Lancashire and South Cumbria Integrated Care System











Urgent and emergency care five-year strategy 2024 –2029

Contents

Foreword

Urgent and emergency care services are a fundamental part of our health and care system. They are there to respond when we have an accident or become unwell and need urgent attention from health and care professionals.

These services are under enormous pressure which has been increasing year on year. Demand for urgent and emergency care is rising as more people are living with long term physical and mental health conditions. Nationally, and in Lancashire and South Cumbria, hospitals are busier than before the COVID-19 pandemic. We are seeing long delays for people, including those who are waiting for ambulances and those in hospital beds waiting to be discharged. This means that we are not delivering the best quality of care, experience, and outcomes as we would like. In Lancashire and South Cumbria, we also have significant financial challenges as we are spending more on healthcare than our budget allows. Therefore, we need to reduce spend across our system yet continue to make our services more efficient and effective for the benefits of our population and staff.

However, we are seeing innovation across the NHS in England which is changing the way we work as an entire health and care system: organisations are working more collaboratively together, we are seeking to integrate services across health and social care, we are embracing digital advances and new technologies and we are focusing more on delivering care in the community that is proactive, high quality, and closer to home.

Improving urgent and emergency care is a priority for our system and for the NHS nationally. This is reconfirmed by guidance and strategic planning from NHS England – most recently, the NHS 2024/25 priorities and operational planning guidance and the NHS Urgent and emergency care recovery plan year 2. We are embracing changes, responding to their direction, and working to achieve the national commitment to improve waiting times and patient experience. In 2023/24, we successfully achieved the national target to improve Emergency Department (ED) performance (76% of people seen within 4 hours by March 2024) and ambulance response times (26 minutes 'category 2' non-life-threatening emergency calls within the target of 30 minutes). However, we cannot stand still. This year's national targets are higher and systems are asked to focus on maintaining the expansion of capacity delivered during 2023/24, increasing productivity, improving clinical outcomes and continuing to develop services which shift activity away from acute hospitals for people with unplanned care needs. As a system, we recognise that performance in relation to urgent and emergency care needs to further improve going forwards and we are committed to making this happen for the benefit of our population.

The purpose of this strategy is to guide how we transform our urgent and emergency care services, both clinical and non-clinical, over the next five years to enable people to easily access the right care and support which meets their needs. It describes our challenges and the opportunities for the future; it sets out our vision and priorities. Core to this strategy are - transforming services in the community to deliver urgent care closer to home; eliminating variation in service in different parts of Lancashire and South Cumbria; making sure that services have the right capacity to meet the needs of our population; ensuring our services are fit for the future.

This strategy has been produced by Lancashire and South Cumbria system-wide partners, including acute Trusts, local authorities, North West Ambulance Service, mental health, primary and community care, voluntary and community, faith and social enterprise sector, place-based partners and the public.

While we recognise that the formation of our integrated care system is still in its early stages and evolving, working in partnership at place and system is integral to change the way we deliver urgent and emergency care for the better. Our four place-based partnerships will lead the delivery of this strategy so they can meet the needs of their local communities. They will also collaborate so that everyone, no matter where they live in Lancashire and South Cumbria, will have access to the same standard of high quality, safe and timely urgent and emergency care.

We recognise the enormity of the ambitions we are describing but we want to be bold and aim high to improve services for our population. By working together, we can achieve our vision set out in this document.

Thank you to all partners who have supported the development and production of this strategy.

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Executive summary

Our challenges and opportunities

We know the key factors which are contributing to pressures in urgent and emergency care: population growth, more people living with long-term conditions, high levels of deprivation, unhealthy lifestyles, variation in our services, poor quality of some of our healthcare buildings and workforce shortages.

These factors come together to emphasise the need for resilient, high-quality urgent and emergency care services which can respond in a timely manner when someone becomes unwell, and support them to recover and remain as well and independent as possible. These services must be fit for the future and able to manage increasing demand. Therefore, we need to do things differently.

Our vision is to create

An urgent and emergency care system that enables people to easily access the right care and support, at the lowest level of intervention, that best meet their needs, and delivers better outcomes and affordability.

Our five aims are:

1. Adapt our urgent and emergency care system so that it is fit for the future to meet increasing demand.
2. Ensure people can access high quality, safe and affordable care, in the right place by the right professional.
3. Enhance preventative care and proactive care to reduce avoidable contact with urgent and emergency care.
4. Address the needs of our local communities.
5. Embrace opportunities for innovation.

Our commitments and what this means

In this strategy, we make commitments. These are the priority actions we are implementing which will enable us to achieve our aims over the next five years. This strategy, and our commitments, are aligned with the three areas of focus in our system recovery and transformation plan to reduce waste and duplication, improve quality and transform services.

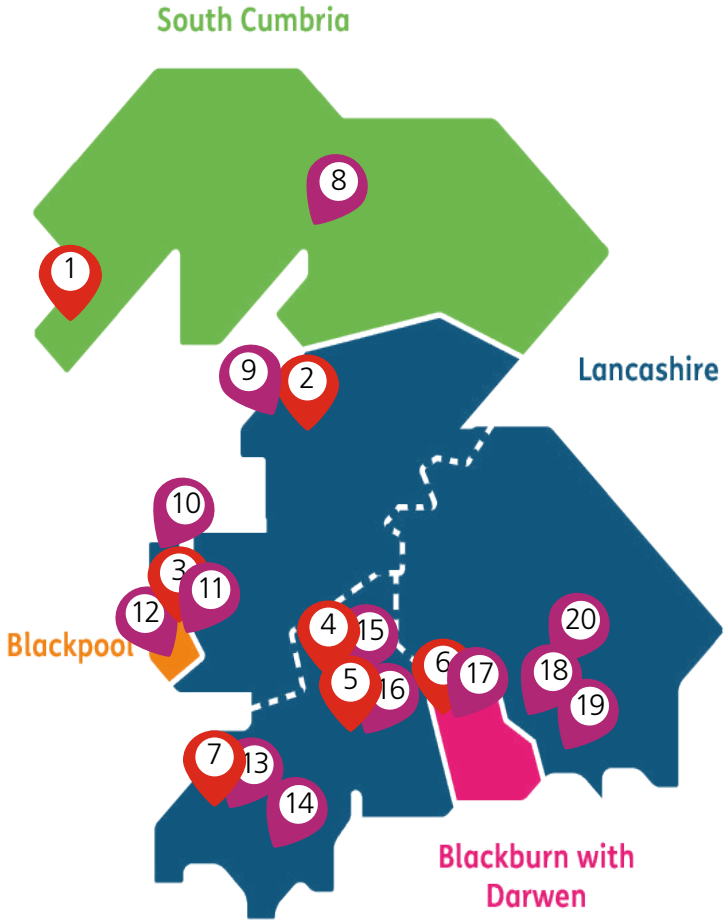
This will deliver benefits for our population and the staff who work in our health and care services. We will improve quality of care, experience for our patients and staff, and performance. This strategy is for all ages and covers urgent and emergency care for physical health, mental health, and care needs.

Urgent and emergency care involves many different services and organisations and is interdependent with many other aspects of our health and care system. Working together as an integrated care system is paramount. We will continue to involve the public and listen to what matters to them at each step of the way. We do not underestimate the scale of the asks within our strategy. However, we are confident that with a whole system partnership approach, we will improve our urgent and emergency care system.

Chapter one - Overview of urgent and emergency care in Lancashire and South Cumbria

Emergency care involves life-threatening illnesses or accidents. Urgent care involves non-life-threatening illnesses or injuries which still need urgent attention from health and care professionals. Services range from Emergency Departments (EDs), 999 ambulance calls and Urgent Treatment Centres to NHS 111, urgent GP appointments and Urgent Community Response teams.

Urgent and emergency care services form an end-to-end pathway, from the point at which someone becomes seriously unwell, to when they are well enough to be discharged, potentially continuing to receive longer-term support from other services. Urgent and emergency care services experience peaks and troughs in demand. For example, these services tend to be busier during winter, when more people are likely to become unwell with the onset of colder weather and illnesses such as colds, flu and norovirus.



Emergency Departments

1. Furness General Hospital.
2. Royal Lancaster Infirmary.
3. Blackpool Victoria Hospital.
4. Royal Preston Hospital.
5. Chorley and South Ribble Hospital.
6. Royal Blackburn Hospital.
7. Ormskirk General Hospital (children's).

Urgent Care Centres / Minor Injury Units

8. Westmorland Hospital UTC
9. Morecambe UTC
10. Fleetwood UTC
11. Blackpool Victoria Hospital UTC (Co-located)
12. Blackpool Whitegate Drive UTC
13. West Lancashire UTC - Ormskirk Hospital (co-located)
14. Skelmersdale Walk-in Centre
15. Royal Preston Hospital UTC (co-located)
16. Chorley Hospital UTC (co-located)
17. Royal Blackburn Hospital UTC (co-located)
18. Accrington Minor Injury Unit
19. Rossendale Minor Injury Unit
20. Burnley General Hospital UTC

Services involved in urgent care

Acute Trusts:

Provide urgent and emergency care services in hospital and in the community:

- University Hospitals of Morecambe Bay NHS Foundation Trust: delivers services across North Lancashire and South Cumbria.
- Blackpool Teaching Hospitals NHS Foundation Trust: delivers services in Blackpool and across the Fylde Coast.
- Lancashire Teaching Hospitals NHS Foundation Trust: delivers services across Central Lancashire.
- East Lancashire Hospitals NHS Trust: delivers services in Blackburn with Darwen and across East Lancashire.
- Mersey and West Lancashire Teaching Hospitals NHS Trust: delivers services in West Lancashire and in Cheshire and Merseyside outside our system.

Primary care:

197 GP practices across Lancashire and South Cumbria provide a wide range of health services including medical advice, vaccinations, examinations and treatment. They also support urgent access to a broad range of health professionals. Primary care delivers a significant amount of urgent care, for example through urgent same day appointments. Primary care also encompasses dental, ophthalmology and pharmacy services.

Ambulances:

North West Ambulance Service handles 111 and 999 calls, finding the most suitable solution for callers, which includes dispatching a clinician to the scene, providing clinical care on site, transporting people to hospital if needed (using emergency or non-emergency transport), offering emergency advice over the phone or referring people to other services.

Integrated Urgent Care providers:

A range of providers across Lancashire and South Cumbria deliver integrated urgent care services, for example Minor Injuries Units, Urgent Treatment Centres, Out of Hours services and Clinical Assessment Services which assess and treat a person's needs, direct them to services and can divert them from attending ED to an alternative service.

Community provision:

Community health services deliver a range of support such as district nursing, wound care, virtual wards, and 2-hour urgent community response. People can also access advice and treatment for some common ailments quickly through pharmacies.

Social care (Local Authorities):

Provide advice and support to people so they can remain as independent as possible for as long as possible in their own home. This can include practical help with daily living, access to specialist equipment, as well as support with personal wellbeing such as building relationships and urgent additional crisis care support if someone's health and social situation has deteriorated. The service will assess the person for need and then determine how this will be met and funded and ensure there is adequate provision in place. Some of this care will be delivered at home or may require a person to move temporarily or permanently into a care (home) setting. As well as direct care, Local Authorities also provide public health services.

Mental health:

Lancashire and South Cumbria NHS Foundation Trust provides care for people needing support for their mental health and wellbeing. This includes services for people experiencing a mental health crisis. Other organisations, including primary care, local authorities and the voluntary and community, faith and social enterprise sector also provide mental health services and support.

Hospices:

Care for people from the point at which their illness is diagnosed as terminal to the end of their life and provide respite care. People approaching the end of their lives access urgent and emergency care more often in the last 1000 days of their life, when there is an opportunity to do things differently and support them to receive care in their preferred place. Their vision as a sector is to improve the lives of people in our communities.

Voluntary and community, faith and social enterprise:

These organisations provide a range of different support related to urgent and emergency care. For example, 'take home and settle' services support people after discharge from hospital, helping them to regain independence, providing advice, direction to other services, assistance with some day-to-day activities and companionship.

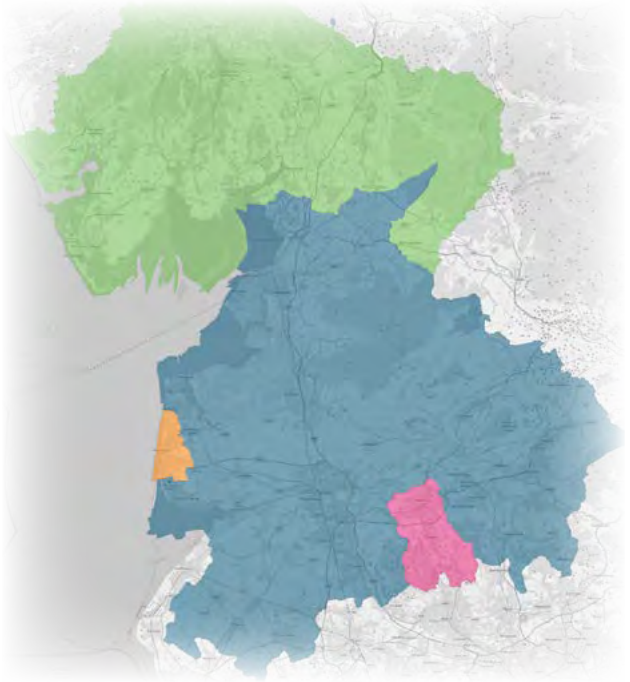
Urgent and emergency care also interacts, and is interdependent with many other functions of health, care and other public services. For example: police, fire and rescue, care homes, domiciliary care providers, services which provide planned care, support for people with long-term conditions and health promotion advice, diagnostics, as well as services linked with the wider determinants of health such as housing and education.

Working in our boundaries

In Lancashire and South Cumbria, there are four 'places', aligned with our upper tier local authority areas: Blackburn with Darwen, Blackpool, Lancashire, and South Cumbria. However, our acute Trusts often deliver services across multiple places. For example, East Lancashire Hospitals NHS Trust mainly provides services to people living in Blackburn with Darwen and in East Lancashire. For the purposes of urgent and emergency care, the footprints of the acute hospital Trusts and our places, will be the geographical areas based on which we will plan and deliver change. Within these 'footprints' there are a number of partners involved. For example NHS Trusts, primary care, local authorities including upper tier and district councils, hospices and voluntary, community, faith and social enterprise (VCFSE) organisations who come together to improve services for local communities. It is imperative that organisations continue to work collaboratively.

Collaborative working is crucial, not only for partners within Lancashire and South Cumbria but also more widely with our neighbouring Integrated Care Systems: North East and North Cumbria, Humber and North Yorkshire, West Yorkshire, Greater Manchester and Cheshire and Merseyside. This is key to support organisations which work across boundaries and for people who live on the borders of Integrated Care Systems. For example, Mersey and West Lancashire Teaching Hospitals NHS Trust is based in Cheshire and Merseyside Integrated Care System and we work closely to support urgent and emergency care services in West Lancashire. This will also help address wider population health needs, ensure consistency as far as possible and enable alignment with national NHS strategy and guidance.

This strategy should be read and implemented alongside wider strategies, for example, the Lancashire and South Cumbria Integrated Care Partnership Integrated Care Strategy, the Lancashire and South Cumbria Integrated Care Board Clinical Digital and Workforce strategies, and Cheshire and Merseyside's Shaping Care Together strategy. It is also necessary to ensure connectivity with other important transformational programmes of work that are interdependent with urgent and emergency care. In particular, the transforming community care programme, which is referred to in chapter 5, and the acute services configuration programme, which is focusing on how hospital services are arranged to meet population needs, make best use of resources, address fragile services, enable service reconfiguration, and on defining the acute clinical service blueprint and delivery roadmap for the future.



