
- Follow up patients to see variety of patients – not just those where there was a problem. Positive behaviour reinforcement as hear the good decisions made rather than just the ones that went wrong. Reflective learning process and supportive training.

Sustainable by:

- Triage to local services
- Prevents attendance at ED when not appropriate

Acute Hospital

- Balanced approach of educate patients as to how to use the service for next time for some agreed presentations combined with re-direction without being seen for a further list of presentations with a gradual increase in the number an volume of turned away presentations. This should be refined and monitored by a system wide patient feedback system to follow up on what happens after redirection. This would help support clinician confidence in redirection and manage risk.
- Visible hospital and system support for this approach to manage clinical risk.
- Education of patients and staff for the changing approach
- Communications and education essential to the change of approach
- Further develop EMAS See and Treat provision through supporting paramedic crews with risk based decision making – underpinned by accessible DOS and patient follow up to support reflective learning
- More 7 day service availability to provide ED alternatives
- Diagnose and discharge – focus on treatment elsewhere in the system and feedback to clinicians on outcomes. IVs etc. . needed. Impact on community and SC.
- Culture - risk sharing address blame culture
- Single point of access is essential.

Sustainable by:

- Prevents admissions, speeds up home support as appropriate

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

7. Proposed future care system

Diagnosis, Treatment and Care

Home

- Greater collaboration across PC, EMAS and urgent care for GP to support with telephone (consideration of face to face and capacity)
- Need to consider technology to communicate with the right clinical or social care teams or urgent care services, or having the right support to help people use this technology to do so
- Technology – video consultation and visible information across settings – consider populations who do not have access
- Workforce, funding and culture change – extended role and hospital at home – consideration of risk culture
- System commissioning – simple and transparent proposal for the ICS
- Central coordination from clinical perspective and signposting - physical or electronic – visibility, simple and easy
- LTC monitoring must be better – manage the gap between diagnosis and crisis management

Sustainable by:

- Provides confidence of virtual access to prevent patients seeking appointments in UCC or visits to ED

Neighbourhood

- Adapt use of pharmacy services to improve advice, diagnosis and OTC treatment for some (deemed) urgent cases
- Connect the Community Pharmacy system more fully within the UC offer
- Greater range of extended roles in the community to support UC responses underpinned by funding, education and capacity – link to in-reach model
- 111 First - Capacity, skills and technology to support advance care planning – connection of information – consistency and trusted assessment.
- Develop range and coverage of UC offer in community settings through a combination of developing same day GP/PC access matched to need balancing resources across the ICS

Sustainable by:

- Streamlined and coordinated care from community care providers to which patients can be appropriately directed via 111 First

Acute Hospital

- Clear and consistent process in managing those that self-present at ED to prevent subjective decisions to see and treat these avoidable cases
- Technology is very 'piece meal' – a consistent Technology strategy needs to be developed to prevent so many different technological approaches being used across the system
- Matching diagnostic slots for urgent care with capacity
- Extended roles with existing workforce – continued development
- Close working with community services including in-reach extended roles
- Developing effective acute community information flow

Sustainable by:

Diagnosis and treatment of true emergency cases in the Acute hospital, coordinated through an integrated care approach

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

7. Proposed future care system

Post-Care

Home

- See community and voluntary sector as a key partner to health and social care – how seen and engaged with
- Self-care and self-management and education.
- Greater collaboration across all settings and partners to ensure education and knowledge is imparted to provide improved self-care and self-management of LTCs
- LTC services need to be accountable for patient education around self-management and signpost to support groups
- Patients to have access to own health information (e.g. PKB) to enable management of own health.

Sustainable by:

- Appropriate services supporting patients in a timely manner, through coordinated and appropriate engagement of local and home physical and social care services

Neighbourhood

- Develop Trust between organisations, lack of capacity when patients in wrong place.
- Consider development of community bed facilities to support alternative care provision.
- Development of social prescribing model to identify and manage the wider determinants of health. Robust provision and visibility in each care setting with timely support as soon as discharged
- Follow up to see if patients are accessing the services they have been signposted to as part of an ongoing feedback model
- Reduce repeat readmissions, integrated teams in the community to identify and support these patients.
- Accessibility to DoS, how easy to use. Needs to be up to date live. (One ICS wide DoS not multiple DoS for mid-Notts / Nott City / South Notts etc.)

Sustainable by:

- Embed single pathway, simplified for patients to understand and follow – removed obstacles, (e.g. referral back to GP for onward care)

Acute Hospital

- Need to change culture. Without joined up IT systems prescribing history isn't clear.
- Brief conversation as part of discharge planning from hospital to educate patients on self-management/ post-care plan – with clarity of which services are required
- ED process on discharge. Normal TTOs are better if pharmacy are involved. Nottingham pharmacy presence in ED (not 24/7), successful. Rollout to SFH.
- Right info on discharge gives assurance to patients they will have the support they need at home or in community setting, MH or other.
- Timely connection with post discharge care

Sustainable by:

