Urgent Care Strategy
2015 – 2020
Approved by Governing Body
15 March 2016
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NHS East Riding of Yorkshire CCG - Urgent Care Strategy, March 2016
1 Purpose

East Riding of Yorkshire Clinical Commissioning Group’s (ERYCCG) Urgent Care Strategy sets out our intentions for commissioning urgent and emergency care across East Riding of Yorkshire. This includes our vision and proposed urgent care commissioning model.

A planned approach over the next five years will be necessary to achieve the required service transformation. It will require further engagement with our service users, carers, the public, our partners and our staff so that their views shape what we do. We recognise also that more detailed planning and modelling will need to be undertaken to understand what is achievable within the constraints and challenges of the current environment to deliver the strategy and achieve the aim of improving the experience and outcomes of people needing access to urgent care services within the boundaries of the East Riding.

1.1 Scope of urgent care

Urgent care involves a response to any unplanned contact within the NHS by a person requiring or seeking help, care or advice. Urgent care includes unplanned care and emergency care. Demand can occur at any time and services need to be available to meet this demand 24 hours a day.

2 National drivers

A national review of Urgent and Emergency Care in 2013 recognised the need for functional urgent care integration across the NHS, to deliver better outcomes and make accessing urgent advice and treatment much less confusing for people.

The review has resulted in the development of a national specification and standards for urgent and emergency care services (‘Safer, Faster, Better: good practice in delivering urgent and emergency care. A Guide for local health and social care communities’ – National Health Service England (NHSE), August 2015). These are intended to support commissioners in achieving a fundamental redesign of NHS urgent care and deliver a functionally integrated 24/7 urgent care service which provides the public with access to both treatment and clinical advice. This will include NHS 111 providers and GP Out-of-Hours (OOH) services, community services, ambulance services, emergency departments and social care.

Implementation of the Urgent and Emergency Care Review and the National Health Service England (NHSE) requirements emerging from this, is a priority for commissioners. An initial focus is the establishment of Urgent and Emergency Care Networks, across a wider footprint, to work strategically with local System Resilience Groups which will provide an operational focus across their local health economy. This Strategy supports implementation of the review.
and re-design of unplanned care for the East Riding of Yorkshire, within the wider footprint of the Urgent and Emergency Care Network.

The Strategy is also consistent with the Francis report (2013) which calls for a fundamental change in culture in the NHS, whereby the patient’s care and safety should be put first, with the patient being the priority in everything we do.

3 Local drivers

The local urgent and emergency care system is fragmented with discrete services such as NHS 111, general practice, emergency departments, the ambulance service, walk-in centres and Minor Injury Units, all offering a slightly different range of services available at varying times. This fragmentation of services, with different organisations working alongside each other without any clear and shared agreement about governance, potentially puts both staff and patients at risk.

In the current disjointed system, it is not clear who is responsible for care as patients move across organisational boundaries. The existing governance regime and reporting does not cover all patients and the whole of their episode of care. Where a service works with many others, such as NHS 111, mechanisms are not fully in place to promote direct feedback from the providers so that issues at the interface point are addressed.

The health and social care needs of the population of the East Riding of Yorkshire are also changing. A combination of an ageing population, the changing expectations people now have around the timely care they receive, an emerging evidence base of the benefits of care closer to home, the growing advantages and expectations of technology and a predicted increase in demand will all place additional pressures on this health and social care economy. In particular:

- there is a significant increase in the number of frail and elderly people in the population who require higher levels of care
- the need to deliver services to a rurally dispersed population spread over 1000 square miles (2590km2)
- the need for better understanding amongst patients, the public and professionals of the unplanned care services available and how to access them
- no Emergency Services/Accident & Emergency (A&E) Department on the patch, with the nearest centre located at Hull in addition to unplanned care being provided locally through a series of Minor Injury Units (MIUs)
- low utilisation of MIUs and an over-reliance on A&E - nationally, only 8% of attendances to A&E are ‘blue light’ and this is reflected locally
- significant confusion regarding access and navigation through unplanned care
Stringent financial constraints also exist, with health budgets only seeing small increases in real terms. This is compounded by an increasing and ageing population which will put increased demand on health services. This means we will have significant challenge in delivering our Urgent Care Strategy within our existing and future resources, requiring sign up to achieving the desired outcomes and collaborative working by organisations from all sectors across the whole health system. It also means local people will need to be aware of and support the changes that will need to be made to deliver our ambition for urgent care.

The CCG is re-procuring community services, which includes minor injuries services, step up and step down beds and out of hours GP services. The Urgent Care Strategy recognises the key interdependency with the community services programme and consideration of the impact of the community services procurement will need to inform the Urgent Care Strategy implementation. This includes consideration of whether there is a need for formal consultation to ensure an appropriate and co-ordinated response, enabling the views of local people, particularly service users and carers, to be taken fully into account.

4 Where we are now

Unplanned care in the East Riding forms part of a complex healthcare system with a range of professionals including GPs, nurses, pharmacists, independent nonmedical prescribers, dentists, ambulance personnel, community clinician’s, ED (A&E) staff, specialist stroke, cardiac and trauma centres as well as out of hours GP services and MIUs. The most common points of access to emergency and urgent care services in the minds of the public remain 999, A&E Departments and General Practice. Current urgent and emergency care services are configured as shown overleaf:
Growth in the number of people in the East Riding using urgent and emergency care is leading to mounting costs and increased pressure on resources. Current unplanned care provision in the East Riding shows fragmentation of the system and inconsistent service provision. This means that patients are less able to access the most appropriate urgent or emergency care service to suit their needs, leading to duplication and over-use of services such as A&E.

