Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**21 March 2018**
Subject:	**Lincolnshire Urgent and Emergency Care**

Summary:

This report provides information on the Lincolnshire Urgent and Emergency Care Strategy 2018-2021, and the development of the plan to support the delivery of strategy. .

Actions Required:

(1) To consider and comment on the report, including the Lincolnshire Urgent and Emergency Care Strategy 2018-2021 (Appendix A to this report).

(2) To note the report on the Urgent Care Streaming Service (Appendix B) in the context of the Lincolnshire Urgent and Emergency Care Strategy 2018-2021.

1. Background

1.1 Context

The Lincolnshire Sustainability and Transformation Partnership (STP) developed and approved the Sustainability and Transformation Plan in October 2016. Seven key priorities have been identified one of which being urgent and emergency care. To support this key priority, The Lincolnshire Urgent and Emergency Care Strategy 2018-2021 (the strategy) has been drafted.

Our vision for urgent and emergency care is:

> *"To transform our urgent and emergency care services into an improved, simplified and financially sustainable 24/7system that delivers the right care in the right place at the right time for all of our population."*

The strategy is cognisant of the strategic direction set by the Urgent and Emergency Care Review and the Five Year Forward View.

Consultation has been undertaken amongst organisations via the A&E Delivery board, and the strategy was approved at the System Executive Team (SET) on 24 January 2018.

1.2 Urgent and Emergency Care Definitions

1.2.1 – Urgent and Emergency Care

There is no nationally accepted definition for 'urgent care' and 'emergency care'. The Lincolnshire Urgent and Emergency Care Strategy 2018-2021 uses the following definitions:

Urgent Care – the provision of care for patients who require prompt advice or treatment, but whose condition is not considered life-threatening.

Emergency Care – immediate of life threatening conditions, serious injuries or illnesses.

1.2.2 – A&E Activity Definitions

The A&E Attendances and Emergency Admissions Monthly Return Definitions document sets out national definitions for A&E Attendances and Emergency Admissions monthly returns. Types of A&E Service are:

- Type 1 A&E department – A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients – Lincoln County Hospital and Pilgrim Hospital, Boston are examples of Type 1 A&E departments.

- Type 2 A&E department – A consultant led single speciality accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients. There are no examples of Type 2 A&E departments in Lincolnshire.

- Type 3 A&E department / Type 4 A&E department / Urgent Care Centre – Other type of A&E / minor injury units (MIUs) / Walk-in Centres (WiCs) / Urgent Care Centre, primarily designed for the receiving of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining

characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. An appointment based service (for example an outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours services), or a dedicated primary care service (such as GP practice or GP-led health centre) is not a Type 3 A&E service even though it may treat a number of patients with minor illness or injury.

Examples of UCCs in Lincolnshire are Louth County Hospital, and Skegness Hospital. Examples of MIUs in Lincolnshire are John Coupland Hospital, Gainsborough; Johnson Hospital, Spalding; and Stamford and Rutland Hospital.

The East of England Clinical Senate Report, November 2017, states that:

'The majority of patients presenting at Grantham and District Hospital A&E were type 3 patients, the department did not support patients of higher acuity.'

1.2.3 – Urgent Treatment Centres

The Urgent Treatment Centre Principles and Standards document, published by NHS England in July 2017, sets out a core set of standards for urgent treatment centres to establish as much commonality as possible. By December 2019 patients and the public will:

- Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
- Have a consistent route to access urgent appointments offered within 4 hours and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.
- Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.
- Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS 111, local GPs, hospital A&E services and other local providers.

1.3 Case for Change

The Lincolnshire urgent and emergency care system has been operating under extreme pressure over the past 36 months (see table 1) with consistent failure to achieve the NHS constitutional standard that states that 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours. Whilst the most pressure is evident in the A&E functions, the whole system is not operating efficiently by reactively responding under pressure to manage demand and flow.

In addition to this a confusing picture of urgent care provision is currently in existence in Lincolnshire with the public being presented with a multitude of different

service names and routes into urgent care. Some services with different names deliver the same care and some services with the same name can deliver completely different levels of care. This is further highlighted above with the national definition for type 3 departments covering MIUs, WICs and UCCs.

In summary our current urgent and emergency care system demonstrates the following case for change:

- Complicated service provision, multiple 'front doors'
- High dependency on GP practices, out of hours service and the Clinical Assessment Service (CAS) to deliver increasing demand for same day urgent care services
- Increasing demand for NHS 111 and 999 services
- High number of ambulance conveyances
- Public confusion about where to go for services
- Historical difficulties with recruitment and retention across the urgent and emergency care workforce
- Poor adherence to the NHS constitutional four hour standard.

Table 1 – A&E performance figures

Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
84.51 %	83.92 %	85.21 %	87.30 %	87.60 %	90.67 %	91.19 %	89.17 %	90.17 %	86.41 %	86.52 %	84.88 %

Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
82.73 %	81.07 %	80.32 %	80.54 %	83.52 %	81.18 %	78.56 %	77.81 %	78.40 %	81.37 %	82.60 %	77.47 %

Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
75.67 %	75.36 %	79.12 %	82.21 %	76.86 %	81.58 %	78.49 %	77.73 %	76.68 %	77.54 %	79.37 %	69.46 %

Jan 18
66.99 %

1.4 Four Programme Areas

The Transforming Urgent and Emergency care services in England - Urgent and Emergency Care Review end of Phase 1 Report identifies five key elements for the future of urgent and emergency care services in England which must be taken forward to ensure success. The five elements are:

1. Providing better support for people and their families to self-care or care for their dependents.
2. Helping people who need urgent care to get the right advice in the right place, first time.

3. Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
4. Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.
5. Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

Building on these five elements, the strategy has identified four key programme areas for which, when fully implemented, will ensure that urgent and emergency care services operate from a system perspective to provide an improved, simplified and financially sustainable urgent and emergency care system in Lincolnshire.

1.4.1 – Supporting Self-Care / Self-Management and Prevention

- By December 2018, there is a national mandate to have 111 online available to the public. Work is ongoing on a regional basis to identify a provider for this service, with implementation planned for the summer months to meet national deadline.
- The Directory of Services will be further developed to ensure that self-care and voluntary sector services are identified ensuring that the public can be well supported to self-care.
- The delivery of this programme area will closely link with STP self-care work programme and the Joint Health and Wellbeing Strategy

1.4.2 – Helping People with Urgent Care Needs to Get the Right Advice or Treatment First Time.

- Nationally there is a requirement for 50% of all NHS 111 calls to result in the patient being passed across to a clinician for advice and guidance. This target is already being met in Lincolnshire.
- The Clinical Assessment Service (CAS) delivers this service in Lincolnshire and supports the reduction in hospital attendances.
- The CAS service has been developed in recent months to provide direct clinical advice to care homes and paramedics. Pilot programmes for this have recently been completed and the impact identified.

Further projects to support this programme area include:

- A one year pilot to trial CAS undertaking video-consultation as enhancement to telephone based triage
- Roll out of direct booking from hear and treat services into Urgent Treatment Centres (UTCs) and in hours primary care
- To further develop integrated service delivery between urgent care / Integrated Neighbourhood Working same day response / Mental Health and primary care.

1.4.3 – Providing a Highly Responsive Urgent Care Service Out of Hospital So People no longer Choose to Queue in A&E

- The Next Steps on the NHS Five Year Forward View (5YFV) states that by December 2019, urgent care facilities will be provided through UTCs to ensure as much commonality as possible. National Urgent Treatment Centre principles and standards have been published, and in Lincolnshire work is underway to establish where these facilities will be located and timescales for implementation.
- In addition to UTCs based in the community UTC's will be co-located at the Emergency Departments in Lincolnshire. In addition to the principles and standards published nationally, these centres will incorporate the current Urgent Care Streaming Service and have effective streaming to relevant specialities to minimise the need for patients to attend the emergency department.
- Urgent Care Streaming Service – for a detailed report please see appendix B.

Further projects to support this programme area include:

- Progression of GP access hubs
- Further development of effective patient pathways
- Links with palliative care
- Links with community mental health services
- Links with community pharmacy

1.4.4 – Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise changes of survival and a good recovery

Further projects to support this programme area include:

- Review of emergency care arrangements following the acute services review
- Review of workforce model for urgent and emergency care in Lincolnshire
- Review of ambulatory emergency care model to ensure standardisation across all sites in Lincolnshire
- Development of Outline Business Cases (OBC) to support the provision of primary care on the Lincoln, Pilgrim and Grantham site through UTCs.

1.5 Lincolnshire Urgent and Emergency Care Delivery Plan

To support the implementation of the strategy, a comprehensive delivery plan is in the process of being produced. The delivery plan will include the projects identified above to support both the recovery and transformation of urgent and emergency care in Lincolnshire.
Specific milestones and timescales will be identified in the plan to ensure projects are appropriately managed.

1.6 Enabling programmes

Enabling programmes for urgent and emergency care will run across all four of the programme areas, and are closely linked with the STP enabling programmes. They include:

- Information Communication Technology (ICT) – the introduction of 111 online, and direct booking of GP appointments
- Estates – work has been undertaken at the Lincoln and Pilgrim site to support urgent care streaming. Further OBCs are being developed by Lincolnshire CCGs to support the delivery of primary care led UTCs
- Workforce and organisational development – a workforce plan for urgent and emergency care will be developed to support the delivery of the strategy in line with timescales set by Lincolnshire Workforce Advisory Board.
- Finance – the financial implications of the strategy will be developed alongside the delivery plan and will be closely linked to the financial recovery plan for Lincolnshire STP. This will ensure that services are financially sustainable.
- Communication and engagement – ensuring robust and meaningful engagement with patients, carers, staff and stakeholders to support the successful implementation of the strategy.

2. Consultation

This is not a direct consultation item. However, where proposals for major reconfiguration of services are developed, they will be subject to full public consultation, including the involvement of the Health Scrutiny Committee for Lincolnshire.

3. Conclusion

The report outlines the Lincolnshire Urgent and Emergency Care Strategy 2018 – 2021 and identifies the four key programme areas being developed to support the delivery of the strategy.

The strategy incorporates national expectations and requirements and has close links with the Lincolnshire STP. The A&E Delivery Board will receive monthly progress reports to ensure work is progressing as identified in the delivery plan. In addition to this, monthly urgent and emergency care progress reports are submitted to the STP.

