Urgent and Emergency Care Strategy 2014-19:
For Airedale, Wharfedale & Craven and Bradford

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Airedale NHS Foundation Trust
Airedale, Wharfedale and Craven Clinical Commissioning Group
Bradford City Clinical Commissioning Group
Bradford District Care Trust
Bradford Districts Clinical Commissioning Group
Bradford Teaching Hospitals NHS Foundation Trust
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## Acknowledgement

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- NHS Yorkshire and the Humber Commissioning Support
- Healthwatch Bradford
- Bradford Health Partnerships Project
Executive summary

Introduction

The Airedale, Wharfedale and Craven (AWC) and Bradford urgent and emergency care stakeholder communities have come together to develop this strategy and vision for the transformation of urgent and emergency care services for the next five years.

The strategy is a departure from the historic incremental service-based approaches taken to improve urgent and emergency care as it acknowledges that these will not bring about the scale and scope of change required to address current issues and meet future needs. Instead it recognises that urgent and emergency care is a broad range of responses that need to operate and co-operate within a co-ordinated system to deliver the best patient experiences and outcomes. This holistic system-wide approach will require the collective commitment and enthusiasm of all stakeholders to embrace the challenges to deliver a next generation urgent and emergency care system and to develop new or poorly utilised pathways such as self-care. All stakeholders are committed to transforming the current system to create person-centred, high quality care that is sustainable both clinically and financially.

In the context of this strategy the urgent and emergency care system includes a broad range of services spanning primary, secondary, social and community care that respond to urgent requests from the general public for reassurance, diagnosis and treatment. The outcome of this strategy should be an inclusive transformed urgent and emergency system that meets the needs of each resident whether they are an adult or a child, irrespective of ethnicity, cultural heritage, physical disability or mental health problem. The strategy should ensure parity of esteem between physical and mental health related issues.

Context and rationale

It is well acknowledged nationally and locally that the urgent and emergency care system is under considerable pressure as it continues to deliver a high quality service against a backdrop of increasing patient demands and expectations and constrained financial and staff resources. To try to address this, a range of national policies and reviews has been produced over recent years with the aim of transforming the nation’s health and social economy as a whole, and urgent and emergency care in particular. The direction of change is being driven through emerging design principles and commissioning guidance for a next generation urgent and emergency care system. In summary, patients should receive the right advice and care in the right place, first time. Services should be available 24 hours a day, 365 days a year, be easier to navigate and be built around the patient rather than the patient fitting into them. There also needs to be radical shift in the balance of care from hospital-centric to community-based.

Across AWC and Bradford there has been a continued increase in the demand for urgent and emergency services. Every individual element of the system is reporting increased pressure; for example, the footfall through our two A&Es is rising at approximately double the growth rate of the resident population, there are significant increases in the number of calls to 999, and demand for the out-of-hours GP services is exceeding contracted levels by 50%. But pressure on our urgent and emergency care system is simply not a function of increased volume. There are a range of other factors such as inability to access primary care in a timely manner, the inefficient flow of patients through the system due to availability of resources to support discharge particularly at weekends, high levels of conveyance to A&E and, as people live longer, more are presenting with multiple long-
term and increasingly complex conditions. Looking forward, there is no sign that this pressure will abate as people increasingly want services that better fit around their lifestyles. Patient expectations of what the NHS will provide continue to rise and an increasingly ageing population requires even greater levels of support.

Against a backdrop of constrained financial resources and national shortages of many key staff, the traditional approach of refining existing services and plugging gaps will not address the pressures being faced, necessitating a fundamental shift in approach to deliver system-wide change. This requires changes to the way urgent and emergency care is delivered with primary and social care increasingly becoming the default volume provider of urgent care through easily accessible, patient-centred and responsive services, reducing the need to attend hospital. However when hospital care is needed, it should have the right facilities and expertise to provide the best outcomes for patients. Services must be better aligned and traditional barriers between services must be broken down to allow effective collaboration across the whole system to deliver a safe, high quality and seamless patient experience, within the current tight fiscal climate.

The vision for the strategy will be met through the achievement of seven objectives, delivered through three priority themes that define the key urgent and emergency care system areas that need to be addressed. Underpinning these priority themes are five cross-cutting themes that provide delivery functions that are common to all. Realisation of this strategy will be achieved through a combination of direct delivery through an urgent care programme and, where appropriate, delegated delivery via the other transformation programmes that comprise the Integration and Change Board (ICB) portfolio. The needs of vulnerable, protected, marginalised and minority groups such as young people, frail, elderly or those with mental health issues will be explicitly incorporated into the detailed design of implementation plans.

**Our Vision**

“a simple to navigate, sustainable and customer focussed high quality urgent and emergency care system providing 24/7 access that ensures patients are seen by the most appropriate health professional at the right time in the right setting”

**Objectives**

1) To improve patient experience through the creation of a patient and carer friendly urgent and emergency care system that is open for business 24/7, easy to navigate, responsive to their needs and lifestyles, and treats them with respect and dignity, whilst ensuring parity of esteem between physical and mental health related issues.

2) To make primary care the default and first port of call for urgent care needs through clearly differentiated services with patients supported and guided through the system to find the right service for their needs.

3) To increase the confidence of people to take greater responsibility for their own health and wellbeing through targeted information and support for self-care and through public health campaigns.

4) To reduce the incidence for hospital based care through alternative comprehensive community based support and management of frail and vulnerable people and those with long term conditions, through increased use of technology to facilitate remote consultation and support, and ambulatory pathways that minimise the need for conveyance to hospital based services.

5) To deliver high quality and responsive hospital based emergency care through dedicated Major Emergency/Emergency Care Centres supported by real-time access to diagnostics.

6) To reduce the need for acute admission through alternative community based services provision and when admission is necessary to improve the flow of patients through hospital based urgent and emergency care through rapid assessment by the right person and enhanced provision and management of intermediate care services and beds.

7) To improve patient outcomes by ensuring that the patient is seen quickly by the right clinicians, health professional first time, that the pathways between the different elements of urgent and emergency care are, seamless, efficient and user friendly, underpinned by effective sharing of patient data.

**Priority Theme 1: Access and convenience**

- improve the access to general practice
- enhance the role of pharmacists
- seek ways to enhance the role of paramedics
- ensure that there is adequate emergency dental provision.
- enhance the capability of NPS111
- ensure the NPS111 Directory of Services provides up to date Information
- review and revise ‘In’ and ‘out-of-hours’ GP services
- deliver a share of the art Urgent Care Centre(s)

**Priority Theme 2: Acute and specialist services**

- develop existing resources to create Emergency Care Centres
- lobby for a Specialist Emergency Care Centre for Bradford and AMIC
- improve access to and availability of diagnostics to support rapid diagnosis
- continue to develop ambulatory emergency care pathways
- develop and implement whole system pathways for LTC and ambulatory care sensitive conditions (ACSC), including enhanced services for ACSC

**Priority Theme 3: Managing demand and flow through the system**

- increase the capability of the general public to support their own care
- increase the self-management of long term conditions
- enable the proactive management of long term conditions
- develop and implement new care models for people with LTC
- support care, nursing and residential homes to better manage unscheduled need for urgent and emergency care
- continue to develop the use of technology such as tele-health/medicine
- increase the flow of patients that are safe to be clinically discharged from hospital
- support the discharge to patient’s homes 7 days a week
- continue to develop pathways from primary care/ home/community care to acute care to deliver a seamless and efficient patient experience.
- develop access to rapid diagnostics to support community based care
- work with the 999 ambulance service to reduce the dispatch of ambulances, and if dispatched, to reduce conveyance to hospital.

**The Outcome**

“an urgent and emergency care system that meets the needs of the people of FWC and Bradford, where all parts of the system function cohesively, are integrated with the wider health and social care economy, make best use of and are deliverable within the resources available to deliver improved quality, and patient experience”
This strategy has been developed by the AWC and Bradford System Resilience Group in collaboration with the respective Clinical Commissioning Groups, Acute Foundation Trusts, Bradford District Care Trust, Local Medical Committee, Yorkshire Ambulance Service, Community Pharmacy West Yorkshire, Bradford Metropolitan District Council Public Health and children’s and adult Social Care, Healthwatch Bradford, Health Partnership Project and wide engagement with patients and the general public across AWC and Bradford.

I would like to thank all of those that contributed to the development of this strategy, to help us get to this point, and look forward to the next phase, which is the implementation.

On behalf of Airedale, Wharfedale and Craven, Bradford City and Bradford Districts Clinical Commissioning Groups,

Dr Andy Withers
Clinical Chair Bradford Districts Clinical Commissioning Group
Chair of Airedale, Wharfedale and Craven and Bradford System Resilience Group
Urgent and Emergency Care Strategy 2014-19 for Airedale, Wharfedale and Craven and Bradford

1.0 Introduction

1.1 This Urgent and Emergency Care Strategy outlines the strategic vision and direction for the development of urgent and emergency care services in Airedale, Wharfedale and Craven (AWC) and Bradford for the next five years in order to provide person-centred, high quality care that is sustainable both clinically and financially.

1.2 It provides a single unifying vision for urgent and emergency care provision and creates a framework within which to develop a new seamless, high quality, responsive, easy to navigate service, using an integrated whole systems approach. This strategy sits within a wider portfolio of national and local change and its success will rely on ensuring alignment and realisation of inter-dependencies with other strategies, programmes and projects.

1.3 The strategy describes the national and local context, the need for change, and the approach that will be adopted to redesign and improve urgent and emergency care services to address current issues and future needs. The document acknowledges that this approach differs from previous interventions to improve urgent and emergency care and recognises that implementation will need to overcome a number of challenges in order to be successful. Without this more radical approach AWC and Bradford will not benefit from an urgent and emergency care system that contributes to improved health and wellbeing of local people.

1.4 The strategy defines specific priority themes that will deliver the agreed strategic objectives. It is recognised that some key elements will be delivered by existing AWC and Bradford programmes and by national initiatives, with the key role of the strategy being to provide focus, direction, coherence, linkage and synergy across the different activities to deliver the vision. This strategy seeks to deliver an inclusive transformed urgent and emergency system that meets the needs of each resident whether they are an adult or a child, irrespective of ethnicity, cultural heritage, physical disability or mental health problem.

1.5 The success of this strategy will depend on the collective commitment and enthusiasm of the different partners and stakeholders to embrace this agenda and drive change. This strategy has been developed by the System Resilience Group (SRG) comprising representation from the main stakeholders across the urgent and emergency care landscape in AWC and Bradford, following engagement with the public. The final endorsement of the strategy will be sought from the Integration and Change and Health and Wellbeing Boards representing Bradford and North Yorkshire.

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1 Please refer to Section 10: Governance and Implementation
2 Please refer to Section 10: Governance and Implementation
3 Please refer to Section 10: Governance and Implementation
2.0 **National context**

2.1 There is widespread national recognition and agreement that the NHS is under considerable and unrelenting pressure to deliver better patient outcomes against a backdrop of tightening resources and increasing patient demands. Over the last few years there has been considerable focus on the need for transformational change to manage these pressures to deliver better patient experiences and outcomes as it has been recognised that incremental change will not deliver the benefits that health and community suppliers, patients and the government are seeking. These changes impact all areas of the health and social care economy, and over the last few years national attention has increasingly focussed on the urgent and emergency care system. The following section provides a summary of the national context and drive for change within the urgent and emergency care system.

2.2 For the purposes of this strategy, the definition of urgent and emergency care has been aligned with that from the Department of Health (2011)\(^1\):

>`Range of responses that health and care services provide to people who require – or who perceive the need for – urgent advice, care, treatment and/or diagnosis quickly and unexpectedly. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need.'`

2.3 Breaking the mould without breaking the system (2011)\(^2\) identified six themes for commissioners to consider when seeking to move towards an integrated 24 hour, seven day (24/7) urgent care system:

1) build care around the patient not the existing services
2) simplify an often complicated and fragmented system
3) ensure the urgent care system works together rather than pulling apart
4) acknowledge prompt care is good care
5) focus on all the stages for effective commissioning
6) offer clear leadership across the system while acknowledging its complexity

These themes have been echoed in subsequent reviews and policy documents on patient care in general and urgent and emergency care in particular.

2.4 The Health and Social Care Act (2012)\(^3\) articulated the need to improve integration of services, as the experience of care for too many patients is fragmented between different parts of the health service and between the NHS and social care. This legislation seeks to shift the current emphasis on acute and episodic care towards prevention, self-care and integrated and well-co-ordinated care to cope with an ageing population and increased prevalence of chronic diseases and long-term conditions. The Act supports a change in a commissioning model with the focus being on patient outcomes, and more responsive services that fit around the patient rather than expecting the patient to fit around services.

