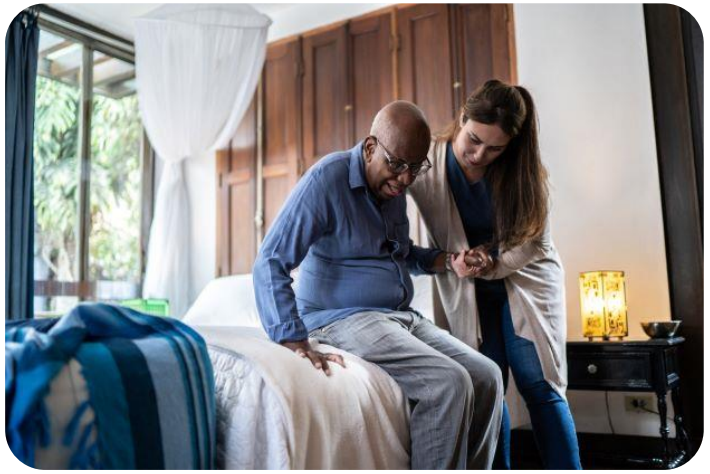
The Future of Technology in Health & Social Care

TEC Services Association – Oval Cricket Ground
8th November 2023

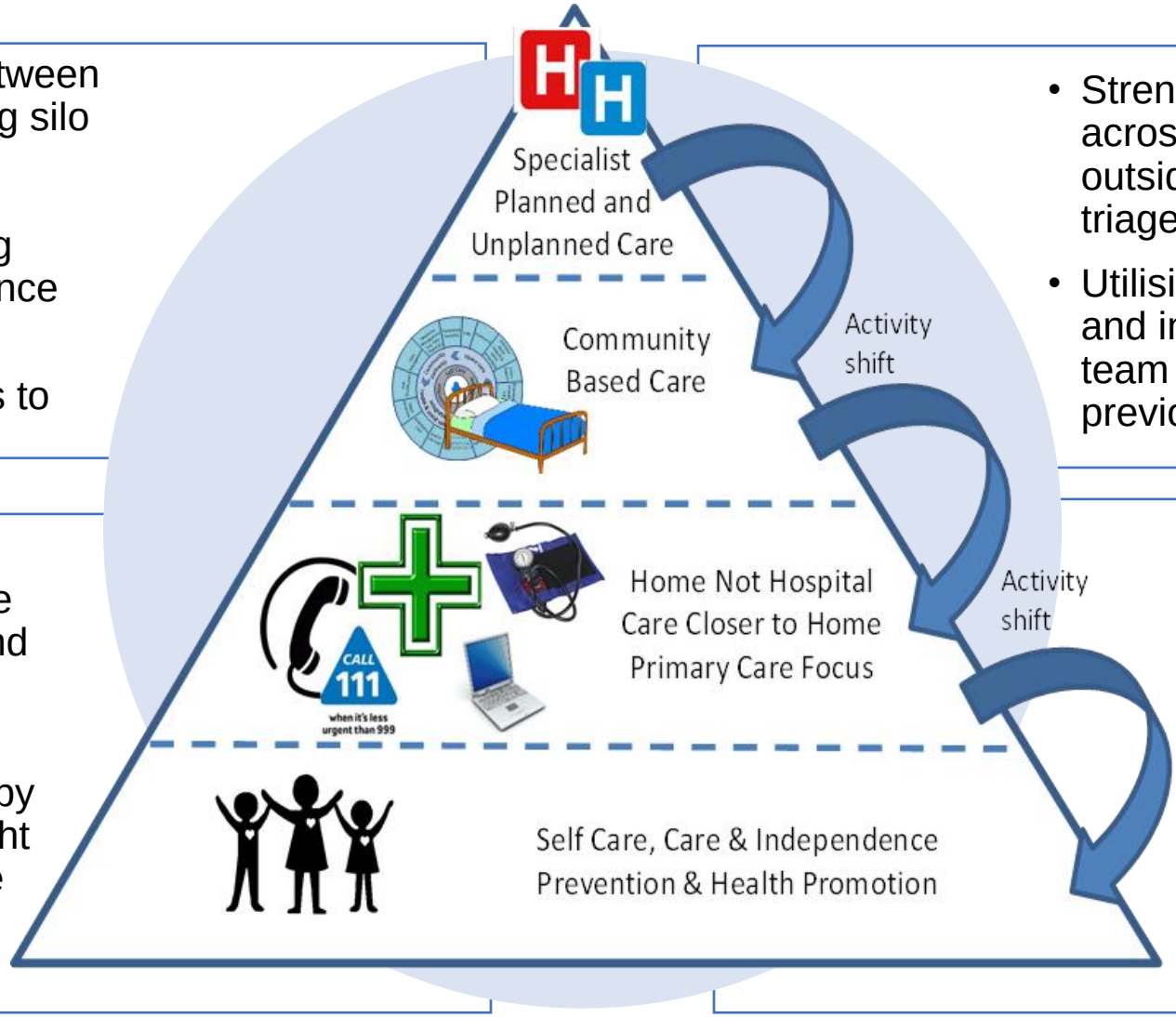




Matthew Winn

Chief Executive - Cambridgeshire Community Services NHS Trust and Specialist advisor to NHS England on Intermediate Care

Coordinating care improvement approaches

- Breaking down barriers between organisations and removing silo working will deliver improvements in the care patients receive, increasing quality and patient experience
- Whole system approach reducing unnecessary trips to ED

