PEOPLE FIRST: a response from health and care leaders to the urgent and emergency care system crisis

PEOPLE FIRST is a resource to help system leaders and service providers. It was designed and developed:

- using outcomes from CQC's urgent and emergency care workshop, held in May 2022
- by members of the CQC National Emergency Medicine Specialist Advisor Forum.

This new resource recognises the unscheduled care pathway as a continuum, with solutions required across the artificial divides between primary, secondary, community and social care. It aims to:

- support the design of person-centred urgent and emergency care services
- encourage innovation across integrated care systems.

Contributors

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We would also like to thank our colleagues from across health and social care who gave up their time to join us at our London workshop in May 2022. People shared their first-hand experiences on the front-line with us, both in audience conversations

and in frank table-top discussions. Their invaluable help made this event highly regarded and valued. It also greatly informed PEOPLE FIRST and its recommendations.

Finally, our very sincere thanks to Margaret and Rachel Young, who kindly agreed to share Margaret's story with us. They hope their reflections will make a difference, and we are grateful for their honesty and courage. We urge fellow health and social care leaders to reflect on the issues discussed and on the positive changes that can be made together.

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How to use PEOPLE FIRST

What PEOPLE FIRST is

PEOPLE FIRST is a practical resource designed to help system leaders and service providers:

- embed the principles of person-centred, urgent and emergency care within (and between) integrated care systems
- encourage innovation and share examples of good practice.

It was developed from the outcomes of CQC's urgent and emergency care workshop held in May 2022, by members of CQC's National Emergency Medicine Specialist Advisor Forum.

The forum consists of senior clinicians who provide professional and specialist advice to CQC in carrying out its work. The workshop was attended by more than 250 leaders from across health and care. They all understand and are witness to the impact of the current pressures on people and on staff every day.

How to use PEOPLE FIRST

The resource is divided thematically and covers the following topics:

- Prevention
- Escalation
- Optimising Pathways
- Leadership
- Equality
- Flow
- Innovation, information and technology
- Risk sharing
- Staffing and training
- Transformation

Each section shares the views of current system leaders on the pressures and challenges the sector faces. This is followed by actionable key suggestions and good practice examples. These aim to inspire other system leaders to effect positive change.

Sources

PEOPLE FIRST builds on learning from:

- CQC's urgent and emergency care workshop held in May 2022
- Margaret's story
- CQC's urgent and emergency care system wide inspections from 2021/22
- Patient FIRST, a support tool created for emergency departments, published in 2020.

About the urgent and emergency care workshop, May 2022

Following the UEC systems inspections, CQC convened an urgent and emergency care workshop. The workshop's outcomes are the building blocks of this resource. Around 250 leaders came from all sectors: adult social care, primary care, community healthcare, urgent care, acute and ambulance NHS trusts, and mental health trusts. They aimed to solve three questions:

1. How do we support people to stay well at home, and what services do we need to do this?
2. What services do we require to ensure a person with a new unmet care need is seen by the right team, in the right place at the right time?
3. How can we safely discharge people from hospital as soon as they are able, with the right care and support in place?

Foreword by
Sir Robert Francis, KC

No-one can deny that our emergency services are in a critical state, and with bed capacity now overwhelmed in our hospitals, they are constantly failing to meet reasonable expectations for response times, quality of care and safety. The importance we accord to emergency care is demonstrated by the inclusion of standards for response times in the NHS Constitution.

The performance figures against these standards speak for themselves. In August 2022:

- the England mean average response time for Category C1 [life threatening, such as a cardiac arrest] was 9:08 (standard = 7 minutes), and the 90th centile was 16:20 minutes (standard = 15 minutes).
- the C2 [such as a chest pain or stroke] mean response time was 43 minutes (standard = 18 minutes), and the 90th centile was a staggering 1 hours 33 minutes (standard = 40 minutes).
- of the patients who attended an emergency department (type 1) only 58% had a decision made to admit, discharge or transfer them in four hours.
- 28,756 patients waited in an emergency department for more than 12 hours after a decision was made to admit them. In August 2021 this was 2,787 patients.

In April 2022, the mean average time from 999 call until arrival at hospital for patients who had a stroke was 1 hour 54 minutes. To that has to be added the 58 minutes to receive thrombolysis and/or the 1 hour 30 minutes to get from arrival at hospital to a CT scan.

Similar if not more alarming figures could be produced for the response after arrival at emergency departments, confirmed by the almost daily reports of alarming ambulance queues.

However, the figures do not address the reality of what this means for patients. That is why Margaret's story, which has inspired this paper, is so important and should be

watched by all who read this. It shows how in one case, but a case clearly representative of so many others, the dysfunction of the system leads to serious deterioration in health and a corresponding increase in the demand on the service as a whole.

This paper rightly describes the situation as a system crisis and alerts us to the danger of gross delays becoming the new normal, while undermining the trust and confidence the public are entitled to have in their NHS and social care services and the already stressed morale and wellbeing of our hard working and dedicated NHS and social care staff.

Fortunately none of the leaders brought together to inform this paper are complacent, and all are committed not just to identifying the systemic issues which combine to cause these awful results, but to describe the actions which could change things for the better. I was privileged to participate in discussions attended by 250 leaders from all points in the system, from frontline services to ICS to national level. It is out of their contributions and their real life experience that the suggestions in this paper have come.

