Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Strategy for Urgent Care

Governing Body meeting

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Is your report for Approval / Consideration / Noting

Consideration and approval.

Are there any Resource Implications (including Financial, Staffing etc)?

There are no new resource implications, although there will be implications regarding prioritisation of resources within the CCG.

Audit Requirement

CCG Objectives

- To ensure there is a sustainable, affordable healthcare system
- To improve patient experience and access to care
- To improve the quality and equality of healthcare in Sheffield

Equality impact assessment

An Equality Impact Assessment has been completed.

PPE Activity

The paper highlights the findings from the engagement undertaken with the public.

Recommendations

The Governing Body is asked to consider and approve the attached strategy for urgent care.

Strategy for Urgent Care

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Executive Summary

This strategy for urgent care describes the need for improvement in Sheffield's urgent care services, a vision for urgent care in Sheffield, and arrangements for achieving that vision, including a proposed action plan for the next six months.

Members of the public have told us that they find current service arrangements confusing and difficult to use appropriately, and national policy is clear that access to urgent care needs to improve.

Our vision is that *"Our new model of urgent care will provide care where needed in the most appropriate setting that is easy to understand and to access for both patients and clinicians".* In Sheffield, in line with the National Vision:

*For those with **urgent but non-life threatening** needs:*

- *We must provide highly responsive, effective and personalised services outside of hospital, and*
- *Deliver care in or as close to peoples' homes as possible, minimising disruption and inconvenience for patients and their families*

*For those people with more serious or **life threatening** emergency needs:*

- *We should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.*

In line with this vision, the strategy aims to achieve the following outcomes:

1. Reorganise local urgent care and services so that the system is less confusing and easier to access
2. Improve access to urgent care provided by GP practices
3. Encourage and support self-care
4. Reduce the number of people attending A&E who could have been treated more quickly and more locally elsewhere
5. Reduce the number of emergency admissions to hospital and the length of stay
6. Ensure urgent care services have access to information to enable them to support people with long term conditions and people approaching the end of their life
7. Integrate physical and mental health care, improving the response for people with mental health problems, dementia, autism and learning disabilities
8. Improve children's urgent care
9. Reduce waiting times for care
10. Reduce expenditure on urgent care

At the heart of this, a future model of urgent care is described, in three components:

- The out of hospital urgent care response.
- Acute hospital provision for serious and life threatening conditions.
- Improving the emergency care pathway through assessment, admission and discharge.

1 Introduction and National Context

1.1 Introduction

Urgent care is the term we use to mean care that is needed immediately or cannot wait long, as opposed to "planned care", by which we mean routine appointments with GPs, consultants or other professionals that are organised in advance.

Urgent health care services include NHS 111, pharmacies, urgent appointments with GPs or other primary care professionals, walk in centres, A&E, and urgent admissions to hospital.

We believe that urgent health care in Sheffield can and must be improved. This document sets out the following:

1 Key issues and the need for a local urgent care strategy

2 Patient experience of current services

3 The vision for future urgent care services

4 Governance structure for implementation with a high level plan

This strategy forms a key element of Sheffield's strategy for Care Outside of Hospital and will be delivered in conjunction with the Primary Care and Active Support and Recovery strategies.

1.2 National Context

The NHS 5 Year Forward View describes the need for a redesign of urgent and emergency care services for people of all ages with physical and mental health problems. Delivery will be through the implementation of immediate improvements and service redesign as well as longer term planned transformation and implementing new models of care. For Sheffield this will mean a significant change in the way that our urgent and emergency care services are provided to our local population; with more care being delivered closer to home and a reduced number of hospital attendances and admissions.

The Five Year Forward View also describes the establishment of Urgent and Emergency Care Networks that will ensure:

- Patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies.
- Networks of linked hospitals are developed that ensure patients with the most serious needs get to specialist emergency services.

- That hospital patients have access to seven day services where this makes a clinical difference to outcomes.
- Proper funding and integration of mental health crisis services, including liaison psychiatry.
- Strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.
- New ways of measuring the quality of the urgent and emergency services
- New funding arrangements
- New responses to the workforce requirements that will make these new networks possible.

1.3 National Strategy for Urgent and Emergency Care

A National strategy for Urgent and Emergency Care (UEC) has been developed with the key priorities focussing on improving out of hospital care, strengthening primary care and developing in hospital care. Sheffield CCG share this ambition and through local and regional collaboration will work together to create an UEC system for Sheffield's patients in order that they can readily access care at a time when they need it. This will be achieved by improving access to and availability of GP appointments, building on the existing successful partnership working with local pharmacists to improve knowledge for self-care and self-medication for minor illness, ensuring that when a life threatening issue arises our patients can be seen quickly and safely in the Emergency Departments.

1.4 Key Emerging National Themes

From a national perspective urgent care in the NHS needs to start to look like what patients tell us they need and not what has been historically offered.

Key developments that must be included in our local service development are:

- A single number for patients to call for all of their urgent health needs.
- Ambulance services being recognised as mobile treatment services rather than only providing conveyance to hospital – Hear, See and Treat.
- Patients being able to speak to a clinician if needed.
- Patient records are always available to clinicians wherever the patient is accessing care (the 111 service, when calling 999 and in the community or hospital).
- Patients can be booked into the right service at a time that is convenient to them.
- Care is provided at home or close to home unless a specialist service is needed.
- Specialist decision support and care is provided through a network.

1.5 Urgent and Emergency Care Network and the Sustainability and Transformation Plan

We will ensure a consistent region wide approach to the interpretation and delivery of the national direction of travel through the local Urgent and Emergency Care Networks (UECNs) of which Sheffield is a core member. The local direction agreed within the

network will be aligned with the vision for the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP). This will ensure delivery of the key regional local priority of the provision of a high quality service offer that is consistent and standardised across our region. This will mean that when people need to access services when they are either at home or travelling (whether in Sheffield or across the region) they will have a clear understanding what services are available, which best meets their needs and a standard way of accessing them.

The strategy and approach outlined below for Sheffield is consistent with the emerging national and local Urgent and Emergency Care Network plans that seek to implement the key themes noted above. This will ensure a sustainable system for Sheffield where patients are seen in the most appropriate place by the appropriate clinician. This approach will also enable both of Sheffield's accident and emergency providers to continue to provide and improve the major trauma and other specialist urgent care services they offer both to Sheffield's patients and the wider region.

2 Current Services and the Need for Change

2.1 Configuration of Local Services

Urgent and Emergency Care in Sheffield is designed to meet the needs of the Sheffield population as well as providing a major trauma centre for the wider South Yorkshire and Bassetlaw region.

The configuration of current services is described below and separated into Major Trauma, Accident and Emergency and the Urgent Care functions. Activity levels and funding are summarised in section 2.8.

1. **Major trauma**: *a regional service for those with more serious or life threatening needs requiring specialist input.* This is currently delivered through two major trauma centres (adult and children's). This service is largely outside the scope of this strategy, as it serves a wider population and has been the subject of recent work to define its purpose and operation.

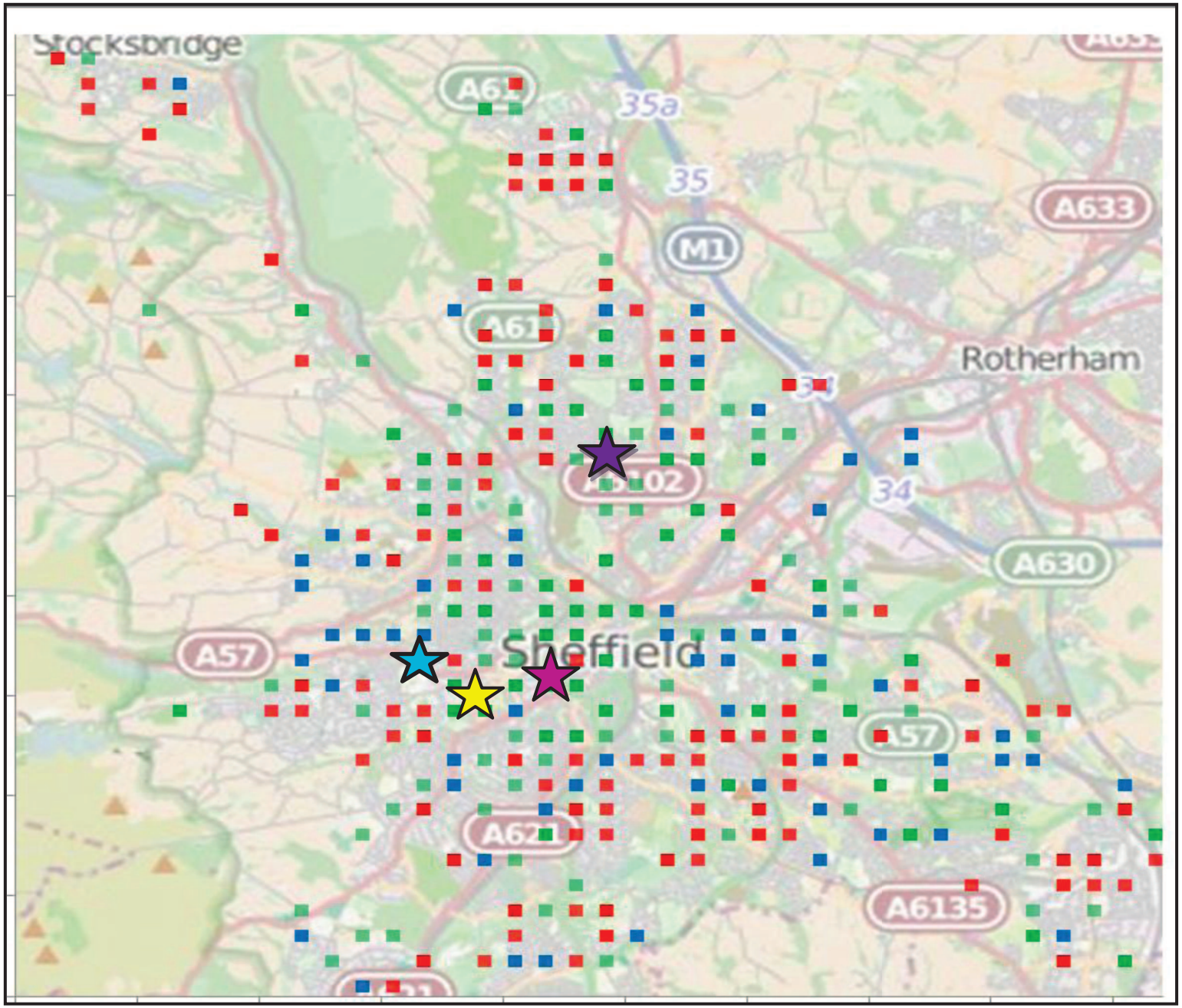
2. **Accident and Emergency**: *a city service for those with more serious or life threatening needs not requiring specialist input but requiring the right level of expertise, processes and facilities.* This is currently delivered through two A&Es (adult and children's). Recently, adult services have found it challenging to meet the four hour wait target. We know that some people who attend A&E could have been treated by more local services, e.g. urgent GP appointments.