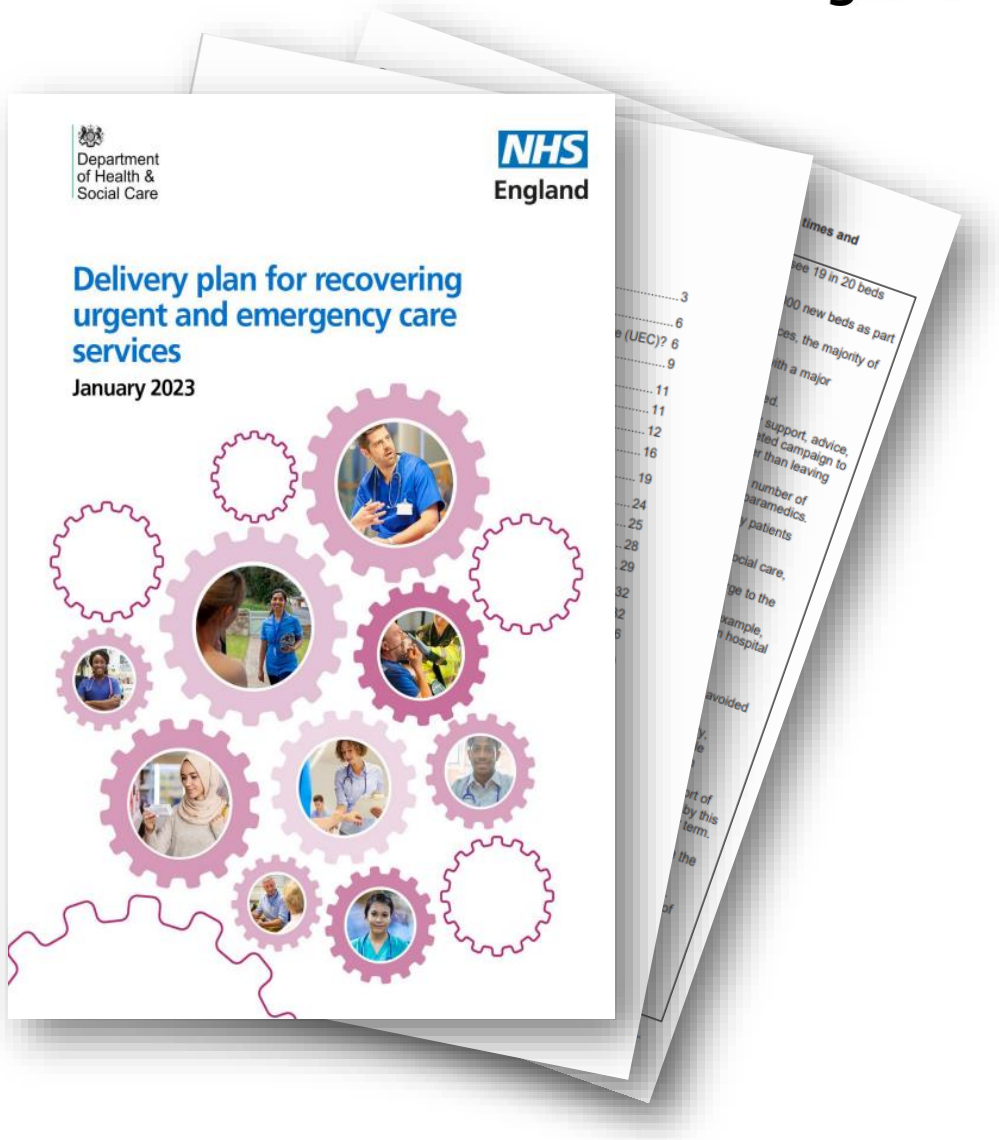


- Strengthening service offers across UEC, improving access to outside services for bookable triaged appointments
- Utilising community based teams and incorporate them as part of team morning huddles to review the previous evening capacity

- Balancing the system before winter case mix, demand and capacity
- Strengthening Access and Capacity within the system by placing the patient in the right service not a default service

- HARIS Principles
- Learning systems and clinical conversations

Delivery plan for recovering urgent and emergency care services



The plan’s five key areas of action

Increasing capacity

Investing in more hospital beds and ambulances. Making better use of existing capacity by improving flow.

Growing the workforce

Increasing the size of the workforce and supporting staff to work flexibly for patients.

Improving discharge

Working jointly with all system partners to strengthen discharge processes. More investment in step-up, step-down and social care. A new metric based on when patients are ready for discharge - data published ahead of winter.

Expanding and better joining up health and care outside hospital

Stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home, including to avoid unnecessary admissions to hospital.

Making it easier to access the right care

Ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

Expanding and better joining up new types of care outside hospital

Community health services, including therapy services, help keep people well at home and in community settings close to home. They can reduce pressures on hospitals and emergency services and improve patient experience and outcomes.

Improve care for those who fall or live with frailty

Use of UCR - consistently reaching 70% of patients referred within 2 hours, service operates for at least 12hrs a day

Making use of new technology and better collaboration, including between ambulance services and community care

