NHS Rotherham CCG Governing Body – November 2015

CHIEF OFFICER'S REPORT

Lead Director:	**Chris Edwards**	Lead Officer:	n/a
Job Title:	**CCG Chief Officer**	Job Title:	n/a

Purpose

This report informs the Governing Body about national/local developments in the past month.

CCG Annual Assurance 2014/15

The attached letter provides a formal record of our final assurance rating for 2014/15, and should be read in conjunction with our formal letters of feedback for Quarters 3 and 4 from NHS England

Final 2014/15 Assessment:
NHS England's headline assessment of the CCG is: "Assured" and this is supported by individual assessments of each of the six assurance domains described in the 2014/15 CCG Assurance Framework.

The letter from NHS England gives more detail

Appendix (1)

CCG Assurance: Checkpoint Discussion

Meeting with the regional team on 1 October 2015, at the Sandal Rugby Club in Wakefield.
The attached letter details key points of the discussion and actions.

Appendix (2)

Rotherham Health & Wellbeing Strategy

The Rotherham Health and wellbeing strategy has been approved by the Health & Wellbeing Board subject to approval by the Governing Body. Once approved the strategy will be designed and formatted for publication.

Appendix (3)

Rotherham Petition Against Marches

An online petition against repeated extremist protests in Rotherham which have regularly closed down town centre shops was launched on the 5th October.
The petition – led by Rotherham Council Leader, Cllr Chris Read - aims to draw Government attention to the significant adverse impact which the series of marches and demonstrations are having on the town and the strength of feeling which exists.
At the same time, leaders of Rotherham agencies, groups and communities have joined forces in a statement of solidarity, calling for a halt to the disruption caused by the protests and encouraging local residents and business people to sign up, and encourage everyone they know to do the same.

Under the banner of Enough is Enough, partners have come together to galvanise a borough-wide commitment to promoting positive images of Rotherham and its prospects for the future, whilst reiterating the need for justice for the victims and survivors of child sexual exploitation, and discouraging any activity which detracts from these aims. **Appendix (4)**

Partners call on the Government to look again at the current legislation around protest activity, given the number of marches which have taken place over the last 18 months in Rotherham and the impact on community relations. They refer to a number of what appear to be racially-motivated attacks on local people over recent weeks.

The petition adds weight to correspondence which Government Commissioners – appointed earlier this year to run Rotherham Council – and others in the town have already sent to the Home Secretary Teresa May in a bid to stop the demonstrations.

The petition can be found at: www.rotherham.gov.uk/enough

Commissioners Working Together

Working Together Commissioners have held discussions with scrutiny committee colleagues across Mid and South Yorkshire, Bassetlaw and North Derbyshire on 12 October 2015.
The attached presentation gives a good overview of the work to-date and what needs to be actioned in the future.

Appendix (5)

GP Chair Appointed to Urgent and Emergency Care Network for Commissioners Working Together

Dr Steve Lloyd has been appointed as chair to the Commissioners Working Together Urgent and Emergency Care Network (UECN). Steve is Chair of Hardwick CCG and a GP Principal in North East Derbyshire. He has been clinical lead on the East Midlands urgent ambulance contract and involved with National Ambulance Commissioners Network. He has also worked as county lead on 111 and sessional clinical lead for the county Out Of Hours provider in Derbyshire and regional 111 provider. He is a member of East Midlands Clinical Senate Council and has recently been nominated as a commissioning representative on the East Midlands Trauma Network.
Steve will work one session a week to get the network established and is keen to ensure that true clinical engagement is at the very heart of the network. He will be in touch with chairs and provider colleagues soon.
Maddy Ruff, from Sheffield CCG will be taking over the Accountable Officer lead for the urgent care work stream of Commissioners Working Together.

Urgent and Emergency Care Networks operate strategically, covering a footprint of 1-5 million (depending on population density, rurality, and local factors). Their purpose is to improve the consistency and quality of UEC by bringing together system resilience groups (SRGs) and other stakeholders to address challenges in the urgent and emergency care system that are difficult for single SRGs to address in isolation. This includes coordinating, integrating and overseeing care and setting shared objectives for the Network where there is clear advantage in achieving commonality for delivery of efficient patient care (e.g. ambulance protocols, NHS 111 services, clinical decision support and access protocols to specialist services such as those for heart attack, stroke, major trauma, vascular surgery and critically ill children).

