NHS

North East Essex
Clinical Commissioning Group

North East Essex System

Urgent Care Strategy

2016-2019

North East Essex
Clinical Commissioning Group

Version control

Version number	Date	Authority	Nature of Changes	Comments
V1	15/7/16	Morag Kirkpatrick	New document	
V2	19/7/16	Morag Kirkpatrick/Elizabeth Wheatley/Hasan Chowhan (HMC)	Additional information and headings included	Also sent to Kate Vaughton and Jo Hall (JH) for comments.
V3	22/7/16	Morag Kirkpatrick	Further additional information added	Vision Diagram from this version tabled to SROG 29/7/16 to present the headlines of strategy.
V4	2/8/16	Morag Kirkpatrick/Nicole Smith	Further additional information added	
V5	8/8/16	Morag Kirkpatrick	Timescales included, track changes accepted to date	Sent to Sam Hepplewhite and Pam Green for comments.
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Vision diagram	10/8/16	Morag Kirkpatrick	Strategy discussed at Health Forum Committee, Tendring Meeting to capture views	No amendments required
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V9	6/9/16	Morag Kirkpatrick/CRG (GP Elected) members	Additions added: Mental Health End of Life	
V10	12/9/16	Morag Kirkpatrick	Track changes accepted from v9,	Version included in Urgent care paper for

			added in public health info.	September Board for comments. Paper Sent to HMC, JH, GS, Pam Green for comments. No amendments made.
Verbal presentation	10/11/16	Morag Kirkpatrick/Sandy Measor	Verbal presentation and discussion of UC strategy with Local Pharmacy Committee	No amendments made.
V12	14/11/16	Morag Kirkpatrick	Version saved for submission to Board	For approval at Nov CCG Board
V13 FINAL	1/12/16	Morag Kirkpatrick	Version V12 approved by Board 28/11/16	Following amendments: • Removal of watermark • Change of title to system strategy.

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North East Essex System Urgent Care Strategy (2016-2019)

1. Executive Summary

North East Essex (NEE) has engaged with the public through two Big Care Debates and undertaken more specific audits, including a recent listening exercise with the public to understand how people use local urgent care services. These told the CCG that services needed to be simple to use, with consistency of access and a more joined up approach between services. Furthermore, it highlighted that people were not aware of all out of hospital urgent care services or how to access these, requesting clearer self-care information and signposting.

The Urgent Care Strategy outlines a vision for North East Essex that ensures people who require support in a crisis are able to access the right service, first time. Through development of a robust integrated Urgent Care Service (IUCS), the public will have a single point of access for urgent care, which is able to provide access to support for physical, mental and social health through an integrated approach that is seamless to the patient.

A theme throughout the document is a greater emphasis on supporting people to self-care and access pharmacy support. This is underpinned by a programme of regular education and communication to the public and an expectation that clinicians will, where clinically safe to do so, redirect people to self-care or to a pharmacy.

The vision provides stronger integration to Care Closer to Home, Mental Health and End of Life services and the expectation that where possible people will be supported to manage their health care needs and prevent crisis but where this happens, the aim will be 'Home First', wrapping care around the person and reduce unnecessary hospital (or other) attendance.

A number of initiatives will be commenced during the first year that supports our vision, such as Streaming in the Emergency Department, stronger self-care messaging and Discharge to Assess models.

Alongside the embedding of the Integrated Urgent Care Model, the strategy will run in parallel to the implementation of the Primary Care strategy and undertake a review of out of hospital urgent care services to ensure that the system (services and the workforce) is fit to support the vision for urgent care in the future.

2. Statement of Intent

NEE CCG is committed to achieving the aims of the NHSE Five Year Forward View (FYFV) by 2020 by providing modern, efficient, high quality urgent healthcare. The public has told us that the current system is confusing, making it difficult to access the right service. To change this, we are willing to break down old organisational boundaries and professional behaviours and are prepared to meet the challenges and make the decisions and system changes necessary to ensure our urgent care services meet the needs of our patients and are sustainable in the future. Through this approach we aim to develop a single point of access for urgent care that is able to take ownership of a patients problem and seamlessly able to direct them to the most appropriate service; patients will be discouraged from walking into a service that is not the most appropriate for their need however will be supported through the single point of contact to access to access the right care first time.

We will focus on five key areas for improvement:

- Streaming at the Front Door (Emergency Department) to Ambulatory Community care and Primary Care services.
- NHS 111 – Increasing the number of calls transferred for clinical advice
- Ambulances – Dispatch on Disposition to enhance patient outcomes, code review pilots and Health Education England (HEE) increasing workforce.
- Improved Flow – implementation of models to enhance patient flow, working in the best interests of patients.
- Discharge – mandating a 'Discharge to Assess' and 'Trusted Assessor' type models supported by close working with local authorities to ensure successful implementation for whole health and care system.