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\(^4\) The terms ‘community providers, community care services or community services’ comprise a broad spectrum of services and providers such as local authorities, Bradford District Care Trust and those provided by voluntary and community sector organisations.
2.5 The Francis report (2013)\(^{(4)}\) called for a fundamental change in culture in the NHS, whereby the patient’s care and safety is put first, with the patient being the priority in everything done.

2.6 Urgent and emergency care is one of the priorities in the ‘Everyone Counts’ planning guidance for clinical commissioning groups (CCGs) for 2013/14\(^{(5)}\) and 2014/19\(^{(6)}\) through transformational change to deliver high quality care for all. This planning guidance stresses the importance of access to the highest quality urgent and emergency care, treating patients as close to home as possible, seven day urgent and emergency services, and the development of urgent and emergency care networks with major specialised centres supported by other emergency and urgent care facilities. The NHS England Business Plan 2014-17, Putting Patients First\(^{(7)}\), clearly sets out the objectives for delivering high quality health care now and for future generations, defining a number of business areas that directly impact on the urgent and emergency care landscape.

2.7 The vision for services that should be available seven days a week was initially set out in the Everyone Counts: Planning for Patients 2013/14\(^{(5)}\) planning guidance. The Seven Days a Week Forum was subsequently established to give all NHS commissioners the evidence, insight and tools to move the NHS towards this vision, and stated ‘patients in every community in England should be able to access urgent and emergency care services, and their supporting diagnostic services, delivered in a way that meets the clinical standards we have developed, seven days a week’. The Summary of Initial Findings of the Seven Days a Weeks Forum (2013)\(^{(8)}\) included a list of clinical standards for urgent and emergency care that all patients should expect to receive seven days a week. These focus around the following areas:

- patient experience
- time to first consultant review
- multi-disciplinary team review
- shift handovers
- diagnostics
- consultant directed interventions
- mental health
- ongoing consultant review
- transfer to community, primary and social care
- quality improvement

2.8 In parallel with the above, NHS England reviewed the evidence base to identify the main challenges faced by the urgent and emergency care system in England. The review\(^{(9)}\), which reported in June 2013, provided compelling evidence for the need to transform the system and a set of four emerging principles and 12 design objectives that should be delivered by any future urgent and emergency care system\(^{(10)}\). Emerging from the review was a phase one report\(^{(11)}\) that effectively set out the blueprint, with five key elements, for how urgent and emergency care should be delivered in the future:

- provide better support for people to self-care
- help people with urgent care needs to get the right advice in the right place, first time
- provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E
• ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
• connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts

2.9 The NHS Outcomes Framework 2014/15\(^{[12]}\) set out the high-level national outcomes that the NHS should be aiming to improve, divided into five domains:

- preventing people from dying prematurely
- enhancing quality of life for people with long-term conditions
- helping people to recover from episodes of ill-health or following injury
- ensuring that people have a positive experience of care, and
- treating and caring for people in a safe environment and protecting them from avoidable harm

Whilst none of these specifically relate to urgent and emergency care, the urgent and emergency care system is one of the key health systems that underpins the ability to realise improvement.

2.10 The Government’s mandate to NHS England April 2014 to March 2015\(^{[13]}\), stated that mental health issues should be treated on a par with physical health issues and the Mental Health Crisis Care Concordat\(^{[14]}\) established national agreement of core principles and outcomes, including an ambition for local area Mental Health Crisis Declarations that mirror the principles of the national Concordat.
3.0 Local context

3.1 Whilst there are national drivers for change this strategy for Bradford and AWC must also address local needs, taking into account local priorities, existing urgent and emergency care resources and existing programmes of change.

3.2 Local strategies reflect the national position with a desire to transform the urgent and emergency care system. The strategies of the three CCGs that cover Bradford \(^{15, 16}\) and AWC \(^{17}\) each include the need to transform urgent care as a priority. The Five Year Forward View (2014-19) of the Bradford District and Craven Health and Care Economy \(^{18}\) delivers a collective vision to create a sustainable health and care economy that supports people to be healthy, well and independent. It acknowledges the issues driving change within the urgent and emergency care system, and includes the vision defined in this strategy and the objectives that must be achieved to deliver the vision.

3.3 The Airedale, Bradford and Leeds Joint Strategic Needs Assessment (2012) \(^{19}\), the North Yorkshire Joint Strategic Needs Assessment (2012) \(^{20}\) and the resultant and respective Health and Wellbeing Strategies \(^{21, 22}\) do not explicitly focus on urgent and emergency care but have priorities which will impact on the future of services that support people when they are in need of urgent or emergency care, as a route to improving overall health and wellbeing.

3.4 The footprints of the AWC, Bradford City and Bradford Districts CCGs have a range of range of urgent and emergency services from an out-of-hours service to Accident and Emergency units. Annex 2 provides further details of the services that are available to the populations covered by the AWC and Bradford CCGs.

3.5 The Airedale NHS Foundation Trust (ANHSFT) Forward Plan Strategy 2013/14 - 2015/16\(^{23}\) includes urgent care as one of its key themes, ‘aiming to respond to existing demands, implementing a whole health system approach to the management of emergency care’. It is seeking to transform current provision through the delivery of a different whole health system model of urgent care including:

- changes to the way emergency care is provided at Airedale: re-locating acute medical, ambulatory care and surgical assessment units so that front end services are co-located together with the emergency department. The new unit will incorporate new ways of working including delivery of acute care by acute specialists and geriatricians rather than specialty physicians, more reliance on Advanced Nurse Practitioners to substitute for and supplement them to deliver a sustainable workforce and improved access to diagnostics.

- changes to the process and flow of non-elective patients through the hospital. This will be delivered through “Right Care Programme” work-streams that focus directly on urgent care to improve key areas such as the efficiency of patient discharge, reduced re-admissions, reduced requirement for admissions for patients with long-term conditions through improved access to urgent care, and the development of models for seven day working. Key to delivery of these changes will be the development of a model for a sustainable workforce.

- with the support of key partners, to significantly develop the infrastructure and management of urgent care across the whole health economy. This includes a single point of access for step up and step down intermediate care services and the increased use of telemedicine in nursing homes.
3.6 Bradford Teaching Hospitals NHS Foundation Trust’s (BTHFT) draft clinical service strategy 2014-2019 includes urgent care as a key theme as it intends to review and redevelop its urgent care delivery model. This will include the further development and implementation of new acute medical and ambulatory care models which will reduce unnecessary hospital admissions.

3.7 With regard to urgent care, it is BTHFT’s intention to work with local health economy partners to reduce attendances at A&E or assessment facilities. Often, A&E attendance is not the most appropriate way in which to meet patient needs from a quality, patient experience and financial perspective. The Foundation Trust has a busy A&E department with more than 130,000 attendances each year and as a result, urgent care is seen as a key priority for transformation and integration through:

- providing better support for people to self-care
- helping people with urgent care needs to get the right advice in the right place first time
- providing highly responsive, simple to navigate, urgent care services to patients
- ensuring those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
- connecting all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

For the Foundation Trust this means the opportunity to co-locate an Urgent Care Centre and develop the A&E to become a Specialist Emergency Care Centre (SECC) (see 3.10) building on its teaching hospital status and reflecting the significant challenges of the population.

3.8 The West Yorkshire Urgent and Emergency Care Network is collaboration of the 10 CCGs that cover the West Yorkshire region to oversee the development of urgent and emergency care services and provision across the region and across CCG boundaries. Examples of region-wide services are NHS 111, West Yorkshire Urgent and Care (WYUC), and Yorkshire Ambulance Service. This network is developing an overarching urgent and emergency care strategy for West Yorkshire with which this strategy will align and contribute.

3.9 Critical care is an essential element of the urgent and emergency care system and it underpins all secondary and specialist services. Admissions to critical care must be timely, meet the needs of the patient and avoid the transfer of patients needing critical care to other hospitals. The delivery of this strategy must ensure that these essential critical care elements requirements continue to be optimised locally and within the context of the West Yorkshire Critical Care Network.

3.10 The NHS England phase one report recommended the creation of between 40-70 major emergency care centres (renamed specialist emergency care centres) across England as part of the reform and transformation of the urgent and emergency care system. At the time of developing this strategy there is an ongoing discussion regarding the number of centres to be located within West Yorkshire; one is expected to be located in Leeds, with additional sites being discussed by the West Yorkshire Urgent Care Network. It is ambition of this strategy that a specialist emergency care centre should be located at BTHFT.

3.11 This ambition aligns with the Everyone Counts 2014/19 commissioning guidance which states that a detailed understanding of local of patient flows and the most pressing needs of
the population should underpin plans for the nature, number and location of urgent and emergency care facilities and services to meet local needs. BTHFT primarily serves an urban population of over 420,000 in Bradford but also accepts patients from across AWC making this geographic ‘catchment’ area one of the largest nationally. As travel times to receive treatment are critical for some conditions, to achieving successful patient outcomes such as stroke, it is essential that local specialist services are readily available and patient journey times are minimised wherever possible. Extended travel times, particularly for patients from AWC, could significantly affect their patient outcomes if BTHFT did not attain SECC status.

There is already a trend for ANHSFT patients to transfer to Bradford where sustainability and proximity has been identified as an issue, for example BTHFT will be accepting a 400-plus per annum shift of stroke patients from ANHSFT.

3.12 The range and nature of the specialist services offered by BTHFT have developed in response to the specific and unique challenges presented by the significant demographic variability of the population combined with a high ethnic mix and unemployment rate in Bradford. These challenges include:

- one of the highest rates of infant mortality nationally
- one of the highest birth rates in Europe
- higher than national average for premature death.
- 31% of population live in 10% most deprived areas of the country
- significantly higher than average incidence of cardiovascular and renal disease and diabetes
- patients that are not willing to travel far for their healthcare so access their local emergency department whether it is equipped and appropriate for their needs or not.

To address these unique local needs, BHTFT has built critical mass in specialist services such as stroke thrombolysis, emergency vascular, special paediatrics, critical care and interventional radiology. Failure to achieve SECC status could not only result in loss of these services, with direct and negative impacts on patient access, but also could have significant negative knock-on consequences on the ability of BTHFT to deliver other essential specialties such as cancer, renal, vascular, urology, plastics and some elements of general surgery and to recruit and retain high calibre staff.

3.13 Local authorities (LAs) deliver a broad range of support and services that contribute to the urgent and emergency care system (Annex 2), providing alternatives to hospital, and diverting people from A&E, police stations and acute care. Working in partnership, the LA and Bradford District Care Trust (BDCT) are the main providers of mental health care across AWC and Bradford. These organisations work co-operatively in the development and delivery of crisis and out-of-hours provision including the First Response Service and intensive home treatment team both of which have access to LA staff. The local planning and implementation of the crisis care concordat, that mirrors the principles of the national Mental Health Crisis Care Concordat, is being led by the CCGs, LA and BDCT together and in partnership with the third sector and the plan is to implement a crisis care pathway across all agencies linking existing and new services.

3.14 As one of the district’s main providers of mental health and community health services, Bradford District Care Trust (BDCT) has an essential role in contributing to an efficient, holistic urgent and emergency care system. The September 2014 Care Quality Commission inspection of BDCT rated the an overall quality of care as ‘good’ but noted that service users have difficulty accessing crisis mental health services at night because the
commissioned level of crisis team resource only allows for telephone contact; those who need immediate assessment are currently directed to the accident and emergency departments of the two acute Trusts with potential long waits and breaches because the liaison psychiatry teams are also not commissioned on a 24 hour basis.

3.15 In response to the above findings and subsequent discussion at a Quality Summit, a partnership plan has been drawn up which describes the key priorities for a better mental health urgent care offer. These will be addressed by a new CCG and LA-led mental health Partnership Board which brings all agencies together to implement enhanced services such as: a 24/7 psychiatric liaison service, a 24/7 crisis service incorporating a ‘First Response Team’ along the lines of the successful model in Sunderland, improved places of safety, reductions in ‘out-of-area’ placements and improved care co-ordination resource in community mental health teams. BDCT had already identified these areas as priorities for development in its five-year plan (2014-19) and successful implementation should enable delivery of the objectives of the Crisis Care Concordat.