3. **Urgent Care**: *a local out of hospital service that supports people with urgent care needs that do not require the expertise, processes or facilities of an acute hospital site.* In Sheffield this is currently delivered by a number of providers. GPs and pharmacies provide the vast majority of urgent care, with Sheffield GPs providing approximately 3.4 million consultations per year. These are supported by a GP out of hours collaborative, a walk in centre (WIC), the 111 service, an eye casualty unit and optometrists in Primary Care.

   In addition, Sheffield, through the Prime Minister's Challenge Fund, has piloted four community hubs providing additional urgent access to GP care in the evenings and at weekends. All of these services are supported both in and out of hours by a well-established pharmacy provider that has gained national recognition for its quality and breadth of services.

However, it is important to note that patients and clinicians both find that urgent care services out of hospital are confusing, with multiple options and the risk that people choose an inappropriate service.

Illustration of demand for out of hours services from Sheffield's GP practices and the location of key support services



- Walk In Centre
- Minor Injuries Unit / Eye Casualty
- A&E Children's
- A&E Adults

Location of GP Practices

- Lowest 20%
- 20 – 40%
- Mid 20%
- 60 – 80%
- Highest 20%

2.2 Patient Experiences of Using Existing Services

In order to understand the experiences of Sheffield's patients when using local urgent care services an engagement exercise has been undertaken, which was supported by all GP practices in the city. A number of public meetings were held and key local groups were also contacted for contributions.

A copy of the full report can be found on the CCG's website (www.**sheffieldccg**.nhs.uk/) along with a supporting report from Healthwatch. Examples of local groups contacted include ZEST, Chily Pep, the Community Wellbeing Team, Sheffield Cubed, Sheffield Futures, Activity Sheffield, Shipshape and Together Women.

The team also worked with colleagues in Sheffield City Council in order to contact the nine protected groups via the Equalities Hubs. Connections were also made with SOAR in the north of Sheffield through the Social Cafés run by Mind.

In areas highlighted as high users of Accident and Emergency, patients were asked for their experiences whilst attending their GPs in Burngreave, Page Hall and Crystal Peaks.

Finally, particular efforts were made to contact harder to reach groups, with visits including meeting residents of sheltered accommodation, a dance club for older ladies and a local epilepsy support group.

The engagement process highlighted a range of issues. A number of recurring themes emerged:

- Problems with access to and variability of GP services.
- Patients are confused as to what services to use and when.
- Patients were frustrated when asked to repeat their history to each clinician they encountered.
- Patients find the local system fragmented with a lack of integration across health and social care.
- Patients had mixed experiences of staff attitude giving descriptions of both of excellent, caring communication and the reverse.
- Different services available to patients depending on where they live in the city.
- Variability of community support/resilience.
- Alternative services available in the community – care closer to home – transport.
- Discharge failures – follow up and consistency of care.

The key focus of the strategy and proposed model will be to reflect these findings and where possible address this changing need. Significant further engagement is planned and this will be part of the wider overarching Care Outside of Hospital agenda.

2.3 Health Needs in Sheffield

The main causes of poor health and premature death in Sheffield are cancer, cardiovascular disease, respiratory disease and liver disease. Each year in Sheffield almost 42% of premature deaths are caused by cancer, and 25% by cardiovascular disease.

Tackling this ill health largely lies with Public Health work and long term condition management. It will be a core element of the CCG's drive to reduce inequalities.

However, despite these efforts patients will still at times need urgent care and services need to be in a position to respond and support the patient in the context of their longer term condition and not simply as an acute illness.

2.4 The Interrelationship between Mental and Physical Health

25-30% of all patients admitted to hospital with a physical illness also have a mental health condition. In most cases this is not actively addressed while the patient is in hospital. This can lead to poorer outcomes of the physical health condition, longer length of stay and for older people an increased risk of discharge to institutional care.

When developing Sheffield's strategy for Urgent Care there is therefore a clear need to ensure greater integration with local services and professionals providing support for both physical and mental health. There is a growing body of evidence that from an urgent care perspective this will reduce demand for A&E services from people with mental health problems or learning disabilities, reduce emergency admissions and readmissions and reduce length of stay in acute hospital.

Significant progress is being made in this area as part of the mental health liaison work stream. This will also integrate with the locally agreed action plan developed out of the national Crisis Care Concordat.

2.5 Children's Services

Sheffield has a dedicated Children's hospital which is in a relatively central location with a high level of Paediatric expertise and so it is not surprising that Sheffield children are high users of the Emergency Care Department. Local clinicians estimate that up between 30%-40% of the Sheffield activity could be managed within a primary care model.

In the wider context the work progressed through the Working Together Programme shows that the current Paediatric rota for acute care across South Yorkshire is not sustainable in its current form. The provision of Paediatric medical care in some areas is really challenged, which potentially means the flow into Sheffield Children's hospital could increase.

Within the hospital there is the potential to improve the model of care provided to children presenting at the Emergency Department and so models around acute assessment of paediatric care are being actively considered.

Along with the above a key element of the local vision is to manage more children's care within community settings and so better links are needed between Children's care across primary and secondary care. Locally, there is also the potential to take this a step further and develop the existing model of care within the community between primary and secondary care services. However, to enable this to be effective greater integration of the pathways of care in the community is required. To enable this integration and ensure more care is provided outside of hospital Child Health Hubs are also being considered to provide early intervention and support services in order to prevent the need for higher levels of care.

It should be noted that the detail and planning of this will be articulated by the Children and Young People's portfolio.

2.6 End of Life Care

In Sheffield there is a range of high quality specialist and generalist end of life care services. End of life care is delivered in a wide range of settings, hospital, hospice, care home and in patients own homes. However the use of end of life care best practice tools is variable and the majority, around 54%, of deaths currently occur in hospital. This is in contrast to national research that has shown that between 50 and 70% of people would prefer to die at home.

Sheffield has an End of Life Care Strategy (2015-18) that sets out the local vision for end of life care. People approaching their end of life, many with multiple long term conditions, are likely to seek urgent care. Proactive planning and advance care planning should enable this to be managed in a way that activates the plan in order to keep the person in their preferred place of care. Delivery of this requires information sharing to ensure all key parties (including GP Out Of Hours (OOH) and the ambulance service) are aware of the advance care plan and care coordination.

2.7 Summary of Key Issues the Strategy Should Address

Considering all the above, this strategy needs to:

1 Reorganise local urgent care and services so that the system is less confusing and easier to access
2 Improve access to urgent care provided by GP practices
3 Encourage and support self-care
4 Reduce the number of people attending A&E who could have been treated more quickly and more locally elsewhere
5 Reduce the number of emergency admissions to hospital and the length of stay
6 Ensure urgent care services have access to information to enable them to support people with long term conditions and people approaching the end of their life
7 Integrate physical and mental health care, improving the response for people with mental health problems, dementia, autism and learning disabilities
8 Improve children's urgent care
9 Reduce waiting times for care
10 Reduce expenditure on urgent care

To conclude, in Sheffield an urgent care system is required that is responsive to need, uses its resources optimally and, where further care is needed rapidly, discharges its patients into a planned pathway of care or self-care. Furthermore, based on current configuration and the needs of the local population, the model for the delivery of urgent and emergency care needs to deliver more care outside of hospital. Hospital provision should focus on delivering only the care that only hospital can provide. The following sections of this strategy set out our proposed vision for urgent care in Sheffield and how we plan to achieve it.

3 Performance, Spend and Opportunities

3.1 Urgent and Emergency Care Demand and Performance

The Sheffield urgent care system is currently under pressure and this is most obviously manifesting itself in access to treatment times in the adult A&E and delays in ambulance handovers of patients. Due to the implementation of a new IT system daily verified 4 hour performance data had not been available for a number of months. However, during that period the unvalidated data available along with proxy measures such as ambulance handover times has implied that this target was not being achieved. However, from the first of May regular reporting of data has resumed and trajectories have been agreed for ongoing and sustainable delivery.

