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Leeds CITY COUNCIL

WEST YORKSHIRE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Meeting to be held in Halifax Town Hall, HX1 1UJ on
Monday, 21st December, 2015 at 11:00am

(A pre-meeting will take place for ALL Members of the Committee at 10:30am)

MEMBERSHIP

Councillors

Councillor D Lee	-	Bradford Council
Councillor F Shaheen	-	Bradford Council
Councillor M James	-	Calderdale Council
Councillor H Blagbrough	-	Calderdale Council
Councillor L Smaje	-	Kirklees Council
Councillor M Walton	-	Kirklees Council
Councillor B Flynn	-	Leeds Council
Councillor P Gruen (Chair)	-	Leeds Council
Councillor B Rhodes	-	Wakefield Council
Councillor Y Crewe	-	Wakefield Council

Please note: Certain or all items on this agenda may be recorded

Agenda compiled by:
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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (*In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified on this agenda.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES** As this is the first formal meeting of the West Yorkshire Joint Health Overview and Scrutiny Committee, there are no previous minutes to consider.	
7			**TERMS OF REFERENCE** To consider a report that presents the terms of reference for the West Yorkshire Joint Health Overview and Scrutiny Committee and sets out the proposed arrangements for Chairing meetings for the current municipal year, 2015/16.	1 - 6

Item No	Ward/Equal Opportunities	Item Not Open		Page No
8			**URGENT AND EMERGENCY CARE** To consider a report that introduces information associated with the West Yorkshire Urgent and Emergency Care Vanguard and associated programmes of work.	7 - 94
9			**WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS** To consider a report that introduces information associated with the West Yorkshire Association of Acute Trusts.	95 - 102
10			**CANCER WAIT TIMES** To consider a report that introduces information associated with cancer waiting times and the associated performance of Leeds Teaching Hospitals NHS Trust, including information associated with the timely referral of patients across West Yorkshire.	103 - 114
11			**TOBACCO INVESTMENTS** To consider a report that introduces information relating to a request for scrutiny received by Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) and considered at its meeting on 20 October 2015, as they may have an impact on the other local authority areas within West Yorkshire.	115 - 120

Item No	Ward/Equal Opportunities	Item Not Open		Page No
12			**SOURCES OF WORK** To consider a report that introduces further information that may inform the future work programme of the West Yorkshire Joint Health Overview and Scrutiny Committee.	121 - 130
13			**WORK PROGRAMME** To consider the future work programme of the West Yorkshire Joint Health Overview and Scrutiny Committee.	131 - 134
14			**DATE AND TIME OF NEXT MEETING** To be determined.	

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 21 December 2015

Subject: West Yorkshire Joint Health Overview and Scrutiny Committee – Terms of Reference and appointment of the Chair

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report presents the terms of reference for the West Yorkshire Joint Health Overview and Scrutiny Committee for Members' information.

2. The report also sets out proposed arrangements for Chairing meetings for the current municipal year, 2015/16.

Recommendation

3. Members are requested to note the Scrutiny Board's terms of reference and agree the proposed arrangements for Chairing meetings for the current municipal year, 2015/16.

1.0 Purpose of this report

1.1 This report presents the terms of reference for the West Yorkshire Joint Health Overview and Scrutiny Committee and sets out proposed arrangements for Chairing meetings for the current municipal year, 2015/16.

2.0 Background information

2.1 For the past 18 month, the Health Scrutiny Chairs of the five West Yorkshire Authorities have periodically met on an informal basis focusing on the establishment and progress of the Health Futures Programme.

3.0 Main issues

3.1 To ensure the previous arrangements continued on a more formal basis, each of the five West Yorkshire authorities have sought approval to establish a formal Joint Health Overview and Scrutiny Committee in line with the terms of reference presented at Appendix 1. In addition, each authority has appointed two members to sit on the joint committee. Details of the membership are set out elsewhere on the agenda.

3.2 The processes for approving the establishment of a formal Joint Health Overview and Scrutiny Committee and appointing its membership have varied between authorities, depending on the governance arrangements of the constituent authorities.

3.3 At the previous informal Chairs' meeting, it was agreed that, once established, Cllr Peter Gruen (Leeds City Council) would act as Chair of the joint committee for the remainder of the current municipal year. The joint committee is therefore asked to endorse this approach.

4.0 Corporate Considerations

3.1 Consultation and Engagement

3.1.1 The terms of reference were formally considered and approved by each of the constituent West Yorkshire authorities, based on the associated governance arrangements for each authority.

3.2 Equality and Diversity / Cohesion and Integration.

3.2.1 The Joint Committee will ensure that equality and diversity/cohesion and integration issues are considered as part of its future work.

3.3 Resources and Value for Money

3.3.1 This report has no specific resource and value for money implications.

3.4 Legal Implications, Access to Information and Call In

3.4.1 The establishment of the joint committee and the associated terms of reference were formally considered and approved by each of the constituent West Yorkshire authorities, based on the associated governance arrangements for each authority.

3.5 Risk Management

3.5.1 This report has no risk management implications.

4.0 Recommendation

4.1 Members are requested to note the Scrutiny Board's terms of reference and agree the proposed arrangements for Chairing meetings for the current municipal year, 2015/16.

5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TERMS OF REFERENCE AND WORKING ARRANGEMENTS

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide for local NHS bodies to consult with the appropriate health scrutiny committee where there are any proposed substantial developments or variations in the provisions of the health service in the area(s) of a local authority.

Under the legislation health officers from NHS bodies are required to attend committee meetings; provide information about the planning, provisions and operation of health services; and must consult with the health scrutiny committee on any proposed substantial developments or variations in the provision of the health service.

Where proposals to change health services cross local authority boundaries there is a requirement to establish a joint health committee. In Yorkshire and the Humber, a protocol has been established between the 15 upper tier local authorities for establishing a joint health scrutiny committee where proposed changes affect more than one local authority area. Joint health scrutiny committees may also be established to consider other issues of mutual interest.

The chairs of the five West Yorkshire Councils health overview and scrutiny committees met on 21 November 2014 and agreed to pursue establishing a West Yorkshire Health Scrutiny Committee. The purpose of the West Yorkshire Health Scrutiny Committee is to; consider any proposals from the NHS for substantial variation in service that have West Yorkshire wide implications; to meet NHS England to discuss any matters with West Yorkshire wide implications; and to be the first place for dialogue between West Yorkshire Council's Scrutiny Panels and West Yorkshire Commissioning Collaborative (known as 10CC).

The West Yorkshire Health Scrutiny Committee has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.

- To meet regularly with NHS England to:

    - Receive updates on national developments and other matters from NHS England
    - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.

- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)

- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.

- To undertake shared development activities from time to time.

Working Arrangements

- The West Yorkshire Health Scrutiny Committee will meet at least four times a year as a formal body meeting in public.

- Each local authority will host one meeting a year and provide the administrative support to that meeting.

- Each local authority will nominate two members to sit on the West Yorkshire Health Scrutiny Committee

- The quorum for the West Yorkshire Health Scrutiny Committee will be five Members, with Members from at least three of the five local authorities present.

- Agenda, minutes and committee papers will be published on the websites of all the five local authorities.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 21 December 2015

Subject: Urgent and Emergency Care

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report introduces information associated with the West Yorkshire Urgent and Emergency Care Vanguard and associated programmes of work.

Recommendation

2. Members are requested to consider the information presented and determine any further joint scrutiny actions.

1.0 Purpose of this report

1.1 This report introduces information associated with the West Yorkshire Urgent and Emergency Care Vanguard and associated programmes of work.

2.0 Background information

2.1 For the past 18 month, the Health Scrutiny Chairs of the five West Yorkshire Authorities have periodically met on an informal basis focusing on the establishment and progress of the Health Futures Programme. Urgent and Emergency Care is one of the priority areas of work identified within the Health Futures Programme.

2.2 A West Yorkshire Joint Health Overview and Scrutiny Committee has now been established and draws its membership from the five constituent West Yorkshire local authorities.

2.3 The Joint Committee has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.

- To meet regularly with NHS England to:

  - Receive updates on national developments and other matters from NHS England
  - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.

- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)

- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.

- To undertake shared development activities from time to time.

2.4 The West Yorkshire Urgent and Emergency Care Vanguard and associated programmes of work are being taken forward by the West Yorkshire Commissioning Collaborative.

3.0 Main issues

3.1 Details of the West Yorkshire Urgent and Emergency Care Vanguard are presented at Appendix 1. NHS England guidance on Urgent and Emergency Care services is presented at Appendix 2.

3.2 Appropriate NHS representatives have been invited to attend and present these details at the meeting, addressing any questions/ queries from the Joint Committee.

4.0 Recommendation

4.1 Members are requested to consider the information presented and determine any further joint scrutiny actions.

5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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HEALTHY FUTURES

Better health for all across the West Yorkshire region

Urgent and Emergency Care Vanguard Network

Nigel Gray

Dr Guy Brookes

Dr Phil Foster

Colin McIlwain

21 December 2015

NHS

Summary

-Urgent and emergency review

-Background to the Vanguard programme

-Content of the programme

-Progress so far and next steps

Urgent and emergency care review

NHS England review led by Sir Bruce Keogh in 2013/14

Current pattern of emergency services set in 1970s

Since then technology has advanced, public behaviour and expectations have changed and demand has been rising

Public feed back that the system is complex, at times hard to navigate: many people default to attending A&E

Two main conclusions:

- improve the offer to people outside of hospitals
- further improve care for people who are seriously ill and need to be admitted to hospital

Recommendations of the Keogh Review

Provide better support for people to look after their own health, supported by improved care planning and giving people better information

Helping people with urgent care needs to get the right advice in the right place, first time: developing the 111 service to help with this

Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E: general practice, pharmacies and ambulance service have a greater role to play here

Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery

Connecting urgent and emergency care services so the overall system becomes more than just the sum of its parts.

Vanguards: New Models of Care

Vanguards initiated by the *Five Year Forward View* for the NHS, published in 2014 and are encouraged to develop so called new models of care

Idea behind them is that they lead the way for the rest of the NHS by introducing new ways of working

Vanguards are responsible for developing a plan for the future approach to NHS and care services in certain service areas, including urgent care

West Yorkshire is only one of two Vanguards based on Urgent and Emergency Care (UEC) Networks

UEC Networks were set up across England, 24 in total, to lead work on delivering the Keogh review: Vanguards are expected to deliver sooner and share learning with the rest of the country

Size of network reflects existing systems that provide urgent care

Further material on the Keogh review

NHS England has published guidance for local communities in *Safer, Faster, Better* on good practice for delivering urgent and emergency care with messages for health and social care services (link at end of slides)

Issues covered include:

- improving understanding of capacity and demand
- messages for commissioners
- advice on all parts of the system from primary care through to hospital inpatient services
- importance of addressing mental as well as physical health
- addressing services for all ages of people who need care

West Yorkshire Vanguard

Based on the West Yorkshire Urgent and Emergency Care Network

Representatives from all parts of West Yorkshire and from different types of services on the leadership team

Involving a wider group of staff in developing its programme

Engagement with citizens, patients and staff is essential

Much of the programme will be delivered locally through Clinical Commissioning Groups working with local authority partners and the providers of services

West Yorkshire dimensions are about getting to a more standard offer and making connections where these are needed

VanguardWork Streams and Enablers

What we are trying to achieve

- Increase in the care that can be provided in primary care services across the week with the aim to reduce the numbers of people who feel they need to go to A&E
- Improving the sign posting to services for people with urgent care needs backed up by a clinical advisory service for front line community services
- A more responsive approach to services for people in a mental health crisis with a single operating model across providers
- Further improvements in specialised emergency care through a network of hospitals with common standards
- A consistent approach across West Yorkshire to care records to give better access to staff caring for people
- A better process for contracting for urgent care services within the NHS
- Better recruitment and retention of staff into urgent care services and develop new skills for staff

Progress so far

- Initiated the Vanguard Programme with leadership team including NHS, local government and Healthwatch involvement
- Specialist emergency services: discussions with the six acute trusts on issues and how they will develop as a network
- Work with CCGs on enhanced general practice developments
- Taken stock of current services provided in West Yorkshire
- Developed a “Value Proposition” for NHS England: a requirement of all Vanguards and programme has been assessed by NHS England
- Value Proposition sets out the initial objectives for the four work streams of the programme
- Early progress on new NHS payment models for urgent care
- Sub-programme to develop the single operating model for mental health services

Next steps

Build engagement with public and staff on the programme: starting in early 2016 on primary care, mental health and acute services

Maintain and develop dialogue with Health and Wellbeing Boards and scrutiny committees

Develop the work stream plans

Ensure that the network's plans are informed by local plans and also feeds into the 2016/17 operational planning round for the NHS

NHS England asking local systems to develop overall strategies for the *Five Year Forward View*: the Vanguard work needs to be reflected in them

Key contacts

Chris Dowse

- Chief Officer, North Kirklees CCG
- Chair, West Yorkshire Urgent and Emergency Care Network

chris.dowse@northkirkleesccg.nhs.uk

Eric Davies

- Vanguard Programme Director

eric.davies@northkirkleesccg.nhs.uk

Colin McIlwain

- Interim Director, West Yorkshire Urgent and Emergency Care Network

colin.mcilwain@nhs.net

Annexes

Link to the Five Year Forward View: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Link to guidance on the Keogh Review "Safer, Faster, Better: https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

On following slides: details of the Vanguard programme's work streams and supporting enablers and feed back from NHS England on the programme and suggestions for future work

Primary Care Work stream

Vision/Aims/Purpose	**Vision** - ensure no one ends up being seen in A&E because they cannot get access to primary care when it is required (identified through Keogh) **Aims & Purpose -** The clear aspiration for this work-stream is to ensure that Primary Care participates fully in the implementation of the Keogh recommendations and this will be achieved through active engagement across primary care, partner organisations and importantly patients and the general public The output will be the development of a consistent offer across West Yorkshire in terms of implementation of the 3 levels of Primary Care. 'Early implementers' will be identified to test out the processes, the implementation, the engagement to help inform roll out in other areas.
Lead & Support	**Clinical Commissioner Lead**: Dr Andy Withers **Commissioner Lead:** Carol McKenna **Support**: Lynne Parkes, Programme Lead
Progress to date	Work-stream group established Membership of work-stream includes clinicians from all SRG and representatives from key partners Core aims of the work-stream identified – to be 'tested' with the wider community Workshop planned to develop thinking further Meeting to start to develop the engagement plan scheduled
Next steps	Continue to develop work-stream and project structure and process Secure funding Complete stakeholder mapping Communications and engagement planning meeting scheduled for 19.11.2015 Workshop planned for early December to further expand thing re approach – date to be agreed

Hear See and Treat Work stream

Vision/Aims/Purpose	**Vision**- For the ambulance service provider to become a treatment provider rather than merely a transport provider. **Aims & Purpose –** To develop new ways of working that supports the principle of care closer to home when that is appropriate whilst ensuring that those requiring conveyance for care and treatment are transported in an appropriate time frame in an appropriate way to the most appropriate place to receive that care and treatment
Lead & Support	**Commissioner Lead**: Jo Webster **Clinical Commissioner Lead:** Dr Adam Sheppard **Provider Lead:** Dr Phil Foster **Support**: Lynne Parkes, Programme Lead John Cartwright, Programme Manager, YAS
Progress to date	Work-stream group established Deliverables in 15/16 and 16/17 identified Project plan in development Executive engagement and support within YAS evident Move towards Joint Commissioning Board for Ambulances Services commenced
Next steps	Continue to develop programme management Secure funding Develop delivery plan Develop communications and engagement plan

Mental Health Work stream

Vision/Aims/Purpose	**Vision**-People with Mental Health should have equitable provision for their mental and physical health. Aims & Purpose- to improve MH provision across West Yorkshire reducing urgent and emergency care demand through the delivery of a collaborative approach to service provision based on best practice and available evidence.
Lead & Support	**Lead**: Simon Large, CEO Bradford District Care Trust **Support**: Andrea Willimott, Programme Lead
Progress to date	Leadership group established and held a number of high level meetings. Agreement on five work programme areas and task and finish groups to support delivery being established. Building on the Crisis Care Concordat partnership work. Established the West Yorkshire Criminal Justice & Mental Health Forum
Next steps	Three CEO's from the Mental Health Trusts meeting Tuesday 17/11/15 Next MH leadership meeting scheduled for the 25/11/15 Task and finish groups to be in place, met and reviewed KPI's and resources Nov/ Dec 15 TOR for groups to be drafted and signed off

Acute Services Work stream

Vision/Aims/Purpose	**Vision-** all patients with urgent & emergency needs in West Yorkshire will get the right care, in the right place, first time every time. **Aims & Purpose**-To utilise the West Yorkshire Association of Acute Trusts to go further and faster together to deliver clinically and financially sustainable services. To design and deliver an Acute Urgent & Emergency Care system that integrates effectively with the wider health and social care system to provide high quality , resilient and sustainable services that deliver the best outcomes for patients. Build on the West Yorkshire track record to innovate through technology and change the way in which clinical resources and expertise is delivered to patients. An approach across networks at scale rather than in individual institutions to enhance clinical productivity and workflows, the delivery of 7/7 working across a large population driving up quality and experience for patients and their families.
Lead & Support	**Lead**: Chris Dowse, Chief Officer, North Kirklees CCG and Chair of the West Yorkshire Urgent Care Network **Support**: Andrea Willimott, Programme Lead
Progress to date	YHEC Report- Healthy Futures 10 cc Julian Hartley and Clive Professor Kay joined the WY UEC Vanguard Leadership Team WYAAT have begun to work together and commence discussions on a number of transformation areas. Mid Yorkshire Hospitals NHS Trust- meeting the Challenge
Next steps	Potential programme/project structure Roles responsibilities and governance Resource requirements Support Clinical Reference Group and T&F Groups Work across all organisation boundaries to implement change Develop project implementation plan Supporting implementation of models within Trusts Recruit from within providers to maximise benefits

System Leadership

Vision/Aims/Purpose	**To support the Vanguard to deliver its ambitions will require significant determination, leadership and system wide organisational development. We will establish a forum through the leadership group to explore and help understand the challenges ahead and how we can work collaboratively with our strategic partners to meet and address these.**
Lead & Support	**Lead**: Chris Dowse, Chief Officer North Kirklees CCG, Chair West Yorkshire Urgent and Emergency Care Network **Support**: Eric Davies, Programme Director
Progress to date	Leadership group established and held a number of high level meetings. West Yorkshire system wide launch event held during September Meetings with all SRGs to understand challenges and priorities Relaunch of the Urgent and Emergency Care Network NHS England Site Visit – Chris Dowse commended for her exemplar leadership Vanguard Updates discussed at HWB Boards and 10cc
Next steps	Working with OD Specialists we will explore and agree the West Yorkshire way to system leadership. With the support of NHS England we will identify coaching support for the leadership team

West Yorkshire Care Record Work stream

Vision/Aims/Purpose	**Vision** – That health and social care professionals will have access to appropriate information required to make correct decisions regards care and treatment at the point of access to care **Aim & Purpose -** West Yorkshires UEC Vanguards overall aspiration of achieving right care, right time and in right place depends significantly on the ability to share health and social care records at point of care
Lead & Support	**Commissioner Lead**: Alastair Cartwright **Clinical Commissioner Lead:** TBC **Support**: Lynne Parkes, Programme Lead
Progress to date	• Established the work-stream group • Summarised Vanguard visit by email for Informatics colleagues in other WY CCGs • Added WY UEC Vanguard as a reference in each of the 11 CCG 'local digital roadmaps' (NHS E October requirement) • Met with YAS to explore short term opportunities with the Leeds Care Record for this winter (further discussions to take place) • Very informal discussions on possible short-term people resources with other local organisations • Input to develop of value proposition
Next steps	• Continue to develop project management structure and processes for the work-stream • Secure funding and associated resources • Technical fact finding, leading to early view on options • Develop high level plan including mapping out options (and possible need for business case for capital)

Workforce Enabling Work stream

Vision/Aims/Purpose	**Vision-** To create a framework across West Yorkshire's Health and Social Care partners that seek to encourage collaborative approaches to staff pay, education and career development across partner organisations thus reducing competition for staff between partners and agency/ locum spend **Aims & Purpose**- To promote and market West Yorkshire as the place to work in partnership with care home businesses. To understand and articulate the skills and competencies required for a workforce fit for the future and develop those people currently in our workforce to deliver these new skills. To develop an attractive offer around career development for our workforce to make roles interesting and different from elsewhere, including rotational roles and joint appointments between partners. Joint appointments across organisations and agencies Support for existing staff to work across patient pathways Evaluation of new roles and their effectiveness System wide workforce planning intelligence Talent management The Retainer Scheme allows GPs who are only able to work part-time to retain their skills working in an approved practice with an Educational Supervision and time for protected learning We will work with Local authority colleagues to scope and agree a collaborative offer regarding care home staff and social care staff. Return to Nursing The Induction and Refresher Scheme aims to attract UK-qualified GPs back into General Practice who may not currently be working in General Practice, and to offer a suitable induction programme to doctors who have not undertaken GP training in the UK but who are eligible to work as GPs in the UK, and who would like to continue their GP career in the UK.
Lead & Support	**Lead**: Nigel Gray, Chief Officer, Leeds North CCG **Support**: Andrea Willimott, Programme Lead
Progress to date	System leaders approached and agreement to work collectively across West Yorkshire, seeking to plan an event, form a working group and take this forward. Establishing key relationships, gathering intelligence on work undertaken and potential for wider adoption and standardised approaches.
Next steps	Potential programme/project structure Roles responsibilities and governance Resource requirements Develop project implementation plan Supporting implementation of models within Trusts

Intelligent Led Priorities

Vision/Aims/Purpose	**To support the Vanguard identify its priorities for transformation using an evidence based, best practice approach.** **To ensure that we assist our transformational programmes in utilising and evidence based, best practice approach that models the system change, identifies the outcomes and can demonstrate the benefits to patients using our services**
Lead & Support	**Lead**: Dawn Lawson, Chief Executive Academic Health Science Network **Support**: Eric Davies, Programme Director
Progress to date	We have commenced work with North England CSU who have been identified to support us with the modelling. We have an analyst working with us to help understand the challenges to help identify the case for change.
Next steps	We will complete our baseline modelling of our transformational work streams by the end of December 2015 and include this in our 2016/17 Value Proposition.