3.16 The Integration and Change Board (ICB) has identified seven major programmes of change to transform the health and social economy of AWC and Bradford. Each of these programmes is at a different stage of development and mobilisation, three of which were only been agreed in the summer of 2014. As this strategy is taking a system-wide approach it is expected that some areas will fall within the remits of the other ICB programmes. It is expected that this strategy will be realised through a combination of direct delivery via the emerging urgent and emergency care programme and, where appropriate, delegated delivery through the other programmes, primarily integrated care for adults, self-care and prevention and transforming primary and community services. Realising the interdependencies across the portfolio will be key to delivery of this strategy.

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5 Representatives from Bradford District Care Trust, service users, carers, 3CCGs, primary care, voluntary and community sector, local authorities and West Yorkshire Police

6 Please refer to Section 10: Governance and Implementation
3.17 The 2014 plan for the Better Care Fund will support the delivery of this portfolio of integration and change programmes, in particular those relating to urgent care and integrated care. These two programmes are closely inter-related because getting care right at home will reduce demand on urgent and emergency care services. The urgent care programme, which will be the implementation vehicle for this strategy, will ensure the interdependencies between these programmes are realised to deliver the change needed in urgent and emergency care system.

3.18 Supported by NHS England, AWC CCG and its partners have been working with Oliver Wyman international consultancy firm to explore new and more radical models of care, based on best practice, which have the potential to transform health and social care systems and improve quality and outcomes. This work builds on, and complements, the existing Right Care strategy and, subject to agreement and consultation, AWC could become a national accelerator site with additional central resource available to support adoption of change at pace and scale.

3.19 The strategy also acknowledges that there are a number of other local initiatives which must be recognised and incorporated within its delivery. Some of these are currently active or imminent; others have a longer timeframe but are expected to occur within the lifetime of the strategy. Examples of these include:

- ‘Right Care’ Future State vision for the AWC health and social care economy
- Better for Bradford, Airedale, Wharfedale and Craven: right care, right place, first time\(^{(27)}\)
- Pharmacy First pilot scheme in Bradford City and AWC (Annex 2)
- Airedale telemedicine hub
- Primary care development and quality improvement
- Gold standard end of life pathway
- NHS 111: national revision of the specification that will impact on local delivery
- Decision on the future of the Hillside Bridge Walk in Centre (Annex 2)
- Self-care
- Re-development of emergency departments at both AFT and BTHFT
- Expanded scope and capacity of the Intermediate care programme including the virtual ward
4.0 The need for change

4.1 This strategy does not promote change for change sake, but responds to the need for improvement in the way people access and experience services, building on what currently works well and proposing changes to areas that need improving. The urgent and emergency system is experiencing unsustainable stress from a number of areas; increasing pressure for emergency admissions, greater patient expectations of accessibility and availability, and advances in care and treatments that allow people to live longer but to potentially present with more complex and multiple conditions. It is therefore essential that new ways of working are put in place to not only mitigate against this pressure but to be able to manage additional impacts from the predicted growth in the population across the three CCGs. Changing mind-sets to place increasing emphasis on prevention and self-care to improve health and wellbeing will be vital for reducing or constraining future demand for urgent and emergency care.

4.2 The current urgent and emergency care system comprises a range of dedicated and professionally delivered services that are providing the residents of AWC and Bradford with a service that has a high overall patient satisfaction rating \(^{28,29}\), delivering good patient outcomes and generally meeting most of its statutory targets. However, the evidence is clear that the system is being squeezed from all directions including tightening resources, increasing patient demands, and societal expectations of 365 day, 24 hours, seven days a week ‘right now’ access to services that meet their needs rather than those of the system.

4.3 Although the population data by CCG before 2011 is not available, the most complete CCG based data set uses Office of National Statistics (ONS) resident population data for Bradford district, which covers Bradford, Airedale and Wharfedale, but excludes Craven. The population in the Bradford district has shown a historic year on year average growth of approximately 1% over the period 2002 to 2012 \(^{30}\). For the purposes of this strategy it has been assumed that the growth in Craven has been broadly similar to that of Bradford districts.

4.4 An estimate of resident population number and age distribution within each of the three CCGs was produced by the ONS in 2011, and by applying their expected growth rates for each age band it is possible to obtain an estimate of population growth by age group up to 2021 (Figure 1).

![Figure 1: Predicted population growth in Bradford and AWC 2011-2021](image_url)

Source: Bradford Public Health Observatory \(^{30}\)
4.5 The extrapolation shows that total population is expected to grow from an estimated 572,500 in 2011 to 623,000 in 2021. Over this time period the greatest percentage increases in population are likely to occur in the 60+ age group, with the 0-9 age group predicted to return a growth of over 14%. However due to a different demographic mix across each of the three CCGs, this headline growth is not equally felt, as the Bradford City CCG footprint comprises a significantly higher proportion of young people aged 0-19 (approximately 35%) and AWC CCG footprint has a significantly higher proportion (approximately 26%) of people aged 60+. Both of these age cohorts present particular challenges to A&E facilities in terms of the environment in which to effectively treat them and, for the 60+ age group, the increasing complexity of the conditions they are presenting with as they live longer. The future urgent and emergency care system will need to ensure that it can effectively manage not only the needs of a growing population in general but also the specific needs of certain demographic groups that are expected to grow faster than the general population.

4.6 Whilst population growth over the last 10 years has grown at approximately 1% per year, attendances at A&E have grown by nearly double this rate over this same period. A&E attendance at Bradford Royal Infirmary and Airedale General Hospital has risen from about 154,000 in 2004/5 to 184,000\(^{(31)}\) in 2013/14 - a 19% increase without a commensurate increase in resources to deal with the additional footfall. The age profile of A&E attendees mirrors the demographic profiles of Bradford and AWC, with over the 0-19 age group comprising over 30% of footfall at Bradford Royal Infirmary and the 60+ age group approximately 27% at Airedale general. When compared to the national average A&E attendees by age for period 2011-13, Bradford Royal Infirmary has received a significantly higher number of children aged between one and nine years, whereas at Airedale General Hospital attendees from the adult cohort aged 70-89 significantly exceeds national average (see below). These attendance profiles bring their own challenges when trying to deliver a deliver an efficient service.

<table>
<thead>
<tr>
<th>Age group</th>
<th>National average attendance at A&amp;E</th>
<th>AGH A&amp;E attendances 2011-14</th>
<th>AGH difference from national average</th>
<th>BRI A&amp;E attendances 2011-14</th>
<th>BTHFT difference from national average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>7.3%</td>
<td>6.8%</td>
<td>-0.5</td>
<td>9.3%</td>
<td>+2.1</td>
</tr>
<tr>
<td>5-9</td>
<td>4.6%</td>
<td>5.0%</td>
<td>+0.3</td>
<td>6.3%</td>
<td>+1.6</td>
</tr>
<tr>
<td>75-79</td>
<td>3.6%</td>
<td>4.4%</td>
<td>+0.8</td>
<td>3.0%</td>
<td>-0.6</td>
</tr>
<tr>
<td>80-84</td>
<td>3.5%</td>
<td>4.4%</td>
<td>+0.8</td>
<td>2.9%</td>
<td>-0.6</td>
</tr>
<tr>
<td>85-89</td>
<td>2.8%</td>
<td>3.9%</td>
<td>+1.0</td>
<td>2.3%</td>
<td>-0.5</td>
</tr>
</tbody>
</table>

Attendance-related pressure on A&E is also exacerbated by timing of presentation, which is increasingly out-of-hours, and can unexpectedly peak in volume. This makes it increasingly difficult to respond within agreed targets and negatively impacts on the flow of patients through the system. Increased footfall is one element contributing to the pressure hospital-based urgent and emergency care services are facing, as there are a number of other factors that also contribute, such as an increase in patients presenting with major conditions\(^{(32)}\), higher attendance at, and admission from, A&E on Saturday, Sunday and Monday which misalign with discharge rates, staffing issues due to national recruitment challenges, and lack of viable alternatives to A&E. Whilst individual elements in isolation may not significantly increase pressure on the system, their combined and cumulative impact can be significant as impacts in one part of the system compound those in others. The current
pressure shows no signs of abating, and with projections for those age groups that generally require greater input of NHS resources predicted to grow faster than the population as a whole, it is clear that this position is not sustainable. It is also clear that this is simply not just an A&E problem, as there a number of factors unrelated to A&E that impact on people arriving appropriately at A&E and efficiently leaving hospital.

4.7 ‘999’ and ambulances play a key role in the urgent and emergency system, not only in terms of treating people but also in managing patient flow through the system and attendance at A&E. The 999 service will dispatch a response eg double-manned ambulance or rapid response vehicle if appropriate. If the problem can be treated via the telephone, they will provide a ‘hear and treat (and refer)’ response. The ambulance service will either treat the patient in situ (‘see, treat and refer’) or treat and convey (‘see, treat and convey’) to an A&E unit. Yorkshire Ambulance Service (YAS) also provides a conveyance role for cases that require urgent admission or urgent treatment. The ‘hear and treat’ response accounts for approximately 10% of 999 calls, but those that are calling 999 for ‘hear and treat’ should really be calling NHS 111, indicating a need for improved patient awareness of NHS 111. Approximately 75% of ambulances dispatched result in conveyance with only 15-17% being treated at the scene \(^{(33)}\). In relation to those patients that are conveyed to A&E, it is known that approximately 20% of patients will be discharged without follow-up \(^{(34)}\) indicating there is potential to reduce conveyance to A&E either by increasing the treatment at the scene or by providing and an alternative to A&E which could focus on the more minor end of issues leaving A&E to focus on emergencies. Similarly, increasing the volume of ‘hear and treat’ could reduce the dispatch of ambulances to calls that may not require them, freeing up valuable resource that could be used to improve response times for more serious calls.

4.8 Primary care plays a key role in the urgent and emergency care system, through a combination of support for self-care of minor illnesses, self-management of long-term conditions, responding to requests for urgent appointments and reassurance, to being a gatekeeper to access to hospital-based services. The primary care system comprises a number of services including general, medical and dental practices, NHS 111, pharmacies, optometrists, the out-of-hours GP service and walk-in provision. The primary care system suffers from a number of issues that contribute to the pressure that the urgent and emergency care system is facing:

- **Access, convenience and responsiveness**: Whilst general practices are just one element of primary care, the following - which focusses mainly on general practice - is illustrative of the main issues being experienced. General practices are the preferred and generally first port of call for most people seeking urgent care, consistently receiving high satisfaction ratings \(^{(28, 35)}\), but they are under considerable pressure as the number of appointments has increased significantly over the last five years. National figures indicate that the number of annual consultations has risen by 40 million across England alone since 2008, taking the figure to 340 million. One of the consequences of this increased demand for consultations is that patients express dissatisfaction with access to their GP as they often cannot obtain an urgent appointment on the same day; they are frustrated by the way appointments are booked which can relate to how quickly they can get through to the practice by phone once it opens, and the fact that they have to wait longer than desirable for appointments. In addition, many working people find the availability (opening times) of routine services such as general practices inconvenient as it coincides with their normal working day \(^{(28)}\). These issues drive some to seek alternative services which can result in the use of A&E as a default ‘back-up’, especially as they know they will always be seen and will only have to wait a maximum
of four hours \(^{28, 36}\). For some people the proximity of a service is a major consideration that influences their choice of service, as those living close to an A&E department or the walk-in centre tend to use these as an alternative to seeing their normal GP. Access to urgent dental care across Bradford City and Districts, especially over the weekend period, is a significant issue as evidenced by the high number of dental-related calls to NHS 111 on this issue. This is an area that needs to be addressed to ensure that patients are treated in a timely manner without the need to call on alternative services.

- **Duplication of services and not meeting the need for which it was designed.** The walk-in centre in Bradford has limited opening times, only sees patients by appointment, and is used by a high proportion of people already registered with a general practice in Bradford. As such it is effectively duplicating existing general practice and out-of-hours services and, effectively, is not being accessed by people not registered in Bradford. The current location of the facility is poorly connected to the city centre which dissuades patients without transport from using it, leading them to seek alternative sources of care \(^{28}\).

- **Demand for Out-of-hours services:** The demand for out-of-hours services is significantly higher than expected, which is either tapping into an unmet demand or responding to issues of access and convenience of general practices. In some cases the out-of-hours service provides services that should be delivered in 'in hours' services such as repeat prescriptions \(^{37}\).