The opportunity to refresh the urgent care strategy is being undertaken in recognition of the need to integrate with wider programmes of work such as Primary Care transformation, and the Care Closer to Home approach. This requires a continual drive for complete system ownership from local authorities, the voluntary sector, mental health and physical health services to effect large scale change.

3. Our vision for Urgent Care in North East Essex

Our vision for out of hospital urgent care is to become an extension of the Care Closer to Home Model; supporting the public to self-care and prevent crisis where possible, but with a network of community professional and voluntary support for those that need it.

There will be a stronger emphasis on the community reaching in to the acute hospital to support and challenge colleagues to consider 'home first' at every stage of patient's journeys to ensure admissions to hospital are appropriate and as short as possible. As part of this approach, a trust assessor model will be adopted to support greater integration and reduce duplicate assessments for our patients.

There will be a true single point of access for out of hospital urgent care through developing the 111 and out of hour's service (to be known as 'Integrated Urgent Care'). We envisage this will have the ability for patients to access physical health, mental health and social health support, fully integrated with the Care Closer to Home Community Gateway and other single points of contact, with access to the relevant patient records.

We recognise that the current urgent care system is complex and means patients can often default to A&E. This was recognised nationally in the Urgent and Emergency care review, end of phase 1 report which stated 40% of patients attending A&E are discharged requiring no treatment at all. The Integrated Urgent Care Service (IUCS) will support patients being directed to the most appropriate service, with potential for bookable appointment systems in the future. This will be supported in parallel with strong communication plans to ensure the public can be confident of where to go in a crisis and no longer feel A&E is the only option.

The Out of Hospital Urgent Care system will have one set of strategic measures and include patient focussed outcomes and experience, access and value for money.

Our vision is in response to listening to our public and stakeholders, including, our recent Big Care Debates, where people have asked for the following outcomes;

- To reduce complexity in the system to enable patients and clinicians to make an informed choice
- To ensure there is consistency of provision across the services regardless of what time of day or day of the week the patient presents
- That support is provided by people with the right skills, in the right place and at the right time.
- To feel assured that the resources available are used in an efficient way and services are sustainable to deliver future demands.

4. National Context and Case for Change

The North East Essex Urgent Care strategy was developed with system partners in 2014. Since this time, there have been some significant advances in the national strategic direction.

In 2013, there was national recognition that urgent care services were unsustainable in their current configurations. There was call for simplification of services and that the public should not be expected to make rational decisions of where to go in times of crisis (Transforming Urgent and Emergency care services in England, 2013).

Following the Urgent and Emergency care review, System Resilience Groups (SRGs) across CCGs were established to facilitate local solutions and alignment of out of hospital services with winter resilience. As part of this, Vanguard areas would increase the pace of change and were supported to develop large transformational projects. The review also initiated the wider 111/Out of Hours vision for more integrated services and called for system wide measures to support this.

During early 2016, NHS England's planning guidance (2016) cited further embedding of the integrated approach with the call for Sustainability and Transformation Plans (STP's); focusing on commissioning for places and people, not around organisations. It allows CCGs to look further than traditional commissioning footprints.

NHS England has more recently signalled a need to focus on recovery of urgent care performance and develop SRGs into Local A&E Delivery Groups. As part of the recovery 5 mandated improvement initiatives have been outlined;

1. **Streaming at the front door** – to ambulatory and primary care.
   This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.
2. **NHS 111** – Increasing the number of calls transferred for clinical advice'. This will decrease call transfers to ambulance services and reduce A&E attendances.
3. **Ambulances** – Dispatch on Disposition (DoD) and code review pilots; HEE increasing workforce.
   This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance and an increase in 'hear and treat' and 'see and treat' to divert patients away from the ED.
4. **Improved flow** – 'must do's that each Trust should implement to enhance patient flow.
   This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the 'SAFER' bundle will facilitate clinicians working collaboratively in the best interests of patients.
5. **Discharge** – mandating 'Discharge to Assess' and 'trusted assessor' type models.
   All systems moving to a 'Discharge to Assess' model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system.