I suggest that all members of ICS Boards and Partnerships should ask themselves how they can implement each and every one of the suggestions, if they have not done so already. It has been clear for a long time that the crisis in emergency care cannot be solved by that part of the service alone. Change is required throughout health and social care services. Patients cannot wait until the gaps in staffing have been addressed when there is not even a national workforce strategy in place. They will not get the safe treatment and care they need unless the staff we now have are given all the support they need. Our hospitals will not regain the capacity they need to cope with increased demands without new ways of working.

The time to action many of the recommendations in this paper is now. Patients like Margaret are entitled to no less.

Sir Robert Francis, KC

Chair, Healthwatch England

Introduction

In summer 2022, following a series of coordinated inspections across the urgent and emergency care pathway in 10 integrated care systems, CQC convened a workshop to bring together leaders from across health and care. These leaders came from all sectors: adult social care, primary care, community healthcare, urgent care, acute and ambulance NHS trusts, and mental health trusts.

These clinical leaders described an urgent and emergency care system in crisis – the system now routinely sees people spend over 12 hours in emergency departments, one that is working constantly at maximum capacity, without the ability to pass patients safely onto full wards. A system where nationally ambulances now regularly queue outside hospitals, and for sustained periods of time. Although recently this was common in some major emergency departments, this scale and challenge is something never before witnessed. A system where people in the community are at risk of, and at times coming to, avoidable harm when they can't access emergency and urgent care services. Where severe challenges to community and primary care provision mean that people are deteriorating in their places of residence, and sometimes being unnecessarily admitted to hospitals. Where social care has such severe staffing problems that it can no longer sustain the pressures put upon it.

The conclusions they came to paint a stark picture of a health and care system in crisis, with people experiencing avoidable harm as a result. The workshop focused on what the response should be: from leaders, from staff, from national oversight bodies including CQC and from government. It recognised that action is needed from all parts of the system, and identified opportunities for integrated system improvements that see partners and regulators working together for the benefit of patients and populations.

This document is the output of those discussions, created and driven by CQC's National Emergency Medicine Specialist Advisor Forum. The forum consists of a number of senior clinical leaders who provide professional and specialist advice to CQC in carrying out its work, and who see the impact of the current pressures on people and on staff every day.

The workshop feedback was unanimous in the need to bring about change; radical and bold solutions must be urgently sought and sustainably delivered, to ensure

that fears that this situation represents a worrying new status quo within the health and social care are not realised.

They were clear that solutions must not focus on the NHS alone – that system leaders need to move away from reactive 'quick fixes' such as tents in the car park or corridor care to proactive long-term solutions and to address the enormous gap in resources and capacity.

In developing their ideas and suggestions, and to ground their discussions in the huge challenges that people in need of care are facing every day, colleagues have used the story of Margaret, as told by her daughter Rachel. There are thousands of people like Margaret in England currently, living with frailty, but this could be anyone across England with an unmet health or social care need.

This document sets out what the clinical leaders believe is needed to bring about real change, centred on the following:

1. Build collaborative leadership and a strong, open and honest culture

These form the basis of effective health and social care systems, but they are not always encouraged or rewarded. Accountability is often limited to individual systems or services, without wider consideration of accountability held in other, often related systems, or between systems. What is needed is collaborative leadership, a strong, honest and open relationship with people, and a culture of learning and improvement.

2. Share the risk across and within hospitals and the whole health and social care system

The new integrated care systems need to use their autonomy and budgets to affect radical change. Margaret spent a substantial amount of time outside the places best suited to her particular needs, with the inevitable increased risk of harm at each stage. This risk can be reduced through better access to, and therefore risk sharing between, pre-hospital care, the emergency department, inpatient care and social care.

3. Optimise flow and pathways

Connecting care, resources and systems so that people can seamlessly flow from one part of health and social care to another, while maintaining safety and quality, effective outcomes and people's positive experiences. Margaret's journey was characterised by barriers across multiple care providers and systems. Many of the flow and pathway challenges faced now appear hard-wired: barriers to accessing social care, which result in barriers to accessing inpatient care, which result in barriers to providing elective, cancer and urgent care, which result in barriers to timely primary and pre-hospital care.

Optimal pathways should identify risk, with early support from local services, including connected pathways for frailty and social care (inside and outside the hospital).

4. Work to retain experienced and valued staff

Ways need to be found to retain NHS and social care staff and avoid them leaving for other organisations – by ensuring sustainable workloads, a work-life balance and better pay, terms and conditions, and by supporting the staff who stay. Services that are excessively supported by inexperienced or agency staff will increase the risk to people and compromise their safety. There need to be ways to incentivise staff who are willing to work flexibly across the system, including between the NHS and social care.

In support of these themes, a number of clinical leaders from the National Emergency Medicine Specialist Advisor Forum have come together and, using the outputs of the workshop, developed the PEOPLE FIRST resource, to help system leaders and service providers. Building on Patient First first developed by CQC in 2020, this new tool recognises the unscheduled care pathway as a continuum, with solutions required across the artificial divides between primary care, secondary care, community care and social care.

The aim of PEOPLE FIRST is to support everyone to design person-centred urgent and emergency care services and to drive innovation across the system.

Margaret's story

Meet Margaret and Rachel

Told by her daughter Rachel, Margaret's story spans the breadth of primary, secondary and, community healthcare and social care. It powerfully illustrates how the current challenges facing health and social care affect people's lives.

There are currently thousands of people like Margaret. In Margaret's case living with frailty, but this could be anyone across England with an unmet health or social care need.

Margaret's story

Watch the film of Margaret's Story

The impact

The health and social care system in England is currently facing severe challenges, this meant it did not deliver for Margaret.