- **Potential to enhance the role of allied primary care services to manage better the overall pressure (or demand) on the urgent and emergency care system.** Primary care in its widest sense includes a wide range of services, and the evidence suggests that allied health care professionals such as pharmacists, and optometrists, who undergo years of specialist training, are underutilised by the general public for their urgent care needs. For example, pharmacists are primarily used for dispensing over the counter medicines and prescriptions \(^{28}\), but they have a wealth of knowledge and experience that could be applied to diagnosis and treatment of self-limiting minor conditions. In this way they could provide a viable alternative to general practice, thus freeing up appointments for patients with more serious complaints. Similarly, optometrists are traditionally used by the general public for eye tests and dispensing glasses, but have also have the skills and expertise to diagnose and in some cases treat eye-related conditions. A recent publication from The College of Optometrists suggests that nationally between 1.46-6% of A&E attendances and 1.5-2% of GP consultations are eye-related. Up to 78% of eye-related cases attending A&E are ‘non serious’ with 50-70% being neither an accident nor emergency \(^{38}\). Across Bradford and AWC, It has been estimated that there are approximately 2200 eye-related attendances at A&E per year (approximately 1.3% of footfall). By working with optometrists to explore how they can support urgent eye care it may be possible to reduce some of the eye-related attendances at A&E and at GP surgeries.

4.9 The 2013 NHS ‘Call to Action’ programme identified mental health as a key priority for all three CCGs, as described in the Five-Year Forward View \(^{18}\). Investment in adult and older people’s mental health services is dropping in real terms at the same time as psychiatric morbidity and suicide rates are increasing \(^{39}\). Mental health problems are the largest single source of disability in England, accounting for 23% of the total ‘burden of disease’ \(a\) composite measure of premature mortality and reduced quality of life\) and research evidence consistently demonstrates that people with long-term conditions are two to three times more likely to experience mental health problems than the general population \(^{40}\).
People with severe mental illness tend to suffer more from physical health conditions than the general public, one consequence of which is a greater demand on physical health services. Making ‘parity of esteem’ between mental health and physical health a reality will not only result in better care for people with mental health issues but should also lead to reductions in GP attendances, A&E attendances and acute admissions, not just for mental health crises but for a wide range of physical health problems too.

4.10 There are a number of other factors that also contribute to increased pressure on the urgent and emergency care system:

- **Risk aversion:** There is a natural tendency for people and health and social care practitioners to err on the side of caution as this is considered to be the safest option, but, despite best intentions, it can contribute to the pressures experienced by the urgent and emergency care system. This may be manifested in a number of ways; for example, a parent will take their child directly to A&E rather than wait for an appointment with a GP \(^{(28)}\), or a patient may be conveyed to A&E when they could have been better treated in an alternative setting. Clinicians can also err on the side of caution which can result in patients being sent to A&E or being admitted to a hospital bed when it may not be fully justified. This is a complex issue, not an exact science, and is related to the way people perceive and respond to risk, assess the potential seriousness of a particular condition, their confidence in decision-making and the options that are available to them at the time.

- **Poor co-ordination and integration between health, community and social care services:** Better management in the community can reduce the total number of people with long-term conditions needing urgent and emergency care services, but when they are admitted they are often more acutely ill, so need more complex treatments and longer stays in hospital. On balance, however, it is believed the benefits of the former far outweigh the latter from both a patient’s experience and outcome perspective and from more efficient use of urgent and emergency care resources.

- **Data sharing** between different elements of the urgent and emergency care system is sub-optimal due to systems interoperability. This can result in patients being taken to A&E as a risk averse default position, when other more appropriate options would allow treatment in situ.

- **Flow of patients through the system:** The flow of the patients through the system is a significant issue for urgent and emergency care. The availability of beds, in hospital and in intermediate care settings (the latter when people are clinically fit to be discharged from hospital), negatively impacts on the flow of patients, increasing pressure on the elective and non-elective parts of the system. Delays in nursing needs assessments and availability of intermediate support in social care and home settings can also slow or prevent the discharge of patients over weekends, which can fall to approximately one third of the discharge rate experienced Monday to Friday \(^{(41)}\). Increasing the capability to discharge seven days a week should contribute to reducing the pressure that hospital-based care is facing.

- **Vulnerable, protected, marginalised and minority groups:** the current system does not always deal as well as it could with people from these groups. The issues can range from lack of translation services, perceived lack of respect and dignity by staff, and inappropriate access to urgent and emergency care due to lack of understanding of need
(patient and/or health care professional/practitioner), cultural heritage or poor location of services \(^{(28)}\).

- **Complexity and awareness of the urgent and emergency care services**: The urgent and emergency care landscape comprises a range of health and social care services that can be confusing for people to navigate leading in some cases to inappropriate choice of service. Patients can default to A&E departments, where they know they will be seen within 4 hours \(^{(28, 36)}\). As Anna Bradley Chair of Healthwatch England \(^{(36)}\) stated:

> "Open all hours, with drugs on tap and guaranteeing to see patients within four hours, A&E has become NHS Express. The problem is it was never designed to be a catch-all service and nor should it be allowed to become one.

> "I’m not absolving us of our responsibility not to clog A&E whenever we get the sniffles, but until the health and care sector offers a more consumer-friendly experience, things are unlikely to improve."

4.11 Correct staffing levels and skill mix are fundamental to ensuring the delivery of a high quality and responsive urgent and emergency care system. Workforce planning will be critical to the success of the move towards 24/7 working, the integration of health and social care, the need to explore alternative models of care to embrace the transformation and integration agenda, the shift from hospital-centric to community-based care and the proposed reconfiguration of acute and specialist services. Ensuring there is a sustainable workforce presents particular challenges as there are well documented national shortages of certain health professionals and Bradford - as a location to live and work - can have negative impacts on ability to recruit. However these challenges will need to be factored into the plans to deliver this strategy.

4.12 People’s expectations of what they should receive from a service are also changing rapidly. Technology and the move to a 24/7 lifestyle mean that people increasingly expect 365 day 24/7 access to services, to be able to see who they want, when they want, at a time and place convenient to them. This desire applies as much to health and social care as it does to any other service. In addition, the continual development of new medicines and procedures means that a far broader range of conditions can now be effectively treated; raising individuals’ expectations of what they can routinely expect to receive from the healthcare system at a faster rate than with which the service can keep pace. The urgent and emergency health landscape has evolved to meet these needs by designing and delivering a range of services to meet them. However in some cases the end result has been fragmented services, which are not as accessible as they could be, not always in the most convenient location, and not fully integrated to deliver a seamless service to patients.

4.13 The pattern of service improvements to date has generally occurred through a number of individual interventions that have sought to balance better the demand and supply of services based on recommendations for improvement or perceived gaps in provision. Whilst these may have a local benefit, their overall impact may be difficult to detect and have unforeseen consequences such as moving activity to other parts of the system.

4.14 Over time this approach has resulted in a proliferation of different services that can be difficult for users (patients) and suppliers (health and social care professionals) to navigate, may not be as fully integrated into the urgent care system as they could be, and in some
instances may result in services being available in some locations but not others.

4.15 In addition to the demographic and patient-related issues, the financial environment in which the services are operating is playing a major role in the need for change. It has been estimated that if, under the current healthcare system, the real-time funding freeze for the NHS is extended to 2021/22 - whilst patient demand continues to rise and no productivity gains are realised - there will be £54 billion shortfall for the NHS as a whole. Even after expected productivity gains this shortfall has been estimated to be £34 billion, excluding estimates of shortfall in the funding for social care which is under similar demand and fiscal pressures. At a local level, it has been estimated that the health and social care services in Bradford are facing a shortfall in funding estimated to be in the region of £364 million over the next five years. This indicates that urgent and emergency health and social care services, and the way they are delivered, must change to contribute to meeting this funding gap, whilst protecting patient experiences and outcomes and the critical mass and sustainability of specialist services that service the population of AWC and Bradford.
5.0 Approach used to develop this strategy

5.1 This strategy has been developed using both a top-down and bottom-up approach. The top-down element comes from the national recognition of the need to transform the health and social care economy which includes the urgent and emergency care system. National policies and plans are articulating the desire to move toward 24/7 access, patient-centred services, better information sharing and integration of health, social, and community services, producing a blueprint for a future urgent and emergency care system. These developments will be driven nationally, but must be implemented locally.

5.2 The bottom-up element derives from local strategies and evidence that highlight and address the issues within the footprint of the AWC and Bradford CCGs, to take account of the needs of the population. This strategy has been influenced by consultation with delivery stakeholders and the general public.

5.3 There is a shared understanding and agreement between the stakeholders of AWC and Bradford that the current urgent and emergency care system is unsustainable in its current form and that the previous method of incremental improvement and evolution will not meet future demand and patient expectations. There is a shared commitment for the need for bold and radical redesign of the urgent and emergency system to create a user-friendly, flexible and system, delivered by integrated teams of people that have collective responsibility for a patient’s journey. This approach will ensure that the urgent and emergency care services meet people’s needs, reduce inequalities and deliver improved patient outcomes.

5.4 This means realigning and reconfiguring urgent and emergency care to ensure the system is more responsive to patient’s needs, increasing self-care, wrapping packages of care and support around patients to maximise their treatment in local settings whilst ensuring efficient pathways to acute emergency services when conditions require it.

5.5 This approach is bold and ambitious; necessitating the need in some cases for a step change in the way the various elements of the urgent and emergency care interface and are delivered. It is critical that the system is treated as a whole as it is needs to be more than the collective sum of its parts if it is to deliver the expected benefits.

5.6 This strategy aims to move away from the more traditional approaches that have historically focussed on improving and evolving single elements to a system-based approach involving greater integration of services, and new ways of working will present challenges. This may be difficult for some stakeholders initially, as traditional barriers will need to be broken down, vested interests overcome, and new ways to incentivise different ways of working will need to occur. It will require changes to the way tariffs are negotiated and agreed, and smarter commissioning and procurement to deliver more innovative resource-efficient services where integration and patient-centred seamless working is as much a priority as patient outcomes. However, if these issues are not addressed, the scale of change required will not occur. There is a strong desire from all stakeholders for a new urgent and emergency care system in AWC and Bradford and agreement of this strategy is the first step on the journey to turning this desire into reality.

5.7 The development of this strategy has been strongly influenced by the emerging principles from the NHS England’s Urgent and Emergency Care Review and subsequent Phase 1 report that defined five key elements for future urgent and emergency care services in
England. These have been used as a high level blueprint for a transformed urgent and emergency care system in Bradford and AWC that builds on existing system strengths to deliver a bold programme of change.

5.8 The strategy has been developed from the perspective that the mental health needs of patients are on par with physical health needs and that all implementation plans must take this view into account. The stakeholders that contributed to the development of this strategy took the conscious decision that the needs of every patient irrespective of age, gender, ethnicity or physical or mental impairment must be built into the design and implementation of the programmes and projects that will deliver the strategy.

5.9 The strategy must also contribute towards the delivery of key areas for improvement that should lead to the good patient outcomes defined in that NHS Outcomes Framework (12), many of which align with the Social Care and Public Health Outcome Frameworks. As this strategy requires the close collaboration between a range of services and stakeholders and should contribute to the delivery of these outcomes, it is critical that there is a clear path from the implementation of this strategy to the outcomes. The alignment between the NHS Outcomes Framework, Keogh’s ‘system design objectives’ and the objectives and work programmes of this strategy is shown in Annex 3.

5.10 The development of this strategy has taken into account the following patient-focussed principles:

- The patient will experience a seven days a week service that is working as one integrated and whole system although provided by multiple agencies.
- The patient will be supported to remain in their usual place of residence wherever possible.
- The patient will be empowered to take greater control of their care needs and will be involved in the design of their own support package.
- Increasingly, patients will experience proactive rather than reactive care.
- Patients that are vulnerable to needing urgent care services will have the information that they need and a plan to support them and their carers to manage their condition effectively.
- Patients and the public are central to designing the right systems and are at the heart of decisions being made.
- Patients and the public know how to access information and guidance in the event of needing urgent care so they are able to receive the right advice in the right place first time.

5.11 In 2013/14, the expenditure by Bradford and AWC CCGs on urgent and emergency services was over £124 million, excluding social care and NHS England-contracted general practice and dental services. Given the current financial climate it is unlikely that additional recurrent funding will be forthcoming to support implementation of this strategy so it has been assumed that delivery will occur mainly within existing financial resources. The use of non-recurrent funding may, on a case by case and exceptional basis, support pump-priming or parallel operations required to support implementation and change.
6.0 Vision, outcome and key objectives

6.1 The vision for the urgent and emergency care system of Bradford and AWC is:

“A simple to navigate, sustainable and customer-focussed high quality urgent and emergency care system providing 24/7 access that ensures patients are seen by the most appropriate health professional at the right time in the right setting.”