The current configuration of Urgent Care Emergency (A&E) Department facilities is at Hull Royal Infirmary, Scarborough, York, Scunthorpe and Grimsby Hospitals.

Implementing our Strategy will involve reviewing and the re-design of the Six Minor Injuries Units across the East Riding, to develop a model for delivering a service to a national specification and standards, in a network with other urgent care services and A&E Departments. This will require significant leadership and collaboration across all organisations involved in commissioning and delivering urgent and emergency care across the Humber and North Yorkshire sub-region.
In line with the national review outcomes, the local situation shows a need for all parts of the local urgent and emergency care system, including A&E, Urgent Care Centres, Minor Injuries Units (MIUs), GPs, pharmacies, the ambulance service, NHS 111 and crisis response teams to work in a more joined up way as part of a single system, well understood by people when they need care and advice. Key to this is closer collaborative working with Hull CCG and Hull and East Yorkshire Hospitals NHS Trust to look at how the urgent care pathway can be simplified, coordinated and integrated around populations, with community-based services wrapped round primary care facilitating flow through clear and simplified pathways.

Home needs to be the default setting for care, or care delivered as locally as possible and people need to be supported by community teams which include the social care and voluntary sector, co-ordinated by GPs with access to hospital specialists, delivering a primary care led response to urgent and emergency care needs which is part of the wider unplanned care network. All of this requires a transformation of care locally to provide one system that is easy to use and that makes best use of all the resources wherever they may be. The evidence base shows the underlying challenges demand a joined up response across all services. It will also require effective engagement with local people to ensure they understand, inform and shape the changes we need to make.

4.1 Current funding

The table below illustrates the level of funding the CCG allocated to unplanned care services during 2014/2015:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor Injury Units/GP Out Hours</td>
<td>£4.745m</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>£6.280m</td>
</tr>
<tr>
<td>NHS 111</td>
<td>£0.6m</td>
</tr>
<tr>
<td>YAS</td>
<td>£11.618m</td>
</tr>
<tr>
<td>Total</td>
<td>£23.238m</td>
</tr>
</tbody>
</table>

5 Our vision

Our vision for urgent care is:

Patients receive treatment in centres with the right facilities and expertise whilst also assuring that individuals can have their urgent care needs met by services as close to home as possible whilst providing a safe, sustainable and affordable service.
This will mean a fundamental shift in the way urgent and emergency care services are provided, improving out of hospital services so that more care is delivered closer to home with reduced hospital attendances and admissions. This needs to be within a system which is safe, sustainable and that provides consistently high quality.

Our ambition is to develop an integrated approach to urgent and emergency care, particularly emergency medical admissions to hospital, involving hospitals, community, primary care and ambulance services through joint service planning and sharing of clinical information across different agencies.

In line with NHS England’s Review outcome and represented in the diagram below, our vision for integrated urgent and emergency care services will ensure that patients with more serious or life threatening emergencies receive treatment in centres with the right facilities and expertise (red section of the diagram), whilst also assuring that individuals can have their urgent care needs met locally by services as close to home as possible (blue section of the diagram):
Reflecting the requirements emerging from the national Review, the CCG will work with the Hull and East Riding System Resilience Group to ensure the effective delivery of urgent care in the East Riding of Yorkshire, in coordination with an overall urgent and emergency care strategy collaboratively developed and agreed through the regional Urgent and Emergency Care Network. This Network has been established collaboratively by CCG’s and other partners across an agreed North Yorkshire and Humber footprint.

6 How stakeholder engagement has shaped our strategy

We have worked closely with our community in seeking the views of patients, carers and the public prior to developing the Strategy. Feedback from surveys and engagement events involving patients, carers and the public has helped us to understand what matters to local people as we plan services and has been used to shape this Strategy.

Our engagement activity has included:

<table>
<thead>
<tr>
<th>Engagement Activity</th>
<th>When</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Insight Research (Polling Survey)</td>
<td>March 2014</td>
<td>1,150</td>
</tr>
<tr>
<td>Urgent Care ‘Afternoon Tea with the NHS’ events’ – Cottingham and Bridlington</td>
<td>February 2014</td>
<td>25 in total</td>
</tr>
<tr>
<td>Community Care Commissioning Strategy Engagement Events</td>
<td>February 2014</td>
<td>160</td>
</tr>
<tr>
<td>Patient and Public Survey</td>
<td>March – June 2013</td>
<td>38</td>
</tr>
</tbody>
</table>

The results from the Public Insight Research in March 2014 indicated that people viewed other options to reduce the number of people using A&E unnecessarily as:

- Minor Injuries service - 83%
- Services you can get from your GP practice outside normal working hours - 77%
- Minor ailments service - 70%
- Access to someone who could give you advice on your condition - 64%
- Access to a bed in the community where you could be cared for and helped with recovery - 64%
- Access to health and social care workers who could support you in your own home - 54%
- NHS 111/Other - 48%

The feedback emphasises that all of the possible options are good potential ways for lowering the amount of people using A&E departments unnecessarily but that some are better than
others. People also expressed the view that there should be a focus on educating them about the uses of A&E and other NHS services to ensure proper usage of services in the future.

Responses to the **GP Out of Hours Survey** in March 2014 helped us to understand that people see the most and equally important considerations in providing urgent care are:

- waiting times
- the advice and treatment provided
- trust and confidence in the service

The majority of people requested that a priority consideration when planning services should be the rurality of the East Riding of Yorkshire area, with services provided in locations accessible by public transport and located to provide equitable access to everyone in the East Riding as far as is possible with an agreed maximum travel distance or travel time.