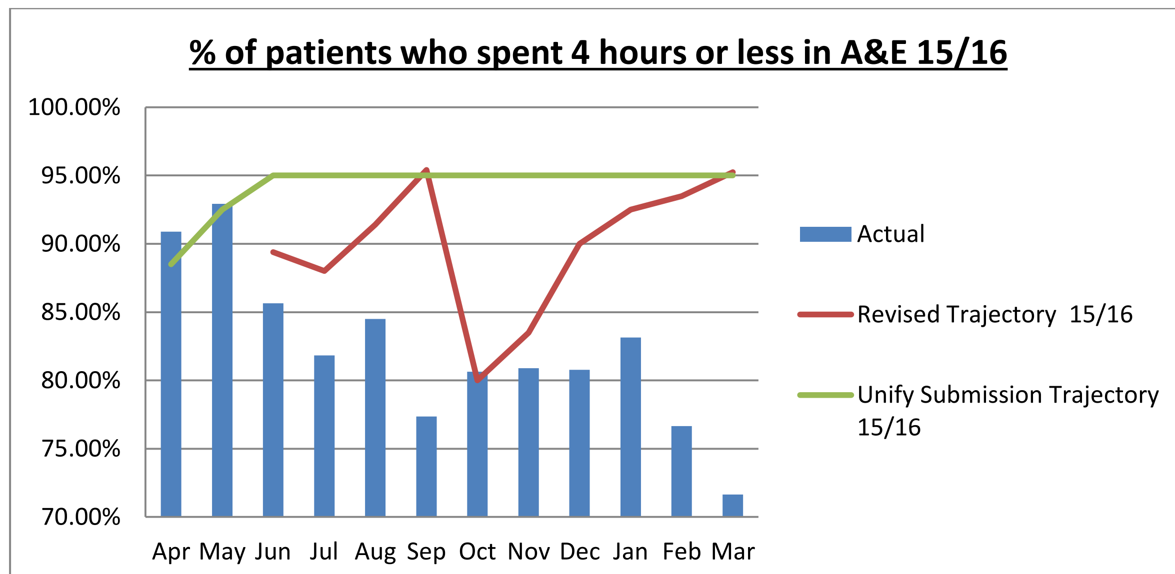
5. North East Essex Background

Locally, North East Essex (NEE) has engaged with the public through 2 Big Care Debates and more specifically undertaken a number of audits and a public listening exercise to understand how people use local urgent care services. These told the CCG that current services are confusing and needed to be simple to use, with consistency of access and a more joined up approach between services. Furthermore people are using out of hospital urgent care services because they were not sure where else to go, asking for clearer self-care information and signposting. Local residents felt that their GP practice was valued however following public concerns that access was cited in the Big Care Debate as difficult, more recently in our listening exercise we are told that a significant proportion of the local public no longer attempt to see their GP as a first line option.

During 2015/16 NEE has successfully procured a new model for out of hospital care. The Care Closer to Home model is a multi-speciality community provider (MCP) as described in the Five Year Forward View. It commenced on 1st April 2016, delivering care in a patient centred way, with case management delivered through neighbourhood teams wrapped around clusters of GP practices.

For Urgent care however, despite a number of initiatives to reduce attendances and admissions to hospital, such as a Rapid Assessment Service, High Intensity User Group and GP in Emergency Operation Centre (EOC), we have continued to see an overall increase in demand in all urgent care services and continue to fail to consistently meet the constitutional standard for 95% of people assessed in A&E within 4 hours:

Table 1 – A&E Performance 15/16

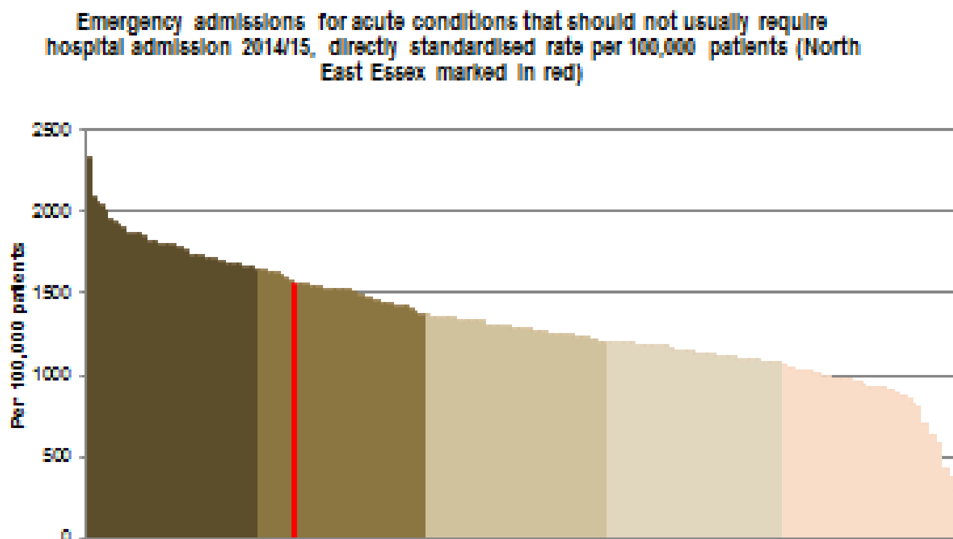


The overall 2015/16 year position was 82.1%. There were several reasons for the underperformance of A&E that need to be taken into consideration when redesigning urgent care services in the future:

