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|  |  | **Draft Northern Lincolnshire Integrated Urgent Care Plan 2021**

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| PR Progress / Indicator RAG status |
|  | Work unable to progress; actions not deliverable |
|  | Work is behind schedule; progress has been made but the timescale has not been achieved |
|  | Progress is being made; progress is good and action is likely to be achieved within timescale |

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| **No.** | **Workstream: A&E Front End Improvement Plan** | **Risk: Failure to improve A&E Performance. Continued instability in the A&E Departments.**  |
| **Aim** | **Lead** | **Deliverables****(SMART objectives)** | **Timescale** | **RAG** | **Cost (unidentified)** | **Update** |
| 1 | Urgent Care Service  | To implement a multidisciplinary team Urgent Care Service (UCS) at the Emergency Department front door in SGH and DPOWH  | AA | To Deliver streamlined and efficient high quality patient care to patients requiring urgent and emergency care and ensuring patients are seen by the right person at the right time in the right service.Reduced crowding in ED | Phase 1 – Oct 21Phase 2 – Dec 21Phase 3 - TBC |  |  | •6 Work streams established to focus on the development of an urgent care service (USC).Visit to North Tee’s taking place 8.9.21 where this model is in place and this is to be fed into further pathway discussions on 9.9.21•Phased implementation plan now agreed which supports the agreed model, workforce, engagement & IT requirements. •Intensive engagement & pre implementation week w/c 4/10•Model & workforce changes to commence w/c 11/10 |
| 2. | Front Loading Rapid Assessment | Increase ability for rapid assessment at the ambulance handover area | AA | Improve performance by reducing numbers of ‘low’ acuity patients waiting for less complex treatment | Phase 1 – Oct 21Phase 2 – Dec 21Phase 3 - TBC |  | TBC | •The implementation of the UCS provides an opportunity to review the resource allocation to enable initial early senior assessment.•As part of UCS ambulance handover ad triage becomes one with one 2 x nurse and 1 x HCA as redeploying the streaming nurse |
| 3. | ED Streaming | Improve streaming processes in departments to allow more patients to be streamed away from ED to Primary Care, UCS, GP OOH and community alternatives. Links to other initiatives within this plan to increase accessibility and service capacity of alternative services to enable ED to stream away from ED for appropriate patients.Maximise number of patients seen in alternative services.Reduced crowding in ED | AA | 2 x nurse and 1 x HCA as redeploying the streaming nurse | Phase 1 – Oct 21Phase 2 – Dec 21Phase 3 - TBC |  | TBC |  |
| 4. | SDEC | Improve timely access to same day emergency care for acute & speciality services | AA | A)Increase SDEC operating hours and capacityImprove completion rate of direct referrals from GP/SPA/EMAS/111 to SDECB) Implement electronic referral process to SDEC | Funding dependant |  | Delivery subject to identification of funding  |  •Pilot for speciality in reach and extended opening hours taken place on the SGH site and continues in pilot form•Bid submitted for winter funds to allow acceleration of phase 3 IAAU extension of SDEC hours for both SGH & DPOW•Planning in place to look at SDEC model overnight, currently SDEC Patients in ED overnight are brought back the following day |
| 5. | Portering | Ensure timely response to patient movement from ED | AA | Ensure portering needs for ED match demand and peaks | Oct 21 |  |  | Capacity & demand exercise carried out with the development of a demand heat map, work stream in place working through current model and staffing requirements |
| 6. | Paediatric Urgent Care Pathway | Ensure paediatrics are assessed and treated in ED within 4 hours of arrival and necessary steps have been taken to ensure they are safe on discharge | AA | A)All children to be seen and depart ED within appropriate timeframeB)Ensure any child/family that leaves ED without being seen is safeC)Medical & Nursing workforce meet national (RCPCH) standards | March 22 |  |  | •Pathway development taking place around paediatrics in ED, including seen within 1 hour and safeguarding follow upon discharge•Baseline staffing model to be implemented as per mandated standards (as per CQC/RCN requirements), paper developed •Interim plans to be put in place to support patient safety in ED, workforce to be agreed•All PEN nurses have now received training, next step is the training sign off•Although there is a Dedicated children’s area with the ED to improve oversight of unwell children at SGH DPOW still remains an issue•CCG have agreed to 55K to be provided to fund the Hospital @ Home Pilot this winter. Date of commencement of the new model to be agreed at a meeting with the CCG on 29/09/21•List now produced on a daily basis for the Safeguarding Team on children leaving ED without being seen•Increase cover by Paediatric Emergency Nursing team to cover peak hours on both sites – now to go to full consultation delaying implementation |