It was also expressed that vulnerable people, particularly those who are elderly, would need special consideration to ensure that they received a good quality service that was equitable in relation to the wider population. Things it was felt needed to be particularly considered were:

- keeping waiting times as short as possible
- keeping travel distances to a minimum
- being especially mindful about meeting the needs of vulnerable people

People who attended the **Urgent Care ‘Afternoon Tea with the NHS’ events** in February 2014 provided rich feedback about both urgent care and better self-management support for people with long term conditions:

- investment in the workforce is important to ensure quality of care in terms of capacity, specialist and adequate care
- people want care to be patient centred by considering the individual’s circumstances and patient choice, with quality of care and communication seen as important in providing patient centred care
- access to treatment and services are restricted by lack of parking and spaces reserved ambulance services and the duration of waiting times
- people wanted better communication with patients and between departments and primary and secondary care
- emergency patient diversionary pathways infringes on patient choice and access for visiting relatives; unplanned care should be available locally without an appointment as access to adequate advice affects their decision to call an ambulance
• Staff awareness, training and consideration for vulnerable groups such as dementia, mental health and learning difficulties is important when they are accessing services; the Butterfly scheme, patient passport and Learning Disability liaison workers were all cited as important elements to enable people with learning disabilities effective access of mainstream service

• People expressed strongly the need to recognise the importance of clinics and self-care education.

• Self-management of conditions was generally supported but is dependent on relevant and accessible medication, advice, education and support

• There was a clear view that those with long term conditions who know their condition and what urgent care is required should have access to medication and treatment without having to go through the formal pathway

The following themes emerged from a patient and public survey between March – June 2013:

• The MIUs in the East Riding all open at different times of the day and days of the week providing different levels of service which is confusing to both patients and health care professionals

• MIUs are sometimes not very busy when they are open

• People think it is better to have fewer number of MIUs open with extended hours than a multiple number of MIU locations with shorter opening times across ERY

• People think the types of services we currently offer in a MIU unit is about right

The survey response to flexible use of the MIU indicated that people think:

• All MIUs should have x-ray facilities

• Other services that could be offered include:
  o Assessment for older people who have had a fall or general ill health deterioration who might otherwise end up in A&E needlessly
  o Drop in clinics for LTC or dementia support
  o First aid courses
  o Minor ailment reviews, advice and support
  o Physiotherapy for management of acute musculoskeletal injuries
  o Podiatry for foot and toenail problems

• It would be better to call it minor illness service not minor injuries

In line with the national review outcomes, feedback from local people through engagement activities strongly suggests that navigating the unplanned care system is confusing for the public and people would prefer to access local Minor Injuries or GP services for urgent (non-emergency) care. We also recognise that local people view General Practice as central to
future service planning because it is regarded as a trusted, local and reliable point of contact for health care needs.

The wealth of feedback and comments provided so far has formed a robust starting point in developing and shaping our Strategy. The CCG recognises that actively engaging with local people, service users and carers is central to further developing the model for services local people need and the outcomes that are most important to them. We will develop a communications and engagement plan as a key part of further developing and implementing our Urgent Care Strategy. Through this we need to help people to understand and seek support for the changes we will need to make to our existing services so that we can implement a new model that will deliver our vision for urgent and emergency care.

7 Our desired outcomes

Delivering a fully integrated urgent and emergency care service will be key to realising our aspirations. We will further develop measures and indicators, collaboratively with local people, service users, carers, partners and staff, to monitor our progress in delivering our desired outcomes, outlined below:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>What does this look like?</th>
<th>What is the measureable outcome?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved health outcomes through addressing poor practice, improving care continuity and reducing admissions to hospital.</td>
<td>More people have access to timely, high quality, cost effective urgent care services in the right setting whilst ensuring that the population knows how to access the right care, in the right place at the right time.</td>
<td>• Reduction in attendances at A&amp;E.</td>
</tr>
<tr>
<td>Improved patient experience through making the urgent and emergency care system easier to navigate.</td>
<td>Standardisation of urgent and emergency care services with effective signposting to help patients choose the right service.</td>
<td>• Number of people accessing urgent and emergency care through primary care and community urgent response and Minor Injuries Centre/services/UCCs. • Patient experience feedback indicating satisfaction with urgent and emergency care. • People’s health records are available to NHS 111 and people are booked in by NHS 111 to the right service for them, when convenient for them.</td>
</tr>
<tr>
<td>Outcome</td>
<td>What does this look like?</td>
<td>What is the measureable outcome?</td>
</tr>
<tr>
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<td>----------------------------------</td>
</tr>
<tr>
<td>More cost-effective care through integrated urgent and emergency care services that manage demand more effectively.</td>
<td>An integrated urgent and emergency care system which is safe, sustainable and that provides consistently high quality and value for money.</td>
<td>• Hospital emergency admission rates for acute exacerbations of urgent conditions that could be managed out of hospital or in other settings without admission to an inpatient bed.</td>
</tr>
</tbody>
</table>

### 8 Realising our vision

This Strategy builds on the national core vision and commissioning standards for Urgent Care which embeds NHS 111 as the point of access for all patients. This will lead to a transfer of care into fully integrated urgent care services in which organisations collaborate to deliver high quality clinical assessment, advice and treatment, to consistent standards and processes and with clear accountability and leadership.

Central to this will be the creation of a ‘Clinical Hub’ offering patients who require it access to a wide range of clinicians but also offering advice to health professional in the community so that no decision needs to be taken in isolation. The ‘Hub’ is a new feature of the national model and will be developed collaboratively across a wider footprint but integral to local urgent and emergency care services.

The national specification requires clinicians in the Hub to be supported by access to clinical records such as Special Patient Notes* (SPN) and the Summary Care Record** (SCR). In line with this and other requirements, such as direct booking, implementation of our Strategy will place a greater focus on increasing local IT system interoperability over time, to support cross-referral and the direct booking of appointments into other services.