4. Appendices

These are listed below and attached to the report

Appendix A	Lincolnshire Urgent and Emergency Care Strategy 2018 – 2021
Appendix B	Urgent Care Streaming Service Report

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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APPENDIX A

Lincolnshire Sustainability and Transformation Partnership

Lincolnshire Urgent and Emergency Care Strategy 2018-2021

Version Control

Version	**1.0**
Document Name	**Lincolnshire Urgent and Emergency Care Strategy 2018 - 2021**
Author	**STP Urgent Care Team**
Approving Board	**SET via A&E Board for their consultation and recommendations**
Approval Date	**24/01/2018**

Version	Section / Paragraph / Appendix	Description of Amendments	Date	Author / Amended by
0.1	Entire document	Complete first draft	05.12.17	Sarah Stringer / Cheryl Thomson
0.2	Entire document	Addition of paragraphs on Transitional Care, updates to UTC section, AEC section. Amendments Ruth Cumbers	07.12.17	Sarah Stringer/Cheryl Thomson
0.3	Entire document	Amendments Sarah Furley	08.12.17	Sarah Stringer/Cheryl Thomson
0.4	Entire document	Updates from consultation feedback from A&E Delivery Board members	08.01.18	Sarah Stringer/Cheryl Thomson
0.5	Section 1.5	Updated to add in strategic intention for reduction in A&E attendances	18.01.18	Sarah Stringer/Cheryl Thomson
0.6	Section 1.2 Section 3.3.1	Additional information on Grantham Inclusion of repeat dispensing changes	23.01.18	Sarah Stringer/Cheryl Thomson
1.0	Entire document	Approved by SET	24.01.18	SET

Contents

1. Introduction:

Our vision is:

> *"To transform our urgent and emergency care services into an improved, simplified and financially sustainable 24/7 system that delivers the right care in the right place at the right time for all of our population."*

1.1 Purpose

The purpose of this urgent and emergency care strategy is to set out our plans for the future development of urgent and emergency care across Lincolnshire in line with our vision.

The strategy has been written in alignment with the Lincolnshire Sustainability and Transformation Plan (Lincolnshire STP) and has close links and interdependencies with primary care, planned care, prevention and self- care, women's and children and access to mental health services. In addition to this, the strategy is cognisant of the strategic direction set by the Urgent and Emergency Care Review, led by Professor Sir Bruce Keogh. The review recognises the growing pressures on A&E departments, citing two specific points for consideration. Firstly, an aging population with increasingly complex needs leads to an increase in the demand for urgent and emergency care, and secondly the inconsistency of services makes a difficult and confusing experience for patients leading to the use of A&E as a default. In addition to this Lincolnshire has also experienced difficulties with recruitment and retention across the urgent and emergency care system, and is facing unprecedented financial pressures.

The Five Year Forward View published by NHS England in 2014 highlights the need to transform urgent care over the next five years, with an emphasis on better support for self-care, integration between urgent and emergency care services, new care delivery models and strengthening primary care. On a local level, Lincolnshire is currently undergoing an Acute Services Review and is in the process of developing a Single System Plan. These will be considered and will influence the development of the Lincolnshire Urgent and Emergency Care Strategy 2018-2021, which will culminate in a streamlined and flexible delivery model for urgent and emergency care in Lincolnshire.

1.2 What is urgent and emergency care?

Whilst there is no one clear definition of 'urgent care' there is general consensus around the meaning. For clarity in this strategy, the term urgent care will refer to:

- The provision of care for patients who require prompt advice or treatment, but whose condition is not considered life-threatening.

The term emergency care will encompass:

- Immediate or life threatening conditions, serious injuries or illnesses.

This strategy is focussed on urgent and emergency care in Lincolnshire and the services that fall under the definitions above. As such the service areas (that apply to all ages) within scope are:

- Self-care
- NHS 111 (triage by phone and online)
- Clinical Assessment Service (CAS)
- Out of Hours Service
- Urgent Treatment Centres
- GP / Primary Care Access Hubs
- Primary Care in hours
- Community Pharmacy
- Mental Health Services
- Integrated Neighbourhood Working (INW) encompassing both integrated neighbourhood networks and integrated neighbourhood care teams
- Ambulatory Emergency Care (AEC)
- 999
- A&E

The following urgent and emergency care services are not in scope:

- Major trauma services
- Emergency surgery
- Intensive Care Services
- Urgent and emergency care services at Grantham District Hospital. Following the overnight closure of Grantham A&E in August 2016, significant work is being undertaken to design the substantive urgent and emergency care services that will be offered on the site. This work is mindful of the East of England Clinical Senate report (December 2017) and is being managed in line with the Pre-consultation Business Case being produced by the STP operational delivery unit. Whilst out of scope for this strategy, any service redesign work will be closely linked and incorporated in the Lincolnshire Urgent and Emergency Care delivery plan.

Lincolnshire's urgent and emergency care network extend across the county borders to other hospitals such as those in Nottingham, Sheffield, Grimsby, Scunthorpe, Peterborough, Leicester and Kings Lynn which already link in to the Lincolnshire hospital network to provide services such as cardiothoracic surgery, neurosurgery, children's specialist surgery and major trauma (multiple breaks such as those in a car accident).