New Payment Models

Vision/Aims/Purpose	Transforming the payment models for urgent and emergency care is a significant part of the system wide development of our urgent and emergency care system. We know that there are significant financial challenges across our health and social care system which require new ways of working.
Lead & Support	**Lead**: Martin Wright, Chief Finance Officer Leeds North CCG **Support**: Lynne Parkes Programme Lead **Support**: Andrea Willimott, Programme Lead
Progress to date	We have held a number of meetings and a workshop with Finance and Commissioning Leads across West Yorkshire. Monitor and NHS England have supported these meetings and recently held a New Payments forum meeting in London where all Vanguards came together.
Next steps	We will work with our transformational work streams to agree service models that will be shadow counted and evaluated during 2016/17. These will be phased in during 2016/ 17

Engagement and Consultation

Vision/Aims/Purpose	To develop and implement the West Yorkshire approach to how we will engage with staff, patients and carers as part of the West Yorkshire Urgent and Emergency Care vanguard. To ensure that the views of the people, who use urgent and emergency care services, are properly reflected in any service transformation.
Lead & Support	**Lead**: Rory Deighton, Chief Executive North Kirklees Health Watch (on behalf of the 5 Health Watch Organisations) **Support:** Kirsty Wakeman **Support**: Eric Davies, Programme Director
Progress to date	We have developed our draft outline strategy for Engagement and Consultation and commenced work on a stock take of all engagement work that has been completed across West Yorkshire.
Next steps	We will arrange to meet and discuss our plans with Engagement and Consultation leads across West Yorkshire.

Feedback from Site Visit

NHS England Vanguard team met with the West Yorkshire team on 22 October 2015 and headlines from the feedback are:

- **Congratulations to the whole team – this is big, complex and exciting**
- **Chris Dowse was highly commended for her leadership**
- **Impressed that mental health is so well integrated into this work**
- **Had all the right partners in the room – balance correct (best they have seen)**
- **Fabulous thinking and progress on developing plan**
- **All work-streams have been identified – fantastic**
- **Programme Management Office is under resourced currently**
- **Acute hospital alliance is great and ambitious but highly appropriate**
- **New payment models for NHS services – we are ahead of the game here**
- **Workforce activity is patient focussed – great**
- **Thinking about future of 111/999 services – all going in the right direction**

What Should we look to strengthen?

Programme Management Office – needs to be bigger – recognise the critical path and define the dependencies of work streams

Workforce – need more work with Health Education England but need to show the difference in two years so it can't all be based on recruitment. – where's the innovation?

Scope – try not to boil the sea – needs further refinement with granular plans for concrete objectives. Consider use of rapid improvement cycles to have quick impact, without over analysis. How to use social movement expertise suitably?

More clarity on the leadership development piece – take care not to over think

Develop basket of indicators across West Yorkshire that looks at the health of the system as well as targets (e.g. 4 hour waits). What can be standardised and what should be localised (e.g. ambulatory care)

Conduct a confirm and challenge on the objectives to ensure that they are suitable and appropriate

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Transforming urgent and emergency care services in England

Safer, faster, better: good practice in delivering urgent and emergency care

A guide for local health and social care communities

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03926**
Document Purpose	Guidance
Document Name	Safer, Faster, Better: good practice in delivering urgent and emergency care. A Guide for local health and social care communities.
Author	UEC Review Team and ECIST
Publication Date	August 2015.
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Care Trust CEs, Foundation Trust CEs , NHS England Regional Directors, NHS England Directors of Commissioning Operations, Emergency Care Leads, Directors of Children's Services, NHS Trust CEs, System Resilience Groups; Urgent and Emergency Care Networks
Additional Circulation List	CSU Managing Directors, Medical Directors, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS Trust Board Chairs, Allied Health Professionals, GPs, Special HA CEs
Description	This document is designed to help frontline providers and commissioners deliver safer, faster and better urgent and emergency care to patients of all ages, collaborating in Urgent and Emergency Care Networks to deliver best practice.
Cross Reference	Revised planning guidance for 2015/16; Five Year Forward View
Superseded Docs (if applicable)	N/A
Action Required	Best practice
Timing / Deadlines (if applicable)	**N/A**
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Document Status

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Transforming urgent and emergency care services in England

Safer, faster, better: good practice in delivering urgent and emergency care

A guide for local health and social care communities

Version number: 28 FINAL

First published: FINAL

Updated: (only if this is applicable)

Prepared by: UEC Review Team and ECIST

The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

This report has been endorsed by the following partners:

Contents

1 Document summary

1.1 Transforming urgent and emergency care services in England

The NHS Five Year Forward View (5YFV) explains the need to redesign urgent and emergency care services in England for people of all ages with physical and mental health problems, and sets out the new models of care needed to do so. The urgent and emergency care review (the review) details how these models of care can be achieved through a fundamental shift in the way urgent and emergency care services are provided to all ages, improving out-of-hospital services so that we deliver more care closer to home and reduce hospital attendances and admissions. We need a system that is safe, sustainable and that provides high quality care consistently. The vision of the review is simple:

- For adults and children with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.

- For those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery.

As part of the review, a number of products are being developed to help create the conditions for new ways of working to take root and when combined, deliver an improved system of urgent and emergency services. The review proposes that five key changes need to take place in order for this to be achieved. These are:

- Providing better support for people and their families to self-care or care for their dependants.

- Helping people who need urgent care to get the right advice in the right place, first time.

- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.

- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.

- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

NHS England is collaborating with patients and partners from across the system to develop a suite of guidance documents and tools to promote best practice and support commissioners and providers in achieving a fundamental shift towards new ways of working and models of care. These guidance documents are being

developed as a suite entitled ‘Transforming Urgent and Emergency Care Services in England’ and are designed to be read together. The suite comprises the following components:

- Role and establishment of urgent and emergency care networks (UECNs), published June 2015.
- Clinical models for ambulance services.
- Improving referral pathways between urgent and emergency services in England.
- ‘Safer, faster better: good practice in delivering urgent and emergency care’, published July 2015. This good practice guide focuses on the safe and effective care of people with urgent and emergency health problems who may seek or need specialist hospital based services.
- Urgent and emergency care: financial modelling methodology.

1.2 Purpose

This document is designed to help frontline providers and commissioners deliver safer, faster and better urgent and emergency care to patients of all ages, collaborating in UECNs to deliver best practice.

It sets out design principles drawn from good practice, which have been tried, tested and delivered successfully by the NHS in local areas across England. However, the guide should not be taken as a list of instructions or new mandatory requirements. Implementation should be prioritised taking into account financial implications and local context.

This document has been prepared by NHS England in conjunction with the Emergency Care Intensive Support Team (ECIST). Contributions have been sought from the review’s delivery group (comprising a wide range of experts in urgent and emergency care services, as well as patient representatives).

1.3 Audience

The primary audiences for this document are providers and commissioners of urgent and emergency health and social care services to all patient groups, including children and people with urgent mental health needs.

The secondary audience for this document is the wider membership of UECNs. Suggested membership for these Networks is outlined in the r*ole and establishment of urgent and emergency care networks*, which forms part of the suite ‘Transforming urgent and emergency care services in England’.

1.4 Structure

The document begins with an introduction arguing the need for collaboration and consistency in the delivery of best practice in urgent and emergency care. It refers to

the evidence base that underpins the review and goes on to set out design principles for a number of key service areas.

1.5 How it will be used

The revised planning guidance for 2015/16 required UECNs to start establishing themselves across England from April 2015, acknowledging that they already exist in some parts of the country. Commissioners and providers should utilise the principles outlined in this document, tailoring them to meet local need as identified by the UECNs across England. The recently published *Five Year Forward View (see:* http://tinyurl.com/nhs5yearforwardview*)* emphasises the importance of this and how we will increasingly need to manage health care systems through networks of care, not just by, or through, individual organisations.

The planning guidance 2015/16 further outlines that commissioners should take into account their duties as defined by the Equality Act 2010 and, with regard to reducing health inequalities, the Health and the Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities and address health inequalities (see: Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duties http://tinyurl.com/pvj2onl).

Safer, Faster, Better will be updated regularly to reflect emerging practice and the developing evidence base.

2 Introduction

This guide has been written for providers and commissioners of urgent and emergency care in England. Our aim is to create a practical summary of the design principles that local health and social care communities need to adopt to deliver safer, faster and better urgent and emergency care for people in all age groups with physical or mental health problems. For ease of reference, we have divided the guide into sections covering major topics. However, delivering safe and effective urgent and emergency care cannot be done from within organisational or commissioning silos. It requires cooperation between and within numerous organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do.

Everything we discuss has been turned into reality somewhere in the country. All the building blocks are available and have been tested by clinicians and managers and shown to work. However, we know from experience that piecemeal implementation of great care in isolated parts of the pathway only creates disjointed ‘islands of improvement’. Critical mass is only developed when good practice is implemented systematically, without unwarranted variation, along the entire pathway.

The challenge is considerable. A social movement, committed to ensuring that urgent and emergency care in England is truly world-class, is needed. This guide is a contribution to making that happen.

3 The evidence base

There is a considerable evidence and experience base for 'what works well' in urgent and emergency care systems, and the damage caused by poor patient flow[1]. A summary was published by the Review in 2013 and is available at: http://tinyurl.com/UECRph1EvBase.

It is important that clinical and managerial leaders across local health communities are aware of the evidence so they can create a compelling narrative of good practice to inspire safer, faster, better care.

Below are some top, evidence-based principles that everyone should know:

- Preventing crowding in emergency departments improves patient outcomes and experience and reduces inpatient length of stay (see: http://tinyurl.com/edcrowding).

- Getting patients into the right ward first time reduces mortality, harm and length of stay (see: http://tinyurl.com/patientboarding).

- Patients on the urgent and emergency care pathway should be seen by a senior clinical decision maker[2] as soon as possible, whether this is in the setting of primary or secondary care. This improves outcomes and reduces length of stay, hospitalisation rates and cost (see: http://tinyurl.com/benefitsofcdc).

- Daily senior review of every patient, in every bed, every day, reduces length of stay and costs of care (see: http://tinyurl.com/bmjopen).

- Frail and vulnerable patients, including those with disabilities and mental health problems of all ages, should be managed assertively but holistically (to cover medical, psychological, social and functional domains) and their care transferred back into the community as soon as they are medically fit, to avoid them losing their ability to self-care (see http://tinyurl.com/acutecaretoolkit3). Ambulatory emergency care is clinically safe, reduces unnecessary overnight hospital stays and hospital inpatient bed days (see: http://tinyurl.com/acutecaretoolkit10).

- Acute assessment units enhance patient safety, improve outcomes and reduce length of stay (see: http://tinyurl.com/amureview).

[1] The term 'flow' describes the progressive movement of people, equipment and information through a sequence of processes. In healthcare, the term denotes the flow of patients between staff, departments and organisations along a pathway of care (see: http://tinyurl.com/patientflow p7-12).
[2] The term, 'senior clinical decision maker', is used throughout this document and should be taken to mean a clinician with the skills and competencies to assess, determine a treatment plan and safely discharge patients under their care. Consultants and general practitioners typically fall within this definition. Doctors in their third year of specialist training (ST3) or above; experienced non-training grade doctors; and nurses, therapists and other clinicians with recognised advanced skills and training may also be considered to be 'senior clinical decision makers' within their spheres of competence.

- Mental health problems account for around five per cent of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions. Mortality and morbidity ratios amongst people with mental illness are much higher than amongst the general population (see: http://tinyurl.com/ncnkbar). Well-resourced liaison mental health services provided seven days a week and 24-hour a day are cost effective and an essential part of any urgent and emergency care system (see: http://tinyurl.com/p4lwkox).

- Continuity of care is a fundamental principle of safe and effective practice within, and between, all settings (see: http://tinyurl.com/mjjz97g and http://tinyurl.com/qcuerdk). The sharing of and access to key patient information is essential to this.

- Getting patients to definitive, specialist hospital care can be more important to outcomes than getting them to the nearest hospital for certain conditions, such as stroke, major trauma and STEMI (for examples, see: http://tinyurl.com/q82nk5q; http://tinyurl.com/klybmcn; http://tinyurl.com/m93duu3).

- Properly resourced intermediate care, linked to general practice and hospital consultants, can prevent admissions, reduce length of stay and enable home based care and assessment, including supporting 'discharge to assess' models (see: http://tinyurl.com/llgak9d and http://tinyurl.com/k9zjl6h).

4 General principles of good patient flow

4.1 Balance capacity and demand

- The first essential in maintaining good patient flow is to ensure that there is enough capacity along all parts of the pathway to manage demand.

- Demand should be taken to mean all referrals or presentations to a service, not just its historical activity. Measuring activity can often underestimate demand, as it may exclude referrals or presentations that have been deflected (for example, by refusals to accept a referral due to 'no capacity'; patients leaving without treatment due to long waits; abandoned calls because no one was available to answer the phone, etc.).

- Patterns of urgent and emergency referrals and presentations, while not random, will always exhibit variation hour by hour and day by day (this is 'normal variation'). When calculating demand, it is therefore essential to take into account normal variation and not to plan around averages. Ignoring variation and planning to meet average demand will inevitably mean the service is under regular stress and queues will develop that may be difficult and expensive to manage.

- Variation in demand for a service can be best illustrated using statistical process control (SPC) run charts. The upper control limits on an SPC chart represent the

level of demand that, if planned for, will enable to service consistently to manage demand, except in unusual circumstances.

- Capacity relates to a service's ability to treat referrals or presentations to it. In health care, capacity will mean clinicians, support staff, diagnostics, procedures etc. While beds are often referred to as 'capacity', this is really a misnomer. Beds are places where patients wait to be treated. They are not the treatment itself and therefore are not capacity.

- Imbalances between demand and capacity will create bottlenecks and delays along the pathway. These imbalances can be caused by temporary or long-term under-resourcing of services along the pathway or, paradoxically, by over-resourcing (for example where a new surgical service floods diagnostic imaging or intensive care due to poor planning). Smooth flow requires all parts of the pathway to be resourced to meet demand (including normal variation), but not over resourced.

4.2 Keep flow going

- Maintaining patient flow through hospitals relies on a dynamic equilibrium between admissions and discharges. In broad terms, the daily number of discharges will equal the daily number of patients a system has capacity to manage, divided by length of stay.

- For example, if a system has capacity (hospital staff/procedures/intermediate tier support etc.) to manage around 250 acute inpatients each day and hospital average length of stay is five days, we will expect around 50 discharges a day (note there will be some variation in numbers treated and discharged).

- If admissions increase by 10%, it will be necessary to discharge an extra 10% a day to keep the system in balance. This can be achieved either by increasing capacity (doctors/nurses/tests) so that more patients can be treated each day, or by increasing efficiency. In the short term, this can be done by everyone working harder and in the longer term through better processes. If neither capacity nor processes are changed, there is a likelihood that a hospital or service will rapidly reach a tipping point and fill up with patients waiting for capacity to become available to treat them. The ever growing number of patients typically leads managers and staff to see the problem as mainly one of lack of beds, rather than lack of capacity or a need to improve processes.

- Beds are important only insofar as they are places where patients are monitored receive nursing care and spend time recovering. If the number of beds is insufficient, treatment capacity cannot be brought to bear to treat all the patients who could be treated. Queues therefore develop (e.g. trolley waits in A&E) and resources are wasted (e.g. operations not carried out due to lack of beds). Closing beds without either increasing capacity or efficiency is generally a recipe for an overcrowded hospital. However, increasing beds above the number needed to match available treatment capacity is inefficient and will have no beneficial impact on discharge or treatment rates.

- Having a greater number of patients in beds than capacity to treat them stretches staff, reduces efficiency, creates harm and halts flow. The result is increasing length of stay and a sicker patient population.

4.3 Reduce variation

Unwarranted variation is a major obstacle to achieving safe, cost effective patient care and flow. Research has shown there is huge variation in clinical practice between hospitals; between hospital departments; between community teams; and between individual clinicians, even where statistically the patients and facilities are identical. The variation is so large, that it is impossible to say that all patients could be receiving good care.

To reduce variation, it is essential to apply simple rules that set boundaries within which health professionals and managers work. The following, good practice principles, should be considered to improve safety, patient flow and help reduce variation. These principles are outlined more fully in the sections that follow.

- Urgent or emergency care patients in any setting should receive the earliest possible review by a senior clinical decision maker.

- All emergency hospital admissions should be seen and have a thorough clinical assessment by a competent consultant as soon as possible but at the latest within 14 hours of arrival at hospital.

- All adult patients[3] should have a National Early Warning Score (NEWS) established at the time of admission.

- Consultant involvement for patients considered 'high risk' (defined as where the risk of in-hospital mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected) should be within one hour.

- There should be a senior review of the care plan and its delivery, for every patient, in every bed, seven days a week.

- Consider all potential acute admissions for ambulatory emergency care unless their care needs can only be met by an inpatient hospital stay.

- People in mental health crisis presenting at emergency departments should have their mental as well as any physical health needs assessed as rapidly as possible by a liaison mental health service.

- All potential admissions to acute mental health inpatient services should be assessed for intensive home treatment by crisis resolution home treatment teams

[3] NEWS is not appropriate for people under 16 or pregnant women (see: http://tinyurl.com/nn7oa7x page xiii).

unless there are significant immediate issues of risk, safety and complexity that warrant assessment under the Mental Health Act.

- Hospitals and local health and social care communities should prioritise activities aimed to achieve the earliest possible discharge of patients. A realistic expected date of discharge, with associated physiological and functional criteria for discharge, should be established as a goal for professionals and patients to work towards.

- Best practice is to establish a time, as well as a date, of discharge. This focusses clinical teams and increases the proportion of morning discharges, which are essential to avoid hospitals and emergency departments becoming overcrowded in the middle of the day.

- Assertively manage frail older people, and younger people with specific vulnerabilities, such as learning disability or those with long term conditions, ensuring they have their needs comprehensively assessed on arrival and are discharged immediately they are clinically ready for transfer home or to on-going care facilities.

- Promptly assess and place patients into the most appropriate care stream to meet their needs.

- All hospitals should promote 'internal professional standards' (IPS) that have been agreed by clinical teams as the basis for response times and relationships between departments (for the theory underpinning IPS, see: http://tinyurl.com/p35uqmv)

- All health services should actively seek to provide continuity of patient care.

- Design the capacity of health services to manage variation in demand, not just average demand.

4.4 Manage interfaces and handovers

Effective handover of patients between organisations and clinical teams is absolutely essential to patient safety and maintaining flow. It is good practice for all services regularly to review how effectively patients are handed over both internally and externally, and work collaboratively to improve processes along the whole pathway. The following principles should be considered:

- Hospitals and ambulance services must agree handover processes that ensure patients wait safely for assessment and ambulances are released promptly.

- All registered health and social care professionals, following telephone consultation or clinical review of a patient, should be empowered, based on their own assessment, to make direct referrals for patients to mental health crisis services and community mental health teams.

- All teams receiving emergency patients must be informed of the patient's arrival. Best practice is to include an agreed, formal communication method such as situation background assessment recommendation (SBAR) (see: http://tinyurl.com/2arr26m).

- Good practice is for all patients being referred for admission or assessment to be discussed with the receiving clinical team.

- All patients being admitted from emergency departments should be discussed with the receiving team to agree an appropriate plan of care.

- All patients with additional care complexity should be flagged and have additional needs discussed with receiving teams (e.g. patients with learning disability needing reasonable adjustments to standard care processes).

- All patients leaving hospital must have a completed e-discharge letter for themselves and their general practitioner and relevant associated professionals, including health visitors, school nurses etc. Where discharges are complex, best practice would include a telephone discussion with the GP.

The following sections cover good practice principles that can be applied to the main components that make up local urgent and emergency care systems in England. The sections build on each other and should not be read in isolation. Exemplary practice in one component will not produce good performance in a system. The system is organic, relying on all its parts working together to produce results.

