PEOPLE FIRST

Summary of key suggestions

Prevention

- Local services should monitor the health of vulnerable people in their communities so they can:
    - recognise and react to deterioration in people's health
    - provide early support to prevent unnecessary hospital admission.
- Run effective falls prevention programs in all ICS communities.
- Increase the role of voluntary organisations. So, they can provide support and assistance to vulnerable people. For example, those at risk of loneliness and social isolation.
- Index conditions like COPD (chronic obstructive pulmonary disease), frailty and heart failure. So, they are better supported by clinicians working across primary, secondary care and community services.
- Consider widescale use of urgent community response teams (UCRs) to respond to category 3 or 4 emergencies from 999 calls.
- Carry out regular system reviews to identify people who attend urgent care services multiple times. Develop additional support and care for those people to help them stay well and prevent avoidable hospitalisation.

Escalation

- Recognise the role for ambulance services in determining risk across the system. They are often the first organisation to know where demand exceeds the supply of services.
- Make real-time ICS dashboards available to all staff. They should contain relevant, actionable data to inform day-to-day planning and decision-making.
- Acute provider escalation plans should:
    - be visible to all staff and stakeholders
    - be based on live data

    - contain clearly defined escalation points
    - link those escalation points to effective action plans.
- Staff should work to agreed clinical performance standards with mitigations in place at times of pressure.
- Evidence full capacity protocols within provider organisations and the wider system. Mutual support mechanisms should be embedded across the system.
- Consider how best to support trusts in need of mutual aid and support during times of escalation, including financially.

Optimising Pathways

- Provide consistent same day emergency care (SDEC) with clear routes for referrals from other providers. For example, GPs, community response teams, NHS 111, ambulances, or via emergency departments (EDs)
- Give direct access to GP and community service booking systems for acute and social care providers.
- Create urgent community response teams (UCRs) to manage minor injuries in the community. They should include representatives from:
    - GP practices
    - social services
    - community therapy
    - pharmacy
    - senior emergency department decision makers.
- Provide rapid access to support packages 'wrapped around' a person's care. This can help people stay independent and stop a rapid decline in their health.
- Keep an updated directory of services (DOS) for NHS 111 and 999 services. This gives all teams a list of referral options available in primary and community care.
- Implement the new NHS booking and referral standard (BaRS). This standard:
    - allows people to book direct appointments with services in a time slot that works for them.
    - helps healthcare workers triage more efficiently.

Leadership

- Promote use of:
    - cross-service audits
    - innovation in cross-service delivery
- As part of a person-centred strategy that spans the whole ICS.
- Assign an executive sponsor (from any partner organisation) to:
    - oversee urgent and emergency care
    - provide strategic oversight of the whole patient pathway (including admission and discharge).
- Develop local protocols. NHS bodies, local authorities and other partner organisations should work together to:
    - establish the role and responsibilities of each organisation
    - set up planning processes to help staff make the right decisions at the right time about people's short- and long-term health needs.
- Show evidence of system-wide collaboration that aims to:
    - encourage continuous learning between specialties
    - increase safety
    - refine and improve care pathways.
- Establish a stronger presence for clinical leadership roles within leadership and operational models. This is vital. Create Same Day Emergency Care (SDECs) with effective, responsive clinical leadership.

Equality

- Ensure directories of services (DOS) explicitly address people with protected characteristics.
- Develop and design services in coproduction with local communities. Create pathways that meet the needs of people at place and neighbourhood level.
- Irrespective of diversity demographics, consider the creation of:
    - equality and diversity champions at operational levels
    - diversity boards within governance structures.
- Create an inclusive workforce culture that supports diversity and equality in senior roles.
- Give people information in a suitable, easy-to-understand format.

- Increase education and training support across the whole system. This improves access to good quality training for all staff.
- Assess how the delivery of different models of care may worsen health inequalities, perhaps inadvertently. Take into account:
    - various options for commissioning models and agreements at the integrated care board level.
    - reduction of disparities between urban and rural areas.
- Recognise and understand how inequalities and deprivation affect different neighbourhoods and places within integrated care systems. Respond accordingly across the system.

Flow

- Adopt the recommendations from Patient FIRST.
- Ensure home transport systems are timely and effective and cover all the organisation's catchment areas.
- Use hospital at home and 'virtual wards' to provide practical support for early facilitated discharge.
- Show evidence of effective initial assessment by senior decision-makers in services.
- Provide the correct number of senior decision-makers in 111, 999, primary care and acute services. Determine the number needed based on patient acuity and demand. Staffing levels should be regularly reviewed to ensure the right level of risk is taken.

Innovation, information and technology

- Share IT systems across the ICS to give system partners live, relevant and accurate data. Provide the right amount of support to implement it well.
- Make sure electronic patient records are available to all system partners.
- Use technology that aids effective decision-making, while minimising the need to switch between IT systems. For example, digital notes that include blood tests and radiology on the same system.
- Use virtual review systems to reduce avoidable hospital admissions and delayed discharge.

- Explore innovative partnerships with networks from academia, research and industry.
- Plan safe and efficient flow of people in acute trusts using future prediction models such as:
    - predicted attendances
    - projected occupancy for beds in care homes, intermediate care and discharge to assess.
- Consider digital solutions that help support people with urgent health and care needs.

Risk Sharing

- Establish a system-wide risk register that tracks risks in real-time across sites and services. This gives everyone an overview of risks across the system as a whole. It also offers accountability and helps system leaders decide how risk can be best shared across the entire ICS.
- Measure potential and actual harms regularly, and across the whole ICS. Share this information so action can be taken in real-time.
- Share risk, indemnity, accountability and responsibility across the ICS. Integrated Care Boards should be aware of risks across the entire UEC system, including those which start in the community and ambulance response times.

Staffing and training

- Build and incentivise a fully flexible and sustainable workforce. Use a system-wide approach with the right number of people and the right skills mix to deliver care as needed across the ICS.
- Offer innovative and flexible staff rostering. Examples include, self-rostering, annualised jobs plans, combined rotas and surge staffing.
- Enable staff to develop transferable skills so they can move between organisations.
- Support staff health and wellbeing, for example provide 'safe' areas for staff to use on shift and clear routes for feedback.
- Upskill community and acute teams to work smoothly across organisations where necessary.

- Provide frailty in-reach teams and specialised care for older people in emergency departments seven days a week. Collect frailty and dependency data from those patients that have not been diagnosed before.
- Give the right clinical validation and support to NHS 111 and NHS 999 to help safely reduce avoidable hospital admissions.

Transformation

- Equalise pay, terms and conditions across the health and social care workforce.
- Shift from a primarily hospital-based model of urgent and emergency care, to one that provides more services in the community.
- Use person-centred design principles to deliver care that prioritises people's needs, not the system itself.
- Share accountability and learning as part of a joined-up safety culture.
- Create public information campaigns, so people know the right service to turn to when they need help.
- Be honest about when, where and how people will receive care. Build upon learning from the pandemic to simplify governance and bureaucracy.
- Use transformation funds that are affordable and already available for NHS commissioners. For example, the Better Care Fund (BCF).