- Rise in Demand and level of patient acuity – admission avoidance schemes have taken longer to implement than anticipated due to system ownership of pathways.
- Workforce - Staffing shortages across the system & high use of agency, often resulting in high sickness levels.
- Poor clinical engagement - Key recovery schemes not receiving senior clinical ownership to support implementation at ground level.
- Inconsistent implementation of agreed schemes - Competing priorities and lack of focus on key schemes led to inconsistent implementation of initiatives not delivering anticipated outcomes.
- CQC Regulatory Action- Competing pulls on resources led to these being diverted to support CQC actions rather than agreed recovery initiatives.

- Impact of North East Essex Pressures - Supporting community services have experienced lower levels of capacity due to high sickness levels etc., impacting heavily on patient flow.

Evidence from the Health and Social Care Information Centre (SCIC) Indicator Portal, suggests that there are a number of acute conditions that should not usually require hospital admissions. These include: Influenza, pneumonia and other vaccine preventable conditions; angina, dehydration and gastroenteritis; pyelonephritis and kidney/urinary tract infections; perforated/bleeding ulcer; cellulitis; ear, nose and throat infections; dental conditions; convulsions and epilepsy. The diagram below demonstrates that North East Essex is positioned in the second from upper quintile compared nationally, suggesting there is scope to improve on out of hospital urgent care support.



Source: NHS Digital (Health and Social Care Information Centre Indicators)

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Essex County Council

6. What Good Looks Like for North East Essex

There was agreement in early January 2016, as part of the SRG with our system partners, a commitment to follow 4 principles, to underpin all strategic and operational decisions:

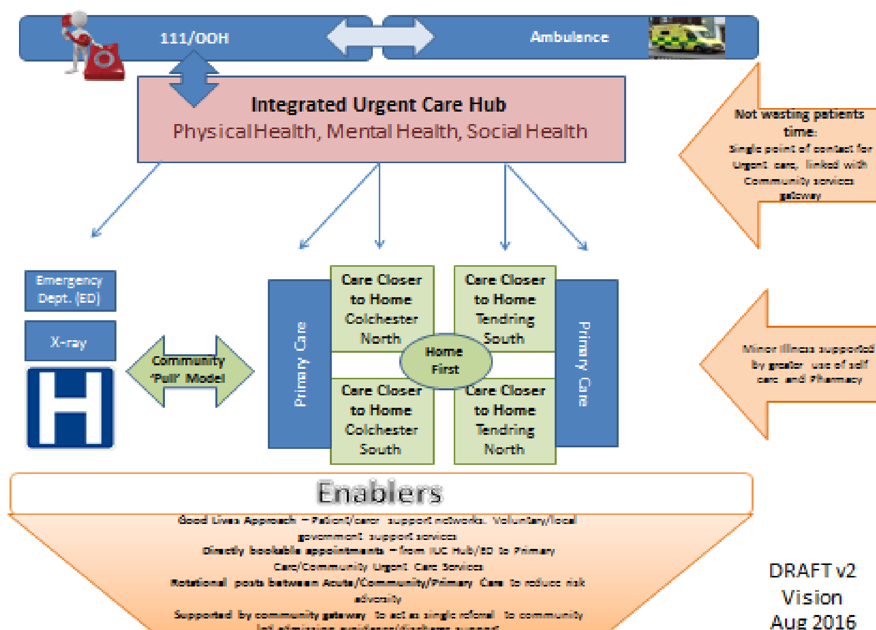
1. Home First - We will work as a system and with all service providers to ensure that the principle of home first is embedded in all decisions made about patients and how services are configured and delivered. Everyone has a bed and that bed is at home.

2. Avoiding Failure Demand - When a patient with a long term condition is admitted to hospital we, as providers and commissioners of services in NEE, have failed to manage demand. When considering planned care demand, there are services that could be provided by primary care and closer to the patient's home rather than them having to see a consultant specialist. In turn this supports the trust to use its specialist capacity to meet the needs of the correct patients.