5 Governance and whole system partnership

NHS England's guidance document, the 'Role and establishment of urgent and emergency care networks', advises that the planning and delivery of urgent and emergency care improvements is divided between system resilience groups (SRGs) and UECNs, with networks focussed on programmes that cannot easily be delivered at a more local level by SRGs or clinical commissioning groups (CCGs).

To successfully deliver operational scrutiny and oversee strategic developments across the complex, multi-agency emergency care pathway, the following good practice principles should be applied:

- SRGs must have senior level participation and commitment, including chief officers and executive directors. A local lead officer or chief executive should chair the group. Regular participation from senior clinical staff for all age groups, including secondary care consultants and GP clinical leads is necessary. Senior attendance from mental health providers, adult and children's social care, ambulance services and NHS 111 is essential.

- The SRG should 'get things done' through clearly defined works streams and specialist groups that are formally accountable to it. These need to involve a wide group of senior clinical staff from across the system, with clear reporting lines to the SRG.

- Where there are overlapping work programmes (such as those focused on integrating care or managing chronic disease), relationships need to be clear, transparent and formalised to avoid confusion. Shared information about the remit, membership and content of work programmes is important.

- An important role of UECNs is to maintain an oversight of the whole pathway, especially at the interface between organisations. One way of achieving this is to agree standards at key points along the emergency pathway, including response time standards. These should be monitored (ideally using live information 'dashboards') and reviewed to identify pathway bottlenecks that need whole system attention.

- Strong links must be established and clearly articulated between SRGs, UECNs and local Mental Health Crisis Care Concordat steering groups (see: http://tinyurl.com/lbcnaq3).

- UECNs and SRGs need to have an agreed strategic vision of what 'good' services and pathways look like for all patient groups, which is meaningful to stakeholders across the system. The vision should be developed with effective patient, carer and public input, as well as that of health and social care professionals and managers. The 2014/15 resilience guidance contains a schematic example (see p23-24 http://tinyurl.com/oa7ks5x), while some local systems use a set of patient centred principles. The vision needs to be used by members of the UECN/SRG to engage clinicians to develop improvement objectives and milestones, especially at the interface between organisations.

- It is important that UECNs and SRGs develop clear quality and performance frameworks to enable them to hold their systems to account. Well-designed whole system performance dashboards, that include outcome measures and patient and carer experience data, are useful in highlighting system bottlenecks and priority themes for action.

- Local systems should take responsibility for assessing demand and capacity at key points in the pathway for all patient groups. It is important to avoid scaling capacity to meet average demand - it should be designed to manage demand variation of up to two standard deviations from the mean4.

- Demand and capacity planning should take into account demand pressure-points, such as those around bank holidays, school holiday weeks, festivals and as a consequence of temperature extremes (for references on weather effects on health, see: http://tinyurl.com/Weather-effects)
- The UECN should create an expectation that prediction and prevention are as important as escalating to meet demand surges.

[4] Planning capacity to meet average demand will mean that on 50% of occasions, capacity will be inadequate and queues will form. Fluctuations in demand must therefore be taken into account. Best practice is to use statistical process control (SPC) run charts to plot demand over time and variation. As a rule of thumb, capacity and processes should be planned to manage between 85% and 95% of normal variation in demand at an appropriate level of granularity (e.g. hourly or daily).

- UECNs and SRGs have an important role in establishing effective partnerships between the health, social, voluntary and community care sectors. The growth in demand for non-elective care and the sizeable funding challenges for local authorities and health services creates scope for conflict and tensions. Collective action and risk sharing are essential if these challenges are to be met without damaging patient care.

6 Commissioning

- A commissioning strategy for urgent and emergency care should be developed using a collaborative approach with health and social care partners across the whole system. Involvement from the voluntary and community sector, patients and carers is important.

- The strategy needs clearly to define, 'what good looks like', be evidence based, have clear outcome measures and map demand and the capacity needed to manage it.

- SRGs, working in partnership with CCGs, should be responsible for the strategy development process so that the strategy and commissioning intentions are understood by all partners.

- A plan is needed within the strategy to develop extended, seven-day access to all relevant services in the local health and social care system, and take into account the ten clinical standards for seven day services (see: http://tinyurl.com/ngt79hp).

- Clear plans are required for how the population with frailty, or additional needs due to disabilities, will be managed in all settings, with the aim of enabling people to remain in their own homes as long as possible and ensuring that admissions to hospital are appropriate and as short as possible.

- The rate and trend in potentially preventable admissions of patients with ambulatory care sensitive conditions (ACSC) is an important part of the strategic analysis (see: http://tinyurl.com/mjwz7mc). A higher than expected rate should trigger a review of the whole system approach to the management of the specific patient groups and conditions that are outliers. These often include frail older people (with urinary tract infections) and people with learning disabilities (with epilepsy, see: http://tinyurl.com/m5syabd). It is important that every ACSC admission is alerted to the patient's GP, as such admissions are in principle preventable with good quality primary care.

- The strategy should operationalise the principle of 'parity of esteem', incorporating the requirements of the Mental Health Crisis Care Concordat to ensure that services for people experiencing mental health crisis are at all times as accessible, responsive and high quality as other urgent and emergency services (see section 16).

- Commissioning levers can be used to promote collaboration and mutual support between providers. The benefits of continuity of provision and care should be considered before formal procurement exercises are contemplated.

- A strategy is necessary to maximise support for self-management so that carers, individuals and their families feel better able to manage their physical and mental health (or that of those they care for) and can avoid unplanned admissions. This can be achieved through personalised care and support planning for people with long-term conditions and identifying a range of support services to help people build their knowledge, skills and confidence (e.g. through structured education programmes, information resources, peer support, use of technology and connecting people to their local community).

7 Demand management

7.1 Reducing acute hospital admissions

- The urgent and emergency care review evidence base suggests that schemes designed to reduce hospital admissions or readmissions need to be carefully selected, properly designed and rigorously evaluated.

- Commissioners and providers need first to focus on the relatively small number of interventions that are well-evidenced to be effective in reducing admissions before investing in less well-proven schemes.

- Where the evidence base is limited or absent, rigorous evaluation needs to be built into demand management schemes. Implementation should be programme managed using effective improvement tools (such as plan, do study, act (PDSA) cycles) and appropriate research methodologies. The project should clearly state what the aim is (e.g. 'the aim is to reduce admissions from primary care by 3% within 6 months'). The project should be evaluated against this aim. Due to the risk of optimism bias, any evaluation needs to be independent of staff and organisations that may have a stake in the 'success' of a project (a guide to evaluation is at: http://tinyurl.com/n9b76jj).

- Purdy et al (2012: http://tinyurl.com/p7qgskk) carried out a comprehensive systematic literature review to identify interventions that are effective in reducing unplanned hospital admissions. She found good evidence relating to a relatively small number of interventions:
    - Education with self-management reduces unplanned admissions in adults with asthma and in chronic obstructive pulmonary disease (COPD) patients.
    - Pulmonary rehabilitation is a highly effective intervention in patients who have recently suffered an exacerbation of COPD.
    - Exercise-based cardiac rehabilitation for coronary heart disease is effective. Specialist clinics, with ongoing follow-up for heart failure patients, reduce unplanned admissions (but not in asthma patients or older people).
    - Visiting acutely at-risk populations in the community may result in less unplanned admissions. The current programme of individual care planning for the most frail older people, which was implemented after Purdy's study,

has had promising results reported in some areas. There is a strong case to commission randomised control trials to strengthen the evaluation of this and similar programmes.

- It should be borne in mind that while the evidence base suggests that only a small number of the interventions studied reduce unplanned admissions, there have been few studies of the combined effect of multiple linked projects run collaboratively across a locality. Improvement science suggests that improving and smoothing the whole pathway is much more effective than optimising parts of it. This should be considered when evaluating the evidence base and planning future interventions.

- Many studies have shown that up to a quarter of admissions of frail older people could be avoided if there is an early review by a suitably qualified clinical decision maker supported by responsive intermediate care services (see: http://tinyurl.com/k9zjl6h). Early expert intervention with multiagency support to manage older people may be more promising than other interventions that have been attempted (see: http://tinyurl.com/nhdcgys).

7.2 Supporting people to manage long-term conditions

- Proactively managing long-term conditions should involve creating programmes to help people develop the knowledge, skills and confidence to manage their physical and mental health, access the support they need, make any necessary changes and be better prepared for any deterioration or crisis.

- People who are more 'active' in relation to their physical and mental health – who understand their role in the care process and have the knowledge, skills and confidence to take on that role – are more likely to choose preventative and healthy behaviours and have better outcomes and lower costs (for a discussion, see http://tinyurl.com/q63eufg).

- People with long-term conditions or additional vulnerabilities (such as learning disability) who present acutely may often be doing so as a result of inadequate planning and support (including self-management) in the community or lack of confidence in or access to effective services near to home (see Healthcare for All 2008).

- Health and social care professionals need to work collaboratively with individuals and their carers on personalised care and support planning that identifies the outcomes that are important to the individual, what support is needed to achieve these and the actions they can take themselves to self-manage (for more information see: http://tinyurl.com/nadg8kc).

- There are a range of different interventions, programmes and networks that can help individuals to better manage their health and well-being including peer support, structured education programmes, tailored and accessible information

resources, health coaching, behavioural change programmes, and linking people to voluntary and community resources.

- Children, young people and their families should have the opportunity to become 'expert patients' with access to services that help them to develop the self-confidence and self-management skills needed to deal with the impact of their condition.
- Integrated, multi-agency approaches to the management of long term conditions should be focused around the needs of children, young people, and their families, to enable a coordinated package of care, including a quality assessment, and access to a key worker approach.

7.3 Managing seasonal pressures

- Typically, around 50% of adult emergency admissions to acute hospitals have lengths of stay of two days or less, and 80% stay less than seven days. The admission rate of the <7day cohort has no obvious seasonal variation, and therefore does not directly contribute to 'seasonal pressures'. However, the number of these shorter admissions varies randomly by around 25%, which can trigger in-day bed pressures.

- Around 15% of adult emergency admissions remain in hospital for between seven and twenty-one days and utilise more than 40% of bed days. This cohort is distinctive in displaying a drop in bed occupancy just before Christmas followed by a considerable increase after Christmas. Easter can display a similar pattern.

- Trusts need to have sufficient capacity to manage the random variation inherent in the number of shorter stay admissions. Above average admission numbers require increased efficiency and effort (for example, more frequent board rounds[5], more early morning discharges). Of equal importance is the need to ensure that length of stay does not creep up when, due to normal variation, admission numbers fall and pressure on beds is reduced. To achieve this it is essential that activities associated with expediting straightforward discharges continue to be prioritised.

- Managing the longer stay cohort, many of whom will have complex discharge needs, needs considerable focus from clinical teams and multiagency collaboration. The post-Christmas rise in length of stay is not generally due to admissions being 'sicker'. It is due to a relative fall in whole system discharge capacity over the holiday period, leading to hospitals becoming crowded. Regaining equilibrium can take much longer than expected because processes have been destabilised. This means that even when the discharge capacity returns to normal, it may not be able to cope with the increased demand for discharge services. There will therefore be a period before the system re-stabilises.

[5] The terms 'ward round' and 'board round' are used throughout this guide. A board round is a rapid, 'desk top' review of the progress of each patient on a ward that does not generally involve seeing patients in person. A ward round involves a clinical team meeting their patients face to face, and typically is a longer and more detailed process than a board round.

- Loss of discharge capacity can rapidly destabilise a hospital and create a downward spiral from which it is difficult to recover. This typically happens after Christmas and Easter, although funding issues may chronically reduce discharge capacity and with it a hospital's resilience.

- It is essential that the need to maintain a relentless focus on straightforward as well as complex discharges, and to maintain whole system discharge capacity, is seen as a priority.

7.4 Balancing elective and emergency care

- Best practice is to segregate elective surgery from emergency care entirely through the use of dedicated beds, theatres and staff. This greatly reduces cancellations and improves outcomes and flow.

- It is essential to avoid both surgical and medical outliers due to the associated risks, poor outcomes and increased length of stay.

- Surgeon of the day (or of many days) models, with a surgical team entirely dedicated to managing emergency admissions, is essential (see section 24).

- Day surgery and ambulatory emergency (surgical) care should be maximised to reduce pressure on beds.

- Surgical admissions should be carefully planned based on expected length of stay of individual cases. This is best done centrally through a bed bureau and not left to the discretion of individual surgeons.

- Surgical staffing and theatre capacity should be planned to meet variation in seasonal demand. This is important to manage all cases within the national 18 weeks standard.

- Any backlog of patients who have breached 18 weeks needs to be addressed before the winter, as accelerating elective surgery at a time of high winter demand may be impractical.

8 Escalation plans

Year round capacity planning and escalation plans are essential for all health care organisations. The following guidance should be considered in order to achieve this:

- Local integrated health and social care escalation plans need to clearly define trigger levels for escalation across all organisations.

- Linkages between the escalation plans of partners across the local health community are important, so that mutual support is achieved at times of stress.

- The practical and concrete actions that will be taken by individual organisations in the event of escalation being triggered should be clearly described. This must go beyond a communications cascade.

- As most escalations are due to high hospital occupancy levels, escalation plans need to focus on processes to review and rapidly discharge patients who are medically fit but held up in hospital. This should involve the whole local health community working collaboratively, not just acute hospitals.

- Opening additional beds at short notice is a high risk tactic that may worsen, rather than alleviate, pressures by straining staffing resources, increasing length of stay and providing sub-optimal care. Before opening beds at short notice, a trust's executive team should satisfy itself that:
    - Every patient, in every bed, has been reviewed by his/her consultant that day.
    - There has been a rapid review of every patient who has been assessed to no longer require acute inpatient care by a team of clinicians and practitioners from the hospital, general practice, community health and social care services, the voluntary sector and commissioners. The aim must be to discharge safely as many patients as possible.
    - There is a clear de-escalation plan to close the beds as soon as possible.
    - Escalation wards will have dedicated consultant, nursing and therapy staffing, with twice daily consultant ward rounds. The nurse in charge should be senior, experienced and seconded to the ward until it is closed.
    - Escalation wards will not be used to accommodate frail older people moved from other wards to become 'outliers'.
    - The hospital's 'full capacity protocol'[6] has been invoked.

- Timely de-escalation protocols are important.

- There should be sufficient clinical leadership and involvement from primary and secondary care to resolve local issues in relation to escalation.

- It is important systematically to review the effectiveness of system and organisational policies following periods of escalation. The information from this review should be used to inform capacity and demand planning.

- An assessment of how escalation processes are operating should be a standing item on the agenda of both the system resilience group and urgent and emergency care network.

- Any decision to reduce or close a service (including residential and nursing home beds) should be discussed with the executive leads of all areas and organisations that will be affected, and a plan should be made to support the impact of additional activity on other services.

[6] A 'full capacity protocol' enables patients to be 'boarded' on inpatient wards before a bed has formally been vacated. See: http://tinyurl.com/qbmdd27.

- If a system is very frequently in a state of heightened escalation, it is likely that it is in fact operating within normal process variation. Using extraordinary tactics to manage normal variation is inappropriate. A fundamental review of demand and capacity combined with systematic process changes will be necessary.

9 Primary care

9.1 General practice

Urgent care in general practice matters. Primary care clinicians have many more interactions with patients than any other part of the NHS. Early diagnosis and treatment in primary care reduces harm and distress for patients. Effective and timely responses can avoid unwell adults and children being driven to use emergency departments. Achieving this is difficult, even in practices that are performing well, due to rising demand and skill shortages. Nevertheless, many practices are managing to deliver high quality urgent care by adopting a small number of good-practice principles:

- Focus particularly on responding to the small number of requests for an urgent home visit. Typically this involves a rapid assessment by a clinician, usually by phone so that, if needed, the home visit can be prioritised. This early response provides greater opportunity to plan an alternative to a hospital admission whilst other community services are able to respond and, if admission is needed, avoids delay with the associated risk of deterioration.

- Define a practice standard for the time from first call/contact to initial assessment, and from first call/contact to clinical intervention or referral for any cases identified as urgent – then audit and monitor performance against this standard.

- Offer a range of options for patients to access same-day care. These may include telephone consultations, e-consultations and walk-in clinics, as well as face-to-face appointments. Channelling patients into a single, rigid process inevitably disadvantages some, can lead to ‘gaming’ of the system and may lead to inappropriate use of emergency departments. The overall aim should be that no patient should have to attend A&E as a walk-in because they have been unable to get an urgent appointment with a GP.

- Provide early morning appointments for children who have deteriorated during the night to avoid parents attending A&E because of anxieties and doubt that they will get an appointment.

- Look at the practice’s operational model to ensure that continuity of care, particularly for the elderly and those with long term conditions or additional vulnerabilities, is provided so far as is practical and that the processes (for example of using the duty doctor to assess and see those looking for an urgent appointment) don’t make this more difficult.

- Establish mechanisms to ensure that the practice takes part in the discharge planning of frail and vulnerable patients. The discharge of clinically vulnerable patients should be reframed as the transfer of care to the general practice-led

community health and social care team so that this team can become more active in the reception and re-settlement of their patients back in the community.

- Practices can play an important role in supporting patients with long-term physical and mental health conditions with personalised care and support planning. They can also help patients to self-manage their condition(s) to reduce the risk of crises.

- Ensure that the practice team has the right skills and competencies in place to deal with paediatrics and develop a training plan in conjunction with local specialist paediatric services where there are skills gaps.

SRGs and CCGs should coordinate local health and social care services to support general practices in the management of patients with urgent care needs:

- GPs and adult and paediatric on-take consultants should consider dedicated telephone numbers to enable rapid discussions to ensure patients enter appropriate clinical pathways.

- Intermediate and social care services should support general practice to manage patients without defaulting to acute hospital admission.

- Ambulance services should have immediate telephone access to general practice to enable discussion of appropriate patient dispositions.

- Practices should use agreed protocols with ambulance services for requesting ambulance transport, which include expected timeframes for responses. This can help optimise the use of ambulance resources.

These types of changes in the environment within which general practice works can be transformative – but practices need to work with others to shape the support that they need.

9.2 Out-of-hours primary care

- Primary care out-of-hours (OOH) services need to have arrangements in place with NHS 111 to enable call-handlers to directly book appointments where appropriate.

- Commissioners and providers should minimise the number of 'hand-offs' between different people to avoid unnecessary re-work. Where possible, warm transfers should take place between staff within the integrated NHS 111 service, with early identification of the best person to meet the patient's needs (e.g. dental nurse, pharmacist, senior clinician).

- Processes need to be in place to minimise delays between NHS 111 receiving a call and a patient being assessed over the telephone by an out of hour's clinician. It is good practice for commissioners and providers to investigate cases that took longer than an agreed period, from the start of the initial call to the end

of the final call, that results either in reassurance and advice, or in a face-to-face consultation. The aim of the investigation should be to improve processes.

- Providers and commissioners should monitor the percentage of patients referred (or self-referred after an initial call to the service) to hospital, A&E and the ambulance service. This should be measured across both NHS 111 and the primary care out of hours service and be part of an SRG's standard data dashboard.

- Primary care out-of-hours services, NHS 111 and commissioners need to agree how best to implement primary care dispositions indicated by clinical assessment systems (such as NHS Pathways). Such agreements should always put the best interests of patients first, which may require a degree of pragmatism.

- The co-location of primary care out of hours services with emergency departments provides opportunities for collaboration, routine two-way transfer of appropriate patients and can help decongest emergency departments (see: http://tinyurl.com/og9qv7t for further guidance on primary care supporting emergency departments).

- Co-located services should actively encourage transferred patients to use the service best suited to meet their needs rather than defaulting to attend emergency departments.

9.3 Residential care homes

The needs of care home residents require co-ordinated input from generalists and specialists of multiple disciplines in partnership with social care professionals and care home staff. This can reduce unnecessary admissions that are often linked to prolonged hospital stays. Partnerships are essential, built on shared goals, reliable communication and trust. Partners should agree to share joint responsibility for resident's outcomes. The following guidance should be considered for local implementation:

- It is important that patients being considered for admission from care homes are discussed with a senior clinical decision maker in the hospital and with the patient's GP, so that an optimal plan for the individual patient is agreed and understood, taking into account the wishes of the patient and their family.

- Residents should receive comprehensive, multiagency assessment on admission and should agree, with appropriate involvement of relatives/carers, a person-centred care plan that is reviewed at least once every six months.

- The majority of residents of care homes are older people with dementia (although some will be younger with learning disabilities). Acute mental health assessment should be considered where mental and/or physical health problems are expressed with challenging behaviours. Assessments should be multi-disciplinary. Particular care should be taken if antipsychotics are prescribed to people with dementia (see: http://tinyurl.com/nf9fbxl).

- Care needs to be planned to include regular medicines reviews and falls risk assessments. A ceiling of care should be established with respect to future health crises and added to the care plan.

- Advance care planning for end of life care should be offered to all residents. This should be based on established good practice, such as the gold standards framework (see: http://tinyurl.com/qhvdbjp), and be accompanied by education and training for staff and access to specialist palliative care when required.

- 'Do not attempt active resuscitation' orders (DNAR) are clinical decisions that should be based on a patient's clinical condition and likelihood to benefit. However, a DNAR decision must not be taken to mean that other treatments and interventions should be withheld (see: http://tinyurl.com/lk5tozp).