6.2 The intended outcome of the strategy is:

“A sustainable urgent and emergency care system that meets the needs of the people of AWC and Bradford, where all parts of the system function cohesively, are integrated with the wider health and social care economy, make best use of - and are deliverable within - the resources available to deliver improved quality, and patient experience.”

6.3 The vision will be realised through meeting the following seven key objectives:

- To improve patient experience through the creation of a patient- and carer-friendly urgent and emergency care system that is open for business 24/7, easy to navigate, responsive to their needs and lifestyles, and treats them with respect and dignity, whilst ensuring parity of esteem between physical and mental health related issues.

- To increase the people’s confidence to take greater responsibility for their own health and wellbeing so that self-care increasingly becomes the default response for people to manage minor self-limiting conditions and, with appropriate support and guidance, their long-term conditions.

- To make primary care the first port of call when people have urgent care needs with services being clearly differentiated, easy to access, and - where necessary - supported and guided through the system to find the right service first time.

- To reduce the incidence of hospital-based-care through alternative comprehensive community-based support and management of frail and vulnerable people and those with long-term conditions, through increased use of technology to facilitate remote consultation and support, and ambulatory pathways that minimise the need for conveyance to hospital-based services.

- To deliver high quality and responsive hospital-based emergency care through dedicated specialist emergency/emergency care centres supported by real-time access to diagnostics.
• To reduce the need for acute admission through alternative community-based services provision and, when admission is necessary, to improve the flow of patients through hospital-based urgent and emergency care through rapid assessment by the right person and enhanced provision and management of intermediate care services and beds.

• To improve patient outcomes by ensuring that the patient is seen quickly by the right clinician/health professional first time and that the pathways between the different elements of urgent and emergency care are seamless, efficient and user-friendly, and are underpinned by effective sharing of patient data.
6.4 From a patient’s perspective, the delivery of this strategy will change the urgent and emergency care system from this . . .

If the system is not working for me then why should I stick to using it that way ... because it doesn’t work then we use it wrong too.

It’s hard for me to always choose the right service as there are seem to be so many of them.

I do what they say. I call my GP at 8am, I wait and wait then they tell me all the appointments are gone in 10 minutes.

A&E is the last resort. I don’t like going there but you can’t always get to see your GP, or if you have a kid.....it’s a waste of time but you don’t have a choice.

It’s ridiculous because there are lots of things that you wouldn’t need to come here (A&E) for if you could seek advice elsewhere.

I only refer to the pharmacist if I’ve got a prescription from the GP so it’s literally just a collection point.

NHS 111 has been really helpful for me, giving me the right advice, but it wasn’t very personal, and they keep asking me the same question again and again.

When my GP is closed I use the out-of-hours service but it is swamped now as people can’t get to see their GP.

There are lots of people from different services that to look after my long-term health needs but they don’t seem very co-ordinated to me.
6.5 To this...

The new Urgent Care Centre is a great alternative to A&E.

I'm only taken to one of the new emergency care centres if I really need to.

The GP out-of-hours service is so much better now and it quickly gives me the help I need.

It's dead easy to find the service I need, it's open for business 24/7 and it works for me.

I can quickly see my GP at a time that fits in with me.

I'm not seeing my GP so much as I use my pharmacist for a lot more than just collecting my prescriptions.

The new enhanced NHS 111 is so much better and they can book an appointment for me with a wide range of services.

The people that look after my long-term health needs come from different services, but it feels to me just like one team.
From a healthcare professional’s perspective, the delivery of this strategy will change the urgent and emergency care system from this . . .

Hospital nurse: I wish the support was there to discharge more patients over a weekend to reduce pressure on our beds.

A&E doctor: the system clearly isn’t working ..... sometimes so many people turn up it’s hard to see them all within the four hour target time.

NHS 111: people get frustrated having to give the same information several times.

Out-of-hours service: so many people need us that we run out of capacity to see them as fast as we would like.

GP: if we could give more people the confidence to look after their own health they wouldn’t need to see me so often.

Pharmacist: I have so much more to offer than just filling prescriptions.

Ambulance service: if we offer more choices for treatment we could reduce the number of people taken to A&E.

GP: there so many people trying to get appointments it’s hard to see everyone on the same day.

GPs, nurses and social care: we’re starting to work as an integrated team to support people with complex conditions ... it’s early days but we are starting to make a difference.
Discharge manager: the move to 24/7 working has had a huge impact on our ability to efficiently discharge patients out of “normal working hours”.

Urgent Care clinician: the new centre co-located with emergency care is great... people are seen in a much more effective way than before and it frees up the emergency teams to focus on patients with more serious conditions.

Out-of-hours service: we have sorted out the capacity issues and can better meet the demand for our help.

GP: we use a mix of face to face, phone and internet consultations to make it easier for our patients to see us.

GP: the self-care and prevention campaigns have really helped people to take more responsibility for their own health.

Pharmacists: people don’t just see me for their prescriptions ... I give them lots of help and advice with their health needs.

Ambulance service: we have reduced the number of people we take to A&E as we now have alternative treatment options.

NHS 111: the enhanced service is so much better and we can now book appointments with a wide range of services.

GP: we use a mix of face to face, phone and internet consultations to make it easier for our patients to see us.

GPs, community nurses, social workers: we can now give 24/7 fully integrated care to patient and have the right information to support this.

Urgent Care clinician: the new centre co-located with emergency care is great... people are seen in a much more effective way than before and it frees up the emergency teams to focus on patients with more serious conditions.

Out-of-hours service: we have sorted out the capacity issues and can better meet the demand for our help.

GP: the self-care and prevention campaigns have really helped people to take more responsibility for their own health.

Pharmacists: people don’t just see me for their prescriptions ... I give them lots of help and advice with their health needs.

Ambulance service: we have reduced the number of people we take to A&E as we now have alternative treatment options.

NHS 111: the enhanced service is so much better and we can now book appointments with a wide range of services.
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7.0. **Priority themes and key elements**

7.1 This section describes the priority themes and key elements that emerged during development of the strategy which will need to be addressed if the urgent and emergency care system is to be transformed to meet current issues and future demands. Under each theme are a number of key elements that will be addressed to deliver the vision of this strategy. The strategy has not prescribed defined work programmes, as the landscape is rapidly changing, allowing the definition of the final programme(s) that deliver the vision, the freedom to take account of this shifting external environment.

7.2 The themes and elements recognise that there a number of existing and emerging programmes and projects already taking place that fall within the scope of this strategy. The strategy seeks to be a framework under which all relevant urgent and emergency care activities can be delivered, providing a means to provide complementarity not duplication and coherence not fragmentation. The urgent care programme will form one of the main delivery vehicles for this strategy. Responsibility for the delivery of some elements of this strategy may be delegated to, or be delivered in collaboration with, the transformation programmes within the Integration and Change Board portfolio, principally integrated care for adults, self-care and prevention and transforming primary and community services. This will prevent duplication of activities but allow interdependencies between the different pieces of work to be realised.

7.3 Allied to the recognition that the priority themes and their component elements need to set within the context of existing activity, it is acknowledged that the pace of change across the footprint of the three CCGs may differ as local priorities and drivers are addressed. For example, the work in AWC to identify new models of care may result in this area becoming a national accelerator site and as such health and social care system transformation may progress in a different way and trajectory compared to Bradford.

7.4 This strategy provides a framework for delivery, emphasising the need to take a systems-based approach to transforming urgent and emergency care. As such agreement and implementation of the strategy will not halt existing projects and programmes or delay delivery of existing plans as all have a role in the transformation of the system. However, it is expected that, where required, the shape of existing activities may need to change to accommodate this approach.

7.5 The strategy recognises that some key elements are subject to national or regional (West Yorkshire) specifications, contracting and developments. In these cases, stakeholders will use their influence to shape policy and delivery to support delivery of this strategy. National examples include the move to 24/7 working and the NHS 111 future specification, with regional examples being the West Yorkshire two year plan for developments in general practices, Yorkshire Ambulance Service, NHS 111 and West Yorkshire Urgent Care.

7.6 Aligned to the national drive towards 24/7 working, the Integration and Change Board and the Bradford Health and Wellbeing Board have stated that by 2019 they will ‘implement a 24/7 integrated care system across the health and care economy’. The ambition of this strategy is that, where applicable, this should relate to the highest level (level four) of service provision as defined by NHS England (42).

7.7 The strategy does not have priority themes targeted at adults or children, specific conditions or patients that may be considered frail, vulnerable, in a minority or have mental health
issues. This has been a conscious decision made by stakeholders. Explicitly built into the design and implantation of the programmes of work that will deliver this strategy will be the needs and requirements of these patients and, where appropriate, their carers so they are accounted for and realised. In practice this should enable equity of access, service and experience for all, but the means by which this is achieved will differ depending on the needs and requirements of the individual.

7.8 Possible adverse impacts on potential service users with an Equality Act protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex, sexual orientation), those who live in a particular area or who experience disadvantage will be initially identified through an Equality Impact Assessment on this strategy, which will be built on as more detailed plans are developed and further public engagement occurs. Actions to reduce any potential impact will then be incorporated within the relevant work programmes as they are developed. Engagement work associated with the implementation of this strategy will involve a broad range of local people.

7.9 The detailed development, and subsequent implementation, of the urgent care programme that will support the realisation of this strategy will be based on analysis of available evidence, assumed demand for a particular service, identification of best practice and review of alternative models of delivery to identify the best options for delivery. Physical access, including parking and public transport will be considered within these options.

7.10 **Priority theme one: access and convenience**

It is clear from national and local surveys that access to primary care is an issue for some patients, and that current services do not always align with people’s expectations or modern lifestyles. It is acknowledged that the current urgent and emergency care system can be complex and difficult to navigate. The goal of this priority theme is to ensure that the primary care system - defined as general, medical and dental practices, NHS 111, pharmacies, optometrists, the out-of-hours GP service and walk-in provision - becomes the first port of call for urgent care needs. Where patients or their carers are unsure of the service they need, they will be supported to find the correct one through a no ‘wrong door approach’ where each part of the system can efficiently signpost to the correct service.

With the creation of the Integration and Change Board’s transforming primary and community services, some aspects of this theme may be delivered by this new programme once scoping has been completed.

**Key elements**

- We will improve the access to general practices through greater availability of appointments, user-friendly booking systems and extended opening hours to fit better with people’s lifestyles.
- We will enhance the role of pharmacies for treating self-limiting conditions, for provision of repeat prescriptions without the need to first see a GP and for supporting patient self-care.
- We will gain a thorough understanding of the role that optometrists can play in urgent and emergency care and seek ways to enhance their current role within the system.
- We will work with NHS England to ensure that there is adequate emergency dental provision.
• We will enhance the capability of NHS 111 based on the new specification from NHS England extending the ability to book appointments on behalf of the patient to a broader range of urgent and emergency care services.
• We will improve right-first-time patient navigation to, and better co-ordination across, urgent and emergency care services through ensuring the NHS 111 Directory of Services (DoS) provide increasingly real time information on services, their capacity and capability and via encouragement of wider adoption of the DoS as a referral tool by other urgent and emergency care services.
• We will review the models of ‘in’ and ‘out-of-hours’ GP service provision to identify and implement a sustainably resourced model of delivery that meets the needs of the Bradford and AWC CCG population.
• We will develop an urgent care centre - based on the emerging guidance from NHS England and co-located at BTHFT with emergency/specialist emergency care provision - that will deal with minor ailments and injuries, allowing emergency care centres to focus on more serious and life-threatening conditions.
• We will review the case for an urgent care centre at ANHSFT, based on the emerging guidance from NHS England and the emerging new model of care for AWC.