- Ensure coordination of Post-care starts from the acute hospital

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

7. Proposed future care system – key features

	Home	Neighbourhood	Acute/ MH Hospital
Pre - Care	• Education Programme to enable the population to improve self-care and self-management, for both patients and families. • Using opportunities to engage for education such as anti-natal classes, mother and toddler groups; services accountable for raising awareness of 3rd sector support groups, e.g. Respiratory signposting Breathe Easy - need to scope what is available and what health and social care is able to provide • Better engage with self-help charitable organisations and training – RoSPA, Red Cross - CPR training, St. Johns, - enabling the population to gain confidence in self-care and supporting others • COVID has forced people to increase the use of online support groups – where technology exists and people are happy using it, this needs to be instilled into the behaviours and culture of healthcare.	• Strengthened care home support to reduce calls to emergency services out of hours. • Multidisciplinary support from PCNs to care homes in their communities • Citizen education programme to support the population to understand their health status and then to know what it means to promote self-care and self-management – also promote self-checking of BP, blood-sugar, etc. • Educate HCPs to improve their awareness of available urgent care services – use the DoS to provide access and to enable signposting of the right service.	• Routine redirection to 111 first for patients that could be successfully managed in settings closer to home – Robust system wide patient feedback systems to follow up on patient outcomes after redirection to support ongoing learning and to modify redirection approaches • Support for people presenting with mental health issues that need crisis management, need to avoid this with early intervention available at home or locally. This access point needs to be simplified to make it a clear pathway for this cohort. • Raise awareness of clinical teams to be able to signpost. • Generic letters to GPs need to include information on the identified condition for which the patient attended ED.
Connect & Triage	• Is there is a need to simplify contact through a single access point, numerous (0300, 0345 etc.) numbers exist but very few are known meaning some services are not accessed when needed – these patients can unnecessarily end up in ED. • The ICS needs a ROBUST DoS – accurate and comprehensive. Consistent. All services need access to this, but also need to be accountable for its upkeep. • Range of services that call handlers will need to be aware of and know about is great in theory but practically may not work – the level of advertising to make this work needs to resemble the COVID media coverage. 111 First needs to robustly be in touch with, and understand the available and appropriate services very well. • To enable efficient data and record sharing, single system approach is important, however where not possible, integration with improved connectivity is required.	• Need to consider governance changes to allow HCPs to access medical records and information to provide clinical expertise, (community pharmacies don't have access to GP systems – only prescription info) Pharmacists are trained in managing minor illnesses and provide health and wellbeing advice. • Some community services do run 24/7 and there is access to step up when required and through improvements in the appropriate links (e.g. Lings Bar) these services can be better utilised with patients offered improved access to the right service. • To improve partnership working and minimise overloading of UEC access points, the DoS needs to accurately reflect the live status to allow patients to be appropriately (re)directed to the place they will be quickly seen. • Funding and commissioning of UEC services needs to appropriately follow patients.	• Diagnose and discharge – refer treatment on from the acute setting if it can be undertaken elsewhere when needed. IVs etc. Impact on community and SC • To support UEC model, more local community services need to consider 7 days working, although this will need more staff.
Diagnosis, Treatment & Care	• For UEC commissioning – need a simple and transparent proposal for the ICS across provider services • Central coordination from clinical perspective and signposting - physical or electronic – visibility, simple and easy • LTC monitoring can be more effective– gap between diagnosis and crisis management	• Adapt use of pharmacy services to improve advice, diagnosis and OTC treatment for some (deemed) urgent cases – appropriate guidance and support should be accessible. • 111 First - Capacity, skills and technology to support advance care planning – connection of information – consistency and trusted assessment. • PCN Community Treatment Centres for local Minor injury/illness care	• Clear and consistent process in managing those that self-present at ED to prevent subjective decisions to see and treat these avoidable cases • Matching diagnostic slots for urgent care with capacity • Extended roles with existing workforce – continued development • Close working with community services including in-reach extended roles • Developing effective acute community information flow
Post Care	• LTC services need to be accountable for patient education promoting self-management and signpost to support groups • Patients to have access to own health information (e.g. PKB) to enable improved management of own health with support on App – or online.	• In order to reduce repeat readmissions, integrated teams in the community need to identify and support these patients • Need to ensure there is one DoS for the ICS not 3 for each ICP, it should be well-maintained with listed services accountable for the information it holds – daily updating as appropriate.	• Brief conversation as part of discharge planning from hospital to educate patients on self-management/ post-care plan – with clarity of which services are required • Right info on discharge gives assurance to patients they will have the support they need at home or in community setting, MH or other

8. Transformation Proposal

Prevention and self-care – Education, awareness and signposting: **High Priority**	Education of the ICS population can be supported in several ways to reduce or avoid the need for urgent care services. Risk mitigation needs to be introduced, to prevent accidents through collaborative programmes of work with 3rd sector organisations that have an existing focus in this area, such as RoSPA. There is a need to educate the wider population with a focused target on the under 5s, over 75s and 15-24 year olds highlighted as the highest users of UEC services. The opportunity to reduce service demand from these groups requires joint working between existing health and care providers of these cohorts, who understand their needs and reasons they are higher users of UEC services, and with 3rd sector organisations already working with these age groups to develop a support structure focused on prevention. The other CCSS service reviews have identified a range of education and support opportunities for patients living with LTCs to support them in self managing their care at home and help avoid the need for UC responses. Many of these citizens would benefit from receiving knowledge and education in managing their conditions better through self-management approaches, with support from peers, voluntary and charitable groups in addition to new and existing support from their health and care providers. This can further help reduce demand on services in primary and community care to acute services, including ED, through reduced exacerbations or deteriorating patients where self-management approaches can prolong healthy living. A precursor to this is education on healthy living and making healthy lifestyle choices including healthy diets, reducing alcohol consumption, smoking and recreational drugs. These lifestyle changes can help reduce the rate of increase in the burden of diseases, such as diabetes, heart disease, respiratory disease and stroke. Introducing education programmes for HCPs focused on raising the awareness of all population groups as part of a MECC approach would strongly contribute to the success of such prevention programmes. Further education programmes in schools and the wider community covering physical and mental health first aid skills should be supported by the ICS to grow community knowledge in basic care and treatment following injury or illness. This should be alongside a focus on enabling citizens to understand and monitor their health status (BP, weight etc). **Impact & Benefit** • Improved patient outcomes – longer healthier living • Reduced demand of UEC services supporting sustainability **Alignment –** .ICS wide principles delivered through PCN community approaches
Communication, Public Engagement and continual feedback **High Priority**	Communication and engagement with the public will we vitally important to the effective function of a more integrated urgent care model with greater care volumes delivered closer to home. This will have to align with national communication campaigns for example in relation to the use of 111 services. A key more expanded element that has emerged from the review is the need for routine feedback on patient outcomes and experience for patients directed to different parts of the urgent care service offer. This will be essential to understand that redirection met patient need but also to give confidence to care professionals in the risk judgements that they make in directing patients to alterative settings after from the core A&E offer. The feedback system could follow some of the principles of retail feedback of customer experience now routinely sought in the commercial sector in all interactions with customers. Such a model would require ongoing resourcing an support but will be vital to understanding what happens to patients and further refining a more integrated urgent care model. **Impact & Benefit** • Provide coordinated awareness across ICS population • Opportunity to educate and assure patients of improved care focus • Enables simplified offer to be communicated **Alignment –** ICS wide approach and application for consistency and resilience