- Where safe and efficient to do so, it is good practice to bring care to the resident in the care home, including GP and specialist reviews and clinical interventions (e.g. intravenous antibiotics and subcutaneous fluids).

- Care home staff at all hours must be aware of each resident's advance care plan and the agreed response to unexpected events.

- All care homes need a falls strategy to avoid inappropriate referrals to the ambulance service and hospital. Staff training to assess risk and manage residents who have fallen is important. They should be supported by community health services, local pharmacies and ambulance professionals trained to manage fallers without defaulting to conveyance to hospital.

- Care home staff should be supported by NHS and social care professionals through training and education, 24/7 access to advice, rapid response teams and encouragement to use clinical tools, protocols and service improvements.

- All local health communities need up to date strategies and commissioned services for the care and management of people in care homes that is based on good practice guidance, such as that from the British Geriatrics Society (see: http://tinyurl.com/njtwllt).

9.4 Community pharmacy

Community pharmacies can make valuable contributions to local health communities' urgent care programmes. They can enhance patient safety and reduce pressure on other parts of the local health community, particularly general practice, thus creating headroom for the management of patients with more serious problems. NHS England has published a toolkit to support this (see http://tinyurl.com/o4mpq5k).

- Community pharmacies can reduce pressure on general practice and enhance patient safety where they are proactively involved in:
    - medicines reviews
    - repeat prescription management
    - supporting hospital discharge (see: http://tinyurl.com/leb5vws)

    - medicines reviews of patients in care homes
    - multi-disciplinary community health service reviews of patient with long term conditions
    - supporting patients to optimise medicines use
    - supporting self-care for minor ailments and long term conditions
    - providing urgent access to medicines
    - providing flu vaccination to at risk groups

- NHS 111, general practice receptions and urgent care centres should have protocols to direct patients to community pharmacies where these can appropriately respond to a patient's care needs, including to services locally commissioned from pharmacy by NHS England, CCGs and Local Authorities.

- The local Directory of Services should reflect services available from community pharmacy and pharmacy opening hours. NHS England has published, '*Urgent Repeat Medication Requests Guide for NHS 111 Services: how to refer directly to pharmacy and optimise use of GP out of hours services'*. (see http://tinyurl.com/px7wps9).

- When providing clinical services, such as minor ailments services and provision of urgent repeat medication, it is helpful if community pharmacies have access to patient care information. The Health and Social Care Information Centre (HSCIC) has been commissioned to support all community pharmacies in England to implement access to the Summary Care Record (see http://tinyurl.com/pt9m75t).

Community pharmacy has an important role in promoting health and wellbeing and prevention of disease (e.g. flu vaccination to over 18s in at-risk groups has been commissioned nationally. See http://tinyurl.com/pyg9s96).

10 Community services

10.1 Community nursing, rapid response, early supported discharge

It is good practice for commissioners and providers of community health services to work together to turn what is currently urgent care into planned care by developing:

- Support for self-management, including helping to build peer networks and disease or disability support groups.

- Facilitated connection to voluntary support for mental, physical and personal needs and to address social isolation.

- Support for individual carers before they get to crisis point.

- More timely diagnosis of dementia and debilitating impacts of ageing.

- Prevention of falls and other mobility deteriorations.

- Personalised care and support planning, including advance care planning for end of life that can be done by older people themselves or with help from friends and family, advocates, spiritual leaders, solicitors or health and social care professionals. This needs to go beyond the highest risk people who are typically picked up using risk stratification tools. Schemes aimed at earlier intervention to prevent health crises in people lower down the risk stratification pyramid are particularly important.

- Support for nursing and residential homes to prevent admission.

- Education and support to children, young people and their families in community settings to create a 'virtual ward in the community' (for example, in injury management or illness prevention and management).

- Support to key professionals such as health visitors and school nurses in preventing admissions and responding rapidly to the needs of children and young people.

- Crisis care planning to enable direct access to specialist hospital wards for people with specific conditions and symptoms.

To achieve these objectives, it is necessary to:

- Build community capacity to ensure a timely response. Teams need to be able to respond rapidly, seven days a week and into the late evenings, and engage wider personalised community support. Access to equipment and short term care packages is essential.

- Develop person-centred, rather than task-based, care delivery.

- Promote collaboration and integration between nurses in general practice, community based services and voluntary support.

- Develop metrics that measure outcomes as well as activity and processes.

- Simplify processes so that hospitals, general practice, ambulance services and social care can make referrals with a single phone call.

Best practice is for community services to be organised to support 'discharge to assess':

- Wherever possible, frail older people should be transferred from hospital back to their normal place of residence as soon as the treatment of their acute problem is complete.

- Multidisciplinary functional assessments generally should be carried out in a patient's normal place of residence, rather than in a hospital, before decisions are made about higher levels of care (e.g. transfer to a nursing or residential home).

- Integrated health and social care teams should respond rapidly, so that assessment and basic care can be put in place within two hours of a person arriving home.

10.2 Community hospitals

Where commissioned, good practice is for community hospitals to provide:

- Step-up care: to prevent inappropriate admission to acute care by taking referrals from the community or care home settings.

- Step-down care: to facilitate a stepped pathway out of hospital by taking referrals from acute hospitals and to facilitate the return of patients to their normal place of residence ('home').

Investment in community hospitals should not be at the expense of domiciliary community health and social care services, which should be the preferred pattern of service provision. An appropriate balance should be struck, with beds being provided for the minority of cases that cannot be reabled in their normal place of residence.

Community hospital beds should be managed in accordance with the good practice principles that apply to acute hospitals:

- All patients need an expected date of discharge (EDD), which should be set by a senior clinician, within 14 hours of admission to a ward. Functional and physiological criteria for discharge should also be established so treatment goals are clear. The EDD should be tailored to the patient's condition and treatment goals and not based on an arbitrary length of stay.

- It is good practice for every day to start with a multidisciplinary board round. Those present need to include a senior clinician (which can be a GP, a senior nurse practitioner or a senior therapist), the nurse in charge, and other representatives from the allied healthcare professional team. This meeting should be short and focussed on checking each patient's progress against their goals, removing any barriers to discharge and managing internal waits.

- As the vast majority of community hospital patients will be frail older people, it is essential that the team understand, apply and deliver comprehensive geriatric assessment.

- Daily senior review, by a competent clinician who may be a doctor, senior therapist, advanced nurse practitioner or consultant, should be normal practice 7 days a week.

- At least one ward round a week should normally include a hospital consultant with expertise in managing frail older people.

- Patients should be accepted for admission based on their ability to benefit from the care provided. There should not be arbitrary exclusion criteria.

- Discharges by midday should be the norm to allow new patients to be admitted early enough in the day for safer and more effective care.

- Care providers, including relatives, must be involved in and made aware of discharge plans. Any required ambulance transport should be confirmed as soon as the timing for discharge is known.

- Processes should be in place to ensure discharges can happen at the weekend if patients have achieved their treatment goals. Ensuring that treatment goal criteria are documented in a way accessible to nursing and therapy teams will support this.

11 Urgent care centres (Walk-In & Minor Injuries Units)

- Urgent care centres (UCC) that are co-located with emergency departments provide an opportunity to stream patients with less serious illnesses and injuries to a service that is resourced to meet their needs, while reducing crowding in emergency departments. To preserve flow, UCC staff and cubicles must wherever possible be entirely separated from the majors/admission stream.

- UCCs must aim to manage most of their patients within two hours of presentation. Triage is generally inappropriate in UCCs – best practice is to use a 'see and treat' approach, with protocols to ensure that those waiting for treatment are fast tracked where necessary.

- Adults and children should generally be assessed and treated at the first point of NHS contact capable of meeting their immediate needs. Redirection may lead to assessments being duplicated, patients inconvenienced and necessary care delayed.

- Where UCCs are co-located with emergency departments, it is essential that there is appropriate integration, with shared governance arrangements and clearly defined protocols for the two-way transfer of patients. Commissioners must ensure that this requirement is embedded in contracts and effectively delivered where separate providers deliver care within an emergency centre.

- UCCs that are remote from emergency departments should be part of wider clinical network, with clear transfer arrangements and shared clinical governance.

- Procedures must be in place to ensure safeguarding of children and adults occurs to guard against the possibility of repeated presentations with injury.

- Commissioners need to ensure that the aim of UCCs is clear to avoid costly service duplication. Co-located UCCs may have a useful role in managing people with minor illnesses to avoid emergency department crowding. However, it may be more appropriate for other UCCs to focus on treating less serious *injuries* that would otherwise gravitate to an emergency department, rather than on illnesses that are best managed by in and out-of-hours general practice and community pharmacies.

- Recent good practice guidance on primary care in emergency departments has been produced by ECIST, the Primary Care Foundation and the Royal College of Emergency Medicine (see: http://tinyurl.com/mbgauyk).

12 NHS 111

- Commissioners should refer to the NHS 111 Commissioning Standards document for a detailed description of the NHS 111 integrated service (a revised version is due to be issued September 2015).

- Commissioners, SRGs and UECNs should develop a functionally integrated service, incorporating NHS 111 and primary care out-of-hours services, and collaboration with ambulance services. There need to be close links with in-hours primary care and other health and social care partners. The aim is to provide patients with an enhanced urgent care treatment and advice service with a single point of access for all health and social care urgent calls.

- It is important that the local directory of services (DOS) is complete, accurate and continuously updated so that a wide range of agreed dispositions can be made following initial assessment. The DOS must include information regarding services available to support individuals at high risk of, or experiencing, mental health crisis.

- It is essential that a stable and properly resourced and skilled team is in place to ensure that the DOS is maintained and developed.

- NHS 111 must use an evidence based clinical assessment tool to help determine the clinical priority of callers. It must be connected to the DOS to define the service that best meets their needs.

- Call centres should have on-site clinical support so that call handlers have immediate access to professional advice (see also section 9.2, out-of-hours primary care).

- Call handlers require training to meet the needs of those with sensory impairments and disabilities (e.g. deafness, dementia, learning disability).

- Systems should be in place to enable the direct booking of appointments and the electronic sharing of patient information between service providers.

- Calls categorised as ‘green calls’ to the 999 ambulance service and NHS 111 should, where appropriate, undergo further telephone clinical assessment before an ambulance disposition is made.

- A common clinical advice hub across NHS 111, ambulance services and out-of-hours GPs should be considered to support clinical review and help patients with self-care advice to avoid onward referral.

- NHS 111 should have the ability to auto-dispatch ambulances where a 999 response is required.

- The integrated NHS 111 service should have access to all special patient notes (SPNs) and advanced care plans (ACPs). It is important that these influence how relevant calls are dealt with. Details of the plans should be shared appropriately with receiving organisations in the patient's best interests. SPNs should be regularly updated by the responsible general practitioner.

- The staffing capacity and capability of NHS 111 services must take into account variation in call volumes by hour of day and day of week so that calls can be responded to in a timely manner without queues developing. This applies to call-handers, supervisors and clinicians. It is also important to ensure that all patient problems can be effectively addressed, including mental health, dental and medication needs.

- If queues of calls form, the NHS 111 service must take appropriate steps to minimise the risk to patients through messaging and clinical oversight of the nature of the caller's condition, escalating calls for immediate intervention where necessary.

- Processes should be established to ensure that the integrated NHS 111 service contributes to the co-ordination of the care of frail and vulnerable patients, developing links with social care and voluntary agencies to support ongoing care.

- Services should provide detailed management information and intelligence to local health systems regarding the demand for and use of emergency and non-emergency healthcare services to enable evidence based planning.

- Continuous improvement needs to be at the heart of integrated NHS 111 services, with providers working in partnership with commissioners and clinical leads to review calls, investigate incidents and look for opportunities to make the services better for patients.

13 Emergency ambulance services

Ambulance services play a central role in the provision of urgent and emergency care. Ambulance services and their commissioners should work together to develop a mobile urgent treatment service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital. The following, good practice principles, should be used to inform service development plans:

- Ambulance services should consider maintaining 'clinical hubs' in their control rooms to ensure the appropriateness and timeliness of responses provided to patients. Hubs should be staffed by a range of clinicians, which may include pharmacists, midwives, palliative care nurses and specialist or advanced trained paramedics and offer 'hear & treat' care to patients, as well as clinical support to paramedics on scene.

- As in other health contexts, care delivered by senior clinical decision makers (such as specialist or advanced paramedics / nurses) produces better clinical outcomes and can reduce demand for an emergency ambulance transport for non-critical 999 calls through ‘see & treat’, referral to community services or other pathways.

- SRGs should ensure that paramedics have routine access to community health and social care services to enable them safely to manage more patients at scene, either treating and discharging or referring onward to other appropriate services.

- Local health communities, through their SRGs and wider networks, should work collaboratively with ambulance services to develop and evaluate alternatives to conveyance to hospital, including:
    - Pathways to take patients directly to urgent care and walk-in centres in accordance with agreed and clearly documented standardised clinical criteria.
    - Referral direct from competent ambulance professionals to hospital specialties, including direct conveyance to assessment and ambulatory emergency care units, and out-patient appointments (same or next day).
    - Working with community mental health teams to provide triage and/or crisis care at home or in the community, and when necessary, conveyance to a designated health or community-based place of safety rather than to an emergency department or police station.
    - Falls partnership vehicles with advanced, multidisciplinary practitioners, or direct access to falls services.
    - The use of ambulances in alcohol ‘hot spots’ to provide a field vehicle to treat minor injuries at the scene or care for intoxicated people until they can safely make their own way home.
    - Increasing the scope of practice for more paramedics to provide ‘see and treat’ and ‘hear and treat’ care.
    - Paramedic practitioners undertaking acute home visits on behalf of GPs to avoid unnecessary admission and admission surges.
    - ‘Call back’ schemes for ambulance crews both in-hours and out-of-hours to GPs.
    - Joint planning with GPs and acute trusts for the management of high-volume service users/frequent callers.
    - Direct referral to intermediate care/community rapid response nursing services and direct conveyance to hospices.

- For patients who do need to be taken to hospital, ambulance services can help minimise handover delays by:

    - Reviewing patients’ conditions and needs en-route and sending details ahead to the receiving emergency department in the case of any special requirements/circumstances.
    - Avoiding the use of ambulance trolleys for patients who are able to walk into the department.
    - Using alternative vehicles to convey patients to the emergency department (e.g. patient transport service vehicles to transport patients, thus keeping paramedic staffed ambulances available.

    - Implementing electronic patient handovers.
    - Sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation when demand rises.

- The local healthcare system should work with ambulance services to enable them to have access in real time to patient care plans to develop a whole systems' approach to patient management and flow.

- Handover delays should be systematically and jointly reviewed by ambulance operations managers, hospital managers and clinicians. Shared actions can then be developed and agreed to maximise local availability of ambulances to respond to emergency calls.

- Local health communities must actively cooperate to ensure that ambulance queuing and handover delays are minimised. Where patients experience long waits, their national early warning score (NEWS or, for children, an agreed paediatric equivalent) should be recorded, pain assessed and managed and essential care given. Written guidelines must be agreed between the ambulance service and receiving hospital clarifying specific responsibilities for the care of waiting patients.

14 Emergency departments

The following principles of good practice should be considered to improve safety and flow, and to help reduce unwarranted variation and manage demand:

- Emergency departments (EDs) should be resourced to practice an advanced model of care where the focus is on safe and effective assessment, treatment and onward care. While it is essential to manage demand on EDs, this should not detract from building capacity to deal with the demand faced, rather than the demand that is hoped-for.

- ED crowding adversely affects every measure of quality and safety for patients of all ages, and for staff, and creates a 'negative spiral of inefficiency'. The main causes of ED crowding include surges in demand and lack of access to beds in the hospital system due to poor patient flow and high hospital occupancy rates. These can result in the physical and functional capacity of the ED (especially staffing and numbers of cubicles) and internal processes and responsiveness of other services being exceeded. Performance against the 4-hour standard is a useful proxy measure of crowding.

- The staffing of emergency departments should be planned so that capacity meets variation in demand, rather than average demand, and the variation in demand patterns between different patient groups including children, frail older people and people with mental health problems.

- The majority of emergency departments have 24/7 liaison mental health services to ensure that people of all ages presenting with acute mental health needs receive timely assessment by a skilled mental health professional. All ED staff should receive specific training in working with people with mental health needs.

- Effective clinical staffing models, based on different professional groups, led by senior emergency physicians, are required. If GP referrals are routed via ED, there should be the appropriate workforce to receive the demand. Such staffing models should aim to deliver a capable, sustainable and resilient workforce. The ED nursing and ancillary workforce should be configured to deliver care, and maximise efficiency, using currently accepted best practice.

- The ED shop floor should be well-led with real time 'command and control' achieved through a senior medical, nursing, and administrative team. A good leadership model involves regular board rounds, walk-throughs and active progress chasing.

- There should be a joint plan with the ambulance service to manage ambulance handover safely, with dedicated ED staff to take ambulance handovers and care for waiting patients. Suitable chairs should be available so that where appropriate, patients are not obliged to wait on ambulance trolleys.

- Triage, where used, should be a brief and value adding process aiming to prioritise care, provide first aid and analgesia, and initiate key investigations and

treatments. However, triage may act as a bottleneck at times of high arrival rates and there should be triggers to manage this problem, which may require a senior overview of all patients waiting.

- Co-located urgent/primary care models should be considered. Where there is a co-located urgent care model there should be shared governance and a single 'front door' (see section11and http://tinyurl.com/lqcstpv)

- The co-location of GP out-of-hours services with emergency departments provides opportunities for collaboration and the two-way transfer of appropriate patients.

- 'See and treat' for 'minors' is an alternative to processes involving triage. It can free up nurses, thereby increasing the number of staff treating patients and reducing queues. Departments using see and treat take steps to fast track patients with red flag conditions and often use a 'navigator' role to supervise waiting patients.

- Rapid assessment systems can improve safety and efficiency for certain patient groups and reduce length of stay in the ED. They do not significantly improve crowding that is caused by exit block. Rapid assessment systems generally require dedicated space, equipment and staff and wherever possible should be consultant led.

- Separating patients into streams (e.g. 'majors', 'minors', 'resuscitation', children's 'majors' and 'minors') based around similar processes promotes higher quality care and is beneficial. Streams and workforce should be configured, where possible, to work independently so that demand in one area does not impact upon function in another.

- Secure, audio-visually separate facilities and care should be provided for children in accordance with the recommendations of Royal College of Paediatrics and Child Health (see: http://tinyurl.com/kr4kmju).

- Emergency medicine doctors should focus on those patients who require resuscitation, have undifferentiated conditions and musculoskeletal injuries. There should be clear clinical pathways for the prompt transfer of care from ED to in-patient specialist teams, especially for high volume pathways including acute (internal) medicine, frailty and paediatrics.

- Fast-track processes to bypass the main emergency department patient streams are important for some patient sub-groups with clearly differentiated conditions, such as hip fracture, bleeding in early pregnancy, stroke and STEMI.

- Close attention to reducing waste within the ED can improve effectiveness. Standardising clinical processes and pathways can improve overall quality.

- Using internal professional standards to agree expectations of and between the emergency department and supporting services can greatly improve cooperation between departments and overall effectiveness.

- ED standards should include all the A&E national care quality indicators, not just the 4-hour standard.
- Response standards should be agreed with inpatient teams and wards, radiology, and pathology, and should be monitored. Examples include time from referral to being seen, time from decision to admit to reaching the destination ward and time from request to report/result.
- Within this framework, escalation procedures should be established with clear triggers and meaningful actions, to deal with both surges in demand and crowding.

- Clinical Decision Units are highly effective environments supporting the delivery of modern emergency care. Together with ambulatory care, frailty units, other short stay units (such as paediatric assessment units), and early access to appropriate outpatient clinics, they help reduce overnight admissions and maximise shorter episodes of care. Where there is a CDU, standards for clinical review should be agreed. These units should not be used for time-standard breach avoidance or for patients waiting for a decision to admit.

15 Ambulatory emergency care (AEC)

- Each acute site should consider establishing an AEC facility that is resourced to offer emergency care to patients in a non-bedded setting. Models may vary between hospitals, including emergency department (ED) based models and physician-led models outside of the ED.

- The aim of AEC is to manage as many patients as possible who, in the absence of an ambulatory care facility, would need to admitted to an inpatient ward. Hospitals introducing AEC for the first time should expert to convert 25% of their adult acute medical admissions to ambulatory care episodes.

- The aim should be to consider all patients for AEC management as a first line unless they are clinically unstable. Patients should be streamed to AEC based on fulfilling four simple rules:
  - The patient is sufficiently clinically stable to be managed in AEC.
  - The patient's privacy and dignity will be maintained in the AEC facility.
  - The patient's clinical needs can be met in the AEC facility.
  - The patient requires emergency intervention.

- The AEC facility should have immediate access to a senior doctor who is responsible for agreeing the case management plan for each patient.

- The time frames for initial assessment and medical review in the AEC facility should be similar to those in the main emergency department.

- Patients in the AEC facility should have access to diagnostics within the same timeframe as all other emergency patients.

- The percentage of patients who are transferred from the AEC facility to inpatient wards should be monitored. A low rate may suggest risk aversion, while a high

rate may indicate problems with patient selection (around 90% of referrals should be managed without admission to an inpatient ward).

