Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Urgent and emergency care pathways across Harrogate, Knaresborough and rural neighbourhoods

November 2024

National focus on urgent and emergency care

Nationally, the NHS in England is in the second year of delivering the Plan for Recovering Urgent and Emergency Care Services, released in January 2023.

The delivery plan focuses on improving waiting times and experience, and delivering two performance standards;

- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours.
- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average.

Meeting this challenge will require sustained focus on five areas:

- Increasing urgent and emergency care capacity– increasing the number of beds and ambulances and implementing same day emergency care in every hospital to avoid unnecessary overnight stays
- Increasing workforce size and flexibility – increasing clinical capacity in the 111 service
- Improving discharge – to establish care transfer hubs in every hospital
- Expanding care outside of hospital to avoid emergency admissions – bolstering community urgent response and improving utilisation of virtual wards
- Making it easier to access the right care – through improving access to mental health services via 111.

Local ambition - *"…the right care at the right time, avoiding unnecessary hospital attendances and admissions".*

Oversight and planning of urgent and emergency care services for Harrogate, Knaresborough and rural neighbourhoods is undertaken at a system level by partners from across primary, secondary and community healthcare and the local authority. Urgent and emergency care has three themes that underpin activities to improve local provision and care, and meet the national performance standards; admission avoidance, in-hospital care and processes, and discharge.

Admission avoidance

Primary care – to provide timely care close to home and deliver vital health interventions including the vaccination programmes which prevent ill health

111 / 999 services – increasing connectivity to wider community services across the system to offer more patients an alternative to hospital services

Pharmacy First – enabling people with minor ailments to receive treatment from community pharmacies

Alternative pathways to admission – supporting proactive multi-disciplinary assessment in the community and at the front door of the Emergency Department (ED)

Same Day Emergency Care – enabling patients to be assessed, diagnosed and treated within the hospital without being admitted overnight.

In-hospital care and process

Ambulance handovers and Emergency Department flow – to ensure patients receive timely emergency care and ambulances can be redeployed promptly

Patient flow and escalation processes – movement and escalation throughout the hospital to maintain emergency care capacity

Frailty – developing specific frailty assessment pathways for vulnerable patients

OPTICA (Optimised Patient Tracking and Intelligent Choices Application) – facilitating the tracking and sharing of patient information between health and social care colleagues to improve communication and smooth discharge planning.

Discharge and beyond

Discharge to assess pathways – enabling assessment of ongoing need to be made outside of the hospital setting

Intermediate care pathways – to enable recovery, rehabilitation and reablement to take place in the most appropriate setting, and at home where possible

Care transfer hubs – to bring health and social care teams together to triage referrals and plan next steps for patients with ongoing health and care needs.

Admission avoidance – core services and developments

Admission avoidance focuses on providing timely, accessible care to prevent deterioration and the need for hospital admission. Focused on addressing health needs in the community, this approach helps maintain patients' independence and mobility, reducing the risk of harm associated with extended hospital stays beyond the medical phase.

Admission avoidance

- **Primary care access** –provides support to patients living with long-term conditions, and those requiring same day urgent care. Capacity increases are planned for the winter period annually, with out of hours support provided across practice and hubs in Harrogate, Knaresborough and Ripon.
- **Pharmacy First** – enabling local people with minor ailments or those requiring an urgent supply of routine medication, to receive support from local pharmacies
- **111 services** – full review of the Directory of Service completed (the tool 111 colleagues use to identify the right service for patients) to ensure more patients are directed to the right service first time
- **999 services** – From November 18th, implementation of an Integrated Care Coordination Hub - adding GPs to the ambulance service contact centre team to review low acuity calls and redirect calls to appropriate alternative services – safely connecting people to the right care to meet their needs and avoiding unnecessary deployment of ambulances
- **Hospital at Home services –** Harrogate and District Foundation Trust (HDFT) provide services designed to support patients in their own home, including consultant-led care for patients who would otherwise be in hospital and urgent crisis response services (within two hours) for frailty-related clinical conditions which would otherwise result in a hospital admission.
- **Frailty assessment in the Emergency Department** – from September 2024, HDFT have extended their ED team to include therapists who are able to assess frail, older people and recommend suitable community pathways as an alternative to admission.

Key indicators of system health and performance

- 81% of Harrogate patients describe their experience of contacting their GP practice as good (compared to 67% nationally)
  The national GP Patient Survey, January 2024
- Circa 25% more GP appointments were delivered in quarter one of 24/25 than in the same period before the pandemic (*nationally, GPs are delivering a fifth more appointments than pre-pandemic)*
  NHS England website
- Across North Yorkshire, over 90% of 111 calls over the last six months have been answered within 120 seconds (resulting in a 300% reduction in calls being abandoned)
- Consultant-led hospital at home beds have increased from 10 to 18 in 2024.

In hospital care and process

Maintaining efficient patient flow is an important factor in a healthy urgent and emergency care system, ensuring that ED resources are available for those with urgent needs and preventing the use of escalation areas. Robust escalation processes, communication between departments, and health and social care colleagues, and efficient discharge processes support timely, high-quality care and facilitates patients' safe return home, reducing unnecessary days in hospital.