Commissioning Standards Integrated Urgent Care – Letter from Dame Barbara Hakin

Commissioning Standards have recently been published. They bring together NHS 111, GP out-of-hours and clinical advice under a single commissioning framework. They are intended to support commissioners to deliver the transformation of urgent care services as set out in Sir Bruce Keogh's Urgent and Emergency Care Review and more recently the Five Year Forward View.

Appendix (6)

Communications Update

- The CCG campaign to reduce the amount of medicines waste has been launched. The campaign message encourages people to tell the CCG about any excess medicine problems so that the medicines management team can help.
- The winter communications campaign has now started, focused on ensuring patients get the right care, first time. A range of information material is being distributed throughout Rotherham and face-to face conversations taking place to encourage appropriate use of health services throughout winter. The local campaign links closely to the national campaign messages.
- The closure of the Chantry Bridge Practice at the end of October was covered in the Rotherham Advertiser following the distribution of letters to patients informing them of the need to register elsewhere.
- Information from the Primary Care Strategy, presented at Health Scrutiny, was reported in the Rotherham Advertiser. The story focused on GP workforce issues and self-care.
- There has been a recent press release from Doncaster and Bassetlaw Hospitals NHS Foundation Trust reporting a year-to-date deficit of £12 million. We are advised that there is no detrimental impact on the quality and safety of patient care as a result of this financial position.

Direct Dial: (0113) 8247511
Our ref: MD/MJ
Date: 14 October 2015

NHS England – North (Yorkshire & the Humber)
3 Leeds City Office Park
Meadow Lane
Leeds
LS11 5BD

Dr Julie Kitlowski, Chair
Chris Edwards, Accountable Officer
Rotherham CCG

Dear Julie and Chris

Re: CCG Annual Assurance

Thank you for meeting and working with us over the course of 2014/15, and engaging in the CCG Assurance process. The purpose of this letter is to provide a formal record of your final assurance rating for 2014/15, and should be read in conjunction with our formal letters of feedback for Quarters 3 and 4.

I am grateful to you and your team for the work you had done to prepare for the various assurance conversations and meetings we have held, and the open and transparent nature of our discussions which have led to productive discussions.

Final 2014/15 Assessment

Our headline assessment of your CCG is: **"Assured"** and this is supported by individual assessments of each of the six assurance domains described in the 2014/15 CCG Assurance Framework:

Domain	Assessment
Are patients receiving clinically commissioned high quality services?	Assured
Are patients and the public actively engaged and involved?	Assured
Are the CCG plans delivering better outcomes for patients?	Assured
Does the CCG have robust governance arrangements?	Assured
Are CCGs working in partnership with others?	Assured
Does the CCG have strong and robust leadership?	Assured

This is the final review using the six domains of the 2014/15 framework. Subsequent assurance meetings will be held on the basis of the new assurance framework with its five components: well led organisation, delegated functions, performance & outcomes, financial management and planning.

NHS Constitution standards

Key indicators within the Delivery Dashboard have shown significant improvements throughout the year, particularly in regards to diagnostic test waiting times. Significant work has been undertaken between the CCG and The Rotherham NHS Foundation Trust (TRFT) to resolve RTT pathway issues and validate and clear RTT backlog.

A&E continues to prove a challenge locally with TRFT failing the 4 hour target for 2 out of the 4 quarters of the year. This will be a matter for ongoing review and discussion in 2015/16.

NHS Statutory Duties and Key Areas of Challenge

I have noted that there had been improvement in the delivery of the A&E standard at TRFT (the standard was achieved in Q1 2015/16), and that significant work had been completed in the resolution of RTT pathway and backlog validation. You have expressed the view that the Trust's management team had shown resilience and transparency in the development and implementation of improvement plans.

We have reflected on how the Working Together programme, and you indicated your expectation that work with the King's Fund would help secure progress, although this will be tested when real decision making is required. We have discussed the need for effective collaborative governance arrangements and strong clinical leadership of the overall programme. You have confirmed that Rotherham CCG is ready to take a leading role and participate in such arrangements.

We have discussed the rapid progress required in the development of an Urgent and Emergency Care Network for South Yorkshire and Bassetlaw, and the actions being taken to make progress. You reflected that the work on urgent care models in Rotherham is well-established and we agreed that it will be essential to align this to the work of the wider network going forward.