1.3 National Vision

Nationally the Urgent and Emergency Care Review sets out a simple two point vision with the view that if the first part is managed correctly, pressure will be relieved on hospital based emergency services which will allow delivery of the second part:

1. For those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible minimising disruption and inconvenience for patients and their families.
2. For those people with more serious or life threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.

Recognising the need for local interpretation, the national vision for urgent and emergency care is shared in Lincolnshire.

1.4 Principles / Objectives

The principles for Urgent and Emergency Care (UEC) in England are described in the UEC Review End of Phase 1 Report. The principles outline a system that:

1. Provides consistently high quality and safe care, across all seven days of the week;
2. Is simple and guides good, informed choices by patients, their carers and clinicians;
3. Provides access to the right care in the right place by those with the right skills, the first time; and
4. Is efficient and effective in the delivery and services for patients.

Following national engagement a series of patient focussed objectives for system change were published, these objectives are incorporated in the Lincolnshire Urgent and Emergency Care Strategy:

1. Make it clear how I or my family/carer access and navigate the urgent and emergency care system quickly, when needed.
2. Provide me or my family/carer with information on early detection and options for self-care, and enable me to manage my acute or long-term physical or mental condition.
3. Increase my or my family/carer's awareness and publicise the benefits of 'phone first'.
4. When my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.
5. Improve my care, experience and outcome by ensuring the early input of a senior clinician in the urgent and emergency care pathway.

6. Wherever appropriate, care for and treat me where I present (including at home and over the telephone).
7. If it's not appropriate to care for and treat me where I present, take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to highly specialist care if needed.
8. Ensure all urgent and emergency care facilities can transfer me urgently, and that the transport is capable, appropriate and approved.
9. Real time information, essential to my care, is available to all those treating me.
10. Where I need wider support for my mental, physical and social needs ensure it is co-ordinated and available.
11. Each of my clinical experiences should be part of programme to develop and train clinical staff and ensure development of their competence and the future quality of services.
12. The quality and experience of my care should be measured and acted upon to ensure continuing improvement.

1.5 Strategic aims

The five strategic aims for the future of urgent and emergency care, set out in the UEC Review End of Phase 1 report are stated below:

- Firstly, we must provide better support for people to self-care;
- Secondly, we must help people with urgent care needs to get the right advice in the right place, first time;
- Thirdly, we must provide highly responsive urgent care services outside of the hospital so people no longer choose to queue in A&E;
- Fourthly, we must ensure that those people with more serious or life threatening emergency care needs to receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery; and
- Fifthly, we must connect all urgent and emergency services together so the overall system becomes more than just the sum of its parts.

This strategy will describe how the above national aims will be adopted in Lincolnshire. It is our overarching strategic intention in line with the Lincolnshire Sustainability and Transformation Plan (STP) that we will achieve a 27.5% reduction in A&E attendances (based on a 2015/16 baseline of 358,414). The accountability for delivery of this target goes beyond urgent and emergency care service redesign. Programmes of work spanning all domain areas of the STP e.g. Integrated Neighbourhood Working (integrated neighbourhood networks and integrated neighbourhood care teams) and operational efficiency programmes will all be contributors to achieving this target.

2. The urgent and emergency care system in Lincolnshire

2.1 The current system

In Lincolnshire, as elsewhere in the country, we currently have a confusing picture of urgent care provision. The public are confronted with a multitude of different service names and routes into urgent care. Some services with different names deliver the same care and some services with the same name can deliver completely different levels of care.

If this is our perception of services as health care professionals, then for the public the urgent care system must be even more confusing and frustrating. As we develop this strategy into an ongoing delivery plan all changes we wish to make must involve testing back with the public to sense-check our plans and assumptions.

The following describes the broad overview of current urgent care service delivery:

- The main routes into urgent care are ringing a GP, ringing NHS 111 and walking into A&E or community based walk in centres; minor injury units or urgent care centres. Less utilised routes are using online self-care/self-management or going to a pharmacist as first port of call for advice.
- GP practices deliver the vast majority of the public's urgent care same day needs and enhanced clinical navigation at GP surgeries are beginning to assist in terms of streaming patients to see a practice GP or nurse, go to pharmacist etc.
- There were over 74,000 patients conveyed to hospital by ambulance in Lincolnshire in 2016/17.
- From the start of the Lincolnshire NHS 111 contract with DHU 111 (East Midlands) CIC (October 2016 to October 2017) there were 215,000 calls made to NHS 111 from Lincolnshire patients.
- When the public ring NHS 111 (after a 'Pathways' triage by a health advisor) if a patient needs to speak to a clinician they are put through to the Clinical Assessment Service (CAS) or they are directed to a service (predominantly primary care) after interrogation of the Directory of Service (DoS). The DoS is a critical database maintained by the Lincolnshire Urgent Care Team which signposts patients according to the type of clinical need and level of clinical urgency. The NHS 111 health advisors already have the capability of directly booking the current out of hours GP service.
- Lincolnshire CAS has been in place for over a year and establishing a CAS to deliver higher level clinical triage is an expectation nationally.
- CAS will hear and treat many calls (effectively closing the urgent care episode with self-care) or may advise patients to go to their GP. CAS clinicians also have the capability of deploying a member of staff from the LCHS urgent care home visiting service (physical health needs), a voluntary sector service e.g. HART team or may ask a patient to come in to be seen by an out of hours GP (in any of the OOH bases in Lincoln, Boston, Grantham, Louth, Skegness,

Gainsborough or Spalding). CAS clinicians may also decide an ambulance is required (work is ongoing to allow automatic dispatch capability) or advise a patient to go A&E.