In terms of national context it should be noted that for adults this is in line with the national position where only five type 1 A&E providers of a total of 138 achieved the national target in February (most recently published national data).

These performance issues have not been seen in the city's children's A&E department which was one of the few trusts nationally achieving the target.

It is clear that the A&E target is an indicator of broader systems issues and so consideration will be given to the whole urgent care system. Therefore the scope of this strategy will incorporate a number of features, for example, reducing avoidable admissions, reducing length of stay and ensuring effective and efficient patient flow within the acute sector. Links will also be made with the Care Outside of Hospital agenda in order to provide alternative services and reduce overall demand.

3.2 Current Spend and Opportunities

From a financial perspective, national benchmarking and local data suggest that taking this systems approach will produce a significant opportunity to reduce costs. It should be noted that whilst the local data suggests that both activity and spend have remained relatively stable over the last three years (see Appendix A) the emerging national picture forecasts significant increases in both demand and cost in the coming years.

Current activity and funding:

Nationally, the vast majority of urgent care is provided by GPs working in general practice and this is also the case in Sheffield. Data is not available (nationally or locally) to differentiate between the urgent and routine appointments provided. However, it is estimated that in Sheffield every year approximately 3.4m appointments (urgent and routine) are offered to local patients (adults and children). Similarly, Sheffield's patients also seek advice and guidance from local pharmacies with regard to their urgent care needs (this data is also not available nationally or locally). It should also be noted that recently additional appointments have been provided by the community hubs supported

by the Prime Minister's Challenge Fund. These developments are still at the pilot stage and so data has not been included. However, lessons learned will be incorporated into future planning and system developments.

In terms of other local urgent care services the table below sets out details of activity and expenditure in order to give an indication of their relative size and scale. It should be noted that the units of activity provided are not directly comparable and so caution is advised in terms of reaching early conclusions regarding potential opportunities.

Service	Activity (2015/16)	Spend (2015/16)
Major Trauma Adults	334	£1.7m
Major Trauma Children's	14	£0.1m
Adult's A&E (includes A&E, MIU and Eye Casualty)	136,100	£13.7m
Children's A&E (note just A&E attends as children do not attend MIU or Eye Casualty)	50,664	£4.8m
Adult Non-Elective activity (cost includes admissions and excess bed days)	52,462	£105.3m
Children Non-Elective activity (cost includes admissions and excess bed days)	9,171	£6.8m
Ambulance Services (999)	80,000	£16.8m
The 111 Service	133,443	£1.1m
The Walk in Centre	65,640	£2.8m
The GP Out of Hours Collaborative	49,541	£3.7m

Possible opportunities to reduce costs and QIPP:

- In terms of optimising the system and patient flow national benchmarking suggests an opportunity of £1.7m in excess bed days and so the immediate focus of work will be around a citywide partnership approach to patient flow.
- This will be complemented by the development of a clinical model ensuring patient assessment prior rather than post admission. Early data suggests that this model reduces GP admissions by 20-25%. In addition it is anticipated that the agreement and implementation of a local assessment tariff will deliver QIPP savings in the current financial year of approximately £1.25m.
- In terms of effective utilisation of scarce resources last year over 4000 patients were conveyed to A&E by ambulance who did not receive significant care or investigation and of these over 1000 did not wait to see a clinician. In terms of QIPP savings for this area the immediate anticipated savings will be approximately £100k. This work will also help to ensure safer and improved access to ambulance and A&E services.
- Standardisation of local out of hospital urgent care services to ensure compliance with national guidance regarding Urgent Care Services, Emergency Centres and Emergency Centres with specialist services.

4 Strategy for Future Services

4.1 Vision

"Our new model of urgent care will provide care where needed in the most appropriate setting that is easy to understand and to access for both patients and clinicians".

In Sheffield in line with the National Vision:

*For those with **urgent but non-life threatening** needs:*

- *We must provide highly responsive, effective and personalised services outside of hospital, and*
- *Deliver care in or as close to peoples' homes as possible, minimising disruption and inconvenience for patients and their families*

*For those people with more serious or **life threatening** emergency needs:*

- *We should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.*

In achieving the above we will address the changing needs of our ageing local population as well as those requiring standalone episodic care, the rising levels of unplanned admissions, the current system fragmentation and the overly complicated pathways of care that are difficult to navigate.

4.2 Ambitions

To achieve this vision we have developed 6 strategic ambitions.

1. **Our population will have access to information and a supported level of activation that will enable self-care in order to meet their needs for both urgent care and management of long term conditions.**

2. **The public and care professionals will find urgent care straightforward to access.**

3. **Patient experience of urgent care will be seamless, supported by well described and efficient care pathways.**

4. **Out of hospital services will be designed to deliver a responsive service that is integrated and delivered collaboratively by all key providers.**

5. **Our Sheffield hospitals will solely do what only hospitals can do.**

6. **Our payment and contracting mechanism will deliver a local currency that drives the rapid transformation and sustained delivery of the new urgent and emergency care model.**

5 The Future Model for Urgent Care

The future model for Urgent and Emergency Care is described below in three components:

1. The out of hospital urgent care response.
2. Acute hospital provision for serious and life threatening conditions.
3. Improving the emergency care pathway through assessment, admission and discharge.

5.1 Developing the clinical model

In recent months and years there have been a number of individual positive developments such as the Right First Time programme. However, the above sections show that services are still often difficult for patients and professionals to navigate, and in Sheffield admissions for the frail and vulnerable are increasing with care too often provided by acute services designed to support accident and trauma rather than support for frail and elderly patients and long term condition management.

We propose a new approach that will ensure that the GP's clinical philosophy of 'safety netting' and the patient's home being a place of safety is routinely adopted, rather than the current secondary care physician approach, which instead attempts to mitigate risk through admission to an acute bed.

The new model will look to refocus the configuration of services to reflect the changing needs of the local population and implement a key principle of the Care Outside of Hospital strategy. Local services will be seen and developed as part of an integrated system and will focus on the patient rather than the needs of individual providers with health, social and third sector services better integrated.

The model proposed is primarily focussed on adult services and although many of the same principles apply to children's services and indeed, most primary care services are available to both children and adults, it does not include consideration of children specific services. These will be the focus of separate pieces of work informed by regional developments and delivered by the Children's portfolio and the Working Together Programme.

As part of developing the detailed model significant work will be undertaken to review the evidence base (national and local), build on the engagement to date with both public, patients and providers. Current services will also be appraised in terms of their ability to support the new model, performance and cost effectiveness.

In summary, the proposed approach for urgent care services aims to:

- Simplify services to ensure ease and timely access by patients through simplification of pathways.
- Integrate services in order to support the core aims of reducing unplanned admissions.
- Improve significant issues around system performance.

This approach will also highlight the key links and interdependencies with the Primary Care and Active Support and Recovery Strategies.

Delivering the future model for urgent care in Sheffield will in some cases require major changes to existing services. In order to ensure there is a clear mandate a formal consultation is likely to be undertaken over the summer as part of the Care Outside of Hospital programme.

Services will be configured to support people with:
- Urgent but non-life threatening needs
- Serious or life threatening needs

5.1.1 Urgent but non-life threatening needs

Currently, in hours Sheffield GPs are still providing the majority of urgent care in the city and this will continue. Alongside the Urgent Care Strategy the CCG has developed a draft Primary Care Strategy that sets out our plans for developing primary care services and the primary care workforce.

However, in Sheffield, self-care and the knowledge of how to access services appropriately will be a priority. This will be delivered through a comprehensive programme of communication and engagement with the local population.

The campaign will highlight what patients can/should do in terms of self-care along with signposting to key supporting services such as Sheffield's pharmacy out of hours service for minor illness. This will be an area of particular focus as the service was re-commissioned last year with the provider now offering an even wider range of supporting services than prescribed by current national best practice (both in and out of hours).

Social prescribing will also be developed in Sheffield to ensure greater support across neighbourhoods and the city as a whole with the aim of building individual patient resilience and reduce their use of and need for urgent care services.

In terms of patients seeking urgent care services outside of contacting their GP, the 111 service will be the main point of entry. The service will further develop locally in line with the national agenda and build on the very positive relationship between 111 and the local GP OOH collaborative to ensure ever increasing integration with the Single Point of Access (SPA). In the last year SPA has successfully co-located with social care, ensuring

routine and appropriate use of wrap around health and social care services avoiding inappropriate conveyance to hospital where alternatives exist.

For patients requiring urgent care in their own home successful partnership working with Yorkshire Ambulance Service (YAS) will continue to ensure citywide implementation of 'Hear, See and Treat' and routine use of the Pathfinder software to ensure effective links with supporting wrap around services.

Finally, for the last six months additional urgent capacity within the community has been provided by four GP hubs providing urgent primary care out of hours. These hubs, funded by the Prime Minister's Challenge Fund have offered an alternative to A&E for key cohorts of patients who have struggled to access their GP. The hubs have been signposted through the 111 service and local GP practices. A&E staff have also been diverting patients to the hubs where clinically appropriate. An evaluation will be undertaken of the pilots to understand their cost effectiveness/impact on the wider health system and this will inform decisions around future commissioning.

However, in the immediate term the hub currently based within the GP out of hours collaborative at the Northern General Hospital will be moved in front of A&E to improve ease of physical access for patients. This will also provide an opportunity to pilot a co-located primary care clinical hub and also enable greater integration and co-location of supporting services such as the Single Point of Access. In the longer term the development of an urgent primary care centre in front of A&E will be explored.