| 7 | Trust Wide Roles & Responsibility for patient flow  | To reduce LOSTo make available capacity thus reducing ED bottlenecksProvide a safe, efficient and effective patient journey from admission to discharge | AA | A)Ensuring site team roles and responsibilities include ED wait management and support in decompressionB)Ensuring there is a cohesive, effective and proactive response across the organisation to the pressure in ED with defined triggers and actionsC) Improve patient flow and embed D2A fully throughout the trust ensuring escalated issues are addressed | Dec 21 |  |  | Work taking place around effective and proactive response across the organisation to the pressure in ED with defined triggers and actions, Sheffield documentation currently being reviewed to adapt for NLaG and workshop to take place W/C 11/10 to agree action cards •Operations Centre workforce review ongoing, final business case to be approved•LOS reviews in place with Medicine & Surgery to be confirmed•Operations Centre workforce Roles & Responsibilities to be agreed and engagement exercise to take place with workforce•Revised D2A Escalation process in place, currently being monitored to ensure effectiveness |
| 8. | ED Roles & Responsibilities | Remove variation in the clinical lead roles and provide clarity on roles and responsibilities to enable a consistent safe approach to shift leadership | AA | Remove variation in the clinical lead roles and provide clarity on roles and responsibilities to enable a consistent safe approach to shift leadership | Phase 1 – Oct 21Phase 2 – Dec 21Phase 3 - TBC |  |  | •Appointment of UCS clinical lead•Roles & Responsibilities currently being finalised for ED clinical lead in majors along with leadership coaching exercise •Further workforce engagement to be finalised during phase 1 of UCS implementation once SOP approved this will ensure all UCS workforce have clear roles & Responsibilities along with workforce that will transfer to Majors (i.e. Streaming nurse) |
| 9. | ED Workforce | Ensure workforce in ED matches demand and is of the correct skill mix at all times | AA | 24/7 ED consultant cover at both hospitals Undertake review of medical workforceUndertake review of nursing workforceGap analysis of workforce & skill mix | Dependant on funding Part of 22/23 business planning TBC |  |  | Consultant business case approved and recruitment exercise commenced•Middle Grade business case approved and staff consultation to commence 1.10.21•Nursing recruitment exercise complete and training programme commenced |
| 10. | Improve Management and Clinical Oversight  | Implement tier system of Medicine Management oversight within both EDs to improve live escalation, issue resolution and support to frontline staff | AA | Improved escalation and support to ED staff | May 2021 | Completed |  | Tier system implemented and in place |
| 11. | A&E Pre-Streaming | HCV joining Phase 2 rollout of clinical triage Technology before patients are booked at A&E reception to encourage patients to consider alternatives to ED (including direct booking) | MO | Reduce number of A&E attendances and influence local behaviour change to 111 First | Oct 2021 | Paused |  | Agreed that the acute trust will pause the pilot for ED streaming & redirection tool to enable focus and development on the urgent care service. |
| 12. | HALO Posts  | Improvement in Ambulance Turnaround times, appropriate direction of patients and improved communication / education between organisations / departments  | Sue Cousland /Alastair Smith / Anne Marie Hall  | Working on Band 7 funding x 7 days a week @peak period – to be determined at both Grimsby and Scunthorpe ED’s  | October 2021 |  | Use of non-recurrent Ambulance funding for Q3/Q4  | Funding approved for HALO input across 4 acute sites in Lincs 7 days a week for peak periods only - planned to start beginning of October for Q3 and Q4.Recruitment underway. |
|  | **Workstream: Redirection from A&E** | **Risk: Continued elevated A&E attendances. Risk to delivery of 111 First agenda.** |  |
| **Aim** | **Lead** | **Impact (SMART objectives)** | **Timescale** | **RAG** | **Cost** | **Update** |
| 13. | Rollout of Primary Care Access Hubs Pilot NEL | Awaiting additional Systm1 module to allow 111 booking into Hub 1 (Meridian/Roxton). Hub will open to patients for direct booking via 111 immediately upon successful testing of booking (no later than 1 September). Hubs 2 & 3 in planning and expected to commence pre-winter. | Jill Cunningham | Reduction in A&E attendances circa 25 per day – rising to circa 75 per day on full rollout. | Hub 1 open by 1 OctoberHub 2 & 3 open by 1 November |  | Currently £22 per patient | IT installation and testing planned for w/c 20/9. Expect Hub 1 go live early Oct. |