Chapter two - The case for change

Pressure in urgent and emergency care services

This strategy has been developed at a time of enormous and increasing pressure for all our urgent and emergency care services across the whole pathway from urgent same day appointments and out of hours services in primary care, ambulance services, integrated urgent care providers, acute hospitals, mental health, community-based services, and social care.

Services are experiencing growing demand, alongside challenges with infrastructure, workforce and funding. The country has an ageing population with increasing need for health and care support. More than 25% of adults in England live with two or more long-term health conditions, which makes it more likely that someone will require urgent and emergency care. The COVID-19 pandemic has also contributed to people being more unwell and has caused delays for many people in receiving or seeking medical care.

Capacity across our whole urgent and emergency care system in Lancashire and South Cumbria is not able to meet the needs of our population. This pressure has knock-on effects. Delays in care for people waiting for urgent and emergency care leads to poorer outcomes. Our staff are also having to work in a consistently and increasingly tough environment, taking its toll on their experience and wellbeing. When urgent and emergency care services are experiencing high levels of demand, it becomes more challenging to continue to deliver planned, routine care. The COVID-19 pandemic created a backlog in waiting lists, and it is more important than ever that we maintain delivery of planned and elective care throughout the year. Every year, we make plans for how urgent and emergency care services will manage demand and cope with busy periods like winter. However, we want to be more proactive and take a longer-term perspective to planning and transformation in urgent and emergency care services.

We are also missing opportunities to provide earlier, more proactive, care and support 'upstream', which might help people stay well, predict and prevent someone's condition deteriorating and minimise the need to access urgent and emergency care. Nationally, and in Lancashire and South Cumbria, we are trying to evolve how we deliver health and care services, so they are less centred around hospitals and shift to more community-based support (where clinically safe to do so), with a greater focus on preventative, predictive and proactive care to help people to stay well. We know this would lead to better experience and health outcomes for our population.

Two key indicators of pressure in urgent and emergency care services are how long people are waiting to be seen and treated in Emergency Departments (EDs) and how long ambulances are taking to arrive. These are two key metrics which are focused on as part of the national plan for recovering urgent and emergency care services.

Nationally, ED attendances have been increasing over time. Despite a reduction during the COVID-19 pandemic, the volume of activity has returned and surpassed pre-pandemic levels. This is also true for us in Lancashire and South Cumbria.

19%
Increase in ED attendances

We have more emergency hospital admissions than in other areas of the country and we are seeing record numbers of people attending our emergency departments. ED attendances have increased significantly faster between 2018/19 to 2023/24 by 19%, versus 6% growth for England as a whole.

Our EDs and hospital beds are fuller than they were pre-pandemic. This means people have to wait longer in ED to be seen and treated, and if they need to be admitted, they need to wait in ED until a bed on a ward becomes available. Currently, between 19% (1 in 5) and 32% (1 in 3) of people attending ED in Lancashire and South Cumbria are then admitted to hospital. More attendances and prolonged time being spent in ED departments means the caseload seen by each ED at any one time has increased significantly. This has driven an increase in spatial footprint used by the ED, an increase in ED staffing and a requirement to treat patients in inappropriate locations (for example, corridor care).

106,576
Remained in hospital beyond being fit for discharge

A contributing factor to long waits for hospital beds is that we are experiencing challenges discharging people to the right place, and with the right ongoing treatment, care, and support. Many of the people in hospital beds are clinically ready to leave hospital but their discharge is delayed. From February 2023 to January 2024, 106,576 people remained in hospitals across Lancashire and South Cumbria beyond the date when they no longer needed acute hospital care.

Within hospitals, over-crowding in ED leads to a worse patient experience and prolonged time in a hospital bed and/or failing to mobilise (for example staying in hospital once someone no longer needs acute hospital care) increases the risk of infection and deconditioning harm (loss of muscle strength, poorer mental wellbeing, and sense of loss of independence). For some people who require emergency admissions for mental health care, sometimes we are unable to admit them quickly locally due to increased demand, our beds being fully occupied and delays in discharging people once they are well enough. Therefore, people are having to be admitted to beds located further away from their local area or even outside Lancashire and South Cumbria. This means they are separated from their communities, families, carers, and friends and away from local services which makes it harder to coordinate their care and discharge arrangements. We know this is detrimental to their quality of care and experience.

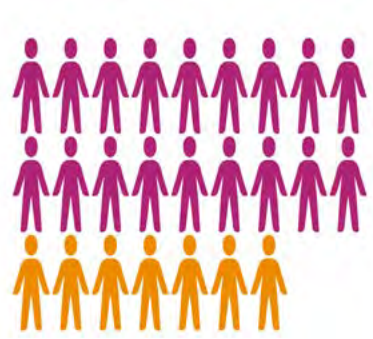
Ambulance services are also receiving increasing numbers of calls. When EDs are busy, it can take longer for ambulance crews to hand over patients to hospital teams. Some ambulances and their crews are therefore delayed whilst people are waiting for a bed within the department. As a result, people in the community are having to wait longer for ambulances to arrive, associated with poorer outcomes.

Population health

We know the key factors which increase demand for urgent and emergency care:

- **population growth,**
- **more people living with long-term conditions,**
- **high levels of deprivation,**
- **unhealthy lifestyle choices,**
- **variability in accessing care between communities.**

In order to address the widening health inequalities for people living in different areas of Lancashire and South Cumbria we need to develop longer-term improvement plans to enable our system to best meet the needs of our population.



There are nearly 1.8 million people living in Lancashire and South Cumbria. By 2033, our population is expected to increase to 2.05 million. We are above the national average for people aged over 50, and over the next few years, we are expecting a dramatic increase in the number of people aged 85 and older. However, as well as for older adults, we have also seen a recent increase in the number of ED attendances for children aged 0 to 9, and we must also focus on meeting the needs of our children and young people.

Nearly a third of our population live in some of the most deprived areas of England. For a variety of reasons, a person living in a community with higher levels of deprivation is more likely to suffer avoidable ill health, and consequently, poorer health outcomes and a shorter life expectancy. Life expectancy in Lancashire and South Cumbria is lower than the national average and there is significant unwarranted variation between our neighbourhoods in the number of years people can expect to live a healthy life. Healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of 68 years for children born today. In some of our neighbourhoods, current healthy life expectancy is 46.5 years.

In deprived areas, there is typically the least support or access for prevention and proactive management of health and wellbeing risks; people's first interaction with health and care services tends to be in a crisis or emergency situation and there tend to be higher rates of activity in urgent and emergency care. In Lancashire, the rate of emergency hospital admissions doubles from the least deprived to the most deprived areas.

The main causes of ill-health in our Integrated Care System are cancer, conditions relating to the heart or lungs, mental health and conditions relating to the brain or nervous system.

Over 20,000 people living in Lancashire and South Cumbria have five or more long-term health conditions. More people are likely to be living with long-term conditions in the future due to advances in medical science. The complexity and acuity of the needs of our population is increasing which means people require more support from health and care services.

We know there is variation in how our urgent and emergency care services operate and what services are available to people in our four places. Historically, our organisations worked largely independently, and commissioning of services was done differently in each place. This means that the service offer and how people access services can be different depending on where they live. This can cause inefficiencies due to duplication or lack of coordination and there is variation in terms of how well different services are performing. It is not always clear to the public or to staff in health and care services what is available which makes it harder for people to access the right care at the right time in the right place for their needs. They may also end up accessing services multiple times as their needs were not fully met, or they did not see the right service first time. We need to integrate, streamline, and coordinate our urgent and emergency care services to address inequalities and improve quality, while also accounting for local needs and nuances.

Demand and capacity

Demand for urgent and emergency care services in Lancashire and South Cumbria is greater than the available capacity.

Estates:

We have challenges with our healthcare estate including ageing buildings, a lack of space, and some buildings no longer being fit for purpose. For example, Royal Lancaster Infirmary has an Emergency Department designed to look after 40,000 people a year, but is currently seeing 60,000. Due to growing demand and changes in the way we deliver care, we also do not always have our estate set up in such a way to support the new ways of working we want to adopt to deliver more care in the community or to be able to work more closely and collaboratively including primary care, mental health, physical health services, social care and the voluntary, community, faith and social enterprise. The New Hospitals Programme is a once-in-a-generation opportunity to transform our hospitals. We are investing to address ageing buildings at Royal Preston Hospital, Royal Lancaster Infirmary and Furness General Hospital. However, this programme is not just about physical infrastructure but new ways of delivering better health and care as a system, including a shift to more care being delivered in the community and virtually. This will ensure we have the right capacity to meet the needs of our population and can avoid people being admitted to beds located outside our system further away from their communities, families, carers and friends.

Workforce:

Health and care services across Lancashire and South Cumbria are experiencing workforce challenges, for example with recruitment and retention. Staff capacity is stretched to deliver services while managing high vacancy rates and high rates of sickness absence. This puts additional pressure on staff, who in turn may be more likely to decide to leave or experience poor health and wellbeing themselves. To fill these gaps, we are using high levels of agency and temporary staffing, which incurs considerable financial cost and can have an impact on quality in terms of the continuity of care people receive and how well teams are able to work together. Although our workforce has grown over the past few years, challenges persist, and we need to collaborate and be innovative to make the best use of our staff across the whole system, and to attract and retain talent.

Finance:

Our system is facing significant financial challenges, as we are consuming more healthcare financial resources than we are allocated. We spend 60% of our budget on hospitals. While there are economies of scale, acute hospital care is still expensive, and we have some people in hospital because the care they need is not available in the community. This does not help us to achieve the best outcomes for our population, nor to secure value for money. In particular, we are spending more on urgent and emergency care relative to the size and needs of our population compared to other health systems and we have seen our urgent and emergency care costs grow faster in Lancashire and South Cumbria over the last few years than England as a whole. We must strengthen and expand the care that is available in the community and join up the provision of acute, primary and community care with social care, mental health care, wider local authority services and the voluntary sector across our places. We must do things differently to improve the quality and productivity of our services and to make sure they are sustainable and affordable in the long-term.

Our system partners recognise the significant financial challenges we face and as a system we need to deliver £530m of efficiency savings during 2024/25 and beyond. The total savings requirement equates to 11% of the system funding allocation and there is high risk associated with the full delivery of these savings. Included within this are unfunded cost pressures relating to the urgent and emergency care pathway, such as costs associated with corridor care, escalation wards and delayed discharges, amounting to approximately £85 million across our acute trusts. We must phase out these unfunded costs through the delivery of this strategy in 2024/25 and 2025/26.

Future demand on urgent and emergency care

If we do not change the way we deliver services, we will have an unsustainable challenge. Based on population growth alone, by 2028, this could mean:

- 15,374 more ED attendances
- 5,952 more admissions to hospital or short stays for people who attend ED, with particular growth in admissions for over 65s
- 7,649 more people being in ED over 4 hours from 207,664 to 215,313 people, the majority of whom will be aged 65+
- 3,221 more people waiting over 12 hours in ED from 63,497 (8% of all attendances) to 66,718
- 2,933 more ambulance conveyances to hospital
- 9.3% more people potentially requiring reablement support

Chapter three - Opportunities for the future

We have considerable opportunities to make transformational changes in how we deliver urgent and emergency care, working together as a system providing clinical and non-clinical leadership. In doing this, we will build on great work which has already started.

Living well:

Our vision is to improve our health and wellbeing and support our population to live well. We will work together to prevent ill health and enable people of all ages to experience improved health for longer. This includes supporting people who are already mentally or physically unwell in living with and managing their conditions and stopping them from getting worse, helping people to make healthy lifestyle choices and more widely focusing on the things which cause poor health and wellbeing. We will also focus on supporting carers and their wellbeing. To do this, we must understand unfair differences and tackle inequalities across mental and physical health.

Developing our partnerships:

There is an opportunity to build on the collaborative and partnership working between partner organisations, which has already begun. This will help us to better join up health and care services. Place-based improvement plans will be developed to set out priorities for each year and how this strategy will be delivered. There will be oversight from the Urgent and Emergency Care Delivery Boards, which are aligned to the footprints of our acute hospital Trusts and have representation from partner organisations working in that area. They will ensure that all partner organisations are working together effectively to drive change.

Shifting activity away from acute hospitals to settings in the community for people with urgent care needs:

We will make sure we have the right capacity both in and out of hospital and strengthened community pathways as safe and effective alternatives to acute hospital attendances and admissions. This includes using digital tools that support individuals to manage their health and wellbeing and to receive specialist support and care closer to home. This brings us multiple benefits in terms of quality and outcomes, patient and staff experience, as well as operational and financial improvements. People can receive care more quickly, either at home or nearer home. We will integrate care in the community which helps people stay healthy for longer and significantly improves our out of hospital offer. It cares for them through preventing ill-health, managing long-term conditions, recovering from periods of intensive care, avoiding unnecessary hospital visits and admissions, and at the end of their lives. We will focus on proactive, holistic care, on what matters to an individual and support them to stay as well and independent as possible.

Ensuring our services are equitable for our population:

We have an opportunity to redesign services to provide an urgent and emergency care service offer which is fairer for our population, no matter where they live in Lancashire and South Cumbria. This would also build consistency for our residents and for our staff and make it clear which services are available and what they provide. This work will be led by our places, which means we can make sure services truly meet the needs of our residents, by allowing for local nuances and enabling places to make adaptations for the specific needs of their communities. We will also continue the work we have already started with priority areas with high levels of deprivation and unplanned hospital admissions to learn what matters to the people living there to shape our strategic direction, co-design solutions and reduce health inequalities.

Building high quality, efficient and sustainable services:

Our system is focusing on reducing waste and duplication, improving quality and transforming services. Through quality improvement, we will be able to make best use of our resources, strengthen our services and improve outcomes and experience for our patients and staff. For example, we can take new approaches which maximise the use of digital and technology, including supporting our population with self-care and improving their wellbeing through digital tools.

Supporting the Lancashire and South Cumbria integrated care system of the future:

The New Hospitals Programme will transform the way we deliver services to meet the needs of our growing population. The development of our new hospitals will continue into the 2030s and beyond. We need to ensure urgent and emergency care services start to deliver the vision for our future hospitals with clear care processes enabled by the right resources through a transformed system approach that delivers great outcomes.

Chapter four - Vision, aims and objectives

The NHS in Lancashire and South Cumbria is committed to putting our population's needs at the heart of all we do.

Across the NHS, urgent and emergency care services are changing to ensure that patients get the right care, in the right place, at the right time. Further enhancements to urgent and emergency care services will ensure that we provide a modern, responsive service fit for the future which is patient centric.

Our vision is to create:

An urgent and emergency care system that enables people to easily access the right care and support, at the lowest level of intervention, that best meets their needs, and delivers better outcomes and affordability.

By:

Improving quality and outcomes / Improving patient and staff experience / Improving performance

Aims and objectives

Over the next five years, Lancashire and South Cumbria aims to:

Adapt our urgent and emergency care system so that it is fit for the future to meet increasing demand by:

- Proactively planning for the future as a system.
- Using actionable insights and intelligence from data to understand the challenges facing urgent and emergency care and making sure we have the right capacity available, enabling people to move through the health and care system in a seamless way.
- Re-designing integrated urgent care services to meet future demand.
- Ensuring services are resilient so that they meet demand and are financially sustainable.
- Making the best use of our resources to deliver the best value and quality of care for the Lancashire and South Cumbria healthcare pound, reducing waste and duplication.

