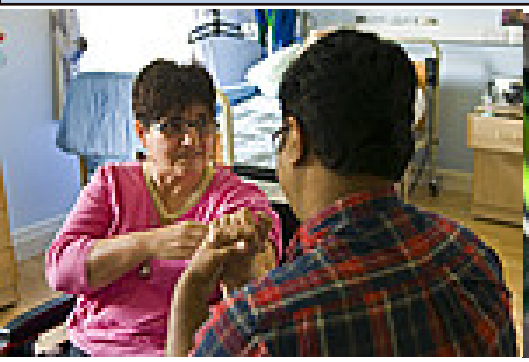
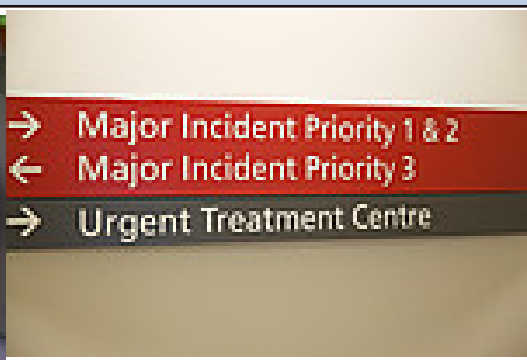
APPENDIX 2

County Durham and Darlington Urgent Care Strategy 2015 – 2020





Key contributors

This strategy has been written by Anita Porter, Senior Commissioning Support Officer, North of England Commissioning Support Unit with and on behalf of County Durham and Darlington System Resilience Group Members whose representation is comprised of:

- NHS North Durham Clinical Commissioning Group (ND CCG)
- NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG)
- NHS Darlington Clinical Commissioning Group (DCCG)
- Durham County Council (DCC)
- Darlington Borough Council (DBC)
- County Durham and Darlington NHS Foundation Trust (CDDFT)
- North Tees and Hartlepool NHS Foundation Trust (NTHFT)
- Local Pharmaceutical Committee (LPC)
- City Hospitals Sunderland NHS Foundation Trust (CHSFT)
- North East Ambulance Service NHS Foundation Trust (NEAS)
- County Durham Healthwatch
- Darlington Healthwatch
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- NHS 111
- North of England Commissioning Support Unit (NECS)
- NHS England
- Durham Police Authority
- Durham and Darlington Fire and Rescue Service

All organisations logos will be inserted here in final published version.

Foreword

The System Resilience Group are currently working within a health and social care system that is rapidly evolving. Legislation that underpins the delivery of health and social care has been recently revised and the need to continue to strive to deliver high quality healthcare, maximising the benefit to patients from limited resources remains a fundamental challenge.

In recent times, there has been increasing pressure placed on urgent care systems as patients seek greater assurance regarding their condition and rapid response from services. We are keen that this highly responsive provision remains, but that, wherever possible, patients are treated in the right place, at the right time and by the right professional. Thus, urgent care should not be thought of as a stand-alone, discrete service but an integrated philosophy embedded within patient pathways to ensure that our patients receive a joined-up approach to their care, from all agencies involved, ideally in the community where they live.

The System Resilience Group for County Durham and Darlington has taken a whole systems approach in developing the strategy to ensure these principles are embedded from the beginning. Evidence suggests that attendances at emergency departments continue to rise, a significant proportion of which could have been more appropriately dealt with by primary and community services. Previous engagement has shown that this is what patients would prefer. This would also result in better utilisation of specialist emergency department skills, and enable more effective relationships between the patient and their primary care clinician in managing their condition.

This Urgent Care Strategy aims to improve people's ability to care for themselves through patient self-management programmes, improve patient access to urgent care from primary and community services and improve emergency care provision provided within hospital settings and by ambulance services.

There are a number of principles that underpin how all partners will work together and develop:

- a whole-system approach that has the patient journey and experience at the heart of the planning process;
- urgent care services are easier to navigate for patients as well as clinicians and those in social care or children's services, through the strengthening of the NHS 111 as a single point of access service;
- services that are streamlined to avoid duplication, utilising the options to co-locate services to drive efficiency and patient safety;
- close working relationships with all our stakeholders to develop an integrated approach, using shared records and information technology systems, and ensuring communication between services is optimised and systems of monitoring are standardised;
- a preventative approach through patient self-management programmes;
- primary and community services that support the prevention of hospital admissions and support hospital discharge, with particular reference to services supporting the frail elderly and those with complex needs;
- a better patient experience for people who have emergency care needs or who need a stay in hospital;
- partnership working with neighbouring boroughs, to ensure patient care is not compromised by boundary issues.

Contents

1 Executive summary

1.1 The Department of Health defines urgent and emergency care as the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly. This could include, for example, accident and emergency (A&E), walk-in, and minor injury and illness services.

1.2 Nationally, statistics from NHS England Winter Health Check, March 2015, states that since the winter of 2009/10 there has been a 14.1% increase in A&E attendances, and a leap of 26.3% since the winter of 2004/5. Emergency admissions have risen by 8.8% since the winter of 2009/10 and by 25.7% since 2004/5.

1.3 Between November to February 2014/15 there was a total of 7,063,000 A&E attendances, 190,000 more than the same period last winter. At its peak the system managed 446,000 attendances within one week during December 2014, followed by 440,000 the following week. Both record figures recorded for a winter period. Actual admissions showed a similar increase in demand, with a total of 1,821,000 during 2014/15, compared to 1,770,000 the previous winter.

1.4 Two key factors are clearly identified as contributing to the growing pressures on A&E:

- An ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care.
- Many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E.

1.5 This strategy has been developed by the County Durham and Darlington System Resilience Group supported by NHS Improving Quality (NHS IQ). The strategy covers the period 2015 to 2020 and has been shaped by the standards encompassed within NHS England's Planning Guidance, Everyone Counts 2015/16 to 2019/20, key national and local reviews of urgent and emergency care services, NHS England's Five Year Forward View, and the Eight High Impact Interventions.

1.6 The local vision for this strategy has been agreed by the System Resilience Group as:

'Patients are seen by the right health/social care professional, in the right setting, at the right time, to the highest quality and in the most efficient way providing the best outcome for the patient.'

1.7 The vision is underpinned by seven objectives. All actions stated within the action plan help to achieve one or more of the seven objectives. Overall the strategy aims to ensure that all patients are seen by the right person, in the right setting at the right time, as well as having a key focus on reducing demand overall for urgent and emergency care services to ensure resources can be appropriately targeted and effective.

1.8 To achieve the above, there are a number of agreed principles that underpin how all partners will work together and develop:

- a whole-system approach that has the patient journey and experience at the heart of the planning process;
- urgent care services are easier to navigate for patients as well as clinicians and those in social care or children's services, through the strengthening of the NHS 111 as a single point of access service;
- services that are streamlined to avoid duplication, utilising the options to co-locate services to drive efficiency and patient safety;
- close working relationships with all our stakeholders to develop an integrated approach, using shared records and information technology systems, and ensuring communication between services is optimised and systems of monitoring are standardised;
- primary and community services that support the prevention of hospital admissions and support hospital discharge, with particular reference to services supporting the frail elderly and those with complex needs;
- a better patient experience for people who have emergency care needs or who need a stay in hospital;
- partnership working with neighbouring boroughs, to ensure patient care is not compromised by boundary issues.

1.9 To achieve the local vision for urgent and emergency care, several workstreams will provide a focused approach to the delivery of the strategy action plan and will be responsible for reporting progress into the System Resilience Group on a monthly basis.

1.10 In order to evidence that the implementation of the strategy is a success, there are a number of critical success factors identified. These include the constitutional key performance measures but also that:

- patients report that they are accessing the right service, at the right time, first time;
- positive patient reports of their experience of all urgent and emergency care services within the system;
- providers feel supported and have sufficient resources to meet patient needs;
- commissioners feel their investment is cost effective and resulting in positive patient outcomes.

As part of the work to consider how best to implement this strategy, the System Resilience Group will consider the best ways to effectively measure these success factors.

1.11 **Appendix 1** provides a summary 'plan on a page' of the whole strategy.

1.12 The County Durham and Darlington System Resilience Group overall responsibility for the capacity planning and operational delivery urgent and emergency care across the health and social care system. The System Resilience Group will be responsible for overseeing the implementation of the Urgent Care Strategy.

2 Introduction

2.1 There is a national focus on urgent and emergency care services across England. In response to this, the County Durham and Darlington System Resilience Group have developed this urgent care strategy specifically focusing on the standards in Everyone Counts 2015/16 to 2019/20. The strategy sets out a joint vision and patient centred principles, together with whole systems solutions to achieving them.

2.2 The strategic direction set out in this strategy will engage the public, key stakeholders, Overview and Scrutiny Committee, and Health and Wellbeing Boards to make sure it is right for County Durham and Darlington.

2.3 Members of the System Resilience Group that have been involved in the development of this strategy include Durham Dales, Easington and Sedgefield Clinical Commissioning Group who Chair the System Resilience Group working in partnership with North Durham Clinical Commissioning Group, Darlington Clinical Commissioning Group, Durham County Council; Darlington Borough Council; County Durham and Darlington NHS Foundation Trust; Durham Police Authority; County Durham and Darlington Fire and Rescue Service; Tees, Esk and Wear Valleys NHS Foundation Trust; North East Ambulance Service; County Durham Healthwatch; Darlington Healthwatch; Local Pharmaceutical Committee; other local acute trusts and NHS England.

2.4 The Chair of each System Resilience Group meet together every month at the Urgent Care Network. This meeting supports System Resilience Group Chairs to have a regional focus, commission some services regionally, share good practice and information.

2.5 Local commissioners and providers are committed to the development of an evidence-based service model that will provide local people with equitable access to high quality, safe and effective urgent care services at the right time and in the right place. The consolidation of urgent care provision across County Durham and Darlington will deliver on our commitment to provide urgent care services that are geographically located to provide equity and consistency of service.

2.6 To ensure that the public and key stakeholders are appropriately involved in the local development of urgent and emergency care in line with this strategy, across County Durham and Darlington, engagement work in relation to specific actions included within the strategy action plan will be undertaken by individual Clinical Commissioning Groups as the strategy action plan is realised over the next five years.

2.7 To support local healthcare provision in England, the NHS Constitution sets out the principles and values under which all healthcare services should operate. First developed in 2009 as part of the NHS Next Stage Review led by Lord Darzi, it also sets out the rights and responsibilities of the public, patients and staff delivering and benefitting from healthcare services provided by the NHS. The current version was updated in April 2013.

2.8 Underpinning the NHS Constitution are a number of rights that clearly specify maximum waiting times and emergency care response times that all patients should be able to expect. These standards are regularly monitored locally through the System Resilience Group as well as by NHS England and will be used to help measure success in the delivery of this strategy. For urgent and emergency care these include:

- A maximum four-hour wait in A&E from arrival to admission, transfer or discharge.
- All ambulance trusts to respond to 75 per cent of Category A (the most urgent) calls within eight minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

(Handbook to the NHS Constitution, March 2013)

2.9 In addition to the above constitutional rights for general urgent and emergency care, the System Resilience Group will also be responsible for monitoring the 62-day cancer and diagnostic waiting times. The constitutional rights for patients in relation to these are:

- A maximum two month (62-day) wait from urgent referral for suspected cancer to first treatment for all cancers.
- A maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer.
- A maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers).
- Start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.
- Be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

(Handbook to the NHS Constitution, March 2013)

2.10 The support structure to implement the national urgent care vision within each region and locally to each Clinical Commissioning Group area will include an Urgent and Emergency Care Network, replacing the current Urgent Care Networks, working across several Clinical Commissioning Group geographical areas enabling strategic oversight of urgent and emergency care on a regional footprint and that patients with more serious or life threatening conditions receive treatment in centres with the right facilities.

2.11 In the North East, the Urgent and Emergency Care Network will cover the North East Region, North Cumbria and Hambleton, Richmondshire and Whitby Clinical Commissioning Group area. The purpose will be to improve the consistency and quality of urgent and emergency care by addressing together challenges in the urgent and emergency care system that are difficult for single System Resilience Groups to achieve in isolation.

2.12 The County Durham and Darlington System Resilience Group overall responsibility for the capacity planning and operational delivery urgent and emergency care across the health and social care system. The System Resilience Group will be responsible for overseeing the implementation of the Urgent Care Strategy.

2.13 Improving the urgent and emergency care pathway across County Durham and Darlington is included in all three Clinical Commissioning Group's current Commissioning Intentions. In January 2015 the County Durham Health and Wellbeing Board referred to the Better Care Fund Strategy target to reduce emergency admissions and overall activity across the urgent and emergency care system by 3.5%.

Vision, outcomes and objectives

2.14 The local vision for this strategy has been agreed by the System Resilience Group as:

'Patients are seen by the right health/social care professional, in the right setting, at the right time, to the highest quality and in the most efficient way providing the best outcome for the patient.'

Outcome

2.15 The overall outcome for the whole strategy is an urgent and emergency care system that is able to meet the needs of the County Durham and Darlington population, both adults and children, within the resources available, delivering improved quality and patient experience.

Strategy objectives

2.16 The implementation of the strategy will be overseen by the System Resilience Group, with the establishment of specific sub-groups, as required, to explore, design, plan and implement the projects to meet stated objectives and outcomes.

2.17 Seven objectives have been developed together by all partners during a series of workshops held to facilitate the strategy development. The objectives have been based on the key national messages and local strategic direction for urgent and emergency care services. The seven local objectives are:

Seven Local Objectives	
1	People are central to designing the right systems and are at the heart of decisions being made.
2	Patients will experience a joined up and integrated approach regardless of the specific services they access.
3	The most vulnerable people will have a plan to help them manage their condition effectively to avoid the need for urgent and emergency care.
4	People will be supported to remain at their usual place of residence wherever possible.
5	The public will have access to information and guidance in the event of them needing urgent or emergency care.
6	The patient will be seen at the right time, in the right place, by a person with the appropriate skills to manage their needs.
7	The patient will not experience any unnecessary delay in receiving the most appropriate care.

3 What should good urgent and emergency care services look like?

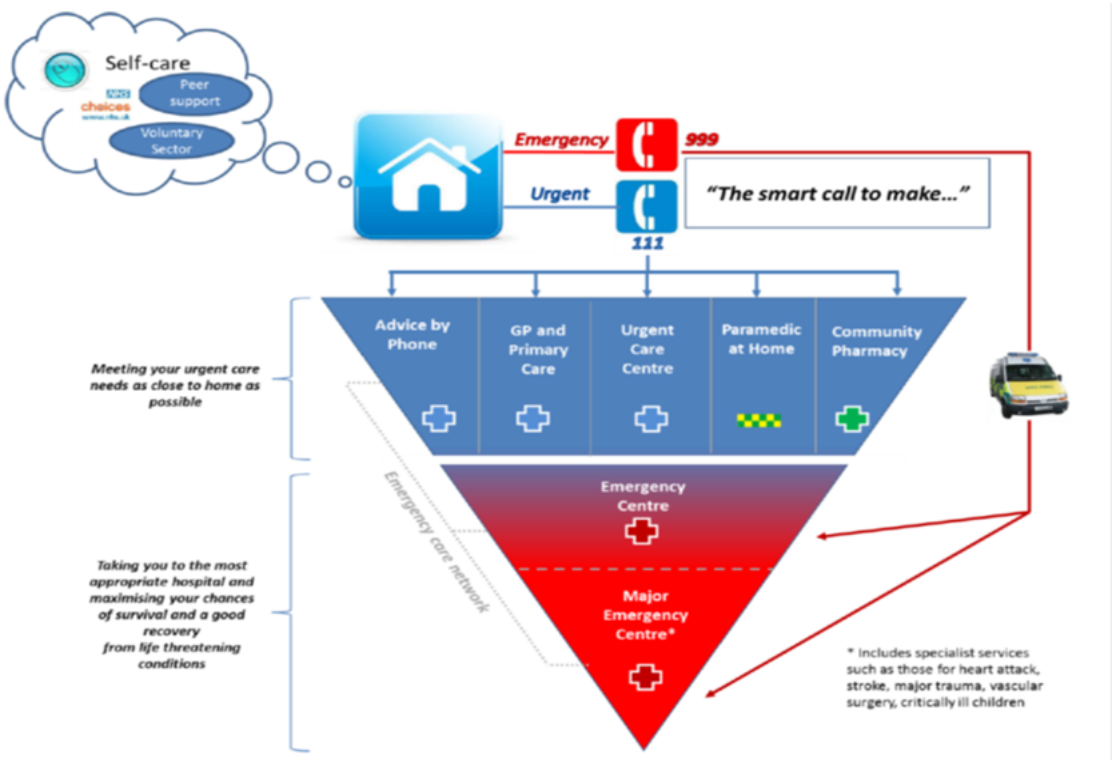
National approach

3.1 The national vision for urgent and emergency care is captured within **Transforming urgent and emergency care services in England. Urgent and emergency care review end of phase one report *High quality care for all, now and for future generations.* Professor Sir Bruce Keogh, November 2013** with two aims:

1 People with urgent but non-life threatening needs must have a highly responsive, effective and personalised service outside of hospital – as close to home as possible, minimising disruption and inconvenience for patients and their families.