It is proposed that the centre is clinically led by local GPs ensuring that strong links are maintained with both the Primary Care and Active Support and Recovery programmes. This clinical approach will enable effective interface both with individual patients and supporting services (neighbourhood, locality or city-wide) ensuring timely focussed wrap around care where needed and that health, social and third sector services are better integrated.

From a clinical perspective the new approach places the GPs and their clinical philosophy of 'safety netting' and the patient's home as a place of safety at the core, rather than the current secondary care physician approach which instead attempts to mitigate risk through admission to an acute bed. This approach will further reduce pressure on hospital services by ensuring the routine and effective use of community based alternatives.

In summary the proposal:

- Reflects the national direction of travel and evidence base.
- Reflects the needs highlighted by local people through the engagement work undertaken.
- Enables a primary filter to redirect patients where appropriate away from A&E/secondary care to alternatives and reduce pressure on A&E performance.
- Provides signposting to, and integration with, wrap around supporting services (either physical or virtual) via the Single Point of Access (at the point of potential admission and discharge from hospital).

- Ensures a clinical approach to risk management which sees the home rather than the hospital as a place of safety.
- Mitigates current pressures and also reduces overall costs (reducing A&E attendances, admission avoidance and reducing length of stay).

5.1.2 Serious or life threatening needs

In addition to developing an integrated out of hospital urgent care response, patients with serious or life threatening injuries will continue to access service in an acute hospital setting. Sheffield's high acuity urgent and emergency care services will be part of the networked service provision across the South Yorkshire and Bassetlaw footprint which is currently being developed as part of the Sustainability and Transformation Plan.

This will ensure existing clinical expertise and patient pathways are not only retained locally but are also further developed through the adoption of national and regional best practice. This approach will ensure patients receive timely triage and assessment prior to admission and are rapidly transferred to the appropriate specialty which best meets their needs.

5.2 Emergency Care Pathways

When developing local emergency care pathways Sheffield CCG has and continues to work closely with Sheffield Teaching Hospitals Foundation Trust which has resulted in a shared local ambition to ensure highly responsive, effective and personalised services for patients requiring urgent and emergency care. This has resulted in a programme of work with key highlights outlined below. It should be noted that much of this work is based on the national best practice *'Safer, Faster, Better'*.

5.2.1 Interface between Secondary Care and Ambulances Services

Effective and efficient interfaces between acute providers and ambulance services are key to ensuring avoidance of unnecessary conveyance to hospital and timely hand over of patients. A key focus of addressing these issues will be the continuation of tripartite discussions between the CCG, the acute hospital and ambulance providers in order to facilitate effective partnership working and implementation of regional and national best practice.

5.2.2 Acute Physician and 'Assess to Admit' pathways

In recent months these pathways have been redefined and have moved away from the assumption of confirmed admission. The new approach is one of assessment and admission only when there is clear need and benefit to the patient.

A key element of this work has been the piloting of a Medical Assessment Centre which has shown promising early results. However, it is clear that it will need significant expansion in order to realise its full potential.

This new pathway, which will be underpinned by the development of a local tariff, now acts as an additional filter to unnecessary admission and also supports A&E by understanding the need for assessment while avoiding the assumption of admission and also enabling use of alternatives to hospital care.

5.2.3 Flow within the acute sector and Proactive Care

In 2013 the NHS Services, Seven Days a Week Forum developed ten clinical standards describing the minimum level of service that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

STH will be an early adopter focussing on the following standards:

Standard 2: Time to Consultant Review
Standard 5: Access to Diagnostics
Standard 6: Access to Consultant-directed Interventions
Standard 8: On-going Review

It is anticipated that this work will be underpinned by formal contracting processes in order to decrease overall length of stay and the delivery of agreed local internal flow standards. This will ensure that local acute services move to the upper quartile in terms of national benchmarking.

A key element of this will be STH becoming a morning organisation to free up beds earlier in the day to ensure timely admission of patients and greater operational resilience.

5.2.4 Discharge of Patients

Implementation of the Lorenzo system will further support discharge planning by transparently providing expected dates for discharge and 'ready to go' dates with all patients who are not medically fit for discharge having a daily review (Monday to Friday) by a senior clinician.

Also, medication required on discharge (referred to as TTOs) is currently one of the key blocks to timely discharge. In order to understand and address this issue Sheffield Teaching Hospitals has undertaken a 'deep dive' review which will result in an action plan for delivery trust wide next year.

5.2.5 Discharge of Complex Patients

Significant work has been undertaken in the last year by the acute sector with a new pathway enabling patients to be discharged and receive assessment for their on-going care in their own homes rather than in hospital.

In the coming year this will be further developed by Sheffield City Council to enable the same pathway to be used for patients being discharged to both residential and care homes.

6 Proposed Outcomes

Along with the delivery of the new clinical model a number of key required outcomes have been identified in response to the issues highlighted above.

6.1 Reorganise local urgent care and services so that access into the system is less confusing by:

- Working with key local partners to reduce the number of entry points to services and ensuring that they are configured in a way that best meets the population needs.
- Further development of the already established local single point of access for patients (the 111 service) to ensure consistent appropriate use of local services.
- Ensure the implementation of emerging national guidance regarding the integration of the 111, 999 services and local providers. This will enhance clinical triage capacity to ensure the correct outcome for the patient.

6.2 Improved access to urgent care provided by GP practices.

- This will be addressed through the Primary Care strategy.

6.3 Encourage and support self-care by:

- Delivery of a citywide communications programme providing patient education and raising awareness of availability of local services.
- Development of citywide social prescribing with the aim of supporting self-care.
- Provision of education to patients through the Active Support and Recovery programmes, local providers and GPs.

6.4 Reduce the number of people attending A&E who could have been treated more quickly and more locally elsewhere by:

- Implementation of the new clinical model (see section 5) ensuring signposting of patients to alternative services where appropriate. For example, the relocation of the GP out of hours collaborative and the piloting of the urgent primary care centre.
- Continuation of local pharmacies offering additional support, education and services (both in and out of hours) through core services and the minor ailments scheme.
- The implementation of the Active Support and Recovery programme and Primary Care strategy.

6.5 **Reduce the number of emergency admissions to hospital and reduce the length of stay.**

Emergency Admissions will be reduced by:

- Further development of the already established local Single Point of Access for professionals (SPA) to ensure equitable access and routine appropriate usage of all local services and further integration of health and social care.

- The implementation of the Pathfinder software within the 999 service to further increase the appropriate use of alternative services and reduce conveyance to hospital.
- The development of an urgent primary care centre in front of A&E on the Northern General site as per the implementation of the new clinical model.
- Undertake the full roll out of the acute physician led Assess to Admit pathway (ambulatory care and medical assessment unit) across Sheffield Teaching Hospitals.

Length of Stay will be reduced by:

- Ensuring the routine usage of the agreed readmission pathway in order that patients are conveyed directly to the appropriate specialty (rather than A&E or ward at either the Northern General or Royal Hallamshire Hospital) and so avoiding outlying and the need for transfer between the two sites.
- Implementation of the discharge to assess pathway to include patients being discharged to both residential and care homes.
- Routine application of the 'Safer, Faster, Better' best practice guidance to ensure proactive care and discharge planning for all patients.

6.6 Ensure urgent care services have access to information to enable them to support people with long term conditions and people approaching the end of their life by:

- Working with the AS&R programme to ensure the robust assessment of patients at risk of admission to enable providers to deliver a joined up approach.
- Routine implementation and usage of shareable person-centred care plans (including OK To Stay Plans).
- Ensuring alternative pathways to admission are accessible to first responders allowing them to refer to community services if appropriate, e.g. following a fall, rather than transport to A&E.
- Care providers identifying those approaching their end of life to enable advance care planning and better coordination of care in the last year of life.
- Ensuring the best care in the last months, days and hours in line with One Chance to Get it Right.

6.7 Integrate physical and mental health care, improving the response for people with mental health problems, dementia, autism and learning disabilities by:

- Implementation of the Mental Health Liaison Programme and its integration with the locally agreed action plan developed out of the national Crisis Care Concordat ensuring improvement in parity of esteem and that true inclusion and 'reasonable adjustments' are in place within urgent care services.

6.8 Improve children's urgent care.

- Develop a Rapid Access Clinic to provide support from Consultant Paediatricians to GPs in the community and improve the management of Paediatrics.
- Undertake a review of the whole pathway of care pre-presentation at the emergency department (South Yorkshire footprint to enable a collective view).
- Following the review consideration of the potential models of care to improve integration and best management of Paediatrics through a pathway of care in both the community and acute sectors (commissioners and providers).
- Exploration of a new model of integrated care for community child health services.

6.9 Reduce waiting times for care.

- Delivery of the new clinical model and key actions outlined above will ensure sustained achievement of the NHS constitutional A&E standard.
- Implementing, as per above, effective signposting, simplification of access points and improved communication between providers will ensure that people are seen effectively and efficiently.

6.10 Reduce expenditure on urgent care through the following:

- Preventing activity by helping local people to manage their own conditions better (see above).
- Ensuring the configuration of the urgent care pathway to assess rather than admit (see above).
- Diverting activity to an alternative clinically appropriate local service or the patient's home based service where appropriate (see above).