3. Not Wasting Patients' Time – We will work together in such a way that patients do not spend time waiting unnecessarily, do not have to repeat themselves, that decisions are fast and next steps in their pathways are delivered quickly. Patients will not spend days in hospital that add no value or attend appointments or have diagnostics that do not contribute to the overall outcome of their care.

4. Pull not Push Model - We will ensure that services provided are delivered in such a way that patients are pulled from the hospital back to their homes when they need to be admitted and need support to return home.

The diagram below demonstrates how we see the vision for urgent care being supported by our principles and integrated with the community care closer to home approach:



Good Lives Approach - Embedded across the system will be the expectation that professionals and the public engage in conversations not assessments, acknowledging that the patient is the expert in their own life and the professional can only support them in achieving wellbeing. The aim is to build sustainable community resilience in line with the STP, using alternative support networks to those traditional statutory services and giving the patient greater control of their lives. In a crisis, this means not making long term and life changing decisions or presumptions but supporting the patient to get the help they need at that point in time – *HOME FIRST*.

Greater Support for Self Care – Our starting point must be to equip as many people as we can with the skills and knowledge to support self-care. This will be achieved by providing easily accessible information so people feel supported without the need to see a health care professional and when they do see a professional, using the good lives conversation to help people help themselves in the first instance. This will rely on strengthening our links with the Voluntary sector and maximising My Social Prescription to build community resilience. – *AVOIDING FAILURE DEMAND.*

Significantly enhance the clinical hub – the hub delivered as part of the 111 and OOH will be expanded to ensure that this meets physical, social and mental health needs and can act as a **single** point of access. This will not necessarily mean clinicians of each expertise being in the hubs, but services aligned to facilitate timely access and the 'warm transfer' of call. This hub will be supported by a comprehensive directory of services to ensure patients receive the appropriate advice to resolve their issue first time. Services will have access to medical notes, meaning patients will not have to wait to be called back, or repeat their information -*HOME FIRST/NOT WASTING PATIENTS TIME*

Greater Access to Primary Care – with the ultimate aim being that no patient attends A&E as a 'walk in' because they have been unable to access an urgent GP appointment. This will be supported by the primary care transformation programme ensuring there are a range of options for patients to contact their local GP such as e-consultations, telephone consultations, and improved access to appointment.–*NOT WASTING PATIENTS TIME/AVOIDING FAILURE DEMAND*

Improved integration with mental health services – Currently, the Strategy for Mental Health is under review however there is an expectation that access to mental health crisis services will form close links with the Integrated Urgent Care model.

Currently we would support the plans within the existing North Essex Crisis Care Concordat Action Plan to continue to deliver mental health liaison roles within the ED and the Street Triage service to ensure that people requiring crisis support in relation to their mental health, that this is quickly identified and people can be supported by staff in services with the right skills. This will be further strengthened through the ability for the IUCS to access mental health clinicians to ensure ED is not the default position for these people, where ED is not best suited to meet their immediate need. *AVOIDING FAILURE DEMAND*

Increased ambulatory care conditions managed in the community – patients with these conditions will wherever possible be managed in the community. Some patients will require the services of an acute hospital however; a community focus will be maintained to ensure they can be discharged

back to their home with the appropriate level of care required - *AVOIDING FAILURE DEMAND/PULL NOT PUSH MODEL.*

End of Life Care – An aim within the NEE End of Life Strategy is: 'Improving urgent and emergency care services and reducing avoidable admissions and preventing unnecessary hospital stays – enabling integrated care pathways and the development of community based services'.

It is imperative that all Urgent Care Services, including the IUCS is able to access the End of Life Register to enable quick identification of people's needs and wishes at end of life and that the Single Point of Access for End of Life (SinglePoint) is closely linked with the IUCS model to ensure that people in crisis are supported to remain at home where that is their wish at end of life. *HOME FIRST/AVOIDING FAILURE DEMAND*

7. Actions to support achievement of the vision

Short Term (2016-2017):

- Introduction and testing of triage and streaming in the Walk in Centre and Minor Injury Units.
- Commencement of Streaming from the Emergency Department to Primary care and self-care.
- Increased community presence in ED and short stay units to ensure patients are not admitted when not required.
- Increased engagement and strengthened partnership working with local authorities and Voluntary services as we develop new ways of working.
- Winter planning – Engaging the whole system to test and implement schemes that will support the expected increased demand over the winter period and support longer term sustainability.
- Undertake a demand and capacity analysis to underpin the support provided to the system, ensuring that there are clear indicators for measuring success of schemes and can enable an exit strategy to be quickly implemented for those that do not have the expected impact. This will support the use of resources being used in the most effective way to maximise the benefit to patients.
- Frailty model - 14 Beds in the Emergency Assessment Unit (EAU) designated as the Elderly Frail Unit (EFU) will be amalgamated into EAU. Linked to this an Elderly Short Stay Unit (SSU) will be Commissioned on Birch Ward from 29th July 2016 as part of the hospital's Care of the Elderly Project (31 beds). Patients coming through EAU will be identified for LOS (<7days) and Frailty. A live list of Short Stay appropriate patients will be maintained on EAU with all patients having a daily Consultant review.

