CONNECT: Urgent and Emergency Care

Winter update for staff

Northamptonshire Health and Care Partnership

November 2018

Working together to transform urgent and emergency care this winter – and beyond

This is the first in a new series of staff update bulletins from the Northamptonshire Health and Care Partnership (NHCP) to share details of the work we are doing together across the county's health and care organisations. Further updates on our urgent and emergency care work – as well our other priority areas of work – will follow in the future.

Our urgent and emergency care system

Our urgent and emergency care services are more than just our accident and emergency services – they are all the health and care services that support people in our community when they are very ill or in need of care that prevents them becoming ill. Across Northamptonshire Health and Care Partnership, many of our providers offer care to support people when they are very unwell.

Every part of the NHS and social care services around the country are under pressure during winter and while we are doing our best, Northamptonshire is in the same position. We know that part of that pressure is caused by the fragmented way in which our services are provided, and how we have historically worked together.

What this means in reality is that the services which support our older people in Northamptonshire are really feeling the pressure. Too many of our older people become ill and spend nights in a hospital bed when they could have been managed by the NHS and social care at home or through day attendance at hospital or a local health centre. Too much time spent in hospital unnecessarily often leads to adverse patient outcomes like hospital-acquired infections and loss of independence.

As a result, our health and care system is having to allocate too much resource providing reactive care for people who have already become very ill or need extra rehabilitation time due to lost muscle strength, skills and confidence. We know this needs to change, so as a Partnership of Northamptonshire's health and care organisations we are working on:

- **Improving our collective understanding of our system pressure points – areas where we can see better outcomes if we change what we are doing**
- **Reviewing our urgent and emergency pathways of care for our community, before people might need A&E and once they leave hospital, in particular for older people**
- **Distributing our care better to manage demand before people might need admission to urgent care, manage it differently while they are in hospital and manage it in another way once they leave**
- **Creating more regular collaboration across providers so our care is streamlined around the patient**
- **Collaborating differently for winter 2018/19, learning from our collaboration and engaging with people to create future services that are right for our community needs.**

What's happening this winter?

What's happening this winter in Northamptonshire?

Winter is a challenging time for the whole health and care system – and last winter Northamptonshire's urgent and care services faced major challenges. We know that if we don't take action to address these challenges, this winter could be even worse.

That's why we've been working together across all Northamptonshire's health and care organisations – through our A&E Delivery Board, our Chief Executives Group and our Chief Operating Officers Group – to take specific action ahead of winter 2018/19 to improve patient and service user outcomes and ease pressure across all our urgent and emergency care services.

STEP ONE: THE CHALLENGE

The first collective step we have taken as a system is to identify the main causes and consequences of our winter challenge. These are:

- An increase in the number of people attending our A&E departments
- Worsening performance in our A&E departments against national targets
- Bed occupancy in our acute hospitals consistently above 100 per cent
- An increase in the number of beds occupied per day for non-elective (unplanned) admissions to hospital
- Patients staying in beds for longer than they need to (i.e. after they're medically fit to leave hospital)
- Most of these issues affect people over the age of 65 more than any other age group

STEP TWO: WHERE WE CAN MAKE CHANGE

Our next step in tackling the winter challenge is to identify the areas where we can make change. These are:

- Before A&E – reducing the number of older people attending A&E by improving the care they receive for existing long-term illness before it reaches crisis point
- A&E front door – improving access to care for illness that doesn't require hospital admission
- In hospital – improving the discharge process so patients don't stay in hospital longer than they need to
- Leaving hospital – making sure the right care and support is available for patients outside hospital

STEP THREE: HOW WE CAN MAKE CHANGE

Understanding the areas we need to change has enabled us to agree a programme of work which is being implemented this winter. This work will be led by the following delivery teams, working collaboratively across all our health and care organisations:

KGH in-hospital	NGH in-hospital	Intermediate care	Reducing delays	Complex discharge process	Primary care

What work is being done?

What work is being done – and what will that mean for our staff?