Ensure people can access high quality, timely, safe and affordable care, in the right place by the right professionals by:

- Ensuring people can access and be seen in the most appropriate urgent care setting for an individual's needs in a timely way, in or out of hospital.
- Promoting and maximising utilisation of out of hospital services available for both staff and the public.
- Reducing the length of time people stay in hospital and the numbers of people unable to leave hospital when they no longer need to be there.
- Communicating effectively and sharing key messages including through social media, engaging people and reaching seldom heard populations.
- Creating an easier way to ensure people are directed to the most appropriate service.

Enhance preventative and proactive care to reduce avoidable contact with urgent and emergency care by:

- Focusing on education and support for people to live well and make healthy choices, and preventing the onset of long-term conditions.
- Embedding population health management through data and predictive analytics to identify people at risk of developing a health condition or of deterioration in their condition and taking a proactive, strategic approach to support them earlier.
- Supporting people to stay well and manage any long-term conditions effectively, using digital tools where possible to support them to self-manage and interact with their health and care providers.
- Providing health and wellbeing and self-care advice to service users and carers, including signposting to existing points of access in the community and the right service to prevent attendance to ED or hospital admission.
- Strengthening proactive advanced care planning to ensure people's choices are taken into consideration, particularly for those receiving end of life care to ensure their wishes are respected and adequately planned for, reducing emergency interventions.

Address the needs of our local communities by:

- Utilising local population health data and population health management, demographic and whole system activity and flow data to identify priority areas of focus year on year.
- Developing actions to transform, improve and streamline pathways locally.
- Identifying gaps in provision across health and care.
- Ensuring care is equitable and addresses health inequalities.

Embrace opportunities for innovation by:

- Maximising the offer of support tools available from NHS England.
- Working collaboratively and sharing good practice and outputs of local and national innovation across system partners.
- Embracing opportunities for digital and technological developments, emerging technologies and innovative approaches to improve the timeliness, quality and efficiency of care, and the experiences of both people using our services and our staff.
- Continually re-evaluating impact using system data and intelligence, to become a learning health system.

The achievement of the aims will help our system to become financially stable by making efficiencies. This requires time and significant commitment from all our partners to transform services which will support our financial recovery.

Chapter five - Our commitments

Over the next five years, we will achieve the vision set out within this strategy.

We recognise that, as a system, we are already doing a lot of work to improve urgent and emergency care; nevertheless, there is more to do. These commitments represent our priority actions to improve urgent and emergency care services. They are aligned to our overarching strategy for Lancashire and South Cumbria Integrated Care Partnership which describes the priority areas of focus to improve the health and wellbeing of our population and to ensure health and care services are more joined up and easier to access. They also align to national guidance issued by NHS England. These commitments will help us to deliver our vision, and the national ambitions. This is supported by investment funding from NHS England to help us to transform services, create additional capacity and improve performance, quality and experience for our staff and patients. Over time, we will respond to new national asks from NHS England and further develop our plans to continue our improvement journey.

Digital and technology will need to underpin transformation efforts as an overarching enabler. This will transform when, where and how health and care services are delivered. Insights from data will give us the intelligence about our patients and communities to do things differently, supported by workforce transformation to empower our staff with the knowledge and skills to do so.

Access to the right care

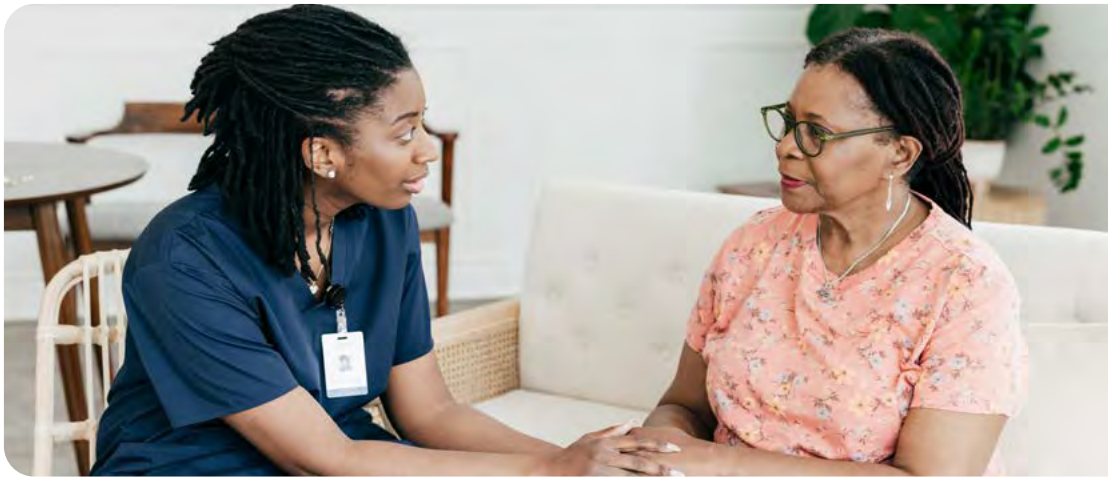
We recognise health and care services can be complex for people to navigate. We will transform the way services are accessed across Lancashire and South Cumbria to ensure patients are efficiently directed to the most appropriate services for their needs. We will ensure that information is available to the right professionals at the right time to enable optimal care and seamless transitions of care, which will be achieved through spread and adoption of the Connected Care Record and deployment of a Whole System Flow solution. We will implement:

- **Single point of access/care transfer hub:** We will standardise how we coordinate urgent care through a single point of access/ care transfer hub. The hub will have access to service information and capacity available to identify the best service for someone's needs, supporting them to access care in the community where appropriate. The hub will facilitate directing people to the right care setting, with the right clinician or team, at the right time. This will happen when someone becomes unwell and requires urgent care. The service will also coordinate any onward care required when someone is discharged from hospital. This will streamline the patient experience and pathway from end-to-end.
- **Acute respiratory infection hubs:** In line with national guidance, we will roll out this service to provide same day urgent assessment for people with illnesses that affect the lungs, such as, chest infections. These illnesses become more common during winter and so we can improve access to urgent care in the community. The service will provide prompt assessment and management and help to reduce some of the pressure on Primary Care and ED, particularly at busy times such as during winter. We will consider a robust offer for children and young people, with an aspiration to enable walk-in or same-day appointments for children under the age of 5.
- **Mental health:** Our initial response service aims to direct people easily to the right support via a single point of access.

Expansion and transformation of out of hospital urgent and emergency care

We will continue to shift urgent and emergency care away from hospitals and into the community where this is appropriate for someone's needs, so that pathways enable people to receive care in the community where this is safe and appropriate to avoid hospital admissions and attendances. We have already begun to implement new ways of providing urgent care closer to home. We will continue to strengthen and expand these pathways:

- **Virtual wards:** Virtual wards support people who would otherwise be in hospital, to receive the acute care, monitoring and treatment they need in their own home or usual place of residence, safely and conveniently as an alternative to being in hospital. Since our implementation of virtual wards began in 2022, we now have 424 virtual ward 'beds' available across Lancashire and South Cumbria, mainly focusing on care for people with frailty and respiratory infections. Our short-term intention is to make sure this capacity is being fully utilised. This will include increasing adoption of digital health technologies in virtual wards. We will continue working to integrate virtual wards with other urgent and emergency care services to ensure it is offered as an equivalent choice where safe and appropriate. We will also broaden the scope of conditions which can be managed on a virtual ward and promote the model for children and young people. We will maximise the use of diagnostics in the community to support delivery of virtual care, clinical decision-making, and care planning. Over time, our ambition is to grow virtual ward capacity further. Virtual wards provide a significant opportunity to reduce pressure on our hospitals and improve experience and outcomes by enabling people to receive urgent care at home.
- **2-hour Urgent Community Response:** Urgent Community Response teams provide urgent care for people at home if their health or wellbeing suddenly deteriorates and they become at risk of hospital admission within the next 2 to 24 hours. They provide fast access to health and social care professionals within 2 hours. In Lancashire and South Cumbria, we are consistently exceeding the target for 70% of people being referred to be seen within 2 hours. Consistently, we are achieving over 90%. Our ambition is to further increase referrals to these services. This will help more people to avoid going to hospital and to remain at home, with rapid access to the support and care they need.
- **End-of-life care:** A key part of this strategy will be to improve care for people receiving palliative care and approaching the end of their lives, to incorporate more end-of-life care support into urgent and emergency care pathways, to provide palliative care access in emergency situations. This will enable us to provide more palliative and end of life care out of hospital and avoid unnecessary ED attendances and acute hospital admissions which can be distressing for the individual and their family and carers. For example, hospice at home and virtual ward services can support managing end-of-life care needs at home, providing a better experience for patients and their families and enabling people to die in their preferred place.
- **Additional out of hospital services:** We will also focus on ensuring other high-quality and consistent out of hospital services are accessible to our population in an emergency. This will include falls services to visit and support someone who has had a fall at home, and services which provide enhanced support to people living in nursing and residential care homes, who may frequently require urgent care if they become unwell.



Expansion of services in the community

Urgent and emergency care services must be supported by physical health and mental health services as well as public health and social care in the community. This also includes diagnostics in the community. These services are fundamental in helping people to live with good physical and mental health and wellbeing for longer. They also provide care for people with long-term conditions, including helping them to manage their condition and preventing it from getting worse. We need to expand these services to respond to the needs of our population and ensure we have a robust health and care system for the future.

Our integrated care strategy describes key actions we will take as a system to improve preventative and proactive care in the community.

- We will **enhance and signpost our service offer in the community** to support people to easily access the right care they need, leveraging the important role of organisations in the community such as pharmacies. For example, we will continue to implement and embed the Pharmacy First service which launched in January 2024. Pharmacy First enables pharmacists to prescribe appropriate medicines to treat seven common conditions such as earache, sore throats, and urinary tract infections, aiming to address these conditions before they get worse. Previously, someone suffering from one of the seven conditions would most likely have required a GP appointment to get a prescription.
- **Community health service transformation:** We have established a programme to transform community health services as we know we have variation in our spend and outcomes across Lancashire and South Cumbria. The Transforming Community Care Programme will focus on the medium to longer-term transformation of community services over the next 2-10 years to create thriving community services. It will also maximise the use of technology to support a holistic approach to care in the community that is co-produced with residents and partners within Lancashire and South Cumbria and which leads us to the new hospitals being in built in the late 2030s. The areas of the medium to longer term development will be:
  - ◊ **Enhanced Care in the Community** – including intermediate care future delivery models to standardise provision where possible, with nuances reflected in line with population needs.
  - ◊ I**ntegrated Neighbourhood Teams** – truly accelerating integration to provide effective approaches to mental and physical health, wellbeing and end of life care based on core universal principles for thriving services, which are built around local population needs to reduce health inequity and take advantage of technology enabled care to keep people safe and well in their homes or as close to home as possible.
  - ◊ **Creating Healthy Communities** – working in collaboration with our population and public health, local authority, and voluntary, community, faith and social enterprise colleagues to develop innovative approaches that support and enable communities to live their healthiest lives and reduce health inequalities across the system.
- **Mental health:** We are developing a new integrated offer for community mental health services. This will involve multi-agency working with a person at the earliest opportunity, bringing teams together to wrap around individuals and meet their needs holistically and seamlessly. We will also develop a programme of preventive work in partnership with mental health and paediatric colleagues to address the increased urgent care demand for children with emotional health and wellbeing needs.

Redesign of integrated urgent care services

Integrated urgent care services can be accessed through NHS 111 and help people with urgent, but not life-threatening conditions. Integrated urgent care supports people to access the most appropriate service for their needs and delivers advice and treatment. Services include Minor Injury Units and Urgent Treatment Centres, which can diagnose and manage many common ailments, and out of hours services which are arrangements to access healthcare when GP practices are closed. These services are really important options for our population to support them to get the right care they need from the right professionals at the right time.

Across Lancashire and South Cumbria, there are multiple providers of multiple services which are operating in different ways. We have an opportunity to redesign our integrated urgent care services to:

- Maximise integration of services and make it feel more joined up for our population and staff.
- Improve ease of access to services.
- Reduce unwarranted variation and standardise provision across Lancashire and South Cumbria, yet allowing for local nuance.
- Build resilience and sustainability for the future.
- Develop the skills of our workforce.
- Maximise financial efficiencies.

In-hospital capacity

Nationally, the NHS has sought to increase capacity to meet demand for urgent and emergency care in hospitals, and to improve the way we support people with urgent care needs. In line with this, we will continue to focus on:

- **Same day emergency care:** Same day emergency care provides urgent care in hospital to people with certain conditions through rapid assessment, diagnosis, and treatment. They do not need to be admitted to a hospital bed and the aim is for them to be able to go home the same day. This avoids longer than necessary stays in hospital and frees up some hospital beds. Our aim is to reduce variation in the way we deliver same day emergency care. We will also implement the learning from the same day emergency care pathway at East Lancashire Hospitals NHS Trust when designing future models of care for children.
- **Acute frailty services:** The NHS aims to provide acute frailty services at hospitals with EDs open for 24 hours which will aim to quickly see and assess people who are frail. The service has input from therapists, nurses, pharmacists and specialist doctors for a holistic assessment and treatment plan. We will work to reduce variation in our acute frailty service provision and improve the identification of those who could benefit from specific frailty services.

Improve hospital flow and discharge

- **Acute hospital flow ward processes:** We will reduce variation in how we work between our different hospitals and consistently implement best practice to make our processes more efficient and reduce length of stay. We will bring forward discharge planning discussions earlier during a person's hospital admission, especially for those people who are likely to be discharged home. We will standardise how care transfer hubs work to coordinate discharge planning, thereby ensuring people have the holistic care and support they need to continue their recovery in the community and reduce re-admissions to hospital. We will ensure that end of life care and palliative care expertise is embedded in these processes to improve patient care and decision-making, minimising prolonged or inappropriate stays in hospital, and enabling rapid discharge to a preferred place of care for people approaching the end of their lives.
- **Intermediate care**: Intermediate care provides short-term support for someone when they are discharged from hospital to help them to recover and be as independent as possible, including reablement and rehabilitation. Intermediate care has high potential beneficial impact to support people to regain independence, remain living in their usual place of residence for longer, and help avoid someone needing to go into hospital or long-term residential care unnecessarily. We will focus on improving access to, and the quality of, our intermediate care provision across Lancashire and South Cumbria. This will be supported by use of data to make sure we have the right capacity in place.
- **Community bed productivity and flow**: Similarly to acute hospitals, we will focus on ensuring that discharge processes are as efficient and speedy as possible for people in our community beds. Community beds include community hospitals and short-term rehabilitation in residential care.
- **Mental health:** We will work together as a system to support our patients to ensure when they are clinically ready for discharge from hospital, it happens at the right time and without delays. Our main focus is to make sure that our patients have the right wrap-around support in place to enable people to return to their home or receive care in the best possible place to meet their needs. If we can do this, it will free up bed capacity within our hospitals and will avoid any further delays for people waiting in the community who require an admission to a mental health bed.
- We will use whole-system data and intelligence to improve flow into and out of our hospitals.