In-hospital care and process

- **Upgraded Emergency Department at Harrogate General Hospital** – including a dedicated service for minor injuries and minor illness. Development of a Rapid Initial Assessment and Treatment space, optimising space for patients with the most urgent need and supporting rapid ambulance offloading and handover
- **Internal flow and escalation processes** – maintaining the flow of patients through the emergency department and hospital is a priority when ensuring timely access to emergency care. Monitoring and planning of patients waiting to come into hospital; patients in each ward and department; and patients awaiting discharge, is live and constant throughout the day. Clear escalation protocols are enacted if there are surges in demand
- **'Super September'** – saw hospital and community teams trial new ways of working to meet the urgent care needs of patients. Frailty assessment in the ED (rather than once a patient is admitted) were particularly successful and will continue to be delivered with a view to avoiding admissions where possible and starting therapy planning at the point of admission where the patient is assessed to need inpatient care
- **Launch earlier this year of OPTICA (Optimised Patient Tracking & Intelligent Choices Application**), a secure cloud application which tracks all admitted patients and the tasks relating to their discharge in real-time through their hospital journey. OPTICA is the first record that combines hospital and social care information to ensure all members of the team have live access to the same information
- **Additional patient transport –** to be put in place between December and March to support patients to return home in a timely way when they are discharged from hospital and optimise the flow of patients through the hospital.

Key indicators of system health and performance

- ✓ 90% of patients are assessed by a nurse within 15 minutes of arriving in the Emergency Department
- ✓ 90% of handovers from the ambulance crew to ED colleagues occur within 30 minutes
- ✓ In October, 73% of patients entered and left ED within 4 hours (putting Harrogate in the top third of trust's nationally).

Harrogate Hospital's upgraded ED department

Discharge and beyond

Effective discharge processes focus on ensuring patients leave hospital safely and with any adaptations or ongoing care that they may need. Effective discharges reduce the risk of readmission, provide assessment for ongoing need in the most suitable place and enable recovery, rehabilitation and reablement in the most appropriate environment to foster long-term wellbeing and independence.

Discharge and beyond

- **Intermediate care pathways** – Harrogate has several intermediate care pathways that enable recovery, rehabilitation and reablement to take place outside of the acute hospital setting once medical care is complete. Intermediate takes place at home where needs can be safely met or in a community bed if further rehabilitation is required. In Harrogate, there are 14 intermediate care beds available for patients requiring further support before they return home.
- **Discharge to assess** – this process, delivered in collaboration by health and social care colleagues, ensures patients' ongoing care needs are assessed in the most appropriate place once they are medically ready to leave hospital; this may be at home with additional temporary support. or in a community bed if further rehabilitation is required.
- **Care transfer hubs –** Launched in August at HDFT, the care transfer hub brings together a multidisciplinary health and social care team together in one location. The hub will support streamlined decision making, reduce delays in patient discharges and ensure that patients' ongoing health and care needs are met in the most appropriate setting.

Key indicators of system health and performance

- Reduction in length of stay (average number of days in hospital) for patients experiencing frailty
- Over 600 people a year go home with support for shopping, meals, and visits from a Home from Hospital service provided by Carers Resource
- Harrogate system partners consistently ensure that people who no longer need to stay in hospital receive timely support to continue their recovery at home or in an appropriate facility in the community.

Key system challenges impacting urgent and emergency care in Harrogate

Whilst progress is positive, there are several key challenges impacting on urgent and emergency care locally which system partners will continue to address;

- **Rising demand and complexity** – rising demand for urgent and emergency care has intensified capacity pressures across the entire health and social care system. Annually, HDFT is seeing an increase in hospital attendances and an increase in the proportion of people requiring admission (indicating patient complexity is increasing). Pre-covid, the hospital would have seen 120 – 140 patients per day – the average now is closer to 170 patients per day. Demand for 111, GP services, social care and other public services is also rising – perpetuated by an ageing population and the lingering impact of Covid on the population's health. The response to this includes efforts to strengthen community-based care and support, better connect physical, mental health and social care services, and better utilise the skills of voluntary sector partners in supporting health and wellbeing

- **Capacity constraints across the system** – finite capacity across the whole system in the face of rising demand. Limited resource, both in terms of physical space and workforce, can make it difficult to provide care and support in the right place, first time. The challenge is further complicated by the growing number of patients presenting with complex, multifaceted needs. Meeting these needs requires continued collaboration between health, social care and other local authority departments

- **Data infrastructure and connectivity** – nationally, the progress towards integrating data systems and fostering connectivity between providers has been slow. The Yorkshire Care Record, currently being piloted across Humber and North Yorkshire, is a digital shared care record solution that enables patient information from multiple sources to be accessed securely and updated in real time

- **Sustainability of primary care services** – nationally, the increasing demand for services, combined with increased overhead costs and workforce challenges, raises concerns about the long-term sustainability of primary care. Addressing these issues at a system level is essential in ensuring that primary care can continue to play its crucial role in providing continuity to people with complex needs and ensuring patients are supported by the right service to meet their needs.