- On ringing NHS 111 callers identified to have mental health needs are passed directly through to the Lincolnshire Partnership Foundation Trust (LPFT) mental health single point of access, or can be routed to this service by CAS. Patients with mental health needs who attend A&E often have needs that by this point are escalated and require mental health crisis team intervention.
- See and treat urgent care service provision is delivered via the following facilities:
    - A minor illness and injury unit at Sleaford (minor injuries 7 days and Urgent Care evenings and weekends),
    - Three minor injury units at Gainsborough, Spalding and Stamford,
    - Two Urgent Care Centres in Louth and Skegness.
- All patients arriving at one of our three A&E departments go through the urgent care streaming service to ascertain if their clinical needs could be met through a primary care service/GP out of hours or by a social worker/a mental health specialist etc. instead. Direct streaming into relevant specialist departments within the hospital also take place to avoid a hospital admission e.g. into Ambulatory Emergency Care (AEC) departments.

The NHS constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours. Within Lincolnshire, the four hour A&E performance has been falling since the winter of 2014/15 leading to a system wide recovery plan being developed to support the consistent re-achievement of the standard.

2.2 Case for change

In summary our currently configured urgent and emergency care system demonstrates the following clear case for change:

- Complicated and confusing urgent care service provision (different service names, misleading road-signs, unclear website signposting). Multiple ‘front doors’.
- High dependency on GP practices, out of hours service and CAS to deliver increasing demand for same day urgent care services.
- Under developed empowerment of the public to self-care/self-manage with low investment in advice, guidance and online clinical triage.
- Increasing demand for NHS 111 and 999 services.
- High number of ambulance conveyances (East Lincolnshire area being the highest in the East Midlands region).
- Public confusion about where to go for services
- The need for further development between existing ‘hear and treat’ services
- Integration between mental health and physical health urgent care services
- Poor adherence to the NHS constitutional four hour standard

- Historical difficulties with recruitment and retention across the urgent and emergency care workforce.

3. Success in 2021 for urgent and emergency care

Our vision for an improved, simplified and financially sustainable urgent and emergency care system will be achieved though strengthening the development of self-care/self-management and highly responsive urgent care services delivered in the community, allowing the emergency departments to focus on caring for the most sick and vulnerable patients.

3.1 Supporting self-care / self-management & prevention

The focus for reducing the requirement of patients experiencing urgent care needs is of paramount importance in terms of preventing unnecessary contacts, calls and attendances.

This will be achieved by a two-fold approach:-

- Increasing the empowerment of both patients and carers to self-care, self-manage their health and care needs and
- Increasing connection and support to statutory agencies, private health and care sectors e.g. care homes, voluntary sector and informal groups that deliver preventative care.

To deliver this aspect of the strategy close links will be developed with the STP self-care strategy and Joint Health and Wellbeing Strategy.

3.2 Helping people with urgent care needs to get the right advice or treatment first time

Getting the public who have urgent care needs the right level of advice and treatment is critical to prevent further escalation that may result in ambulance conveyance and/or A&E attendance/hospital admission.

The development of an NHS 111 online solution is mandated nationally to be in place by December 2018. The NHS 111 online solution essentially takes the same clinical governance route that is delivered when a person calls NHS 111 in terms of triaging patients and searching on the local Directory of Services.

NHS 111 continues to be advocated and will be increasingly marketed to the public as the gateway for urgent care health needs. National targets are in place (already being met in Lincolnshire) that 50% of all NHS 111 calls result in the patient being passed across to a clinician for advice and guidance. In Lincolnshire this service is delivered by the Clinical Assessment Service which will be continually developed to support the reduction in hospital attendances.

3.3 Providing a highly responsive urgent care service out of hospital so people no longer choose to queue in A&E

3.3.1 Community Pharmacy

A key element of provision of urgent care services out of hospital is the continued development of our community pharmacy provision. Our intention is to utilise community pharmacies to consistently achieve the following deliverables:

- Providing emergency supplies of prescription medicines;
- Supporting self-care of minor illnesses and providing minor ailment services;
- Providing flu vaccinations;
- Reducing repeat prescription workload in general practice through repeat dispensing;
- Supporting people with long term conditions to get the most benefit from their medicines;
- Minimising adverse effects and admissions related to medicines;
- Helping people understand new medicines and changes to medication (especially on discharge from hospital).
- Any changes to repeat dispensing arrangements

3.3.2 Integrated Neighbourhood Working

Integrated Neighbourhood Working through the delivery of both integrated neighbourhood networks and integrated neighbourhood care teams will support admission avoidance through the delivery of patient centred, individualised care in the community. Integrated neighbourhood working will provide same day response at a local level, supporting the patient being treated in their own home. In addition to this the function will interface with urgent care services at a countywide level should the acuity dictate.

The four key characteristics that make up integrated neighbourhood working are:

- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care;
- A combined focus on personalisation of care with improvements in population health outcomes;
- Aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards and
- Provision of care to a defined, registered population of between 30,000 and 50,000.