There are a wide range of activities that are already happening or planned to happen that will contribute to the realisation of this priority theme, a selection of which is included below:

• The three CCGs are applying to NHS England to co-commission primary care services to meet local needs better.
• General practice Quality/Quality Improvement Groups are working with their respective CCGs on a number of priority areas, one of which is access. The Productive Primary Care Access review is seeking to review general practice capacity compared to demand and find innovative solutions to improve access.
• In Bradford and AWC over 80% of general practices across have signed up to the extended hours enhanced service contract to provide extended opening hours in 2014-15.
• The Pharmacy First scheme (Annex 2), is operating in Bradford City and there are plans to roll it out in the autumn in AWC.
• Bradford City and Bradford Districts CCGs have persuaded NHS England to commission additional dental provision in Bradford to resolve the current demand issues.
• A new national specification for NHS 111 is being developed and the three CCGs are working to influence the final specification (publication date not known).
• Ongoing updates of the Directory of Services to ensure the information it provides is accurate and reflects any changes to local delivery.
• A capacity service review of West Yorkshire Urgent Care has been completed that identified areas for improvement to deliver a more efficient and sustainable service. The initial short-term actions are expected to be completed by autumn 2014.
• First Response supports 24/7 access to mental health services through assessment and signposting across the three CCGs.
• A review of Hillside Bridge Walk-in Centre, informed by a public consultation, will be carried out towards the end of 2014.

7.11 Priority theme two: acute and specialist services

Hospital-based acute and specialist services should only be needed once a patient’s condition cannot be managed in a home or community setting. Once the patient accesses
these services they should be treated as quickly as possible, by the right clinician in a safe and appropriate environment. The evidence suggests that concentrating services in specialist hospitals provides best patient outcomes, is more cost-effective and makes best use of resources and staff expertise, while ensuring that specialist staff can be more easily recruited and their training maintained. The intent of this strategy is that critical mass of specialist expertise should be preserved and enhanced wherever possible to ensure the best outcomes for the patients of Bradford and AWC, and the ambition for a SECC to be located in Bradford will play a significant role in realising this. The intention of this priority theme is not to close any hospital or A&E departments but to ensure that their emergency services align with the emerging guidance from NHS England to deliver facilities that are able to receive a full range of emergency patients of all ages and which provide for the reception, resuscitation, diagnosis and if necessary onward referral of patients.

**Key elements**

- We will develop existing resources to create Emergency Care Centres based on the emerging blueprint from NHS England at BTHFT and ANHSFT
- We will build a compelling case and lobby for a SECC to be based within the Bradford and AWC CCG footprint.
- We will improve access to and availability of diagnostics to support rapid diagnosis by the Urgent and Emergency Care Centres.
- We will continue to develop ambulatory emergency care pathways to reduce acute admission rates
- We will review and develop enhanced whole system (health, social, community and self-care) pathways for long-term and ambulatory case sensitive conditions (ACSC), initially focussing on conditions where there is greatest potential to safely reduce demand on acute care through optimising other care options.
- We will deliver enhanced services that will improve the care of patients with these for ambulatory case sensitive conditions.

There are a wide range of activities that are already in place or planned that will contribute to the realisation of this priority theme, a selection of which is included below:

- A new A&E department is being built at ANHSFT, expected open in October 2014, that will provide enhanced facilities such as separation of adult and children’s waiting facilities, a quiet room for people to use during stressful times, separate screened area for ambulances and greater use of technology to allow staff to see the results of diagnostic tests at the patient’s bedside. The new A&E department will be better equipped to cope with peaks in demand by providing a central hub at the heart of the treatment area. This new facility will be at the heart of an Emergency Care Centre being proposed at ANHSFT.
- BTHFT is developing plans for the redesign of its accident and emergency department, which includes the co-location of an urgent care centre. The redesign will have added focus on paediatric facilities to reflect the high volumes of paediatric attendances that occur at BTHFT. The work is planned to be delivered in summer 2015, with completion before winter 2015, and will underpin the proposed location of a SECC at BTHFT.
- Work has begun to develop the case to influence West Yorkshire Urgent Care to locate a SECC at BTHFT. The NHS England timescale for designation of the SECC is the same as the above and the case will evolve as further guidance is released.
- BTHFT is part of the Ambulatory Emergency Network that aims to significantly increase the use of ambulatory care pathways to reduce assessment unit activity and overall
acute admission rates by allowing a significant proportion of emergency adult patients to be managed safely and efficiently on the same day therefore avoiding admission to a hospital bed. This is also one of ANHSFT’s priorities and one of their change programme work streams.

- There is a lot of activity to support the development and implementation of pathways particularly around respiratory, stroke, cardiovascular and cancer covering the spectrum from prevention and self-care through diagnosis, treatment and aftercare. It is also proposed to focus improvements across 10 ACSC pathways using local CQUINs to drive improvements.
- ANHSFT opened a new Ambulatory Care Centre in February 2013, which has already had a significant positive impact on the flow of patients at Airedale General Hospital.

7.12 Priority theme three: Managing demand and flow through the system

A critical element in the better management of demand on the urgent and emergency care system is a need to ensure that people are empowered to take greater responsibility for their own health and social care needs and to be involved in the development of plans and the design of care packages of support to meet their needs. This must be complemented with changes to the way health and social care services work, bridging the gaps between different health professionals and between health and social care, which can result in the development of new and more patient-centred models of care. People’s needs should be managed as close to their home environment as possible, but when they need hospital-based care, their journey back to their home base should be as efficient and supporting as possible.

Self-care, prevention and improved management of long-term conditions through proactive support and care delivered through multi-disciplinary teams have the potential to reduce the impact on the flow of patients into urgent and emergency care. Improved patient knowledge, inclusion in the design of the their care package and the joining up and integration of services should deliver these benefits as people are cared for longer in their local environment rather than being regularly admitted to hospital for short periods of time. Access to rapid diagnostic services should also aid clinical decision making, reducing the occurrence of default risk-averse admission to hospital.

Safe and efficient clinical discharge is an important factor in the flow of patients through urgent and emergency care system and the necessary models of care including facilities and resources need to be available to enable safe and efficient discharge. Improved provision of intermediate beds and integration of health, social and community services that provide intermediate care should allow the timely and efficient discharge of patients. A significant proportion of the work relating to integration of health, social and community services for improved in-community and intermediate care is in the process of being delivered by the integrated care for adults programme, and the AWC new models of care based on the Oliver Wyman workshops will radically change the way care will be delivered. Delivery of self-care elements of this Priority Theme may occur in collaboration with or be delegated to ICB’s new self-care and prevention programme to increase coherence and reduce duplication. The urgent care programme will need to work very closely with these developments to ensure interdependencies are realised.
**Key elements**

- We will increase the capability of the general public to support their own care through a combination of targeted information and improved promotion of, and access to, primary care services as the main source of support for self-care. Public health campaigns will support awareness of and early diagnosis of the major conditions that affect the population of Bradford and AWC.
- We will increase the self-management capability of those with long-term conditions through the support of integrated teams of health, social and community care providers.
- We will embed the proactive management of long-term conditions through the integrated multi-disciplinary teams of health, social and community care services.
- We will develop, evaluate and implement new models of care for people with long-term conditions and complex needs.
- We will support care, nursing and residential homes to manage better the unscheduled need for urgent and emergency care.
- We will continue to develop the use of technology such as tele-health/medicine in those instances where there has been shown to be positive condition benefit, to provide patient reassurance and better management of their conditions.
- We will increase the flow of patients that are safe to be clinically discharged from hospital through better provision of intermediate beds and integration and availability of intermediary care services.
- We will facilitate and support discharge to patients’ homes, including care and residential homes, seven days a week.
- We will continue to develop pathways from primary care/home/community care to and from acute care to build a robust urgent and emergency care network across the Bradford and AWC footprint, and where appropriate with adjacent networks, to deliver a seamless, high quality and efficient patient experience.
- We will develop access to rapid diagnostics to support community-based clinical decision-making to manage better the need for admission to hospital.
- We will work with the 999 ambulance service to identify ways to reduce the incidence of 999 ambulance dispatch and, if one is dispatched, to reduce the need for conveyance to a hospital.

There are a wide range of activities that are already occurring, or planned to occur, that will contribute to the realisation of this priority theme, a selection of which is included below:

- Self-care comprises a wide range of existing activities spanning a range of conditions and services. It is an integral part of the integrated care for adults programme, and the Better Care Fund plan comprising the development of information packs, culture change programmes for staff and patients, and the City of Bradford Metropolitan District Council (CBMDC) First Contact service that aims to improve access to a range of services. An outline bid for £500,000 has been submitted to The Health Foundation to further develop these three key areas.
- CCG-led public health campaigns such as Bradford Beating Diabetes and Bradford’s Healthy Hearts are delivering tangible benefits in the early identification and management of these two conditions.
- There is a dedicated ‘Gold Line’ phone number provides 24/7 help and advice to seriously and terminally ill patients and their carers to support them in their preferred place of care.
• The Bradford City Expert Patient Programme provides courses to people to help them to manage their health condition and stay in control.

• Helping people with long-term and complex conditions through self- and proactive management is one of the prime goals of the integrated care for adults programme across Bradford and AWC. This is being achieved through the integration of health and social care professionals to provide seamless and coherent packages of care to patients. This work is also being supported through the national Avoidable Admissions Enhanced Service that aims to encourage GPs to play a greater role in this agenda.

• The Specialist Eating Disorder and Intensive Home Treatment (SPEEDIHT) service provides seven day support to reduce the need for hospital-based care for young people suffering from eating disorders and other mental health conditions.

• The Adult Mental Health Acute Care (AMHAC) pathway, which spans the three CCGs, provides community-based support for adults with mental health problems to facilitate better the flow of patients between hospital and community-based care.

• Supported by NHS England, new models of care are being developed and evaluated in AWC that could deliver a more radical approach to health and social care integration and transformation.

• AWC is using technology to support care homes (residential and nursing) through a new service that provides ‘virtual’ rapid specialist opinion to patients in these settings, and in their own homes. The service uses a live on-screen video link to enable hospital consultants to review patients and provide care or advice without the need for them to attend hospital. This service is being rolled out to 50 care homes in Bradford.

• The tele-health hub based at ANHSFT provides clinical and technical support services for patients who have an installation of a telemedicine and /or tele-health unit. In collaboration with local trusts, it provides a range of tele-health services on a 24/7 basis particularly for people with long-term conditions.

• Across Bradford and AWC, one of the key goals of the integrated care for adults programme is the delivery of an integrated intermediate care offer that supports more efficient discharge from hospital. The virtual ward – together with better mapping of community bed capacity and the pulling together of a several services into a single point of access hub - will bring significant benefits. The development of the virtual ward will begin this journey to more rapid access to diagnostic facilities as those that are “in” the ward will have the same access to diagnostics as someone in a hospital setting.

• The Airedale Collaborative care team (ACCT) not only helps to prevent unnecessary admissions but also provides 24/7 support to facilitate efficient hospital discharge.

• Yorkshire Ambulance Service is implementing initiatives that have the potential to reduce conveyance. For example they are working collaboratively with care homes to ensure that care home residents receive the right care in the right place, and the Paramedic Pathfinder initiative to support finding alternative pathways for patients.

7.13 Cross-cutting work streams

In defining the priority themes, it was evident that there were a number of delivery areas that underpinned all of the themes: communication and engagement, information sharing systems, estates, workforce development business intelligence and finance. It is envisaged that these will be embedded into each of the activities that will comprise the urgent care programme, building on the existing Systems and Infrastructure Programme that underpins the ICB portfolio.
7.14 **XC1: Communications**

We will develop and implement a communications plan to engage and inform the stakeholder community; patients, carers and general public about the services that are available to them, how best to use them, expectations of what they can receive from them and the benefits of self-care; health/social/community staff and stakeholders about the developments in the urgent and emergency care landscape and how to help patients and carers navigate their way to the most appropriate service, and all relevant stakeholders during the detailed design of the work programmes.

7.15 **XC2: Information sharing systems**

We will build on existing work in the integrated care for adults programme to ensure that clinical information can be shared between the different elements of the urgent and emergency care system, so that lack of patient information does not become a barrier to providing the best outcome for the patient. A key element of this will be the work planned for the delivery of a cross-system integrated digital care record to fully support urgent and emergency care, as one of the three national accelerator sites (Safer Hospitals, Safer Wards Technology Fund).

7.16 **XC3: Estates**

The implementation of this strategy, particularly around the creation of urgent, emergency and specialist emergency care centres, will require significant changes in physical infrastructure to ensure optimal configuration of services and facilities and modelling to ensure new facilities are future-proofed as much as possible. The final configuration and delivery of services should also take into account patient access including vehicular access, car parking and public transport. The required expertise will be built in as required by the individual work elements.