* **Special Patient Notes** – this is information recorded about people with complex health and social care needs that is made available, shared in advance or at the time of consultation to enable health professionals to effectively meet the needs of these individuals. It is especially important for out of hours services who are unlikely to have any prior knowledge of a patient that they need to assess.

** Summary Care Record – an electronic record that contains important information about medicines an individual is taking and any allergies from or bad reactions to medicines that the person has previously experienced. Authorised healthcare staff have access to the SCR to improve decision making and provide clinicians treating patients in an emergency or out-of-hours with faster access to key clinical information.
Working as part of the Urgent and Emergency Care Network (8.1.1), our aim is to develop an integrated urgent and emergency care service, supported by an integrated clinical advice service (Clinical Hub) which will enable delivery of a functionally integrated urgent care service based on the national specification and standards, illustrated diagrammatically below:

In this way, the current unplanned care system will be transformed to provide a systematic, integrated model of urgent and emergency care services, both community and hospital based, across the CCG’s footprint, 24 hours a day 7 days a week, with capacity to flex to meet local patient needs.

The new system will provide clearer navigation for individuals to enable them to choose the most appropriate service for their clinical condition with appropriate decision making when an individual perceives that an urgent care need exists. This will enable us to meet our NHS Constitution targets (see Appendix 1), together with implementing the recommendations in the national Review.

Redesigning the urgent and emergency care system is likely to be highly challenging and will require effective collaborative working with Network and other local partners. An Action Plan and timescales to deliver the changes required will need to be agreed by both CCGs and providers, working together, with a focus on the national requirements such as the Clinical Hub, but also on:

- providing effective signposting to help patients choose the right service
ensuring that hospital and community services can adjust service levels in response to changes in demand, so that need and provision are kept in balance

- ensuring that A&E departments adopt best practice for handling 'majors' including early senior review
- ensuring that hospitals and local authority social service and housing departments work effectively together to reduce delayed discharges and shorten lengths of stay
- mapping and analysing patient flows around the system to identify bottlenecks and the scope for changing pathways to reduce the use of hospitals and to ensure that there is sufficient capacity across the health and social care system

8.1 Our urgent care model

Development of our local urgent care model will be based on the following principles:

- provides consistently high quality and safe care, across all seven days of the week
- is simple and guides good, informed choices by patients, their carers and clinicians
- provides access to the right care in the right place, by those with the right skills, the first time
- is efficient and effective in the delivery of care and services for patients
- care provided by services as close to home as possible

Our model will be based on the national Commissioning Standards for Integrated Urgent Care and the national commissioning specifications (NHS England: Commissioning Standards Integrated Urgent Care September 2015), reflecting the integration of all elements of urgent and emergency care, with reconfiguration of the minor injuries service and optimising the use of facilities. The model will incorporate the requirement for robust governance arrangements, with alignment of urgent and emergency care services with agreed local A&E Departments to provide clinical supervision, support and advice. The model will be developed through consultation with service users and carers, clinicians, and other health, social care and voluntary sector partners across our local health economy.

In implementing the national guidance and cognisant of the need to make best use of scarce capacity and resource in Primary, Community and Secondary Care, with no A&E Department on patch, our current thinking is to reconfigure the minor injuries service, including consideration of consolidating Urgent Care Centres (UCCs) with A&E departments in line with the national specification and developing a primary care and community urgent response. To realise this ambition and new model for urgent care we will need to work with partner and provider organisations to identify the changes and action required across all areas of our existing urgent and emergency care provision, as outlined in the next few pages:
8.1.1 Urgent and emergency care network

The national review outlined the need for CCGs to work together across a larger footprint and national guidance requires that an Urgent and Emergency Care Network is collaboratively commissioned to the national specification and across a comparable catchment population. Developing the Network will include the integration of Urgent Care Centres (UCCs) and Minor Injuries services in a wider network of Acute A&E departments. This will enable robust clinical governance through clinical leadership, access for UCC clinicians to specialist emergency clinician support and training and development of the workforce, including potential rotation of staff across service areas to maintain and develop skills.

To meet the national Review outcomes, our Strategy recognises the need to work collaboratively with CCGs and other partners across the wider North Yorkshire and Humber footprint, as part of the Urgent and Emergency Care Network, developing a clear and active role within the Network to shape the overall plan for development of urgent care across the footprint.

<table>
<thead>
<tr>
<th>Action No.</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>N1</td>
<td>Agree and establish Network footprint</td>
<td>December 15</td>
</tr>
<tr>
<td>N2</td>
<td>Design and agree Network model, including governance arrangements</td>
<td>March 16</td>
</tr>
<tr>
<td>N2</td>
<td>Develop a collaborative plan for delivery of urgent and emergency care deliverables, including:</td>
<td>June 16</td>
</tr>
<tr>
<td></td>
<td>• a Clinical Hub</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• access to specialist advice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• establishment of green ambulance calls</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• identify the urgent care facilities for designation</td>
<td></td>
</tr>
</tbody>
</table>

8.1.2 Major trauma network

The configuration of acute provider sites within the Major Trauma Network of North Yorkshire and Humber, which went live in April 2012, is:

- York Hospital – A&E Department
- Scarborough Hospital – A&E Department
- Hull Royal Infirmary – A&E Department and Major Trauma Centre
- Scunthorpe General Hospital – A&E Department
- Diana Princess of Wales Hospital, Grimsby – A&E Department

Major trauma service requirements are the commissioning responsibility of both local and specialist commissioners, with distinct pathways for adults and children. Our
Strategy is to make sure the development of our model includes integration of major trauma pathways, based on agreed principles of specialised care, working closely with local trauma units. This will include review of how of specialist rehabilitation is commissioned to support this element of the model.