Delivery of the above ambitions will not only meet local needs but also ensure the delivery of the national developing themes:

- 111 should be a fundamental part of the local NHS and it should be able to book patients directly into services.
- Development of better and more easily available self-care options.
- Promotion of pharmacy services.
- Accelerated development of advance care planning and end of life care.
- Patients should be able to contact a clinician when needed and have access to GPs 24 hours a day and 7 days a week. This should be in a uniform way that is easy for patients to understand and use.
- There should be a Single Point of Access (SPA) for services and this should encompass both health and social care.
- Co-location of community based urgent care and ambulatory care and delivery of care closer to home where appropriate, practical and affordable.
- Uniformity in services; as current configurations and variability of A&Es, Walk in Centres (WICs) and Minor Injury Units (MIUs) are confusing for patients to use and access.
- Health/summary care records should be available for access across care pathways.
- A focus on influencing patient and clinician behaviour in order that care and services are appropriately accessed and used/provided.

7 Enablers

7.1 Networks and the footprint for commissioning/delivery

In terms of designing the core elements of local urgent care services, it is proposed that the commissioning footprint for both adults and children should be as current. This is due to the size of the local population, the CCG's co-location with the local council, and the configuration of existing local providers.

It is key that, as the strategy is delivered, strong links are maintained with both the Primary Care and Active Support and Recovery programmes, so as services transform they retain an ability to interface effectively both with individual patients and supporting services (neighbourhood, locality or city-wide) to ensure timely focussed wrap around care where needed.

From a regional perspective a number of urgent care services are contracted and commissioned on a larger footprint (ambulances, patient transport, the 111 service etc.) so a key requirement of local services as they develop will be an ability to communicate and work effectively with providers working both in and outside Sheffield.

Recognising this, Sheffield is an integral member of the South Yorkshire and Bassetlaw Urgent and Emergency Care Network, Working Together programme and the developing Sustainability and Transformational Plan (STP). This will ensure that local plans are congruent with regional commissioning aspirations and developments. Where possible these developments will be used to accelerate the delivery of local service transformation, for example by adopting key initiatives piloted through the vanguard sites.

Proactive links will also be made with providers working on regional footprints such as Yorkshire Ambulance Services (YAS) so again key initiatives and learning from other areas can be adopted with the learning and experience gained used to expedite local implementation.

7.2 Patient Transport

Efficient transport systems are a key element underpinning any urgent care system. There is emerging evidence that length of stay is impacted by the time of arrival in hospital. Local services are due to be re-procured on a regional footprint in the next eighteen months. To inform this process a 'deep dive' review has been undertaken to understand local issues in order that future services meet local needs.

7.3 Ambulance Services (999)

Effective partnership between ambulance services and acute providers is key to ensuring that conveyance is avoided where appropriate, and interface and handover are efficient.

Sheffield has a well-established Emergency Care Practitioner workforce and this will continue to develop with the systematic rollout of the Pathfinder software.

Sheffield CCG is also working in collaboration with the other CCGs across the Yorkshire and Humber region and a draft strategy has been agreed which includes the following:

- Development of Care Closer to home
- Improvement of out of hospital services
- Reduction of unnecessary attendances at hospital and admissions
- Ensuring that patients are appropriately treated at scene
- Ensuring that the ambulance services have the right processes, facilities and equipment to maximise patient survival
- Moving from a traditional response to one where there is guaranteed access to state of the art treatment as per the objectives of the Urgent Care Networks
- Integration of 999 & NHS 111 services
- Better deployment of available technology including video conferencing
- An available multi-disciplinary team approach potentially including drugs and alcohol services, midwives and mental health specialists

- Further development of **a Hear and Treat** service including:
    - 24 hours a day and 7 days a week availability
    - Skilled assessment diagnosis and treatment at scene
    - Optimum medical input at the start of patient journey
    - Home management as appropriate
    - An empowered workforce able to take responsibility for prescribing and independent referral working within a multi-disciplinary team
    - Revisions to core clinical pathways so that they are compatible with the new approach. These could include mental health long -term conditions and end of life care.

- Reduced conveyance of patients through:
    - Partnerships with other emergency services including Fire and Rescue.
    - Partnerships with independent providers
    - Partnerships with Voluntary and third sectors

Links have also been made with the West Yorkshire Vanguard focussing around the integration of the 111 and 999 call handling and clinical hubs which it is anticipated will reduce demand on hospital services. Where appropriate, learning from this new approach will be incorporated into local commissioning of services.

7.4 Information Technology

Well-developed local information technology will be vital to ensuring system integration and ensuring appropriate access to patient summary care records across care pathways. Links will be made with Sheffield's Digital Roadmap Development Group to ensure that as the city's IT develops it meets the needs of urgent care (patients, providers and clinicians)

and supports and facilitates integration of services and care pathways. The aim is use technology to support care outside hospital. Care planning will be facilitated by developing technological support for self-monitoring and care, with escalation triggers to allow patients to be kept out of hospital.

7.5 Workforce

A robust, sustainable and resilient workforce will be vital in delivering an effective local urgent care system. This is a significant issue which is being tackled both regionally and nationally with future workforce requirements needing to be determined in the short, medium and long term.

In Sheffield, in terms of delivering the new clinical model there is a need to understand how these future needs will impact locally with urgent care services delivered by a range of clinical professions and allied health professionals. This will achieved through developing a clear understanding of the current workforce profile and future model requirements. This will also require close working with Health Education England to ensure any gaps are addressed and new extended roles are developed where needed. This will feed into the emerging Primary Care Strategy ensuring local workforce planning also takes urgent care into account. Our involvement in the SYB Urgent and Emergency Care network will facilitate regional solutions where a larger footprint is required.

8 Governance and Assurance

This strategy will be led by the CCG as part of the Care Outside of Hospital programme.

Governance and assurance will be provided by the establishment of an Urgent Care Board (see Appendix B for timescales for establishment) which will include the senior local stakeholders and also link with the current key provider led work streams.

The Urgent Care Board will use the outline in Appendix B to develop a system wide approach to the delivery of the key outcomes identified. This will ensure that the plans and timescales are owned by all the key partners and stakeholders across the city.

Delivery of these programmes and projects will be supported by robust project management and supported by the Programme Management Office. This will ensure effective and timely monitoring of progress and proactive management of risk. Monitoring of progress will be provided through a dashboard of indicators and detailed delivery plan. These will be shared via the Integrated Performance and Delivery Board (IPDG) and the System Resilience Group.

9 Delivery and Implementation

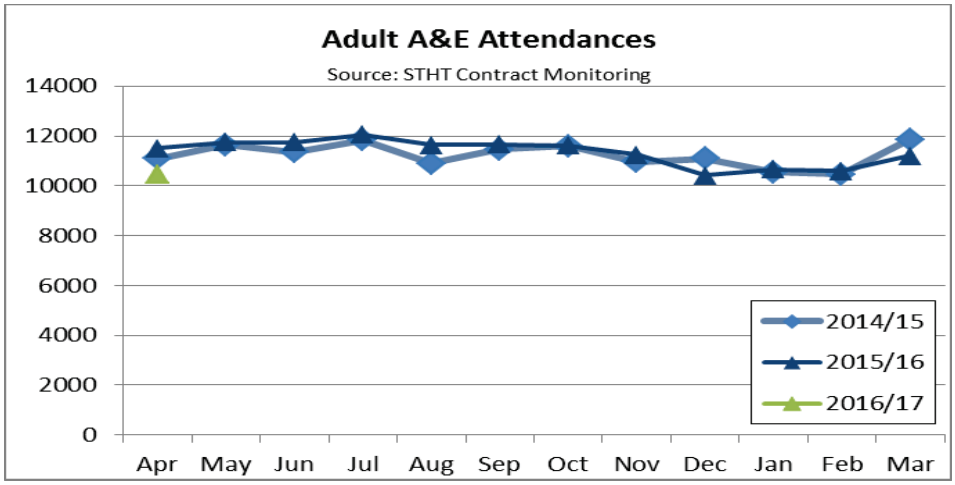
As outlined above, this strategy will be implemented by a partnership of providers and commissioners across the city represented by the Urgent Care Board. This city wide partnership will oversee the development and implementation of plans in order that the key outcomes of the strategy are realised. It will also ensure a systems approach is maintained and that key partners held to account.

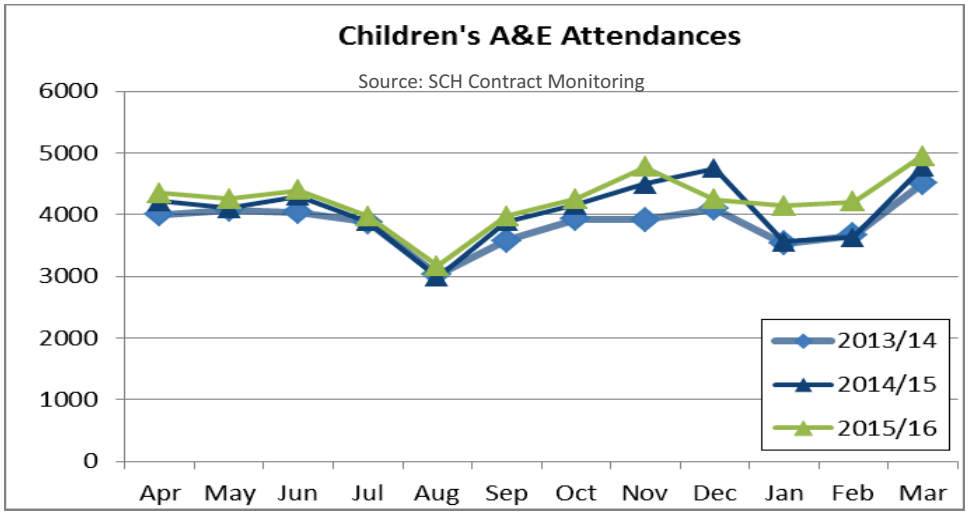
In summary, urgent care needs to change in line with the changing needs of the city's population. The system needs to be reshaped so that care can be delivered much closer to the patient's home, with support services available that allow care to occur in the place most appropriate to the patient. This requires a change in culture, contracts and services, but represents one of the biggest opportunities we have in Sheffield for removing inefficiencies and improving patient outcomes.