Kettering General Hospital – in-hospital

The challenge

Too many patients are being admitted to hospital beds at KGH when ambulatory care (care that doesn't require an overnight stay) would have been more appropriate for their needs had it been available as an option. Avoidable hospital admissions can have an adverse impact on a patient's overall health – particularly if they are older – and it also means fewer beds are available for very ill people who really need them. Our challenge is to improve the availability of ambulatory care at KGH so more patients can get the care they need in the right place, while also enabling more patients to leave hospital when they're medically fit to do so.

What are we doing?

- We are planning to extend the opening hours of the ambulatory care unit at KGH to 8am-10pm (currently 8am-8pm) this winter so that more people can access this kind of care when it's the most appropriate option for their needs. This will be effective once recruitment is complete. Staff at KGH have been involved and engaged in helping us to shape our proposals for the ambulatory care unit.
- We are also implementing new processes to make it easier for patients to leave hospital beds when they are medically fit to do so (as described in Intermediate Care section below). Significant investment has been made in developing our Integrated Discharge Team and ensuring we have more staff based on our wards supporting discharge, especially from urgent care areas.
- Other initiatives in place at KGH include 'hot clinics', rapid access clinics and dedicated assessment areas across a range of specialist services so more patients can access the right care in the right place, without having to be admitted to hospital.

Northampton General Hospital – in-hospital

The challenge

Just like at KGH, there are too many patients being admitted to hospital beds at NGH when the best treatment for them could be provided in other ways. This is not good for their overall health and contributes to over-occupancy of beds, which is a particular issue in winter.

What are we doing?

- At the beginning of October we opened the new Nye Bevan assessment unit. The 60-bed unit is designed for patients who need emergency assessment, enabling staff to properly determine the most appropriate treatment for those patients and thereby reducing the number of beds occupied unnecessarily and reducing pressure on our busy emergency department.
- A 28-bed winter escalation ward will be open at NGH from December to March and additional medical and nursing staff recruited to provide additional capacity and resource over this challenging period.
- Improvements are being made to the ambulatory care unit at NGH, including an increase in staff, so more patients can be assessed and treated without needing to be admitted to hospital.
- Integrated Discharge Teams (IDTs) will join daily consultant ward rounds (see Complex Discharge Process section) and 16 discharge co-ordinators will support each ward to enable patients to leave hospital as soon as they're medically fit to do so.

The Nye Bevan assessment unit at NGH

What work is being done? (continued)

What work is being done – and what will that mean for our staff?

Intermediate care

The challenge
Intermediate care supports people to prevent them from being unnecessarily admitted to hospital and, on leaving hospital, to aid their recovery and help them to live independently. This could mean returning home with support from specialist community teams or it could mean rehabilitation and therapy at a community hospital. In Northamptonshire, too many people are being admitted to hospital when instead they could be supported at home with the right care. Equally, for those people that do need to go into hospital, too many are then discharged to a residential or nursing home or receive complex care at home.

What are we doing?
It's recognised that more staff and resources are needed to tackle this challenge, so:

- We are in the process of recruiting more than 55 new staff members to our intermediate care teams – this will increase our capacity to provide the support patients need at home or in community hospitals.
- We have provided funding for additional intermediate care packages to make it easier for patients to either get the support they need at home or to leave our acute hospitals when they are ready.
- We are making the discharge process more efficient for patients with complex care needs (see Complex Discharge Process section below).

Reducing delays

The challenge
One of the key difficulties we face in our urgent and emergency care system is that we can't always help medically-fit patients to leave hospital as quickly as we should. Even though we are bringing in new processes and extra resource to address this challenge (as described the Intermediate Care section above and the Complex Discharge Process section below), a large number of our hospital beds are still occupied by patients waiting to be discharged to receive care in another setting. We need to do additional work to get this cohort of delayed patients down to a more manageable number so we can implement our new discharge processes more effectively on a day-to-day basis.

What are we doing?

- We have secured funding from NHS England to invest in additional solutions and resource so we can support more delayed patients to move to a more appropriate care setting. This includes the provision of residential and nursing home places, though the first priority will always be to enable patients to be supported in their own homes wherever possible.
- Decision-making and planning for patients to leave hospital will happen at the same time as their clinical treatment, so that by the time they are ready to be discharged they will have a clear care plan in place.
- We have implemented the 'Discharge to Assess' model. This means that where appropriate, patients are provided with short-term support in their normal place of residence while their longer-term needs are assessed.
- Additional interim care home beds have been procured across the county, so patients can be cared for at the same time as being assessed for their on-going needs. Once this assessment is complete, a permanent placement will be sourced.