Big Picture (2016-2019):

1. **Integrated Urgent Care procurement (111/OOHs)** – 'Go live' with the integrated 111 and Out of Hours service is by the 1st October 2017 with a phased implementation of the Integrated Urgent Care Hub that will support the single point of contact through providing clinical and professional expertise that ensures patients can access the right care, first time. This will include support for Physical Health, Social health and Mental Health – *HOME FIRST/NOT WASTING PATIENTS TIME/AVOIDING FAILURE DEMAND*
2. **Review of Out of Hospital Urgent care services** will be undertaken during 2016/18 to build a sustainable model that supports the vision. This will include consideration of approaches for the future of out of hospital urgent care services including the Walk in Centre, Minor injury units and services that support the front door of A&E – *HOME FIRST/NOT WASTING PATIENTS TIME/AVOIDING FAILURE DEMAND.*
3. **Social Health** – There will be stronger partnership with social care; with integration seen through the integrated Urgent Care service and the Care Closer to Home community model, embedding the Good Lives approach to build community resilience (as detailed in the STP). This will include strengthening of the local care market and shared ownership in the future capacity and demand planning – *HOME FIRST/AVOIDING FAILURE DEMAND*
4. **Ambulance -**The East of England Ambulance Service NHS Trust (EEAST) is reviewing its current operating model including changing skill mix, providing new bespoke response models specific to the localities in which they work and enabling more patients to be treated at or near to their homes, preventing unnecessary attendance and admission to hospital. This new model will create a career ladder for staff and also mean that the most appropriate resource is tasked to patients' needs thereby reducing waiting, improving response times and increasing efficiency through better utilisation.
   The Ambulance Service to continue to accept warm transfers from the IUCS and in the future there is the expectation that IUCS will accept calls from the 999 EOC (subject to local governance procedures), and offer clinical support to the ambulance service, providing a clinical response to those patients where appropriate *HOME FIRST/AVOIDING FAILURE DEMAND*
5. **Greater use of pharmacy** – A recent Quick Guide: Extending the role of community pharmacy in urgent care has highlighted an untapped resource that could support a number of areas including**;**
   a. Provision of emergency supplies of prescription medicine – locally we know that 27% of Our of Hours activity is providing a repeat prescription service which could be shifted to pharmacy.
   b. Supporting Self-care of minor illnesses – the national estimation is that 3% of A&E consultations and 5.5% of GP consultations for common ailments could be managed in community pharmacy. This would locally support our streaming and triage model – *HOME FIRST*

8. What won't we do?

- Create multiple single points of access based around organisations.
- We won't be treating patients if they walk in to the wrong place if clinically safe to redirect them. (Patients will be educated through supporting communication planning to choose the right place, the CCG aim to reduce complexities and introduce triage to support this).
- Require patients to repeat their information time and time again, their information should follow them across the system, only being asked to expand on information not repeat.

9. Urgent Care Sustainability Enablers

- **Digital Roadmap** – Ensure care records are accessible and shared within appropriate systems – The Five Year Forward View makes a commitment that, by 2020, there would be "fully interoperable electronic health records so that patient's records are paperless". This was supported by a Government commitment in Personalised Health and Care 2020 that "all patient and care records will be digital, interoperable and real-time by 2020". It is clear that 'digital' technology has a significant role to play in sustainability and transformation. This includes delivering primary care at scale, securing seven day services, supporting new care models and transforming care in line with key clinical priorities. Local health and care systems are developing Sustainability and Transformation Plans (STPs) and the best plans will harness the opportunities that digital technology offers (NHS England).
- **Technology** – the use of wider technology to support health and social outcomes (linking with the digital roadmap) will be actively sought. North East Essex already has a GP Health App that enables quick and easy access to local services and referral processes. This is being expanded further to support a public facing function with future capabilities able to explore improved communication about local services and increased self- care knowledge and support.
- **Workforce** -Through developing the vision for out of Hospital Urgent care and understanding the interdependencies with community and primary care services, there will be an economy wide workforce strategy as part of the STP that builds training for key staff roles, rotational posts and a recruitment and retention plan fit for the future model. This will allow development of new types of workforce and ensure key staff are able to drive forward the system principles and good lives approach. The strategy will link with national programmes of work such as Ambulance and 111.
- **Discharge to Assess/Trusted Assessor**– Building on the partnership with Physical, social and mental health services, there will be the mandating of the discharge to assess model and the trusted assessor approach, this will be linked to robust sharing of information arrangements and pull approach that will support patients to be pulled into the community as soon as safe to do so– *PULL NOT PUSH MODEL/HOME FIRST/AVOIDING FAILURE DEMAND*
- **Communication planning** – An urgent care communication plan has been developed as a working document to improve information flows and allow patients to make the correct choices. It focuses on engagement with our local population, stakeholders and NHS staff