2 People with serious or life-threatening emergency needs should be treated in centres with the very best expertise and facilities in order to reduce risk and maximises their chances of survival and recovery.

3.2 The diagram below represents the look and design of the new system proposed by Sir Bruce Keogh.



(Transforming urgent and emergency care services in England, Nov 2013, Page 23)

3.3 As well as the Keogh review, a number of other national reviews of urgent and emergency care and subsequent guidance have been produced in recent years:

- The walk-in centre review: final report and recommendations, Monitor, February 2014.
- Emergency admissions to hospital: managing the demand, Comptroller and Auditor General Health, October 2013.
- A promise to learn – a commitment to act: improving the safety of patients in England, National Advisory Group on the Safety of Patients in England, August 2013.
- Review into the quality of care and treatment provided by 14 hospital trusts in England: Professor Sir Bruce Keogh, July 2013.
- Report of the Mid Staffordshire NHS Foundation Trust public inquiry executive summary, Robert Francis QC, February 2013.
- Emergency care and emergency services: view from the frontline, Foundation Trust Network, 2013.

3.4 Together these reviews provide a clear agenda for improving urgent and emergency care systems across the country with a view to achieving the national vision:

- Help people to manage their own health through **self-care** and management for urgent but non-life threatening needs.
- Help people with urgent care needs to get **the right advice in the right place at the right time**, including enhancing the current NHS 111 service to facilitate this.
- Provide **responsive urgent care services** outside of hospital so that people with non-emergency needs no longer choose to seek treatment at A&E departments.
- Introduce **two levels of emergency departments**, Emergency Centres and Major Emergency Centres, to ensure that people with 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 urgent and emergency care services together in **emergency care networks** so the overall system becomes more than just a sum of its parts.

3.5 Underpinning the national vision and work being progressed to put it in place, some of the national reviews focused on improving hospital standards, patient safety and performance, underpinning the fundamental need to deliver high quality care. These reviews called for cultural change enabling transparency, accountability, clear standards that services were measured by that patients understood with evidence-based compliance.

3.6 Captured by Sir Bruce Keogh in his review of 14 trusts reporting high mortality rates (July 2013), but key to all the reviews into hospital practices and performance, five key areas were identified as safety, workforce, clinical and operational effectiveness, governance and leadership. With these in mind, Keogh identified eight ambitions for hospitals in England to deliver.

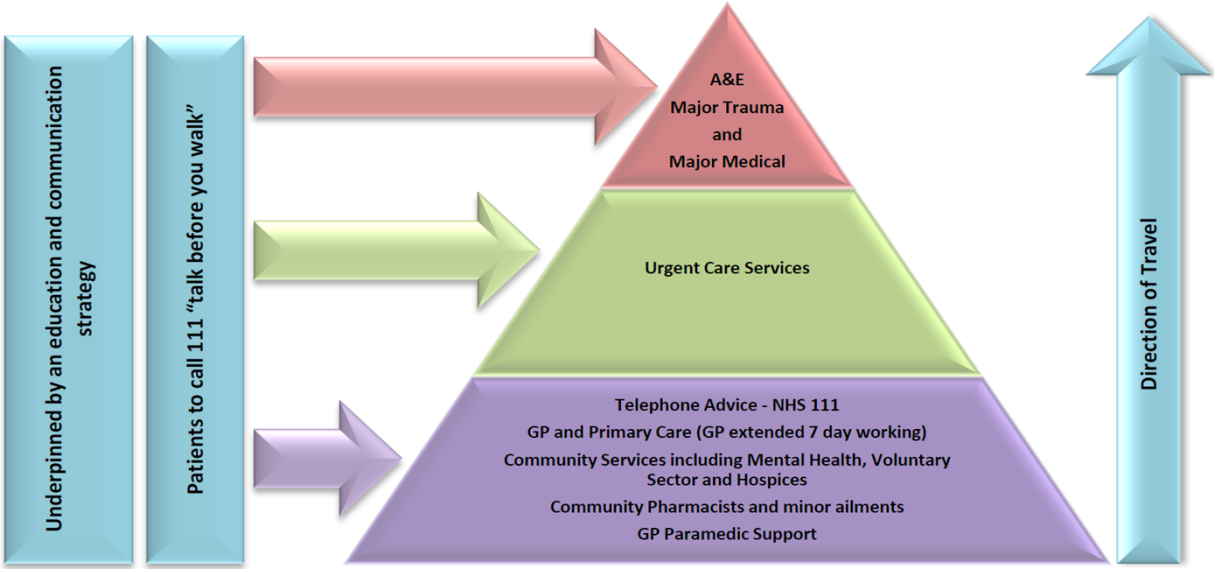
Keogh Review Ambitions	
1	Demonstrable progress towards reducing avoidable deaths in our hospitals.
2	Confident and competent use of data and other intelligence for the forensic pursuit of quality improvement by leaders of provider and commissioners.
3	Patients, carers and members of the public will increasingly feel treated as vital and equal partners in the design and assessment of their local NHS.
4	Patients and clinicians will be involved in and have confidence in the quality assessments made by the Care Quality Commission.
5	Professional, academic and managerial isolation for hospitals will be a thing of the past.
6	Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients.
7	Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today.
8	All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

3.7 With exceptional A&E, emergency ambulance and NHS 111 pressures, and learning experienced during winter 2014/15, NHS England developed Eight High Level Interventions, detailed in **Appendix 2**, that all have key benefits to improving urgent and emergency care services for patients. As such the Eight High Impact Interventions are non-negotiable and therefore now underpin this strategy implementation and local actions stated within the action plan have been aligned where possible.

Local approach

3.8 Using the national approach and applying its principles locally in County Durham and Darlington, Clinical Commissioning Groups need to ensure effective use of existing services such as primary care, community nursing, NHS 111 services and other rapid response services as part of their strategies for urgent and emergency care. The national approach support people being assessed and treated as close to home as possible, reducing the pressure on acute resources and ensuring patients are supported in the right place at the right time.

3.9 The County Durham and Darlington System Resilience Group would like to ultimately see the following model commissioned for patients requiring urgent and/or emergency care.



Securing quality in health services (SeQIHS)

3.10 The Securing Quality in Health Services (SeQIHS) Programme was established in 2012 by the former Primary Care Trusts across County Durham, Darlington and Tees and has been continued by the five Clinical Commissioning Groups across this geographical area, working also in association with Hambleton, Richmondshire and Whitby Clinical Commissioning Group. The programme is focused on continuing to improve and sustain high quality hospital services in the Durham, Darlington and Tees area.

3.11 The programme is looking at delivering agreed clinical quality standards in the following clinical areas: A&E, acute medicine, acute surgery, critical care, acute children's care, maternity and neonatology, and interventional radiology in the context of the financial and workforce resources available to support implementation of the standards.

3.12 In the latest phase of the programme, clinicians from secondary and primary care have been working together to describe a model of care that will maximise our ability to deliver the standards.

3.13 During the lifetime of this urgent and emergency care strategy, it is anticipated that the SeQIHS Programme will make recommendations on the model of care and configuration of services and opportunities to commission services differently, based on the principle of keeping services local wherever possible and centralise services where necessary.

3.14 The model will aim to describe different levels of care and the number of sites where this care will be available. It is essential that these recommendations fit with the urgent and emergency care services in primary care and in the community to ensure that patients receive the right care in the right place in a timely manner.

3.15 There is a substantial amount of work to be carried out to deliver the next phase of planning, including expanding the public and stakeholder engagement and involvement, developing a long list of scenarios and reducing it to a short list of options, modelling and evaluating the options and ensuring that any proposals that emerge on a County Durham and Tees area are consistent with local plans and developments.

3.16 The County Durham and Darlington System Resilience Group welcomes the work to date undertaken by the SeQISH programme and recognising necessity for this to be taken forward to ensure a sustainable urgent and emergency care system across the south of the region.

4 National and local context

National statistics

4.1 Nationally, statistics from NHS England Winter Health Check (March 2015) states that since the winter of 2009/10 there has been a 14.1% increase in A&E attendances, and a leap of 26.3% since the winter of 2004/5. Emergency admissions have risen by 8.8% since the winter of 2009/10 and by 25.7% since 2004/5.

4.2 Between November to February 2014/15 there was a total of 7,063,000 A&E attendances, 190,000 more than the same period last winter. At its peak the system managed 446,000 attendances within one week during December 2014, followed by 440,000 the following week. Both record figures recorded for a winter period. Actual admissions showed a similar increase in demand, with a total of 1,821,000 during 2014/15, compared to 1,770,000 the previous winter.

4.3 NHS 111 faced similar unprecedented levels of demand, managing 4.6 million calls during winter 2014/15. This represents an increase of one million calls, or 27% on the same period the previous year. Nationally of all the calls triaged, just 11% had ambulances dispatched and 7% were recommended to A&E.

4.4 It is recognised that these figures demonstrate the increased patient needs that staff had to cope with this winter, during which time the NHS in England continued to provide a robust service, admitting, treating and discharging more than nine out of ten people across the course of the winter.

4.5 The current urgent and emergency care system has complex supply and demand flows and some national recruitment challenges, particularly for GPs, paramedics and key acute and emergency medicine staff.

4.6 Two of the key factors contributing to the increased levels of demand on A&E departments are:

- An ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care.
- Many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E.

National guidance

4.7 The current national direction and guidance has evolved in recent years. Since 2010, policy objectives have evolved with commissioning responsibilities transferring to Clinical Commissioning Groups, a focus on offering patients greater choice, high quality care and the challenges of both financial and increasing demand pressures on the urgent and emergency care system resulting in several instrumental national reviews bringing together some fundamental questions to be addressed and offering a new vision, proposed design of urgent and emergency care for the future and a blueprint for achieving it.

4.8 The Everyone Counts Planning for Patients Guidance 2014/15 to 2018/19 set out a five year strategic plan for Clinical Commissioners. With a focus on quality, convenient access to services for all, driving change through innovation and value for the public purse, the guidance set a challenging agenda of transformational change for Clinical Commissioning Groups around the county.

4.9 The NHS Five Year Forward View (October 2014) sets out the key focus for how the NHS will be sustained and improved for everyone over the next five years with an emphasis on prevention, health promotion and greater patient control of their own care. Enabling people to be responsible for their own health will result in people living healthier lives, and help ensure that urgent and emergency care resources are available for those who really need them.

4.10 The NHS Five Year Forward View includes integration of A&E departments, GP out-of-hours services, urgent care services, NHS 111 and ambulance services. The guidance sets out opportunities for new models of care, such as a multi-specialty community provider – where GPs are enabled to combine with nurses, and other community health and social care, to create integrated out-of-hospital care.

4.11 In August 2014, NHS England published 'Transforming urgent and emergency care services in England. Update on the urgent and emergency care review, urgent and emergency care review team' an update on progress in addressing the system changes highlighted by Sir Bruce Keogh. The update acknowledged that the vision set out in the original report would take three to five years to put in place and set out work progressed to date including:

- Working closely with local commissioners in developing five year strategic and two year operational plans.
- Undertaking trials for new models of delivery for urgent and emergency care and seven-day services.
- Developing new ways for paying for urgent and emergency care services, in partnership with Monitor.
- Completing and introducing a new service description for NHS 111.
- Provision of commissioning guidance to support new ways of delivering urgent and emergency care.

4.12 NHS England are developing a suite of guidance documents and tools to facilitate the achievement of the national vision including the Eight High Impact Interventions, supporting a fundamental shift towards new ways of working and models of urgent and emergency care.

4.13 With regard to supporting Mental Wellbeing, HM Government published the Mental Health Crisis Care Concordat, February 2014, which is a joint statement committing a range of key partners to *'…*work together to improve the system of care and support so people in crisis, because of a mental health condition, are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.' The Mental Health Concordat also has a key focus on supporting the recovery of people with mental health problems.

4.14 A new three part payment system for urgent and emergency care consisting of a guaranteed element (core), a variable element to account for fluctuations in demand (volume based) and a payment element linked to outcomes and performance is planned to be introduced across both urgent and emergency care services nationally. Currently there are often different payment systems in place for different types of urgent and emergency care services which act as a barrier to services working together. The new payment system will address the barriers and act as a driver for services collaborating and working together.

Local statistics

4.15 **Appendix 3** details local performance for 2013/14 and 2014/15 against the national constitutional performance measures for urgent and emergency care. Reflecting the national trends, locally there has been increasing demands on the whole urgent and emergency care system from GP practices, urgent care services and A&E departments. All local acute trusts have seen an increase in both attendances at A&E and actual admissions during winter 2014/15. Alongside this, all services are experiencing increasing complex and multiple health needs as people grow older and their frailty increases.

4.16 Nationally, the expectation is that all acute trusts assess and treat a minimum of 95% of people within both urgent (Type 3) and emergency (Type 1) care within four hours. Locally this has fluctuated, with performance by City Hospitals of Sunderland and sometimes County Durham and Darlington NHS Foundation Trust particularly struggling to meet the target consistently. In Sunderland, the introduction of the 'Perfect Week' in March 2015 has yielded some improved results. North Tees and Hartlepool NHS Foundation Trust have fared better overall and have recovered their performance much quicker.

4.17 Emergency ambulances should be able to handover the patient to the A&E department safely and be able to get back on the road within 15 minutes. At peak times this target is much more difficult to achieve and handover times can increase. Locally there are stark differences between the ambulance handover times achieved between the North East Ambulance Service and each acute trust with North Tees and Hartlepool achieving the best performance.

4.18 The number of people having to wait to be discharged from hospital due to a hold up of their discharge plan being put in place varies significantly between acute trusts. City Hospitals of Sunderland have seen a significant decline in the numbers of delayed discharges experienced over the last two years, County Durham and Darlington have also experienced a recent decline, and North Tees and Hartlepool are experiencing an increasing trend. There is still a significant amount of work to do locally to ensure that discharge processes are working more effectively to prevent delays in transfers of care and this is a current key priority for County Durham and Darlington System Resilience Group.

Local demographics and health inequalities – County Durham

4.19 The health of people living in County Durham has improved significantly over recent years, but remains worse than average for England. Health inequalities remain persistent and pervasive. Levels of deprivation are higher and life expectancy is lower than average for England. Local priorities for tackling these inequalities include reducing smoking, tackling childhood and adult unhealthy weight, promoting breastfeeding, reducing alcohol misuse, reducing teenage conceptions (and promoting good sexual health), promoting positive mental health, and reducing early deaths from heart disease and cancer.

4.20 Much of the population in County Durham suffer from avoidable ill-health or die prematurely from conditions that are preventable. Lifestyle choices remain a key driver to reducing premature deaths but it is clear that social, economic and environmental factors also have a direct impact on health status and can worsen existing ill health.

4.21 The vision for the County Durham Joint Health and Wellbeing Strategy is to:

'***Improve the health and wellbeing of the people of County Durham and reduce health inequalities'***

Central to this vision is the belief that decisions about the services provided for service users, carers and patients, should be made as locally as possible and involve the people who use them. The vision is supported by the following Strategic Objectives that outline the areas of priority for the Board:

1. Children and young people make healthy choices and have the best start in life
2. Reduce health inequalities and early deaths
3. Improve the quality of life, independence and care and support for people with long term conditions
4. Improve the mental and physical wellbeing of the population
5. Protect vulnerable people from harm
6. Support people to die in the place of their choice with the care and support that they need

4.22 In County Durham some of the demographic trends are:

- The population in 2013 was reported to stand at 515,900.
- The 65+ age group was projected to increase from almost one in five people in 2013 (19.2%) to nearly one in four people (24.7%) by 2030, which equates to an increase of 39.8% from 99,000 to 138,400 people.
- The proportion of the County's population aged 85+ is predicted to almost double (+ 95.2%) by 2030.
- Life expectancy is improving for both males (77.9) and females (81.5), but is still below the England average (79.2 for males), (83 for females).

(Joint Strategic Needs Assessment 2014 statistics)

4.23 Social isolation and loneliness is a significant and growing public health challenge for County Durham's population. It affects many people living in County Durham and has a significant negative effect on health and wellbeing across the life course. Anybody can be affected by social isolation or loneliness and it can 'affect any person, living in any community'. It is costly to local health and care services and can

increase the chances of premature death.

(Adapted from County Durham Joint Health and Wellbeing Strategy 2015-2018)

4.24 The County Durham Joint Health and Wellbeing Strategy states that 'A Wellbeing for Life Service has been implemented to help people achieve a positive physical, social and mental state. The wellbeing approach goes beyond looking at single-issue healthy lifestyle services and a focus on illness, and aims to influence the circumstances that help people to live well, and build their capacity to be independent, resilient and maintain good health for themselves and those around them'. This is in addition to a range of other services to support people to remain health and as independent as possible, including short term rehabilitation.