Scale up virtual ward capacity for frailty and acute respiratory infection, building on the evidence of what has worked well this year

Develop transfer of care/discharge hubs to ensure safe and timely hospital discharges

Admission alternatives for the acutely unwell

Key primary routes of referral

Key referral routes – step up:

- Self-referral
- GP / primary care
- Care homes
- UCR
- Community services
- ED
- SDEC
- 999/111
- SPOA
- Local authority

- TEC suppliers
- Supported housing providers

Key assessment settings and onward referral sources

More acute/specialist

SDEC

ED & Frailty Assessment Units

999/111

Urgent Treatment Centres

More community

Urgent Community Response
2 hour response for 9 key conditions

More primary

ARI hubs

Wider services

Local authority e.g., falls service

Assessment & episodic treatment in community

Preventing admission: Community and primary care

Primary Care and Pharmacy
Short term interventions

Community Services
Specialist and non-specialist (non-acute) treatment and care

Preventing admissions: acute hospital at home needs

Virtual Wards
Acute hospitalisation at home – planned and unplanned

Key onward referral sources & medium/longer term care and support

Discharge pathways

Intermediate Care
Step down incl. reablement, equipment provision

Social Care
Equipment and short-term interventions

Digital support
Monitoring and lifestyle support

Primary Care
Ongoing treatment and support

Social Care
Medium- and long-term care and support

Most potential for admissions to be prevented here, particularly where services play key distinct clinical roles across key patient presentations e.g. acute, non-acute, frailty, diagnostics, pharmacy

What is a two-hour urgent community response?

Two-hour UCR services provide assessment, treatment and support to people

- over the **age of 18**
- in their **own home** or usual place of residence
- experiencing a **health or social care crisis**
- at **risk of hospital admission** within the next two to 24 hours