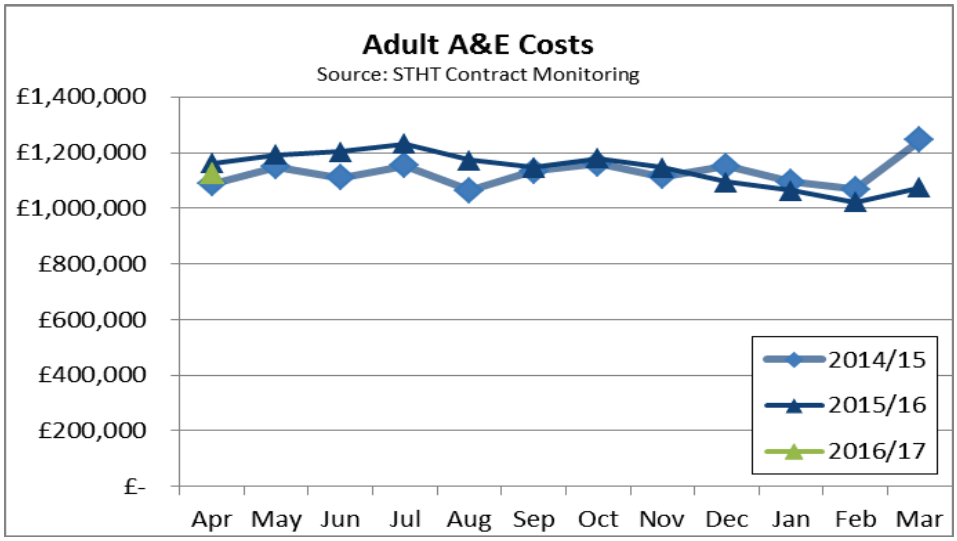
Appendix A

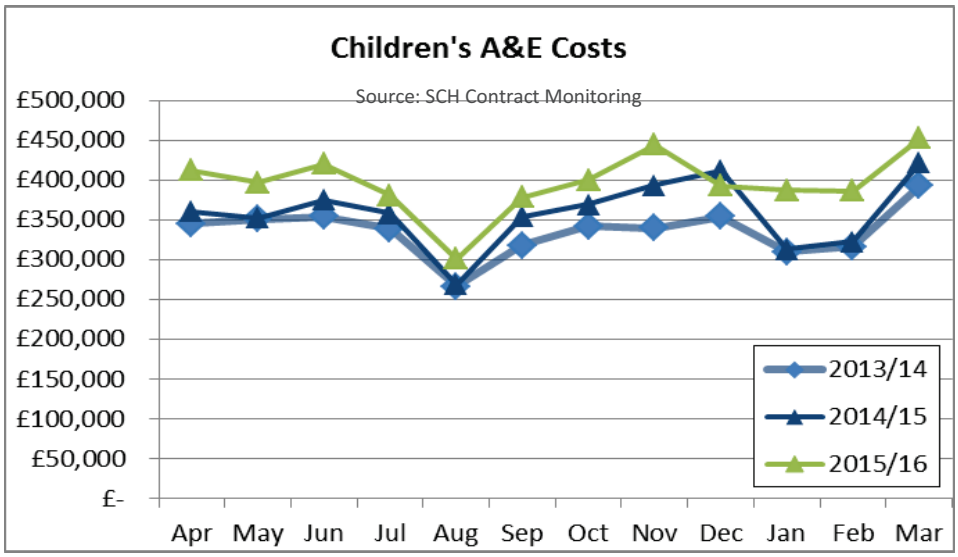
Below is the data for the last three years showing trends for A&E attendances, A&E costs, inpatient spells and their associated costs and also the cost incurred for excess bed days.

It should again be noted that whilst the local data suggests that both activity and spend have remained relatively stable over the last three years the emerging national picture forecasts significant increases in both demand and cost in the coming years.






Adult A&E Costs
Source: STHT Contract Monitoring
£1,400,000
£1,200,000
£1,000,000
£800,000
£600,000
£400,000
£200,000
£-
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2014/15
2015/16
2016/17


Children's A&E Costs
Source: SCH Contract Monitoring
£500,000
£450,000
£400,000
£350,000
£300,000
£250,000
£200,000
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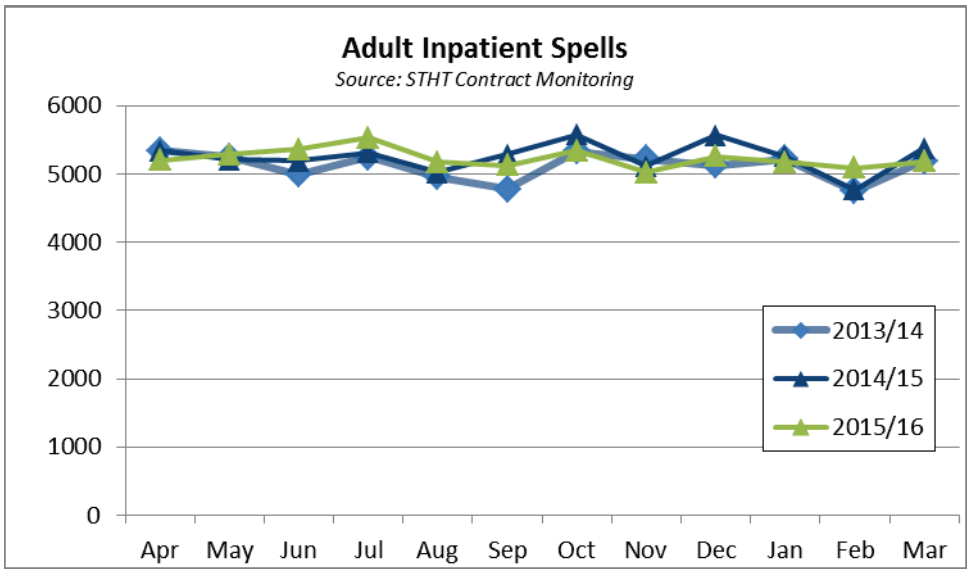
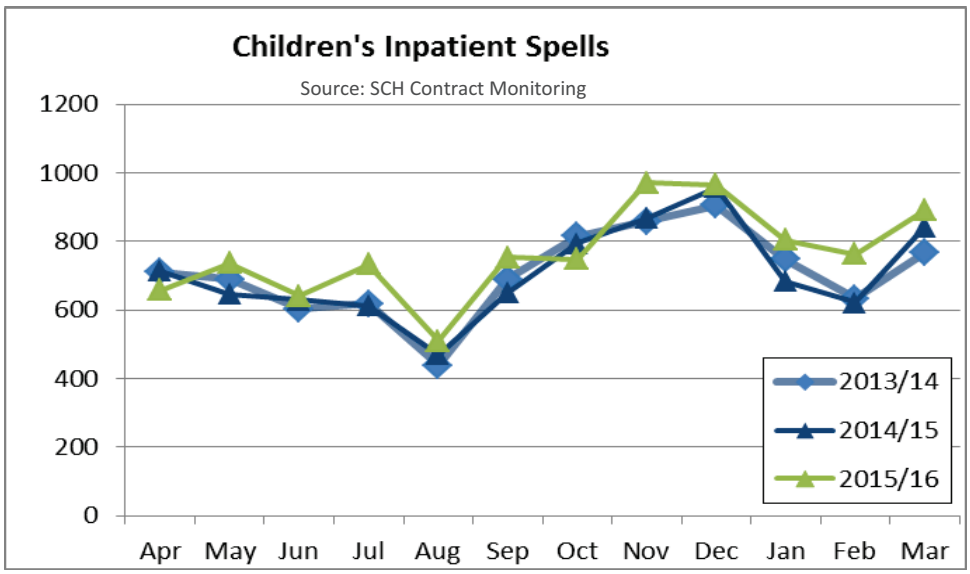
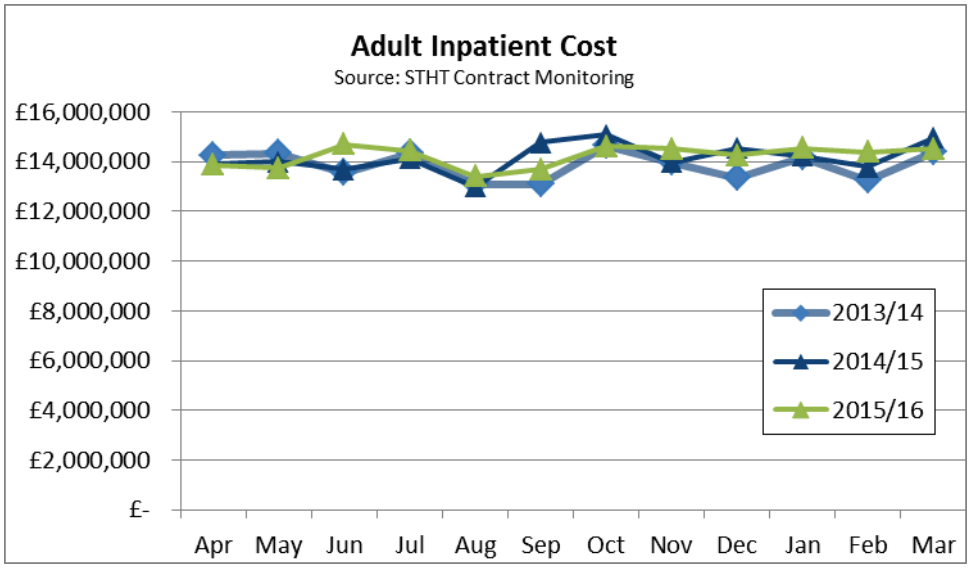
£100,000
£50,000
£-
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2014/15
2015/16