<table>
<thead>
<tr>
<th>Action No.</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>Align Urgent Care and Major Trauma Networks through agreed collaborative process</td>
<td>TBC</td>
</tr>
<tr>
<td>T2</td>
<td>Ensure network design includes major trauma sites and processes, including governance arrangements</td>
<td>TBC</td>
</tr>
</tbody>
</table>

8.1.3 Primary care led minors department
Access to the A&E Department is classified as a ‘minor’ (access on foot and are not seriously ill) or a ‘major’ (access usually by ambulance and the person is seriously ill).

In developing the urgent care service we will work with Hull and East Yorkshire Hospitals NHS Trust to consider options for the development of an Urgent Care Centre which includes a primary care-led minors stream in the A&E Department at Hull Royal Infirmary, to optimise this service and impact on flow of people through A&E. This means people accessing the A&E Department on foot will be appropriately triaged and directed to the appropriate response which will be to see a primary care clinician within A&E and not other pathways through the A&E Department that are appropriate to people who are seriously ill. This will significantly improve the current service at HRI which is provided exclusively by GPs, is not 24/7, has no direct booking facility and inconsistent patient flow through the stream.

We will also work with York Teaching Hospital NHS Foundation Trust, in collaboration with Scarborough and Ryedale Clinical Commissioning Group, to implement a 24/7 primary care-led minors stream in the A&E Department at Scarborough Hospital during 2016. This will support the delivery, in both Hull and Scarborough, of the right care for people who attend A&E who can be managed though a minors response, reducing inappropriate use of the A&E service. Scunthorpe General Hospital has developed a minors streaming process as part of a recent re-configuration of the urgent care service.

To achieve our ambition in the East Riding, we will develop a model that has GPs, together with other clinicians and healthcare professionals, such as nurses with practice nurse skills and pharmacists, delivering a minors service. Appropriate referrals to this stream by the A&E reception will improve patient flow through the A&E department and ensure patients presenting with urgent care needs that can be managed by a primary care urgent care response are directed appropriately. The
primary care urgent care response will include direct management, signposting to another service or directly booking an appointment with the patient’s GP, as appropriate. Direct booking would also be a feature of the UCC described in 8.1.4 where it is expected that GPs would be able to directly book patients into appointments in the UCC.

<table>
<thead>
<tr>
<th>Action No.</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>Work collaboratively with HEYHT to design model for primary care led minors service</td>
<td>July 16</td>
</tr>
<tr>
<td>M2</td>
<td>Agree pathways and streaming</td>
<td>July 16</td>
</tr>
<tr>
<td>M3</td>
<td>Work with Hull and East Yorkshire Hospitals NHS Trust to develop an option for an Urgent Care Centre at Hull Royal Infirmary</td>
<td>TBC</td>
</tr>
</tbody>
</table>

8.1.4 Urgent care centres and minor injuries service

There are currently Six Minor Injuries Units (MIUs) across the East Riding. As detailed in the CCG’s Community Services Strategy (2014 – 2016), utilisation of the existing Units is low, with an over-reliance on A&E, particularly in Withernsea, Hornsea and Driffield, in addition to difficulty in staffing the Units. Understanding whether the current MIU service provision represents consistency, equity of access, best use of resources and value for money to deliver the desired outcomes is a priority.

As part of producing an action plan to implement the Strategy, the CCG has reviewed the current Minor Injuries service provision and will further consult with local people to understand their views so that appropriate action can be identified in relation to MIUs, recognising the challenge of delivering a re-design of MIUs, in line with national requirements, within an environment of significant financial constraints.

Based on likely affordability and sustainability, the CCG could consider the following options:

1. Establish Urgent Care Centres co-located with Emergency (A&E) Departments
2. Establish an Urgent Care Centre in the East Riding – would allow delivery of national specification within affordability and sustainability requirements but would provide an Urgent Care Centre in one location only
3. Consolidate services in fewer centres as MIUs (not UCCs) with standardised hours, diagnostics and better use of technology, co-located with GP Out-of-Hours and linked to a UCC at Hull and Emergency (A&E) Departments
4. Status quo remains – continuation of inequality of provision and low value for money; national criteria not met
Modelling work to understand the impact of a re-design of the existing MIUs and further consultation with local people will need to be completed to inform the options for the re-design of MIUs.

In line with national requirements and the re-design of MIU’s, the CCG will work with Hull and East Yorkshire Hospitals NHS Trust to consider an option to develop an Urgent Care Centre at Hull Royal Infirmary. This would be accessible 7 days of the week and integrated into the wider urgent and emergency care network ensuring appropriate clinical governance (see section 8.1.1).

In line with the national specifications for UCCs and minor injury services, a range of diagnostics would need to be available in UCC within agreed times. Technology is central to the service to enable MIUs and UCC to provide clinical support to each other and link with A&E departments for access to senior decision makers and specialist support. The clinicians would have access to a range of pathways including:

- Booking / referring patients into alternative health and social care services
- Step up beds / homecare
- Pharmacy support
- Delivery of home visits

Wherever possible patients would access Urgent Care and Minor Injuries Units/services through the integrated 111 service but there would also be capacity in UCCs and MIUs to see patients who self-present. Pathways would be developed in collaboration with the ambulance service to ensure patients are brought to the UCC or MIUs, if clinically appropriate.

**8.1.5 Primary care and community urgent response**

Primary care, integrated with social care and nursing teams in the community, will play a vital role in delivering accessible urgent and emergency care. Our Strategy will review the current support to Primary Care to ensure better integration with MIUs, UCCs, out of hours provision and community services. This will improve both the access and response to same day urgent care requests in general practice, with reduction in clinical variation and the number of people attending the Emergency (A&E) Department at hospitals.