Starts within **2 hours** of the referral being made

Single point of access should be used

Multidisciplinary team

Growth in UCR activity

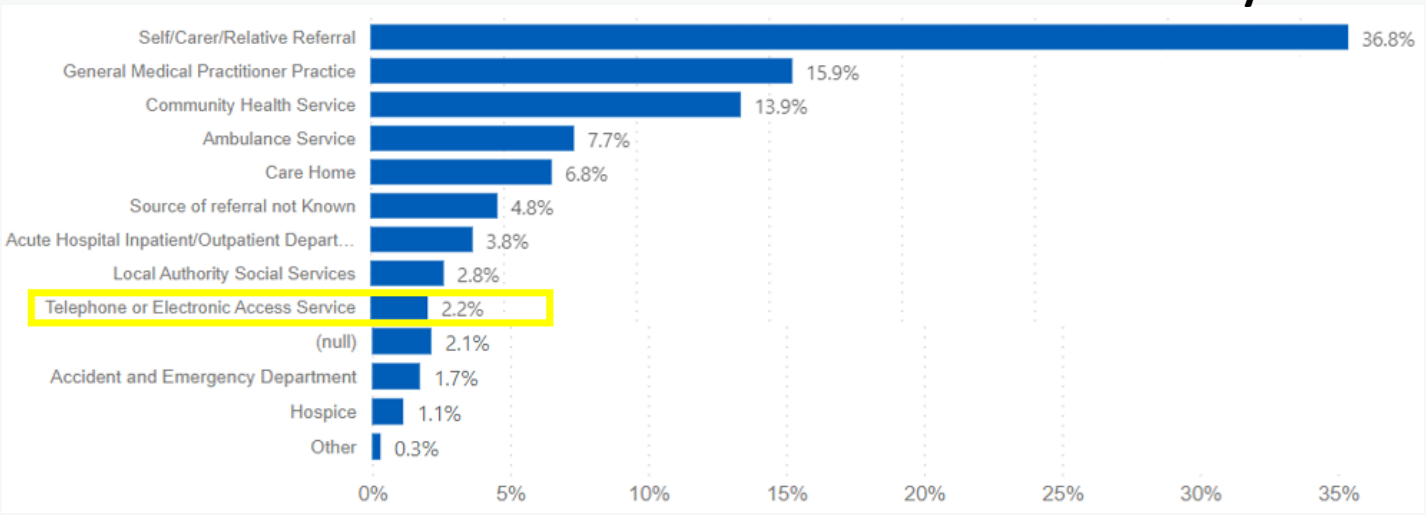
UCR referrals have grown over the last 12 months: from around 44,000 2-hour referrals in July 2023 from 24,000 in July 2022.

44,000 2-hour referrals equates to about **152,000 care contacts** (face to face or virtually delivered).

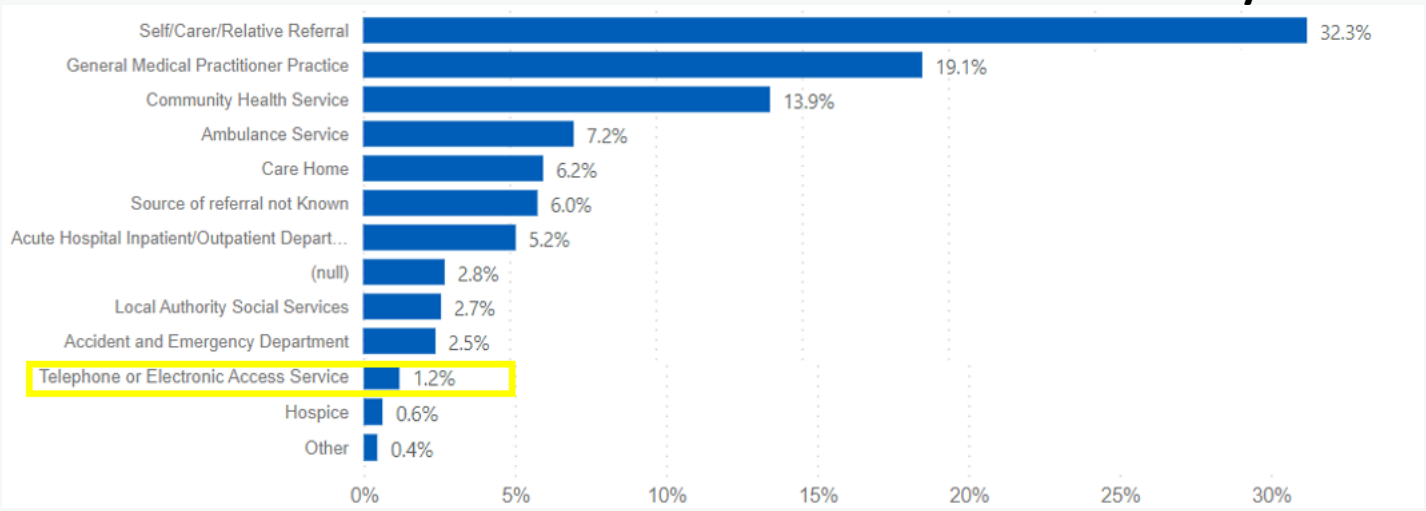
TEC referrals into UCR have also grown – in July 2022 there were 525 per month, but this has grown to 1,455 in July 2023.