- While this care process is called 'ambulatory' care, it is important not to exclude non-ambulant, frail, older people who might benefit, simply because they are unable to walk.

16 Mental health

16.1 The Mental Health Crisis Care Concordat

- Services for people with urgent or emergency mental health needs should be commissioned and delivered in line with the principles of the Mental Health Crisis Care Concordat (see: http://tinyurl.com/pbea9ub).

- An effective local crisis care pathway should be developed, with the following key components:

    1. Good governance, through setting measurable standards of care and outcomes (for example, see: http://tinyurl.com/od97awv).
    2. Empowerment of people and their families, through the provision of accessible information (for example, see: http://tinyurl.com/nl8e9g3).
    3. Prevention, through identifying and addressing the causes of crisis in local joint strategic needs assessments (for example, see: http://tinyurl.com/pke76ca).
    4. Improved and timely access to the right care through effective out-of-hospital care (for examples, see: http://tinyurl.com/o7bvw2j and http://tinyurl.com/oc2qkkm and http://tinyurl.com/ocfq5ue).
    5. Seven day a week, 24-hour liaison mental health services in acute hospital settings (for example, see: http://tinyurl.com/q5uq2v6).

16.2 Accessing care

- Commissioners, working with mental health providers, should ensure that care pathways are clearly defined in their directory of services for use by NHS 111, GPs, the ambulance service, police and social services to avoid the inappropriate conveyance to emergency departments of adults, children and young people.

- Mental health providers should work in multidisciplinary teams with GPs to risk-stratify patients and identify frequent attenders. These patients can then be case-managed proactively, with support to carers, and offered personalised care planning and support for self-management to help identify how to avoid the need for crisis care.

- Adequate local places of safety should be commissioned so that people of all ages detailed under S136 of the Mental Health Act can be assessed and cared for in an appropriate environment.

- Community mental health services should work collaboratively with police and ambulance services, particularly exploring multidisciplinary street triage models, to provide a joint response that reduces conveyance and admission rates and avoids emergency departments being the default entry point into the system.

16.3 Liaison mental health services

- 24/7 liaison mental health services for people of all ages should be commissioned in line with recognised quality standards (see: http://tinyurl.com/nffha77) and be available at all times within one hour of referral by an emergency department to navigate patients swiftly to appropriate physical or mental health services. Liaison mental health services providing senior decision makers at the front of the pathway can reduce repeat attendances, reduce admissions and inpatient length of stay and ensure that the patients get the right National Institute for Health and Care Excellence (NICE)-approved treatment (e.g. for self-harm). Response standards should also be agreed for liaison mental health service assessments on the wards.

- Alcohol intoxication should not automatically be used as an exclusion criterion to delay initial assessment by either ED staff or mental health teams (while noting that any assessment under the Mental Health Act of an intoxicated person has the risk of leading to poorly informed decisions and legal challenge and so must be carefully considered) .

- Where a patient is at high risk and needs to be assessed under the Mental Health Act but does not have an immediate physical health need requiring physical health treatment or admission, a standard for that assessment should be set by commissioners for a response within the 4 hour A&E standard.

- The Mental Health Act requires patients to be assessed by an approved mental health professional (AMHP) and by two S12 assessing medical practitioners, one of whom has previous knowledge of the patient, usually the patient's GP. It is important that the pool of S12 responders is large enough to ensure timely assessment under the Mental Health Act. Local Authorities also need to ensure that they commission sufficient AMHPs to meet local demand.

- Children and young people with mental health needs are especially vulnerable. Commissioners should ensure that emergency department and paediatric emergency department staff have rapid access to paediatric mental health liaison via both telephone consultation and an on-site response from a dedicated pool of children and adult mental health (CAMH) professionals, 24-hours a day, seven days a week.

- In their work to integrate mental health in the local UEC pathway, SRGs should ensure that:
  - Senior responsible officers from the whole of the health and social care economy lead the process of improvement, keeping the person at the centre of the service.
  - An all-ages approach is taken.

- Training in mental health awareness, brief interventions and signposting becomes a mandatory part of the training of all UEC professionals.
- Mental health NICE guidelines and quality standards are adhered to – e.g. self-harm (see: http://tinyurl.com/pbpsbs6).

17 Paediatrics

Much of the good practice highlighted in this paper for adult services is relevant for paediatric care. However, paediatric standards are generally more demanding as paediatrics is a very short stay specialty service and is increasingly provided on a network basis (see: http://tinyurl.com/o8nuj7f). The following good practice principles should be considered by commissioners and providers of children's health services:

- Children and their parents/carers need to be confident that the minimum national standards have been built into agreed care pathways. These are summarised in the Intercollegiate Emergency Care Standards (see: http://tinyurl.com/kr4kmju).

- All staff should follow the recommendations outlined within the guidance document, *Safeguarding Children and Young People: roles and competences for health care staff* (see: http://tinyurl.com/kcorx6l).

- There should be a focus on ensuring that effective primary and community services can be accessed. GP paediatric access must be good, particularly after school hours and into the evening.

- There should be a commissioned, 24-hour children's place of safety service away from the emergency department (ED).

- In hospitals, there should be either a separate paediatric ED or a separate children's stream that includes a specific reception and waiting area, assessment and treatment area and clinical decision unit that meets national standards.

- Dedicated paediatric staffing is important, including paediatric nurses 24/7, a sub-speciality qualified ED consultant or a lead consultant, ENPs or paediatric practitioners. There should also be staff rotations between paediatric and adult EDs and inpatient units.

- Short stay paediatric assessment units should be considered to provide an alternative to both the ED and to admission (see: http://tinyurl.com/npfgte4).

- Triage systems should be paediatric specific and operated by practitioners with training in paediatrics. This will allow streaming of children and young people to be seen by the most appropriate health care professional (e.g. GP, paediatric emergency nurse practitioner, ED clinician).

- EDs need 24/7 access to paediatric mental health liaison (PMHL) through telephone consultation and an on-site response from a dedicated pool of CAMH professionals skilled in dealing with psychiatric emergencies and managing the risk of young people who self-harm or attempted suicide.

- A separate primary care stream should be developed if there are substantial numbers of attendances that might appropriately be managed by primary care clinicians.

- Initial assessments should incorporate appropriate treatments such as antipyretics and pain relief.

- Provision should be made for high volume surges to reduce the risk of children waiting more than 15 minutes for assessment. This should include a senior decision maker undertaking rapid overviews of any children waiting.
- A dedicated consultant or middle grade should be present throughout the opening hours of the paediatric service.

- Commissioners should develop, agree and monitor response standards with all relevant providers, to ensure timely access to appropriate community paediatric services.

18 Acute medical assessment

The following good practice principles should be considered to improve safety and patient flow:

18.1 Streaming of patients referred to medical specialties

- All patients referred for emergency assessment should be discussed with a senior clinician who is immediately available to receive the call.

- The senior clinician receiving the call should be able to offer a minimum of four options to the referring clinician:
    - Advice.
    - An appointment in an out-patient clinic.
    - Assessment in an ambulatory emergency care facility.
    - Admission to an acute assessment unit (and access to an acute frailty service where appropriate) or directly to a specialty service.

- The most appropriate options should be determined locally, and should aim to maximise the non-admitted options.

18.2 Advice

- Typically a senior clinician, with good local knowledge of available services, can handle 10-15% of GP referrals over the phone without the need for the patient to attend hospital.

- This senior clinician should be able to refer to rapid response, hospital at home and intermediate care services to be able to offer the best options to the referring clinician to allow patients to be appropriately managed without attendance at the hospital.

- The clinical conversation with the referrer from primary care can be used to pre-plan the patient's care and manage their expectations. This may include informing the patient that their care will be in an outpatient setting; requesting investigations before arrival; or planning their transfer back to primary care.

18.3 Appointment in out-patient clinic

- All high volume medical specialties (including paediatrics) should ensure that out-patient capacity is available for patients referred in as emergencies. This should include patients with long term conditions who are experiencing an exacerbation or complication related to treatment. This is especially relevant for patients already attending the service.

- Specialist nurse services are an important option in the patient streaming process, and provide patients with access to expertise in managing exacerbations of their illness.

18.4 Acute Medicine Unit (AMU)

- Best practice is to plan the physical and functional capacity of AMUs to meet variations in the number of admissions of at least two standard deviations from the mean. The number of beds / trolleys should be based on turning them over up to twice during each 24-hour period. Inadequate staffing or physical capacity can lead to increased outliers, poor outcomes and prolonged length of stay. It is important to note that patients requiring side rooms on the AMU often wait longer for another side room to become available on an appropriate ward. This should be taken into account when planning physical capacity.

- Patients on the AMU should have face-to-face contact with a senior clinician at least twice daily. The process of providing ward rounds should meet the standards of the RCP/RCN ward round document (see: http://tinyurl.com/qcj4zhu)

- Senior clinical review on the AMU, usually by a consultant, should commence as early as possible and normally within one hour for sick patients and three hours for all others. AMUs should consider designing rapid assessment models that systematise early senior review.

- Where this standard cannot immediately be met 24/7, workforce plans need to be developed to meet it and as an absolute minimum, first consultant review of clinically stable patients should be commenced within 14 hours.

- Board rounds should be used to co-ordinate a multi-disciplinary approach to patient care, and to maintain the tempo of care.

- The AMU should have pharmacy support to ensure the immediate availability of medications for discharge and medicines reconciliation for patients with polypharmacy.

- An expected date of discharge should be established as part of the care plan and linked to functional and physiological criteria for discharge.

- Specialty in-reach into an AMU should follow an agreed process, which can be based on attendance at board rounds or on request by senior decision makers. The transfer of patient care from the AMU to specialty teams should follow good handover guidance (e.g. using SBAR). Once a patient has been accepted as requiring inpatient specialty care, the patient should be reviewed daily by the specialty, even if remaining on the AMU or transferred to another ward.

- Senior therapy support to the AMU to facilitate the early assessment of patient mobility and functional capacity is important. Ready access to equipment such as walking aids and commodes is required, so that patients assessed as needing these aides will not be delayed unnecessarily.

- Discharge planning should begin on the AMU and include:
    - Anticipated discharge needs.
    - Place of discharge.
    - Discharge date and time.
    - Follow-up arrangements.

- Frail older people should be managed by clinicians competent to deliver comprehensive geriatric assessment. This is best delivered in a discrete area, either on the AMU or in a dedicated facility. Evidence suggests liaison services are neither effective nor cost-effective.

19 Short stay medical units

- It is good practice for acute hospitals to provide short stay medical units for patients with an anticipated length of stay of up to 72 hours. These are best co-located with assessment units as part of the AMU.

- Consultants should provide ward cover in blocks of more than one day to provide continuity of care and be present seven days a week and into the late evenings. This will reduce delays and improve outcomes.

- Twice daily, seven day a week face-to-face consultant review is an important feature of a really effective short stay service.

20 Planning transfers of care from hospital to community

The following good practice principles should be considered when designing processes for the safe and effective transfer of care of patients from hospital to community settings:

- From the time of admission, all patients (and their carers) need to know four things:
    - *What is going to happen to me today?*
    - *What is going to happen to me tomorrow?*
    - *How well do I need to be before I can go home?*
    - *When can I expect to go home?*

- To answer these questions, every patient must have a medical care plan that contains:
    - Clinical criteria for discharge (functional and physiological),
    - linked with a patient specific expected date of discharge (EDD) and
    - a differential diagnosis.

- EDDs should be set by a consultant. They should represent a reasonable judgement of when a patient will achieve their treatment goals (clinical criteria for discharge) and can leave hospital to recover and rehabilitate in a non-acute setting (usually in their normal place of residence).

- EDDs should be set no longer than 14 hours after admission.

- The progress of every patient towards their EDD should be assessed every day at a board or ward round led by a senior clinical decision maker, who should normally be a consultant. EDDs should only be changed with the agreement of the consultant.

- It is important that patients are actively engaged in the discharge process as this promotes realistic expectations and can improve outcomes, self-care ability and patient experience.

- It is essential that a hospital's discharge profile mirrors its decision-to-admit profile so that beds are available as admission decisions are made. In many cases, changing the discharge profile, so that all patients leave two or three hours earlier each day, will be sufficient. This can be achieved by ensuring that take-out drugs, discharge letters, transport, essential equipment and carers are all prepared. Of equal importance is a 'can-do' attitude amongst clinical staff, who should prioritise activities necessary to achieve prompt discharges.

- Maintaining a steady flow of transfers out of hospital over weekends and bank holidays is essential to avoid very high occupancy levels at the beginning of the week. Routine consultant weekend presence is necessary, supported by diagnostics, a multidisciplinary team and community health and social care services. Priorities should include seeing all potential discharges and patients with a NEWS score of >3.

- Patients should be transferred out of acute hospitals as soon as they cease to benefit from acute care (i.e. have achieved their clinical criteria for discharge). At every board and ward round, the following questions should be considered:
    - If the patient was being seen for the first time as an outpatient or in A&E, would admission to hospital be the only alternative to meet their needs?
    - Considering the balance of risks, would the patient be better off in an acute hospital or in an alternate setting?
    - Is the patient's clinical progress as expected?
    - What needs to be done to help the patient recover as quickly as possible?
    - What are the patient's views on their care and progress?

- Providers should systematically maintain a list of patients who are no longer benefitting from being in an acute hospital. This list may include patients who are officially reported as having a delayed transfer of care (DTOC), but should not be limited to them. The term 'medically fit for discharge' should be avoided, as it is too vague to be helpful.

- Run charts (using statistical process control) of officially reported delayed transfers of care should be maintained to identify trends. Collaborative action by health and social care should be triggered where the number of DTOCs exceeds an agreed threshold (for example a statistically relevant trend above 3.5% of the permanently established bed base).

- Progress-chasing meetings should take place daily to review all patients who are no longer benefitting from acute inpatient care. Attendees should include NHS community services and social services staff. Attendees must be briefed on relevant patients and able to sign off actions on behalf of their organisations.

- Support services in the hospital, primary and community care setting must be available seven days a week and into the late evenings to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

- Primary and community care services should have access to appropriate senior clinical expertise (e.g. by phone), and where available an integrated care record, to mitigate the risk of emergency readmission.

- Responsive transport services must be available seven days a week.

- In addition to the above, all prolonged hospital stays above a locally defined level (e.g. 10 days) should be reviewed at least twice weekly. During such reviews, three key questions should be asked:
    - Has the patient ceased to benefit from acute hospital care?
    - What needs to be done now to expedite a safe discharge?
    - What could or should have been done earlier in the patient's stay to prevent or mitigate a long length of stay?

- 'Discharge to assess' is the concept of planning post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This should be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this. Many health communities have committed as a whole system to develop comprehensive pathways based on this principle.

21 Bed management

The following, good practice principles, should be considered to improve bed management:

- All acute and community hospitals and acute mental health inpatient wards need to maintain a real-time bed state that is widely and easily available to all staff. Predictive information (taking into account rolling averages and variation) on admissions and discharges throughout the day is needed to inform decision making.

- A dedicated named lead should be assigned for patient flow 24/7. This individual should be responsible for managing a clearly defined escalation process where demand for beds is predicted to exceed capacity.

- Acute hospitals should have agreed 'full capacity protocols' that are triggered when emergency departments (EDs) reach predefined occupancy levels. The protocol may include processes to transfer appropriate patients to inpatient wards to wait for beds to become free; to mobilise additional staff to move patients who have been assigned beds on wards out of the ED; and to trigger additional discharge board rounds.

- Following assessment, patients on acute medical units who require longer stay specialist management should be handed over to specialty teams, which should be responsible for managing them throughout their episode in hospital.

- Best practice is for adult patients with an expected length of stay of less than two midnights to be managed in a short stay unit (ideally co-located with the acute medical unit) and not transferred to a specialty bed unless clinically indicated.

- Handovers between consultants for non-clinical reasons and transferring patients to non-home wards as outliers are associated with poor clinical outcomes and should be avoided. Frail older people should never be transferred to inappropriate wards as outliers due to the high risk of decompensation, harm and extended length of stay.

- Frail older people should be managed assertively with the shortest possible length of stay in a specialist short stay unit for older people or, where a longer length of stay is justified, a ward specialising in acute medicine for older people. Such patients should not be transferred more than once following assessment on an acute medical unit.

- Acute hospitals should ensure that there are enough staff and beds on the AMU for the next 4-hours work (e.g. if the admission rate is between two and four patients an hour during daytime, then 16 beds and enough staff need to become available during that period to ensure adequate flow and timely assessments).

22 Pathways for frail and vulnerable people

The following, good practice principles, should be considered to help improve the safety and effectiveness of pathways for frail and vulnerable people.

- It is essential that frail older people (including those with dementia) receive care by a team of professionals competent to assess and manage their individual

needs. Early diagnosis and treatment will minimise time in an acute hospital while maintaining functional status or giving the best chance of restoration of function (see: http://tinyurl.com/cebaqz3)

- Best practice is to identify patients with frailty syndromes in the community and provide appropriate support (see: http://tinyurl.com/msc9ctu).

- Comprehensive geriatric assessment is the cornerstone of care. Teams may provide this from a ward base (including acute frailty units) or as a mobile team. Early identification of patients with frailty syndromes at the time of proposed admission is essential so that assessment is not delayed. Best practice is to deploy consultant led acute frailty teams at the front of the hospital pathway to identify patients with frailty. Where this is not possible, a suitable assessment tool may be used to identify patients with frailty (for example, see: http://tinyurl.com/nkazj22)

- Usual functioning should be recorded on admission and used to inform clinical criteria for discharge. There should be goal setting by the multidisciplinary team aiming to attain sufficient functional status to allow the patient to return to their normal place of residence.

- It is essential for teams to ensure there is no further deterioration in physical and mental function while a patient is in hospital.

- There should be an agreed complex discharge planning process with shared responsibility for success between the acute trust, community and social care.

- Restorative care and parallel social care assessment should continue in a place of safe care (ideally the patient's usual place of residence) other than an acute hospital (the 'discharge to assess' model). If there is a wait for community capacity to become available, active re-enablement should start in the acute hospital as soon as the patient has met his/her clinical criteria for discharge. This should include helping patients to dress in their own clothes, to walk and exercise and to avoid unnecessary time in bed.

- Transfer to ongoing re-enablement services should be seamless, with a clear process to ensure that therapeutic goals are clearly communicated.

- Assessment of a patient's suitability for transfer to a community hospital can be done by any competent health care professional based on a patient's ability to benefit from a longer period of inpatient rehabilitation. It is vital for flow that patients waiting in acute hospitals for rehabilitation beds are pulled into them at the earliest opportunity.

- Other patient groups with vulnerabilities require additional considerations, input and adjustments to standardised care in order that their needs are fully recognised and met. These groups may include people with acquired brain injury and people with physical and learning disabilities. Trusts should develop vulnerable patient group pathways and processes (e.g. most trusts employ

learning disability liaison nurses to support development of pathways and train and assist staff around the specific issues that might arise or need addressing).

23 General acute wards and specialty teams

- There should be simple rules in place to standardise ward processes and minimise variation between individual clinicians and between clinical teams. Implementation of the SAFER bundle should be considered (see: http://tinyurl.com/ngz67l3).

- Ward round check lists should be used routinely (see: http://tinyurl.com/pgrtzbw).

- Ward rounds should always include an appropriately senior nurse and other members of the multidisciplinary team (for best practice guidance on ward rounds, see: http://tinyurl.com/nat2d7a).

- Wherever possible, specialty consultants should work in teams, with at least one member of the team ward-based and responsible for inpatients as 'consultant of many days', while the remainder focus on other activities. Separating emergency from elective care enhances continuity and avoids conflicting responsibilities.

- Daily senior medical review (by a person able to make management and discharge decisions) must be normal practice seven days a week. Daily, early morning board rounds enable teams rapidly to assess the progress of every patient in every bed and address any delays and obstacles to treatment or discharge. A second, afternoon board round is best practice. Patients whose condition warrants face to face review should be identified by the nursing team and highlighted on the board round.

- All patients should have a consultant approved care plan containing an expected date of discharge and clinical criteria for discharge, set within 14 hours of admission.

- Morning discharges should be the norm, to reduce emergency department crowding, to allow new patients to be admitted early enough to be properly assessed and for their treatment plan to be established and commenced. The aim should be for 35% of the day's discharges to have left their wards by midday. This requires teams to prioritise activities associated with discharge.

24 Surgery

The following good practice principles should be considered when planning and delivering processes aimed to improve the safety and flow of patients requiring surgical assessment or intervention:

24.1 Hospital care

- Surgical resources should be planned to meet the daily demand for elective and emergency admissions. This can vary considerably by day of the week and time

of the day. Best practice is to model bed numbers on not less than two standard deviations from the mean demand, not on averages.

- Surgical treatment of acutely ill patients must take priority over planned, elective surgery when necessary. Adequate provision for urgent access to operating theatre time must be available such that it does not impact on elective operating for the efficient management of both patient pathways.

- Emergency centres should consider dedicated surgical assessment units. These may be nurse led, supported by consultant led surgical teams. There should be care pathways for common conditions such as abdominal pain and abscesses.