Adult Inpatient Spells
Source: STHT Contract Monitoring
6000
5000
4000
3000
2000
1000
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2014/15
2015/16


Children's Inpatient Spells
Source: SCH Contract Monitoring
1200
1000
800
600
400
200
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2014/15
2015/16


Adult Inpatient Cost
Source: STHT Contract Monitoring
£16,000,000
£14,000,000
£12,000,000
£10,000,000
£8,000,000
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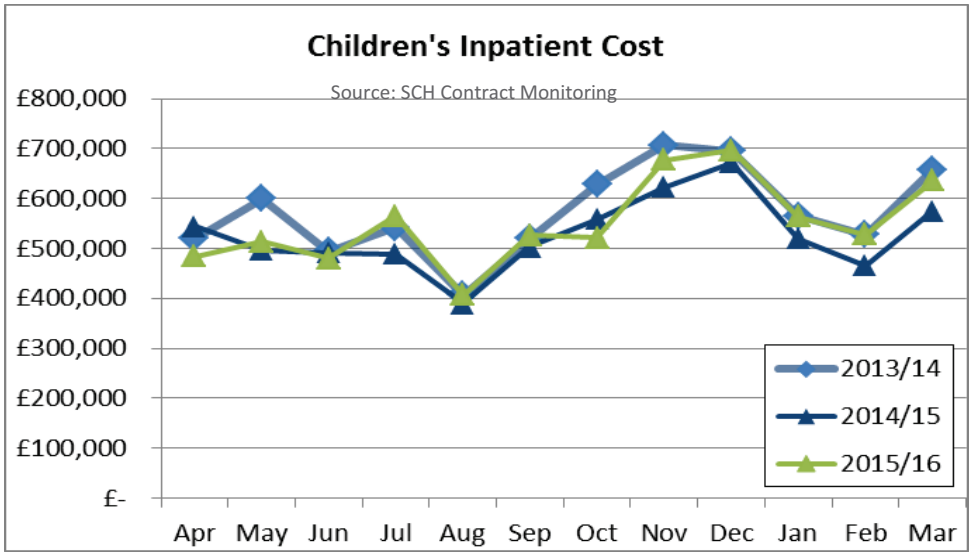
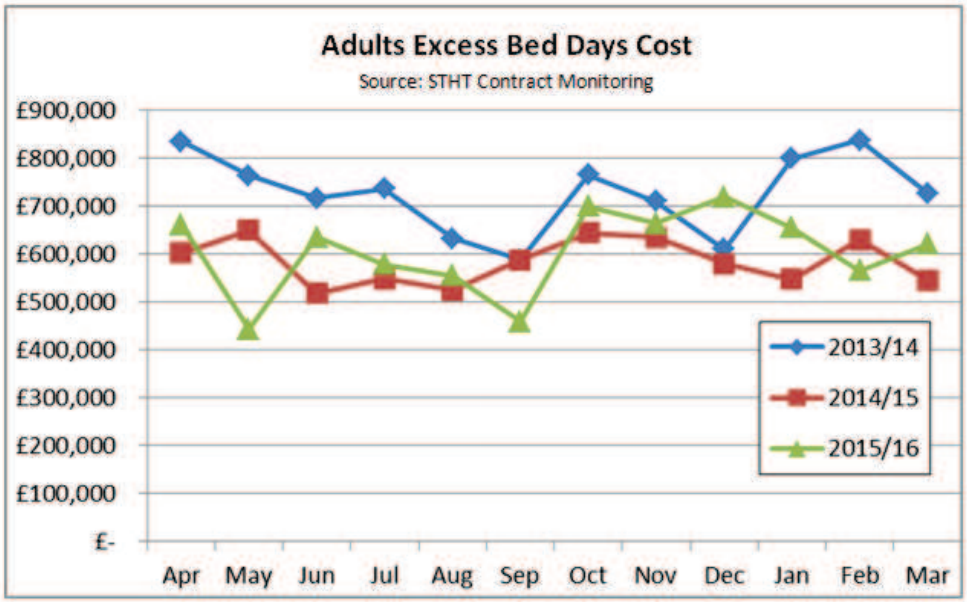
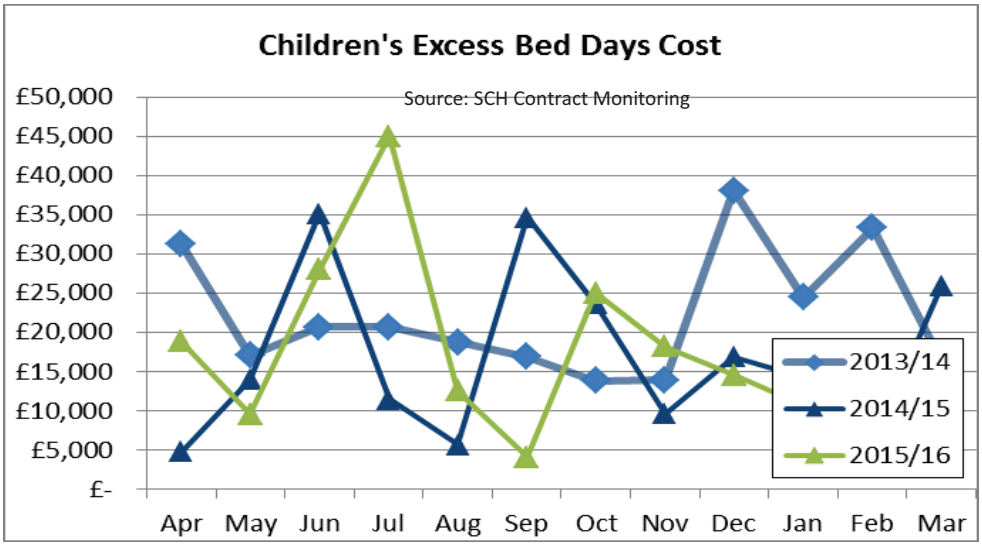
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2014/15
2015/16


Children's Inpatient Cost
Source: SCH Contract Monitoring
£800,000
£700,000
£600,000
£500,000
£400,000
£300,000
£200,000
£100,000
£-
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2014/15
2015/16


Adults Excess Bed Days Cost
Source: STHT Contract Monitoring
£900,000
£800,000
£700,000
£600,000
£500,000
£400,000
£300,000
£200,000
£100,000
£-
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2014/15
2015/16


Children's Excess Bed Days Cost
Source: SCH Contract Monitoring
£50,000
£45,000
£40,000
£35,000
£30,000
£25,000
£20,000
£15,000
£10,000
£5,000
£-
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2013/14
2014/15
2015/16

Appendix B: Urgent Care Strategy Delivery Plan

Outcomes/Milestones	Action	Start	Finish
Developing the Urgent Care Strategy			
Complete and sign off the urgent care strategy		1-May-2016	24-May-2016
Establish the Urgent Care Board			
Key initial stakeholder meeting and development of UC Board (May 2016)		26-May-2016	26-May-2016
UC Board to confirm the city wide strategy and implementation plan		26-May-2016	30-Jun-2016
Monthly Board meetings (city-wide membership)		16-Jun-2016	31-Mar-2017
Continuation of public and patient engagement			
Continue to engage with the out of hospital strategy and the ongoing public and patient engagement plan		25-May-2016	31-Mar-2017
Reorganise local urgent care and services so that the access into the system is less confusing			
Reduce the number of entry points to services and ensure that they are configured in a way that best meets the population needs.	Review local Urgent Care services and entry points	1-Jun-2016	15-Aug-2016
	Findings presented to Urgent Care Board with recommendations for future developments	15-Aug-2016	31-Aug-2016
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
Further develop the already established local single point of access for patients (the 111 service) to ensure consistent appropriate usage of local services.	Review Directory of Services and usage.	1-Jun-2016	15-Aug-2016
	Recommendations presented to Urgent Care Board with recommendations for future developments	15-Aug-2016	31-Aug-2016
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
Implement the emerging national guidance regarding the integration of the 111, 999 services and local providers. This will enhance clinical triage capacity to ensure the correct outcome for the patient.	Work with Urgent and Emergency networks to develop options to implement at regional level.	1-Sep-2016	1-Sep-2016
	Options presented to Urgent Care Board with recommendations for future developments	1-Oct-2016	31-Oct-2016
	Recommendations presented to Governing Body for future commissioning arrangements	3-Nov-2016	3-Nov-2016
Pilot a primary care co-located clinical hub	Relocation and co-location of GP OOH collaborative and PMCF hub	1-Nov-2016	30-Nov-2016
	Evaluation of pilot (incorporating professional and patient views)	1-Nov-2016	28-Feb-2017
	Recommendations presented to Governing Body for future commissioning arrangements	1-Apr-2017	1-Apr-2017