dealing directly with patients. It will drive 4 key messages to the public to create an informative dialogue.

1. Use the right service the first time right care, in the right place at the right time
2. Self-care is sometimes more time and cost effective than other services
3. Use of pharmacist – no appointment needed and often receive required treatment
4. Long Term Conditions – patients empowered to manage their own conditions with support when required to prevent hospital admission.

A variety of channels will be used, some of which have not been used before to reach our wider audiences. There will be a link created to NHS England, PHE and neighbouring CCGs which will enable a co-ordinated approach to be taken with both local and national campaigns. This will enable key messages to be delivered with consistency, to be easily-understood and well timed to various stakeholders, general public and other NHS organisations.

- **Estates** – There will be consideration to the impact on estates provision throughout the review of urgent care services, with the aim of minimising void space while ensuring that services are able to be delivered in premises that are fit for future purpose. There will be an integral link with the overarching North East Essex Estates Strategy.
- **Patient Engagement and consultation** – Ongoing engagement with the public will be integral to the achievement of the strategy and will include use of existing health forums. Feedback will be actively sought alongside changes to the system to use patients and their experience and outcomes as a measure of success.

10. Timescales

Action	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
Planning									
Refresh Urgent Care Strategy in line with National and Local directives									
Implementation of Vision									
Launch of Urgent Care strategy									
Integrated Urgent Care Procurement with Suffolk – Market Engagement Event									
Integrated Urgent Care procurement – Advert (commencement of formal procurement process)									
Integrated Urgent Care Procurement go live with implementation									Oct 17
Review of Out of Hospital urgent care services in NEE, including public engagement.									
Implementation of outcome from Out of Hospital Urgent Care review – April 2018									April 18
Supporting schemes									
Streaming from ED									
Winter Resilience Planning									
Piloting of new winter resilience schemes									

11. Governance

Accountability for development, implementation and review:

- Delivery and monitoring of progress of the Urgent Care Strategy will be owned by the North East Essex System Resilience Operational Group, reporting directly to the North East Essex A&E Delivery Board.

This strategy will be subject to periodic review; however there are a number of triggers that would instigate a full or partial strategic review outside of normal practice:

- There has been a significant variation in performance of strategic goals or initiatives
- Significant deterioration in financial performance of CCG or other partner organisation.
- Significant change in organisational structure, such as a merger
- Significant change in government or regulatory policy

The NEE A&E Delivery Group will be responsible for determining the level of change required to initiate a review based on the predefined triggers identified.

12. Glossary of Terms

Care Closer to Home	A vision, strategy and clear delivery plans that will: • Put people at the centre of their care Involve people in planning and developing services • Commission integrated health and social care which is high quality, evidence-based, cost-effective and sustainable • Ensure people receive seamless services across their health and care needs. This model has been commissioned for community services in NEE since 1st April 2016.
Code Review Pilot	Piloting the introduction of an 'Amber' Category call. It is expected that a number of Red calls can be moved to Amber with a new response call of 19 minutes. These calls will still be responded to by a double staffed ambulance but allows the service to have greater ability to manage responsiveness to red calls.
Community Gateway	North East Essex has commissioned a community gateway via the Care Closer to Home Procurement which went live on April 2016. This gateway acts a single point of access for health care professionals to access North East Essex Community Services.
Community Resilience	Communities and individuals harnessing local resources and expertise to help themselves and in an emergency, in a way that complements the response of the urgent and emergency services.
Digital Roadmap	Localised plans to harness the opportunities that digital technology can offer. Includes consideration to interoperable electronic health records.
Discharge to Assess	Where patients are discharged once they are medically fit but with assessment for longer term needs by appropriate services, in their own home.
Dispatch on Disposition	Relating to ambulance emergency 999 calls, allowing more time to triage red 2 calls (to identify the clinical situation and take