Development of digital solutions to connect the system including Directory of Services (DoS) **High Priority**	A robust 'Live' DoS is being developed nationally with access across the ICS to make it compatible between 111 and ED systems. It should allow full visibility and be technically able to operate a bookable model. Ease of use, 'live' updates and comprehensive cover and availability are essential to make it the key reference point for services for UC professionals. Through 111 and 999 call-takers, the DoS allows an integrated search, so once call-takers reach the end of the assessment, the coding produced is able to link to the required services, e.g. a coded MH assessment will link to available services for MH. There is added advantage of searching through NHS Finder, which also maps against key search terms used for coding patients. Clinical HCPs can also access the DoS and search through NHS Finder. The governance for adding existing or new services, should be rigorous. The functionality provides the benefits of a live 'red, amber, green' system – allowing paramedic or ambulance crews (or other organisations) to view whether the provider status is showing default status (green) available capacity; amber to indicate a visual steer on how much capacity may remain; or red status removing the provider from being accessed – with governance of changing status managed by the CCG. The DoS should be accessible universally across the ICS, with UEC providers, MH, social care, community and all appropriate providers listed with status showing. This requires appropriate training and a coordinated, joined up approach to maximise the benefits it can provide. Digital solutions should also connect the urgent care system by increasing the information available to UTC/ ED prior to the patient attending to increase ' heralded' (known) patients and enable services to plan the patients care prior to arrival and build on the existing 111 first digital work to connect the CAS and ambulance service to UTCS, GPs to offer up additional alternative pathways for patients **Impact & Benefit** • Robust go to reference for appropriate UEC triaging and referrals • Provide assurance the most up-to-date and relevant services are listed • Helps enable the right care by the right person as quickly as possible **Alignment –** ICS wide approach rather than ICP level. Integration with Local Authority service directories.
Developing of PCN/ Community Treatment Centres for Urgent Care **High Priority**	There is evidence in the ICS that the availability of walk-in/ UC offers can generate healthcare demand as well as meet demand that would otherwise present in ED. However this needs to be considered alongside the reality that within the ICS there is variation across the system in the amount of same-day GP appointments available and capacity is not well matched to areas of higher deprivation and healthcare need. This local position reflects some of the features of the national situation that there fewer GPs per head of need adjusted population in deprived areas than in affluent areas (Health Foundation 2020). As such the main strategic focus should be on the development of a consistent urgent care offer in designated PCN community hubs (Community Treatment Centres) that can meet on the day minor injury and illness alongside a range of other community services on the behalf of a group of practices. This approach may be less likely to generate excess demand as it will be more integrated with existing primary care models. The focus of this development should be on the areas of highest deprivation first to help meet local urgent care need and then rolling the approach out across the ICS. When considering A&E classified UC/ minors provision it is relevant that in Nottingham in particular there is a model that is heavily weighted to ED provision compared to other midlands systems. With the context that there is very little evidence of any economy of scale in direct costs from A&E size (NHS Benchmarking 2019), expanding UCC provision may be a viable option if the development of on the day primary care capacity in PCNs, reflective of deprivation and with system equity, is unable to meet demand. Nevertheless UC provision will continue to need to be provided co-located to ED offers as part of a coherent UC model. This will need to be 'Right-Sized' with the development of the more local UC offer in PCNs and matched to the success of that more local provision in meeting UC need in the healthcare system. **Impact & Benefit** • Reduces inappropriate ED visits and rebalances urgent care capacity across the system • Provides more equity in primary care availability **Alignment –** PCN level development within ICPs

8. Transformation Proposal

111 First with multidisciplinary Clinical Assessment Service **High Priority**	The NHS 111 First aims to provide a single Clinical Assessment Service (CAS) to enable HCPs working outside of the hospital setting, staff in care homes, paramedics and other community based clinicians to make improved decisions about how to support patients closer to home, potentially avoiding ED attendance. This will bring together healthcare and social care providers. With rapid progress nationally to deliver NHS 111 First, the ICS needs to be in a position, to use this as an opportunity to enable a 'connect and triage' model approach (opposed to 'walk up and wait') to provide Urgent and Emergency Care (UEC) services across the ICS. This will require a phased approach that will need to be delivered collectively by provider organisations across the system as a multi-disciplinary team to support the skillmix needed to provide IUC to patients in the right place first time. NHS 111 First will maintain its place as the first line of contact for the Urgent and Emergency Care (UEC) system by: • Direct bookings into GP practices, as well as refer on to community pharmacies who support urgent care; • Using the CAS to simplify the process for GPs, ambulance services, community teams and social care to make referrals via a single point of access for urgent response from community health services; • Becoming the single universal point of access for people experiencing mental health crisis by 2023/24, ensuring that anyone experiencing mental health crisis can call NHS 111 and have 24/7 access to the mental health support they need in the community The model needs to be supported by the prevention, education and self-care initiatives to have an impact on overall demand growth. **Impact & Benefit** • Provides easy single entry into UEC pathway with access to advice and support, referral to appropriate services (including social care) and treatment through telemedicine • Reduces inappropriate visits to UCC/ UTC and ED **Alignment –** ICS wide approach
EMAS - See and Treat model development. **High Priority**	See and Treat and Hear and Treat are already substantial elements of the EMAS service offer with approximately 40% of calls resulting in either of these outcomes. The review has identified that with greater access to a 'live' and comprehensive DoS as well as timely advice and guidance that these numbers could be higher. In the new model of care it will be essential to effectively link in calls to the most effective disposition to meet patient need. Integrating call systems could support this and the DoS will be a vital element to making this even more successful. Continuing to improve crew access to patient records to make the best conveyance decisions for patients with known conditions **Impact & Benefit** • Avoid unnecessary conveyance to ED • Provide more timely and appropriate care in the patient's home • EMAS responses more closely aligned to the wider healthcare system **Alignment –** ICS wide approach in partnership with other EMAS health systems