7.17 **XC4: Workforce development**

The implementation of this strategy will raise a number of workforce issues as it will involve new ways of organisational and/or individual working, which in some cases may include new and emerging roles. We will develop workforce development plan(s) that will firstly define the resource needed to deliver the services - including means to retain existing and attract new staff - and secondly, working with Local Education and Training Board, to ensure that staff have the necessary skills and knowledge to support the realisation of this strategy. These plans will build on, and where necessary, add to existing workforce development plans being implemented as part of integrated care for adults programme.

7.18 **XC5: Business intelligence and finance**

Wherever possible the development and delivery of the urgent care programme must be built on robust business intelligence to support the case for change, to evaluate options for implementation, and to measure the resulting benefits. Included within this stream is the continued development of the urgent care dashboard as a tool to monitor achievement of benefit. Assigning a monetary value to the initial estimates of benefit and to the actual realisation of benefit will be one element in determining the success of the programme.
8.0 **Critical success factors**

There are a number of factors that are critical to success of the realisation of this strategy:

- commitment of all stakeholders to implement the strategy
- engagement of the public and patients
- integration of health and social care provision that increases the proportion of people being treated in the community
- effective and efficient patient pathways across the urgent and emergency care system, supported by information systems that allow data sharing
- removal of barriers to access so that people can be seen or heard at a time and place convenient to them, by the right clinician
- services that are as accessible and personalised as possible so that they meet the different needs of all local people
- close working with the other ICB transformational programmes of change, particularly the integrated care for adults, self-care and prevention and transforming primary and community services programmes
- embedding of new skills, change behaviours and culture within internal and external stakeholders
- a collaborative partnership approach to delivery between commissioners and providers
- a critical mass of buy-in and leadership across the health, social and community system
- effective cross-agency working within the health and social care system and allied organisations such as West Yorkshire Police.
9.0 Expected benefits and local metrics

It is anticipated that the strategy will deliver the following benefits:

- improved patient experience and outcomes
- improved access to primary care
- improved quality of services
- better health outcomes within a sustainable workforce and financial envelope
- improved management of urgent and emergency care demand to reduce pressure on the acute elements of the system
- a right first time urgent and emergency care system that reduces inappropriate access
- reduction in bed days
- improved ability to meet and sustain nationally and locally agreed targets

To determine whether the strategy is delivering the expected benefits a number of local metrics will be used as key indicators of success, which may be refined as plans for delivery are finalised. It is not possible at this point to accurately define the quantum of change that is expected or possible as the urgent care programme, one of the key implementation vehicles for this strategy has yet to be developed. In addition, recent developments to expanded portfolio of programmes suggest that the delivery of some key elements could be delegated to these new programmes. As these newly proposed programmes have yet to be defined in detail, the scale of their impact in relation to this strategy cannot be determined.

It is therefore proposed that the key metrics to monitor the achievement of the strategy should be:

<table>
<thead>
<tr>
<th>Key metric</th>
<th>Expected direction of change and rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to access primary care</td>
<td>Measurable improvements in the ability of people to access primary care which, given the breadth of primary care, is expected to include the following: GP patient survey data (GP access); total number of calls to NHS 111 and reduction in calls related to key issues such as dental; increase in ability to meet the 95% targets for WYUC and reductions in maximum waiting time; number of people accessing the Pharmacy First scheme.</td>
</tr>
<tr>
<td>NHS 111 referral to primary care services or provided with self-care advice and guidance</td>
<td>Increase by x% of people are referred to alternative primary and community services such as Pharmacy First, WYUC, urgent care centres to reduce demand on A&amp;E, or provided with self-care advice.</td>
</tr>
<tr>
<td>YAS conveyance</td>
<td>Increase by x% in the number of people treated at the scene; reduction by x% of conveyance to A&amp;E.</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>Reduction by x% in A&amp;E footfall as patients are dealt with alternative urgent and emergency care services and pathways. The final definition of this key metric and the sub-metrics that contribute to it will, in part, depend on further guidance of how footfall through the proposed emergency/specialist emergency care and urgent care centres is counted.</td>
</tr>
<tr>
<td>Emergency Admissions</td>
<td>Reduction by x% as system-wide improvements to the management and support of patients and their conditions result in fewer admissions.</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Emergency admissions for ambulatory care sensitive conditions</td>
<td>Reduction by x% as new models of care are embedded and people are empowered take greater responsibility through self-care/self-management of their health and wellbeing.</td>
</tr>
<tr>
<td>Patients discharged from hospital per day</td>
<td>A flattening of the current discharge profile across Monday to Sunday due to the move towards 24/7 working across health and social care.</td>
</tr>
</tbody>
</table>
10.0 Governance and implementation

The realisation of the strategy will be dependent on the linkage between the delivery of activities that fall within the various remits of the programmes that comprise the Integration and Change Board (ICB) Portfolio of Programmes (Section 3.16) one of which is the Urgent Care Programme.

Some decisions about services will be made locally as they only impact the footprint of the three CCGs, whereas others, such as the number and locations of SECCs will be subject to discussions taking place on a West Yorkshire based footprint, in line with national guidance.

For operational delivery reasons it is recognised that delivery of this strategy across Bradford and AWC may require different approaches to reflect specific differences in populations in line with individual CCG strategic objectives and plans, which is reflected by separate programmes of activity.

In addition, the strategy has been developed at a time when the governance arrangements of the ICB portfolio of programmes is under review, so structures and reporting may be subject to change. The following diagram therefore depicts the current governance structures for the delivery of the strategy.
The Health and Wellbeing Boards (HWB)\(^7\) for North Yorkshire and Bradford and Airedale will be responsible for the overall alignment of this strategy within the broader health and social care economy of the districts.

The Integration and Change Board (ICB)\(^8\) will provide system-wide leadership and accountability for the overall cross-district strategic delivery of and integration between the programmes within the ICB portfolio (Section 3.16). ICB will

1) agree the scope of the urgent care programme within the wider portfolio of programmes
2) ensure that interdependencies across the portfolio are realised to maximise impact and outcomes, providing high level oversight, co-ordination and monitoring of implementation,
3) resolve strategic and direction issues across and between the programmes that comprise the ICB Portfolio.

The Bradford and AWC System Resilience Group\(^9\) (SRG) is a CCG-led forum where all partners across the Bradford and AWC health and social care system come together to undertake the assurance of service delivery. SRG plans for the capacity required to ensure delivery, and oversee the co-ordination and integration of services to support the delivery of effective, high quality accessible services which are good value for tax payers. SRG, as instigator and champion for this strategy, will ensure that the vision is turned into reality. SRG will:

1) annually review this strategy to ensure continued alignment with national and regional policy and programme developments
2) monitor the implementation of the strategy through progress and exception reports
3) provide assurance system resilience is not destabilised by implementation of the various elements of delivery
4) resolve strategic and direction issues between the individual projects that will deliver the programme of activity to implement this strategy

The Bradford Urgent Care Programme Board

SRG has delegated operational responsibility for the design, implementation and delivery of the Bradford Urgent Care Programme to a sub-group of the SRG which will

1) ensure robust plans are in place to deliver the urgent care programme
2) authorise the different phases and work programmes and projects associated with the implementation of this strategy

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\(^7\) Senior representatives from North Yorkshire County Council/Bradford Metropolitan District Council (elected members and senior officers, Clinical Commissioning Groups, NHS England, Healthwatch, Voluntary Sector and NHS Foundation Trusts.

\(^8\) Senior representatives from Bradford Metropolitan District Council, North Yorkshire County Council, Bradford District Care Trust, Bradford and AWC Clinical Commissioning Groups, NHS England, Bradford Teaching Hospital Foundation Trust and Airedale NHS Foundation Trust.

\(^9\) Clinical Chairs and senior representatives from the AWC, Bradford City and Bradford Districts CCGs, Bradford Teaching Hospitals Foundation Trust, Airedale NHS Foundation Trust, Bradford Metropolitan District Council Public Health and Social Care, NHS 111, Yorkshire Ambulance Service, Bradford District Care Trust, Community Pharmacy West Yorkshire, NHS England, Local Medical Committee (GP representation), Healthwatch Bradford (patients and general public representation) and Health Partnership Project (Voluntary and Community Sector representation).
3) monitor the risks and benefits of the implementation of the urgent care programme
4) work closely with the AWC transformation programme to ensure complementarity and co-ordination of projects and activities as required
5) provide assurance to the SRG that delivery is to plan

The AWC transformation programme

AWC plan to deliver the transformation of urgent and emergency care within the broader programme of change focussed on new models of care. Although the structure of their activities will not align with those proposed for Bradford, the end result of transformation will produce similar outcomes.

For this reason it has been agreed that AWC would have its own programme of activities, and that the prime governance should reside with their existing AWC Transformation and Integration Group, which is a Clinical Commissioning Group-led multi-agency committee that provides leadership and accountability for programmes of transformation and integration across AWC.

The AWC programme will report into SRG in its role as champion of the Urgent and Emergency Care Strategy, and to support its system resilience remit.

10CC and West Yorkshire Urgent and Emergency Care Network: Relationship with decisions on urgent and emergency care services across a wider West Yorkshire footprint

The health and social care economy of AWC and Bradford co-exists within broader geographic footprints, the main one being West Yorkshire. The 10 CCGs that cover West Yorkshire (10 CC10) plus Harrogate and Rural District CCG have come together to develop a high level strategic approach and leadership to issues that are considered a priority across West Yorkshire: stroke, paediatrics, urgent and emergency care, and cancer pathways. To drive each area forward 10CC set up four leadership groups to develop work plans and explore opportunities for planning and commissioning collectively and in collaboration with public bodies; the one responsible for urgent and emergency care is the West Yorkshire Urgent and Emergency Care Network (WYUECN). WYUECN membership includes senior representation from key providers and CCGs from across West Yorkshire, with AWC and Bradford representation essentially drawn from the local SRG.

The role of the AWC and Bradford representatives is to ensure that the views of AWC and Bradford are considered and reflected in recommendations made by WYUECB and 10CC and to communicate them back to the relevant commissioning and provider organisations and to SRG. There is no formal relationship between ICB and 10CC and WYUECN save through individual membership common to both groups. At the time of writing 10CC has not yet developed an agreed mechanism of making decisions that are binding upon its members. Its decision making ability is currently confined to the relevant delegated authority of its individual members.

An example of this that impacts on this strategy is the ambition for BTHFT to be designated as a Specialist Emergency Care Centre (SECC). The 10CC have agreed a time line for a recommendation to be made on the number and locations of the SECCs across West Yorkshire. The WYUECN has been tasked with reviewing the evidence base and proposing

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10 Chief Officers and Chairs of Leeds South and East, Leeds West, Leeds North, Bradford City, Bradford Districts, Airedale, Wharfedale and Craven, Calderdale, Greater Huddersfield, North Kirklees, and Wakefield CCGs
SECC options for West Yorkshire by end of January 2015, with final recommendations to 10CC by the end of March 2015. It is expected that these recommendations, which are in line with national requirements, will be communicated nationally to NHS England (NHSE) and locally via SRGs and CCGs. The final process for SECC designation is currently being worked through by NHSE and commissioners will ensure we work together through the relevant decision making arrangements and delegated authority to influence solutions that work for all of our local population and support our local strategies and priorities whilst meeting any nationally mandated elements of criteria and guidance.
Annex 1: Key policy documents and references

(1) Urgent care definition: http://www.nice.org.uk/guidance/qualitystandards/endolifecare/UrgentCare.jsp
(3) http://www.legislation.gov.uk/ukpga/2012/7/introduction/enacted
(5) Everyone Counts: Planning for patients 2013/14: NHS Commissioning Board
(9) High quality care for all, now and for future generations: Transforming urgent and emergency care services in England: The evidence base from the Urgent and Emergency Care Review: NHS England June 2013
(15) Bradford City CCG: Strategic Plan October 2012
(16) Bradford Districts CCG: Strategic Plan October 2012
(17) Airedale, Wharfedale and Craven Prospectus 2013/14
(23) Bradford NHS Foundation Trust Forward Plan Strategy 2013/14 - 2015/16: ANHSFT personal communication
(24) Bradford Teaching Hospitals NHS Foundation Trust draft clinical service strategy 2014-2019: BTHFT personal communication
(28) Bradford Urgent Care Research: How patients use healthcare services in Bradford: IPSOS MORI 2014
(32) Data and information from BHTFT and ANHSFT
(33) Yorkshire Ambulance Service data
(34) A&E data from the Secondary User service (www. HSCIC.gov.uk/sus/)
(35) http://www.gp-patient.co.uk/
(36) http://www.healthwatch.co.uk/news/nearly-fifth-confess-knowingly-using-ae-non-emergencies
(37) West Yorkshire Urgent Care data
(38) Commissioning better eye care November 2013
(39) NHS Confederation, Mental Health Network, Factsheet January 2014
(40) The King’s Fund, Long-term Conditions and mental health: the cost of co-morbidities, February 2012
(41) Discharge data from the Secondary User service (www. HSCIC.gov.uk/sus/)
(42) NHS services – open seven days a week: every day counts
http://www.nhsiq.nhs.uk/resource-search/publications/every-day-counts-seven-day-services.aspx
## Annex 2: Urgent and emergency care services available in AWC and Bradford