- A hospital offering emergency surgery should have a consultant of the day/many days model, where the surgical team has 24/7 access to dedicated and staffed emergency theatres and is free from all other commitments.

- A surgeon (at ST3 grade or above or a Trust Doctor with MRCS and ATLS) should be available to see and treat acutely unwell ED referrals at all times within 30 minutes and all routine referrals within 60 minutes. Resident doctors should be supported by consultants who are immediately available by phone and who can attend to provide senior support within 30 minutes of request (see Royal College of Surgeons standards at: http://tinyurl.com/qdsd5oh). Surgery on high risk patients must be carried out by a consultant surgeon supported by a consultant anaesthetist.

- All trusts managing patients requiring emergency laparotomy should consider implementing the Emergency Laparotomy Pathway Quality Improvement Care Bundle (see: http://tinyurl.com/oulb8bl)

- All patients considered to be at high risk (>10% mortality) must be reviewed by a consultant in less than four hours (ideally within 60 minutes) if their management plan is undefined and they are not responding to treatment as expected.

- All patients should be reviewed by a consultant within 14 hours of admission and then twice daily while on the surgical assessment unit (SAU) and at least daily on inpatient wards until discharged.

- All patients should be set a consultant approved expected date of discharge as part of the care plan. This should be linked with clinical criteria for discharge.

- Many low risk surgical conditions can be managed through ambulatory emergency care units. These include uncomplicated head injuries, abscesses, kidney stones, urinary retention and early pregnancy bleeding. It is important that bed days are not used where ambulatory care is a viable option.

- Orthopaedic services should be supported by ortho-geriatricians. Hospitals should provide surgical units with proactive ‘in-reach’ from physicians and geriatricians. This can reduce length of stay significantly.

- Hospitals providing emergency care to children must have comprehensive paediatric facilities, 24/7 paediatric cover and paediatric nursing and anaesthetic support. They must also ensure that on-call surgeons have the training and competency to manage the emergency surgical care of children and young people (for a full discussion of surgical standards for children, see: http://tinyurl.com/o3rsc4s and the draft consultation document http://tinyurl.com/q3ksntt).

24.2 Surgical networks

- Hospital surgical services should be part of wider operational networks with an identified network lead. This particularly applies to emergency general surgery (see: http://tinyurl.com/qgndpsb).

- Adult and paediatric emergency surgical services delivered within a network must have arrangements in place for image transfer, telemedicine and agreed protocols for bypass/transfer.

- Agreed guidelines and protocols for the transfer of critically ill patients must be in place, and regularly audited, to ensure patient safety.

25 Care management and the role of social care

- There should be a local agreement between health and social care services that packages of care can be restarted, without an automatic need for reassessment, where a patient's care needs remain largely unchanged. This can be facilitated by implementing a trusted assessor model.

- For the majority of patients, definitive assessment of social care needs should occur outside of hospital (see section 10).

- The multidisciplinary team should have same-day access to social care advice, ideally at the morning board round, or by phone.

- There should be a local agreement between health and adult social care to 'fund without prejudice' while responsibility for funding a patient's care is being established. This will allow assessment to take place outside hospital, ideally at home with support.

- Health and social care communities should work together to reach local agreement that all referral processes are as simple as possible (i.e. simple, short electronic documentation that is quickly and easily completed).

- Trusts in particular should ensure that the legal requirement of Assessment/Discharge Notices from acute trusts to social services - to share patient information (and the required response standards) - are understood and initiated by ward staff (see: http://tinyurl.com/qz7csc7). They should seek feedback from social care that notifications are appropriate to avoid wasting social

workers' time. Embedding care managers, for the most complex patients, within wards encourages a proactive and co-operative approach.

26 Managing Information

Safe and efficient patient care requires effective, timely and appropriate transfer of key information that follows the patient through the healthcare system. This is particularly important in the urgent and emergency care system where, by definition, the patient is accessing care from outside of their routine care providers.

This section should be read in conjunction with the National Informatics Board strategy**:** *Using Data and Technology to Transform Outcomes for Patients and Citizens, A framework for Action (2014) (*http://tinyurl.com/p2tetmd).

26.1 Principles of information flow in urgent care

26.1.1 Enablers

- The NHS Number must be used as the primary identifier along the patient pathway. All activity within an organisation must be able to be identified using it. It is mandatory to include the NHS number in all clinical correspondence.

- Systems should implement the GS1 standard for unique identification of patients using technology to support identification as patients move around the system. It is essential that access to patient information is auditable.

- Improved information flows and access to systems should be used as an opportunity to improve collaborative working. For example, shared information can allow clinicians in community pharmacies to support NHS 111.

- Ambulance services should develop plans to get access to the NHS Number, through solutions such as Spine mini-services or directly. This is a key building block in enabling information captured by ambulance services to be shared. This will also form the basis for use of electronic messaging of information between ambulance services and other parts of the urgent and emergency care system.

26.1.2 Access to data

- While access to patient information should be governed by appropriate information governance controls, this must be balanced against the need to share information to enable integrated and effective care that is in best interests of patients of all ages, as highlighted by the Caldicott 2 principles.

- Patient consent for sharing information must be sought wherever possible, unless it is an emergency or otherwise in the patient's best interests.

- Access to core general practice information should be made available to all services in urgent and emergency care. This should include special patient notes (including any red flags), medicines and contra-indications, and allergies. In the

absence of (or alongside) a local integrated digital patient care record (such as the Hampshire health record), the national summary care record (SCR) should be used, as it offers a low cost, high value solution to summary patient record access (see http://tinyurl.com/opatmmg). The SCR is available to all clinicians across the NHS in England either through the web based application or suitably enabled clinical applications. The SCR should be used by community pharmacies as it becomes available from autumn 2015.

- As of June 2015, 96% of the English population have an SCR containing key details of their medication history and any known allergies and adverse reactions sourced from their GP record. With patient consent, further additional information can be added to the SCR by their GP practice such as significant past medical history and procedures, anticipatory care information, patient preferences and other relevant information often included in special patient notes. Inclusion of this additional information is encouraged to benefit patients in urgent and emergency care pathways. For more information, visit: http://tinyurl.com/khg3868

- Patient held information is valuable in empowering choice and increasing patient safety. Simple tools such as 'This Is Me' (from the Alzheimer's society: http://tinyurl.com/p9wf5vp) should be widely adopted across local health and social care communities.

- Carers are vital to a sustainable health care service and they should also have access to shared digital tools and information (such as access to the NHS Choices website) to support those they look after.

26.1.3 Efficient transfer of information

- The first point of contact must be able to capture enough detail to enable appropriate advice and onward referral.

- Current guidance to NHS 111 is that a 'warm transfer' (i.e. with the call transferred to a person, rather than being added to a queue) must be used wherever possible. The SCR can support this by providing key information to clinical advisors.

- Electronic handover of care using standardised datasets is a key priority. The Academy of Medical Royal College's publication, "*Standards for the clinical structure and content of patient records"* should be followed to ensure that this is achieved safely.

- Electronic discharge summaries must be used to aid safe and effective transfers of care. The Academy of Medical Royal College's agreed headings should be used to provide consistency in the way that information is displayed.

- The NHS directory of services should be developed as a key source of information on local services and used strategically to support navigation and referral of patients to appropriate settings.

- Wherever possible, systems should be designed so that relevant information arrives at a service ahead of the patient (e.g. ambulance services sharing information electronically prior to their arrival at ED; urgent repeat prescriptions being filled before a patient arrives at a community pharmacy).

- At the end of the episode of care, appropriate transfer of care documents should be relayed to the patient's GP and other relevant services, such as community pharmacy, to ensure continuity of care. The patient should also receive a copy.

- Data should be used to support the demand management of urgent and emergency care services. For example, repeat users of services can be identified and followed-up to address their specific care needs.

Reading List

References to the following supporting information are included in this document:

The NHS Five Year Forward View (http://tinyurl.com/nhs5yearforwardview).

Improving Patient Flow (http://tinyurl.com/patientflow).

UECR Phase 1 Report Evidence Base (http://tinyurl.com/UECRph1EvBase).

Crowding and Exit Block in Emergency Departments (http://tinyurl.com/edcrowding).

Boarding – impact on patients, hospitals and healthcare systems (http://tinyurl.com/patientboarding).

The benefits of consultant delivered care (http://tinyurl.com/benefitsofcdc).

A cost-benefit analysis of twice-daily consultant ward rounds and clinical input on investigation and pharmacy costs in a major teaching hospital in the UK (http://tinyurl.com/bmjopen).

Acute care toolkit 3 – acute medical care for frail, older people (http://tinyurl.com/acutecaretoolkit3).

Acute care toolkit 10 – Ambulatory emergency care (http://tinyurl.com/acutecaretoolkit10).

Oxford Journal - effectiveness of AMU's in hospitals: a systematic review (http://tinyurl.com/amureview).

Physical morbidity and mortality in people with mental illness (http://tinyurl.com/ncnkbar).

Guidance for commissioners liaison mental health services to acute hospitals (http://tinyurl.com/p4lwkox).

Continuity of care for older hospital patients (http://tinyurl.com/mjjz97g).

BMJ Open – Which features of primary care affect unscheduled secondary care use – a systematic review (http://tinyurl.com/qcuerdk).

BMJ Research – Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay (http://tinyurl.com/q82nk5q).

British Journal of Surgery – Effect of regional trauma centralization on volume, injury severity and outcomes of injured patients admitted to trauma centres (http://tinyurl.com/klybmcn).

RCP Journal – The impact of consultant delivered multidisciplinary inpatient medical care on patient outcomes (http://tinyurl.com/m93duu3).

National audit of intermediate care summary report 2014(http://tinyurl.com/llgak9d).

RCP National Early Warning Score (NEWS) – standardising the assessment of acute-illness severity in the NHS (http://tinyurl.com/nn7oa7x).

Harvard Business Review – Promise based management: The essence of execution (http://tinyurl.com/p35uqmv).

NHS Quality and Service Improvement Tools - SBAR (http://tinyurl.com/2arr26m).

Crisis Care Concordat – Mental Health (http://tinyurl.com/lbcnaq3).

Operational resilience and capacity planning for 2014/2015 (http://tinyurl.com/oa7ks5x).

Weather effects on health (http://tinyurl.com/Weather-effects).

NHS Services seven days a week forum clinical standards (http://tinyurl.com/ngt79hp).

Quality Watch – focus on preventable admissions (http://tinyurl.com/mjwz7mc).

Improving Health and Lives: Learning Disabilities Observatory – Hospital admissions that should not happen (http://tinyurl.com/m5syabd).

The Health Foundation – Evaluation: What to consider (http://tinyurl.com/n9b76jj).

Interventions to reduce unplanned hospital admissions: a series of systematic reviews (Final Report) - (http://tinyurl.com/n9b76jj).

NCBI - Effect of telehealth on quality of life and psychological outcomes over 12 months (http://tinyurl.com/o5tralq).

BMJ - Effectiveness of paramedic practitioners in attending 999 calls from elderly people in the community (http://tinyurl.com/opyog4w).

British Journal of Healthcare Management – avoidable acute hospital admissions in older people (http://tinyurl.com/k9zjl6h).

International Journal of integrated care – reducing hospital bed use by frail older people: results from a systematic review of the literature (http://tinyurl.com/nhdcgys).

Researchgate article – What the evidence shows about patient activation (http://tinyurl.com/q63eufg).

NHS outcomes framework – personalised care for long term conditions (http://tinyurl.com/nadg8kc).

Primary Care Foundation – urgent care in general practice (http://tinyurl.com/og9qv7t).

Alzheimers.org.uk factsheet: Changes in behaviour (http://tinyurl.com/nf9fbxl).

Gold Standards Framework in end of life care (http://tinyurl.com/qhvdbjp).

MPS – Dilemma: DNR orders (http://tinyurl.com/lk5tozp).

BGS Commissioning Guidance – high quality healthcare for older care home residents (http://tinyurl.com/njtwllt).

NHS England: Community Pharmacy – helping provide better quality and resilient urgent care (http://tinyurl.com/o4mpq5k).

RPS – Hospital referral to community pharmacy: an innovators' toolkit to support the NHS in England (http://tinyurl.com/leb5vws).

Urgent Repeat Medication Requests Guide for NHS 111 Services: how to refer directly to pharmacy and optimise use of GP out of hours services (see http://tinyurl.com/px7wps9).

HSCIC – summary care record rolled out to community pharmacists (http://tinyurl.com/pt9m75t).

NHS Interim Management and support – Primary Care in Emergency Departments: a guide to good practice (http://tinyurl.com/mbgauyk).

Primary Care and Emergency Departments – Report from the Primary Care Foundation March 2010 (http://tinyurl.com/lqcstpv).

Standards for children and young people in emergency care settings (http://tinyurl.com/kr4kmju).

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (http://tinyurl.com/pbea9ub).

London mental health crisis commissioning standards and recommendations (http://tinyurl.com/od97awv).

NHS Choices: a guide to mental health services in England (http://tinyurl.com/nl8e9g3).

Annual Public Health Report 2014: Mental health and wellbeing in Kingston (http://tinyurl.com/pke76ca).

Bradford District Care Trust: Our acute care services (http://tinyurl.com/pke76ca).

Oldham mental health phone triage/raid pilot project evaluation report (http://tinyurl.com/oc2qkkm).

Hertfordshire Partnership University NHS Foundation Trust: Easier access, better care – single point of access success (http://tinyurl.com/ocfq5ue).

Mental Health Network NHS Confederation: Briefing Issue 228 November 2011- The benefits of Liaison Psychiatry (http://tinyurl.com/q5uq2v6).

Mental Health Partnerships: Developing models for liaison psychiatry services - Guidance (http://tinyurl.com/nffha7).

NICE Self Harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care (http://tinyurl.com/pbpsbs6).

Facing the Future: Standards for acute paediatric services (http://tinyurl.com/o8nuj7f).

Safeguarding children and young people: roles and competencies for health care staff (http://tinyurl.com/kcorx6l).

Short Stay Paediatric Assessment Units: Advice for Commissioners and Providers – January 2009 (http://tinyurl.com/npfgte4).

RCP/RCN Ward rounds in medicine: principles for best practice (http://tinyurl.com/qcj4zhu).

Quality care for older people with urgent and emergency care needs (http://tinyurl.com/cebaqz3).

Toolkit for General Practice in supporting older people with frailty and achieving the requirements of the unplanned admissions enhanced service (http://tinyurl.com/msc9ctu).

Dalhousie University Clinical Frailty Scale (http://tinyurl.com/nkazj22).

Safer patient flow bundle (http://tinyurl.com/ngz67l3).

Quality and safety at the point of care: how long should a ward round take? (http://tinyurl.com/pgrtzbw).

Emergency Surgery – Standards for unscheduled surgical care: Guidance for providers, commissioners and service planners (http://tinyurl.com/qdsd5oh).

The Health Foundation Shine 2012 final report: improving outcomes from emergency laparotomy (http://tinyurl.com/oulb8bl).

Children's Surgical Forum – Standards for Children's Surgery (http://tinyurl.com/o3rsc4s).

Standards for non-specialist emergency surgical care of children (http://tinyurl.com/q3ksntt).

RCS England – Emergency General Surgery (http://tinyurl.com/qgndpsb).

Care and support statutory guidance: Annex G the process for managing transfers of care from hospital (http://tinyurl.com/qz7csc7).

National Informatics Board strategy**:** Using Data and Technology to Transform Outcomes for Patients and Citizens, A framework for Action (2014) (http://tinyurl.com/p2tetmd).

HSCIC – Clinical use of the summary care record (http://tinyurl.com/opatmmq).

HSCIC - Summary Care Records (http://tinyurl.com/khg3868).

Alzheimers.org.uk factsheet: This is me (http://tinyurl.com/p9wf5vp).

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Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 21 December 2015

Subject: West Yorkshire Association of Acute Trusts

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report introduces information associated with the West Yorkshire Association of Acute Trusts (WYAAT), including its aims, objectives and details of its projects.

Recommendation

2. Members are requested to consider the information presented and determine any further joint scrutiny actions.

1.0 Purpose

1.1 This report introduces information associated with the West Yorkshire Association of Acute Trusts (WYAAT), including its aims, objectives and details of its projects.

2.0 Background information

2.1 For the past 18 month, the Health Scrutiny Chairs of the five West Yorkshire Authorities have periodically met on an informal basis focusing on the establishment and progress of the Health Futures Programme. Urgent and Emergency Care is one of the priority areas of work identified within the Health Futures Programme.

2.2 A West Yorkshire Joint Health Overview and Scrutiny Committee has now been established and draws its membership from the five constituent West Yorkshire local authorities.

2.3 The Joint Committee has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.

- To meet regularly with NHS England to:

  - Receive updates on national developments and other matters from NHS England
  - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.

- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)

- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.

- To undertake shared development activities from time to time.

2.4 The West Yorkshire Urgent and Emergency Care Vanguard and associated programmes of work are being taken forward by the West Yorkshire Commissioning Collaborative.

3.0 Main issues

3.1 The West Yorkshire Association of Acute Trusts is a collaboration between Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and Mid Yorkshire Hospitals NHS Trust.

3.2 A summary of the association and its aims and objectives, alongside details of its projects, is appended to this report.

3.3 The work of WYAAT is likely to have implications across West Yorkshire and is therefore presented to the Joint Committee for consideration.

3.4 A representative of WYAAT has been invited to attend the meeting to outline the work of the association in more detail and address any questions/ queries from the Joint Committee.

4.0 Recommendations

4.1 Members are requested to consider the information presented and determine any further joint scrutiny actions or activity.

5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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West Yorkshire Association of Acute Trusts

A collaboration between Airedale NHS Foundation Trust,
Bradford Teaching Hospitals NHS Foundation Trust,
Calderdale and Huddersfield NHS Foundation Trust,
Harrogate and District NHS Foundation Trust,
Leeds Teaching Hospitals NHS Trust and
Mid Yorkshire Hospitals NHS Trust.

West Yorkshire Association of Acute Trusts

About us

The West Yorkshire Association of Acute Trusts (WYAAT) is an innovative collaborative which brings together NHS trusts delivering acute hospital services from across West Yorkshire and Harrogate to drive forward the best possible care for our patients.

Our vision is to create a region-wide efficient and sustainable healthcare system that embraces the latest thinking and best practice so we can consistently deliver the highest quality of care and outcomes for our patients.

By bringing together the wide range of skills and expertise across West Yorkshire and Harrogate we have an immense opportunity to work differently, be innovative and drive forward change to support patients. By thinking and working as a system, we can reduce duplication and work more efficiently to deliver the highest quality care for the people of West Yorkshire and Harrogate.

Our members

Our core membership includes the Chief Executives of the following acute hospital trusts:

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Yorkshire Hospitals NHS Trust.

Our aims

The Association is already well established and starting to have an impact in our region. Our members are actively engaged in a range of work across the health and social care community, bringing the acute hospital perspective and expertise to the forefront. As part of the Association's work we will:

- work with local and regional commissioners to inform and shape plans for hospital services and new models of care
- be a strong voice contributing to the development of national policy around acute care
- share and spread best practice across the collaborative to benefit patients
- collaborate on key deliverables that are best achieved through joint working and provide healthy challenge for colleagues where appropriate
- explore and develop new business models that enable the acute hospitals to become more efficient and get best value for money
- improve our systems and processes to support safe high quality, efficient care.

Improving services for local people

Patients are the central focus of all of our work and through the Association we will bring about improvements in health outcomes and patient experience for a population of over 2.3 million.

Through the work of the Association and its members, patients across the West Yorkshire and Harrogate area will benefit from:

- the highest quality of services and care
- improved access to services
- improved and more co-ordinated care pathways
- access to a wider range of clinical specialists
- assurance that the NHS is working as efficiently as possible and getting best value for money.

West Yorkshire Association of Acute Trusts

Our projects: Building a Model Clinical Network

West Yorkshire has a strong track record in technological innovation and embracing it fully to deliver radical change in the way we provide services.

A key focus of our work is to drive forward a 'model clinical network' that will deliver improved and consistent outcomes for our patients by using the latest technology. By doing this work as part of the Association, we will improve clinical productivity and workflows and enable the delivery of seven day working whilst driving up quality and improving the experience for our patients and their families.

Our model clinical network is focusing on three key areas.

- Establishing Horizontal Clinical Networks. Focusing initially on diagnostics this work will lead to the development of a radiology network of expertise across the West Yorkshire and Harrogate areas. Clinicians will maximise the use of the latest technology to support closer working and bring greater capacity to support 24/7 working, ultimately improving access to specialist radiology services for local people.
- Innovative workforce models. Our vision over time is for clinicians to share their specialist expertise across networks of care rather than individual hospitals ensuring patients can receive care as close to home as possible. Creative solutions to workforce planning, recruitment and role development are being explored to support this more agile and efficient way of working.
- Integrated information systems. By bringing together patient information systems and clinical and social care systems we will be able to provide clinicians and others supporting our patients with a full picture of their care pathway. Driving this model forward across the Association's geographical footprint will enable the spread and benefit to be fully realised.

For more information on our work please contact the Chief Executive's Office on 0113 206 5341.