8. Transformation Proposal

Development of Primary Care Urgent Care offer across the ICS **High Priority**	The development of the PCN urgent care model built around community hubs is a core part of the proposed approach in this strategy. These should be focused on meeting on the day primary care need with a multi-professional approach. This will need to consider the rebalancing of resources in the ICS to have equity in on the day appointment availability particularly in areas of higher deprivation. This model will include PCNs and GP practices making best use of technology to promote virtual consultations and 'app' based triaging. It will be necessary for community hubs to have available some level of diagnostic support with x-ray, phlebotomy and ultrasound potential options that could handle a wide range of presentations with appropriate operator skills and competencies. Other elements of the approach should be the PCN level support for care homes with advanced nurse practitioners (ANP) making morning home visits to organise the system day, addressing needs of the elderly early to avoid attendance or admission. PCNs supporting care homes as one of the priorities aligned within ICPs to prevent out of hours referral to ED, but instead get the appropriate teams involved in the care episode, as early as possible. Provision of Person-Centred-Care (PCC) in Community Pharmacies – opportunity to recognise and utilise the pharmacist's skills and training which includes training to manage minor illnesses and providing health and wellbeing advice. Historically this element of care has been undervalued for two reasons: 1. Community pharmacies do not record the consultation and the eventual outcome so there is no evidence to demonstrate value 2. Other parts of the system see this being a private interaction and therefore commercial transaction with little realisation that a significant amount of the advice is given without any link to the sale of a medicine Many pharmacies are open late and at weekends, where without an appointment, patients can benefit from advice and support to manage minor illnesses, which can lead to up to 65 fewer GP appointments. In the Pharmaceutical Services Negotiating Committee (PSNC) Audit, it found patients were 2.25 time more likely to present to A&E had they not been able to visit a community pharmacy after 18.00 when compared to not being able to visit before 18.00. **Impact & Benefit** • Changed culture and thinking • Reduces inappropriate ED visits • Reduce pressure on GPs through a multidisciplinary approach • Greater equity of primary care availability across the system **Alignment –** PCN delivered models within an ICP framework

8. Transformation Proposal – Summary

Integrated Care System
Nottingham & Nottinghamshire

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	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)	Workforce	Technology	Estate/ Configuration	Finance/ Commissioning	Culture	Benefits (*Less than £20,000 per QALY is cost effective)
Prevention & Self-Care – Education, awareness and signposting Promote self-help; access 3rd sector training/ support – RoSPA, St Johns, Red Cross; existing services to signpost to relevant support groups (e.g. Breathe Easy for COPD); use of AI and Apps (NHS App PKB)	High	ICS	Training for HCPs to allow them to better signpost – perhaps as part of mandatory training. Involvement of wider 3rd sector in mental and physical health first aid and accident prevention.	Further App development under trusted governance (e.g. NHS App) to control accuracy of available information and advice.	ICS information sharing approach and potential information hub for healthcare professionals and citizens	Funding models to support education and prevention approaches	Raising importance of self-care agenda and changing culture to teach people to take responsibility for their own wellbeing.	Improved patient outcomes – longer healthier living Reduced access of UEC services supporting sustainability
Communication, Public Engagement and Continual Feedback Clear and detailed plans to engage ICS population in new care models and use continuous patient feedback to refine approaches	High	ICS	Support of system wide patient feedback and reporting as part of routine UC activity	Make best use of existing media and Apps to reach across the ICS.			Development of culture to support ongoing learning about citizen experience of services	Ongoing learning to improve understanding of patient urgent care experience Provide coordinated awareness across ICS population Enables simplified offer to be communicated
Live Directory of Services (DoS) and live system status - Robustly articulated and easily navigable Live DoS. Updated daily accurately reflecting service status Universally available and easily searchable by multiple filters for live status.	High	ICS	ALL urgent and emergency care professionals will need awareness of the Live DoS – how it needs to be managed, accessed, used appropriately	Appropriate system access and training for relevant staff that need to be involved in the use of the Live DoS.		Appropriate commissioning likely to be part of national mandate (i.e. resources to manage Live DoS).	In order to maximise the effectiveness of the Live DoS there should be agreed standards, e.g. ensuring accurate daily updating of provider status to allow appropriate redirection of patient flow	Robust reference for appropriate UEC triaging and referrals Provide assurance the most up-to-date and relevant services are listed Ensures right care, by the right person as quickly as possible
Developing of PCN/ Community Treatment Centres for Urgent Care Primary focus on developing PCN urgent care offers in community hubs with supporting simple diagnostics. Rebalancing same day GP appointment capacity across the system considering deprivation. Right Size ED UC provision.	High	PCN	May be implication on community capacity and services needing additional resources as a result.		Development of PCN community hubs and supporting diagnostics including near patient testing. Right Size ED UC.	Funding model to support community hub activity.	Development of the approach of community hub for urgent care and ED for emergency care. Links to communication and public engagement model	ED for emergencies only strategic direction Changed culture and thinking Educates and assures patients of right pathway
111 First with multidisciplinary Clinical Assessment Service Connect and Triage Model (as opposed to walk up and wait) to include tele-access to clinician and other appropriate HCPs but maintaining links with in-hours local services; access to eSCR; gradually reduce non-emergency flow into ED. Move towards central call handling.	Med	ICS	Mandate should be driven by national rollout of NHS 111 First.	IT systems to enable sharing of patient records – if not one single system then need to ensure connectivity between systems is enabled.	Community hub development as a recognised referral location	Funding model to support community hub activity.	Risk based approach to patient assessment and redirection to more appropriate services. Ongoing monitoring of outcomes to refine model.	Provides easy single entry into UEC pathway with access to advice and support, referral to appropriate services (including social care) and treatment through telemedicine Reduces those visits to UCC/ UTC and ED that can be dealt with elsewhere
EMAS - See and Treat model development – mobile patient records and DOS access to inform alternatives to conveyance – non-emergency appointment booking – further development and system integration	High	ICS	Paramedics to align to new protocols – refer non-emergencies back to call centre for appropriate support (111)	Shared care record/ single ICS wide IT System – read/ write access to update – link to Live DoS			Link between 111 and 999 Link between community providers and acute emergency departments	Patients follow appropriate UEC pathway – ambulance calls for non-urgent cases referred back for local care
Development of Primary Care Urgent Care offer across the ICS – Extended Access used UC, Morning ANP home visits, PCNs supporting Care Homes, Use of technology to enable appointments (COVID learning – video/ telephone consultations, ask my GP App triaging). Pharmacy consultations.	Med	PCN	Development of PCN multidisciplinary capacity Develop a formal structure for Community Pharmacy consultations	Appropriate technology to maintain virtual access models. Use of Apps to list late opening Pharmacies	Community Hubs to develop extended access cover	Funding following patient flows including pharmacy advice	Formalising support and management of minor illnesses from community pharmacists can impact culture and where patients present	Educated patients for improved self-management Reduce emergency attendances/ admissions for exacerbations of LTCs Pharmacy consultations reduce pressure on GPs and also reduce urgent care, ED attendance