Local Demographics and Health Inequalities – Darlington

4.25 In Darlington some of the demographic trends are:

- The current population is estimated to stand at 105,564.
- By 2020 the over 50 population is projected to be 44,220 (40% of the total population) and the over 65s projected to rise to 22,306 (20% of the total population).
- Darlington has some of the most deprived areas in England, and is ranked 75th most deprived local authority out of 326 in England (IMD 2010).
- People in Darlington are living longer. However, life expectancy remains slightly less than the average for England. On average males are living to 78 years (England average 78.9 years) and women 82.4 (England average 82.9 years).

(Adapted from Strategic (Single) Needs Assessment Refresh 2013, Darlington Borough Council)

4.26 The health of people in Darlington is generally worse than the rest of England with some specific local health inequalities to be addressed. These include: 18% of children being classified as obese; long-term health prospects are undermined by above average number of children living in poverty and below-average breastfeeding rates; alcohol-related hospital admissions remain high; the health effects of individual lifestyle choices, particularly smoking, drinking, lack of exercise and poor sexual health are significant, and there is growing concern about the emergence of mental health issues linked to poverty as both a cause and effect.

4.27 Darlington's Sustainable Community Strategy[1] contains two specific objectives focused on helping to improve the health and wellbeing of people living in Darlington: 'more people healthy and independent' and 'more people active and involved' both aimed at addressing the above health inequalities.

4.28 The 'Healthy Darlington' approach is now supporting people to eat well, be more active and live longer, and together with a range of wider initiatives is encouraging people to take care of themselves, with more people using the support and facilities available to make lifestyle choices that support active, healthy living. This is combined with a growing culture of volunteering and active citizenship, in which more and more people are choosing to take care of others or of their neighbourhood as a lifestyle choice, through the growing 'social capital' of volunteering programmes.

[1] 'One Darlington Perfectly Placed' 2008-2026 Revised May 2014

Darlington is an active, engaged community of citizens first and foremost, rather than service users.

(Adapted from One Darlington, Perfectly Placed, May 2014 Refresh)

4.29 The increasing aging population across both County Durham and Darlington coupled with the challenges of addressing poor personal health choices and health inequalities are significant and impact on the demand for our local urgent and emergency care services across the whole system.

Local plans

4.30 The whole system needs to be robust enough to support people to become healthy, stay healthy, and react quickly and effectively when someone needs support. There are a range of local plans developed by all organisations who are members of the County Durham System Resilience Group to support these aims with a wide variety of innovative local approaches and actions. **Appendix 4** details a list of current local plans and strategies. The table below contains some broad themes of what all the plans aim to achieve across the county, together with how this whole systems approach supports the urgent and emergency care system:

Broad Theme	What does this mean?	How does this support the urgent and emergency care system?
Helping people to look after themselves better	Local information and initiatives to encourage people to eat healthily, take regular exercise, reduce or stop smoking, reduce alcohol intake, reduce stress levels, and the development of social networks and support.	Reducing unnecessary demand on urgent and emergency care services by helping people to remain fit and healthy wherever possible.
Helping people to take responsibility for their health and wellbeing	Providing clear and easy to access information and advice about where to go for help, providing health checks, and guidance and support to enable self-care.	People feel supported to be confident and informed about when and where to go for help with their health needs, using pharmacies, GP practices and urgent care services appropriately depending on their level of health need.
Helping people to maintain their independence	Information and advice, social care, planned and reactive, intensive, health and social care services such as intermediate care, for people with complex health and social care needs.	These services are crucial to help people remain at home when it is safe for them to do so, avoiding unnecessary hospital admission, admissions to long-term care and supporting appropriate, safe hospital discharges.
Making sure that people have rapid access to appropriate health and social care service when they need them	Ensuring that local health and social care services are appropriately resourced and joined up to provide rapid interventions when people need them.	Urgent and emergency care resources can be targeted appropriately to make sure people who have urgent or life-threatening health needs receive help in a timely manner.

5 Where are we now?

5.1 This section explains how the urgent and emergency care system is currently managed and what the main services are that currently operate across County Durham and Darlington. The tables detail how these services are currently spread across the county.

5.2 **Appendix 5a and 5b** details the locations of the main urgent and emergency care services across County Durham and Darlington.

How is the urgent and emergency care system managed?

5.3 A robust planning and assurance process is in place, managed nationally by NHS England and locally through each System Resilience Group, to make sure that all organisations contributing to the urgent and emergency care system are appropriately prepared to effectively manage anticipated peak times of demand. This includes the winter period but also other times such as bank holidays.

5.4 The process is supported by national guidance and local experience on where the system needs additional capacity at peak times, and good practice with a focus on continuously improving key areas such as patient flow, ambulance handover management and discharge planning.

5.5 A sub group of the System Resilience Group focuses specifically on improving hospital discharge processes reducing the number of Delayed Transfers of Care (DTOC). Smooth and effective discharge processes help reduce the time spent in an acute hospital bed, therefore improving overall patient flow through the hospital as well as making sure that people returning home from hospital have timely access to the right health and social care support to meet their needs.

5.6 Part of the process is the appropriate allocation and management of resilience funding through the System Resilience Group. For the last two years the County Durham and Darlington System Resilience Group have taken a fair shares approach to the distribution of this funding across all major providers in the system to help them put additional capacity in place during peak demand periods.

5.7 Spend of allocated funding and delivery of agreed capacity and resilience projects agreed are then monitored both locally and nationally with providers required to evaluate their projects at the end of the winter period. Through this process the System Resilience Group partners can continuously refine what initiatives are producing the most benefits on the system and inform where any future funding would be most effectively targeted.

5.8 The System Resilience Group monitors performance on a monthly basis against the NHS Constitutional Standards for Urgent and Emergency Care, 62-day cancer wait timescales, referral to treatment timescales and diagnostics.

5.9 A review of how the System Resilience Group currently works is planned, providing opportunity for partners to discuss and agree together how to ensure a genuine

collaborative and partnership approach to the overall work programme for the System Resilience Group including the delivery of this strategy action plan.

5.10 Throughout the winter, North of England Commissioning Support Unit provide a Surge Management Service on behalf of the North East and Cumbria Clinical Commissioning Groups. The Surge Management Team provide an essential co-ordination and communication point for all foundation trusts and the North East Ambulance Service.

5.11 The team co-ordinate daily conference calls and provide up to date information to help manage capacity across the emergency care system. A Winter Web specifically dedicated to the sharing of information and management of capacity across the regional urgent and emergency care system is in place to support communication across the region.

Primary care and community services

GP practices

5.12 General Practitioners (GPs) look after the health and wellbeing of people in their local community. They support people with a wide range of health needs and also provide health education, offer advice on stopping smoking, diet and fitness, run clinics, give vaccinations and carry out simple surgical procedures. GP practices include a range of staff, for example, nurses, healthcare assistants, practice managers, receptionists and other staff. They work as a team and closely with other community health and social care services including health visitors and midwives, to make sure people receive the best support and advice for their individual needs.

5.13 Some GP practices have additional 'branch' locations so they can deliver services closer to their population. The location of GP practices and their 'branch' locations can be seen in **Appendix 5a**.

5.14 All three Clinical Commissioning Groups currently have extended GP practice working arrangements in place to facilitate increased capacity, flexibility and availability of GP appointments. These vary locally and are detailed in **Table 3.1b**. This type of service is important in supporting the move towards seven-day services available within primary care.

Community pharmacies

5.15 Community pharmacies provide a wide range of NHS services summarised in the table below. Overall they offer free and confidential health advice without the need for an appointment.

	Service Provided
All Pharmacies	Dispensing of drugs / drug tariff appliances / elastic hosiery Repeat dispensing Disposal of unwanted medicines Health advice, travel health advice Promotion of healthy lifestyles Signposting to other healthcare providers
Most Pharmacies	Medication use reviews and prescription interventions Support for people starting to take new medicines

	Advice on minor ailments Sexual health services Support for stopping smoking
Some Pharmacies	NHS health checks Anticoagulant (warfarin) monitoring clinic Substance misuse services Needle and syringe exchange services Alcohol interventions Pandemic and seasonal flu vaccination services Palliative care Services Medication support to care homes Out of hours services – Sunday and bank holidays on a rota basis and 100 hour pharmacies

(Summarised from 'Services available through our Community Pharmacies' County Durham and Darlington Local Pharmaceutical Committee July 2012[2])

5.16 The majority of pharmacies support with minor ailments providing advice and dispensing of prescribed medication. Examples of minor ailments include sore throats, headaches, earache, temperature, allergic contact dermatitis, hay fever, head lice and infant teething.

5.17 **Appendix 5b** details the location of all community pharmacies in County Durham and Darlington.

Telephone advice – NHS 111

5.18 NHS 111 is the NHS non-emergency number. Across the North East region, the North East Ambulance Service provide the NHS 111 service. This includes a telephone triage service staffed by trained advisors, supported by healthcare professionals. This service will ask a range of questions to assess a person's symptoms, enabling them to be directed to the right medical care for their needs. The service is for a wide range of situations where urgent medical support is required but the situation is not life threatening. The service is free to access and available 24 hours a day, 365 days a year.

Other community services

5.19 A wide range of local community health and social care services exist across County Durham and Darlington providing support to the current urgent and emergency care pathway. These include community mental health teams, statutory social care assessment and support, voluntary sector services for example British Red Cross, home from hospital services and hospices.

5.20 It should be noted that some work areas for improving the current local urgent and emergency care pathways link directly to work already being progressed within other pathway areas such as intermediate care, palliative and end of life and frail elderly. As such this strategy will not duplicate work being progressed elsewhere but will work collaboratively to ensure that actions being progressed within other workstreams are delivered in line with the requirements for urgent and emergency care pathway improvements.

[2] http://www.durhamlpc.org.uk/Assets/Contractors_PDFs/0E_AF_75_EE_40_OE/CD_D_Pharmaceutical_Services.pdf

5.21 Across County Durham only, an Intermediate Care Plus service, funded through the Better Care Fund, includes a range of intensive short-term health and social care services to help people get back on their feet has been running through a Single Point of Access from April 2014. The service expands the existing integrated health and social care services by:

- bringing together existing community-based short-term intervention services;
- adding significant capacity to the existing intermediate care pathway;
- providing new, additional community-based short-term health and social care services;
- all under one umbrella, for people who need rehabilitation and recovery support, either within the community and for people returning home from hospital;
- providing a single point of access for health and social care professionals through 24 hours a day, seven days a week, including bank holidays.

5.22 In Darlington, the Responsive Integrated Assessment Care Team (RIACT) is the intermediate care and re-ablement service that supports older people through a range of health and social care professionals and support from the voluntary sector to provide a comprehensive community-based assessment and support service. The service supports older people to stay out of hospital where they can be supported safely and appropriately at home, and helps people with their recovery and rehabilitation following a stay in hospital.
The service is central to the Multi-disciplinary Team work that is taking place as part of the Better Care Fund projects.

5.23 Improving Palliative and End of Life Care is being led by all three County Durham and Darlington Clinical Commissioning Groups with a Strategic Commissioning Plan in place between 2013 and 2018. The strategy focuses on the establishment of a *new social system* for palliative and end of life care, which operates for the best interest of the patient and works together to deliver the best care possible. This will improve collaborative working, strengthen joint ownership and reposition patients and their carers at the centre of the work. Key Palliative and End of Life Strategy deliverables that also facilitate improvements in the urgent care systems include:

- development of single point of access making it easier for palliative patients to know where to go for support;
- development of the multi-disciplinary approach to advanced care planning and emergency care planning;
- standard application of the Deciding Right *(A North-East initiative for making care decisions in advance)*;
- keeping people at home through rapid response, palliative care at home, carer services, implementation of the Deciding Right with regard to care homes.

Table 5.1a Urgent and emergency care services in County Durham and Darlington

Type of Service	What is it for?	Level of need	How is it accessed?	Hours of Operation	North Durham		Durham Dales, Easington and Sedgefield				Darlington	
					University Hospital of North Durham	Shotley Bridge Community Hospital	Seaham Primary Care Centre	Easington Health-works	Peterlee Community Hospital	Bishop Auckland General Hospital	Darlington Memorial Hospital	Dr Piper House
Accident and Emergency	Life-threatening conditions	Emergency	• Emergency Ambulance Transfer • GP referral • Walk-in	24/7, 365 days of the year	✓						✓	
In-hours Urgent Care	Minor illness and injury	Urgent	• Booked appointments • Walk-in • Telephone appointments • Home visits	8am to 6pm Monday to Friday		✓	✓		✓	✓		✓
Out of Hours Urgent Care	Minor illness and injury	Urgent	• Walk-in • Telephone appointments • Home visits	6pm to 8am Monday to Friday, Weekends and Bank Holidays	✓	✓			✓	✓	✓	
Walk-in Centre	Minor illness and injury	Urgent	• Walk-in only • No need to book appointments	8am to 8pm Monday to Sunday				✓				
GP Out of Hours Service	Minor illness and injury	Urgent	• Telephone appointments • Home visits	6pm to 8am Monday to Friday, Weekends and Bank Holidays	✓	✓			✓	✓	✓	
Minor Injury Service	Minor injury only*	Urgent	• Walk-in • Telephone appointments • Home visits									

Table 5.1b Urgent and emergency care services in County Durham and Darlington

Type of Service	What is it for?	Level of need	How is it accessed?	Hours of Operation	North Durham	Durham Dales, Easington and Sedgefield	Darlington
GP Practices	Minor illness and injury	Urgent and Non Urgent/ Routine	• Booked appointments • Telephone appointments • Home visits	8am to 6pm Monday to Friday	31	40	11
Extended GP Practices Opening	Minor illness and injury	Urgent and Non Urgent/ Routine	• Booked appointments • Telephone appointments • Home visits	Hour of extended GP practice opening vary	Extended opening times vary between local GP practices including appointments on Saturday mornings.	South Durham Health: 10 x practices open Saturday 8am – 12pm Durham Dales Health: 5 x practices open Saturday 8am – 1pm Intrahealth: 1 practice open Saturday and Sunday 8am – 8pm 1 practice open Saturday 8am – 1pm 1 practice open Saturday 9am – 12pm	Most GP practices offer extended opening hours but these vary between practices
Pharmacies	Minor illness and injury	Urgent and Non Urgent/ Routine Advice and Information	• Walk-in • Telephone advice and information	Pharmaceut-ical Needs Assessment	52	73	23
NHS 111	Minor illness and injury	Urgent Advice and Information	• Telephone	24/7, 365 days of the year	Regional Service		
Intermediate Care Plus	Prevention of hospital admission and supporting discharge	Non urgent Intensive community based interventions	• Single point of access for health and social care professionals	24/7, 365 days of the year	✓	✓	
Responsive Integrated Assessment Care Team (RIACT)	Prevention of hospital admission and supporting discharge	Non urgent Intensive community based interventions	• Single point of access for health and social care professionals	24/7, 365 days of the year			✓

Urgent and emergency care transport

Life threatening situations

5.24 The North East Ambulance Service provide emergency ambulances staffed with paramedics and emergency care assistants, responding to a wide variety of serious or life-threatening calls. Working alongside ambulance crews, a Rapid Responders Team also provide paramedic rapid response to commence emergency treatment before the ambulance arrives on scene.

5.25 In some serious emergencies, you could also be treated by a medical team from the Great North Air Ambulance. The medical team on the helicopter includes an acute consultant (for example, anesthetists, emergency department consultant) and a paramedic who are skilled in treating patients who have serious traumatic injuries.

Urgent situations

5.26 At present transport is provided for doctors to visit patients at home and for patients who are unable to travel to the GP practice or urgent care service on their own.

Non urgent situations

5.27 Non urgent transport is currently provided by the North East Ambulance Service's Patient Transport Service. This planned service takes members of the public to and from their homes to outpatients' appointments, dialysis, chemotherapy, clinics, physiotherapy or non-urgent transfers between different hospitals.

5.28 This service covers Teesside, South Tyneside, North Tyneside and Northumberland, as well as County Durham and Darlington, and undertakes over a million journeys every year. Crews are trained as ambulance care assistants with specialist knowledge of comprehensive first aid, driving skills and patient moving and handling techniques. Some GP practices organise their own non-urgent patient transport directly outwith this service.

Table 5.2 Emergency and urgent care transport

Type of Service	What is it for?	Level of need	How is it accessed?	Hours of Operation	Coverage
999 Emergency Ambulance Great North Air Ambulance	Life-threatening conditions	Emergency	• Telephone	24/7, 365 days of the year	Regional
Urgent Care Transport	Minor illness or injury	Urgent	• By professionals who need to arrange urgent transport for their patients	24/7, 365 days of the year	County Durham and Darlington
Patient Transport Service	Minor illness or injury Routine appointments Hospital Discharge	Non urgent	• By professionals who need to arrange urgent transport for their patients	24/7, 365 days of the year	Regional

Mental health services

5.29 Urgent and emergency services specifically for people with acute mental health needs are detailed in **Table 5.3**. The two Crisis Teams, one located in North Durham and one in Darlington (but also providing services across South Durham), manage all admissions to mental health inpatient beds and provide an intensive home treatment service supporting prevention of admission and early supported hospital discharge.