3.3.3 Transitional Care

Transitional Care is a component part of Integrated Neighbourhood Working that provides a period of recovery, rehabilitation, reablement and or assessment to determine immediate and longer term needs and or funding requirements for individuals in a local neighbourhood.

Transitional Care's main principles are 'HOME FIRST', Care Closer to Home and coordinating and managing the 'flow' of individuals across the system.
The range of integrated functions / services are designed to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. It is a function rather than a distinctive service, so will incorporate over time a wide range of different services and organisations from across Lincolnshire.

3.3.4 Patient Pathways

To support the delivery of a simplified, streamlined urgent and emergency care service a number of existing and developing patient pathways will be aligned. These will include but will not be limited to:

- Frailty
- End of Life Care
- Long Term Conditions
- Psychological Wellbeing
- Deep Vein Thrombosis (DVT)

3.3.5 Primary Care/GP Access Hubs

The GP Five Year Forward View suggests ways to transform primary care into a more sustainable and attractive field. The move toward more integrated urgent care, enabled by the proposed nationally recommended GP access hubs, will reduce demand within the urgent care system.
The model for GP access hubs will be developed through engagement with all relevant stakeholders in primary care.

3.3.6 Community Mental Health Provision

Linking to the Multi-Agency Review of Mental Health Crisis Services in Lincolnshire, the strategy will support:

- The need for the person experiencing crisis to be at the centre of the process with services working flexibly and in a joined up way.
- For out of hours services to be of the same consistency and quality as those provided during 9 to 5 hours with regard to staffing levels and range of options available
- For there to be greater clarity regarding which services do what and when so that people can access the right service at the right time when support is most needed
- To improve access to the range of options that help prevent crisis
- To embed in the clinical pathway access to those with lived experience in peer support roles at times of urgent need
- To improve access to third sector support provision to extend the range of choice at times of urgent need.

3.3.7 Urgent Treatment Centres

Urgent Treatment Centres in the community

"Urgent Treatment Centre" will be adopted as the consistent way of describing those community-based facilities that are led by general practitioners and which provide both booked and "walk-in" urgent appointments for illnesses and injuries typically managed in General Practice.

All Urgent Treatment Centres are required to meet the new national Urgent treatment centres principles and standards. Work is underway to establish which facilities will be in the county and under what timescales they will be established

Urgent Treatment Centres at the front-door of Emergency Departments

Under national guidance Urgent Treatment Centres will be developed and co-located at the Emergency Departments within Lincolnshire. These centres will incorporate the existing Urgent Care Streaming Service and evolve to provide highly effective patient streaming to relevant specialities minimising the requirement for patients to attend the ED. By having urgent treatment centres co-located with ED's they will act as an effective filter between urgent and emergency care.

3.4 Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery

Whilst this strategy is focussed on the development of self-care/self-management and the strengthening of highly responsive urgent care services being delivered in the community, it is recognised that there is still a cohort of patients who will require the services of an Emergency Department (ED).

The Safer, Faster, Better: good practice in delivering urgent and emergency care guide identifies clear evidence regarding the damage caused by poor patient flow and crowding in Emergency Departments. This strategy will ensure effective patient flow is in place in the EDs and will be closely linked to the Lincolnshire system recovery of the constitutional four hour standard, leading to sustained achievement against the A&E quality indicators.

In line with the recommendations made by the East of England Clinical Senate in December 2017, a single A&E team will support the delivery of standardised clinical pathways and processes across the three main hospital sites, enhancing training opportunities and removing unnecessary variation.

3.4.1 Ambulatory Emergency Care (AEC)

AEC is defined as the provision of same day emergency care for patients being considered for emergency admission. The aim of AEC is to manage as many patients as possible who, in the absence of an ambulatory care facility, would need to be admitted to an inpatient ward.

All patients should be considered for AEC management as a first line unless they are clinically unstable. Patients should be streamed to AEC based on fulfilling four simple rules:

- The patient is sufficiently clinically stable to be managed in AEC
- The patient's privacy and dignity will be maintained in the AEC facility
- The patient's clinical needs can be met in the AEC facility
- The patient requires emergency intervention

As well as having a dedicated trolley area, the AEC will work closely with the UTC at the front door of the ED to ensure that patients are seen in the most appropriate area to manage their need.

4. Workforce and organisational development

A key component of the delivery of this strategy is the development of a robust workforce plan which will encompass:

- The development of a highly skilled workforce for urgent and emergency care with the ability to flex to the areas of greatest need
- The development of new roles in urgent and emergency care with (but not limited to) the following:
    - Clinical pharmacists
    - Nursing associates
    - Allied Health Professionals
- Standardisation of roles across urgent and emergency care services
- Opportunities for personal and career development are offered to make urgent and emergency care an attractive place to work.

5. Information Management and Technology (IM&T)

The Integrated Urgent Care Delivery Plan will work in parallel with the Lincolnshire STP Digital Roadmap e.g. the development of the Care Portal. The ambition of national teams (delivered by NHS Digital) is to encourage the public to think of accessing advice and guidance online is a desirable alternative to calling their GP or going to A&E. The aim is to move technological solutions from:

- running as companions to patients decisions e.g. GP online appointment bookings,
- to substituted delivery e.g. NHS 111 online triage/telemedicine solutions to ultimately having
- consumer led technology e.g. health on demand apps, Artificial Intelligence e.g. Alexa.