People's healthcare needs should determine the care that they receive, not system pressures. It is also vital to help people stay well and independent for as long as possible. As Margaret's story sadly shows, people can experience significant anxiety and harm if they are not cared for by the right team, in the right place, at the right time.

Many exceptional people cared for Margaret, including frontline clinicians and care workers. But, a more personalised and joined-up care plan may have enabled her to stay well at home for longer.

PEOPLE FIRST and Margaret

The aim of the solutions in this resource is to help address the serious challenges faced by Margaret, her family, and those who provide care.

Access to timely, **preventative care** could have helped Margaret. Local services could have provided routine assessments and interventions if they were able to recognise her needs sooner. With support in place, Margaret could have stayed safe and well at home for longer.

Margaret could also have benefited from **optimised care pathways**. Her journey reflects an absence of joined-up care provision. Lack of access to care in her own home led finally to hospital admission.

Margaret experienced difficult and stressful waits in the ambulance and the emergency department. It is crucial that the right senior clinical decision maker sees people to assess their needs. This ensures the best clinical triage at the first opportunity.

An Urgent Community Response team visit may have prevented Margaret from being admitted to hospital. They could have managed her head injury at home and decided what further support she needed.

When Margaret was admitted to hospital, staff should have treated her delayed discharge as a potential harm event. She could have benefited from frailty team provision and a Home First approach to her care.

Instead, like many older people, Margaret health and wellbeing deteriorated in hospital. This meant ultimately, it was no longer safe for her to return home.

Margaret's story also echoes the experience of millions across the country who struggle to access dental care. Without timely treatment, a person's needs can escalate quickly, resulting in pain and loss of dignity.

Flow is crucial if integrated care systems are to be successful. Margaret's health needs brought her into contact with multiple care providers and systems. Artificial barriers between services and long waiting lists in parts of the system make it difficult for people to be transferred easily between services.

Risk sharing can also make a difference. Margaret spent lots of time in care settings that were not best suited to her healthcare needs. This inevitably led to an increased risk of harm. People should receive care in the right environment for their healthcare needs, regardless of service demand. The new integrated care systems will make it easier to monitor risks across pathways and take action to mitigate the effects of excess demand for services.

Her story shows the pressing need for effective, compassionate joined-up care. **Collaborative leadership** is essential to make this work. Cross-system, multi-professional leadership will help improve safety, quality of care and people's experiences.

A lack of **shared data and information** complicated Margaret's journey. Shared GP records would have enabled staff across many services to see Margaret's medical history. It encourages consistency of care and means essential information is not missed. Communication between services and people is also improved, reducing frustration and reassuring people and their families.

Significant **transformation** of the health and social care sector is needed to improve everyone's safety and quality of care. The difficulties Margaret and her family faced show clearly the cost of inaction.

Despite the current challenges, there are positive examples of innovation and change. **PEOPLE FIRST** aims to share this learning with colleagues across health and care. Its authors hope, much like Margaret and Rachel, that sharing their experience and knowledge will improve care for everyone.

We encourage fellow system leaders to share this story with colleagues, as part of operational and strategic discussions. Ask your teams "would this change make a difference to Margaret and her family?"

Prevention

Aims

Helping people to remain well at home is crucial.

To do this, the new integrated care systems (ICSs) should aim to:

- identify vulnerable people at risk of hospitalisation
- provide timely, preventative care
- help people avoid hospitalisation where appropriate.

Context

Services within each ICS must help people to:

- stay well
- maintain a healthy lifestyle
- avoid hospital admission where possible.

Local services need to be able to recognise and react to a decline in people's health in a timely way. It is essential to be aware of emerging risks and needs for the individual and at a wider system level.

Services should use risk assessments and appropriate forms of monitoring. They can then use this information to plan personalised care. Care plans could include referrals to local, non-clinical services through social prescribing. For example, in cases where people are at risk from social isolation. Early access to community services is crucial so people can get advice and support they need.

Services should also be able to refer people to other parts of an ICS quickly and efficiently. Including referrals to a dentist.

Across England, COVID-19 has compounded pressures on dental services. In May 2021, CQC published COVID-19: Dental access during the pandemic. It reported that the reduction in capacity due to the pandemic had significantly impacted access to

dental care. Similarly, Healthwatch England's Annual Report for 2020/21 (published February 2022) reported a 452% increase in feedback about NHS dentists. Access and affordability were people's two main concerns.

Key suggestions

- 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.

Examples of Good practice and innovation

Pre-transfer clinical discussion and assessment
Leicester, Leicestershire and Rutland ICS

For some people, assessment in a hospital setting can be avoided. Nursing teams can proactively take ownership of people. Reassessment and support can then be provided as needed through visits in the community.

See NHS confederation: Pre-transfer clinical discussion and assessment in Leicester, Leicestershire and Rutland ICS.

‘Ageing Well’
Frimley ICS

Frimley ICS has created a steering group called 'Ageing Well'. It aims to help people living with frailty at home. The group focuses on delivery of:

- Enhanced health in care homes
- Anticipatory care
- Urgent community response (UCR).

It provides various types of support, including community rehabilitation and inpatient resources. They also have a virtual frailty ward that helps prevent unnecessary hospital admissions.

Urgent treatment centre
West Cornwall Hospital, Royal Cornwall Hospital NHS Trust

This urgent treatment centre has a team of proactive GPs upskilled in several additional clinical areas. This means the centre can provide a service that prevents patients from needing transfer to the emergency department in Truro. It can also provide other tests and observations on site.