Appendix B: Urgent Care Strategy Delivery Plan

Outcomes/Milestones	Action	Start	Finish
Improved access to urgent care provided by GP practices.			
Implementation of the primary care strategy	See Primary Care Strategy Delivery Plan for actions.	26-May-2016	31-Mar-2017
Encourage and support self-care			
Deliver a citywide communications programme providing patient education and raising awareness of availability of local services.	Implementation of the campaigns: * Public Health England campaign 'One You' * Pharmacy First * 111 * Fresher's * Stay Well This Winter	1-Mar-2016	31-Mar-2017
Develop a citywide social prescribing programme with the aim of supporting self-care.	Urgent Care to work with AS&R as required (See AS&R Delivery Plan for actions and timescales)	26-May-2016	31-Oct-2016
Provide an education to patients through the Active Support and Recovery programmes, local providers and GPs.	Urgent Care to work with AS&R and support PLIs as required (see AS&R Delivery Plan and the CCGs PLI schedule for topics, actions and timescales)	26-May-2016	31-Mar-2017
Self Care Campaign: Support through communications and engagement, our citizens to have the skills, knowledge and confidence to self-care	Continue with the campaign by signposting to key supporting services such as pharmacy	1-Apr-2015	31-Mar-2017
Reduce the number of people attending A&E who could have been treated more quickly and more locally			
Implement the new clinical model ensuring signposting of patients to alternative services where appropriate. For example, the relocation of the GP out of hours collaborative and the piloting of the urgent primary care centre.	Clinical model will be implemented by the actions outlined above and below.		
Continuation of local pharmacies offering additional support, education and services (both in and out of hours).	Review of local services with NHSE guidance 'Extending the role of community pharmacy in urgent care'	26-May-2016	15-Aug-2016
	Findings and recommendations presented to Urgent Care Board	15-Aug-2016	31-Aug-2016
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
	Further development of local pharmacy services programme to exceed National guidance	1-Sep-2016	31-Mar-2017
The implementation of the Active Support and Recovery programme and Primary Care strategy.	see AS&R and Primary Care Delivery Plan for topics, actions and timescales	26-May-2016	31-Mar-2017
Reduce the number of emergency admissions to hospital and reduce the length of stay.			
Emergency Admissions: Further develop the already established local single point of access for professionals (Single Point of Access) to ensure equitable access and routine appropriate usage of all local services and further integration of health and social care.	Review of local SPA service	26-May-2016	15-Aug-2016
	Findings presented to Urgent Care Board with recommendations for future developments	15-Aug-2016	31-Aug-2016

Appendix B: Urgent Care Strategy Delivery Plan

Outcomes/Milestones	Action	Start	Finish
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
Emergency Admissions: Implement the Pathfinder software within the 999 service to further increase the appropriate use of alternative services and reduce conveyance to hospital.	Yorkshire and Humber CCGs to require YAS to implement Pathfinder software	26-May-2016	1-Sep-2016
Emergency Admissions: Develop an urgent primary care centre in front of A&E on the Northern General site as per the implementation of the new clinical model.	Develop Clinical model and specification	26-May-2016	15-Aug-2016
	Recommendations presented to Urgent Care Board with recommendations for future developments	15-Aug-2016	31-Aug-2016
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
Emergency Admissions: Undertake the full roll out of the acute physician led Assess to Admit pathway (ambulatory care and medical assessment unit) across Sheffield Teaching Hospitals.	Pilot Medical Assessment Unit (MAU) for all GP admissions	1-Nov-2015	1-May-2016
	Establishment of MAU on a permanent and ongoing basis subject to contractual discussions	1-May-2016	31-Mar-2017
Expedited discharge	Undertake a rolling programme of Multi-disciplinary Accelerated Discharge Events at times of high demand	31-Mar-2016	31-Mar-2017
STH to implement action plan to reduce emergency readmissions	STH complete readmissions audit	4-Nov-2015	31-Mar-2016
	Review for a 1 week period the presenting patients and route causes for readmission using service improvement resource to create readmission categories	1-Feb-2016	31-Mar-2016
	Integrate readmissions focus into the flow programmes for COPD, #NOF and alcohol/poisons	1-Dec-2015	31-Mar-2016
	Focus clinical audit on <7 day re-admissions to review hospital care and discharge processes linked in particular to higher risk groups	1-Jan-2016	31-Mar-2016
	Monitor readmission rates through Lorenzo and review the potential to flag readmissions on whiteboards	1-Jan-2016	31-Mar-2016
	Re-admissions within 72 hours and patients with post-operative problems who present within 2 weeks of discharge returned to specialty rather than ED - Patients are referred to the right place first time.	11-Dec-2015	31-Mar-2016

Appendix B: Urgent Care Strategy Delivery Plan

Outcomes/Milestones	Action	Start	Finish
Length of stay: Ensure the routine usage of the agreed readmission pathway in order that patients are conveyed directly to the appropriate specialty (rather than A&E or ward at either the Northern General or Royal Hallamshire Hospital) and so avoiding outlying and the need for transfer between the two sites.	Pilot new admission pathway for all readmitted patients	1-Nov-2015	1-Feb-2016
	Establishment of new admission pathway on a permanent and ongoing basis	1-Feb-2016	31-Mar-2017
Length of stay: Implementation of the discharge to assess pathway to include patients being discharged to both residential and care homes.	Sheffield to roll-out internal discharge to assess Trust-wide	1-Nov-2015	1-Sep-2016
	All patients who are medically fit for discharge will have a senior review on a daily basis (Monday - Friday) with review of EDD and RTGs	26-May-2016	1-Sep-2016
	STH to implement a standard outlier policy for all specialities (with the exception of palliative and critical care)	26-May-2016	1-Sep-2016
Length of stay: Routine application of the 'Safer, Faster, Better' best practice guidance to ensure proactive care and discharge planning for all patients.	Stock-take on Sheffield's position with regard to SFB best practice guidelines	26-May-2016	1-Jul-2016
	Findings presented to Urgent Care Board with recommendations for future developments	15-Aug-2016	31-Aug-2016
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
Ensure urgent care services have access to information to enable them to support people with long term			
AS&R programme to ensure the robust assessment of patients at risk of admission (CPM+) to enable providers to deliver a joined up approach.	See AS&R Delivery Plan for actions and timescales		
Routine implementation and usage of shareable person-centred care plans (including OK To Stay Plans).	Stock-take on Sheffield's current level of implementation and usage.	26-May-2016	15-Aug-2016
	Findings presented to Urgent Care Board with recommendations for future developments	15-Aug-2016	31-Aug-2016
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
Ensure alternative pathways to admission are accessible to first responders allowing them to refer to community services e.g. following a fall rather than transport to A&E if appropriate.	Stock-take on Sheffield's current level of implementation and usage.	26-May-2016	15-Aug-2016
	Findings presented to Urgent Care Board with recommendations for future developments	15-Aug-2016	31-Aug-2016

Appendix B: Urgent Care Strategy Delivery Plan

Outcomes/Milestones	Action	Start	Finish
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
Care providers identifying those approaching their end of life to enable advance care planning and better coordination of care in the last year of life, including One Chance to Get it Right.	Stock-take on Sheffield's current level of implementation and usage.	26-May-2016	15-Aug-2016
	Findings presented to Urgent Care Board with recommendations for future developments	15-Aug-2016	31-Aug-2016
	Recommendations presented to Governing Body for future commissioning arrangements	1-Sep-2016	1-Sep-2016
Integrate physical and mental health care, improving the response for people with mental health problems,			
Implementation of the mental health liaison programme and its integration with the locally agreed action plan developed out of the national Crisis Care Concordat ensuring improvement in parity of esteem and that true inclusion and 'reasonable adjustments' are in place within Urgent Care Services.	Formal procurement process currently underway- new service to start Jan 2017	1-Mar-2016	4-Jan-2017
Improve children's urgent care.			
Develop a Rapid Access Clinic to provide support from Consultant Paediatricians to GPs within the community and improve the management of Paediatrics.	SCH to implement.	1-Apr-2016	1-Aug-2016
Undertake a review of the whole pathway of care pre-presentation at the emergency department (South Yorkshire footprint to enable a collective view).	Review of whole pathway of care completed.	1-Feb-2016	13-May-2016
Following the review consideration of the potential models of care to improve integration and best management of Paediatrics through a pathway of care within both the community and acute sectors (commissioners and providers).	CYP Portfolio to consider options.	16-May-2016	31-Jul-2016
Exploration of a new model of integrated care for community child health services.	See Delivery Plan for CYP Community Chil	1-Apr-2016	31-Mar-2017
Reduce waiting times for care.			
Effective Interface between Emergency Services and Secondary Care through implementation of best practice	YAS and STH to implement best practice from region.	10-Nov-2015	18-Dec-2015
	YAS to arrange and provide HALO level management support at times of pressure at NGH	10-Nov-2015	18-Dec-2015
	YAS to ensure routine usage of self handover protocol where appropriate	10-Nov-2015	4-Dec-2015
	Individual PINs for A&E staff to support joint handover in line with rest of region	1-Dec-2015	30-Apr-2016

Appendix B: Urgent Care Strategy Delivery Plan

Outcomes/Milestones	Action	Start	Finish
	Agree & implement change in practice - STH clinicians will not close ED to ambulance discharge	10-Nov-2015	18-Dec-2015
Deliver the new clinical model and key actions outlined above will ensure sustained achievement of the NHS constitutional A&E standard.	See above.		
Implement, as per above, effective signposting, simplification of access points and improved communication between providers will ensure that people are seen effectively and efficiently.	See above.		
Reduce expenditure on urgent care through the following:			
Preventing activity whether by helping local people to manage their own conditions better (see above).	See above.		
Ensuring the configuration of the urgent care pathway to assess rather than admit (see above).	See above.		
Diverting activity to an alternative clinical appropriate local service or the patient's home based service where appropriate (see above).	See above.		