70% of all UCR referrals end with the person staying at home, instead of transfer to ED.

July 2023



July 2022



Virtual wards provide hospital level care at home

virtual ward

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A virtual ward is a safe and efficient **alternative to NHS bedded care**.

Virtual wards support patients who would **otherwise be in hospital** to receive the acute care and treatment they need in their own home.

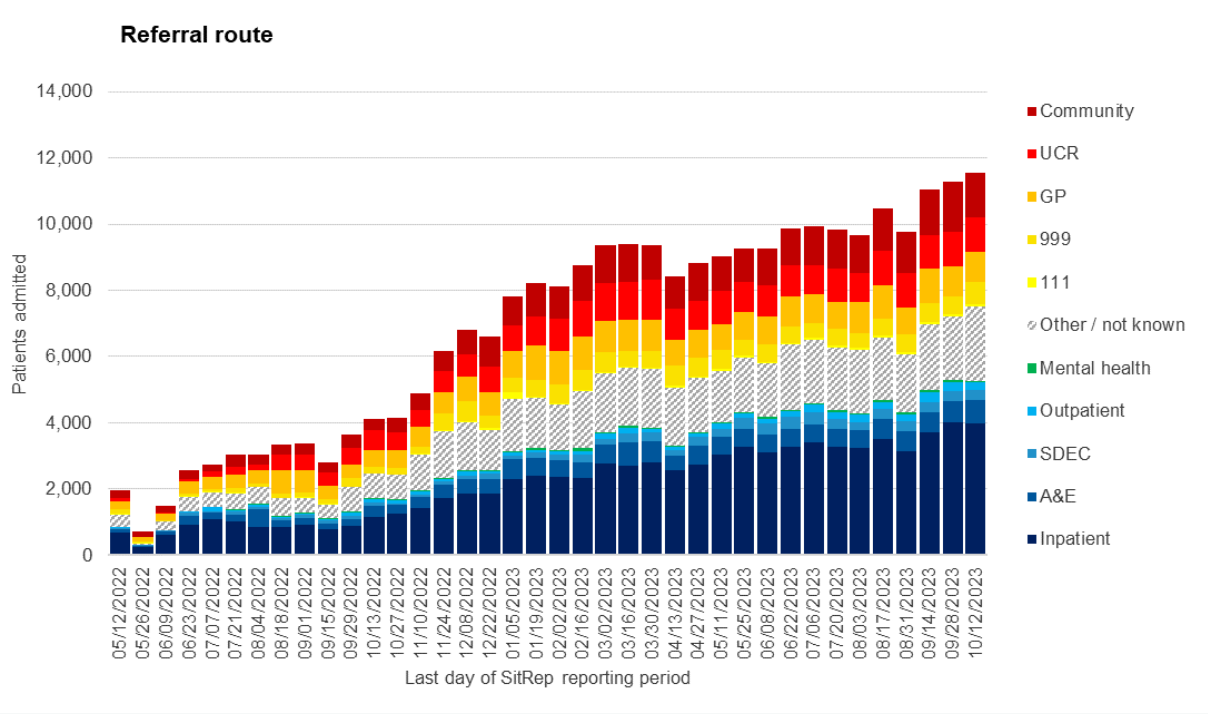
This includes either **preventing avoidable admissions** into hospital, or **supporting early discharge** out of hospital.