Local falls teams
North Yorkshire, Mid and South Essex, South Warwickshire

Where local falls teams exist, they can be highly effective. They can provide:

- urgent support
- falls prevention training for social care providers
- education on how to support people before an ambulance arrives on site.

See these NHS confederation case studies for more information:
Collaboration between primary and community services in North Yorkshire
Urgent community response across Mid and South Essex
Reducing conveyances of older patients in South Warwickshire.

Association of Ambulance Chief Executives’ (AACE) repository

The AACE repository is a great resource for good practice case studies.

Clinical support networks for adult social care services

Senior clinical staff of all professions could offer a support network for adult social care services in their area. Members can be from NHS hospitals or the private sector but should represent all relevant disciplines.

The group could provide advice and guidance to services that care for:

- people living with frailty
- people with a learning disability or autistic people
- disabled people.

Early intervention and support can help people stay well in the community and reduce avoidable hospital admissions.

Collaboration between care homes and dental practices

There are pilot projects that link dental practices to care homes:

- to provide oral health training
- be a single point of contact for care homes, so they can share concerns about the oral health of people who use their service.

This is an excellent example of different services sharing skills and providing preventative care. Early interventions like these can reduce the likelihood of people experiencing dental pain and improve quality of life.

Escalation plans made available to all health and social care professionals

Some GP shared records make treatment escalation plans available to all health and social care professionals. This helps services to provide care that respects the advanced directives of the person needing care. For example, it means hospital admissions only occur if in line with the person's agreed wishes.

Escalation

Aims

Integrated care systems should create effective escalation processes with tangible calls to action, so services across the system can effectively carry them out. All staff and services must understand the escalation plan and how it relates to them.

Context

Escalation plans can often be poorly executed, unworkable or misunderstood by the wider system.

Integrated care system partners and leaders must work together to create effective, system-wide escalation processes. System leaders need to make sure system partners share escalation information. Providing clear routes for feedback is important too. This helps to establish what level of escalation a system is currently in and what actions services should take.

A regularly updated, coordinated escalation plan will identify risk at all system levels. This is very important if integrated care systems are to deliver safe, good quality care. It also helps share risk across services, particularly in a stretched system.

Organisations and staff can become immune to the various levels of escalation if plans are not updated and measured frequently. The best escalation plans are easy to understand and visible to all staff. They show what actions are being taken to mitigate or overcome pressure. This reassures staff that escalation levels are more than a statement of the current status. They are a call to action.

Key suggestions

- 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.

Examples of good practice and innovation

Cheshire and Merseyside ICS

During the inspection of this ICS, CQC saw direct routes in mental health services that signposted people to the right care as quickly as possible.

They also saw proactive management of escalation processes by the ambulance service. This focused on a system-wide response when there was additional pressure on services.

Read the Cheshire and Merseyside ICS UEC system report

North East London Urgent and Emergency Care Hub

Clinical and operational teams from across the system meet 3 times a week to discuss flow across the system. The teams include representation from:

- acute hospital trusts
- the ambulance service
- mental health
- community services.

These regular meetings have improved transparency and accountability between providers. It also provides a space where teams can request or supply mutual aid when needed.

If escalation levels rise any participant can trigger a call at any time.

Optimising Pathways

Aims

Integrated care systems (ICSs) should create person-centred pathways that support people to live healthier lives.

Context

Data and knowledge are often siloed in services and unavailable to the wider ICS.

When people cannot access the care they need, their health can quickly deteriorate. Hospital admission can become unavoidable. For some, often those living with frailty, there is a further risk of hospital-acquired deconditioning. Deconditioning means there has been a decline in functional, cognitive or physical health. It is caused by prolonged periods of bed rest and inactivity. Ultimately, it can be unsafe for some people to return home as they now require full-time care.

We can avoid these situations if we:

- identify patients who are at risk
- provide early support through local services
- create effectively integrated care pathways for frailty and social care
- provide more senior clinical decision-makers to triage people at an early stage.

Key suggestions

- 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.

Examples of good practice and innovation

Safely reduce conveyance of older people
South Warwickshire ICS

South Warwickshire ICS wanted to reduce unnecessary transfers of older people to hospital. The trust and ambulance service decided to work together using virtual wards. This meant ambulance crews could contact clinicians on-scene to seek advice. As a result:

- 48% of cases in people over 80 were managed from their homes.
- only 25% of those over 80 needed transfer to an emergency department.
- those admitted to hospital had reduced length of stays.

See full NHS confederation case study.

Planning to safely reduce avoidable conveyance, ambulance improvement programme
NHS England and NHS Improvement

This publication aims to safely reduce the number of people conveyed to emergency departments (EDs). It identifies areas for nationwide improvement. For example, ambulance services need on-scene access to consultant advice. Some ICSs already do this. In fact, some are developing ways to share videos and images between teams to support this work further.

See Planning to Safely Reduce Avoidable Conveyance to read the full publication.

Safely reduce avoidable conveyance of children Blackburn Royal Hospital

Schemes also exist to avoid child hospital admissions safely. For example, Blackburn Royal Hospital gives GPs direct access to guidance from senior paediatricians or community paediatric outreach teams.

Use of multidisciplinary teams (MDTs) in end of life care

There is excellent work happening in this pathway. Some MDTs have members from across the ambulance service, primary and secondary care. End of life care needs to be a national priority. It is essential to treat people and their loved ones with dignity, and to support their wishes at this critical moment.

Community Diagnostic Hubs

Increase the use of community diagnostic hubs that include services such as pharmacy, dental, nursing and diagnostics. This will make it easier for people to access the care they need. It also reduces pressure on emergency departments caused by non-urgent visits.