Delivery of a primary care and community urgent response described in this Strategy will focus on better integration of existing community services to enhance delivery of urgent and emergency care by both Primary and Community services.
This will include:

1. Development of a primary care and community urgent care response through:
   - Primary Care better supported in new ways of working eg, telemedicine
   - Focus on treating illnesses best managed by in and out of hours GPs and community pharmacists that would otherwise gravitate to Minor Injuries Units/Urgent Care Centres or Emergency (A&E) Departments
   - Community services designed to work with Primary Care in preventative care and support after an urgent care episode

2. Implementation of agreed ambulance diversionary pathways eg falls

The primary care and community urgent care response will include the rapid response function delivered through Community Nursing Teams as part of an integrated Neighbourhood Care service and better access to the Falls service which is delivered both through the Neighbourhood Care service, together with a specialist Falls service. The Falls service forms a key diversionary pathway for the Ambulance, Primary and Community services to avoid conveyance to A&E and admission to hospital.

The CCG will work closely with Primary Care to develop plans to move to a more proactive approach to care planning focused on early identification of people with Long Term Conditions who are at risk of deterioration, including closer working with:

- palliative care teams to support end of life pathway
- community pharmacists to provide access to urgent medication as part of the urgent care pathway
- specialist and community children’s nurses to develop confidence in managing minor illnesses

Services that reduce demand on the urgent care system by minimising the acute exacerbation of a condition through supporting patients in the community are a valuable part of the strategic approach. In implementing this Strategy, we will seek to commission Community services structured in such a way that they can work with the local GP practices to provide preventative care and support patients after an urgent care episode. The CCG’s current procurement of Community Services (2016) offers the opportunity to develop a service specification as a driver for the implementation of integrated community teams that will deliver a range of functions, including urgent and preventative care.

The review will also need to link to the CCG’s Estates Strategy and modelling work currently being undertaken to identify the most appropriate community bed provision to meet the needs of the East Riding population, including where step-up care to a community-based bed is required. This work will align with the implementation of the
Discharge to Assess model to support effective discharge for acute care. In this model, patients are discharged once they are medically fit and have their support needs assessed on arrival at home by integrated community health and social care teams. This enables them to access the right level of home care and support in real-time. Home is the default setting for care or transfer can be step down into a community-based bed if it is not appropriate for a person to return immediately to their usual home. The need for community-based beds for the Discharge to Assess model will form part of the community beds modelling. This work will involve appropriate consultation so that the views of service users, carers and the public can shape the CCG’s plans.

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<thead>
<tr>
<th>Action No.</th>
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<tbody>
<tr>
<td>UM1</td>
<td>Review the Minor Injuries service, including MIU provision, and make recommendations</td>
<td>June 16</td>
</tr>
<tr>
<td>UM2</td>
<td>Secure approval for and implement MIU Review recommendations, as part of development of a primary care and community urgent response</td>
<td>June 16</td>
</tr>
<tr>
<td>UM3</td>
<td>Develop a model and implementation plan for a primary care and community urgent response appropriate for the East Riding</td>
<td>August 16</td>
</tr>
<tr>
<td>UM4</td>
<td>Work with HEYHT to implement a UCC at Hull</td>
<td>TBC</td>
</tr>
<tr>
<td>UM5</td>
<td>Develop and implement diversionary pathways in collaboration with the ambulance service as part of the integrated urgent and emergency care response</td>
<td>June 16</td>
</tr>
</tbody>
</table>

### 8.1.6 Self-care and self-management

GPs, as gatekeepers in the local health and social care system, have a key role in ensuring people are aware of the full range of care and support available. Our Strategy recognises that more information needs to be available to and used by GPs, about the contributions that can be made by other services and agencies to provide preventative care and support for self-care across mental and physical health. Effective use of approaches such as Risk Profiling to identify people at risk of a particular illness or deterioration of an existing condition will enable early intervention supporting wider initiatives in reducing the demand for urgent and emergency care.
The CCG’s Community Services Strategy focuses on prevention and proactive care, delivered through integrated community health and social care teams, working closely with Primary Care; this will support delivery of an integrated urgent and emergency care system. In our urgent care model, both Primary Care and community services will more effectively signpost people to other sources of advice and self-care, as appropriate, which will form part of the wider primary care and community urgent response, including:

- libraries – as a source of self-help and self-management books and other resources
- NHS 111 – will offer advice and guidance for those individuals who ring including signposting to alternative services as clinically appropriate
- community pharmacies – will provide minor ailment schemes

Delivery of our Community Services Strategy will mean people are assisted to develop the knowledge, skills and confidence to manage their own condition within a network of support to ensure that they can manage a deterioration in their condition. This will support a reduction in demand for urgent and emergency care.

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<tr>
<th>Action No.</th>
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<tbody>
<tr>
<td>S1</td>
<td>Align with Community Services Strategy and procurement delivery to design a model for the primary care and community urgent response to signpost people to other sources of advice and self-care</td>
<td>June 16</td>
</tr>
<tr>
<td>S2</td>
<td>Work collaboratively with ERYCC and the community and voluntary sector to identify and develop self-care resources and mobilisation of the community and voluntary sector</td>
<td>September 16</td>
</tr>
<tr>
<td>S3</td>
<td>Develop and implement a Communication and Engagement plan to support more effective self-care</td>
<td>June 16</td>
</tr>
</tbody>
</table>

8.1.7 Integrated NHS 111 and GP Out of Hours

NHS 111 is the national focus for promoting effective, safe care, both via a clinician or through self-care, in the right circumstances. The national Review outcomes require better integration of NHS 111 with urgent and emergency care services, particularly the GP Out of Hours (OOH) Service, so that callers are able to speak to clinicians right away or that appointments are made via the phone service, with the primary care out-of-hours service having arrangements in place for NHS 111 to directly book appointments.