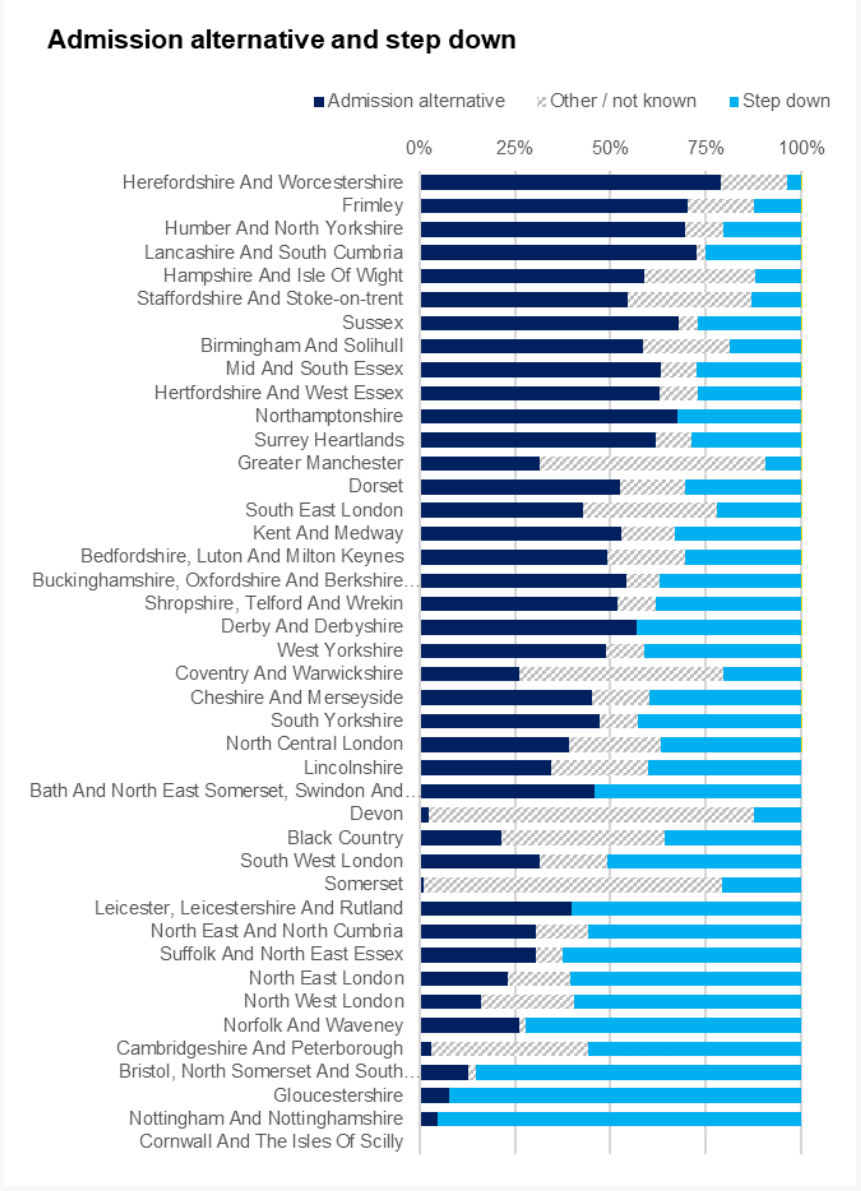
- **The acuity and complexity of the patient's condition differentiates virtual wards from other community and home-based services**
- It provides **urgent access to hospital-level diagnostics** (such as endoscopy, radiology, or cardiology) and may include bedside tests such as **point of care (POC) blood tests**
- It provides **hospital-level interventions** (such as access to intravenous fluids, therapy, and oxygen)
- It requires **daily input from a multidisciplinary team** and sometimes **multiple visits and provisions** for 24 h cover with the ability to respond to urgent visits, often **enabled by technology**
- It requires **consultant practitioner specialist leadership** and **clear lines of clinical responsibility**
- **Defined inclusion and exclusion criteria**, with defined target population and deliver a **time-limited short-term intervention** of 1–14 days.
- **VW patients have equity of access to other specialty advice as though an in-patient**.

NB: A virtual ward **is not** a mechanism intended for enhanced primary care programmes; chronic disease management; intermediate or day care; or proactive deterioration prevention. Wider virtual care supported services (including NHS@home) are scaling to enabling these cohorts to be increasingly supported at home / in the community.

Referral pathways and step up/down

There were 11,546 admissions between 28 September to 12 October 2023.
(489% increase from May 2022)





Admissions from home

- 8% of referrals come from Primary Care
- 9% of referrals come from Urgent Community Response
- 12% of referrals come from Community based Health Services

Admissions from Hospital

- 34% of referrals come from inpatient wards
- 6% of referrals come from Emergency Departments
- 5% of referrals come from SDEC and Outpatient Departments

Final thoughts

- Alignment of teams from health, social care, housing and tec support are (as ever) key to establishing local solutions that support people
- Digital and data interoperability is key – we need to establish how to properly share data across our sectors to target support more effectively
- The ingredients/policy for universal service offers is in place – the hard part is making it work!