Leadership

Aims

Be brave and willing to test new ideas. Collaborative leadership enables shared responsibility and accountability. This can lead to improved population health across the ICS.

Context

Collaborative leadership forms the basis of effective healthcare systems. But, as described in the Health and social care review: leadership for a collaborative and inclusive future (also known as the Messenger report), this is not always encouraged or rewarded. Accountability is often limited to individual systems. There is frequently no consideration of other, often related, systems. Or the relationships between those systems. See Next steps for integrating primary care: Fuller stocktake report for details.

Leadership that engages with regular feedback from staff can develop a robust, open and honest culture. System leaders should encourage a safety culture across their ICS that:

- learns from mistakes
- offers feedback opportunities to all staff.

Leadership development schemes should be made consistently available for primary care. They should be comparable to those at other NHS providers. If successful, they will:

- promote multi-professional leadership across primary care
- increase diversity across primary care and system leadership.

Key suggestions

- Promote use of:

    - cross-service audits
    - innovation in cross-service delivery
- As part of a person-centred strategy than 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.

Examples of good practice and innovation

Same day emergency care (SDEC)
Northwick Park Hospital (part of London North West University Healthcare NHS Trust)
University College London Hospitals (UCLH) NHS Foundation Trust

There are many ways to offer same day emergency care. CQC's UEC systems inspections found some approaches are more successful than others. Northwick Park Hospital and UCLH NHS Foundation Trust use different models for their SDECs. But both are highly effective. Workshop attendees felt that SDEC is more successful when it is:

- flexible and able to adapt to the needs of patients.
- led by the clinical teams that can best support patient demands.

Black Country and West Birmingham Primary Care Collaborative

The Fuller report praised Black Country and West Birmingham Primary Care Collaborative for:

- promoting the interests and sustainability of primary care services
- ensuring a single voice for primary care in decision-making at all levels within the ICS.

The collaborative joins up primary care professionals across the Black Country, including:

- GP practices and federations
- primary care providers and care networks
- local medical committees.

It plays a leading role in the ICS's primary care transformation strategy. It also acts as the primary care Expert Reference Group for their local Integrated Care Board (ICB).

Collaborative leadership
West Yorkshire ICS

West Yorkshire ICS wanted to reduce the number of days people stayed in hospital when medically fit to return home. System leaders formed a discharge group that met weekly to find ways to help people return home safely as soon as they were ready. The group introduced:

- initiatives that shared success across teams and services
- risk appetite assessments in each service to manage local risk
- a transformative culture where leaders share skills and knowledge to improve outcomes.

Equality

Aims

Everyone who needs care should have:

- equitable access to services
- excellent experiences during their care
- the best possible outcomes.

Also, health and social care workers should be able to do their jobs in a supportive environment that is equal, diverse and inclusive.

To achieve these goals, integrated care systems (ICSs) need to:

- reduce the health inequalities experienced by their local population
- improve the workplace culture at system-wide and service level.

Context

What are health inequalities?

Health inequalities exist across England. For those who experience them, they can lead to reduced life expectancy, behavioural risks to health, and avoidable harm or death. They also increase pressure on the health and social care system.

Addressing health inequalities is one of the four main purposes of the integrated care system model. System leaders will need to work closely with partner organisations to achieve this.

The King's Fund defines health inequalities as "avoidable, unfair and systematic differences in health between different groups of people." This can be differences in:

- outcome, such as life expectancy
- access to services
- experience of care

- opportunities to live a healthy lifestyle.

How someone experiences those differences can depend on a combination of factors, including income, location, specific characteristics (such as those protected in law), or if they are part of a socially excluded group (for example, people experiencing homelessness).

People can experience multiple factors and inequalities at the same time. These overlaps (often called intersectionality) mean we should consider people's varying experiences and not see groups of people as homogenous. ICSs should develop policies that reflect this, using person-centred methods.

Reducing health inequalities in integrated care systems

Integrated care systems can use NHS England's Core20Plus5 framework to reduce inequalities in their local population. It helps identify:

- groups in their population who experience poor care
- ways to improve access, experience and outcomes for those groups.

Systems must ensure they meet the needs of groups with protected characteristics. Important groups to consider include:

- people with learning disabilities and autism
- people with serious mental illness
- socially excluded groups, for example, people experiencing homelessness or vulnerable migrants.

Addressing the social causes of health inequalities will improve the health and wellbeing of a system's local population. NHS England's Equality and Health Inequalities Hub has lots of resources and information on this.

Access to good care should not depend on a person's financial situation or location.

For some, English may not be their first language. If they do not have an advocate, navigating the health and care system can be difficult. Access is also difficult for other groups of people, for example people with a learning disability or autism.

Digital innovations can improve access for some groups. But we also need to support groups marginalised by a Digital First approach. See more about this in Regulators' Pioneer Fund project: Regulatory recognition and sharing of innovative practice by NHS GP providers to reduce health inequalities.

A shortage of dental appointments has also widened existing health inequalities. In particular for regions with few NHS dentists. Known as "dental deserts", these areas present a serious risk to the dental health of millions of patients. Currently, oral cancer and type II diabetes cases are on the rise. Dentists could detect these diseases earlier if everyone had access to regular dental check-ups.

Evidence gathered from CQC inspections and stakeholders highlights areas of good practice, for example:

- have an up-to-date directory of services (DOS) for an area. It should be accessible by providers and people who use services.
- include inequality boards within governance structures, including UEC boards.
- create inequality and diversity champions in all parts of the system.