| 14. | Improvement SDEC streaming processes for community based services | Address barriers to direct access to SDEC services for ambulance,111/SPA and Primary Care. Full implementation and embedding of direct access to SDEC. Regular audits undertaken via the Task and Finish Group to ensure direct access is maintained from community without default to A&E attendance. | Jill Cunningham/ Sonia Last/Matt Overton | Reduction in LoSReduction in A&E attendances | SDEC now live. Pathways review ongoing. |  |  |  |
| 15. | Improve Primary Care Access  | A current review of access into primary care services is underway. This will address barriers to accessing services by developing an action plan of areas that require addressing. Continued drive for recruitment to additional roles staff. Stepping back up 100% capacity in the extended access service.  | Sarah Dawson/Erica Ellerington | NL Access review complete action plan developed and being worked on. Taking action plan to various committees w/c 23/8/21 for assurance and support. Extended access 100% step back up. | NL Complete |  |  | NL The surge predicted by NHSE has not been seen however, 111 appointments via CAS are available and under 5’s RSV hot clinic can be stepped up at short notice if needed |
| Local plans for potential RSV surge to manage anticipated demand on primary care and ED.  | Northern Lincs model in place. Trying to access funding to implement an under 5’s RSV hot clinic to step up if demand exceed PC capacity.  | Mid-Sept |  |
| Additional support provided to develop patient comms around use of digital options and online consultation to support patients to utilise. | PC comms plan for 21/22 now agreed to include areas of digital access. Work has commenced |  |  | NL Action ongoing Funding requested for NHSE to support members of the public to access the NHS App. |
| Rollout of digital hubs across NEL to support patients who do not have the equipment to access primary care in this way |  |  |  |  |
| NEL - Additional support through the PCN care home teams in place should there be an urgent medical need affecting multiple patients (e.g. infectious disease outbreak) in care homes.  |  |  |  |  |
| Rollout of RAIDR as a tool for population health management | Fully rolled out but further support required for full utilisation. |  |  | Action ongoing and support provided as and when needed. |
| 16. | 111 First | Continue roll out of 111 First principles across HCV. Strengthening communication in-line with seasonal activities in order to promote use of 111 and avoid inappropriate ED attendances. | Helen Kenyon | Reduction in A&E attendances | Oct 2021 for pre-winter actions |  |  |  |
| 17. | Any to Any Booking | Pilot completed in NEL to test concept. | Nicola Stark | Rollout plan being worked up. Need timescales for NL/NEL |  |  |  |  |
| 18. | 2 hour crisis response | Model forecast 2 hour UCR activity, workforce and cost (demand and capacity requirements) by community services provider (NLAG, CPG) as part of a HCV ICS planning guidance submission. | Lisa Revell/ Ant Rosevear  | Complete and agree with ICS leads 2h UCR activity, workforce and costing forecast modelling for NL and NEL by 30 June 21 | June 21 |  | **NLAG**Q3. £64.595Q4. £152,189FYE. £959,253 | **CPG**£62,666£147,713£931,040 | Completed June 21 as part of ICS work |
| Develop Community Services Data Set (CSDS) reporting for 2 hour UCR aligned to the technical guidance | Implement technical systems required to support CSDS reporting in NL and NEL for 2h UCR, meeting all NHSEI technical guidance, by 1 Oct 21 | Oct 21 |  | CDS reporting technical systems established in NL and feed to national reporting now in place. |
| Develop an operational model for 2 hour UCR service delivery aligned to the technical guidance | Implement operational model for 2h UCR service in NL and NEL, meeting all technical guidance, by 1 Oct 21To deliver NL and NEL 2h UCR activity and thus avoidance of hospital admissions in Q3 and Q4 in line with the following forecast: | Oct 21 | On track | 2H UCR Delivery Group to be established this month, reporting into Northern Lincolnshire Ageing Well Oversight Board. Awaiting confirmation of approval of funding plan following submission via CCG to finance lead (CHCP). Awaiting confirmation of funding draw down to provider for recruitment to commence. |
| 19. | Mental Health Provision - S136 suite  | Provision for 24 hour staffing for Section 136 suites | Mike Reeve/Wendy Fisher | Use of band 3 staff to provide 24 hour alternative S136 suite provision to avoid MH conveyance to A&E | Oct 2021 |  |  | Risk due to staff RDaSH (shortfall covered by Humberside Police currently) |
| 20. | Mental Health Bed Capacity | RDaSH to block purchase private beds | Mike Reeve/Wendy Fisher |  |  |  |  |  |
| Navigo – 12 acute escalation beds proposal in developmentProposal for 5 eating disorder beds subject to recurrent funding |