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

9. Enabling Requirements

Workforce	The main areas of workforce change include • Cross pathway working (primary and secondary and community care) for clinicians, pharmacists and other allied health professionals supported by organisations • New role development to support PCN hubs including multi-skilled roles to support diagnostics • Strong involvement from Public Health consultants to lead the prevention agenda working closely with charitable organisations to provide the public with the confidence to take responsibility for self-care and care of others • Provider workforce to be fully acquainted with DoS and its contents and functionality
Technology	The main areas in which technology can effect transformation include: • A single IT platform providing appropriate access to electronic shared care records – across primary, secondary and community care settings and direct access to a Live DoS and provider status for capacity management • App development/ promotion for signposting locally NHS/ PKB App, but access to 'app' based triaging support. • Better use of reliable handheld devices across community and home settings to improve access to records and access to virtual consultations • Simple diagnostic and result sharing in community hubs including consideration of x-ray, phlebotomy and ultrasound
Estate	The main areas of estate development include • Development of PCN community hubs and supporting infrastructure to enable development of 'community treatment centres' including local diagnostic capacity and near patient testing • Equity in development to ensure capacity meets need in areas of higher deprivation
Culture	Culture development in this area of care includes • Essential focus on the ICS supporting care professionals with risk based approaches in partnership with patients to manage their care in settings closer to home or to refer them to more local services. Requires ongoing feedback and learning as to successful approaches as well as when problems arise • To drive a culture change we need shared and integrated use of workforce across organisations to enable the sharing of resources as there are limited staff groups and expertise, with the introduction of MDTs this should improve education across the workforce.

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10. Urgent Care Services Future Vision

'Bridge to the Future'

From…		Phase 1 1st year	Phase 2 2-3 years	Phase 3 5 years +	To…
• Reactive service with reduced levels of prevention strategies • Inadequate information on self-care • Inconsistent education/ training across the region for general health awareness and for LTCs • Low awareness and sign-posting to self-help resources from HCPs • Inconsistent pathways across ICS	Prevention & Self-Care	• Develop requirements for NHS App/ PKB to build platform for information and support • Commence routine patient feedback on system urgent care experience • Engage RoSPA and 3rd sector • Ensure plans include health checks approaches for vulnerable groups • Comms plan for public engagement to support education and self-care • Co-production plan with citizens to learn from behavioural changes during COVID • Educate HCPs on what's available	• HCPs education on UEC pathways and available services – detailed for provider roles/ organisations and awareness to enable signposting for other HCPs • Self-care resources and information uploaded to App, including service specific guidance for LTCs • Have active support and information from 3rd Sector groups • Education delivery for public underway including mental and physical health first aid and accident prevention	• Robust education programme and self-help resources/ information in place with continuous review for improvement or update • LTC patients familiar with and accessing local support groups • New culture and behaviours embedded in population to enable peer learning • Continuous assess impact and further develop	• Consistent and equitable prevention through wide-spread public awareness and education with sign-posting for early, right intervention by right person • Improved ownership of individual health and wellness by our citizens • Improved supportive interventions to enable self-care of our citizens. • Appropriate technology platforms to enable education of population, HCPs and patients • Wide take up of mental/physical health first aid
• Inconsistent triaging and referrals • No robust education or information on UEC pathway • Community access and support needs improving for patients including urgent referrals to social and mental health care • Poor understanding and use of DOS	Navigation Access Model	• Compiling of DOS and in integrating with LA service directories – also to include 3rd sector • Attain provider buy-in to take ownership of their DoS sections • Consider estate and workforce requirements and detail plan • Agree the simplified pathway alongside national plan for 111 First and ensure this is communicated well to all HCPs • Need to ensure MH offer includes physical health	• New DoS in consistent use by 111 First and other services including community • Clear pathway for MH including physical health UC offer • Developed 111 First service in place with functioning and well used DoS • Approved estate business case as appropriate PCN Hubs/ workforce review underway (linking to new role opportunities) • Easy to follow pathway in place with 111 First - main access point for UEC	• PCN Community Hubs functioning as first point of direct for urgent care from 111 first • Continued integration of MH services • Well established DOS and 111 First service	• Simplified offer of UEC – C4C type model, mental health, social care support • Active DOS delivered aligned to national programme, to improve access to services • 111 First used and understood by ICS population • Improved triaging, improve time to see, in right place, right person, improve quality of care • Community Treatment Centres established in community hubs for minor injury/illness
• Mental health and social care not as well integrated with general health care • Poor support for care homes • Complex patient pathways are different across the ICS with different access points	Connecting the Urgent Care System	• Digital roadmaps in place need implementing to ensure connectivity is live • Need to capture current links to care homes and discharge cells to ensure they do not have to be re-established • Need to understand gaps in MH/ Social care integration with physical health and devise plans to integrate • Scope gaps in care home support – PCN and specialist advice offer – some changes already underway, including links to pharmacy	• IT connectivity to be operational • Support protocols operational for care homes from both PCNs and specialists • Embedded care home and discharge cell protocols and links • Implement models, pathways triaging (via 111 First – including community teams) • Pathways defined for MH and social care UEC aligned to physical healthcare needs • Embed pharmacy PCC within the UC pathway	• Embedded models, pathways and triaging • Integrated physical, social care and mental health embedded for appropriate support and care by right person	• Appropriate referrals with increased care closer to home • True partnership working as one system across the region with IT infrastructure that is fit for purpose serving the needs • Direct links to and support from social care before going through the healthcare system • Routine consultations undertaken at community pharmacies
• Inconsistent follow up and treatment management • Need clarity to avoid elderly overnight stays • Lack of awareness and signposting to 3rd sector support	System Working Day	• Awareness of available services to support local needs to prevent OOH admissions, (e.g. same patient referred at 10am will be discharged cf. if referred at 10pm) – listed in DoS • LTC services to design robust education programmes for LTC patients to help self-management • Maximise social prescribers/ care navigators • Design Community Treatment Centres for day long PC UC access in PCNs/Right Size ED UC offers	• Approach needs to keep some flexibility to cope with changing demands (e.g. pandemic) • Delivery education for self-management to LTC patients, including links to 3rd sector support groups – social prescribers to be involved in this • Start delivery of PCN Community Treatment Centres/Right Size ED UC offers	• Embedded education for LTC patients, with much improved self-management, reduced exacerbations/ ED attendances • Continuous monitoring and promotion of attendance at support groups • Local and non-emergency community care fully defined and accessible through 111 First and signposting by other HCPs • Community Treatment Centres available in every PCN/Right Size ED UC offers	• Regular patient reviews for those with LTCs across the ICS avoiding readmissions • Raised patient awareness and education for self-management and independent living • Accessible 3rd sector and mental health support early in patient journey • PCN Community Treatment Centres providing the majority of urgent care • ED for Emergencies only