<table>
<thead>
<tr>
<th>Primary care</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medical practices</td>
<td>There are 85 GP practices in Bradford and AWC with approximately 609,000 registered patients. They provide access to a wide range of services including advice on health issues, physical examinations, diagnosis of symptoms, prescribing medication and other treatments and support for long-term and ambulatory case sensitive conditions. They are the preferred first point of contact for patients seeking reassurance and treatment for minor ailments and injuries. GP practices are open between 8am and 6.30pm Monday to Friday; some practices have limited evening and Saturday opening.</td>
</tr>
<tr>
<td>Dental practices</td>
<td>70 dental practices cover Bradford and AWC providing dental care mainly in working hours. There is limited access to emergency dental care out-of-hours.</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>There are 144 pharmacies within the three CCGs used primarily for the fulfilment of prescriptions and purchase of OTC medicines. 31 pharmacies are open over seven days a week, commonly between 8am and 11pm. Approximately 70-80% of pharmacies deliver advanced services such as medicines use reviews and/or the new medicines review. Some pharmacies also deliver locally commissioned services which include support for drug misuse, smoking cessation and sexual health services. Pharmacy First is a pilot operating in Bradford City and AWC, which allows pharmacies to provide advice over-the-counter medication, the latter free if the patient receives free prescriptions, for a defined list of self-limiting minor ailments.</td>
</tr>
<tr>
<td>Optometrists</td>
<td>66 opticians provide regular eye tests and eye health checks that can detect early signs of eye conditions such as glaucoma, as well as detecting underlying general health problems, including diabetes and high blood pressure.</td>
</tr>
<tr>
<td>Hillside Bridge Walk-in Centre</td>
<td>Situated in the east of Bradford, it provides access to GPs on a first come first serviced basis between the hours of 2 and 8 pm, seven days a week. Although badged as a ‘walk-in centre’, the service is appointment-based, with approximately 20 appointments available per day. The remit of the centre (Monday – Friday) is to see patients not registered in Bradford before 6pm, after which it can see patients from anywhere. At weekends it can see patients from anywhere.</td>
</tr>
<tr>
<td>West Yorkshire Urgent Care (out-of-hours service)</td>
<td>Provides access to GPs outside of the normal general practice working hours across the whole of West Yorkshire. Access is mainly via NHS 111 referral but patients can also self-refer to one of the four out-of-hours centres within AWC (Airedale General Hospital and Skipton Hospital) and Bradford (Bradford Royal Infirmary and Eccleshill Community Hospital). Most patients are seen at these centres but phone consultations and home visits are...</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
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<td>----------------------------------------------</td>
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<tr>
<td>NHS 111</td>
<td>Provides 24/7 phone advice, guidance and signposting to the whole of West Yorkshire. Service relies on triage using clinical algorithms to provide a diagnostic outcome. It can directly dispatch an ambulance or book at appointment at one of the WYUC centres. It is delivered against a national specification that is currently under revision.</td>
</tr>
</tbody>
</table>
| Bradford District Care Trust                 | Provides a wide range of services to people with community health, mental health and social care needs in addition to specialist support for people with learning disabilities:  
- mental health nurses  
- school nurses  
- psychiatrists  
- social workers  
- healthcare support workers  
- district nurses  
- health visitors  
- allied health professionals (eg psychologists, occupational therapists, speech and language therapists and podiatrists) |
| Community-based services commissioned and delivered by City Bradford Metropolitan District Council (CBMDC), North Yorkshire County Council (NYCC) and Craven District Council (CDC) | Provide a broad range of support and services including  
- residential and nursing care homes  
- day care centres  
- home care and enablement services  
- out-of-hours emergency social care, including approved mental health practitioners  
- equipment to facilitate people living at home |
<p>| Airedale Collaborative Care Team (ACCT)      | ACCT helps people to avoid admission to hospital, and assists in early discharge from hospital by supporting people in their own home or in-patient care beds. It offers rehabilitation programmes that meet individual’s needs to facilitate independence. The team consists of advanced nurse practitioners, nurses, occupational and physiotherapists, mental health nurse specialist, support workers and social care workers. The service is time limited to help support at time when health has deteriorated or more confidence is required. The service is available 24 hours per day, 365 days per year. |
| Out of Hospital emergency care               | Brief description                                                                                                                                                                                           |
| 999 and Yorkshire Ambulance Service (YAS)   | Region-wide service that covers AWC and Bradford to provide access to urgent and emergency services 24 hours a day seven days a week where there is a perceived urgent or emergency assistance. The 999 service will dispatch a response vehicle (eg double manned ambulance or rapid response vehicle) if appropriate. If the problem can be treated via the telephone, they will provide a ‘hear and treat (and refer)’ response. The ambulance service will either treat the patient in situ (‘see, treat and refer’) or treat and convey (‘see, treat and convey’) to an A&amp;E unit. YAS also provides a conveyance role for cases that require urgent admission or urgent treatment. |</p>
<table>
<thead>
<tr>
<th>In-hospital urgent and emergency care</th>
<th>Brief description</th>
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<tbody>
<tr>
<td>Airedale NHS Foundation Trust</td>
<td>A&amp;E services accessed by 50-55,000 residents per year, mainly from AWC area. Open 24 hours/day, seven days a week. Provides self-care, treatment of minor ailments and injuries, diagnostics, and a broad range of acute hospital services.</td>
</tr>
<tr>
<td>Airedale Centre for Mental Health</td>
<td>Co-located with Airedale General Hospital, this provides two acute inpatient wards for adults of working-age plus two older people’s mental health wards (one functional and one organic).</td>
</tr>
<tr>
<td>Bradford Teaching Hospitals NHS Foundation Trust</td>
<td>A&amp;E services accessed by 130-135,000 residents per year - predominately from the Bradford Districts and City areas - and provides several specialist services for west of West Yorkshire. Open 24 hours, seven days a week. Provides access to self-care, treatment of minor ailments and injuries, diagnostics, and a broad range of acute and specialist hospital services.</td>
</tr>
<tr>
<td>Lynfield Mount Hospital</td>
<td>A range of inpatient services including acute beds, a psychiatric intensive care unit, low secure services and an inpatient learning disability unit.</td>
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Annex 3: Linkage between NHS Outcomes framework and the objectives and work programmes of this strategy

<table>
<thead>
<tr>
<th>NHS Outcomes Framework</th>
<th>Keogh ‘system objectives’</th>
<th>AWC and Bradford urgent and emergency care objectives</th>
<th>Work programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>2. Increase my or my family/carer’s awareness of early detection and options for self-care and support me to manage my acute or long-term physical or mental condition.</td>
<td>To improve patient experience through the creation of a patient-friendly urgent and emergency care system that is open for business 24/7, easy to navigate, responsive to their needs and lifestyles, and treats them with respect and dignity.</td>
<td>Access and Convenience</td>
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<td></td>
<td>9. Information, critical for my care, is available to all those treating me.</td>
<td>To make primary care the default and first port of call for urgent care needs through clearly differentiated services with patients supported and guided through the system to find the right service for their needs.</td>
<td>Managing demand and flow through the system</td>
</tr>
<tr>
<td></td>
<td>10. Where I need wider support for my mental, physical and social needs ensure it is available.</td>
<td>To increase the people’s confidence to take greater responsibility for their own health and wellbeing through targeted information and support for self-care and through public health campaigns.</td>
<td>All cross-cutting work streams</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To reduce the incidence of hospital-based care through alternative comprehensive community-based support and management of frail and vulnerable people and those with long-term conditions, through increased use of technology to facilitate remote consultation and support, and ambulatory pathways that minimise the need for conveyance to hospital-based services.</td>
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<td></td>
<td>To improve patient outcomes by ensuring that the patient is seen quickly by the right clinician/health professional first time, that the pathways between the different elements of urgent and emergency care are seamless, efficient and user-friendly, underpinned by effective sharing of patient data.</td>
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Enhancing the quality of life for people with long-term conditions

2. Increase my or my family/carer’s awareness of early detection and options for self-care and support me to manage my acute or long-term physical or mental condition.

9. Information, critical for my care, is available to all those treating me.

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To reduce the incidence of hospital-based care through alternative comprehensive community-based support and management of frail and vulnerable people and those with long-term conditions, through increased use of technology to facilitate remote consultation and support, and ambulatory pathways that minimise the need for conveyance to hospital-based services.

To increase the people’s confidence to take greater responsibility for their own health and wellbeing through targeted information and support for self-care and through public health campaigns.

To reduce the need for acute admission through alternative community-based services provision and, when admission is necessary, to improve the flow of patients through hospital-based urgent and emergency care through enhanced provision and management of intermediate care services and beds.

To improve patient outcomes by ensuring that the patient is seen quickly by the right clinician/health professional first time, that the pathways between the different elements of urgent and emergency care are seamless, efficient and user-friendly, underpinned by effective sharing of patient data.

Helping people recover from episodes of ill-health or following injury

5. Improve my care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway.

10. Where I need wider support for my mental, physical and social needs ensure it is available.

To reduce the need for acute admission through alternative community-based services provision and, when admission is necessary, to improve the flow of patients through hospital-based urgent and emergency care through enhanced provision and management of intermediate care services and beds.

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Acute and specialist services
Managing demand and flow through the system
All cross-cutting work streams
<table>
<thead>
<tr>
<th>11. Each of my clinical experiences should be part of programme to develop and train the clinical staff and ensure their competence and the future quality of the service is constantly developed.</th>
<th>Emergency care are seamless, efficient and user-friendly, underpinned by effective sharing of patient data. To reduce the incidence of hospital-based care through alternative comprehensive community-based support and management of frail and vulnerable people and those with long-term conditions, through increased use of technology to facilitate remote consultation and support, and ambulatory pathways that minimise the need for conveyance to hospital-based services.</th>
<th>All cross-cutting work streams</th>
</tr>
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<tr>
<td>Ensure people have a positive experience of care</td>
<td>1. Make it simpler for me or my family/carer to access and navigate urgent and emergency care services and advice.</td>
<td>To improve patient experience through the creation of a patient-friendly urgent and emergency care system that is open for business 24/7, easy to navigate, responsive to their needs and lifestyles, and treats them with respect and dignity.</td>
</tr>
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<td></td>
<td>3. Increase my or my family/carer’s awareness of and publicise the benefits of ‘phone before you go’.</td>
<td>To make primary care the default and first port of call for urgent care needs through clearly differentiated services with patients supported and guided through the system to find the right service for their needs.</td>
</tr>
<tr>
<td></td>
<td>4. If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.</td>
<td>To increase the people’s confidence to take greater responsibility for their own health and wellbeing through targeted information and support for self-care and through public health campaigns.</td>
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<td></td>
<td>6. Wherever appropriate, manage me where I present (including at home and over the telephone).</td>
<td>To reduce the incidence of hospital-based care through alternative comprehensive community-based support and management of frail and vulnerable people and those with long-term conditions, through increased use of technology to facilitate remote consultation and support, and ambulatory pathways that minimise the need for conveyance to hospital-based services.</td>
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<td></td>
<td>7. If it's not appropriate to manage me where I present (including at home and over the telephone), take or direct me</td>
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<tr>
<td></td>
<td></td>
<td>All cross-cutting work streams</td>
</tr>
<tr>
<td>Treating and caring in a safe environment and protect them from avoidable harm</td>
<td>4. If my need is urgent, provide me with guaranteed same day access to a primary care team that is integrated with my GP practice and my hospital specialist team.</td>
<td>To deliver high quality and responsive hospital-based emergency care through dedicated Specialist emergency/Emergency Care Centres supported by real-time access to diagnostics.</td>
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<td>5. Improve my care, experience and outcome by ensuring early senior clinical input in the urgent and emergency care pathway.</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>over the telephone), take or direct me to a place of definitive treatment within a safe amount of time; ensure I have rapid access to a highly specialist centre if needed.</td>
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