This centres NHS 111 within the nationally prescribed model as a single point of access for urgent and emergency care, which we need to reflect locally, together with processes for direct booking of OOH GP appointments by NHS 111.
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<tr>
<th>Action No.</th>
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<tbody>
<tr>
<td>O1</td>
<td>Identify action to further integrate 111 with both urgent care services and GP Out of Hours service</td>
<td>TBC</td>
</tr>
<tr>
<td>O2</td>
<td>Develop and implement an action plan to deliver an integrated service, including 111 call handlers direct access to GP appointments</td>
<td>TBC</td>
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</table>

### 8.1.8 ‘999’ Ambulance Services

The ambulance service has, traditionally, had two roles in urgent care: responding to 999 calls and transport of acute, mainly older, patients to hospital. However, the ambulance service also has a central role in delivering a mobile urgent treatment service which can treat people at the scene, avoiding unnecessary journeys to hospital.

We will work with the ambulance service to develop a shared understanding of their role in the wider system and the importance not only of 999 work and urgent transports, but also delivery of a mobile urgent treatment service, including more effective use of diversionary pathways. The focus of the ‘999’ ambulance service in our model will be to:

- transport patients with life threatening or life changing conditions to an emergency department
- deliver, where clinically appropriate, both a ‘hear and treat’ hub and ‘see and treat’ or referral to other community services or pathways, model as alternatives to conveyance to hospital
- further develop integrated pathways with other partner services including urgent care centres and health and well-being hubs

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<th>Action No.</th>
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<tbody>
<tr>
<td>A1</td>
<td>Design a local model for a ‘hear and treat’ hub and ‘see and treat’ or referral to other community services or pathways service, in collaboration with the Ambulance service</td>
<td>TBC</td>
</tr>
<tr>
<td>A2</td>
<td>Develop a plan to implement the service</td>
<td>TBC</td>
</tr>
<tr>
<td>A3</td>
<td>Develop and implement a plan to integrate pathways with UCCs, MIUs and health and well-being hubs</td>
<td>TBC</td>
</tr>
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</table>

### 8.1.9 Mental Health Crisis Care

Our Strategy is to work collaboratively with other services and specialties, in line with the Mental Health Concordat principles, to develop a model and effective local crisis care pathway that will ensure parity of esteem between urgent and emergency care responses for people with mental and health needs.
Consistent with the national standards, the model will focus on integrating Mental Health into the urgent and emergency pathway through:

- clearly defined pathways in NHS 111
- mental health providers as part of the Multi-disciplinary Team (MDT) and risk stratification process with Primary Care, providing case management and identification of frequent attenders
- collaborative working with the police and ambulance service to provide a joint response with access to places of safety
- liaison mental health services, with senior decision makers at the front of the pathway, accessible to Primary Care and Emergency Departments

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<th>Action No.</th>
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<tbody>
<tr>
<td>M1</td>
<td>Design a local model for an integrated Mental Health crisis care pathway and urgent and emergency pathway</td>
<td>TBC</td>
</tr>
<tr>
<td>M2</td>
<td>Develop and implement with other key partners a collaborative plan to deliver an integrated Mental Health crisis care and urgent and emergency pathway</td>
<td>TBC</td>
</tr>
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</table>

9 Enablers

9.1 Information Flow and Transfer

The Strategy recognises the need for good information flow as a key enabler to support safe and efficient patient care, particularly in the urgent and emergency care system where patients access care from outside of their routine care providers. This will require timely and appropriate access to health and social care information. Shared information, with professionals such as Community Pharmacies and the ambulance service, will enable NHS 111 and the wider urgent and emergency services to deliver safer, more efficient care.

The information systems in the East Riding are fragmented and implemented within organisational boundaries. Organisations will need to work together to ensure information systems work better and more effectively for the patient rather than the organisation. The model will focus on enabling clinicians delivering urgent and emergency care to have access, as a minimum, to Summary Care Record information and any Special Patient Notes, as well as access to wider health and care information currently held in organisational systems.
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<th>Action No.</th>
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<tbody>
<tr>
<td>IT1</td>
<td>Agree to an approach where information is entered once and then shared as appropriate, including specifically the sharing of clinical information between general practice and the urgent care centres</td>
<td>TBC</td>
</tr>
<tr>
<td>IT2</td>
<td>To have in place agreed data sharing arrangements and supporting procedures and processes and an implementation plan</td>
<td>TBC</td>
</tr>
<tr>
<td>IT3</td>
<td>Identify key information flows, and use cases for sharing information, in line with national specifications and standards</td>
<td>TBC</td>
</tr>
<tr>
<td>IT4</td>
<td>Agree a consistent approach to risk stratification across the East Riding</td>
<td>TBC</td>
</tr>
<tr>
<td>IT5</td>
<td>Explore the use of technology to support a mobile workforce, e-consultations, remote access to experts and delivery of a more digitised service and agree an implementation plan</td>
<td>TBC</td>
</tr>
</tbody>
</table>

**9.2 Care Management and Social Care**

Health and Social care system leaders will work together to reach local agreement regarding the role of social care in the integrated urgent and emergency care model, in line with the national requirements outlined in ‘Safer, Faster, Better: good practice in delivering urgent and emergency care. A Guide for local health and social care communities’ which includes considering a trusted assessor model, same day access to social care advice and optimising referral processes.