What work is being done? (continued)

What work is being done – and what will that mean for our staff?

Complex discharge process

The challenge
A large proportion of beds in our acute hospitals are being occupied by patients who are medically fit to leave hospital, but have complex care needs and can't be discharged until they have a support package in place. Current discharge processes for these patients are slow and result in longer hospital stays than are necessary. This, in turn, has an adverse impact on the patient's overall health and wellbeing.

What are we doing?
We are working to make the discharge process more efficient for patients with complex care needs in the following ways:

- Planning for discharge now takes place at the same time as clinical treatment, not afterwards.
- From 29 October, integrated health and social care discharge teams are working together on acute wards to agree the most appropriate route for patients to return home or a suitable care setting.
- Trusted Assessors are now in place across our health and care system to provide full assessments of patients' needs, avoid duplication and ensure a safe and efficient discharge process.
- A new process is in place to ensure patients declared medically fit to leave hospital have all discharge documentation complete.
- Staff are encouraged to think 'home first' and engage with patients and their families to make sure they are involved with and understand care decisions.
- Additional interim care home beds have been procured across the county, so patients can be cared for at the same time as being assessed for their on-going needs. Once this assessment is complete, a permanent placement will be sourced.
- Work is being undertaken to identify homecare provision for people living in rural areas of Northamptonshire to support their return home.
- Incentive schemes are being explored to ensure people using homecare services receive continuity of care over the festive period.

Primary care

The challenge
Sometimes people turn to our hospital emergency departments for help when the care and support they need would be better provided by their GP practice or another community-based service. This might be because of difficulties getting a GP appointment, or it might be because it is not easy for GPs to access the right treatment advice from specialist clinicians or refer them to a specialist service directly.

What are we doing?

- Evening and weekend 'extended access' GP appointments are now offered at a number of 'hub' locations across Northamptonshire. Patients can currently book these appointments themselves, and plans are also being developed for hospitals and the NHS 111 service to book appointments on behalf of patients. Extended access has created an additional 4,000 appointments outside normal hours over the Christmas and New Year period, including bank holidays.
- To support GPs offering additional appointments, a Winter Indemnity Scheme is being run by NHS England from 1 October 2018 to 31 March 2019. This is designed to meet indemnity costs for GPs working outside of core hours this winter.
- A number of pharmacies in Northamptonshire will be offering the NHS Urgent Medicine Supply Advanced Service. Patients in need of urgent medication can be referred to this service by NHS 111, reducing the burden on urgent and emergency care services.
- Both of our acute hospitals offer a service called Consultant Connect. This enables GPs to make direct contact with specialist clinicians for advice on the best treatment for their patients, or refer patients directly to a specialist assessment unit or for hospital care that doesn't require an overnight stay.
- We are developing a new integrated Directory of Services for Northamptonshire so patients and GPs can easily access a list of the health, care and community-based services available to them.

What work is being done? (continued)

What work is being done – and what will that mean for our staff?

Other activity

Delirium pathway

Sometimes while in hospital people are diagnosed with delirium, a period of increased confusion which can follow an infection or treatment for a medical condition. People with delirium are well enough to leave hospital, but the element of confusion makes it difficult to be sure about the on-going support they may need.

The delirium pathway gives people in these circumstances a short period of time between hospital and home so we can be confident they are able to manage independently after discharge. If you feel your patient has delirium, please refer them to the dementia and delirium team.

Non-weight-bearing pathway

People who are medically fit to leave hospital but have a broken bone or plaster cast may require extra support to enable them to return home. There are two options available to patients in these situations while they wait for their broken bone to heal:

- Return home with a package of care to support their personal care needs
- A temporary bedded placement in an extra care facility with staffing available onsite to support their personal needs

Both of these options are accessed through the Integrated Discharge Team.

All the activity detailed in this bulletin is subject to continual reporting and review, with urgent and emergency care leads from all our health and care organisations meeting regularly to monitor progress and resolve any issues as they arise.

For any enquiries or further information about this bulletin please email: **nhcp.communications@nhs.net**