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11. Conclusions and Next Steps

Conclusions	The review of Urgent Care services as part of the Clinical and Community Services Strategy for the Nottingham and Nottinghamshire ICS has been undertaken using a co-design model where key stakeholders have collaboratively worked together to shape a vision for the future care system. Four key themes were identified for improvement: • Prevention and Self-Care (with emphasis on self-care models and awareness with improved education and preventative care with early intervention); • Navigation and Access Model (efficient navigation and diversion in a simplified offer, including an urgent primary care offer and reviewing 24 hours access for urgent care); • Connecting the Urgent Care System (encompassing mental and physical health, including appropriate social care 24/7 with much improved information technology (IT) to enable much broader partnership working); • System Working day (enabling equitable and universal access supporting the patient's journey with integrated systems; transforming the urgent care service to reduce avoidable overnight stays for the elderly in acute hospitals). The review describes a future urgent care system provided in the most appropriate locations and envisages 7 programmes to transform care: • **High** - Prevention and self-care – Education, awareness and signposting • **High** – Communication, public engagement and continual feedback • **High** – Development of digital solutions to connect the system including Directory of Services (DoS) • **High** – Developing of PCN/ Community Treatment Centres for Urgent Care • **High** - 111 First with multidisciplinary Clinical Assessment Service • **High** - EMAS - See and Treat/Hear and Treat model development • **High** - Development of Primary Care Urgent Care offer across the ICS To achieve these there are a range of enabling requirements for the ICS across workforce, estate, technology, culture and financial systems. Collectively these initiatives can transform and provide long term health improvement and sustainability in the area of Urgent Care in Nottingham and Nottinghamshire ICS.
Next Steps	This strategy sets the future direction of development for urgent care in the ICS and it is proposed it will shape future work of the ICS in a number of ways: • The identified priorities and programmes should be used to inform commissioning ICS, ICP and PCN activity • The enabling activities require development and inclusion in the relevant ICS workstreams to inform their work programmes • The impact on estate and configuration changes require inclusion in a programme of pre-consultation business case development alongside the service changes recommended from other reviews • The aggregate impact of the collective suite of service reviews should be used to shape focus of future service provision in acute and community settings in the ICS

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12. List of Common Abbreviations