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 21 December 2015

Subject: Cancer Wait Times

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report introduces information around Cancer Waiting Times and associated performance across Leeds' Clinical Commissioning Groups and Leeds Teaching Hospitals NHS Trust. It includes information associated with the timely referral of patients from outside Leeds, including West Yorkshire.

2. In line with the terms of reference for the Joint Committee, these details are being shared as they may have an impact on the other local authority areas within West Yorkshire.

Recommendation

3. Members are requested to consider the information presented and determine any further joint scrutiny actions or activity.

1.0 Purpose

1.1 This report introduces information around Cancer Waiting Times and associated performance across Leeds' Clinical Commissioning Groups and Leeds Teaching Hospitals NHS Trust. It includes information associated with the timely referral of patients from outside Leeds, including West Yorkshire.

2.0 Background information

2.1 For the past 18 month, the Health Scrutiny Chairs of the five West Yorkshire Authorities have periodically met on an informal basis focusing on the establishment and progress of the Health Futures Programme. Urgent and Emergency Care is one of the priority areas of work identified within the Health Futures Programme.

2.2 A West Yorkshire Joint Health Overview and Scrutiny Committee has now been established and draws its membership from the five constituent West Yorkshire local authorities.

2.3 The Joint Committee has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.

- To meet regularly with NHS England to:

  - Receive updates on national developments and other matters from NHS England
  - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.

- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)

- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.

- To undertake shared development activities from time to time.

2.4 Details attached to this report were previously presented to a meeting of Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS). In line with the terms of reference for the Joint Committee, these details are being shared as they may have an impact on the other local authority areas within West Yorkshire.

3.0 Main issues

3.1 In June 2015, Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) identified Cancer Waiting Times as a specific area for inquiry during 2015/16.

3.2 Attached is a joint report from Leeds' Clinical Commissioning Groups and Leeds Teaching Hospitals NHS Trust around Cancer Waiting Times and associated levels of performance against national targets. This report was presented to Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) at its meeting on 24 November 2015.

3.3 Key areas of discussion from that meeting were:

- Raising awareness and developing patient understanding of symptoms.
- Challenges associated with the 2 week wait from GP referral and the 62-day treatment target – particularly in relation to referrals from outside the Leeds area.
- The importance to consider and track outcomes alongside timed targets.
- Confirmation that a review of outcomes was reported by Cancer Strategy Board.
- Acknowledgement that UK outcomes were currently below a number of other European countries.

3.4 The following resolutions were made at the meeting:

(a) That the Board notes the current situation regarding cancer performance and monitoring and the progress made to deliver better outcomes and shorter wait times for both Leeds patients and other patients treated at Leeds Teaching Hospitals NHS Trust.
(b) That a further report on cancer outcomes be presented to a future meeting.
(c) That the report presented be submitted to the West Yorkshire Joint Health Overview and Scrutiny Committee for further consideration.

3.5 In line with the above resolutions and the terms of reference for the Joint Committee, the attached details are being shared as they may have an impact on the other local authority areas within West Yorkshire.

3.6 Appropriate representatives have been invited to attend the meeting to present the attached information, address any questions from the Board and generally contribute to the discussion.

4.0 Recommendations

4.1 Members are requested to consider the information presented and determine any further joint scrutiny actions or activity.

5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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NHS Leeds West Clinical Commissioning Group
NHS Leeds South and East Clinical Commissioning Group
NHS Leeds North Clinical Commissioning Group
The Leeds Teaching Hospitals NHS Trust

REPORT TO SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS) **24 November 2015**

Report prepared by: Helen Lewis, Head of Acute Provider Commissioning, Leeds Clinical Commissioning Groups, and Catherine Foster, Head of Cancer Commissioning, Leeds Clinical Commissioning Groups, with input from Angie Craig, Head of Performance, Leeds Teaching Hospitals NHS Trust

EXECUTIVE SUMMARY

This paper outlines the current performance at Leeds Teaching Hospitals (LTHT) and for the local Leeds population against the 62 day GP referral to treatment time for suspected cancer; the approach being taken to improve cancer outcomes for local people; and the way in which the national Cancer Strategy will be delivered in Leeds.

1.0 Background

Cancer performance at LTHT is closely monitored as one of the key national waiting time standards within the NHS Constitution. There is a monthly subgroup of the LTHT Contract Management Board where cancer performance is discussed in detail. LTHT also has an internal cancer board which reports to the Trust Board and there is a system wide network of meetings including a group working on the Leeds Integrated Cancer Services model.

In addition to a focus on performance, the health economy has recognised the need for a forum that takes a system wide and population overview, looking at impact and outcomes for the patients of Leeds. This new cancer strategy group has been established to steer the implementation of the new Cancer National Strategy locally. We wish to ensure that we maintain a strategic overview of service delivery, early diagnosis, patient experience and outcomes as well as on the nationally reported waiting time standards.

This paper is intended to provide the assurance that all possible actions are underway to deliver national cancer performance for the Leeds CCGs' patients and at LTHT where NHS Leeds West CCG is the lead commissioner. It also highlights the difference between the LTHT Trust total performance and that for individual CCG patients and the reasons for this.

2.0 Outcomes for cancer patients

A new cancer outcomes group has been recently established to look at cancer outcomes for the city, led by the Public Health Consultant lead for Cancer. It has been presented at the Health and Wellbeing Board Chair's weekly briefing and will

be brought to the Health and Wellbeing Board in January 2016 for wider discussion. There is a focus locally on improving breast, bowel and lung cancer outcomes and reducing health inequalities and this is the basis for the forward workplan.

Areas for improvement:

- To ensure annual review of population outcomes for cancer in Leeds including staging and routes to diagnosis
- Understand why Leeds mortality and survival is not improving as fast as the England and Yorkshire and Humber average and take appropriate action
- To develop and test patient relevant outcome measures
- Focus on reducing health inequalities across the system but especially NHS Leeds West CCG and NHS Leeds South and East CCG
- For each CCG to consider the need for local action as part of a citywide approach
- Ensure there is robust and sufficient system capacity to diagnose and treat new presentations of cancer in a timely manner including closer working between primary and secondary care, increasing open access diagnostics, and working with specialised services
- To agree strategic priorities for prevention and early diagnosis work in Leeds including:
    - Continue to maintain primary focus on breast, bowel and lung cancers early diagnosis
    - To work across the system to reduce health inequalities through awareness campaigns and commissioning the third sector
    - To understand and monitor routes to diagnosis and staging
    - Continued investment in smoking prevention and treatment, obesity reduction, and alcohol prevention and treatment
    - Promote bowel screening in vulnerable populations
    - Addressing BME specific cancers e.g. Black men and prostate cancer

3.0 Performance

There are a number of national waiting time standards for cancer. This paper outlines performance against the major standards; the 'two week wait' standards and the 62 day GP referral to treatment time standard.

3.1 2 Week Wait and 2 Week Wait breast symptoms performance and risks at Leeds Teaching Hospital Trust (LTHT)

Overall, LTHT delivered the 2 week wait GP referral to first seen standard by the end of quarter 2 (Sept 15) with 93.5% of patients being seen within 2 weeks of GP referral against the 93% standard. However, it under-achieved the two week wait standard for all patients with breast symptoms for quarter 2 (85.2% against the 93% standard). The difficulties in seeing all patients with breast symptoms within two weeks is due to very substantial growth in demand not yet sustainably matched with capacity, despite every effort from existing staff. Two new Advanced Nurse practitioners are now in post and being trained to provide a resilient service from February 2016. We are also working with the Trust on developing new models of care.

The total numbers of patients GPs referred to LTHT as suspected cancer has grown extremely rapidly over the past few years – up by over 60% since 2012/13. In 2013/14 there were 19,107 referrals, rising to 23,190 in 14/15 and we expect at least 26,160 by the end of 15/16.

So while the overall 93% standard is not always met each month, the total number of patients being seen within 2 weeks continues to increase monthly.

The national drive to increase the numbers of patients referred on all pathways to improve outcomes presents an on-going risk to meeting waiting time targets, given the lag times required to increase capacity for some services. Those pathways involving endoscopy are particularly at risk given national recruitment issues in these services, and there are also pressures in radiology services. All partners are working jointly to model demand for 2016/17 as well as possible, but workforce remains a local as well as a national risk. The national cancer strategy is now looking towards a target of 4 weeks from referral to diagnosis which will have an impact on pathways and future performance reporting.

3.2 62 day urgent GP/GDP Referral to Treatment Time Target

LTHT have not achieved the overall national standard for 62 day urgent GP/GDP referral to treatment for some months. The most recent performance for Quarter 2 2015/16 is 81.3% compared to national performance of 81.9% and the required standard of 85%. However, LTHT treated 87.5% of those patients referred to Leeds originally or referred to the Trust by day 38 of their pathway within 62 days of their original referrals. The discrepancy between these two figures relates to the experience of patients referred from other hospitals into Leeds as a tertiary centre. The national performance data requires LTHT to report a 'half breach' for patients who originate in another centre but are treated beyond 62 days in Leeds, even if the patient was not seen in the Leeds team until after day 62.

LTHT has worked hard to tackle internal performance constraints, including some staffing and capacity shortages in gynaecology, urology and lung and has created additional theatre capacity for these specialties. Particular improvements have been made in delivering capacity for robotic prostatectomies and capacity and demand for this service is now back in balance. Improvements have also been made in the lung surgery service. Work is on-going to increase the speed of turn round for diagnostic tests and results to help improve earlier decision making.

The key issue constraint for delivering the 85% target for the Trust as a whole remains late referrals from the District General Hospitals where around 50% of patients are transferred to LTHT after day 38 of a 62 day pathway. Actions are in place to review joint breaches with referring Trusts. There are some encouraging signs that the patients referred in October are being referred earlier which are helping to contribute to improved performance.
The national cancer team are now reviewing the ways in breaches of the target for patients treated across two or more hospitals are reported. Modelling demonstrates that LTHT would achieve the target if there was a different way of allocating responsibility for patients transferred late to the tertiary centre who can then not be

treated in target. Medical Directors to Medical Director letters have been refreshed as have letters to lead cancer managers and LTHT's Chair, has written to Chairs of other providers. The NHS Leeds West CCG Chief Executive has also written to all of local CCGs' Chief Executives to remind them of their role in ensuring their local hospital refers patients prior to day 38.

The attached Appendix 1 performance data demonstrates the difference between the performance for Leeds CCGs at all providers, compared to the performance for LTHT in total. The difference between the two figures demonstrates the impact on the LTHT total position of late referrals and breach sharing for patients originating at other providers.

4. Meeting structures for cancer strategy

An established network of cancer meetings is in place with appropriate governance. Leeds has now established an overarching Cancer Strategy Group, in addition to the operational meetings, to take the overview across the city on cancer delivery and impact on population outcomes. This has representation from all statutory partners and key voluntary organisations. This will ensure we have an integrated approach to delivery of improvements for patients, from public awareness and early diagnosis through to aftercare and 'living with cancer'

5. Current commissioning actions

a) Arrangements are now in place for the System Resilience Group (SRG) to take the overview for cancer. Core work will still be undertaken by the acute care commissioning team and reports passed to SRG as required. A dashboard for SRG is in development.

b) Trust and system wide response to *Improving and sustaining cancer performance* – Monitor/TDA tripartite letters 14 July 2015 and 4 August, LTHT were required to submit a plan addressing the eight key priorities noted in the letter by end of August, most of which are already being covered. LTHT confirmed they have reviewed all pathways and will publish them on Leeds Health Pathways. All the NICE guidance for 2 week wait referrals has been updated, and each referral form is being reviewed.

c) Leeds has been successful with a bid for national Accelerated Coordinated and Evaluated 2 (ACE 2) funding. The ACE bid will focus primarily on the scoping and set up of a 'Straight to Test pathway for patients with unexplained weight loss.' The funding for the pilot is not confirmed yet.

d) The CCGs continue to work with the regional 10CC Cancer group and ensure that our Leeds views are fed into the regional work programme. We are also working closely with NHS England specialised commissioners as cancer commissioning is a shared responsibility for most pathways

e) The CCGs have agreed to fund two clinical sessions to support a half time LTHT lead cancer clinical post that will work across LTHT and primary care to ensure integration of approaches for the whole population.

NEXT STEPS

The NHS Leeds West CCG acute commissioning team continues to closely monitor the overall LTHT cancer performance and that achieved for local patients and those referred by day 38, and to retain an overview of the performance for Leeds patients at all providers. The LTHT Cancer Board has a continued work programme to further improve the timeliness of diagnosis and treatment and develop follow up protocols. Joint work is ongoing to encourage patients to seek early advice on symptoms, to encourage appropriate early referral and improve patient experience and outcomes at all stages of a cancer pathway. .

RECOMMENDATION:

The Scrutiny Board (Adult Social Services, Public Health, NHS) is asked to note

(a) **Note** the current situation with regard to cancer performance and monitoring and the progress being made to deliver better outcomes and shorter wait times for both Leeds patients and other patients treated at LTHT.

Appendix:

1. *Cancer performance data* : Performance data for each of the Leeds CCGs against the National Waiting Times Standards, across all providers, and LTHT's performance across all commissioners

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Appendix 1

Cancer Waiting Times Performance Report

National Standards

Leeds West CCG (All Providers)

	Target	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	2014-15 Q1 + Q2 + Q3 + Q4	2015-16 Apr'15	May'15	Jun'15	Q1	Jul'15	Aug'15	Current month Seen within target	Current month Referrals	Current month Breaches	Aug'15
2 week GP referral to 1st outpatient (suspected cancer)	93.0%	94.3%	93.8%	96.0%	96.8%	96.6%	96.5%	93.2%	97.9%	93.7%	94.9%	94.8%	90.2%	93.5%	92.6%	92.0%	94.7%	91.4%	903	988	85	
2 week GP referral to 1st outpatient (breast symptoms)	93.0%	92.9%	91.9%	93.7%	96.9%	97.9%	96.1%	97.3%	95.3%	96.2%	96.2%	92.6%	88.4%	89.9%	95.1%	91.9%	91.7%	73.3%	126	172	46	
31 day diagnosis to treatment for all cancers	96.0%	97.7%	97.9%	97.4%	99.2%	99.1%	98.6%	90.5%	96.9%	97.9%	95.5%	97.3%	97.2%	97.5%	98.6%	97.9%	99.3%	99.1%	114	115	1	
31 day second or subsequent treatment- surgery	94.0%	94.6%	96.4%	92.5%	86.2%	96.4%	93.9%	84.4%	96.7%	100.0%	97.3%	96.5%	96.3%	100.0%	95.5%	97.1%	93.9%	100.0%	29	29	0	
31 day second or subsequent treatment- drug	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	72	72	0	
31 day second or subsequent treatment- radiotherapy	94.0%	97.8%	98.5%	98.3%	100.0%	100.0%	99.4%	100.0%	100.0%	98.0%	99.3%	99.3%	98.1%	100.0%	100.0%	99.3%	100.0%	100.0%	28	28	0	
62 days urgent GP referral to treatment of all cancers	85.0%	79.3%	84.2%	80.0%	78.2%	89.1%	82.9%	78.8%	73.9%	86.2%	80.1%	83.8%	91.1%	76.9%	84.9%	84.2%	84.4%	90.6%	58	64	6	
62 day referral to treatment from consultant screening	90.0%	100.0%	97.2%	100.0%	100.0%	92.9%	97.3%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	90.0%	100.0%	96.2%	75.0%	100.0%	1	1	0	
62 day referral to treatment consultant upgrade	85.0%	100.0%	86.7%	40.0%	100.0%	60.0%	58.3%	40.0%	66.7%	85.7%	66.7%	76.4%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	5	6	1	

Leeds North CCG (All Providers)

	Target	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	2014-15 Q1 + Q2 + Q3 + Q4	2015-16 Apr'15	May'15	Jun'15	Q1	Jul'15	Aug'15	Current month Seen within target	Current month Referrals	Current month Breaches	Aug'15
2 week GP referral to 1st outpatient (suspected cancer)	**93.0%**	95.3%	95.9%	96.2%	96.2%	95.6%	96.1%	95.7%	95.1%	93.9%	94.8%	95.3%	90.4%	94.1%	93.2%	92.5%	94.7%	94.5%	497	526	29	
2 week GP referral to 1st outpatient (breast symptoms)	**93.0%**	94.1%	95.6%	96.9%	98.8%	97.3%	97.7%	96.4%	92.5%	96.5%	95.3%	94.1%	94.2%	91.1%	98.9%	95.4%	93.9%	83.0%	73	88	15	
31 day diagnosis to treatment for all cancers	**96.0%**	95.8%	96.4%	100.0%	97.8%	98.4%	99.1%	98.9%	97.1%	98.5%	98.3%	98.2%	98.9%	98.7%	96.9%	98.2%	98.0%	100.0%	70	70	0	
31 day second or subsequent treatment- surgery	**94.0%**	92.3%	95.3%	100.0%	92.3%	100.0%	100.0%	94.7%	75.0%	100.0%	92.2%	95.9%	90.9%	89.5%	100.0%	95.2%	100.0%	95.0%	19	20	1	
31 day second or subsequent treatment- drug	**98.0%**	97.4%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	39	39	0	
31 day second or subsequent treatment- radiotherapy	**94.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	98.8%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	21	21	0	
62 days urgent GP referral to treatment of all cancers	**85.0%**	80.0%	77.2%	80.0%	84.8%	75.0%	80.4%	87.5%	79.3%	75.9%	81.9%	81.7%	85.7%	80.5%	75.7%	80.8%	88.9%	80.0%	24	30	6	
62 day referral to treatment from consultant screening	**90.0%**	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	94.4%	93.8%	15	16	1	
62 day referral to treatment consultant upgrade	**85.0%**	100.0%	90.9%	66.7%	100.0%	100.0%	80.0%	100.0%	-	100.0%	100.0%	91.7%	100.0%	50.0%	100.0%	83.3%	100.0%	50.0%	1	2	1	

Leeds S&E CCG (All Providers)

	Target	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	2014-15 Q1 + Q2 + Q3 + Q4	2015-16 Apr'15	May'15	Jun'15	Q1	Jul'15	Aug'15	Current month Seen within target	Current month Referrals	Current month Breaches	Aug'15
2 week GP referral to 1st outpatient (suspected cancer)	**93.0%**	94.9%	93.4%	95.8%	94.4%	95.3%	95.2%	95.0%	96.3%	94.3%	95.2%	94.4%	90.5%	94.9%	92.9%	92.7%	93.8%	92.9%	624	672	48	
2 week GP referral to 1st outpatient (breast symptoms)	**93.0%**	96.1%	94.6%	98.1%	97.3%	98.9%	98.1%	94.2%	97.2%	97.4%	96.3%	93.7%	92.5%	91.3%	97.9%	94.3%	93.2%	79.2%	114	144	30	
31 day diagnosis to treatment for all cancers	**96.0%**	97.8%	97.3%	93.8%	97.8%	95.1%	95.7%	97.6%	95.2%	96.1%	96.7%	96.8%	97.9%	98.6%	97.9%	97.8%	99.2%	98.9%	93	94	1	
31 day second or subsequent treatment- surgery	**94.0%**	86.7%	92.2%	100.0%	94.1%	93.9%	95.3%	90.0%	95.5%	94.1%	93.2%	94.3%	100.0%	100.0%	100.0%	100.0%	92.9%	95.5%	21	22	1	
31 day second or subsequent treatment- drug	**98.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	99.4%	100.0%	100.0%	55	55	0	
31 day second or subsequent treatment- radiotherapy	**94.0%**	100.0%	100.0%	95.3%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	35	35	0	
62 days urgent GP referral to treatment of all cancers	**85.0%**	63.9%	77.8%	84.0%	84.6%	76.2%	82.1%	72.7%	78.9%	83.9%	79.1%	80.0%	91.7%	93.1%	87.2%	89.7%	87.0%	91.3%	42	46	4	
62 day referral to treatment from consultant screening	**90.0%**	75.0%	88.9%	100.0%	60.0%	100.0%	77.8%	100.0%	60.0%	100.0%	100.0%	93.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	4	4	0	
62 day referral to treatment consultant upgrade	**85.0%**	100.0%	87.5%	66.7%	50.0%	100.0%	71.4%	100.0%	100.0%	100.0%	100.0%	86.0%	100.0%	66.7%	50.0%	70.0%	85.7%	100.0%	10	10	0	

Cancer Waiting Times performance

LTHT Trust Total

	Target	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	2014-15 Q1 + Q2 + Q3 + Q4	2015-16 Apr'15	May'15	Jun'15	Q1	Jul'15	Aug'15	Current month Seen within target	Current month Referrals	Current month Breaches	Aug'15
2 week GP referral to 1st outpatient (suspected cancer)	**93.0%**	94.5%	94.3%	95.7%	95.4%	96.0%	95.7%	93.9%	96.4%	93.6%	94.6%	94.6%	90.6%	93.6%	92.5%	92.2%	94.3%	91.8%	1819	1982	163	
2 week GP referral to 1st outpatient (breast symptoms)	**93.0%**	93.6%	93.4%	94.5%	97.4%	98.3%	96.6%	96.0%	94.9%	96.0%	95.6%	92.7%	90.8%	91.3%	96.8%	93.5%	91.9%	73.7%	269	365	96	
31 day diagnosis to treatment for all cancers	**96.0%**	95.7%	96.2%	95.6%	96.4%	97.0%	96.5%	94.0%	94.8%	**97.5%**	**96.0%**	**96.5%**	**96.6%**	97.1%	97.4%	97.0%	97.7%	99.3%	428	431	3	
31 day second or subsequent treatment- surgery	**94.0%**	92.1%	94.4%	94.9%	89.4%	94.5%	94.3%	89.0%	93.5%	98.4%	95.7%	94.8%	95.4%	98.6%	98.3%	97.6%	95.8%	97.0%	160	165	5	
31 day second or subsequent treatment- drug	**98.0%**	99.6%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	99.9%	100.0%	100.0%	221	221	0	
31 day second or subsequent treatment- radiotherapy	**94.0%**	99.3%	99.4%	98.4%	100.0%	99.3%	99.3%	100.0%	99.1%	99.7%	99.9%	99.5%	98.9%	98.9%	99.8%	99.2%	100.0%	99.1%	347	350	3	
62 days urgent GP referral to treatment of all cancers	**85.0%**	71.5%	76.2%	72.1%	77.1%	74.1%	74.8%	74.4%	67.2%	78.9%	73.9%	76.0%	83.2%	74.2%	79.4%	79.0%	81.3%	82.5%	130	158	28	
62 day referral to treatment from consultant screening	**90.0%**	91.4%	92.1%	93.9%	92.9%	94.7%	93.9%	97.3%	94.3%	100.0%	97.5%	94.8%	100.0%	94.9%	97.8%	97.7%	91.7%	96.6%	28	29	1	
62 day referral to treatment consultant upgrade	**85.0%**	93.3%	83.2%	57.6%	63.6%	69.6%	63.6%	75.0%	59.1%	82.9%	74.7%	77.2%	89.7%	59.4%	75.0%	75.2%	91.2%	90.2%	19	21	2	

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Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 21 December 2015

Subject: Tobacco Investments

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report introduces information relating to a request for scrutiny received by Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) and considered at its meeting on 20 October 2015.