5.30 For those individuals who would ordinarily benefit from intensive home treatment but are unable to receive this in their own home, each locality provides a nine bedded crisis recovery house to support short-term interventions and prevent hospital admissions. This service has recently been rated as outstanding against the Care Quality Commission's standards for 'caring' for its person centred approach.

5.31 The acute liaison service provides three main roles – multi disciplinary assessment of individuals attending A&E departments, ward-based support for acute hospital staff, and disciplinary assessment of those presenting with medically unexplained physical symptoms. The service ensures that people with mental health needs or presenting symptoms receive the specialist assessment and support they need.

5.32 A two year pilot crisis and liaison service is currently running across County Durham, working closely with emergency departments and other services, it will undertake assessment and intervention support for children and adolescents out of hours. The pilot does not currently operate in Darlington.

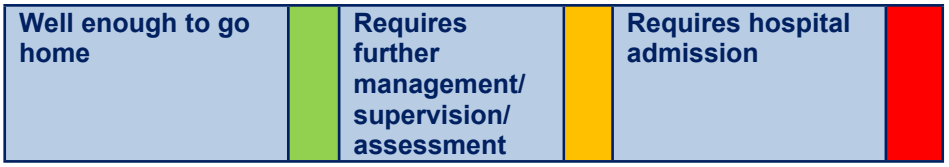
Table 5.3 Urgent and emergency mental health services

Type of Service	What is it for?	Level of need	How is it accessed?	Hours of Operation	North Durham	Durham Dales, Easington and Sedgefield	Darlington
Adult Mental Health Crisis Teams	Potential life-threatening conditions	Emergency	• Telephone • Self-referral by people known to mental health	24/7, 365 days of the year	✓		✓
Children's Mental Health Crisis Teams	Potential life-threatening conditions		• Referral • By professionals who need to	Not 24/7	✓		✓
Children and Adolescent Mental Health Crisis and Liaison Service (Pilot)	Potential life-threatening conditions	Emergency	• Telephone • Self-referral by people known to mental health services or professional	24/7, 365 days of the year	✓	✓	
Crisis Recovery Beds	Urgent mental health needs	Urgent	• By professionals who need to arrange urgent transport for their patients	24/7, 365 days of the year	✓		✓
Mental Health Inpatient Beds				24/7, 365 days of the year	✓		✓
Acute Liaison	Mental health assessment	Urgent	• Health professionals based at acute hospital sites	Not 24/7	✓	✓	✓

Children and young people's services

5.33 The Poorly Child Pathway aims to integrate all aspects of child health and includes pathways which support specialist referral / intervention. Children who attend an emergency department with two episodes of asthma in 12 months are referred to a Consultant Paediatrician. There is also additional support from the paediatric respiratory nurse.

5.34 Clinical pathways for managing common children's illnesses have been developed within the Poorly Child Pathway. Within these pathways there are three categories of severity of illness:



5.35 In Darlington Memorial Hospital, limited support is available from an advanced paediatric nurse practitioner within the emergency department. This is not currently available at University Hospital of North Durham. Both sites benefit from a consultant paediatrician up to 10pm weekdays and six hours in paediatric wards at weekends.

5.36 Paediatrics services provided by County Durham and Darlington NHS Foundation Trust currently do not support urgent care centres.

Alcohol harm reduction services

5.37 In Durham, there were 2,063 alcohol related ambulance callouts in 2012/13 reducing slightly to 2,011 in 2013/14. Saturday and Sunday see consistently higher alcohol related ambulance callouts with peak times of 10pm. Males generally have more alcohol related ambulance callouts than females. The age group 20-29 category accounted for the highest numbers of alcohol related ambulance callouts. A high proportion of alcohol related ambulance callouts are from the most deprived wards. In Darlington, despite a reduction from 2,417 to 2,336 alcohol related admissions during 2012, the current rate for alcohol related admissions still remains high.

5.38 Despite these statistics there is a limited understanding of the demand on A&E services in relation to alcohol. One of the main reasons for attendance at A&E is an injury rather than alcohol itself.

5.39 The 2015 Local Alcohol Profile for England shows that the rate of alcohol specific hospital admissions in County Durham is 468 per 100,000 and remains higher than the England average. The rate of alcohol specific hospital admissions for men is 606 per 100,000 and has increased by 2% over time. Alcohol specific hospital admissions for women is 340 per 100,000 and has increased by 18% over time.

5.40 There are a number of individuals who have alcohol issues, (chronic, mental and behavioural) who are likely to frequently attend urgent care and emergency departments, and more needs to be done to ensure comprehensive recovery support services are available in the community to provide appropriate support and help reduce the number of frequent attenders.

5.41 In 2013/14 there were 186 alcohol related ambulance callouts for young people under the age of 18 across County Durham. A number of emergency department staff in both University Hospital of North Durham and Darlington Memorial Hospital have been trained in identification and brief advice for young people.

5.42 In County Durham, Lifeline provides alcohol and drugs treatment and recovery support for both young people and adults. In Darlington, the North East Council on Alcoholism (NECA) provides alcohol and drugs treatment and recovery support for both young people and adults. The police and Druglink also run an Alcohol Diversion Scheme for low level/first time offenders who pay to attend an awareness course in lieu of further criminal action and/or fines. We are also in early stages of looking at lessons learned from a Local Alcohol Action Area pilot undertaken recently in Middlesbrough, with a view to adopt partnership good practice across the Tees Valley.

Urgent care services

5.43 Urgent care services are split into different types but they all provide assessment and treatment for non life-threatening situations. The different services are:

- Urgent care centres.
- Minor injury units.
- GP out-of-hours
- Walk-in centres.

5.44 In County Durham, an urgent care service is currently provided by County Durham and Darlington NHS Foundation Trust across six urgent care centres located around the county. There is also a separate walk-in service in Easington provided by Intrahealth.

5.45 Some of the common injuries and ailments that can be treated by these services include: chest infections, urine infections, minor burns and scalds, wound infections, suspected eye infections, fevers, cuts, sprains and strains, hand, foot and wrist fractures, insect and animal bites and minor head injuries. Minor injury units usually just assess and treat minor injuries whereas urgent care services, including walk-in centres, may also treat minor illnesses depending on the local service arrangements.

5.46 There are differences in the urgent care services currently available in different locations. **Table 3.1a** shows some differences in how these services are currently provided.

5.47 One of the main differences is when urgent care services are open. Some are only open during the day (in hours), some are only open overnight, weekends and on bank holidays (out of hours). Some are open all the time (in hours and out of hours).

5.48 As part of the range of urgent care services currently available, a GP out–of-hours service operates across the county with GPs based overnight, at weekends and bank holidays in some of the urgent care centres.

Accident and emergency departments

5.49 Located on acute hospital sites, A&E departments provide round the clock, consultant-led care for life-threatening situations such as:

- loss of consciousness;
- acute confusion and fits that are not stopping;
- continuing, severe chest pain;
- breathing difficulties;
- severe bleeding that cannot be stopped.

5.50 County Durham and Darlington NHS Foundation Trust provide A&E departments located in Darlington Memorial Hospital and University Hospital of North Durham. Both hospitals in County Durham and Darlington provide 24 hour consultant-led A&E care. This includes critical care, ambulatory care, acute medicine and surgery. Stroke and vascular surgery is also provided at University Hospital of North Durham.

5.51 Hospitals that have A&E departments that provide this level of emergency care are referred to as being able to provide a Type 1 A&E response. A Type 1 response means 'A consultant-led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients'.[3]

5.52 A lot of work was undertaken at both hospital sites during 2014 including improving the Ambulatory and Rapid Assessment and Treatment routes for patients to ensure that each patient is seen by the right clinician in the A&E department, first time, every time. Beginning with an initial decision by a Nurse Navigator (senior nurse/doctor), patients are guided to the most appropriate practitioner for their needs. Successful pilots of this initiative across both hospital sites resulted in full implementation from 1st April 2014.

5.53 Recent expansion of the Medical Assessment Unit and medical bed capacity has also taken place within the University Hospital of North Durham enabling patients to be directed to the Medical Assessment Unit, where appropriate, without the need for them to first be assessed within the A&E department.

5.54 Some people living in County Durham and Darlington may also use one of the acute hospitals located outside County Durham and Darlington. For example, Sunderland Royal Hospital provided by City Hospitals Sunderland NHS Foundation Trust, the Queen Elizabeth Hospital located in Gateshead or the University Hospitals of North Tees or Hartlepool that are provided by North Tees and Hartlepool NHS Foundation Trust

[3] Emergency Care Weekly Situation Report Definitions, NHS England, April 2014

6 What we want

6.1 The County Durham and Darlington System Resilience Group's strategic direction, set by this strategy will influence individual CCG commissioning intentions. CCG's will then work with their partners to develop local solutions.

6.2 Local analysis of our urgent and emergency care system and supporting national evidence has identified the main challenges that we need to address in County Durham and Darlington to achieve our local vision:

- Increased demand across the whole system for both urgent and emergency care;
- An ageing population and increasing numbers of people with long-term conditions and complex needs;
- A need to ensure vulnerable patients with complex needs, including the frail elderly have proactive and effective support in place to reduce the need for admission to hospital;
- An urgent and emergency care system difficult for both patients and professionals to find their way around;
- Urgent and emergency care services that appear unrelated or fragmented;
- Current systems that are unable to meet future expectations and demand;
- A lack of up to date 'real-time' understanding of how demand flows around the system, particularly surge activity;
- Current potential for duplication and inefficient use of staff resource and skills;
- Historical poor performance in consistent achievement of the A&E 95% constitutional target, and achievement of timely ambulance handover times;
- Reducing the average length of time people need to spend in an acute hospital bed;
- Improving discharge processes to increase patient flow and patient experience;
- Poor public perception of timely GP appointment availability within primary care.

6.3 This section identifies the current Clinical Commissioning Groups' priorities for urgent and emergency care in their local area and the gaps in the current urgent and emergency care pathway.

6.4 **Section 7 – 'How are we going to get there?'** details the actions that will be implemented both locally and regionally to address the challenges, meet the gaps and deliver both the local vision for County Durham and Darlington and the national vision for urgent and emergency care.

Current Clinical Commissioning Group Priorities

6.5 North Durham Clinical Commissioning Group

North Durham Clinical Commissioning Group is working closely with County Durham and Darlington NHS Foundation Trust to support their redevelopment of the emergency care department at University Hospital of North Durham, and also

working in collaboration with neighbouring Durham Dales, Easington and Sedgefield Clinical Commissioning Group in the development of urgent and emergency care services.

Their approach to urgent and emergency care fits with their primary care strategy which supports the development of responsive GP practice-based services over seven days.

6.5.1 Gaps in Current Provision

Two of the key gaps currently identified in North Durham are the need to ensure the physical urgent and emergency care needs of children and young people are met, and that there is a comprehensive and effective minor injury/illness pathway available in-hours within the emergency department.

6.5.2 Immediate Priorities

North Durham Clinical Commissioning Group have engaged with the public to develop their local urgent and emergency care strategy. Their strategy includes a range of actions that recognises GP practices supported by health and social care community services as being central to providing an accessible and responsive seven day service that is able to swiftly and effectively meet local urgent care needs. Some of the current priorities over the next 12 months include:

- Working with County Durham and Darlington NHS Foundation Trust to develop plans for the provision of a new emergency care centre on the University Hospital of North Durham site.
- Monitor the impact of the recently implemented Local Divert Policy to help manage emergency care activity more effectively.
- Following a successful pilot, roll out direct booking of GP practice appointments NHS 111 service.
- Review GP out-of-hours service and consider future fit with integrated service.
- Expand community primary care support to vulnerable patients during week end by providing a GP-led service supported by community matrons and district nursing.
- Support the implementation of the Local Mental Health Crisis Care Concordat action plan.
- Evaluate paediatrics urgent appointments pilot within Cedars Medical Practice, currently facilitating priority urgent GP appointments after school for children and teenagers.

6.5.3 Patient Engagement

During the summer of 2014, North Durham Clinical Commissioning Group engaged the public and key stakeholders on their views about how urgent care is provided. The engagement exercise included online information and feedback forms, and a wide distribution of information about the proposals across health and social care acute community facilities such as hospital waiting areas, GP practices, libraries and leisure centres, focus groups and drop-in sessions.

The feedback received has helped shape the Clinical Commissioning Group's local urgent care strategy. The engagement exercise also identified a general need for the

public to have a better understanding of the difference between urgent care and emergency care, and that patients value their GP practice and in some areas would like to see improvements in access to appointments.

6.6 Durham Dales, Easington and Sedgefield Clinical Commissioning Group

6.6.1 Gaps in Current Provision

Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) are currently reviewing their local urgent care services and are exploring the potential for GP practices to provide more urgent care capacity through better access during the day and extended opening. As part of this work, an audit of the type of healthcare needs currently supported through the existing urgent care services during April to September 2014 was undertaken to help the Clinical Commissioning Group develop a better understanding of the patient needs within urgent care and identify any gaps or duplication in existing service provision.

6.6.2 Immediate Priorities

The Clinical Commissioning Group has considered national guidance in developing its local approach to urgent care. Building on feedback from engagement work undertaken during 2014 with patients using the existing urgent care services, the proposed approach is to place GP practices at the heart of the urgent care system providing access to responsive primary and community care services seven days a week.

Work is continuing to understand the activity, trends, patient flows and resource distribution within current urgent care services, and further engagement and consultation with primary and acute care clinicians, patients and the public will take place.

6.6.3 Patient Engagement

During 2014, DDES CCG undertook an Experience Led Commissioning approach to ask the public and key stakeholders how best to support people with urgent care needs in community settings. The engagement exercise included mapping both patient and frontline staff experiences in particular of primary care (especially general practice and community pharmacy), out of hours GPs, accident and emergency, urgent care centres, self-management of long-term conditions and unexpected health issues, maintaining mental and emotional wellbeing, and community-based support.

The key message from patients was that urgent care centres are their second choice or last resort, with their first choice being their own GP practice.

There were also some suggestions around better communication to help people feel informed, confident and supported when they become ill, and to understand their health issues when they are with urgent care professionals.

6.7 Darlington Clinical Commissioning Group

6.7.1 Gaps in Current Provision

The main gap in the urgent and emergency care pathway currently identified by Darlington Clinical Commissioning Group is the need for integration between

emergency and urgent care services, particularly within the A&E department within Darlington Memorial Hospital.

6.7.2 Immediate Priorities

Supported by national evidence about what works well, Darlington Clinical Commissioning Group are working with County Durham and Darlington NHS Foundation Trust to reconfigure the existing A&E department within Darlington Memorial Hospital to enable an integrated emergency and urgent care service to be delivered 24/7. The aim is to provide local people with equitable access to sustainable, high quality, safe and effective urgent and emergency care services at the right time and in the right place.

6.7.3 Patient Engagement

Healthwatch Darlington hosted two engagement events on behalf of Darlington Clinical Commissioning Group in February 2015. The events attracted over 100 people and focused on exploring better future models of care with the public. The events were informed by NHS England's Five Year Forward View, explaining why change is needed and what services could look like in Darlington for a range of healthcare services including urgent care, primary care and pharmacy.

Urgent and emergency care pathway gaps

6.8 The current gaps in the urgent and emergency care pathway across County Durham and Darlington that need to be addressed to deliver the local vision have been aligned to the seven objectives of the strategy.

6.9 **Objective 1:** People are central to designing the right systems and are at the heart of decisions being made.

Over the years urgent and emergency care systems in County Durham and Darlington have evolved as a result of changes in both national and local policy, time limited funding streams and available resources. Although public and patient engagement has taken place, this strategy provides an opportunity to engage on a local vision across the whole of County Durham and Darlington.

During the life of this strategy, Clinical Commissioning Groups and other key stakeholders within the System Resilience Group will continue to engage with their partners, the public, patients and clinicians to shape and deliver the local vision within their geographical area. This may mean requesting feedback on experience of current services, helping to shape local services and consultation on proposed solutions. The exact nature of engagement and consultation work will vary depending on the nature of the issue the Clinical Commissioning Group is trying to resolve within the overall urgent and emergency care pathway.

6.10 **Objective 2:** Patients will experience a joined up and integrated approach regardless of the specific services they access.

Recent national guidance is supporting the development of an 'integrated service' approach between NHS 111 and both in and out–of-hours primary and urgent care services across each Urgent and Emergency Care Network area. The key elements of this new model have been consulted on across the country by NHS England and the resulting guidance will support regional and local implementation.

In County Durham and Darlington, aspects of this model are already in place with NHS 111 being able to book some direct GP practice and urgent care appointments directly into clinical systems, and NHS 111 having some clinical support to help ensure ambulances are appropriately dispatched to those who really need them.

Locally, there is a need to integrate the falls and frail elderly pathway to ensure an integrated approach to falls prevention for older people, and all Clinical Commissioning Groups have been considering their current make up of primary and urgent care services in their local community and how these can be developed to provide a truly integrated and responsive primary and urgent care approach for local patients.