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<th>Action No.</th>
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<tbody>
<tr>
<td>S1</td>
<td>Agree with ERYCC the Social Care element of the model for an integrated urgent and emergency care service</td>
<td>TBC</td>
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</tbody>
</table>

**9.3 Workforce**

In line with the national specification and standards, we need our workforce to develop emergency care skills and competencies locally delivered to national standards. Our Strategy will require evaluation of new and extended roles to quantify how they impact on urgent and emergency care and to develop appropriate education and training programmes in response. This includes expanding and developing the use of roles such as Advanced Clinical Practitioner and Emergency Care Practitioners, across services and development of a flexible workforce through offering appropriate training and education programmes to enable staff to move between roles. Related to this is the need to develop education and training to enable staff to transfer their existing clinical skills into a different environment, especially moving from an acute to community to patient’s home setting.
Our Strategy also seeks to support the development of GP skills in urgent and emergency care. Recognising the interdependency of this Strategy with the CCG’s Community Services and Primary Care Strategies, the development of an appropriate workforce will require consideration of training in urgent and emergency skills across all professions and the development of a robust workforce plan.

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<tr>
<th>Action No.</th>
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<tbody>
<tr>
<td>W1</td>
<td>Agree roles and competencies required, in line with national standards</td>
<td>TBC</td>
</tr>
<tr>
<td>W2</td>
<td>Identify training needs of Community and Primary Care workforce to implement the Urgent Care Strategy</td>
<td>TBC</td>
</tr>
<tr>
<td>W3</td>
<td>Develop and implement an urgent care workforce plan, aligned with the workforce plans for Community Services and Primary Care</td>
<td>TBC</td>
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</table>

### 9.4 Estates

It is recognised both nationally and locally that:

- there has been investment in buildings that are in the wrong place, and others that now appear to be surplus to requirement, or are rapidly becoming out of date as treatments and care change
- there is a need to separate service provision from building ownership
- providers can change more rapidly and be more imaginative about models of delivery if they are not tied to a particular location
- the piecemeal development of primary care premises should cease and instead primary care development should be part of a wider strategy to develop networked integrated services
- incentives to develop new approaches are required
- better use of estate across the public sector
- consideration needs to be given to the contribution the estate can make to ‘social value’ in local communities

The CCG is developing an Estates Strategy which is looking across the whole local health system and where estate can be used to bring services together with the potential to improve the experience for patients and provide opportunities for service co-ordination and collaboration. In addition, consideration is being given to how to reduce the overall cost of the estate and improve the efficiency with which it is used and improve the appropriateness and quality of the environment for patients and staff within more environmentally sustainable buildings.

A review of the estate has been completed and the CCG is developing a Strategy and estates Road Map to guide implementation. The Estates Strategy needs to support a
future model of urgent care and the development of a primary care and community urgent response through creating opportunities for collaborative working with partners to look at how the estate can be rationalised and used more effectively across partner agencies, whilst providing sustainable access to a range of local urgent care services or support, including how the estate can support the wider health and well-being agenda in localities. This may mean disposal of estate that is surplus to requirements or to allow more appropriate re-provision of services.

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<th>Action No.</th>
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<tbody>
<tr>
<td>E1</td>
<td>Develop and gain approval for the Estates Strategy and Road Map</td>
<td>August 16</td>
</tr>
<tr>
<td>E2</td>
<td>Produce a plan for implementation of the Road Map</td>
<td>Sept 16</td>
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</table>

9.5 Finance

It is recognised that there will be very limited new resource for the NHS, with increased demands on the whole health system and a growth in population over the next ten years. Providers of urgent and emergency care receive different payments. Currently, payment for hospital based urgent and emergency care is almost entirely activity-based, whereas GPs and other providers of urgent care close to home are mostly paid through block contracts. These conflicting payment approaches can be a barrier to these different services working together.

The national Review has highlighted the need for a change in payment mechanisms and incentives to support reform of urgent and emergency care provision. This will require better data on activity, cost and quality and a payment approach that better reflects the system.

National work is still in the development phase and has focused so far on a three-part single, consistent payment – core (fixed), volume based and outcomes and performance based - to drive greater collaboration between all of the services within an urgent and emergency care system.

The payment approach, together with performance metrics, will be further developed by the national team during 2015/16 with pilots and wide scale shadow testing planned for 2016/17. It is proposed that the payment approach will work alongside other payment models. The outcomes from the national work will need to inform development of our local urgent and emergency care payment mechanisms, though commissioners are empowered to develop local approaches that work. This Strategy recognises that the necessary contractual changes and financial modelling will need to underpin local plans for achieving integrated services though in view of the complexity and acknowledging that there is more work to be done on the detailed design, this will require significant further work and capacity, impacting on the timescale for completion of this work.
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<tr>
<td>F1</td>
<td>In line with the national approach, develop a contracting and payment approach, together with performance metrics suitable for the local urgent care system</td>
<td>TBC</td>
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</table>

10 **Strategy Delivery Plan**

The Urgent Care Strategy will be implemented through collaborative working with all key partners in the urgent and emergency care system and consultation with service users, carers and the public. High level actions have been outlined through the Strategy document and these will form the basis of a detailed programme plan with workstreams identified to progress towards an integrated urgent and emergency care service.
## Appendix 1

### Performance Urgent Care and Emergency standards

<table>
<thead>
<tr>
<th>NHS Constitution Standard</th>
<th>Target 2014/15</th>
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<tbody>
<tr>
<td>Commentary % of A&amp;E attendances taking under 4 hours</td>
<td>95%</td>
</tr>
<tr>
<td>Ambulance – category A (red 1) – % attendances within 8 minute response time</td>
<td>75%</td>
</tr>
<tr>
<td>Ambulance – category A (red 2) – % attendances within 8 minute response time</td>
<td>75%</td>
</tr>
<tr>
<td>Ambulance – category A – % attendances within 19 minute response time</td>
<td>95%</td>
</tr>
</tbody>
</table>