Place-based improvement plans

Places are developing improvement plans to support delivery of our strategy. These plans include measurable goals and will be monitored via local Urgent and Emergency Care Delivery Boards to ensure the aims are being achieved. Where further improvements are required, actions will be addressed and agreed as part of a collaborative approach via the Delivery Boards.

With the exception of West Lancashire (see chapter seven), the Year 1 plans are specific to each Urgent and Emergency Care Delivery Board, focusing on the challenges facing different organisations and places across Lancashire and South Cumbria. However, they all consider the following four areas of opportunity:

- The response in the community: keeping people safe and well at home; step-up pathways.
- In hospital flow optimisation: urgent care department processes and flow; inpatient flow.
- Supporting downstream flow and discharge from acute settings.
- System oversight of urgent and emergency care performance and place management of improvement.

The plans have been developed with priorities established for Year 1. These are summarised in appendix A. Improvement plans will be refreshed and updated annually, to set out the priorities for the next year.

Communications and engagement

Communicating and engaging with people is a key component of any strategy. The health and care system can sometimes be confusing and frustrating for individuals and their families and carers. We have developed a communication and engagement plan with system partners focussing on three areas:

- **Prevention:** Helping people to stay well, focusing on how health issues can be prevented by predicting and being addressed earlier.
- **Self-care:** Simple steps people can take to look after themselves when they become unwell, raising awareness of common conditions and how to seek expert advice and self-treatment (such as through pharmacies), alongside programmes of education and information materials. We will support and empower people to build the knowledge, skills, and confidence to self-care, including managing any long-term conditions they may have.
- **Signposting:** Helping people choose the right service at the right time, raise awareness about wider services available and improve ease of access to them, supporting people to seek help when they need it and being able to see the right professionals in a timely way.

As part of our communications and engagement, there will be key focus on education, health promotion and prevention, particularly for children to support them as they grow up to become healthy adults in the future. We will also make clear what services are available and how they run, helping people understand where to go and what to do to access care, when they become unwell. This will help people to look after themselves and know how to access health and care support in the right place. We will ensure that our communication is clear and consistent. We know that communication and education around health and care services, including urgent care and what voluntary support services are available, is crucial.

It is important that we help patients feel supported and empowered, to be able to self-care and manage any physical or mental health conditions they may have, as well as to easily find the most appropriate place to access physical or mental health services, social care, other support and advice when required. We will listen to people and understand what matters to them which will help us to improve how we care for and support people in the way that works best for them.

We will engage people and those with 'lived experience' in all we do, including those who use services as well as their families and carers. This will be a core part of how we deliver this strategy. We will make sure that our further engagement is inclusive and gives everyone a voice to contribute their views.

Our plans will consider place-based approaches for reducing health inequalities, building on work we have already started with our 'priority wards'. We will consider the story the local data tells when viewed through the lenses of deprivation, age, gender and ethnicity and understand the factors driving inequalities. We have already undertaken deep listening exercises to learn what matters to people living in our 'priority ward' areas, which has led to projects to improve health and outcomes such as:

- Proactively seeking out and engaging with patients in a priority ward with a learning disability, severe mental illness or long-term condition who have not engaged with primary care in the last 12 months.
- Focus on adult respiratory issues as a clinical area of focus disproportionately driving ED attendances.
- Connecting with communities to understand causational factors leading to non-elective care.

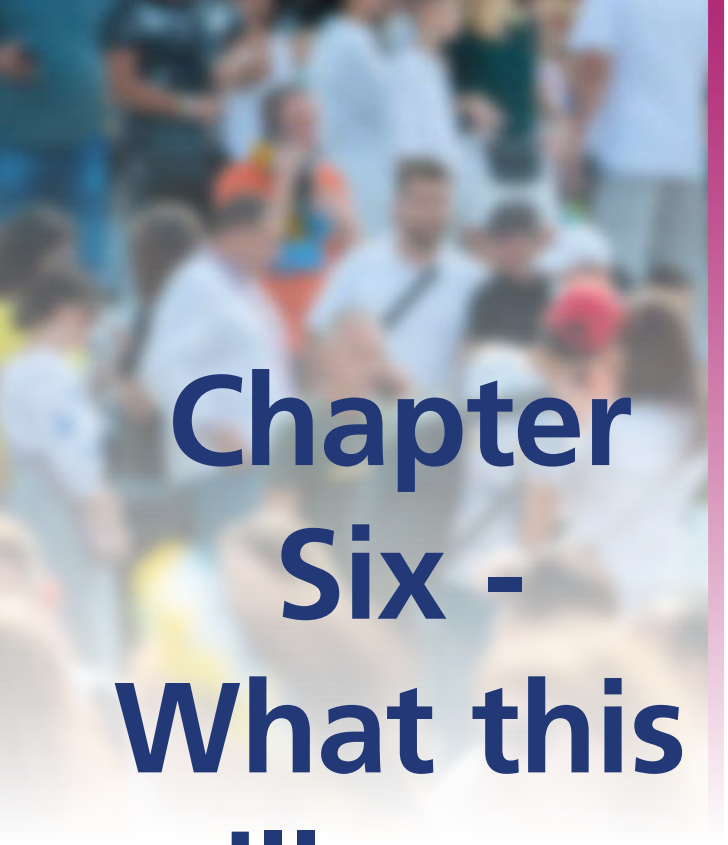
Workforce transformation

Workforce transformation is a critical pillar of our strategy alongside quality, service change and performance. We will follow our overarching Lancashire and South Cumbria workforce strategy, in particular to 'work as one collaboratively and in new ways'; 'recruit and retain a happy and healthy workforce'; and 'develop and grow our own workforce'. Our specific priorities will be to:

- Put staff at the centre of delivering change. It is essential we draw on the experience and insight of our staff to successfully implement this strategy. We will include the full breadth of partners from across sectors and continuously engage with staff. As for other aspects, this will be overseen through our Urgent and Emergency Care Delivery Boards, Collaborative Improvement Board, Integrated Care Board and People Committee. We will follow the principles of the NHS People Promise and ensure workforce is planned within improvement plans.
- Use workforce intelligence to plan for the current and future workforce. We are familiar with the current headline workforce, but we need to understand the current position at a more granular level across all partner organisations in order to prioritise our actions. We must also model the future demand for workforce taking account of new ways of working and future urgent and emergency care service plans – in particular the expansion of out of hospital and community services. We must also model the future supply of workforce taking into account national plans and developments such as the doubling of medical school places.
- Retain and upskill. This is critical as these staff are already on the ground and already have deep experience. We must continue to focus on the wellbeing of our diverse staff, caring for them as we ask them to care for others. We will advertise more attractive opportunities, leveraging our system perspective. We will enable staff mobility and flexibility, for example through digital passports and cross-system working. We will upskill staff and adopt new roles aligned to the future service needs. This will equip staff so they can provide better care for their patients and communities. We will foster stronger, wider staff networks to share good practice and lead transformation.

- Improve recruitment whilst reducing the pressures in acute hospital settings. We will work together with the education sector, employers and NHS England to plan and steer the future pipeline of workforce to align with our strategy. We will use all levers from growth in medical school place numbers through to growing apprenticeships. In parallel, we must substantially de-escalate the use of high-cost agency and locum staff in acute hospital settings.

We are preparing a workforce transformation plan to co-ordinate the implementation of this strategy across Lancashire and South Cumbria. This will need to evolve over time, aligned with our improvement plans.



Chapter Six - What this will mean for our population

More accessible and timely

- Rapid and easy access to urgent and emergency care services when you need them.
- Clarity over which services are available, what they are for, and how you can access them.
- More options for care and support accessible to you in the community and being able to receive urgent and emergency care at home or closer to home.
- Reduced waiting times for ambulances or in emergency departments.
- Reduced waiting times for inpatient care.
- Minimised ambulance handover times and quicker transfers of care.

Safer and improved experience

- You will only be directed to hospital and admitted if you need urgent acute care.
- No corridor care in emergency departments.
- Earlier initiation of treatment to improve outcomes and satisfaction.
- Reduced adverse events with improved safety and care for you.
- Better experience of using services for you, your family and carers.

More efficient

- Shorter stays in hospital and not staying in hospital longer than clinically necessary.
- Speedier discharge processes with onward support that meets your needs as required.
- Lower reattendance rates indicating effective initial treatment.

Better outcomes

- Reduced time for you in community if you require a mental health bed
- More support for your health in the community with better health promotion and prevention.
- Improved support for your mental health and wellbeing.
- Being healthier, living longer, spending more years living in good health and remaining independent for longer.
- Better ability to manage your long-term health conditions, with support from health and care services, and avoid deterioration.

More person-centred

- Signposting to self-care advice and guidance being readily available for specific conditions.
- Collaborative working between your health and care providers so your care feels well-coordinated and personalised to you and your needs, as well as those of your family and carers.
- Involving you, your family and your carers in your care and decisions, and providing the support you need.
- Listening to what matters to you.

Chapter Seven - The role of our partners and places

Across Lancashire and South Cumbria, we have four Urgent and Emergency Care Delivery Boards which are organised around the 'footprints' served by our acute Trusts as shown below:

- Blackpool, Fylde Coast (Blackpool Teaching Hospitals NHS Foundation Trust)
- East Lancashire, Blackburn with Darwen (East Lancashire Hospitals NHS Trust)
- Central Lancashire (Lancashire Teaching Hospitals NHS Foundation Trust)
- South Cumbria, North Lancashire (University Hospitals of Morecambe Bay NHS Foundation Trust)

In addition to this, we recognise that due to the geographical boundaries of the Lancashire and South Cumbria Integrated Care Board with neighbouring Integrated Care Boards, it is reasonable and common practice for the majority of our West Lancashire residents, registered with West Lancashire GP practices, to access Urgent and Emergency Care provision in closest proximity to their place of residence at hospitals located outside of the Lancashire and South Cumbria Integrated Care Board footprint. West Lancashire is one of five geographies which makes up the Mersey and West Lancashire Hospitals NHS Trust with hospital locations in Ormskirk (within our ICB footprint), Southport, St Helens and Whiston which sit within the Cheshire and Merseyside ICB footprint.

We will work collaboratively with both the Mersey and West Lancashire Hospitals NHS Trust and the Cheshire and Merseyside ICB to support and align UEC improvement plans to ensure that the population of West Lancashire have equitable access to quality Urgent and Emergency Care services.

The Urgent and Emergency Care Delivery Boards include representatives of health, North West Ambulance Service, local authorities, voluntary, community, faith and social enterprise organisations, independent sector providers and the other partner organisations. The membership includes clinical, strategic and operational senior leaders from partner organisations to ensure robust, holistic oversight of planning and delivery. In 2023/24, we strengthened these Delivery Boards, and they are in a better position going forwards to oversee performance and improvement. Each Delivery Board works as a partnership and is responsible for ensuring people access safe, timely and effective urgent and emergency care services, reducing waiting times and delays and improving quality. They are focused on the needs of the places and local communities they encompass.

This is important because our places have different demographics and their populations consequently have varied needs from health and care services. Historically, our places have planned health and care services in isolation and so there are differences in the way health and care services are set up and in how they operate across Lancashire and South Cumbria. There are areas of best practice, and while there are shared challenges, there are also unique difficulties. For example, some areas are rural and much more remote than others which can make accessing healthcare more difficult for people who live there. The four places are at different starting points for transforming urgent and emergency care services.

Our strategy needs to be taken forward and implemented by our system partners via the oversight and governance of the Delivery Boards so we can prioritise appropriately and ensure equity, accounting for local needs. The Delivery Boards will also share learning and examples of excellent practice, ensuring consistently high quality urgent and emergency care services for people living across Lancashire and South Cumbria. This will be facilitated by senior clinical leaders, such as Trust Medical Directors and place-based clinical and care professional leads, who are members of the Delivery Boards. They will, together with other clinicians, provide their professional expert input and oversee plans and progress.

The Urgent and Emergency Care Delivery Boards report into the system-wide Urgent and Emergency Care Collaborative Improvement Board which will help ensure services and pathways are consistent where they need to be, to avoid unwarranted variation across Lancashire and South Cumbria Integrated Care System, while allowing for local nuances and ensuring equity. Lancashire and South Cumbria Integrated Care Board will monitor delivery of the strategy, support where challenges are encountered, and in light of progress will review and refresh this strategy on an ongoing basis.

All system partners have a role to play in delivering the urgent and emergency care strategy to ensure citizens receive the right care by the right professional in the right setting.

To deliver this strategy over the next five years, they will:

- **Incorporate urgent and emergency care priorities into place-based improvement plans.**
- **Develop place-specific implementation plans.**
- **Oversee delivery of the strategy and implementation with robust assurance processes.**
- **Align with local and national priorities and ambitions each year.**
- **Communicate and engage with local communities.**

Delivery of the strategy

System partners of each Urgent and Emergency Care Delivery Board will develop a place-based improvement plan, to set out what they will deliver, how and when change will happen. This will ensure that this strategy is implemented to reflect local demographics and circumstances and truly meet the needs of local communities.

The immediate priorities for Year 1 have been established to address the most pressing challenges and maximise opportunities, specific to each place. The detail behind these priorities will be further developed to set out what we aim to achieve by when and the plans will be expanded and refreshed on an ongoing basis to reflect progress and to set out actions for the following four years.

The development and delivery of these plans will be data-driven, using evidence about local communities (now and in the future) to inform decisions and priorities, for example around population health management and opportunities for prevention. This will mean that we can recognise and respond to local challenges, diverse needs, opportunities, and inequalities. For example, while digital exclusion has reduced since the pandemic, 4% of the population nationally are offline and 25% are still considered to have the lowest level of digital capability. Digital exclusion is closely related to health inequality and inequity, and given the challenges in Lancashire and South Cumbria, proportions of people unable to access online services is likely to be higher. Place-based improvement plans will need to consider and support the needs of their local communities.

A communications and engagement plan will underpin each improvement plan, both for staff in urgent and emergency care and in wider health and care services and partner organisations, as well as for the public. This will help people to understand what to expect from changes, the services they can access, as well as when and how they can get involved.

The effectiveness of urgent and emergency care services relies on organisations working together across the pathway. All partner organisations will work collaboratively to harness collective skills, knowledge, experience and commitment, to join up health and care services and deliver new ways of working. This needs to happen to allow us to focus more on the wider determinants of health and wellbeing, helping people to stay well and manage their physical and mental health and care needs in the community, as well as improving outcomes. We will ensure partners understand future pressures and challenges being felt across our system and how we can work together to address them. Working together will enable more holistic care and support that meets people's needs and choices, and provides continuity and consistency in their care. Collaboration, good communication and working in partnership with communities is crucial to ensure that all organisations are able to work effectively and contribute to delivering robust and resilient urgent and emergency care as a system. We will also share good practice both from within and beyond Lancashire and South Cumbria.

Measuring success

It is imperative that we understand what is happening in our urgent and emergency care services, and whether we are moving closer towards achieving our vision and aims, to enable us to effectively deliver this strategy. We have developed key performance indicators which will show clear evidence to assess our progress. We have chosen these metrics as they will show us whether our system is improving in terms of the quality of services, efficiency, performance and outcomes for our population. We will monitor these metrics on a regular basis, so that we can see whether we are on track to achieve our aims.

There are four sets of metrics which we will use to measure success:

Key Performance Indicators

Quality

Performance Metrics

Finance

Key performance indicators

Each place-based improvement plan includes **key performance indicators** to monitor the impact of their initiatives. A summary of the improvement plans 2024/25 is outlined in **Appendix A.**

This data will be reported as part of our urgent and emergency care governance to place-based Urgent and Emergency Care Delivery Boards and the Urgent and Emergency Care Collaborative Improvement Board. We will continually evaluate impact using whole-system data and intelligence, to become a learning health system. This will help us understand what is and is not working as we transform urgent and emergency care and make adjustments to our plans and processes as required through a data-driven, evidence-based approach.