| 21. | CAS provision | Plan 24 hour CAS provision for Northern Lincolnshire ahead of winter 21. Current awaiting outcome of HCV business case for Vocare/CAS. | Sue Rogerson/ Helen Kenyon | Reduction in inappropriate A&E attendances by increasing number of ED/UTC dispositions undergoing clinical validation.  | Oct 2021 |  | Funding identified from ICS/ UEC transformation/CCGs and providers | 24/7 CAS in place, including all ED dispositions from 111 calls and online and primary care 1&2 hr speak to dispositions. Estimated 1,500 calls a week validated across HCV with 1035 redirected |
| 22. | Review of NEL SPA pathways | A review of Community Integrated Urgent Care is underway in NEL. A working group has met to review the SPA offer and undertake a gap analysis. A project plan will be drawn from this work to enable service development to focus on areas of greatest impact ahead of winter 2021. | Jill Cunningham | Improved pathways in community for urgent cases, reduction in ambulance conveyance and A&E attendance. | Oct 2021 |  |  |  |
| 23. | NL SPA | Undertake comprehensive review of the NL Integrated SPA model to ensure sufficiently robust to meet urgent 2 hour community response standards and to support with non-conveyance pathways | Sonia Last/Chloe Nicholson | Undertake review of capacity and demand of NL SPA. Map demand against UCR 2 hour trajectory previously agreed for North Lincolnshire, identifying any gaps. | Dec 21 |  |  | Site visit undertaken of SPA in August 21 feedback from site visit with proposed improvement actions to be submitted at Northern Lincolnshire Ageing well oversight board in November.  |
| Review of workforce requirements and capacity modelling in integrated SPA (aligned to the UCR modelling work). | Understand baseline of current staffing establishment. Develop proposal for any identified improvements. |  | Full allocation of 21/22 ageing well funding provided to support CRT GP and additional capacity into the SPA.Currently in the process of developing integrated community response team offer. |
| 24. | Increased use of hear & treat & see & treat to reduce overall number of conveyances to ED | HCV - Agreeing parameters with ambulance providersUse of Specialist Paramedics based in Scunthorpe First Contact Paramedics in PC Doctor in EOC IN Lincoln for peak periods  | Sue Cousland / Alastair Smith  |  |  |  | SP’s currently in post Discussions being arranged with PC in N and NE Lincs re use of ARRS funding to support rotational Paramedics in PC = £55k max Doctor in EOC – utilising non recurrent ambulance funding  |  |
| Use of IT Tools to enable Ambulance crews to identify, and have access to alternative pathways to ED. .  | Ensure appropriate pathways are utilised and have mechanisms in place to evaluate real time use of pathways |  | Working group established and will commence 18.10.21 to capture key pathways. In addition services are been audited locally and relevant pathways updates where required. Pathway lead to be embedded and consolidate pathways onto IPads.  |
| 25. | A clinical messaging tool to support rapid clinical conversations to support shared decision making for individual patients | HCV - Pilot in the process of being identified using CAS and the SDEC services in York & Scarborough | Helen Kenyon | HCV - Clinical messaging available for SDEC services via the CAS for all 4 providers |  |  | Funding across HCV for 3 years from digital pot | Currently in testing – need to consider timescalesRequest for NL/NEL to become pilot site (EE)Being tested in Scarborough. Go live date delayed because of technical issues. Once live will review other use cases i.e. NEL |
| 26. | EMAS Pathway / Service Improvement Lead  | Utilising intelligence gained from the interim post Improved engagement with crews and exploration of further initiatives to ensure patients access the most appropriate pathways based on clinical need  | Sue Cousland / Alastair Smith  | JD finalised Appointment process to be arranged  | October 2021 |  | Current cost pressure to EMAS  |  |
| 27. | Review of Directory of Services Provision to align offer as system improvement  | Constant review of DoS provision (and real time adjustments) to suit service development and escalation throughout winter. Ensure DoS requirements are reflected in service development and timescales agreed to allow for profile testing. | Elaine Johnson | DoS reflects both service provision arrangements and real time escalations to ensure a reliable service pathway across Northern Lincolnshire. | Sept 2021 and ongoing |  |  |  |
| 28. | Improve EMAS use of alternative pathways to avoid ED conveyance | Access to senior clinician for advice and guidance for chest pain clinical pathways, pain score and risk stratification to support direct access to AMU, SDEC, CCU. Also for acute exacerbations in known patients; such as Paeds where ED may delay specialist treatment. | Sue Cousland / Alastair Smith/ Anne-Marie Hall | Increased use of advice and specialist pathways, thereby reducing ED conveyance. |  |  |  | Expanding clinical assessment team to improve hear and treat and provide additional avenue of support for crews on scene. Collaborative working with NLAG to enable Direct referral to specialist assessment areas and increase utilisation of pathways. A streamlined direct patient pathway from ambulance to a dedicated stroke assessment area outside of ED at SGH will be established, by-passing the ED and reducing any delays for acute stroke patients to be seen by a stroke specialist. Final arrangements to enable this pathway to be implemented (estate, pathways SOP, comms) are being completed for a pathway launch during Oct/Nov 2021.  |