Whilst we are on this long-term route the Health Secretary has challenged the NHS to deliver digital services nationwide and expects every patient in England to be able to do the following online by the end of 2018:

- Access NHS 111 online;
- Access their healthcare record;
- Book a GP appointment;
- Order repeat prescriptions;
- Express their organ donation preferences;
- Express their data sharing preferences; and ·
- Access support for managing a long term condition.

These technological solutions must be put in place in order to meet national designation standards for both Urgent Treatment Centres and Clinical Assessment Services (CAS).

6. Estates

Operational efficiency workstreams in the STP are reviewing and integrating where possible the estates between all statutory providers of health and care services. Various Estates, Transformation, Technology Funds (ETTF) bids are in process this year (2018) and these will be closely linked to this strategy to support urgent care delivery. As this work develops it will be reflected in the UEC Delivery Plan.

7. Communications and Engagement

In order to facilitate comprehensive communications and engagement planning we will establish the following:

- Engage with all relevant commissioners and providers to ensure we are all working to one shared vision.
- Links to our assigned STP communication and engagement leads.
- Engage with patients, relatives and carers and staff to baseline and test the intentions of the strategy and identify areas to change.
- To re-establish an Expert Reference Group of clinicians, key stakeholders e.g. Healthwatch and service users to co-produce our key developments in the Delivery Plan.
- To participate in county-wide STP promotion events and conduct appropriate engagement with key groups (districts, county council, voluntary sector etc).
- Regularly update STP website and newsletters.
- To develop a network of stakeholders who will regularly contribute to the further development of the strategy's delivery plan.
- To develop a comprehensive public awareness campaign for urgent and emergency care.

8. Conclusion/Next Steps

The intention is that the final version of this strategy is developed into a comprehensive Integrated Urgent and Emergency Care Delivery Plan that will be a working document from April 2018. This document will inform the progress reporting to all stakeholders on how the strategy up to 2021 is being delivered. The first version of this delivery plan will encompass the critical milestones over the next three years, with detailed project planning for the financial year 2018-19.

The strategy and plan will be presented to all relevant key stakeholders (including all statutory health and care organisations commissioners and providers, patient and carer groups, county and district councils etc.). There will be particular attention given to making deeper strategic connections with groups leading the other domains of the STP. This strategy will be flexible to adapt to additional recommendations and decisions made from the wider health and care community for example future Clinical Senate reports, the Acute Services Review, the Single System Plan and any other local or national recommendations.

Impact assessments will be jointly conducted with relevant STP areas to ensure a thorough approach to how the urgent care strategy is interpreted and how it is adapted as a result of these tests. These will include but will not be limited to:

- Activity flows/capacity and interdependencies e.g. out of county provision, to downstream/upstream services
- Quality and Equality
- Workforce
- Transport
- Estates
- Finance
- Engagement
- Accessibility of services

The delivery of this strategy by 2021 will ensure high quality, patient-centred, consistent county-wide care that is delivered through a simplified and effective patient journey, ensuring both the financial and operational sustainability of urgent and emergency care in Lincolnshire.

REPORT ON URGENT CARE STREAMING SERVICE

1. Background

1.1 Context

On 9 March 2017 NHS Improvement (NHSI) and NHS England (NHSE) wrote to all trusts and CCG's detailing a number of actions to support the recovery of the A&E performance target. One of these actions was to:

> *Ensure every hospital implements a comprehensive front-door streaming model by October 2017, so that A&E departments are free to care for the most urgent patients*

Grantham District Hospital already has a GP integrated within the Accident and Emergency Department; therefore the implementation of an Urgent Care Streaming Service (UCSS) is focussed at Lincoln County Hospital (LCH) and Pilgrim Hospital, Boston (PHB).

National evidence suggested that approximately 30% of self-attendees at emergency departments have problems that can be managed effectively by primary cares. In addition, local audits indicated that between 30-40% of attendances at A&E could be managed in an alternative setting. It was agreed that 35% of attendances at LCH and 30% of attendances at PHB will be streamed away from the A&E department and seen in the primary care element of the streaming service in Lincolnshire.

The Urgent Care Streaming Service (UCSS) was developed in partnership by commissioners, United Lincolnshire Hospitals NHS Trust (ULHT) and Lincolnshire Community Services NHS Trust (LCHS), with stakeholder involvement from Lincolnshire Partnership NHS Foundation Trust (LPFT), Lincolnshire County Council Adult Social Care, East Midlands Ambulance Service (EMAS) and primary care. The UCSS has been operated as an integrated service with ULHT delivering the initial streaming assessment and LCHS delivering the primary care element of the service. The service is operational between the hours of 08:00 and 23:00 365 / 366 days of the year. The service commenced in Lincolnshire on 27 September 2017 on a phased implantation, and was fully operational by 31 October 2017.

The UCSS has two key elements, the initial streaming assessment and the primary care element. The initial streaming assessment, provided by ULHT, should be carried out within 15 minutes of the patients walking into the A&E department, and should be conducted by a nurse with appropriate assessment experience and training. The primary care element of the UCSS will treat minor illness and ambulatory care, and is provided with a mixture of GPs and Advanced Nurse Practitioners provided by LCHS.