Improving workforce equality, diversion and inclusion

Partner organisations also need clear strategies to overcome disparities in workforce equality, diversity and inclusion. They can achieve this through positive culture change and support for their staff. People working in social care settings may not have the same terms and conditions as healthcare workers. They are also more likely to come from a lower socio-economic group and have other protected characteristics. See further details in the Department of Health and Social Care's Adult social care workforce survey: December 2021 report.

Useful resources

Build Back Fairer: The COVID-19 Marmot Review

Royal College of Physicians (RCP), The NHS 'Road to Recovery': Ethical guidance for endemic COVID-19

Key suggestions

- 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.

Examples of good practice and innovation

Population health and health inequalities steering group
North East London Integrated Care Board (ICB)

North East London has high levels of deprivation and health inequalities. To face these challenges the ICB has set up a steering group that provides strategic leadership for:

- population health management
- reducing health inequalities.

Their successes include a reduction in vaccine inequality. This was achieved using data analysis, local interventions and outreach.

Tackling inequalities in health care access, experience and outcomes NHS England

This guidance contains many useful case studies that highlight good practice in this field. See the full document tackling inequalities in health care access, experience and outcomes.

Flow

Aims

Flow throughout the system is crucial to help services provide timely and effective person-centred care. There must be enough capacity to manage demand.

Context

The flow of people in and out of services needs to improve if integrated care systems (ICSs) are to provide effective, joined-up care for people.

Currently, the healthcare system features several barriers that create difficulties throughout an ICS. Barriers to accessing social care can result in delayed discharge for people. This, in turn, makes it difficult for other patients to access inpatient care, which affects provision of urgent, elective and cancer care. Finally, this affects access to timely primary and pre-hospital care.

ICSs must use their autonomy to seek and provide solutions that dismantle these barriers.

Useful resources

DHSC guidance on hospital discharge and community support

Royal College of Emergency Medicine's Winter Flow Report

BMJ Journal: Six ways not to improve patient flow: a qualitative study by Sara Adi Kreindler

Future Healthcare Journal: Possible futures of acute medical care in the NHS: a multispecialty approach

Key suggestions

- 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.

Examples of good practice and innovation

Working together to improve flow
Walsall Healthcare NHS Trust

The trust introduced several measures to maintain flow and reduce ambulance handover delays. They created:

- the Walsall Together partnership of health, social, voluntary, housing and community organisations
- a highly functional discharge lounge
- multi-specialty Same Day Emergency Care (SDEC) units
- culture and leadership that engages services from all specialties.

Listen to ECIST's (Emergency Care Improvement Support Team) podcast: Ambulance Handover Improvements at Walsall Healthcare on YouTube

Long length of stay Wednesdays
Barnsley Hospital NHS Foundation Trust

This trust holds 'long length of stay Wednesday' meetings each week to discuss:
people who have been hospital inpatients for longer than 7 days
identify barriers to safe discharge.
As part of this, they use:

- a SAFER flow bundle from NHS Improvement (this is a practical tool to reduce delays for patients in adult inpatient wards)
- a length of stay dashboard with executive oversight.

Listen to ECIST's (Emergency Care Improvement Support Team) podcast: Managing risk in the emergency department on YouTube

Discharge to assess (D2A) service
South Warwickshire NHS Foundation Trust

South Warwickshire's D2A pathway is for people who are medically fit to go home, but are waiting for results, routine tests, physiotherapy or home care packages. They commission local care homes and individual practices to provide additional temporary care to help people access the care they need to step down to returning home.

Innovation, information and technology

Aims

Be radical and ambitious:

- Scale up successful innovative practice
- Share learning more widely
- Embrace integrated technologies.

Context

The collaborative approach needed by integrated care systems (ICSs) requires new ways of sharing data and learning.

At the level of people's individual health data, shared GP records can benefit both systems and the people who use services. See the initiatives at Birmingham and Solihull ICS and Cambridgeshire and Peterborough CCG for more on how this works.

Margaret's story shows how frustrating it can be for people and their families when records are not shared between services. Moreover, if services do not have timely access to a person's health record, there is an increased risk of misdiagnosis or inappropriate care. The COVID-19 pandemic made this issue even more acute, as some people cannot always advocate for themselves. Visiting restrictions meant carers and loved ones were not always present to speak on a person's behalf.

At the level of individual services, we should employ innovative measures of cost, performance and productivity. Impact should be measured beyond individual service budgets. System leaders should also consider their influence on the wider health and social care economy.

The scale and delivery of services should be determined by the root causes of people's health needs. For example, efficient, well-resourced community fall teams

can prevent people, often living with frailty, from significant injury. Not only does this benefit the person, it reduces demand for hospital beds and surgery.

At a system-wide level, information needs to be relevant, easily accessible and actionable. Some data, such as capacity or demand levels could be made publicly available. Sharing insights on system pressures can discourage a 'blame game' culture. It allows system partners to:

- make informed decisions
- share risk across the system
- improve access to care.

It also offers greater transparency for users of services.

There needs to be clear understanding throughout the ICS of what innovations work well. Impact should be measured throughout the ICS. The innovations that perform well should be scaled up.

Sharing this learning is important too. It gives all systems and services the opportunity to learn from each other. They can then adopt or adapt those innovations to suit the needs of the people who use their services.

Key suggestions

- 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.

Examples of good practice and innovation

Virtual clinics

Many virtual clinics were established during the pandemic. They should be maintained and iteratively improved. They include:

- virtual follow-up clinics
- virtual wards, SDECs
- fracture clinics.