| Ability of paramedics, as trusted assessors to access to SDEC, including frailty services directly (both acute and community) | Increase the use of SPA pathway for ambulance crews for access to NLaG specialties. | Work to be done with Acute providers to establish direct access to SPA and FEAST at SGH. Collaborative working between EMAS/NLAG ongoing with weekly reviews of the successful and non-successful pathway referrals.The SPA service is reporting that this service is not being utilised by the ambulance crews. This has been fed back to EMAS for their internal promotion of the pathway service amongst their frontline staff. |
|  Clinical validation of Cat 3 and 4 calls to confirm correct disposition provided. | Ensure appropriate outcome is provided following 111 call. |  | Currently in pilot phase will be evaluated once pilot complete. |
| Provision in place for those patients with a long wait for an ambulance response  | To safely manage patients who have long waits to be ambulance attendance |  | Explore how additional support from other services would improve the response to patients with long waits - eg., urgent community response responding directly to cat3 or cat4 calls |
| 29. | Community Capacity  | A winter plan for community and social care has been developed to address escalation and risk management ahead of winter |  | Winter readiness assessment tool rolled out to social care providersCommunity & Voluntary Sector wrap around support in placeIntensive support at home available for escalation of careSupport at Home winter pressures teams on standbyCare workforce recruitment campaign underwayMutual aid and escalation plans in place for workforce pressures |  |  |  |  |
|  | **Workstream: Ambulance Handover** | **Risk: Lack of improvement in ambulance handover performance. Failure to achieve reduction in A&E attendances.** |
| **Aim** | **Lead** | **Impact (SMART objectives)** | **Timescale** | **RAG** | **Cost** | **Update** |
| 30. | Improvement Plan Progress | Handover Plan agreed and being implemented including new handover process, SDEC streaming pathways, self-handover protocol, pathways coordinator post in place to review and improve process across pathways, multiple daily touch points NLaG/EMAS to ensure early communication on operational matters. Progress monitored via Task and Finish Group | Matt Overton | Sustained improvement in Trust handover performance. | In progress - Ongoing action plan with individual timescales for actions |  |  |  |
| 31 | Evidence of improved use of alternative ED pathways | Services are being audited locally in NL & NEL with information fed to relevant pathway if required. This is being currently reviewed weekly SPA and SDEC outcomes. This needs rolling out to all pathways |  | Demonstrate successful use of alternative pathways to ED and direct access to assessment areas and SDEC. |  |  |  | Working group to commencing week commencing, 18.10.21 which will capture key pathways.  |
| 31. |  | Explore the need for ambulances to have direct access to the designated residential home for Covid positive patients. |  | All cubicles comply with IP&C and social distancing requirements. |  |  |  |  |
|  | **Workstream: AEDB/Improvement Subgroup Actions – Enablers and Performance** | **Risk: Failure to deliver 111 First Programme. Failure to deliver reduction in A&E attendances, impact on performance.** |  |
| **Aim** | **Lead** | **Impact (SMART objectives)** | **Timescale** | **RAG** | **Cost** | **Update** |
| 32. | Improvement Subgroup | Develop subgroup of AEDB to specifically consider system improvements and feedback to AEDB | SROs | Improved oversight of improvement plans, trajectory, and system developments ahead of winter 2021. | 31 Aug 21 |  |  |  |
| 33. | Implementation of UEC Clinical Standards | HCV - Awaiting national guidance |  |  |  |  |  |  |
| 34. | Consistent use of ECDS VS 3 across all providers |  |  | HCV - All acute and UTC providers reporting on ECDS VS 3 |  |  |  |  |
| 35. | Full implementation of RAIDR in all providers to support management of demand | HCV - Most providers now on board, further expansion into primary and social care needed |  | All HCV providers reporting fully on RAIDR |  |  |  | HCV - Most providers now on board, further expansion into primary and social care needed-NLCNLaG OPELFreshney Pelham Community Nursing |
| 36. | Comms programme for public and stakeholder on service changes | HCV - Ongoing Comms to socialise the proposed transformation |  |  |  |  |  |  |