There is a need to continue this work as part of the delivery of this strategy to help achieve the overall local vision. This will include progressive work to develop an integrated primary care and secondary care offer within each Clinical Commissioning Group area with local clinical hubs that can provide comprehensive assessment and treatment in the community. There is a challenge within each Clinical Commissioning Group area to ensure that the future local arrangements fit with the national 'integrated service' for both in and out-of-hours so that the patient receives a smooth service from accessing NHS 111 for assistance to being assessed and treated locally for all primary and urgent care needs, seven days a week, 365 days of the year.

To achieve the above, current work to review and understand current services, research and develop best practice local models will continue, with options being considered that may include extended hours services, stronger integration between primary and secondary care and expanding direct booking of GP appointments by NHS 111 and development of local minor illness and injuries pathways.

To achieve an integrated approach that works effectively for both clinicians and patients, the System Resilience Group partners will need to support the development of appropriate clinical access to patient records to facilitate clinicians to provide the safest outcome for the patient's needs.

6.11 **Objective 3:** The most vulnerable people will have a plan to help them manage their condition effectively to avoid the need for urgent and emergency care.

Across all Clinical Commissioning Groups, work has been progressed within primary care to identify the most vulnerable patients at risk of a hospital admission and to make sure they have a joined-up health and social care plan in place providing them with both a proactive and reactive multi-disciplinary team approach to their care needs. The purpose of this it to provide a proactive approach to helping people maintain their health, respond quickly to prevent a deterioration in patient's health, provide proactive and appropriate clinical support in line with their individual needs and help prevent an unnecessary hospital or long-term care admission, and support people with safe discharge where a stay in an acute hospital bed has been necessary.

In addition, some work has been undertaken to identify and understand the needs of people who are the most frequent attenders at A&E departments within County Durham and Darlington NHS Foundation Trust, and developing proactive care management plans to help better support their needs and prevent their need to regularly attend A&E at an emergency.

However, there is still work to be done to help people take responsibility for their own welfare and support the self-management of long-term conditions. Current gaps that need to be addressed include:

- The need to embed the role of peer support, voluntary sector and community networks to help and support people to self-care.
- The development of a strategy to help people self-care through individual focused agreed anticipatory care plans.
- The need to review and develop local falls prevention arrangements, particularly comprehensive management plans within care homes to prevent falls and reduce unnecessary ambulance conveyances and acute admissions.
- Continue the current work to develop comprehensive care management plans across primary, secondary and emergency care to proactively support the people who are the most regular attenders at A&E departments.

6.12 **Objective 4:** People will be supported to remain at their usual place of residence wherever possible.

Across all Clinical Commissioning Groups, gaps have been identified in how current primary, urgent and emergency care services work together to make sure that vulnerable people receive timely and appropriate healthcare and/or social care support so that their health needs can be safely managed at home wherever possible.

This approach helps prevent unnecessary hospital admissions and re-admissions, ensuring acute hospital resources are targeted at those who need acute care, minimises disruption and inconvenience for patients and their families, and helps achieve the best outcome for the patient. These services also support patients with timely, safe hospital discharge.

Some work has already been progressed, including extended opening hours for GP practices, significant expansion of intermediate care arrangements in County Durham, a vulnerable adults wraparound service in Durham Dales, Easington and Sedgefield, and aligning community matrons or advanced nurse practitioners and GP practices to care homes. However, this work needs to continue as part of this strategy implementation to make sure that everyone whose health could be supported at home, has access to the right support for them, when they need it.

Remaining work to achieve this objective includes:

- Making sure that the deciding rights of palliative care patients who have chosen not to be transported to hospital are implemented to respect people's preferred place of death and reduce the number of people dying within 48 hours of a hospital admission.
- Review and evaluate the effectiveness of a range of local additional clinical support to care homes and understand the impact on reducing acute hospital admissions and re-admissions.
- Further development of primary and secondary care clinical hub arrangements supporting care homes and people within their own homes to make sure everyone has responsive, timely and effective health and social care interventions to avoid a hospital admission where appropriate, and support people with timely safe hospital discharge seven days a week.
- Clarification of the scope of the emergency medication service following evaluation, and training and education of health and social care staff in the proper use of inhalers as a preventative measure.
- Clarification of the scope of the minor ailments service in light of availability of real time data.
- There is need to improve the skills of health and social care staff to ensure the consistent application of medication reviews for frail elderly people.
- Developing responsive children's community services that are integrated with urgent and emergency care services. This includes increasing specialist community paediatric capacity to help further support children and their families at home with acute and chronic disease management.
- Ensuring special patient notes are up to date and available for paramedics to contact local clinical support for vulnerable patients.
- Developing intermediate care services in line with the outcome of local reviews.

6.13 **Objective 5:** The public will have access to information and guidance in the event of them needing urgent or emergency care.

One of the key challenges locally is to create an urgent and emergency care system that proactively supports people to use primary and urgent care services as a first port of call for urgent needs, as opposed to going straight to A&E.

Over winter 2014/15 a comprehensive Keep Calm campaign used a wide variety of media to encourage people to go to the right service to meet their health needs, and only going to A&E departments for emergency health needs.

Ensuring patient education and public health messages continue to be a high priority focus and work is progressing with NHS England and local System Resilience Groups through the Urgent and Emergency Care Networks to make sure that national and local messages are consistent to the public, particularly during winter.

More work to be done to address patient perception that a GP appointment may not be available in a timely manner, or that is convenient by asking people who attend A&E departments whether and how they have tried to access primary and urgent care services before attending A&E and, if so, what barriers they faced so that any perceived or actual barriers to accessing primary and urgent care services locally can be addressed.

There is also a need to make sure the current community pharmacy services are fully utilised, and key services such as advice on new medications and medicine use reviews are undertaken consistently by all pharmacies.

6.14 **Objective 6:** The patient will be seen at the right time, in the right place, by a person with the appropriate skills to manage their needs.

Achievement of objective six within the delivery of this strategy is fundamental to ensure that people receive timely support with all their healthcare needs and are not passed between services. This wastes time, creates unnecessary expensive duplication, is demoralising for staff and means that scarce resources are not being effectively used.

A great deal of work is already being undertaken towards providing an urgent and emergency care system that makes sure that people access the pathway at the right place to ensure their health needs are assessed and met first time, every time. However, with such a complex system there is a great deal of work still to do before the right systems are in place to meet this objective.

Current gaps and issues that still need to be addressed include:

- Completing the full relocation of the urgent care service in Darlington within the A&E department in Darlington Memorial Hospital.
- Reducing inappropriate emergency ambulance dispatches to A&E departments by reviewing the clinical triage arrangements with NHS 111 to make sure they are sufficient and working effectively.
- Reducing inappropriate emergency ambulance dispatches to A&E departments by ensuring effective clinical support is in place for paramedics including timely response from local primary and urgent care services.
- Reduce inappropriate referrals to ambulatory care and increase appropriate referrals from A&E departments.
- Monitor progress in the two year reduction trajectory for See, Treat and Convey activity and associated increases in Hear and Treat and See and Treat activity.
- There is a need to make sure crisis and liaison support for children and adolescents with mental health needs are sufficient and effective across County Durham and Darlington.
- There is a need to make sure that clinical and referral pathways into recovery services for both adults and young people with an alcohol dependency are sufficiently robust and effective across County Durham and Darlington.

- Reviewing and expanding Community Mental Health Services across County Durham and Darlington to support people in mental health crisis including people with dementia, and providing a patient centred response.
- All System Resilience Group members need to work proactively with the Directory of Service Team to continuously improve access to the NHS Pathways Directory of Service for County Durham and Darlington to promote easier and faster access to appropriate services across health and social care.

6.15 **Objective 7:** The patient will not experience any unnecessary delay in receiving the most appropriate care.

This objective is linked closely to objective six, in making sure that people do not receive any delays in their assessment or treatment of their healthcare needs. If people are able to access the right service, first time, every time, it should significantly reduce any delays patients experience in accessing the clinical support they need to address their healthcare needs.

However, this objective specifically focuses on ensuring there is no waste in the process or shortage of resources once people arrive at the right service, to make sure their needs can be addressed quickly.

One of the key areas that urgent and emergency care systems across the country struggle with is patient flow from entering A&E departments, right through to being discharged from an acute hospital bed, in a timely manner, with the right health and social care support in place, where appropriate. This is particularly important for people with multiple health needs who often need multi-disciplinary support when they return home.

There is a significant focus from both NHS England and locally within the System Resilience Group by all partners to help improve all aspects of patient flow through an acute hospital. The key areas that need to be addressed include:

- Ensuring that Rapid Assessment and Treat is in place to support patients in A&E and Medical Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
- Making sure that consultant-led morning ward rounds take place seven days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
- Making sure that there is sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.
- Complete the redevelopment of University Hospital of North Durham's A&E department to significantly increase capacity, improve patient flow and patient experience.
- Improving ambulance handover times at A&E departments supporting County Durham and Darlington patients.

- Making sure that the ambulatory care service provided by County Durham and Darlington NHS Foundation Trust has sufficient capacity to manage demand.
- Ongoing work to reduce unnecessary breaches of the 95% four-hour wait target.
- Use collated primary, urgent and emergency care demand levels to help understand fluctuations in overall levels of demand across the whole system, particularly surge activity.
- Continue to develop and improve initiatives that reduce acute bed length of stay, particularly for people aged 75 and over.
- The regional management of demand for emergency ambulances through the Regional Flight Deck and local arrangements in North Durham will need to be reviewed and evaluated to determine their effectiveness.
- There is a need to undertake a full review of the patient transport service and discharge transport services to make sure that these services are able to meet demand, are robust and cost effective.
- Work to better understand blockages and pressures throughout the urgent and emergency care pathway, and the most effective approach to alleviate these pressures will need to be further explored, possibly through the use of NHS England's Data Intelligence Tool.
- Ensuring that the mental health acute care pathway processes are as efficient as possible to make sure patients receive a timely response and improve patient experience.
- Expand the current mental health acute liaison service in A&E to 24/7 coverage.
- Ensure that the re-configurations of A&E departments in both Darlington Memorial Hospital and University Hospital of North Durham include the integration of children's care that is also sufficiently resourced.
- County Durham and Darlington NHS Foundation Trust need to make sure that their consultant ward rounds are timely, efficient and effective in facilitating morning and weekend discharges to improve patient flow.
- Although some work has been progressed there is an overall need to develop seven-day service access to a range of key clinical services to support effective discharge management. These include diagnostics, access to diagnostic scanners, cardio-pulmonary tests and pharmacy.
- Timely access to care packages, particularly at times of pressure, during weekends and bank holidays needs to improve.
- The process for people accessing prescribed medication from community pharmacies following discharge from hospital could be streamlined.
- There is a need to put in place an effective Discharge to Assess[4] model reducing delays in hospital discharge.

[4] Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders; NHS England, February 2014

NHS 111 regional workplan

6.16 There are a number of gaps and issues to be addressed in the urgent and emergency care pathway across County Durham and Darlington that are similar or the same as gaps and issues experienced in other parts of the region. The remit of the Urgent and Emergency Care Network is to look at those challenges that are too big for one System Resilience Group to resolve on their own or to make sure there is a consistent solution in place across a region to prevent duplication of resources.

6.17 A regional workplan has been developed which includes the gaps and issues highlighted in bold under each of the above objectives that will be addressed regionally with input from our local System Resilience Group.

7 How are we going to get there?

7.1 To address the current challenges The County Durham and Darlington System Resilience Group have agreed to work collaboratively to provide:

- integrated urgent care services embedded into patient pathways;
- joined up pathways ideally in the community where patients live;
- simpler, safer and more effective services;
- improved patient experience and outcomes;
- a collaborative response to addressing and resolving system pressures across the whole health economy;
- better quality and value for the tax payer; and
- overall the right care, in the right setting, at the right time.

7.2 In essence, the future of emergency and urgent care services across County Durham and Darlington will seek to meet the seven strategy objectives. All partners will need to work jointly, proactively and effectively to review existing resources and pathways, explore alternative options for provision and consider joint commissioning opportunities to make best use of the resources available and ensure a joined up approach for patients.

7.3 Whilst this strategy intends to deliver a shared vision over the next five years, it is acknowledged that health and social care is continually developing and changing and this strategy will need to be reviewed annually to ensure it continues to meet the needs of the population.

7.4 The urgent care strategy actions will be implemented through three workstream areas with specific actions aligned to each workstream. Project leads will be identified for each action. The System Resilience Group will oversee the implementation of the whole action plan, receiving updates and monitoring progress on a monthly basis.

7.5 Each project lead is responsible for ensuring that each project area is supported by the key enablers, communication, workforce, information management and technology, and engagement during the implementation process.

Links to other care pathways

7.6 It should be noted that some of the actions identified within this strategy link directly to work being undertaken within other care pathways, such as the frail elderly and end of life pathways. A joined up approach to prevent duplication will be implemented where appropriate.

High Level Action Plan

This action plan will be reviewed monthly by the System Resilience Group to monitor progress and updated annually during the life of the strategy. The implementation of the actions identified below will, in the main, be the overall responsibility of the County Durham and Darlington System Resilience Group. However, those that are the overall responsibility of the regional Urgent and Emergency Care Network have been separately highlighted. Overall addressing and resolving the system pressures and ensuring an improved patient experience and better patient outcome is the collective responsibility of the whole health economy.

Those actions that are also aligned to the delivery of NHS England's Eight High Impact Interventions have also been clearly identified.

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
Objective 1: People are central to designing the right systems and are at the heart of decisions being made					
1.1	All System Resilience Group commissioners and providers will ensure that appropriate public, patient and clinical engagement and consultation takes place in the delivery of strategy actions to make sure people are able to input their views into the development of local urgent and emergency services in line with the strategy vision	Clinical Commissioning Groups Local Authorities	All SRG Providers	System Resilience Group	
Objective 2: Patients will experience a joined up and integrated approach regardless of the specific services they access					
2.1	Review current provision where appropriate and develop an 'integrated service' for NHS 111 and in and out-of-hours primary care across the Urgent and Emergency Care Network	All Regional System Resilience Groups	All relevant providers	Urgent and Emergency Care Network	✓
2.2	Review and develop local arrangements for enabling GP practices to provide extended hours/additional capacity and increased access opportunities providing a responsive service to both primary and urgent needs seven days a week	Clinical Commissioning Groups	GP Federations	System Resilience Group	✓
2.3	Review, research and develop community-based urgent care clinical hub arrangements within primary and urgent care, ensuring appropriate fit with the Urgent and Emergency Care Network 'integrated service'	Clinical Commissioning Groups	All relevant providers	System Resilience Group	✓
2.4	Develop robust links with the Frail Elderly pathway to ensure each care home has effective arrangements with primary care, pharmacy and falls services for prevention and response training, to support management	Clinical Commissioning Groups	All relevant providers	System Resilience Group	✓

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
	falls without conveyance to hospital where appropriate	Local Authorities			
2.5	Ensure local primary and community services are integrated effectively to provide proactive and reactive support to those at risk of a hospital admission, particularly frail, elderly people who may also have complex needs.	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
2.6	Support the development of appropriate clinical access to patient records to facilitate clinicians to provide the safest outcome for the patient's needs	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
2.7	Expand NHS 111's ability to directly book appointments with GP practices	Clinical Commissioning Groups	GP Federations	Urgent and Emergency Care Network	
Objective 3: The most vulnerable people will have a plan to help them manage their condition effectively to avoid the need for urgent and emergency care					
3.1	Embed the role of peer support, voluntary sector and community networks to help and support people to self-care	Local authorities	All relevant providers	System Resilience Group	
3.2	Develop a clear strategy to help people self-care through individual focused agreed anticipatory care plans	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
3.3	Review existing arrangements and make sure a robust falls prevention approach is in place including comprehensive care management plans for all care homes with primary care, pharmacy, and falls services for prevention and response training, to support management of falls without conveyance to hospital where appropriate	Clinical Commissioning Groups Local Authorities	All Care Home Providers	System Resilience Group	✓
3.4	Continue to develop comprehensive care management plans across primary, secondary and emergency care to proactively support the people who are the most regular attenders at A&E departments	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
Objective 4: People will be supported to remain at their usual place of residence wherever possible					