They extend to other innovations too. For more information, see Future Healthcare Journal: Possible futures of acute medical care in the NHS and the Hospital at Home Society.

Digital solutions for dentistry
CQC Provider Collaboration Review on Urgent and Emergency Care

In this review, CQC highlighted how digital solutions supported some people with urgent dental needs. They included:

- Remote triage where people send videos and photographs to their dentist to help them diagnose and prescribe.
- 'Attend anywhere' a secure web-based platform for patients with pre-arranged video consultation appointments. This was introduced nationally to improve access for people and reduce travel needs.

CQC's UEC work also saw initiatives that manage demand and capacity. For example, in Gloucestershire, an NHS trust directed people to the appropriate services using both:

- telephone clinical triage
- a dental line that offered a clinical assessment service (CAS).

See the full provider collaboration review.

GoodSAM App
London Ambulance Service and East of England Ambulance Service

Some services have partnered with GoodSAM app. This app connects the ambulance service to a network of trained volunteers by issuing alerts to volunteers on their smartphones. If they are available, they can respond to life-threatening emergency incidents. Subject to robust governance to ensure all volunteers are fully trained, more services could invest in this technology and use it more widely across the country.

Find out more from the London Ambulance Service

Shared system dashboard for ICS partners to support escalation

A system-wide shared dashboard can support escalation measures across an ICS. No decisions should be made on a single metric in isolation. They should offer relevant, actionable metrics that reflect access to all services, not just emergency departments and ambulance handover times.

The dashboard can include access data from:

- GP services
- Dental services
- Walk-in centres
- Minor injury units (MIUs)
- Urgent treatment centres (UTCs)
- Same day emergency care services (SDEC)

This could extend to procedure waiting times, transport services and links, and community and social care bed capacity.

System-wide dashboards that measure performance, productivity and demand beyond urgent and emergency care

The system-wide demand and capacity dashboard may also show the need for services outside urgent and emergency care. For example:

- dental services
- sexual health
- early pregnancy services (EPAU).

System-wide dashboards can also measure productivity and performance. This provides a way of measuring the outputs of services. It can also test the effectiveness of services and pathways, especially when testing new pilots.

Use of artificial intelligence and drones in ambulance services

Some ambulance services are exploring the use of:

- artificial intelligence (AI) in call centres
- drones to deliver automated external defibrillators (AEDs) to remote places.

Risk sharing

Aims

Introduce shared management across the integrated care system (ICS). This requires system partners to be open with each other about risks, so shared management teams can make informed decisions.

Context

People should receive care in right setting for their healthcare needs, irrespective of service demand. Although the majority of integrated care systems can manage demand at normal levels, few are well equipped to deal with excess demand.

Often, this excess demand builds up and manifests in urgent and emergency care (UEC) systems. But it is important to understand that this is often symptomatic of pressure elsewhere in the wider ICS.

The visual of ambulances queued outside emergency departments is only part of the story. For each person waiting in an ambulance waiting to be admitted, there may be many other urgent calls in the community or general practice that still need a response. Professor Keith Willett's letter addressing ambulance handover delays from 2017 states:

"The patients in the urgent care pathway who are at highest risk of preventable harm are those for whom a high priority 999 emergency call has been received, but no ambulance resource is available for dispatch."

All UEC system risks should appear on integrated care board (ICB) risk registers. Also, system leaders should aim to share risk, not just across individual hospitals, but the wider system too.

Key suggestions

- 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.

Examples of good practice and innovation

Risk mapping
North East London ICS

Systems benefit from communication in real-time and the ability to map risks across:

- individual hospitals
- across other services such as ambulance services, mental health trusts and local authority care providers.
- the rest of the ICS

The risks taken by each service are likely to differ, as may the time when they occur. Mapping where and when risks occur across the system means leaders can minimise potential harms by ensuring:

- visibility
- accountability
- shared risk across the system.

Integrated care systems can also use risk maps to track improvements and deteriorations between sites. See this example used by North East London ICS:

Clinical risk sharing checklist - North East London Integrated Care Board (docx, 37.21kB, English)

Staffing and training

Aims

Develop staffing models that:

- are flexible
- can meet current and future demands
- prioritise workforce health and wellbeing
- recognise and reward staff
- value all staff equally
- train staff in transferable skills.

Context

A significant increase in staffing is needed due to increased levels of demand for care. This issue is compounded by the continued impact of COVID-19.

Integrated care systems (ICSs) need to prioritise measures to improve staff health and wellbeing. Many frontline staff report an increase in their own healthcare needs, including mental health issues. Sickness rates have risen throughout the sector.

Implementing these changes will have a positive effect on people who use services too. A happy, healthy workforce is more able to provide excellent care.

Issues around staff retention also need to be addressed. Common reasons for leaving the sector include pay rates, pension issues, flexibility of working and career progression.

Ongoing training and support for existing staff is essential. Retaining trained and competent staff is a good investment compared to recruiting new people. This is because existing staff can support:

- ongoing training
- development of other team members
- development of operational models.

Their knowledge of the organisation is invaluable too.

Overall system design is also important. Staffing decisions should be based on people's needs, not service demands. This means the person who provides care should always be the right person for the task. They should have the correct skills and training to deliver the best possible care.

For more information see:

- NHS England : Our NHS people promise
- Parliamentary committee: Workforce: recruitment, training and retention in health and social care
- Health Foundation: Health and social care workforce analysis

Key suggestions

- 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.