2. In line with the terms of reference for the Joint Committee, these details are being shared as they may have an impact on the other local authority areas within West Yorkshire.

Recommendation

3. Members are requested to consider the information presented and determine any further joint scrutiny actions or activity.

1.0 Purpose

1.1 This report introduces information relating to a request for scrutiny received by Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) and considered at its meeting on 20 October 2015.

2.0 Background information

2.1 For the past 18 month, the Health Scrutiny Chairs of the five West Yorkshire Authorities have periodically met on an informal basis focusing on the establishment and progress of the Health Futures Programme. Urgent and Emergency Care is one of the priority areas of work identified within the Health Futures Programme.

2.2 A West Yorkshire Joint Health Overview and Scrutiny Committee has now been established and draws its membership from the five constituent West Yorkshire local authorities.

2.3 The Joint Committee has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.

- To meet regularly with NHS England to:

  - Receive updates on national developments and other matters from NHS England
  - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.

- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)

- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.

- To undertake shared development activities from time to time.

2.4 The request for scrutiny attached to this report were previously presented to a meeting of Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) at its meeting on 20 October 2015. In line with the terms of reference for the Joint Committee, these details are being shared as they may have an impact on the other local authority areas within West Yorkshire.

3.0 Main issues

3.1 In October 2015, Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) received a request for scrutiny relating to tobacco investments. The request is attached at Appendix 1.

3.2 This request for scrutiny was considered by Leeds City Council's Scrutiny Board (Adult Social Services, Public Health, NHS) at its meeting on 20 October 2015.

3.3 Key areas of discussion from that meeting included:

- The investment decision-making processes for the West Yorkshire Pension Authority and the Council's role in such processes.
- The wider issues associated with ethical/ moral investments.
- The potential role of the West Yorkshire Joint Health Overview and Scrutiny Committee currently being established.
- The role/ involvement of other Council Scrutiny Boards, in particular Scrutiny Board (Strategy and Resources) in examining wider issues around pension fund investments.

3.4 In summarising the discussion, the Chair outlined that the Scrutiny Board was in favour of taking some action that was likely to involve the West Yorkshire Joint Health Overview and Scrutiny Committee and Leeds City Council's Scrutiny Board (Strategy and Resources). It was further outlined that this would necessarily include some further discussions and advice on the most appropriate way forward.

3.5 The Scrutiny Board agreed that the Chair should take the matter forward as outlined and provide an update to the Scrutiny Board at a future meeting.

3.6 In line with the above resolutions and the terms of reference for the Joint Committee, the attached details are being shared as they may have an impact on the other local authority areas within West Yorkshire.

3.7 No other representatives have been invited to attend the meeting for this item.

4.0 Recommendations

4.1 Members are requested to consider the information presented and determine any further joint scrutiny actions or activity.

5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Councillor Matthew Robinson
Conservative Group Office
2nd Floor East
Civic Hall
Leeds LS1 1UR

Tel: 0113 395 1460
matthew.robinson@leeds.gov.uk
Our ref: MR/KM
Date: 1st October 2015

Cllr P Gruen

Sent Via Email

Dear Cllr Gruen,

As you may be aware during the last Council meeting a white paper on healthcare was discussed and I raised the issue, along with my question to Council which is due a written response, on the City Council's investment through the West Yorkshire Pension Fund in tobacco companies.

The Council currently has approximately £180m invested in tobacco companies in the West Yorkshire Pension Fund (WYPF) and yet also spend Council taxpayers money on smoking prevention and stop smoking campaigns.

As part of 'Stoptober', a period of when the NHS seeks to encourage people to give up smoking, I would like to request that your Scrutiny Committee looks into the current approach to smoking by Leeds City Council, how much is currently spent on this, and if the Council will consider action and lobbying other authorities in the WYPF to assist in withdrawing out investment in tobacco firms to send a big and clear message on our commitment to smoking prevention.

Yours sincerely

Councillor Matthew Robinson
Harewood Ward

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Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 21 December 2015

Subject: Sources of Work

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report introduces further information that may inform the future work of the West Yorkshire Joint Health Overview and Scrutiny Committee.

Recommendation

2. Members are requested to consider the information presented and determine any further joint scrutiny actions or activity.

1.0 Purpose

1.1 This report introduces further information that may inform the future work of the West Yorkshire Joint Health Overview and Scrutiny Committee.

2.0 Background information

2.1 For the past 18 month, the Health Scrutiny Chairs of the five West Yorkshire Authorities have periodically met on an informal basis focusing on the establishment and progress of the Health Futures Programme. Urgent and Emergency Care is one of the priority areas of work identified within the Health Futures Programme.

2.2 A West Yorkshire Joint Health Overview and Scrutiny Committee has now been established and draws its membership from the five constituent West Yorkshire local authorities.

2.3 The Joint Committee has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.

- To meet regularly with NHS England to:

  - Receive updates on national developments and other matters from NHS England
  - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.

- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)

- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.

- To undertake shared development activities from time to time.

2.4 In line with the terms of reference for the Joint Committee, details in this report are being shared as they may have an impact across other local authority areas within West Yorkshire.

3.0 Main issues

<u>Yorkshire Ambulance Service NHS Trust</u>

3.1 Yorkshire Ambulance Service (YAS) provides an accident and emergency service to respond to 99 calls, patient transport services and an emergency operations centre (call handling service). The Trust also provides a Resilience and Hazardous Area Response Team (HART) and an NHS 111 core service.

3.2 The Trust provides services across thirteen local authority areas within Yorkshire and the Humber and services are commissioned by Clinical Commissioning Groups (CCGs), with Wakefield CCG acting as the lead commissioner across the Yorkshire and Humber region.

3.3 The Trust was subject to an inspection from the Care Quality Commission (CQC) in January 2015, with the full report published in August 2015. A copy of the full inspection report is available on request or can be accessed via the CQC website at: http://www.cqc.org.uk/sites/default/files/new_reports/AAAD4912.pdf

3.4 Prior to publication of the report, the CQC convened a quality summit with key stakeholders to discuss its findings from the inspection and to allow the Trust to outline its initial response. Local authority overview and scrutiny committees are included as a key stakeholder in this process. However, given the geographical area covered by the Trust, it was agreed that Wakefield Council would lead from a scrutiny perspective. A note from the quality summit is appended to this report.

3.5 At the time the CQC inspection report was published, it was planned that Wakefield Council would receive and monitor the Trusts action plan, with the input from the Chairs' of other local authority overview and scrutiny committees. It is understood that some local authorities across Yorkshire and the Humber have considered the provision and delivery of ambulance services individually. In addition, arrangements are currently in place for Yorkshire Ambulance Service NHS Trust to attend a Scrutiny meeting in Wakefield on 14 January 2016.

3.6 However, given the formal establishment of the West Yorkshire Joint Health Overview and Scrutiny Committee, members are asked to consider the associated priority and merits of reviewing the provision and delivery of ambulance services across West Yorkshire.

3.7 It should be noted that no representatives from YAS will be in attendance for this initial discussion.

Specialised Services

3.8 Attached to this report is a NHS England North Specialised Commissioning for Stakeholder Bulletin, published in November 2015.

3.9 The bulletin sets out a brief summary of Specialised Commissioning alongside the commissioning intentions for 2016/17.

3.10 It should be noted that there were no representatives from the Specialised Commissioning Team available to be in attendance for this initial discussion.

4.0 Recommendations

4.1 Members are requested to consider the information presented and determine any further joint scrutiny actions or activity.

5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Regional Specialised Team (North)

NHS England North Specialised Commissioning Bulletin for Stakeholders

In this first Issue:

Autumn/Winter 2015

Welcome - to the first edition of the North Specialised Commissioning bulletin for stakeholders

This bulletin is designed to update you on a regular basis on issues relating to specialised commissioning in the North of England. The bulletin will be produced twice a year, providing information for stakeholders, but if there is anything urgent in between we will let you know promptly.

In this edition we give a brief overview of Specialised Commissioning and the specialised commissioning team in the North. In addition this bulletin focuses on two of our main priorities; the Commissioning Intentions which is a blueprint for transforming specialised commissioning during 2016/2017 and the direction of travel for collaborative commissioning with CCGs.

Specialised Commissioning in brief

NHS England directly commissions specialised services with a value of approximately £14bn. Ministers are responsible for deciding which specialised services should be commissioned directly by NHS England rather than by CCGs, based on advice from the Prescribed Specialised Services Advisory Group (PSSAG), a multi-disciplinary Department of Health Committee.

There are over 145 services that are commissioned by 10 specialised commissioning teams that are part of NHS England. Around 60 of these are highly specialised (including services for people with very rare diseases). The specialised commissioning teams are grouped by the NHS England regions – North, Midlands and East, London and South.

NHS England specialised commissioning teams directly commission services from trusts and other providers including the independent sector and hold and manage the contracts with these providers

The list of specialised services is under constant review. Each services comes under one of six 'Programmes of Care' (POC):

- Internal medicine – digestion, renal, hepatobiliary and circulatory system
- Cancer
- Mental health
- Trauma – traumatic injury, orthopaedics, head and neck and rehabilitation
- Women and children – women and children, congenital and inherited diseases
- Blood and infection – infection, immunity and haematology

To find out more visit: https://www.england.nhs.uk/commissioning/spec-services/npc-crg/

Specialised Commissioning Team (North)

The NHS England Specialised Commissioning North senior team includes:

Robert Cornall, Acting Regional Director of Specialised Commissioning
Dr Alison Rylands, Clinical Director
Lesley Patel, Director of Nursing
Frances Carey, Acting Director of Finance
Liz Rogerson, Assistant Director of Specialised Commissioning for the North East
Andrew Bibby, Assistant Director of Specialised Commissioning for the North West
Matthew Groom, Assistant Director of Specialised Commissioning for Yorkshire and the Humber
Mary Hardie, Head of Communications and Engagement

Commissioning Intentions for Specialised Services for 2016/17

NHS England's commissioning intentions for Specialised Services for 2016/17 has now been published. The document outlines the strategic interventions we are planning to radically improve the way we commission, review and transform specialised services. The scope of services in 2016/17 will reflect changes agreed by Ministers, and the new mandatory Information Rules tool will provide a consistent base for all contracts with providers of specialised services.

The Commissioning Intentions describe how we intend to strengthen collaborative commissioning, tier specialised services around key geographies and place-based planning whilst ensuring consistent national standards and apply a collaborative process for resolving significant local specialised services issues. It details how we will clinically drive the necessary changes to improve quality alongside continued improvements to transparent, consistent contracting for excluded drugs and devices and collaboration to improve the value for patients in the supply chain.

Changes to the Scope of Specialised Services

Specialist Wheelchairs and Outpatient Neurology services are two services that will no longer be commissioned by NHS England and the budgets and responsibility for their commissioning will be with CCGs in 2015/16

Ministers have also agreed that adult specialised severe and complex obesity services should be devolved to CCG contracts from April 2016.

Other changes that have been agreed by ministers are to transfer the commissioning of the services below to NHS England Specialised Commissioning rather than being commissioned by CCGs; these services will be reflected in NHS England contracts from April 2015:

- some highly specialised adult male urological procedures
- some adult oesophageal procedures
- services for patients with homozygous familial hypercholesterolaemia
- some adult specialist haematology services.

Work programmes by National Programmes of Care for 2016/17

NHS England undertakes service reviews using a structured programme methodology with provider selection carried out in an open and transparent way. Whenever we review a service we seek to ensure public, patient and carer voices are at the centre of our healthcare services, from planning to delivery and we would greatly appreciate the support of our stakeholders including Health and Wellbeing Boards, Oversight and Scrutiny Committees and local Healthwatch organisations to do this.

The services that are being reviewed across the country now and into 2016/17 (listed by PoC) include:

- Mental Health PoC - CAMHS, learning disability transformation, mental health low and medium secure services
- Cancer PoC - stereotactic radiosurgery/radiotherapy (SRS/T), PET CT, proton beam therapy,
- Trauma PoC – hyperbaric oxygen treatment, paediatric burns, spinal cord injury
- Women and Children PoC - genomic laboratories, congenital heart disease, paediatric surgery and paediatric intensive care
- Internal Medicine PoC - intestinal failure
- Blood and Infection PoC - Hepatitis C networks, haemaglobinopathy, specialist infectious diseases

Drugs and devices review spans several PoCs.

Although these services are being reviewed across the whole of England there will be regional and local consultation where appropriate followed by implementation plans that may affect regional and/or local services.

Regional Service Programme for the North

As well as National Commissioning Intentions the document includes the Regional Service Programmes for England. The service programme for the North of England includes the following priorities:

Mental Health
The focus for 2016/17 will be the implementation of the on-going mental health high secure capacity plan and Child and Adolescent Mental Health inpatient (CAMHS Tier 4) mental health provision. Plans have been reviewed by specialised teams and are currently under review by local panels led by NHS England's Directors of Commissioning Operations.

Cancer
An extensive local area work plan has been developed including; radiotherapy in North Cumbria and in Yorkshire and Humber, chemotherapy care closer to home in South Tees, urological cancer services in Greater Manchester, pancreatic cancer services and sarcoma services in Yorkshire and the Humber, South Cheshire cancer pathways, and the Mersey upper gastrointestinal cancer consolidation programme.

Blood and Infection
Addressing service specification and governance issues with regards to HIV services will be a priority in 2016/17. Work will also be undertaken to harmonise contractual and pricing arrangements.

Internal Medicine
The configuration of respiratory services will be reviewed across the North Region. A number of local reviews are also planned including vascular services in the North East and Cumbria and Yorkshire and Humber in collaboration with CCGs, implementing a new bariatric service in the North West, adult cystic fibrosis capacity in Lancashire and implementing the current review of cardiology in the North West and the provision of complex cardiac devices in Yorkshire and Humber

Trauma
Two major trauma reviews are planned to address compliance issues in Cheshire and Merseyside and Greater Manchester. Other reviews planned include prosthetics in North Cumbria, back pain in the North East, and the development of a new model of care for complex rehabilitation in Yorkshire and Humber. Work is also ongoing to roll out the assistive technology service across Yorkshire and the Humber.

Women and Children
Neonatal services and transport are to be reviewed in the North East and North West to consider demand, capacity and configuration. The Children's Epilepsy Surgery Services consultation received

a significant level of feedback and the POC board is currently considering the options in the NHS England response. Work will continue to improve complex discharge process for children who require long term ventilation through the development of a new model of care.

The Commissioning Intentions 2016/17 for Prescribed Specialised Services are published on the NHS England website https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/09/comms-intents-16-17.pdf

To find out progress on the projects or proposed service developments in your local area please contact your Specialised Commissioning hub representative, listed at the end of this bulletin.

Collaborative Commissioning

Specialised services include a diverse range of services from renal dialysis through secure services in mental health to treatments for rare cancers. We know the current commissioning arrangements work well for some patients, but for others they can be an obstacle to providing the best experience of care. We must tackle the latter and do better for all patients. Collaborative commissioning provides a real opportunity to do this, through CCGs and NHS England, each with
Their own responsibilities, working together in a way that delivers better outcomes for patients.

A Specialised Services Collaborative Commissioning Programme Oversight Group was set up in February 2015 to shape and direct the national program to support and enable CCG's with collaborative commissioning for specialised services.

By integrating specialised services with other commissioning functions we can provide greater flexibility in the deployment of pooled funds across different services and increase the scope for joining up care pathways. It is part of a move to place-based commissioning enabling a joined up view of commissioning for a given population. Devolution of specialised commissioning is also consistent with Government policy on devolution such as joining up the local £ as in the Greater Manchester devolution

Ten collaborative commissioning oversight groups have been established across the country and they have identified priority areas for service transformation and redesign in 2015/16. The six national Programme of Care boards have also been asked to identify best practice pathways and care models. In the north, the three collaborative commissioning oversight groups: North East and Cumbria; North West and Yorkshire and Humber, have all met and discussed terms of reference. Work is progressing particularly at pace in the Yorkshire and Humber collaborative as this group have been working together since the beginning of the year.

The way forward

By strengthening collaborative commissioning arrangements there is a clear direction of travel which will deliver more joined-up local, place-based commissioning in the next 3 – 5 years with an aim to fully transfer commissioning responsibility to CCGs.

Specialised Commissioning will need new models of commissioning and new models of delivery to achieve the aims of collaborative commissioning. This means place based commissioning and each service looked at within the context of the whole pathway of care and the population served. And delivery across the pathway and in networked models.

New Models for Commissioning Specialised Services

In order to get the best quality care for patients who need specialised services, ensure services are joined up and avoid duplication, work has begun to look at all the prescribed specialised services and consider on what basis they should be commissioned in future. This work has taken the form of segmenting specialised services into footprints or tiers to devise commissioning models for devolving services to collaboratives in the future. The tiers identified are:

- Group of CCGs
- Health economy eg City /county – such as the Greater Manchester arrangement
- Sub region (eg Yorkshire and Humber)
- National

Using a tool developed by NHS England, services are being assessed against these tiers. Legislation does not currently exist for commissioning responsibility to be delegated in this way, however, in house and external legal advisers are working with NHS England on governance arrangements to support this “tiering” work.

Next steps

Principles to steer the next phase of collaborative commissioning and transforming delivery are currently being worked on nationally and regionally. To find out more and/or get involved in this work, please contact your local Specialised Commissioning Hub, contact details are below:

How to contact us

To find out more about what is happening or to discuss any issue relating to Specialised Commissioning in your area please contact:

For the North West - Andrew Bibby, Andrewbibby@nhs.net, tel: 0113 8252600
For the North East and Cumbria – Liz Rogerson, Liz.Rogerson@nhs.net tel: 0113 8253044
For Yorkshire and the Humber – Matthew Groom, matthew.groom@nhs.net, tel: 0113 8255414

If you have any comments or suggestions for the Regional Specialised Commissioning Bulletin, please contact M.Hardie@nhs.net

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Report author: Steven Courtney
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Report of Head of Scrutiny and Member Development

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 21 December 2015

Subject: Work Programme

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider and agree its priorities and future work programme.

Recommendation

2. Members are requested to consider and agree the priorities and future work programme of the West Yorkshire Joint Health Overview and Scrutiny Committee.

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1.0 Purpose

1.1 This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider and agree its priorities and future work programme.

2.0 Background information

2.1 For the past 18 month, the Health Scrutiny Chairs of the five West Yorkshire Authorities have periodically met on an informal basis focusing on the establishment and progress of the Health Futures Programme. Urgent and Emergency Care is one of the priority areas of work identified within the Health Futures Programme.

2.2 A West Yorkshire Joint Health Overview and Scrutiny Committee has now been established and draws its membership from the five constituent West Yorkshire local authorities.

2.3 The Joint Committee has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.

- To meet regularly with NHS England to:

  - Receive updates on national developments and other matters from NHS England
  - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.

- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)

- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.

- To undertake shared development activities from time to time.

3.0 Main issues

3.1 Members have considered a range of information elsewhere on the agenda and are now asked to consider and agree the priorities and future work programme of the West Yorkshire Joint Health Overview and Scrutiny Committee.

4.0 Recommendations

4.1 Members are asked to consider and agree the priorities and future work programme of the West Yorkshire Joint Health Overview and Scrutiny Committee.

5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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