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
4.1	Ensure that the deciding rights of palliative care patients who have chosen not to be transported to hospital are robustly implemented in all circumstances to respect people's preferred place of death and reduce the number of people dying within 48 hours of a hospital admission	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
4.2	Review and evaluate the effectiveness of a range of local additional clinical support to care homes and understand the impact on reducing acute hospital admissions and re-admissions	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
4.3	Further develop the range of primary and secondary care clinical support to care homes and people within their own homes to make sure everyone has responsive, timely and effective health and social care interventions to avoid a hospital admission where appropriate, and support people with timely safe hospital discharge seven days a week	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
4.4	Clarify the scope of the emergency medication service following evaluation, and training and education of health and social care staff in the proper use of inhalers as a preventative measure	Clinical Commissioning Groups	Community Pharmacies	System Resilience Group	
4.5	Clarify the scope of the minor ailments service in light of availability of real time data	Clinical Commissioning Groups	Community Pharmacies	System Resilience Group	
4.6	Improve the skills of health and social care staff to ensure the consistent application of medication reviews for frail elderly people	Clinical Commissioning Groups Local Authorities	All relevant providers	System Resilience Group	
4.7	Develop responsive children's community services that are integrated with urgent and emergency care services. This includes increasing specialist community paediatric capacity to help further support children and their families at home with acute and chronic disease management	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
4.8	Ensure special patient notes are up to date and available for paramedics to contact local clinical support for vulnerable patients	Clinical Commissioning Groups	North East Ambulance Service	System Resilience Group	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
4.9	Develop intermediate care services in line with the outcome of local reviews	Local Authorities	County Durham and Darlington NHS Foundation Trus	System Resilience Group	
Objective 5: The public will have access to information and guidance in the event of them needing urgent or emergency care					
5.1	Develop and implement patient education and public health messages, particularly throughout winter for urgent and emergency care services, that are appropriately aligned to key national messages	Clinical Commissioning Groups	NECS Comms Team	Urgent and Emergency Care Network	
5.2	Strengthen patient feedback mechanisms to include feedback from patients attending A&E about any perceived or actual barriers they have encountered in trying to first access a GP or urgent care appointment within a timely manner	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
5.3	Ensure public and patient education about the breadth and accessibility of community pharmacy services is comprehensive and effective to make sure community pharmacy services are fully utilised	Clinical Commissioning Groups	NECS Comms Team	System Resilience Group	
5.4	Ensure that community pharmacies provide consistent delivery of key services such as advice on new medications and medicine use reviews	Clinical Commissioning Groups	Community Pharmacies	System Resilience Group	
Objective 6: The patient will be seen at the right time, in the right place, by a person with the appropriate skills to manage their needs					
6.1	Complete the full relocation of the urgent care service in Darlington within the A&E department in Darlington Memorial Hospital	Darlington Clinical Commissioning Group	County Durham and Darlington NHS Foundation Trust	System Resilience Group	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
6.2	Reduce inappropriate emergency ambulance dispatches to A&E departments by reviewing the clinical triage arrangements with NHS 111 to make sure they are sufficient and working effectively	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	✓
6.3	Reduce inappropriate emergency ambulance dispatches to A&E departments by ensuring effective clinical support is in place for paramedics including timely response from local primary and urgent care services	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	✓
6.4	Monitor progress in the two year reduction trajectory for See, Treat and Convey activity and associated increases in Hear and Treat, and See and Treat activity;	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	✓
6.5	Reduce inappropriate and increase appropriate referrals to ambulatory care within County Durham and Darlington hospitals	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
6.6	Make sure crisis and liaison support for children and adolescents with mental health needs is sufficient and effective across County Durham and Darlington	Clinical Commissioning Groups	Tees, Esk and Wear Valleys NHS Foundation Trust	System Resilience Group	
6.7	Make sure that clinical and referral pathways into recovery services for both adults and young people with an alcohol dependency are sufficiently robust and effective across County Durham and Darlington	Local Authorities	Relevant community support services	System Resilience Group	
6.8	Review and expand Community Mental Health Services across County Durham and Darlington to support people in mental health crisis including people with dementia, and providing a patient centred response	Clinical Commissioning Groups	Tees, Esk and Wear Valleys NHS Foundation Trust	System Resilience Group	
6.9	Make sure that the NHS Pathways Directory of Service for County	Clinical	All SRG	System	✓

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
	Durham and Darlington is comprehensively populated with up to date and accurate information to promote easier and faster access to appropriate services across health and social care	Commissioning Groups	Providers	Resilience Group	
Objective 7: The patient will not experience any unnecessary delay in receiving the most appropriate care					
7.1	Ensure that Rapid Assessment and Treat is in place to support patients in A&E and Medical Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	✓
7.2	Make sure that consultant-led morning ward rounds take place seven days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	✓
7.3	Make sure that there is sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	✓
7.4	Complete the re-development of University Hospital of North Durham's A&E department to significantly increase capacity, improve patient flow and patient experience	North Durham Clinical Commissioning Group	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
7.5	Complete the extension of A&E at Darlington Memorial Hospital to include	Darlington	County	System	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
	urgent care and improve care for patients	Clinical Commissioning Group	Durham and Darlington NHS Foundation Trust	Resilience Group	
7.6	Significantly improve ambulance handover times in line with contractually agreed targets at A&E departments supporting County Durham and Darlington patients	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust North East Ambulance Service	System Resilience Group	
7.7	Make sure that the ambulatory care service provided by County Durham and Darlington NHS Foundation Trust has sufficient capacity to manage appropriate demand	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
7.8	Ensure consistent achievement of maximum four-hour wait in A&E from arrival to admission, transfer and discharge at 95% as a minimum	Clinical Commissioning Groups	All Acute Trusts reporting to the System Resilience Group	System Resilience Group	✓
7.9	Use collated primary, urgent and emergency care demand levels to help understand fluctuations in overall levels of demand across the whole system, particularly surge activity	Clinical Commissioning Groups	GP Federations Urgent Care Service	Urgent and Emergency Care Network	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
			Providers Acute Trusts		
7.10	Continue to develop and improve initiatives that reduce acute bed length of stay, particularly for people aged 75 and over	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	✓
7.11	Review and evaluate the implementation, management and effectiveness of the Regional Flight Deck	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	
7.12	Review and evaluate the implementation, management and effectiveness of the Regional Divert Policy	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	
7.13	Review and evaluate the implementation, management and effectiveness of the North Durham Local Divert Policy	North Durham Clinical Commissioning Group	North East Ambulance Service	System Resilience Group	
7.14	Complete a full review of the Patient Transport Service and discharge transport services and implement any agreed recommendations to make sure that these services are able to meet demand, are robust and cost effective	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	
7.15	Work to better understand the blockages and pressures throughout the urgent and emergency care pathway and the most effective approach to alleviate these pressures, possibly through the use of NHS England's Data Intelligence Tool	Clinical Commissioning Groups	All SRG Providers	System Resilience Group	
7.16	Ensure that the mental health acute care pathway processes are as efficient as possible to make sure patients receive a timely response and improve patient experience	Clinical Commissioning Groups	Tees, Esk and Wear Valleys NHS	System Resilience Group	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with Eight High Impact Interventions
			Foundation Trust		
7.17	Expand the current mental health acute liaison service in A&E to 24/7 coverage	Clinical Commissioning Groups	Tees, Esk and Wear Valleys NHS Foundation Trust	System Resilience Group	
7.18	Ensure that the re-configuration of A&E departments in both Darlington Memorial Hospital and University Hospital of North Durham include the integration of children's care that is also sufficiently resourced	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
7.19	Develop seven-day service access to a range of key clinical services to support effective discharge management including diagnostics, access to diagnostic scanners, cardio-pulmonary tests and pharmacy	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
7.20	Ensure timely access to care packages, particularly at times of pressure, during weekends and bank holidays across both County Durham and Darlington	Local Authorities	Local Authorities	System Resilience Group	
7.21	Streamline the process for people accessing prescribed medication from community pharmacies following discharge from hospital	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	

8 How will we measure success?

8.1 There are a number of critical success factors which are essential in order to deliver the plan outlined in this strategy which is outlined below.

Firstly there should be an improvement across all Clinical Commissioning Groups in terms of the constitutional standards as mentioned in Section 2.8 and 2.9 but most specifically in relation to the two relating directly to urgent care:

- A maximum of a four-hour wait in A&E from arrival to admission, transfer or discharge.
- All ambulance trusts to respond to 75 per cent of Category A (the most urgent) calls within eight minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

8.2 In addition there will be other indicators of success, including:

- Patients report that they are accessing the right service, at the right time, first time. These reports may come via patient feedback channels such as patient surveys or the friends and family test.
- Positive patient reported experience of all urgent and emergency care services within the system. Again, this would come via surveys or general feedback.
- Providers feel supported and have sufficient resources to meet patient need.
- Commissioners feel their investment is cost effective and resulting in positive patient outcomes.
- Completion of actions stated within the strategy action plan.
- Minimum 3.5% reduction in overall demand for urgent and emergency care across the whole system.
- Consistent achievement and over-achievement of the national 95% A&E four-hour wait target.
- An improvement in handover times for ambulances at County Durham and Darlington NHS Foundation Trust in line with contractual targets.
- A sustained reduction in delayed transfers of care with consultant-led morning ward rounds seven days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week.
- An increase in the number of patients who use primary care as their first stop for urgent care.
- Able to evidence a reduction in:
    - acute length of stay;
    - inappropriate re-admissions;
    - admissions for people aged 75 and over;
    - reduction in unavoidable deaths in acute settings.
- Services feel they have been enabled to work in a joined up or integrated way.

8.3 As part of the work to consider how best to implement this strategy, the System Resilience Group will consider the best ways to effectively measure these success factors.

8.4 There are a number of key behaviors that will be required from all commissioners and providers contributing to the implementation of this strategy to achieve the critical success factors set out above. These include:

- Strong leadership that empowers individual staff to take responsibility and make appropriate decisions;
- An ability to lead and drive forward cultural change in a positive way;
- The commitment of all stakeholders from frontline staff to executive teams to implementing the strategy;
- A commitment to work collaboratively;
- A determination and mature approach to working through difficult issues collaboratively;
- A recognition that addressing and resolving system pressures is the responsibility of the whole health economy;
- A resolve to ensure that positive patient experience is at the heart of all system changes undertaken.

9 Governance structures

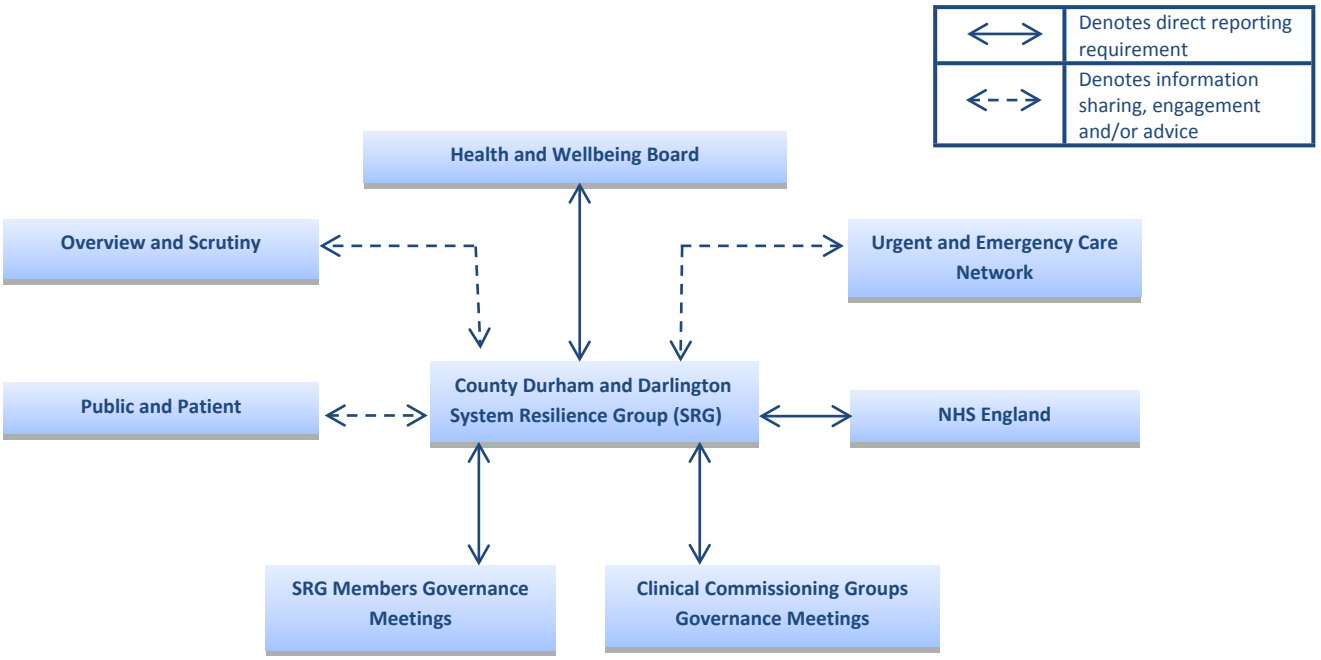
9.1 The System Resilience Group will be responsible for the ownership, oversight and monitoring of the implementation of the strategy action plan.

9.2 Each lead for the actions currently being progressed by the System Resilience Group will be required to provide an update on risks and action taken to mitigate risks on a monthly basis.

9.3 The groups will use the NHS Change Model and its key components to develop the projects, and identify the key enablers and levers that need to be implemented, such as funding streams or outcome measures, to enable transformational change.

9.4 The System Resilience Group is supported by local decision making within partner organisations' own Management Meetings and Boards. NHS England's Durham, Darlington and Tees Area Team has a close working relationship with the SRG, attending the meetings and providing an overall assurance role.

System Resilience Group – Governance Structure September 2015



9.5 More detail on what each of these bodies does is below:

- Health and Wellbeing Board - legal body, responsible for health and wellbeing strategy and ensuring joined up local approach to health and wellbeing overall. The County Durham and Darlington System Resilience Group reports into both local Health and Wellbeing Boards to ensure appropriate engagement and ratification of key areas of work, for example, the urgent care strategy.
- Urgent and Emergency Care Network - based on the geographies required to give strategic oversight of urgent and emergency care on a regional area.
- NHS England - national assurance of local SRG plans and delivery.
- Clinical Commissioning Groups Governance Meetings - local decision making.

- SRG Members Governance Meetings - local decision making.
- Public and Patient - public and patient engagement to support the work of the System Resilience Group is a crucial aspect to ensure the system changes implemented over the life of the strategy are in line with the needs of the public and patients. Appropriate targeted engagement will be undertaken by lead organisations for specific strategy actions as opposed to be being led by the System Resilience Group itself. However, the learning will inform the overall strategic direction as well as help shape local service delivery models.
- Overview and Scrutiny - provides public scrutiny to strategy and system development. The SRG ensures involvement of local Overview and Scrutiny Committees in proposed service changes and the strategy development.
- County Durham and Darlington System Resilience Group - drives delivery, quality, performance, operational resilience, key system improvements, and ensures financial balance.