1°, 2° Care	Primary, Secondary Care	EMCA	East Midlands Cancer Alliance	Notts.	Nottinghamshire
2WW	Two-week-wait	EMRAD	East Midlands Ambulance Radiography	NRC	National Rehabilitation Centre
A&E	Accident and Emergency	ENCH	Enhanced Health in Care Homes	NRCP	National Register of Certified Professionals
A&G	Advice and Guidance	ENT	Ear, Nose and Throat	NRT	Nicotine Replacement Therapy
ACE	Adverse Childhood Experience	EoL	End of Life	NSC	National Screening Committee
ACP	Advanced Care Practitioner	eSCR	Electronic Shared Care Record	NUH	Nottingham University Hospitals
ADHD	Attention Deficit Hyperactivity Disorder	ESD	Early Supportive Discharge	O_2	Oxygen
AF	Atrial Fibrilation	ESDT	Early Supportive Discharge Teams	OCCCF	Ophthalmic Common Clinical Competency Framework
AI	Artifical Intelligence	F2F	Face to Face	OCT	Optical Coherence Tomography
AID	Accessible Information Standards	FeNO	Frasntonal Exhaled Nitric Oxide	OOH	Out of Hours
AK	Actinic Keratosis	FT	Foundation Trust	OPA	Outpatient Appointment
AMD	Age-related Macular Degeneration	FTE	Full Time Equivalent	OPM	Office of Public Management
ANP	Advanced Nurse Practitioner	FU	Follow Up	OTC	Over-the-Counter
App	Application	GBD	Global Burden of Disease	PCN	Primary Care Network
APPG	All Party Parliamentary Group	GOC	General Optical Council	PCP	Personalised Care Plan
ARTP	Association for Respiratory Technology and Physiology	GOS	General Ophthalmic Service	PCR	Patient Care Record
ASC	Autism Spectrum Conditions	GP	General Practitioner	PH	Public Health
AT	Assisitive Technology	GPRCC	General Practice Repository for Clinical Care	PHE	Public Health England
ATAIN	Avoiding Term Admission Into Neonatal units	GPwER	General Practitioner with an Extended Role	PHM	Population Health Management
BAD	British Association of Dermatology	GRASP-COPD	Guidance on Risk Assessment on Stroke Prevention for COPD	PHO	Public Health Organisations
BAME	Black, Asian and Minority Ethnic	H&SC	Health and Social Care	PID	Project Initiation Document
BB	Better Births	HCP	Healthcare Professional	PKB	Patient Knows Best
BCC	Basal Cell Carcinoma	HES	Hospital Episode Statistics	PN	Practitioner Nurse
BEH	Behavioural and Emotional Health	HES	Hospital Eye Service	PR	Pulmonary Rehabilitation
BF	Breast Feeding	HL	Hearing Level	PSNC	Pharmaceutical Services Negotiating Committee
BFI	Baby Friendly Initiative	HNA	Holistic needs assessment	PwER	Pharmacist with Extended Role (in skin health)
BLF	British Lung Foundation	HPV	Human Papilloma Virus	QALY	Quality Adjusted Life Years
BMI	Body Mass Index	HV	Health Visitor	QIPP	Quality, Innovation, Productivity and Prevention
BMJ	British Medical Journal	IAPT	Improving Access to Psychological Therapies	QMC	Queen's Medical Centre
BP	Blood Pressure	ICP	Integrated Care Partnership	RCEM	The Royal College of Emergency Medicine
BSG	British Society of Geriatrics	ICS	Integrated Care System	RCN	Royal College of Nursing
BSL	British Sign Language	ICT	Information and Communication Technology	RCOG	Royal College of Obstetricians and Gynaecologists
BTS	British Thoracic Society	IT	Information Technology	RCOphth	Royal College of Ophthalmology
CAMHS	Child and Adolescent Mental Health Service	IUC	Integrated Urgent Care	RDC	Rapid Diagnostic Centre
CAS	Clinical Assessment Service	IUT	In-Utero Transfer	RNIB	Royal National Institute for the Blind
CBT	Cognitive Behaviour Therapy	KMH	Kings Mill Hospital	RNID	Royal National Institute for the Deaf
CCG	Clinical Commissioning Group	LD	Learning Disability	ROI	Return on Investment
CCSS	Clinical and Community Services Strategy	LMNS	Local Maternity and Neonatal System	RoSPA	Royal Society for the Prevention of Accidents
CES	Cranial Electrotherapy Stimulation	LNU	Local Neonatal Unit	ROVI	Rehabilitation Officer for Visually Impaired
CFS	Clinical Frailty Scale	LOC	Local Optical Council	RTT	Request To Treatement
CGA	Clinical Geriatric Assessment	LoS	Length of Stay	RTT	Radiotherapy
CoC T&F	Continuity of Care Task and Finish	LTC	Long Term Conditions	SALT	Speech and Language Therapy
CoO	College of Optometrists	LTOT	Long Term Oxygen Therapy	SaToD	Smoking at Time of Delivery
COPD	Chronic Obstructive Pulmonary Disease	LTP	Long Term Plan	SBLCB	Saving Babies Lives Care Bundle
COVID19	Corona Virus Disease 2019	LTV	Long Term Ventilation	SC	Social Care
CPR	Cardio-Pulmonary Rescucitation	LV	Low Vision	SCC	Squamous Cell Carcinoma
CQUIN	Commissioning for Quality and Innovation	MBCT	Mindfullness Based Cognitive Therapy	SEND	Special Educational Needs and Disabilities
CUES	COVID Urgent Eye-care System	MDT	Multi-Disciplinary Team	SFH	Sherwood Forest Hospitals
CVD	Cardio Vascular Disease	MECC	Make Every Contact Count	SIGN	Scottish Intercollegiate Guidelines Network
CVI	Certification of Vision Impairment	$MgSO_4$	Magnesium Sulphate	SLT	Speech and Language Therapy
CYP	Children and Young People	MH	Mental Healthcare	SPA	Single Point of Access
CYPF	Children, Young People and Families	Mid Notts.	Mansfield & Ashfield, Newark & Sherwood	STP	Sustainability and Transformation Partnership
DASV	Domestic Abuse and Secual Violence	MMR	Measles, Mumps, Rubella	TC	Treatment Centre
dB	Decibell	NCGPA	Nottingham City General Practice Alliance	TIA	Trans-Ischaemic Attack
DNA	Did Not Attend	NCH	Nottingham City Hospital	TTO	To Take Out
DoS	Directory of Service	NGO	Non-Government Organisations	TYA	Teenage and Young Adults
ECG	Electrocardiogram	NHFT	Nottinghamshire Healthcare Foundation Trust	UC	Urgent Care
ECLO	Eye Clinic Liaison Officer	NHS	National Health Service	UCC	Urgent Care Centre
ECT	Electroconvulsive Therapy	NHSE	National Health Service England	UEC	Urgent and Emergency Care
eCVI	Electronic Certfication of Vision Impairment	NHSI	National Health Service Improvement	UECDI	Urgent and Emergency Care Digital Integration
ED	Emergency Department	NICE	National Institute for Health and Care Excellence	UTC	Urgent Treatment Centre
EFI	Electronic Frailty Index	NICU	Neonatal Intensive Care Unit	VCSE	Voluntary, community and social enterprises
ELBG	Ear Lobe Blood Gas	NIDA	National Institute of Drug Abuse	VI	Visual Impairment
EM ODN	East Midlands Operational Delivery Network	NNU	Neonatal Unit	WHO	World Health Organisation
EMAS	East Midlands Ambulance Service				