Development Needs and Agreed Actions

When we met for your annual review, we discussed the outcome of the assurance review of your 2015/16 Operational Plan, and I confirmed that the CCG plan had been assessed as 'Good'. I commended you on the work undertaken in the preparation of the plans, and that we would like to maintain an on-going discussion with you concerning:

- Delivery of NHS Constitution Standards;
- Delivery of the Parity of Esteem agenda - most notably delivering on the commitment to secure real-terms growth in Mental Health investment, and the new waiting time standards; and
- Better Care Fund, and the urgent care system.

We have discussed the CQC Report on Children's Services in Rotherham, and the need to ensure an effective response to this. You have confirmed that this remains an absolute priority for the CCG. Turning to the CCG relationship with RMBC, and CCG engagement with the Child Sexual Exploitation work programme, you described a good relationship with Local Authority Commissioners and the positive influence they have on day-to-day working between partners in Rotherham. I was pleased to hear that the Health and Well Being

Board has been refreshed, with revised Terms of Reference, and that provider organisations are now members. We will continue to talk to you through 2015/16 about the progress on the CSE work programme and the on-going development of partnership working in Rotherham.

Although we are at an early stage in the development and implementation of your overall vision for general practice in Rotherham, the CCG has successfully taken forward the GP co-commissioning agenda, and this is working well.

I have commended the CCG on the outcome of the recent 360-degree Stakeholder Survey; these are some of the strongest survey results in Yorkshire and the Humber, and are a credit to the CCG leadership team.

Thank you again to you and your team for meeting with us and for the open and constructive dialogue, I hope this letter provides an accurate summary of the discussions and clearly indicates the next steps. We look forward to working with you on progressing work against the assurance components of the new framework outlined above.

Yours faithfully,

Yours sincerely

Moira Dumma
Director of Commissioning Operations
NHS England – North (Yorkshire and the Humber)

NHS England – North (Yorkshire and the Humber)
Oak House
Moorhead Way
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S66 1YY

23 October 2015

Dr Julie Kitlowski, Chair
Chris Edwards, Chief Officer
Rotherham CCG
Oak House
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S66 1YY

Dear Julie and Chris

CCG Assurance: Checkpoint Discussion

I would like to thank you and your team for meeting with me and colleagues from the regional team on 1 October 2015, at the Sandal Rugby Club in Wakefield, and for your on-going engagement in the assurance cycle.

Key points and actions

We shared with you the desktop assessment of the CCG's assurance rating for 2015/16. This will not be finalised and published until after year-end so there is an opportunity for you to focus on improving those areas which are currently assessed as "limited". The CCG is clearly sighted on the performance areas where continued action is required, particularly the delivery of the national ED standard.

The CCG has developed a strong SRG with senior representation from partners across its health and social care community. The SRG will need to focus over the coming winter on improving ED performance ensuring that there is rapid and resilient recovery from any dip in performance, as experienced over the last two months. The physical relocation of the ED within TRHFT is designed to assist this through improved ambulatory care capacity and co-location with the primary care front door services, but is a risk to performance in the short-term.

The development of the hospital chain (Vanguard) across the Working Together footprint offers opportunities for improved care and for addressing potential sustainability issues within the smaller DGH services. CCGs will need to ensure that there are clear and shared commissioning intentions for 2016/17 which establish key principles such as better access across the chain (for example, on 62 day cancer targets) and equity for all patients irrespective of their CCG of residence (such as to implantable cardiac devices). The work of the hospital chain will also need to be led by the wider commissioning strategy for the Working Together programme, so the

on-going development of more formal collaborative commissioning arrangements across CCGs are critical to this. You reiterated your on-going commitment to this approach.

Rotherham CCG has made good progress in implementing 7-day working and will need to ensure that, going forward, this work and your work on the development of a Multi-Community Provider (MCP) is aligned to the collaborative strategies across South Yorkshire & Bassetlaw in areas such as urgent and emergency care. In developing the MCP model, you acknowledge that there is more work to do on engaging with and considering the future configuration of general practice within the CCG's area.

We discussed the outcome of the recent TRHFT Quality Review meeting and you informed us that a recommendation will be taken to QSG to step down from enhanced surveillance to routine monitoring. You are closely monitoring the Trust's action plans and improvements in quality and action planning relating to the CQC review. The CCG is increasingly assured that robust and effective mechanisms are now in place both in the Trust and CCG. .