These indicators will be reviewed and updated as the improvement plans are refreshed year on year.

Quality Standards

We have developed a set of overarching **quality standards** as outlined in **Appendix B** for urgent and emergency care across Lancashire and South Cumbria. Evaluating these key quality standards will ensure we deliver high-quality patient care, patient safety and continuous improvement in service delivery.

Our chosen quality standards provide insight to fundamental aspects such as patient care and safety, which involves evaluating adherence to clinical pathways, protocols, and safety measures, as well as ensuring effective clinical management. They also include information relating to patient flow, waiting times, and emergency preparedness, as these directly impact patient outcomes. Additionally, the patient experience, including communication, dignity, and respect, will be evaluated to ensure we meet quality standards. Without this we lack the patient's viewpoint, which means we miss opportunities to improve services.

Clinical outcomes and performance metrics, such as compliance with the four-hour emergency care target, and broader outcome measures such as mortality rates, will be reviewed against national benchmarks to identify areas needing improvement. From these figures, a regional comparison can be made, allowing us to identify 'hot spots' within the region and opportunities to share what it is working well and systems in place that are driving improvements.

Finally, we will look to understand the physical environment, facilities, and the integration of technology and innovation, which will help to ensure the delivery of care is safe, efficient, and patient-centred. Ascertaining data and information to address these aspects comprehensively is vital for maintaining high standards, improving patient outcomes, and fostering continuous improvement within the urgent and emergency care.

Performance Metrics

Like our quality standards, it is imperative that we understand what is happening in our urgent and emergency care services, and whether we are moving closer towards achieving our vision and aims, to enable us to effectively deliver this strategy. We have developed key performance indicators (see **Appendix B**) which will show clear evidence to assess our progress. We have chosen these metrics as they will show us whether our system is improving in terms of the quality of services, efficiency, performance, finance efficiencies and outcomes for our population. We will monitor these metrics on a regular basis, so that we can see whether we are on track to achieve our aims.

Finance

As previously mentioned, we need to save 11 per cent of the system funding allocation, which includes circa £85 million cost pressure in our acute trusts associated with corridor care, escalation wards and delayed discharges. The strategy will enable us to deliver system wide transformational change e.g. moving care into the community, preventing admissions, which should lead to financial efficiencies.

Further reading

Document	Link
NHS Long Term Plan	NHS Long Term Plan
NHS England delivery plan for recovering urgent and emergency care services	Delivery-plan-for-recovering-urgent-and-emergency-care-services (england.nhs.uk)
Turning challenges into opportunities: The state of our system report - An overview of the health and care system in Lancashire and South Cumbria in 2023	State_of_our_system_report.pdf (healthierlsc.co.uk)
Lancashire and South Cumbria Joint Forward Plan for 2023 onwards	Lancashire and South Cumbria Joint Forward Plan for 2023 onwards (healthierlsc.co.uk)
Lancashire and South Cumbria Integrated Care Strategy 2023-2028	ICP_Strategy_Document (healthierlsc.co.uk)
Lancashire and South Cumbria New Hospitals Programme	New Hospitals Programme
Strategy for working with people and communities	Lancashire and South Cumbria strategy for working with people and communities (icb.nhs.uk)
NHS England universal support offer	UEC recovery plan delivery and improvement support
Intermediate care framework for rehabilitation, reablement and recovery	Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge (england.nhs.uk)
NHS England 2024/25 priorities and operational planning guidance	2024/25 priorities and operational planning guidance (england.nhs.uk)
Lancashire and South Cumbria ICB Digital and Data Strategy	Digital and data strategy (healthierlsc.co.uk)
Fuller review	Fuller report (england.nhs.uk)
Lancashire and South Cumbria ICB workforce strategy	Workforce Strategy

Glossary of terms

Ambulance conveyance
Transport a person to hospital via an ambulance.

Emergency Department (ED)
Emergency department is for serious injuries and life-threatening illnesses. It is also known as Accident and Emergency (A&E) or casualty.

Integrated Care Partnership (ICP)
A statutory committee jointly formed between the NHS (National Health Service) integrated care board (ICB) and all upper-tier local authorities that fall within the Integrated Care System (ICS) area.

Integrated Care System (ICS)/System
Integrated care system (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. An Integrated Care System (ICS) includes both an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP).

Lancashire and South Cumbria Integrated Care Board (ICB)
Lancashire and South Cumbria Integrated Care Board (ICB) was established on 1 July 2022. It is one of 42 Integrated Care Boards in the country and replaced the eight clinical commissioning groups (or CCGs) that previously existed across the region. The ICB is responsible for planning and buying NHS services for people living in Lancashire and South Cumbria.

Lancashire and South Cumbria Integrated Care Partnership (ICP)
A statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area.

Out of hospital
Health and care services and/or support delivered in the community, i.e. not within the hospital setting, and can include receiving care and support at home, or nearer to home. For example, general practice, pharmacy, and social care.

Place
An area covered by a local authority – an area where partners can come together and take action to support local communities.

Place based partnership
Collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing.

Place improvement plan
Place-based partners will develop improvement plans to support delivery of our strategy. These plans will include measurable goals and annual milestones. Plans will use local data and evidence about their local populations (now and in the future) to inform their planning.

Prevention
The term can cover many different types of support, services, facilities, or other resources. It can range from whole population measures aimed at promoting health to more targeted, individual interventions aimed at improving health for one person, or a particular group.

Prevention is often broken down into three general approaches:

1. Primary prevention - aims to protect healthy people from developing a disease or illness (i.e. good nutrition, regular exercise, regular check-ups).
2. Secondary prevention - Secondary interventions such as screening for illness and early intervention measures.
3. Tertiary prevention - Consists of measures to slow down deterioration of existing conditions (i.e. self-management programmes, rehabilitation, and recovery support).

Priority ward
A ward is a geographic subdivision of a local authority area. Analysis has identified 33 'priority wards' in Lancashire and South Cumbria with high levels of deprivation and high levels of urgent and emergency hospital admissions.

Self-care
Self-care is an integral part of daily life and is all about individuals taking responsibility for their own health and wellbeing. This includes the actions people take for themselves every day to stay fit and maintain good physical and mental health, meet their social and psychological needs, prevent illness or accidents, and care more effectively for minor ailments and long-term conditions.

Urgent and Emergency Care Delivery Board footprint
Urgent and Emergency Care Delivery Boards, are aligned to the footprints of acute hospital Trusts and have representation from each place and system partner organisations working in that area.

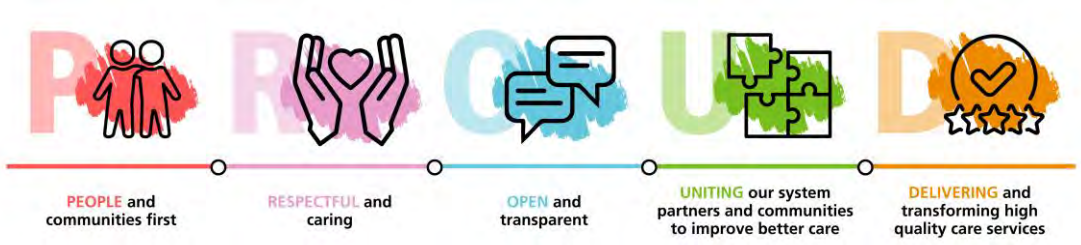
Appendix A

NHS
Lancashire and South Cumbria
Integrated Care Board

UEC 5-year Strategy

Place Improvement Plans

2024/25



Introduction and purpose of this document

Lancashire and South Cumbria Integrated Care Board

This document is Appendix A of the **Lancashire and South Cumbria Integrated Care System Urgent and Emergency Care 5-year strategy 2024-2029**.

It provides a summary of the improvement plans for 2024/25 which have been developed by each local Urgent and Emergency Care Delivery Board to support the delivery of the strategy. The improvement plans will be refreshed and updated annually to set the priorities and milestones for each year.

This document contains thematic findings from analysis and onsite investigations conducted as part of an urgent and emergency care diagnostic, which informed the development of the strategy and improvement plans. Each Urgent and Emergency Care Delivery Board identified priorities for their local needs, workstreams and milestones for 2024/25 to begin to deliver the vision, aims and commitments of the strategy. These priorities and milestones are summarised in this document.

Contents:

** West Lancashire was not part of the UEC diagnostic and improvement plan process described above. Instead, the improvement plan summary below reflects the Mid-Mersey and West Lancashire UEC Recovery Programme plan. See chapter seven of the strategy for further explanation.*

List of abbreviations used in this document

NHS
Lancashire and South Cumbria
Integrated Care Board

Abbreviation	Definition
AFU	Acute Frailty Unit
AMU	Acute Medical Unit
ARI	Acute Respiratory Infection
ASC	Adult social care
BTH	Blackpool Teaching Hospitals NHS Foundation Trust
BwD	Blackburn with Darwen
CIF	Capacity Investment Funding
DOS	Directory of Services
DPW	Days per week
DVT	Deep vein thrombosis
ED	Emergency Department
ELHT	East Lancashire Hospitals NHS Trust
EOLC	End of life care
FGH	Furness General Hospital
FIT	Frailty Same Day Emergency Care
G&A beds	General and acute hospital beds
GP	General Practitioner
IHDI	Immediate Hospital Discharge Information
INT	Integrated Neighbourhood Team

Abbreviation	Definition
LA	Local Authority
LCC	Lancashire County Council
LOS	Length of stay
LSC	Lancashire and South Cumbria
LTH	Lancashire Teaching Hospitals NHS Foundation Trust
MAU	Medical Assessment Unit
MOTD	Manager of the day
NCTR	Not meeting criteria to reside (in acute hospital)
NWAS	North West Ambulance Service
OPAL	Older Persons Assessment and Liaison
PDSA	Plan, Do, Study, Act
QI	Quality Improvement
QOF	Quality and Outcomes Framework
RFD	Ready for discharge
RCP	Royal College of Physicians
SDEC	Same Day Emergency Care
SOP	Standard Operating Procedure
SPOA	Single Point of Access
ST-Max	Short-term care to maximise independence

Abbreviation	Definition
TCI	To come in (arrivals or admission list)
TOCH	Transfer of Care Hub
TOO	Trust Operating Officer
TTO	To Take Out medication
UEC	Urgent and Emergency Care
UECDB	Urgent and Emergency Care Delivery Board
UHMB	University Hospitals of Morecambe Bay NHS Foundation Trust
UTC	Urgent Treatment Centre
WIC	Walk-in Centre