	appropriate action), based upon clinical advice that this would be likely to improve the overall outcomes for ambulance patients. Red 2 calls a category of call type (still serious as a Red 1, but less immediately time critical, like strokes or fits) traditionally to be responded to within 8 minutes.
Emergency Department (ED)	Traditionally referred to as Accident and Emergency Department (A&E), based in the Hospital
Emergency Operations Centre (EOC)	The ambulance service centre where staff handle all our emergency (999) calls and deploy the most appropriate response
End of Life Register	The electronic end of life care information system records the end of life preferences for patients who are nearing the end of life. GPs and specialist nurses will work with patients and their families to determine these preferences and gain consent to add this information to the care register. The use of advance care planning ensures that these decisions and any needs identified are then shared appropriately to help coordinate and provide the best care possible throughout the patients journey
Integrated Urgent Care Hub	A multidisciplinary clinical hub (virtual or physical) that supports the Integrated Urgent Care service (previously known as 111 and out of hours) that as a minimum can: • Where possible people will have their problem dealt with over the phone by a suitably qualified clinician. • People requiring further care or advice will be referred to a service that has the appropriate skills and resources to meet their needs
Good Lives Approach	A 3 tier conversational model introduced by Essex County Council which consists of proportionate 'assessment conversations' under the Care Act. Staff are encouraged to leave behind their old 'assessment' culture and practice and learn how to have proper conversations that listen to what people have to say.
Mental Health A&E Liaison	A team or role with mental health expertise that provides dedicated support to ED for patients requiring mental health assessment, risk assessment and support.
Minor Injury Unit (MIU)	Service that predominantly treats minor injury that patients can attend without appointment
My Social Prescription	A community based scheme addressing the social issues that people often approach medical staff, as well as providing support with their health conditions and encouraging self-care. This is achieved by identifying the most appropriate referral, utilising community assets (i.e. people, services, community resources) to respond to the social need, ultimately improving the quality of life of the patient and family and reducing demand on public services. It also reduces duplication of effort, plus encourages independence and self-care.
Primary Care Transformation strategy	A strategy to support change across GP services to ensure services are fit for purpose and sustainable for the future.
Rotational Posts	A minimum of 2 employees changing position either within an

	organisation or across organisation
Single Point of Access	Simplifying how people access care in an emergency by integrating multiple service single points of contact behind one public facing number.
SinglePoint (Single point of Access for End of Life Care)	A clinically led service made up of specialist palliative care nurses and community general nurses with knowledge and skills in palliative care who are able to expertly triage patients, offering advice and support when appropriate and plan individual care packages, including access to equipment
Short stay units	Refers to bedded areas within the acute hospital that supports a patient up to 48 hours with the expectation that patients can then be discharged home without an extended length of stay.
Streaming	A specific model at the front door of a self-presenting service e.g. ED, which directs patients at the point of attendance to the most appropriate service for their health care needs. For example, a streaming model in ED, directs patients to other services outside the hospital which could treat their presenting problem. This reduces ED waits and improves flow through the department and allows ED staff to concentrate on the patients with complex needs.
Street Triage (Mental Health)	Street Triage is a joint initiative which allows police and mental health professionals to work together to improve outcomes for individuals experiencing mental health crises or distress. Patients historically detained by police under section 136 (S136) of the Mental Health Act 1983 are now assessed at the time jointly with a mental health worker to reduce inappropriate detentions and able to access the right care and support.
System Resilience Group (SRG)	A multi-stakeholder senior leaders meeting to address resilience planning, preparations for winter, and wider transformational changes in line with the Urgent and Emergency Care Review.
Triage	Triage is the process of determining the priority of patients' treatments based on the severity of their condition.
Trusted Assessor	An approach whereby the system aim to reduce duplication of assessment where there are points of handover of care between providers. There is trust of another professional’s assessment and information will only be built upon. This requires information to be shared appropriately.
Urgent Care	Urgent Care has been defined and agreed by both North East Essex, West Suffolk and Ipswich and East Suffolk CCGs as “what is perceived to be urgent by the patient or customer or carer, up to the point at which an assessment is made by the health and social care system, subsequent to which the patient’s or customer’s need might be assessed as indeed being urgent (requiring a response within a 24 hour time frame or less) or not urgent, in which case the urgent care system has a responsibility for ensuring appropriate movement of the patient or customer into the correct channels.”
Walk in Centre (WIC)	Service that predominantly treats minor illness and injury that

	patients can attend without appointment – Open 7 days per week
Warm transfer call	A telephone call that is transferred from one individual to another (usually call adviser to clinician in the context of 111) while the caller is still on the line. The clinician acknowledges the transfer of the caller prior to the adviser backing out of the call

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