Examples of good practice and innovation

Advanced paramedic practitioners

Some ambulance services have invested in training and education to create advanced paramedic practitioners. Their enhanced skill set enables them to provide advanced on-site care and prevent avoidable hospital admissions.

Advanced paramedic practitioners also provide remote support to other ambulance crews from the control room. In some areas, they can work in partnership with other services, rotating between support for GP practices, GP out-of hours services, urgent care services and minor injury units.

See case studies from London Ambulance Service and the Welsh Ambulance Service in the Association of Ambulance Chief Executive's repository.

Multidisciplinary teams (MDTs)

Incentivise services to share staff from across the system as part of multidisciplinary teams (MDTs). Participation in MDTs broadens and develops skills, as staff from different disciplines learn from working closely with each other. This way of working was more prevalent during the pandemic but has largely reverted in recent months.

Transformation

Aims

Integrated care systems (ICSs) must be bold and ambitious. To improve population health in their area, systems must:

- have a clear vision and strategy in place
- design new care models in a person-centred way
- create a positive, empowering workplace culture for all teams in the ICS.

Context

Real change is needed to improve safety across the sector.

During the pandemic, system partners had to work together in new ways. Governance processes were simplified. Also, services adopted a "can-do, must-do" attitude that erased the barriers between them. System leaders should embrace the lessons learned from this challenging period. Especially now, as the sector shifts to a more collaborative, less competitive structure.

New models of person-centred care should be provided by a workforce that is empowered and inspired by the new ways of working. To help this happen:

- System leaders should collaborate to provide rapid and sustainable solutions to workforce challenges.
- Integrated Care Boards should distribute resources equitably across their systems.

It is also essential to be honest with people about how, when and where they will receive care. Margaret's experience shows how frustrating it can be to receive the wrong information. Prior to admission, she was told the emergency department was ready and waiting for her to arrive, but this was not the case. An unexpected lengthy wait ensued, causing stress for Margaret, Rachel and the emergency department staff who could not meet the expectation set.

Key suggestions

- 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).

PEOPLE FIRST in action

Improving patient outcomes with virtual frailty wards and urgent community response teams.

Frimley Health NHS Trust

Summary

Frimley Health NHS Trust have trialled some of the recommendations from PEOPLE FIRST as part of their 2023-2025 strategy. Through use of virtual frailty wards and urgent community response (UCR) teams, they have:

- improved patient outcomes
- reduced hospital admissions
- decreased the length of hospital stays for some patients
- increased patient satisfaction.

About the UCR and Virtual Frailty Ward service

The service aims to offer people the same level of care at home as they would receive if they were admitted to hospital.

It is equipped to deal with frailty related incidents, including:

- falls
- reduced mobility
- acute confusion
- acute infections
- issues caused by chronic diseases, such as heart failure or chronic obstructive pulmonary disease (COPD).

How the service works

A consultant geriatrician leads the team. It consists of:

- advanced nurse practitioners
- registered nurses
- therapists
- pharmacists
- administrative support.

The service operates seven days a week, from 8am to 8pm, and the team can respond within two hours of receiving a referral.

Referrals can come from a variety of sources, including:

- GPs
- 999 and NHS 111 call operators
- care homes and other social care teams
- therapists
- paramedics
- community nurses.

When they receive the referral, the urgent community response team visit the person in their home. They assess and care for the patient.

At this point, a treatment escalation plan (including a ReSPECT form if appropriate) is completed for each patient.

If the patient requires ongoing care at home, the team will admit them to the virtual frailty ward. But, if patients need more support than this, the team can also refer them to:

- a community rehabilitation hospital
- the frailty Same Day Emergency Care team (or other SDEC services)
- a specialist service in the hospital.

These alternative pathways help to further reduce demand for emergency departments in acute hospitals.

Once enrolled, each patient in the virtual frailty ward receives:

- virtual multi-disciplinary team (MDT) assessments, twice a day
- in-person visits from nurses and therapists, once a day.

During these visits, the nurses and therapists can further assess the patient and provide treatment.

The team discharge the patient when their treatment is complete. The patient may receive ongoing support from other community services if needed.

Equipment and resources used

The team have access to:

- the patient's GP records
- shared care records
- acute hospital notes.

They also have:

- a point of care machine that gives blood results within minutes. This helps the onsite team to make treatment decisions and prescribe safely.
- an ECG machine
- a bladder scanner
- a nebuliser.

This set-up enables the team to administer intravenous antibiotics, fluids, diuretics, nebulisers. They also carry oral medications for common acute medical emergencies.

Results and benefits

From April to October 2022 the team cared for 861 patients. Of these cases:

- 90% of referrals received a response within 2 hours
- 85% of cases avoided hospital admission

- The average stay on the virtual ward was 3.4 days. This is much shorter than the 9-day average for an acute hospital stay
- 100% of patients said they would like treatment at home again in the future, and would recommend the service to others.

The team also observed that patients:

- are more likely to recover quickly at home
- are less likely to experience deconditioning and hospital related harm (such as falls, healthcare acquired infection, medication errors or delirium)
- avoid long waits for discharge prescriptions (TTOs), transport and care packages that can cause delayed discharge from a hospital setting.

In addition, the trust's acute hospitals can now transfer patients to the virtual ward for ongoing care. This means in-patients can also leave hospital earlier. This benefits patients, but also reduces pressure on acute hospitals by improving patient flow.

Future plans

The team has an ongoing communications strategy that helps them to raise awareness and share information about the virtual ward with GP practices, 999 and NHS 111 providers.

The service currently manages up to 15 patients every day, with plans further to expand capacity in the future.

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 than 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).