NHS
Lancashire and South Cumbria
Integrated Care Board

North Lancashire and South Cumbria UEC Delivery Board

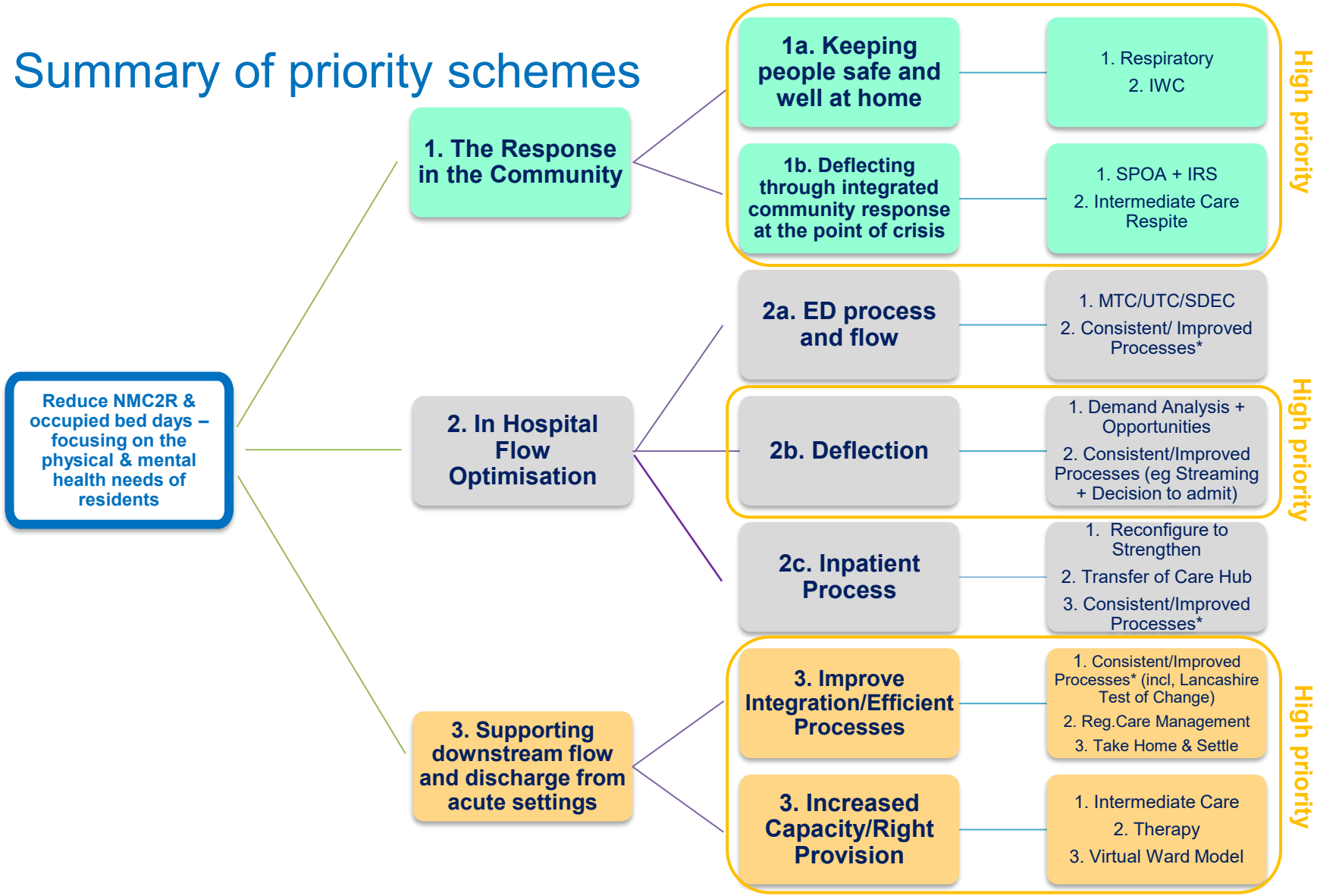
Thematic findings

Lancashire and South Cumbria Integrated Care Board

NHS costs	UHMB's in-hospital UEC costs grew by 38% from 2018/19 to 2021/22 (in line with national average UEC cost growth rate) and by 49% from 2018/19 to 2022/23. In-hospital UEC costs remained approximately constant from 2022/23 to 2023/24. However, in 2021/22, UHMB benchmarked 13.8% above the national average, and second highest of all LSC providers, for in-hospital UEC costs per weighted capita of catchment population. This indicates UEC costs crowding out non-UEC services (e.g., electives, diagnostics) and impacting money available for other sectors.
Population change	Between 2019 and 2023, Morecambe Bay experienced a weighted population growth of approximately 3.7%, slightly below the 4.1% observed across LSC. Over the same period, the increase in annual deaths in both LCC (11.5%) and Cumbria (11.2%) outpaced the national increase of 9.3%. This considerably faster rise in deaths relative to weighted population growth indicates increasing acuity, driving higher demand for primary and acute services. However, the growth in UEC activity, measured by attendances and admissions at UHMB, is significantly higher than the growth in acuity measures and exceeds the national average, suggesting that other factors are also contributing to this increase.
Upstream activity and provision	North Lancashire & South Cumbria benchmarks below the national average, but in line with the system average, for general practice attendance metrics, including appointments attended and same-day attendances (relative to weighted catchment population). Morecambe Bay benchmarks highest of all places in LSC on multiple primary care workforce metrics and is the only place to have more qualified GPs and clinical staff per weighted capita of population than the national average. However, a 24.1% reduction in qualified GPs from 2018 to 2024 suggest this position may not be sustained long-term. Morecambe Bay has experienced reductions in QOF achievement scores since before the COVID-19 pandemic, with those reductions similar to the LSC and national averages.
Acute/ secondary care activity	From 2018/19 to 2023/24, UHMB saw the fastest rise in ED attendances of all LSC providers (25.5%), considerably higher than growth in weighted population or deaths. It has seen a 16.6% increase in emergency/ non-elective admissions, driven by admissions with 0-1 day LOS and admissions of 1+ day LOS falling, suggesting strong use of SDEC pathways. UHMB benchmarks 19% above national average in terms of emergency/ non-elective admissions per weighted capita of catchment population. Analysis and onsite observation indicates that UHMB faces substantial challenges discharging patients, benchmarking considerably higher than the national and LSC averages for % of G&A beds occupied by NCTR patients since 2022. Although there has been a reduction in the number of excess bed days from 2018/19 to 2023/24, suggesting improved patient treatment efficiency, this observation may be influenced by data quality challenges. UHMB benchmarks 4% above the national average in terms of occupied bed days per weighted capita of catchment population.
Adult social care	From 2018/19 to 2022/23, adult social care expenditure grew by 21% in Lancashire and by 11% in Westmorland and Furness, both slower than the national average rate of increase. This increase is substantially lower than the hospital UEC cost growth observed. The data suggests that this cost increase has largely been driven by increases in unit costs for both short-term and long-term care. ASC client numbers have remained relatively stable in both LAs, with Westmorland and Furness costings suggesting a fall in long-term clients and an increase in short term care. The number of ASC clients receiving ST-Max support has fallen in both localities (decrease by 12.4% and 17.1%). Subject to counting and coding changes or transfer of ST-Max funding to NHS responsibility, this may indicate a level of missed opportunity to support residents to maximise their independence and minimise their onward need for both social and health care.

Summary of priority schemes

Lancashire and South Cumbria Integrated Care Board



These priority schemes have been selected through discussions with a UEC implementation plan working group, which first worked to identify all schemes relating to each area of opportunity, and then collaboratively identified those of highest priority. The driver diagram was validated by the UECDB on the 24th of June.

4. System oversight of UEC performance and place management of improvement

ENABLERS >>

- **Renewal of Shared Commitment**
- **Simplified Governance/Reporting**
- **Focused BI Support (Incl. Data Science)**
- **Digital Opportunities**
- **Communications + Engagement Support**
- **ICB enabled Data (111, General Practice)**
- **Developing a shared system view**

Underpinning ICB Programmes and commitment - Population Health, Primary Care, Community Care, Mental Health, NWAS, ICCs/INTs, VCSE

Engagement, Enabling and Involvement: Ensuring our plan has residents, carers and staff at the centre

Key milestones for delivery 2024/25 (subject to capacity) 1/2

NHS Lancashire and South Cumbria Integrated Care Board

Intervention		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1a	**Respiratory**	Morecambe Bay Respiratory Network delivering								
1a	**Integrated Wellness Centre**	Pilot pathfinder		Business case & plan	Rolling out					
1b	**Implement a Single Point of Access**	**Implement test of change 2:** • Reinstate SPOA function but with clinical advisor within the Urgent Community Response hub to triage calls and assess alternative place of care for the patient. • Test if admission is the only outcome for GP referrals re-routed through this process • Identify if algorithm could be developed that would support the bleep holder to not need to take all calls for admission								
		Implement test of change 3: • Explore how SPOA model can be implemented out of hours								
1b	**Intermediate care/ respite therapy**	Derivative of additional intermediate care beds implementation to create respite capacity for step up								
2a	**ED process and flow**									
	Provide SDEC access across all specialties	Scope additional SDEC services			Scope 7-day diagnostic services for SDEC					
			Direct access for NWAS and increased direct access for 111 at FGH							
			Peer review FGH SDEC to identify areas for improvement Pilot direct GP referrals at FGH SDEC							
		Reduction in the number of non-SDEC patients attending at FGH Increased NWAS awareness of available Same Day Services / alternatives to ED								
2b	**Demand analysis and opportunities**	*TBC* – access and review activity data								

Key milestones for delivery 2024/25 (subject to capacity) 2/2

NHS Lancashire and South Cumbria Integrated Care Board

Intervention		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2b	**Consistent/ improved processes**									
	Implement streamlined high volume pathways from Kendal UTC	DVT pathway changes implemented				Community engage-ment Pilot at a GP practice to grow self-referrals				
		Work with Lancaster University to analyse patient behaviour in choosing Kendal UTC Communications and publicity								
	7 day in-hospital Frailty service 70 hours a week	*TBC*								
	Review decision to admit process	*TBC*								
2c	**In-hospital flow optimisation**									
	Discharge to Assess investment, TOCH	Review discharge processes and align as needed								
	Consistent/ improved processes: Increased Senior Decision Maker input and documented diagnosis from ED	4-day Hybrid Triage outcomes reviewed								
		5 FIT beds on AMU and AFU PSDA	5 Bedded bay in FIT Bays on AMU and AFU PSDA piloted for 3 months				Outputs reviewed; next steps			
	Improve and standardise patient flow process					PDSA cycle for rapid assessment and treatment pathways for ED patients				
3a	**Lancashire Test of Change**	Assessing discharge processes and allocation of care requirements								
3a	**LCC registered care management**	LCC brokerage process established; W&F adult social care review								
3a	**Take home and settle**	Delivering – expansion of existing Lancashire based service into South Cumbria								
3b	**Intermediate care/ therapy**	Additional bedded intermediate care capacity in South Cumbria; case for change to meet gap in therapy provision								
3b	**Virtual ward refinement/ expansion**	Delivering								

NHS
Lancashire and South Cumbria
Integrated Care Board

Fylde Coast UEC Delivery Board

Thematic findings

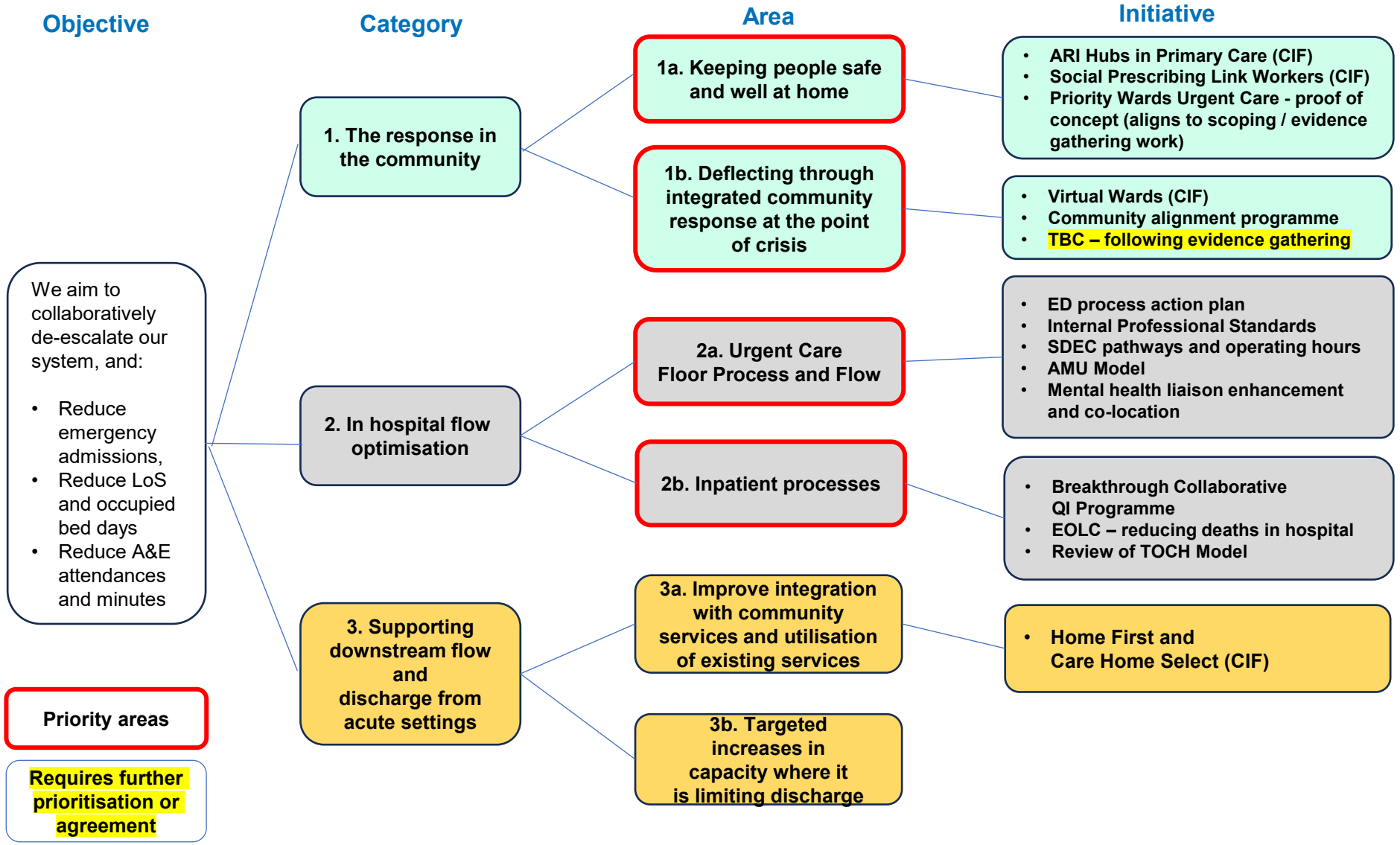
Lancashire and South Cumbria Integrated Care Board

NHS costs	BTH exhibited the fastest in-hospital UEC cost growth among all LSC acute providers from 2018/19 to 2022/23, with cost growth exceeding the national average by 38% from 2018/19 to 2021/22 (the last comparable year). In 2021/22, BTH benchmarked highest in LSC and 20.7% above the national average for in-hospital UEC cost per weighted capita of population. Data from the provider costing system suggests that costs decreased from 2022/23 to 2023/24, falling by ~3%; however, it is not possible to quantify this exactly.
Population change	Weighted population growth has been highly varied on the Fylde Coast. Blackpool (1.5%) has seen the slowest growth in LSC from 2019 to 2023, Fylde and Wyre (~6%) the fastest; compared to ~4% across LSC. Growth in deaths from 2019 to 2023 in the LCC catchment (11.5%) and Blackpool (11.4%) outpaced growth at the national level (9.3%). This considerably faster rise in deaths relative to weighted population growth indicates increasing acuity, driving higher demand for primary and acute services. However, the growth in in-patient UEC activity, measured by admissions at BTH, is significantly higher than the growth in acuity measures and exceeds the national average, suggesting that other factors are also contributing to this increase.
Upstream activity and provision	Over the last 12 months, the Fylde Coast benchmarks highest in LSC for appointments delivered per weighted capita, with Fylde and Wyre being the only place above the national average. Recruitment and retention of qualified GPs appears to be a challenge. Despite increases in GP numbers from 2018 to 2024 both areas benchmark low for appointments delivered by GPs and the number of GPs, with Fylde and Wyre having the fewest GPs in LSC (relative to weighted catchment population in each case). However, the growth in other clinical staff has offset this, with the Fylde Coast having more clinical staff per weighted capita than the national average (March 2024). While experiencing QOF score reductions similar to LSC and national averages, Fylde and Wyre's achievement in atrial fibrillation, hypertension, and COPD were the lowest in LSC and significantly below the LSC average in 2022/23. Capacity constraints in primary care may indicate gaps against the level of need in the population.
Acute/ secondary care activity	BTH has seen the slowest rise in A&E attendances (8.9%) among all providers from 2018/19 to 2023/24, yet it benchmarks highest for attendances per weighted capita. BTH has experienced the largest growth in admissions from 2018/19 to 2023/24, primarily driven by admissions with 0-1 day LOS, while admissions with 1+ day LOS have slightly decreased, suggesting strong use of SDEC pathways. Analysis indicates a decline in performance against flow metrics, with considerable growth in A&E minutes, occupied bed days, and excess bed days from 2018/19 to 2023/24. BTH also benchmarks highest in LSC for occupied beds per weighted capita.
Adult social care	ASC expenditure has grown substantially for Fylde Coast with a 21% increase ASC expenditure across Lancashire and a 26% increase in Blackpool from 2018/19 to 2022/23, however this is in line with the national trend and much lower than the UEC cost growth observed. This has been largely driven by considerable increases in costs for both short and long-term care, combined with a slight increase in the number of long-term clients from 2018/19 to 2022/23 (Lancashire: 0.6%; Blackpool: 8.7%). The number of ASC clients receiving ST-Max support has fallen in both localities. Subject to counting and coding changes or transfer of ST-max funding to NHS responsibility, this may indicate a level of missed opportunity to support residents to maximise their independence and minimise their onward need for both social and health care.

Note: The Fylde Coast, particularly the Blackpool catchment area, experiences significant population churn and is seen as a 'net importer of ill health'. Combined with a large tourist population, the population figures (both actual and weighted) may underestimate the true population size. This may impact all analyses that use a per capita basis but would perhaps be most significant for analyses of A&E and UTC demand, activity and cost.

Summary of priority schemes

Lancashire and South Cumbria Integrated Care Board



Process

Priority areas were identified through discussion at UEC DB Improvement Plan task and finish group with the areas of focus aligning to the areas with the greatest magnitude of opportunity and agreed during the UEC DB Improvement Plan workshop (20th June).

For area 1, the response in the community, the workshop agreed that further evidence gathering is required to define and prioritise the specific cohorts and initiatives to have an immediate focus on. Along with prioritising those schemes which are already funded or being developed. The next steps will finalise this prioritisation.

For area 2, in hospital flow optimisation, the workshop identified a shorter list of priority initiatives which support the improvement opportunities identified.

This approach and next steps were supported by UECDB at the 26th June meeting.