APPENDIX 1 — Urgent Care Strategy 2015 – 20 Plan on a Page

To be inserted. Summary of vision, objectives, actions, outcomes

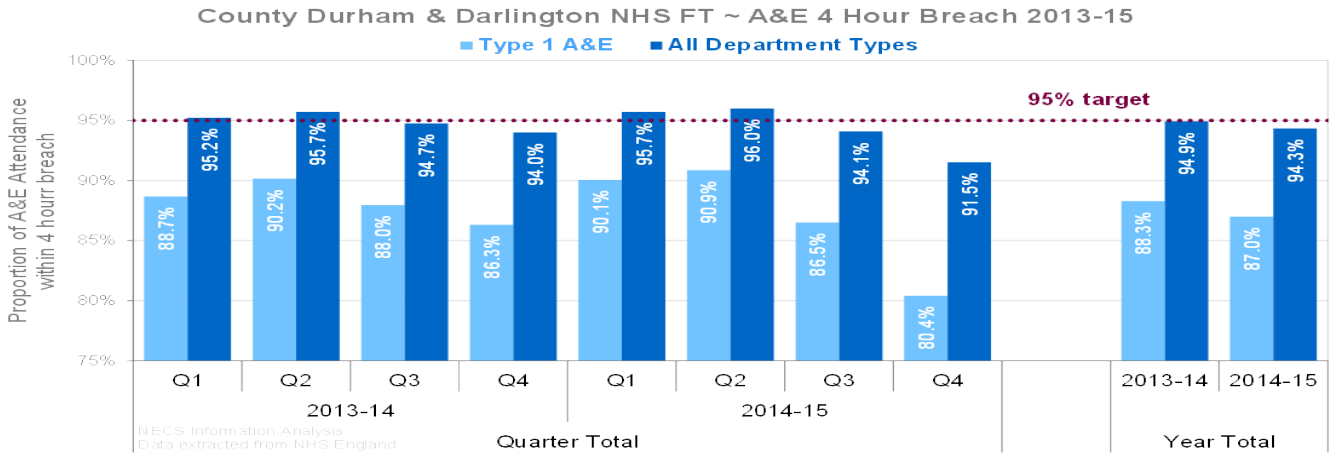
APPENDIX 2 – Eight High Impact Interventions

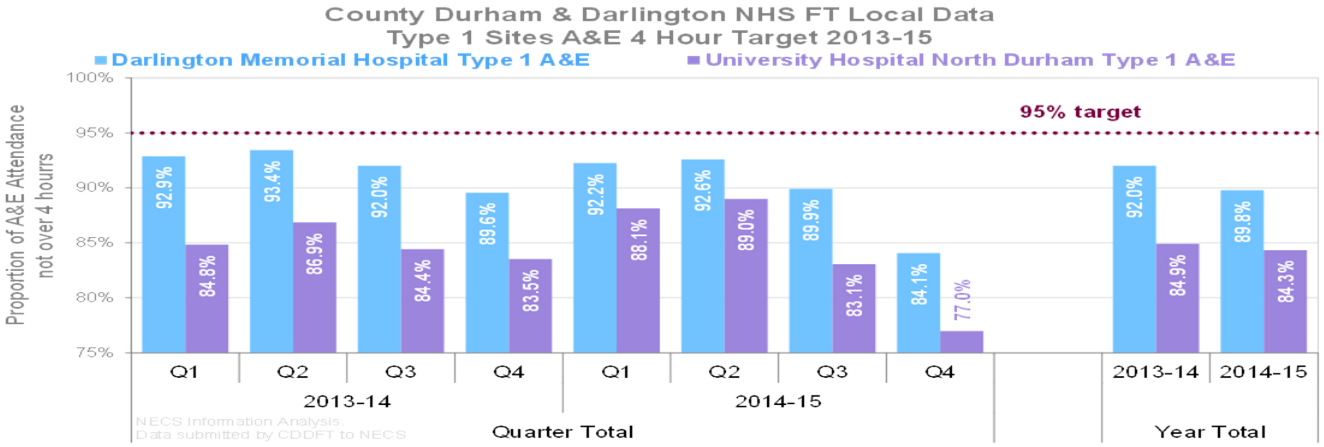
No.	High Impact Interventions
1	No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out-of-hours services.
2	Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.
3	The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.
4	SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
5	Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.
6	Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
7	Consultant-led morning ward rounds should take place seven days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
8	Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the Delayed Transfers of Care (DTOC) rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

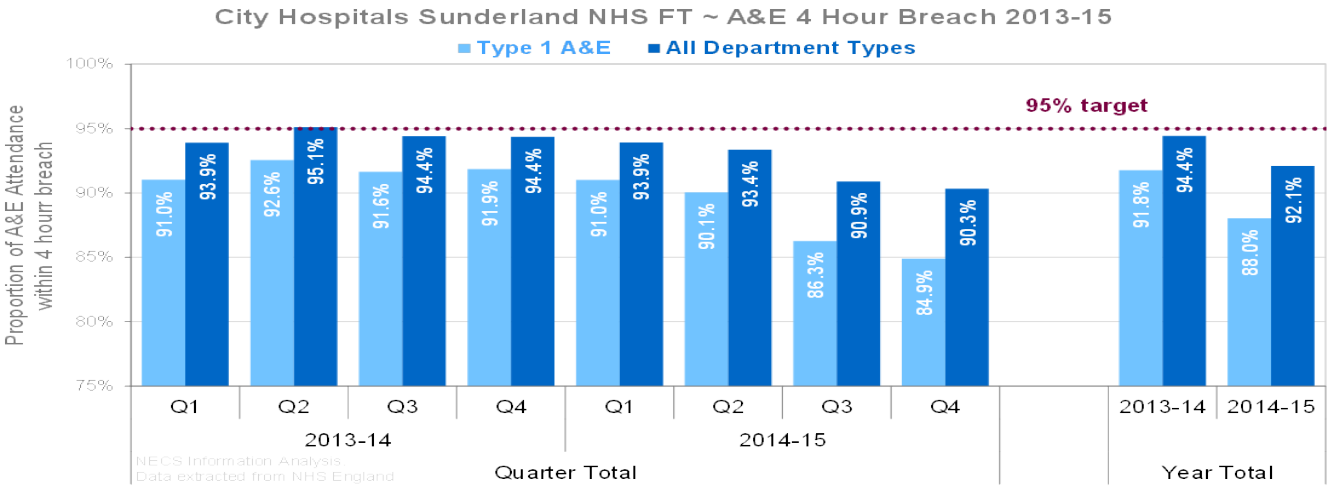
APPENDIX 3 – Local performance and activity information 2013-15

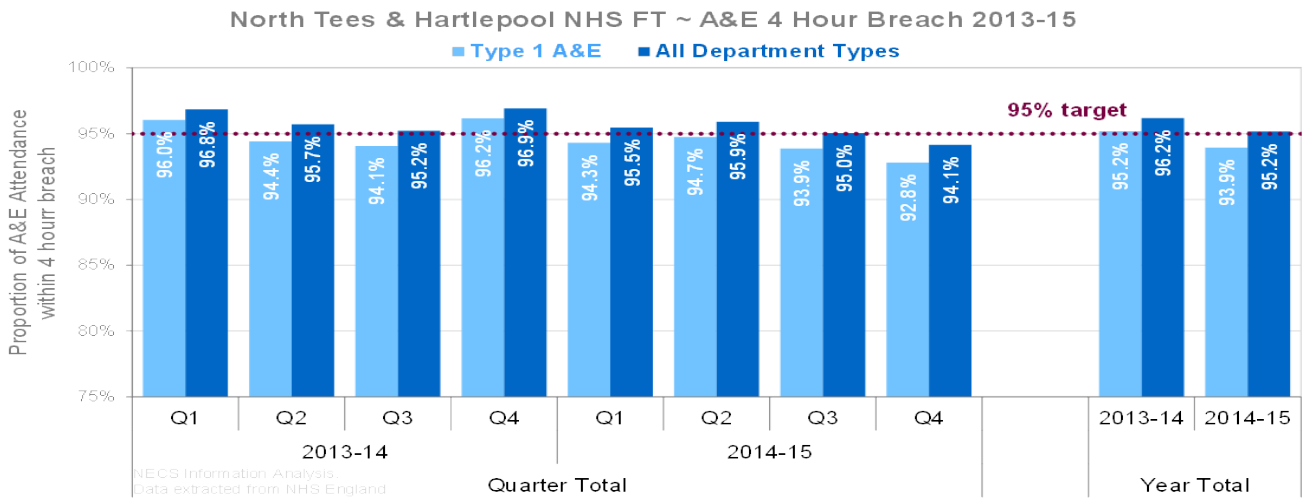
Maximum four-hour wait in A&E from arrival to admission, transfer or discharge at 95%

The ability of each individual trust to achieve the minimum 95% target each quarter and over the year as a whole varies.





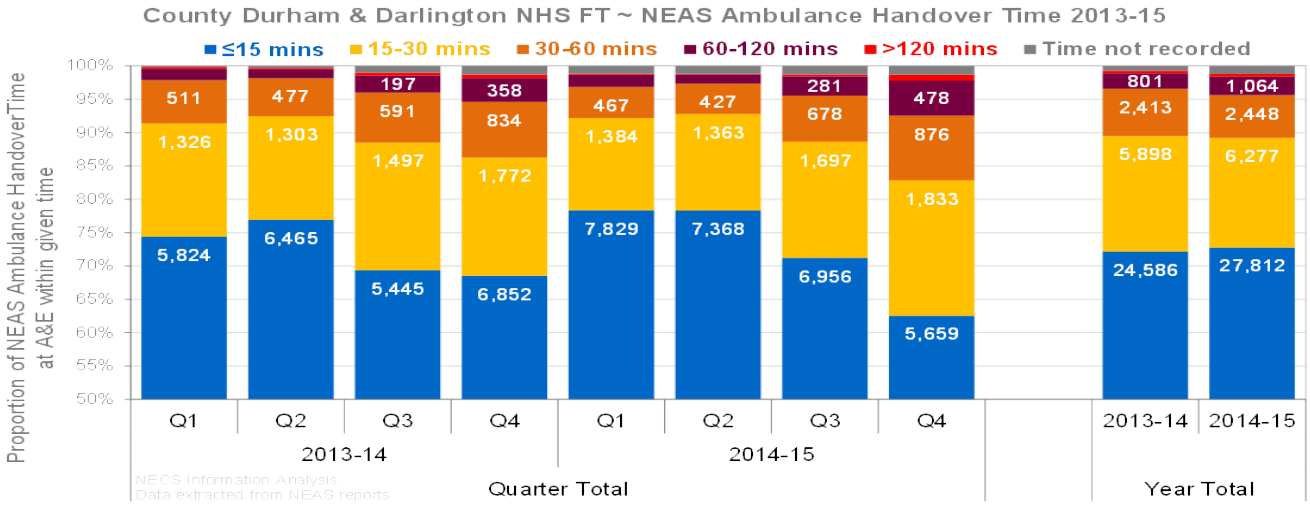


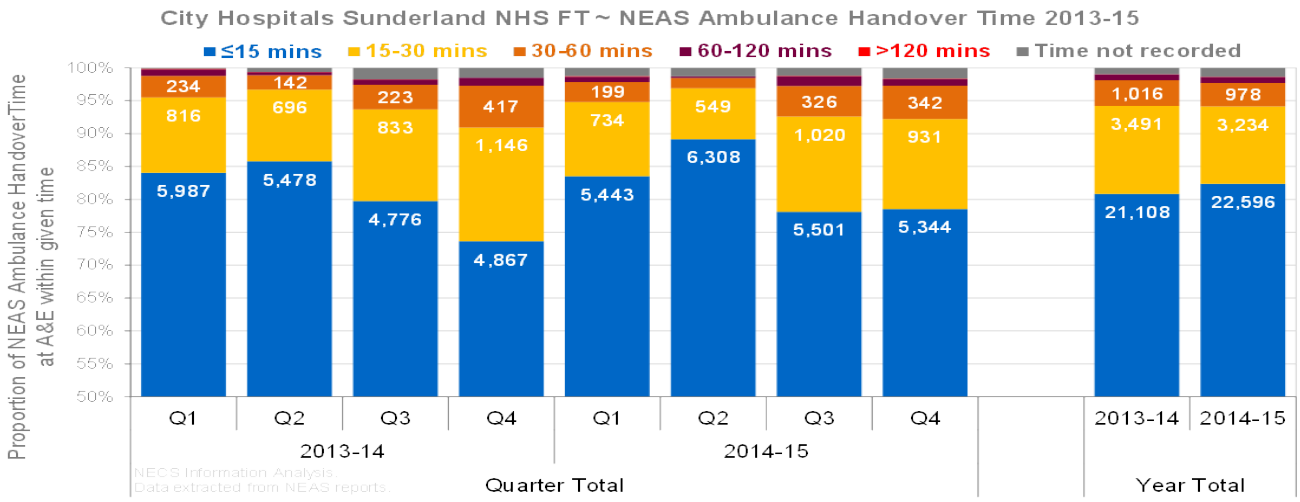


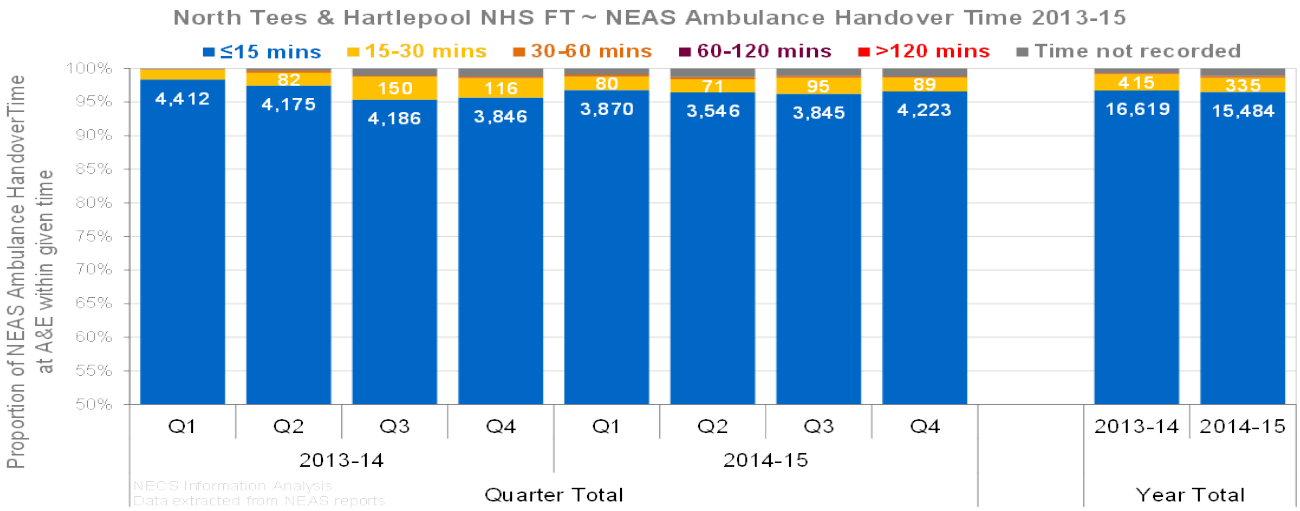
Ambulance Handovers

All ambulance trusts to respond to 75 per cent of Category A (the most urgent) calls within eight minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

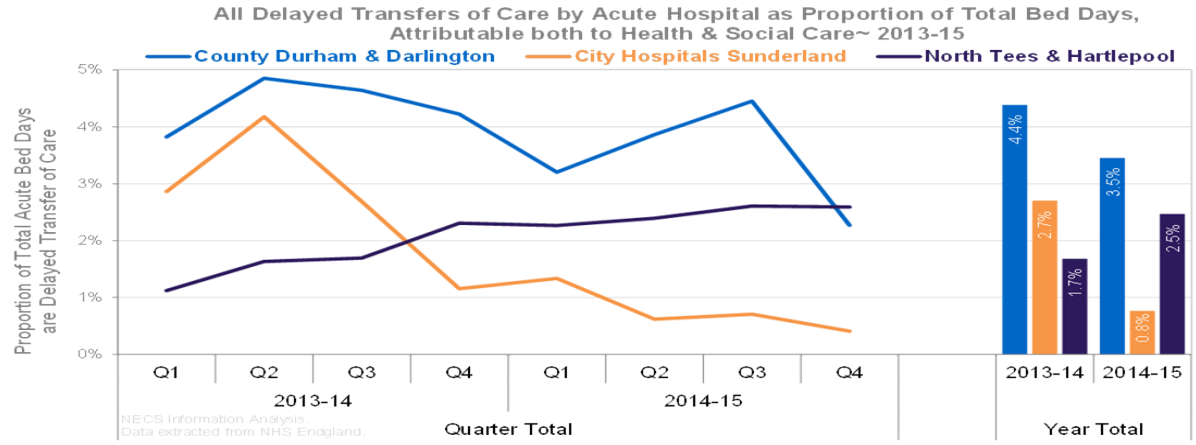
The ability of each individual acute trust to 'clear' an ambulance that arrives at A&E within 15 minutes varies considerably.





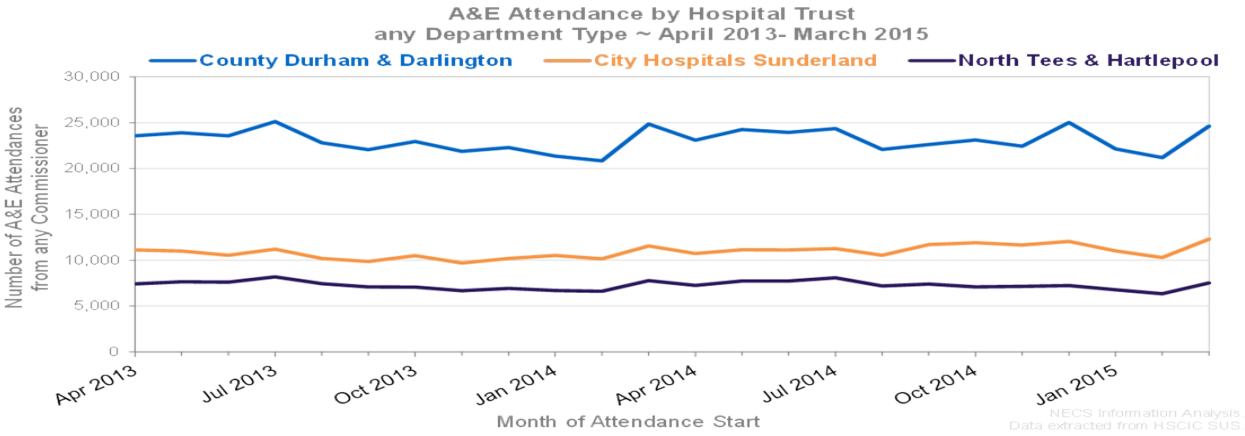


Delayed Transfers of Care

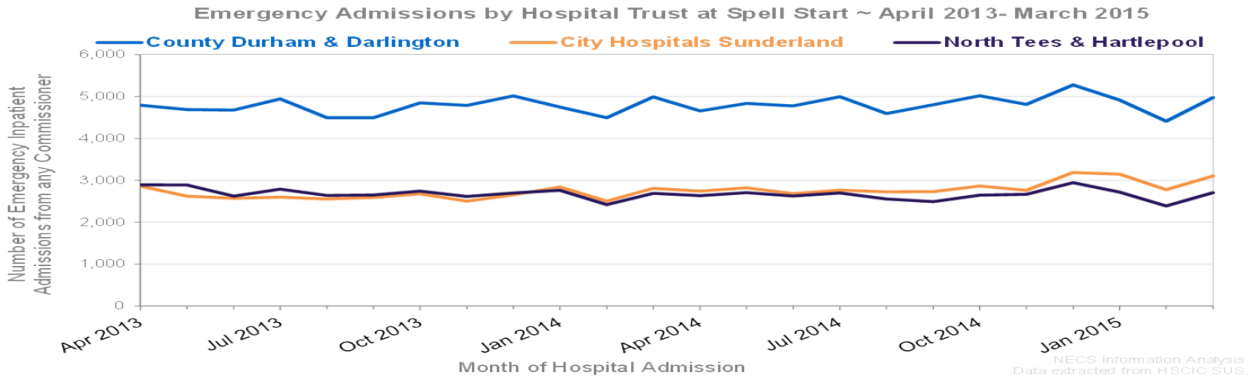


There is a strong focus from NHS England in reducing all delayed transfers of care whether the initial causal factor is health or social care related.