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13. Data Sources

Data Sources	British Medical Journal Local Data from NUH, SFH, Social Care, CCGs, GPRCC, eHealthscope National Institute for Health and Care Excellence NHS England NHS Health and Social Care Boards NHS Long Term Plan NHS Wales Office of National Statistics Public Health England World Health Organisation Pharmaceutical Services Negotiating Committee The Health Foundation NHS Benchmarking

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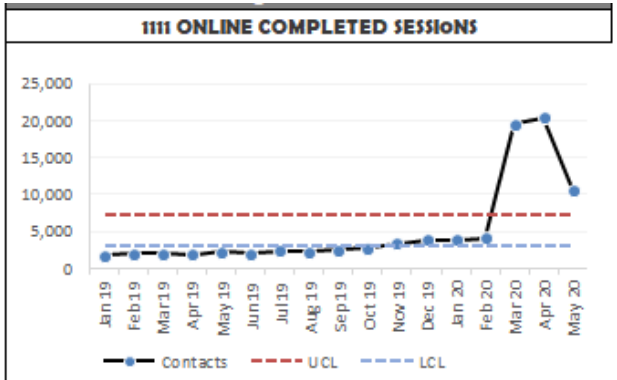
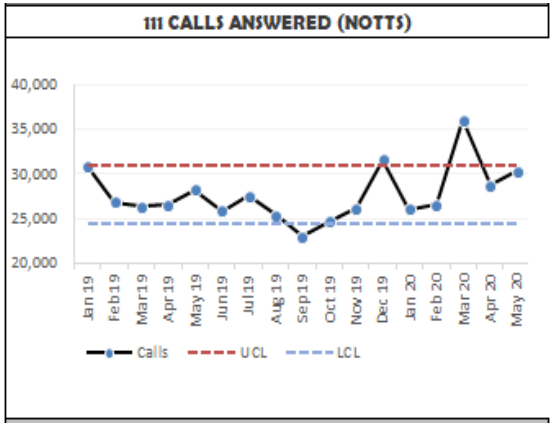
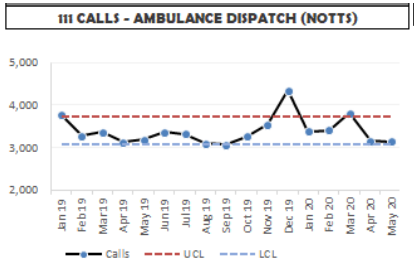
14. Appendix – Summary System Urgent Care Activity

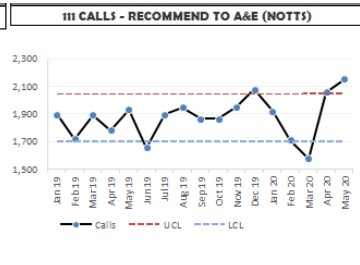
Provider	UCC / ED	Annual Data Mar 2019 - Feb 2020	Monthly Data Avg (Mar 2019 -Feb 2020)	Daily Data Avg (Mar 2019 - Feb 2020)	COVID levels Apr-20
NEMS	KMH PC24	23,654	1,971	65	804
SFH	KMH Children	12,712	1,059	35	17
SFH	KMH ED RESUS	5,945	495	16	378
SFH	KMH ED Majors	44,378	3,698	122	2130
SFH	KMH ED Minors	30,915	2,576	85	1623
	Kings Mill Hospital TOTAL	117,604	9,800	322	4,952
SFH	Newark UCC Dental	244	20	1	4
SFH	Newark UCC Majors	1,879	157	5	78
SFH	Newark UCC Minors	10,538	878	29	402
SFH	Newark UCC Primary Care	9,045	754	25	229
NEMS	Newark UCC PC24	635	53	2	9
	Newark UCC TOTAL	22,341	1,862	61	722
NUH	QMC ED RESUS	1,993	166	5	113
NUH	QMC ED Majors	68,825	5,735	189	3970
NUH	QMC ED Minors (excl NEMS)	65,709	5,476	180	2988
NUH	QMC Eye Cas Majors	1,550	129	4	51
NUH	QMC Eye Cas Minors	18,283	1,524	50	606
NEMS	NEMS@QMC	28,478	2,373	78	172
	QMC Total	184,838	15,403	506	7,900
CityCare	London Rd UTC	53,007	4,417	145	2751
Derbyshire Community FT	Ilkeston UCC	8,097	675	22	264
Leicestershire Community Servic	Loughborough UCC	826	165	5	31
	GP same day appointments	2,398,940	199,912	6,572	185,928
	Total GP appointments	5,980,935	498,411	16,386	330,249
	Same day %	40%	40%	40%	56%

Provider	UCC/ED	Annual Data Mar 2019 - Feb 2020	Monthly Data Avg (Mar 2019 - Feb 2020)	Daily Data Avg (Mar 2019 - Feb 2020)	COVID levels Apr-20
EMAS Nottinghamshire	EMAS Cat 1&2 (life threatening / emergency):	131,473	10,956	360	8,065
	Hear and Treat	9,905	825	27	438
	See and Treat	30,019	2,502	82	3,174
	Treat and Convey	91,549	7,629	251	4,453
EMAS Nottinghamshire	EMAS Cat 3 (Urgent):	44,991	3,749	123	4,425
	Hear and Treat	11,731	978	32	306
	See and Treat	13,472	1,123	37	2,226
	Treat and Convey	19,788	1,649	54	1,893
EMAS Nottinghamshire	EMAS Cat 4&5 (Non-Urgent):	13,357	1,113	37	1,293
	Hear and Treat	10,241	853	28	960
	See and Treat	1,868	156	5	227
	Treat and Convey	1,248	104	3	106









Please note: EMAS Urgent category 3 includes RTA and broken hips etc. Category 4 and 5 are the Urgent Care offering we have used in this review on the advice of EMAS.

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