Key milestones for delivery 2024/25 (subject to capacity)

NHS Lancashire and South Cumbria Integrated Care Board

Intervention		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1a	**ARI hubs in primary care**	Agree place models		Mobilising	Delivering – patient referrals accepted based on agreed pathways					
1a	**Social prescribing links workers roll out**			Rollout	Delivering					
1a	**Priority Wards Urgent Care**	*TBC*								
1b	**Virtual wards optimisation**	Delivering (including establishing general medical virtual ward, November 2024)								
1b	**Community alignment programme**	Define programme structure & objectives Establish full programme governance								
2a	**ED process and flow**	*TBC – Ensure Mprove recommendations fully implemented and embedded*								
2a	**Internal professional standards**		Agree metrics	Policy consult-ation						
2a	**SDEC pathways and operating hours**		Discussion and decision re funding for SDEC expansion							
2a	**AMU model – to reduce waits and avoid admissions**		Scoping of AMU medical and bed model							
2a	**Mental Health Liaison – co-location**	Proposal for LSCFT and BTH boards								
		Agreement of lease arrangements								
		SOP agreed for co-location of teams								
2b	**Breakthrough Collaborative QI programme**	11 wards (acute and Clifton) to reduce LOS by 2 days								
							Summit			
2b	**End of Life Care – reducing deaths in hospital**	Proposals to provide additional capacity developed but currently unfunded Implementation of rapid response model and Hospice expansion if funding identified (2-3 months lead in)								
2b	**Review of TOCH model**	Triage process review completed, and vacancies filled								
		Clifton improvement – pathway and LOS reduction Improvements to end of life discharge process								
3a	**Home First and Care Home Select**	10 slots, 5 DPW			10 slots, 7 DPW					

NHS
Lancashire and South Cumbria
Integrated Care Board

Pennine Lancashire UEC Delivery Board

Thematic findings

Lancashire and South Cumbria Integrated Care Board

NHS costs	ELHT demonstrated the lowest in-hospital UEC cost growth among all LSC acute providers from 2018/19 to 2021/22 and was the only provider with cost growth below the national average. In 2021/22, ELHT also had lower in-hospital UEC costs per weighted capita compared to the national average, highlighting its strong cost performance relative to both LSC and national peers. However, a significant increase in costs in 2022/23 suggests that this may have changed in response to recent pressures. Cost data for 2023/24 is still pending.
Population change	BwD's weighted population grew more slowly (2.5% from 2019 to 2023) than the overall growth in LSC, while East Lancashire matched the LSC-wide growth rate of approximately 4.0%. Notably, BwD was the only place with a slower increase in the deaths (6.5% from 2019 to 2023) than the national average (9.3%), potentially linked to its high Age Standardised Mortality Rate, which is 29.5% above national levels and the second highest in LSC. The faster rise in deaths compared to weighted population growth indicates increasing acuity, driving higher demand for primary and acute services. However, the growth in UEC activity, measured by attendances and admissions at ELHT, is significantly higher than the growth in acuity measures, and higher than national average, suggesting that other factors are also contributing to this increase.
Upstream activity and provision	Pennine Lancashire ranks low on primary care attendance metrics compared to the national and LSC system averages, with BwD and East Lancashire having the fewest appointments attended per weighted capita in LSC. This is likely to be partially driven by challenges recruiting and retaining GP. Both BwD and East Lancashire fall below the LSC and national averages for the number of qualified GPs, and qualified clinical staff, per weighted population. BwD and East Lancashire have seen similar reductions in QOF scores to the LSC average and national average. Capacity constraints in primary care may indicate gaps against the level of need in the population – noting that historic commissioning investment in community may be offsetting some of this..
Acute/ secondary care activity	Data collection issues arising from the Cerner implementation make acute activity comparisons for 23/24 difficult. Despite this, analysis indicates that ELHT has seen a substantial rise in A&E attendances (23.9%), considerably higher than any increases in weighted population or deaths. ELHT has historically (pre 23/24) performed well on in-patient flow metrics, benchmarking lowest among LSC providers on G&A bed occupancy per weighted capita, length of stay, and NCTR (acknowledging that data challenges may have impacted these metrics). On-site observations indicate strong trust leadership and improvement ethos, albeit with opportunities in flow optimisation and improvements to use of existing capacity
Adult social care	Social care costs overall and per capita have grown across Pennine Lancashire, with a 21-22% increase for Lancashire and a 13-14% increase for BwD (below national average for per capita spend). In both LAs this was largely driven by short-term cost increases. This, coupled with the fact that both BwD and Lancs saw higher than national average growth in long term clients (1.8% and 0.6% vs. -0.8% nationally), potentially indicates effective intervention and cost management across ASC and/or variation from national patterns of short-term adult social care spend.

Summary of priority schemes

Aim

To stabilise our UEC system by keeping people safe and well at home.

We will do this through the delivery of timely, well-coordinated, community-based support with safe and effective in-hospital provision available when needed.

Measured by:

1. **Reduction/ elimination of corridor care**
2. **Reduction in delays and escalation level in ED**
3. **Financial savings associated with the above**

1. The Response in the community

Very high priority

- **1a. Keeping people safe and well at home**
  1. INTs (incl. mental & physical health)
  2. Advance care planning
  3. ARI hubs
  4. Care sector improvement
- **1b. Integrated, community-based crisis response (deflection)**
  1. Optimise crisis response and intermediate care step-up pathways
  2. Albion Mill & BwD enablement hub
  3. NWAS deflection

2. In Hospital Flow Optimisation

- **2a. ED process and flow**
  1. AMU pull model from ED
  2. Ambulance handover improvement plan
  3. Optimise ED processes
- **2b. Admission avoidance (deflection)**
  1. Direct access & streaming to SDEC
  2. IHSS at front door
  3. Streaming and referring out

High priority

- **2c. Inpatient flow**
  1. Right size acute bed base
  2. Process optimisation to reduce bed days
  3. Frailty pathway

3. Supporting downstream flow and discharge from acute settings

- **3. Discharge**
  1. Revisit discharge guidance
  2. Digital Trusted Assessment
- **3. Intermediate care (step-down)**
  1. Hospital aftercare
  2. Home first and residential rehab

NHS
Lancashire and South Cumbria
Integrated Care Board

These priority schemes have been selected through discussions with a UEC implementation plan working group, which first worked to identify all schemes relating to each area of opportunity, and then collaboratively identified those of highest priority.

4. System oversight of UEC performance and place management of improvement

ENABLERS >>

- **Renewal of shared commitment to a step-up focused UEC system**
- **Changing our culture – collaborative delivery with collective accountability**
- **Simplified Governance/Reporting across Place/Place+**
- **Levelling up primary care funding**
- **Focused BI and Commissioning Support (Incl. Data Science)**
- **Communications + Engagement Support**
- **ICB enabled Data (111, General Practice)**
- **Developing a shared system view**

Population Health, Primary Care, Mental Health, PCN/INTs, Local authority, VCFSE, ICB Programmes

Engagement, Enabling and Involvement: Ensuring our plan has residents and staff at the centre

Key milestones for delivery 2024/25 (subject to capacity)

NHS Lancashire and South Cumbria Integrated Care Board

Intervention		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1a	**INTs (incl. mental & physical health)**	Mobilising		Delivering						
1a	**Advance care planning**	Scoping	Mobilising		Delivering					
1a	**ARI hubs**	Scoping	Mobilising		Delivering					
1a	**Care sector improvement**	Scoping		Mobilising		Delivering				
1b	**Define step-up pathways/optimise crisis response**	*TBC* – Subject to mobilisation capacity								
1b	**Albion Mill**	Albion Mill Phase 1				Albion Mill Phase 2 scoping				
	Enablement hub	Mobilising		Delivering						
1b	**NWAS deflection of ambulatory activity**	Crews pilot mobilising		Crews pilot delivering						
		ELMS pilot scoping – mobilisation *TBC*								
2a	**Optimise AMU pull model from ED**	Mobilising			Delivering – subject to D2A clearance					
2a	**Ambulance handover improvement plan**	Delivering – continual refinement and improvements ongoing								
2a	**Optimise ED processes**	Mobilising			Delivering					
2b	**Direct access & streaming to SDEC**	Scoping underway – mobilisation *TBC*								
2b	**IHSS at front door**	Subject to discussions regarding mainstream funding continuation (ELHT)								
2b	**Streaming and referring out**	In place but opportunity to refine with broader partners and pathways								
2c	**Right size acute bed base**	B18 live								
		B6 mobilising but unfunded								
		B3 requires funding conversation								
2c	**Process optimisation to reduce bed days**	Discharge dashboard			Medically optimised ward				Criteria led discharge	
2c	**Frailty internal flow and pathway**	Mobilising			Delivering					
3a	**Revisit discharge guidance**	Scoping underway – mobilisation *TBC*								
3a	**Digital trusted assessment**	Scoping underway – mobilisation *TBC*								
3b	**Hospital aftercare service**	Delivering								
3b	**Home first and residential rehab optimisation**	Mobilising		Delivering						

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Central Lancashire UEC Delivery Board

Thematic findings

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NHS costs	In-hospital UEC costs at LTH grew by 60% from 2018/19 to 2022/23, the second fastest growth amongst LSC providers and with cost growth exceeding the national average by 5.2% from 2018/19 to 2021/22 (the last comparable year). In 2021/22, LTH benchmarked below the LSC average, but 4.6% above the national average, for in-hospital UEC cost per weighted capita of population. Data from the provider costing system indicates that the trend of increasing costs has continued into 2023/24.
Population change	Chorley and South Ribble (~6% growth from 2019 to 2023) experienced the fastest population growth in LSC, outpacing both the LSC total (~4%) and Greater Preston (~3%). Annual deaths in the LCC catchment area increased by 11.5% over 2019 to 2023, compared to a 9.3% increase nationally. This considerably faster rise in deaths relative to weighted population growth indicates increasing acuity, driving higher demand for primary and acute services. However, the growth in UEC activity, measured by attendances and admissions at LTH, is significantly higher than any of the growth in weighted population, deaths or acuity measures and exceeds the national average, suggesting that other factors are also contributing to this increase.
Upstream activity and provision	Central Lancashire ranks below the national average but in line with the system average for primary care appointment attendance metrics, including attended and GP-delivered appointments. From 2018 to 2024, Chorley and South Ribble maintained their number of qualified GPs, while Greater Preston saw a decrease of 3.9%, smaller than the national average decrease (4.3%). Both areas exceed the ICB average for GPs per weighted capita but fall short of the national average. Notably, Chorley ranks third lowest in the ICB for qualified clinical staff in general practice per weighted capita of population. Although Greater Preston and Chorley and South Ribble have experienced QOF score reductions similar to the LSC and national averages, Chorley and South Ribble saw a noticeable drop in QOF hypertension achievement. Capacity constraints in primary care, when compared to the national picture, may indicate gaps against the level of need in the population.
Acute/ secondary care activity	LTH has seen a substantial increase in A&E attendances (22.7%) and emergency admissions (14.5%), considerably higher than any increases in weighted population or deaths. Analysis indicates that performance against patient flow metrics is problematic, with LTH experiencing the fastest growth in A&E minutes, occupied bed days (21%), and excess bed days (73%) of all LSC providers from 2018/19 to 2023/24. LTH benchmarks high on occupied bed days relative to weighted catchment population (16.3% above average) and on emergency admissions relative to weighted catchment population (10% above average). Onsite observations show internal and onward flow challenges, with opportunities to optimise processes and work differently with community partners. There is apparent inconsistency between NCTR and other datasets (e.g., excess bed days, observations) indicating potential under-coding of NCTR.
Adult social care	Adult social care costs overall and per capita have grown for LCC, with a 21% increase in costs from 2018/19 to 2022/23. Lancashire benchmarks high (£622/ adult) on adult social care costs relative to England (£524) and the North West Region (£586). Increases in cost have been driven by increases in unit costs per hour: in-house costs per hour have grown 46% and external costs per hour have grown 36%, in both cases faster than the average rate of growth seen for England or the North West Region.

Summary of priority schemes

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Overarching Aim

*We aim to collaboratively **de-escalate** our system to **reduce ED waiting times** and **eliminate hospital boarding and corridor care** through improved patient flow, reduced rates of overnight admission, and demands for acute activity.*

Measured by:

1. ED Waiting time
2. No. Patients receiving corridor care
3. No. of boarded patients
4. Occupied bed days
5. Hospital Admissions – split by LoS – (Deflection and admissions avoidance)
6. Excess bed days – (Ward optimisation)
7. Performance Optimisation – (Linked to Primary Driver)

Alternatives to ED & Community Collaborative

- **NHS 111**
- **Clinical Assessment Service and out of hours primary care**
- **Pharmacy First (Community pharmacy consultation scheme)**
- **Care Connexions - patient navigation**
- **Virtual Wards**
- **High intensity users**
- **Enhanced utilisation of POCT**

ED Performance & In-flow (including alternatives to admission)

- **ED Streaming**
- **SDEC**
- **Acute Frailty Unit**
- **Improve Ambulance handover**

Flow (Hospital flow & LoS)

- **Reduce length of stay**
- **Improve joint discharge processes** (7-day discharge/Intermediate care/alternatives to admission)

Time Limited Home & Bed based support

- **Reduce length of stay**
- **Improve joint discharge processes** (7-day discharge/Intermediate care/alternatives to admission)

Mental Health

- **Initial response service**
- **Mental Health assessment**
- **Delayed transfer of care** (not meeting criteria to reside, including bridge to home initiative)
- **High Intensity users of ED**

System escalation and Coordination

- **OPEL action cards**
- **LSC local escalation and response call SOP**
- **UEC Capacity investment schemes**
- **Winter and Bank Holiday Coordination**
- **UECDB meeting on a page**
- **Assurance of the NHS Impact Ten high impact interventions**

Key milestones for delivery 2024/25 - 1/3

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Intervention		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Alternatives to ED & Community Collaborative										
1a	Explore admission avoidance opportunities with Care Homes to keep people safe and well within the Care Home	*TBC*								
1a	Optimise utilisation of pharmacy first	*TBC – scoping in progress*								
1a	Co-location of care connexion teams to created integrated single point of access team	Mobilised		Expansion due to commence						
1a	Hospice at Home	Mobilised								
1a	Point Of Care Testing for community teams to enhance and provide a sub acute level of care at home	*TBC*								
1b	Develop staffing model within care connexions to meet the needs of population	Links to 1a								
1b	Develop pathways with primary care around rapid access frailty assessments									
1b	Develop step up pathways for Community Services and virtual ward									
1b	Increase utilisation of virtual ward to 80% occupancy									
1b	Participate in INT meetings, including clinical attendance and monitor high risk patients to reduce crisis admissions	*TBC*								
1b	Collaboration work supporting the Category 3 999 calls increase 'Hear & Treat' , 'See & Treat'			Pilot work						
1b	Plan in place to decrease attendances from care homes, with improvement trajectory identified									
1b	Therapy support: To provide admission avoidance services at Chorley District Hospital covering ED and MAU									
ED performance and in-flow										
2a	Eliminate over 60 minute delays in ambulance patient handover									

Key milestones for delivery 2024/25 - 2/3

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Intervention		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2a	Improved time to ED first assessment to ensure patients are assessed within one hour with a plan									
2a	Increase admission avoidance flow	Through patients accessing SDEC including AFU, virtual ward, care connexion, Surgical Assessment Unit, Paediatric Assessment Unit and Gynaecology Assessment Unit at triage, Therapy admission avoidance								
2a	Increase workforce to provide 7-day cover across specialties and front door services									
2a	Improve access pathways to specialties to allow patients to be seen in the right place at the right time and access early senior clinician inpu									
2a	Increase referrals direct to unscheduled care, SDEC, MAU and Virtual Ward									
2a	TOO and MOTD roles / responsibilities and SoP agreed for 24/7 patient flow management									
2a	Creation of new AMU with appropriate pathways									
Flow										
2c	Improvement of ward round and ward discharge planning process based on the RCP guidelines									
2c	Enhance the discharge process to ensure that we increase our patients who are discharged pre 12 mid- day to 33%									
2c	Robust IHDI / TTO process to increase pre midday discharge									
2c	Early supported discharge through virtual ward, enhanced front door therapy services									
2c	Reduce number of patients in boarded and escalated beds									
2c	Top 5 delayed patients with FIT code to show bronze on dashboard to highlight for pre noon discharge									
2c	Reduce average LoS to 8.7 days									
2c	Reduce all inpatient stays to the next best quartile									