Emergency Attendances



Locally all three acute hospital trusts experienced an increase in the overall number of emergency attendances during winter 2014/15.



Both nationally and locally the number of admissions has seen an increase during winter 2014/15.

APPENDIX 4 – Key national and local policy and guidance

National policy and guidance

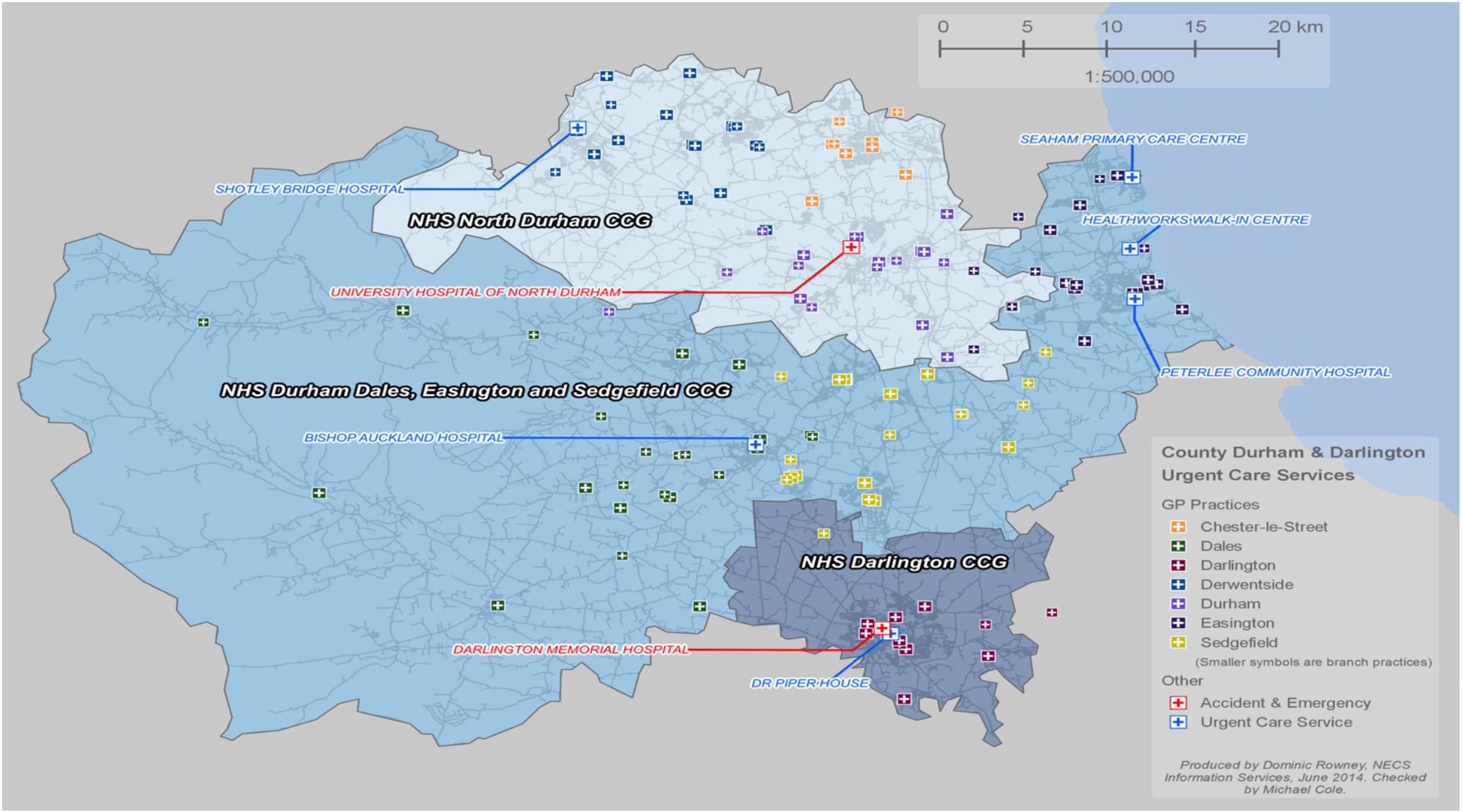
- NHS Five Year Forward View, October 2014
- NHS Operating Framework 2014/15
- NHS England Winter Health Check, March 2015
- Transforming urgent and emergency care services in England, November 2013
- NHS England: Improving A&E Performance Gateway Reference: 00062
- NHS England: Improving and sustaining cancer performance Gateway Reference: 03614
- Royal College of General Practitioners Guidance for Commissioning Integrated Urgent and Emergency Care – A Whole System Approach (2011)
- Primary Care Foundation – Breaking the mould without breaking the system (2011)
- National Ambulance Commissioners Group Achieving Integrated Unscheduled Care - the view from the National Ambulance Commissioners Group (2010)
- Department of Health Equity and Excellence: Liberating the NHS (2010)
- Department of Health A Vision for Adult Social Care (2010)
- The King's Fund: Avoiding Hospital Admissions (2010)
- Department of Health Equity and Excellence: Liberating the NHS (2010)
- Health and Social Care Act 2012
- The Francis Report (2013) http://www.midstaffspublicinquiry.com/report (accessed 8 April 2013)
- Urgent Care Strategy 2013–2018, Hartlepool and Stockton on Tees CCG
- Safe, compassionate care for frail older people using and integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders; NHS England, February 2014
- Handbook to the NHS Constitution, March 2013
- Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis, HM Government, February 2014

Local policy and guidance

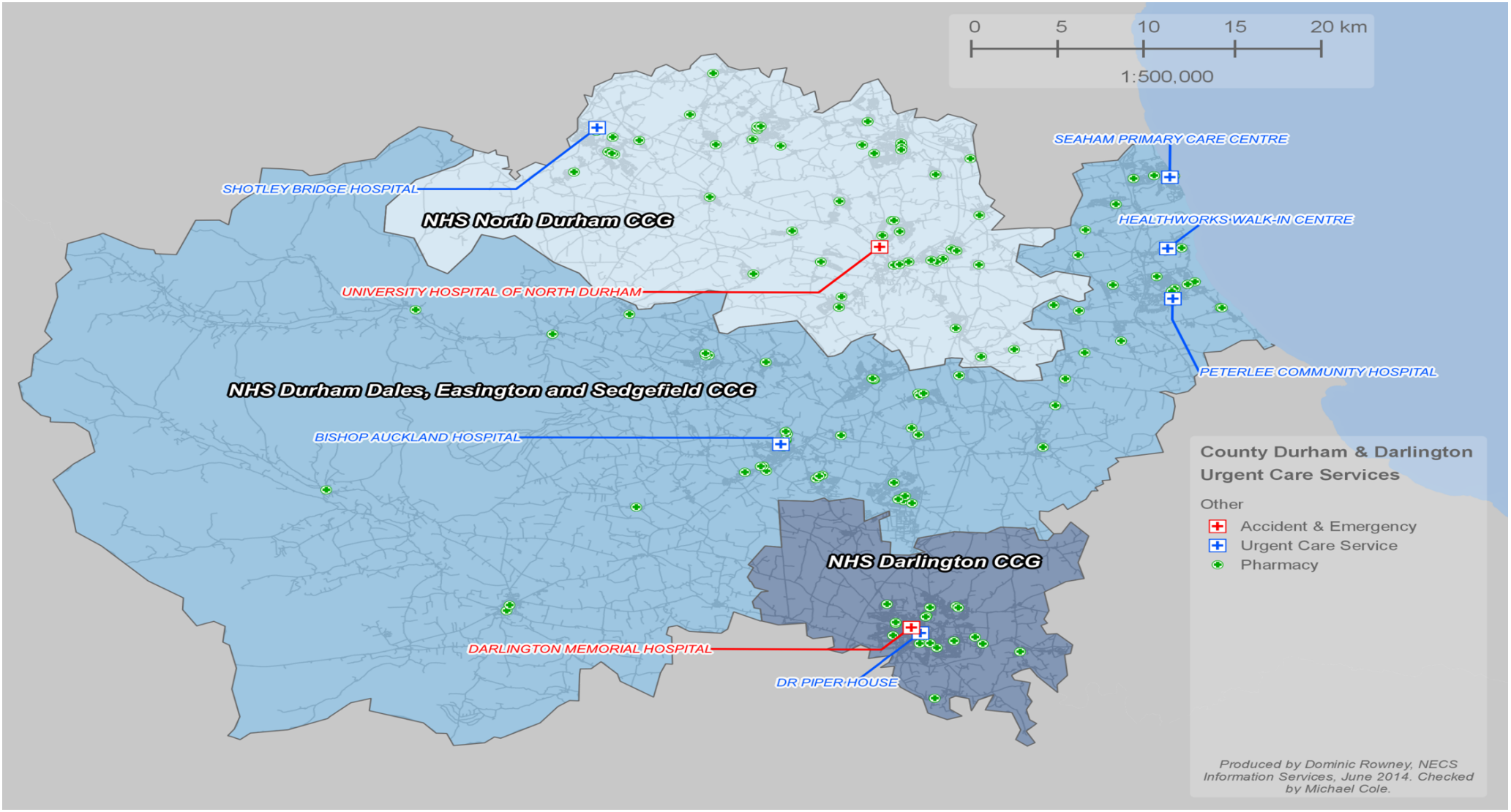
- County Durham and Darlington NHS Foundation Trust Clinical and Quality Strategy: Right First Time 24/7 2014 http://www.cddft.nhs.uk/about-the-trust/quality-matters-our-clinical-and-quality-strategy/right-first-time-247,-our-evolving-clinical-strategy.aspx
- North Durham; Durham Dales, Easington and Sedgefield; and Darlington Clinical Commissioning Groups: Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013–18 http://democracy.durham.gov.uk/documents/s42228/Item%208%20-%20Appendix%202%20%20Improving%20Palliative%20and%20End%20of%20Life%20Care%20Strategic%20Commissioning%20Plan%202013-20.pdf
- County Durham and Darlington Fire and Rescue Service: Three Year Strategic Plan 2015-18 Consultation Document https://www.ddfire.gov.uk/service-plans
- County Durham and Darlington Local Resilience Forum: Annual Report 2013-14 https://www.durham.police.uk/Information-and-advice/Pages/Local-Resilience-Forum.aspx

- Tees, Esk and Wear Valleys NHS Foundation Trust: Business Plan 2014-16 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340252/TEWVALLEYS_Operational_Plan_April_2014_-_March_2016_1_.pdf
- County Durham Partnership: The Sustainable Community Strategy for County Durham 2014-30 http://www.countydurhampartnership.co.uk/Pages/CDP-SustainableCommunityStrategy.aspx
- County Durham Health and Wellbeing Strategy http://www.durham.gov.uk/jhws
- North Tees and Hartlepool NHS Foundation Trust: http://www.nth.nhs.uk/our-vision
- North East Ambulance Service: Strategic Plan Summary for 2014-19 North East Ambulance Service NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust: Operational Plan 2014-16
- *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338071/SUNDERLAND_Operational_Plan_14-16_1_.pdf*
- Durham County Council: Council Plan 2015-18 http://www.durham.gov.uk/media/4847/Council-Plan-2015-2018/pdf/CouncilPlan2015-2018.pdf
- Darlington Partnership: One Darlington Perfectly Placed 2008–26 revised May 2014 http://www.darlington.gov.uk/media/362819/one-darlington-perfectly-placed.pdf
- Sunderland Clinical Commissioning Group: Sunderland Health & Care System Strategic Plan 2014-19: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/392969/SUNDERLAND_Publishable_Summary_Strategic_Plan_1415.pdf*
- Hartlepool and Stockton-on-Tees Clinical Commissioning Group: Clear and Credible Plan Refresh 2014/15 – 2018/19 *http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2013/11/HAST_CCG_5_YEAR_PLAN_FINAL_INTERNAL_WEB-15-August.pdf*

Appendix 5a - Map of current services: hospital sites, urgent care centres and GP practices



Appendix 5b – Map of current services: community pharmacies



Appendix 6 - Glossary

Acute Care	A type of secondary care where a patient receives short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care, or longer term care.
Acute Liaison (mental health)	This service aims to increase the detection, recognition and early treatment of mental health problems, for people within an acute hospital setting.
Acute Medicine	Medicine concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies.
Ambulatory Care	The treatment of a condition that is urgent but that does not need to be assessed and treated within an Accident and Emergency Department. Ambulatory care services may provide assessment and treatment services but the service itself may be provided outside the hospital.
Chronic Care	A type of care that treats pre-existing or long-term illness. Without effective treatment, chronic conditions may lead to disability.
Clinical	The assessment and treatment of actual patients in relation to their healthcare needs.
Clinical Commissioning Groups	NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.
Clinician	A person, such as a doctor or a nurse, who is trained and qualified in the assessment and treatment of medical needs for actual patients, as opposed to a person studying medical research in a laboratory.
Consultant	Medical staff who mainly deliver expert clinical care usually within a team, including the ability to recognise and manage the more complex healthcare needs.
Critical Care	The specialised care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring, usually in intensive care units. This type of care is also known as intensive care.
Emergency Care	A type of care that provides assessment and treatment for people with serious or life-threatening conditions.
Emergency Department	Emergency Department (ED): also known as Accident and Emergency (A&E), or casualty department, is a medical facility specialising in acute care for patients who present without prior appointment, either by their own means or by ambulance.
Experience Led Commissioning	An approach to planning and buying healthcare services. It is built around the idea that if commissioners listen to and deeply understand people's experiences, they will design better, more person-centred services that deliver better care.

General Practitioner	A medical practitioner who treats acute and chronic illnesses and provides preventative care and health education to patients within a primary care setting.
Interventional Radiology	An independent medical specialty that uses minimal invasive procedures to diagnose and treat diseases.
Medical Assessment Unit	Usually receives acutely ill medical patients from primary care via GP referral and referrals from the Emergency Department.
Monitor	Sector regulator for health services in England, Monitor's job is to make the health sector work better for patients.
Multi-disciplinary	Group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.
Multi-speciality community provider	Under this new care model outlined in the NHS Five Year Forward View, GP group practices would expand, bringing in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. These practices would shift the majority of outpatient consultations and ambulatory care to out-of-hospital settings.
Neonatology	Subspecialty of paediatrics that consists of the medical care of newborn infants, especially the ill or premature newborn infant. It is a hospital-based specialty, and is usually practiced in neonatal intensive care units (NICUs).
NHS 111	A three digit telephone service introduced to improve access to NHS urgent care services.
NHS Commissioning Assembly	The community of leaders for NHS commissioning – the 'one team' which will deliver better outcomes for patients.
NHS Constitution	The NHS document that sets out rights for patients, public and staff, and outlines the NHS commitments and responsibilities to make sure the NHS operates fairly and effectively.
Paediatrics	The branch of medicine that deals with the medical care of infants, children and adolescents.
Primary Care	The healthcare given by a health provider who typically acts as the first point of consultation for patients within the healthcare system and co-ordinates other specialists that the patient may need, for example, GPs.
Secondary Care	Secondary care means the healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patients. This may include medical staff who work in an acute hospital environment and those who work within community healthcare teams.
See and Treat	A system developed with the aim of reducing waiting times between patients, thereby reducing the overall maximum wait that some patients experience.
Self-care	Personal health maintenance. Any activity of an individual, family or community with the intention of improving or restoring

	health, or treating or preventing disease.
Unscheduled Care	A term used to describe any unplanned health or social care. Also known as urgent and emergency.
Urgent Care	The delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of the hospital emergency department.
Urgent Care Centre	A centre where urgent but non-life threatening conditions can be treated.
Whole Systems Approach	A whole systems approach is a generic term that means the inclusion of all organisations involved in the commissioning and provision a group of services. Within urgent and emergency care the whole system includes pharmacies, GP Practices, social care, urgent care centres, walk-in or minor injury units, community services, for example District Nursing and Intermediate Care and Acute Hospitals both community hospitals and those with an A&E department.