An UCSS Programme Board was set up to oversee the implementation of the service, with an operational delivery group convened to mobilise the service. This delivery group reported to the Programme Board who in turn reported progress to

the A&E Delivery Board. In addition, a Clinical Governance group has been instigated for the service. This group that meets monthly is chaired by the CCGs with representation from both sites and providers.

1.2 Urgent Care Streaming Service Performance.

The tables below demonstrate the number of attendances seen through the Urgent Care Streaming Service from the commencement of the service on 27 September 2017 to 4 March 2018. The tables highlight that the percentage of A&E attendances has not been achieved thus far with an average of 11.48% across both sites.

Table 1 – LCH and PHB combined total

	Total
Attendances	57025
Urgent Care Streaming	6544
Streaming As A % Of Attendances	11.48%
Returned To ED % Of Attendances	2.01%

Table 2 – Pilgrim Hospital Boston

	Total
Attendances	25252
Urgent Care Streaming	2370
Streaming As A % Of Attendances	9.39%
Returned To ED % Of Attendances	1.99%

Table 3 – Lincoln County Hospital

	Total
Attendances	31773
Urgent Care Streaming	4174
Streaming As A % Of Attendances	13.14%
Returned To ED % Of Attendances	2.02%

1.3 UCSS Review

The UCSS Programme Board requested that, following full implementation of the service on 31 October 2017, a comprehensive review was undertaken to evaluate the effectiveness and identify any opportunities to further develop the service. This review was led by the CCG Urgent Care Team, with input from the commissioners, providers and stakeholders. The review concentrated on the following areas:

- Quality
    - Visits from the CCG lead nurses for Quality and Safety were undertaken on both the LCH and PHB sites. The reports identified areas of good practice as well as some areas that required further development, especially with regard to the standardisation of the streaming assessment. Actions and recommendations from these

visits were fed into the review report and are being followed up in the clinical governance group.

- A clinical audit was undertaken by the LCHS Medical Lead for Urgent Care. The audit had 3 clear aims:
  - Review patients recorded as "returned to ED" to establish whether there was a justified reason for return
  - Review a random selection of patients seen in the ED to establish whether any of these cases would have been appropriate to be seen through the UCSS
  - Identify any potential changes to the streaming specification and or clinical staff skill set which would increase the % of patients that could be seen through the service.

  The audit demonstrated that further work is required regarding the acceptance of streamed patients by specialities in the hospital. This regularly constituted a return of the patient to the ED to have further diagnostics or for the patient to be seen in the department

  The audit concluded that more patients could be seen through the UCSS if the service has access to:
  - Plain radiology
  - Blood testing
  - Additional training for streaming clinical staff (minor injury / gynaecology / assessment of neonates and infants)
  - Improved direct referral pathways to specialities

- Data
  - Number of attendances through the UCSS is monitored on a daily basis and the information shared amongst health partners on the daily performance call.
  - Data was reviewed against the Key Performance Indicators to identify compliance / areas for improvement
  - Incident reporting – Throughout the 3 month review period, 11 incidents were recorded, these were discussed at the clinical governance meetings and any recommendations fed into the review.
  - Finance – cost of delivering the service
- Operational feedback
  - Monthly review group meetings were held with attendance from commissioners, providers and stakeholders. Each aspect of the service was discussed in detail with a different focus at each meeting. In addition to this, the meetings provided the group with an opportunity to identify any areas of the service that required small yet important changes to assist in the smooth running of the service.
  - Feedback from complaints / compliments. Throughout the 3 month review process, 1 concern was raised and dealt with on a local level. 0 complaints and 0 compliments
  - Feedback from primary care – communication was actively pushed out to primary care with a clear route into the review process. The review team was asked to attend the Boston practice managers meeting, and feedback from this session was captured in the review process.
- Review the service specification and make recommendations.
  - The review group revised the service specification in line with the findings from the review and made the following recommendations:

- To support the safety of the UCSS, basic observations to be recorded to generate a National Early Warning Score (NEWS) / Paediatric Early Warning Score (PEWS) score to be included as part of the streaming assessment. This has been implemented with immediate effect.
- Introduction of basic diagnostics tests to the primary care element of the UCSS
    - Including but not limited to point of care testing for bloods, x-rays, swabs and urinalysis
- Removal of the exclusion and acceptance criteria to ensure all patients are to be considered appropriate for the primary care element of the UCSS unless the streaming assessment deems otherwise

1.4 Next Steps

The UCSS review report was taken to commissioners on 9 February 2018. The recommendations were accepted, along with the decision to move to a single provider model for the UCSS. It was agreed that the initial streaming assessment be carried out by a practitioner with primary care expertise to increase the numbers accessing the service.

Both ULHT and LCHS were approached and LCHS has agreed to be the single provider for the UCSS. This has occurred at PHB, with LCHS now delivering the streaming assessment.

From 1 April, the service will move to a single provider specification with the exclusion criteria removed to allow further scope for patients to be seen through UCSS. It is recognised that the introduction of diagnostics will require additional training for staff and therefore a phased roll out of this will take place to ensure that clinical safety is paramount when delivering the UCSS.

2. Consultation

This is not a direct consultation item.

3. Conclusion

The report gives an overview of the introduction of the Urgent Care Streaming Service in Lincolnshire, and of the review process undertaken post introduction of the service.

4. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

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