Key milestones for delivery 2024/25 - 3/3

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Intervention		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Time Limited Home & Bed based support										
3a	**Implement the 'Lancashire Model of Intermediate Care' consistently across the whole of Lancashire**	*TBC* – Phase 1 complete; Phase 2 requires further scoping, dependent on BCF review								
3a	**Integrated approach to Lancashire Care Market management; deliver integrated brokerage model**									
3a	**Design, develop and implement a consistent Lancashire Model of 'Short Term Support'**									
3a	**Manage demand for Care Services in Lancashire**									
3a	**Develop consistent approach to demand management for care and support services and**	Increase utilisation of: remote monitoring, community equipment and assistive technology, care sector support, advance care planning								
3a	**Full review of Lancashire Better Care Fund**									
Mental Health										
3b	**Improve awareness of the Initial Response Service as front door into all mental health services.**	*TBC*								
3b	**Deliver Initial Response Service improvement plan**									
3b	**Complete marketing of Initial Response Service to Central and West Lancashire population**									
3b	**Increase compliance to urgent response times**									
3b	**Explore opportunities to co-locate Mental Health Liaison Team with ED**									
2c	**Implement the Locality Bed Model in Central and West Lancashire**									
System escalation and coordination										
	Commence place winter planning									
	10 high impact interventions	Monitor progress of the 10 high impact interventions at place								
	UEC capacity investment schemes	Review activity, impact and spend of UEC place capacity investment schemes								

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Mid-Mersey and West Lancashire Recovery Plan

Mid-Mersey and West Lancs UEC Recovery Programme

NHS Cheshire and Merseyside

Admission Avoidance

Targets:
- Use of services to avoid conveyance
- Reduction in A&E attendances

Priorities:

NWAS (999 & 111)
- Optimising pathfinder use and potential options
- Increasing awareness/confidence for paramedics & 111
- Increase comms to services referring via 999
- Increase awareness & utilisation of DOS

Use of Community Services
- WIC / UTC review incl. standardisation and utilisation
- Ensure access to services & care co-ordination for patients with long term/complex conditions
- High Intensity Users - consider Voluntary sector support / social prescribing as alternative to medical model
- Enhance IV therapy service in community
- Review of falls pathways and provision

Front Door processes
- Frailty in-reach provision, referral to Urgent Community Response/ virtual wards
- Respiratory in-reach provision
- Virtual ward utilisation including use of 'step up' provision
- ED utilisation of social services

Acute length of stay

Targets:
- Increased number of patients utilising SDEC services
- Reduction in admissions for people aged over 65
- Reduced average length of stay

Priorities:

Front door
- Review ability to implement direct access pathways into assessment units (Southport)
- Launch dedicated minors programme (Whiston)
- Launch dedicated paediatrics programme (Whiston)
- Optimising medical admission model (direct to specialty/SDEC)
- Redesigning local criteria to admit tool (both sites)
- Implement Mental Health steering group and escalation processes for Trust

Patient flow on wards
- Re-launch/monitor 'Home for Lunch' across sites (both sites)
- Agree/standardise escalation process re RFD patients
- Maintain current G&A bed capacity (both sites)
- Formalise Frailty OPAL model (Whiston)
- Review discharge co-Ordinator provision across intermediate care
- Implement pathway for patients from 24hr care direct to Department of Medicine for Older People
- Revise process for medical TCI's to avoid use of ACU/assessment areas
- Review capacity and process for RFD cohorting

Acute discharge

Targets:
- NCTR – using ready for discharge to actual discharge times
- Number of patients entering each pathway

Priorities

Supporting patients and family
- Effective use of 'Choice Policy' in Acute Provider
- Supporting patients and families with effective system-wide communications programme

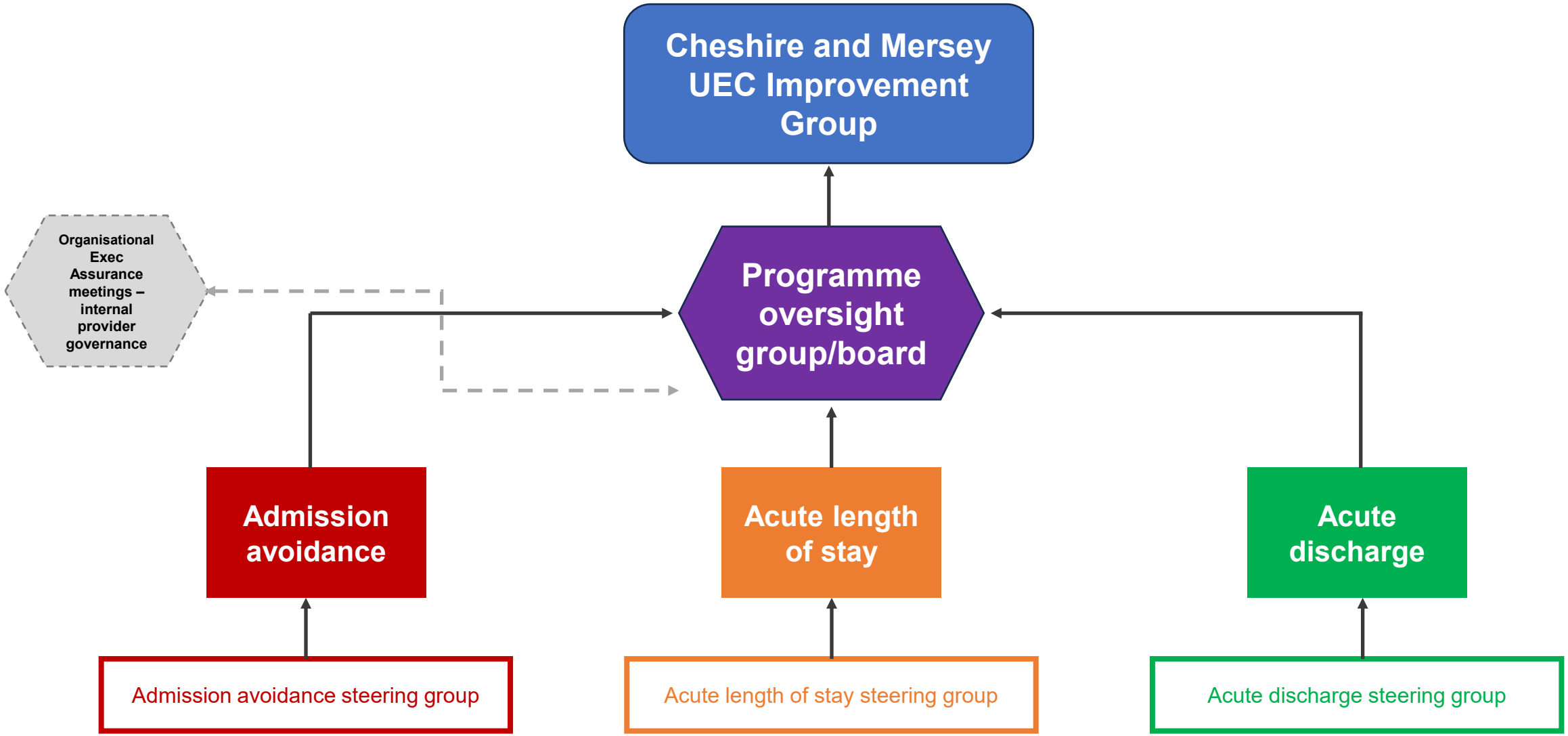
System-wide discharge processes
- Further embed the 'Describe don't Prescribe' ethos within Hospitals – e-discharge
- Review in-hospital discharge processes to standardise approach for rapid discharge across the 4 local authorities
- Review Transfer of Care Hub offer across places including possible trusted assessor model
- Increased use of home first pathway model
- Performance review of pathway 1-3 to identify capacity, demand, best practice and areas for improvement
- Deep dive into pathway 3 processes and associated over-prescription

Enabling Foundations

Trusted Data | Culture and Engagement | Benefits Realisation | Programme Management Office

May 2024	July 2024	Dec 2024	Mar 2025	May 2025
Setup	Design phase	New ways of working	Monitoring & adapting	Embed

Governance


Cheshire and Mersey UEC Improvement Group
Organisational Exec Assurance meetings – internal provider governance
Programme oversight group/board
Admission avoidance
Acute length of stay
Acute discharge
Admission avoidance steering group
Acute length of stay steering group
Acute discharge steering group

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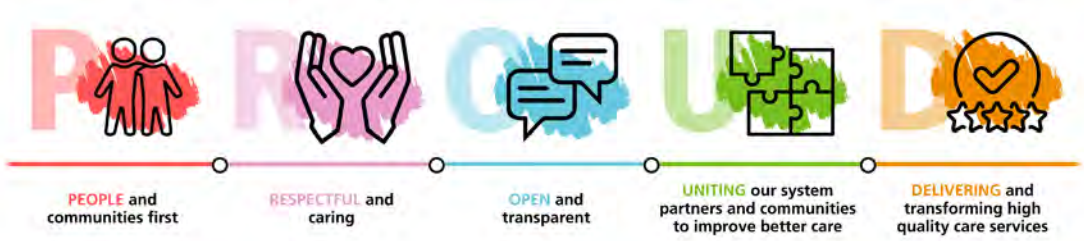
UEC 5-year Strategy

Quality Standards and Performance Metrics

Appendix B



Introduction and purpose of this document

Lancashire and South Cumbria Integrated Care Board

This document is Appendix B of the **Lancashire and South Cumbria Integrated Care System Urgent and Emergency Care 5-year strategy 2024-2029**.

It contains a set of quality standards and performance metrics which have been chosen to provide insight into the quality of care provided by our urgent and emergency care services. Measuring this information is imperative to understand how care is delivered by our urgent and emergency care services across Lancashire and South Cumbria and to assess our progress in delivering our strategy and vision for urgent and emergency care.

Quality Standards

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UEC service area	Quality standard	Indicator	Target	Rationale
Ambulance / 111	Ambulance handovers	Percentage of ambulance handovers completed within 15 minutes	≥ 85%	Minimising ambulance handover times ensures quick transfer of care and frees up ambulance resources
Front door	Time to treatment	Median time from arrival to the start of definitive treatment	60 minutes	Early initiation of treatment can improve outcomes and patient satisfaction
	4-hour standard	Percentage of patients seen, treated, admitted or discharged within 4 hours of arrival in the Emergency Department	78% by March 2025	Ensures timely care and reduces overcrowding in the department
	Time to initial assessment	Median time from patient arrival to initial assessment by a healthcare professional	Within 15 minutes for all patients	Quick assessment is crucial for identifying life-threatening conditions and prioritising care
Flow	Mental Health assessment	Percentage of patients presenting with mental health issues who receive a full mental health assessment within 1 hour of arrival	90%	Rapid mental health assessments are essential for appropriate care and to prevent harm
	Reattendance rate	Percentage of patients reattending the Emergency Department within 7 days of their initial visit	< 5%	Lower reattendance rates indicate effective initial treatment and discharge planning
Discharge	Discharge summary completeness	Percentage of discharge summaries completed and sent to the patient's GP within 24 hours of discharge	100%	Ensures continuity of care and timely communication with primary care providers
Patient experience	Patient experience	Patient satisfaction score based on post-visit surveys or the Friends and Family Test	≥ 90% of patients would recommend the service	Reflects the quality of care and the patient-centered approach of the ED
		Number of complaints, urgent and emergency care related and outcomes of the related investigations		Monthly monitoring and review will be undertaken
Patient safety	Adverse events monitoring	Number and rate of adverse events (e.g., medication errors, falls, pressure ulcers) reported within the department	Continuous monitoring with a focus on reduction and prevention	Monitoring and reducing adverse events improve patient safety and care
Care Quality Commission	Survey	Monitor action plan as to how Trusts are addressing areas marked as "worse than expected"	Continuous monitoring	To improve patient experience, care and safety

Performance Metrics

What this will mean for our people	Indicator	Baseline 1.1.24 – 31.12.24 (unless stated otherwise)	Target	Rationale
More accessible and timely	Improve Virtual ward utilisation	59.47%	80% Occupancy	• Rapid and easy access to urgent and emergency care services • when you need them • Clarity over which services are available, what they are for, and how you can access them • More options for care and support accessible to you in the community and being able to receive urgent and emergency care at home or closer to home • Reduced waiting times for ambulances or in emergency departments • Reduced waiting times for inpatient care • Minimised ambulance handover times and quicker transfers of care
	Maintain the percentage of urgent community response referrals met within two hours	95.4%	70% response within 2 hours	
	Reduce 30–60-minute handover delays	65.4 average delays per day	Less than 5%	
	Improvement in Category 2 ambulance response times	29 mins 33 Secs	As per national objective (currently 30 mins)	
	Reduce the percentage of attendance to emergency departments with a length of stay over 12 hours	8.68%	Less than 2%	
	Achieve all type 4-hour A&E performance	78.22%	As per national objective (currently 78% in March 2025)	
Safer and improved experience	Increase percentage of patients managed away from hospital settings (Hear & Treat/See & Treat)	Hear & Treat 13.92% See &Treat 29.18%	Improvement	• Only the patients requiring urgent acute care will be directed to hospital and admitted • No corridor care in emergency departments • Earlier initiation of treatment to improve outcomes and patient satisfaction • Reduced adverse events with improved patient safety and care • Better experience of using services for the person, their family and carers
	Zero corridor care	No baseline	Zero	
	Reduce percentage of patients conveyed to hospital	See & Convey Non ED 8.01% See & Convey to ED 40.85%	Improvement	
More efficient	Reduction in patients not meeting criteria to reside	20.02%	Improvement to 10% with an ambition of 5%	• Shorter stays in hospital and not staying in hospital longer than clinically necessary • Speedier discharge processes with onward support that meets your needs as required • Lower reattendance rates indicating effective initial treatment
	Reduction in community beds length of stay	TBC	Improvement	
	Reduction in length of stay	LOS >7 days 48.69% LOS >14 days 27.17% LOS >21 days 14.89%	Improvement	

Performance Metrics

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What this will mean for our people	Indicator	Baseline 1.1.24 – 31.12.24 (unless stated otherwise)	Target	Rationale
Better outcomes	Reduction on mental health patients in general acute beds	TBC	Improvement	• More rapid assessments, including mental health assessments, essential for appropriate care and to prevent harm • Reducing the time for patients in community requiring a mental health bed • More support for your health in the community with better health promotion and prevention • Improved support for your mental health and wellbeing • Being healthier, living longer, spending more years living in good health and remaining independent for longer • Better ability to manage your long-term health conditions, with support from health and care services, and avoid deterioration
	Reduction in time to undertake a mental health assessment in the emergency department	TBC	Improvement	
	Reduction in out of area placements for mental health patients	6 (August 2024)	Zero by March 2025	
	Improved access times for urgent mental health support	TBC	Improvement	
More person-centred	Reduction in the number of patients being directed to ED	126.3 patients on average per day	Improvement	• Signposting to self-care advice and guidance being readily available for specific conditions • Collaborative working between your health and care providers, so your care feels well-coordinated and personalised to you and your needs, as well as those of your family and carers • Involving you, your family and your carers in your care and decisions, and providing the support you need • Listening to what matters to you

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