Assurance assessment

The following table sets out our initial assurance assessment of the CCG. Any changes to these assessments will be determined through the continuous assurance cycle, including any additional checkpoint meetings.

Component	Assessment
Well-Led Organisation	Good
Delegated Functions	
Financial Management	Good
Performance	Limited
Planning	Good

We agreed to meet again in late January 2016, at which time we will be in a position to talk in more depth about the planning round, and consider delivery over the winter period. We will also use this meeting to review the position against the five components of the assurance framework.

In addition to the next checkpoint meeting we will of course stay in touch as necessary through our agreed arrangements across the range of our agendas. I look forward to continue working with you.

Yours sincerely,

Moira Dumma
Director of Commissioning Operations
NHS England – North (Yorkshire and the Humber)

Rotherham Joint Health and Wellbeing Strategy

2015-2018 (draft – version 4)

Foreword

Health and wellbeing is important to everybody in Rotherham and enables people to live fulfilling lives and to be actively engaged in their community. The way individuals achieve good health will differ according to their experience, abilities and resources. Unfortunately, we know too many people in Rotherham are not in good health and that significant differences exist between our most and least deprived communities. It is only right, however, given Rotherham's situation that a key focus of the strategy is children and young people, but taking care not neglect other important aspects of health and wellbeing.

As our population grows and changes, health needs change and we need to ensure we are responsive to these changes and continue to offer services that provide high quality care and are accessible to all. We need to also ensure that we have a customer led focus in what we do.

Public sector finances are becoming increasingly stretched, which means that all partners on the Health and Wellbeing Board need to work together to find new ways to deliver services. We hope that this strategy will help to meet these challenges through a shared vision for the health and wellbeing in Rotherham.

The Health and Wellbeing Strategy provides a high level framework which will direct the Health and Wellbeing Board activity over the next three years; it will support the Board's role to provide leadership for health and wellbeing by making the most of our collective resources in the Borough. It doesn't, however, reflect everything we will consider as a Board or that the partners will deliver. It also identifies where the Health and Wellbeing Board can add value to existing strategies and plans for Rotherham. The Health and Wellbeing Strategy and the work of the Health and Wellbeing Board are about working together and I believe it is clear that the Board is now a real partnership, which can only be for the good.

The strategy contains some ambitious aims, but by working creatively, and working together, we feel that they are achievable and that we can make long-lasting changes that will improve health and wellbeing throughout Rotherham.

Cllr David Roche

Advisory Cabinet Member for Adult Social Care and Health and Chair of Rotherham Health and Wellbeing Board

1.0 Introduction

1.1 This is the second Health and Wellbeing Strategy for Rotherham, which has been produced in collaboration with Health and Wellbeing Board partners. This fulfils the duty set out in the Health & Social Care Act (2012) to set the overarching framework for health and care commissioning plans for Rotherham.

2.0 What do we mean by health and wellbeing?

2.1 Health is about feeling physically and mentally fit and well, whilst wellbeing considers whether people feel good about themselves and are able to get the most from life.

2.2 Health is not just about individuals, however, but also about populations. Population health considers how we respond to potential threats to our health, such as the impact of where and how we live our lives, and identifies how best to provide health services that are capable of meeting people's different needs[1].

2.3 People's experience of health and wellbeing is influenced by more than health and care services, and there are stark differences in the life expectancy of people living in the best and worst off parts of the borough. The quality of our built or physical environment, employment and socioeconomic status, housing, transport and access to green spaces are all wider determinants of our health and wellbeing. Black and Minority Ethnic communities generally have poorer health than the general population; whilst much of this difference can be explained by differences in socio-economic status a number of other factors also contribute, including lower take-up of healthcare, biological susceptibility to certain long-term conditions and the impact of racism and discrimination[2].

2.4 Local people can be supported to take responsibility for their health and wellbeing by having a good understanding of their own and their family's health status and the behaviour changes they can make to improve their health now or to prevent ill health developing in the future. Most health behaviours are determined during pregnancy, infancy, childhood and adolescence and by improving the health of children and young people we can start to influence the health and wellbeing of the wider population.

3.0 National context

3.1 *Fair Society, Healthy Lives: The Marmot Review* (2010) provides a framework for tackling health inequalities throughout a person's life. It provides evidence of the social gradient in

[1] Department of Health (2010). *Our Health and Wellbeing Today* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215911/dh_122238.pdf

[2] Parliamentary Office of Science and Technology (2007) Postnote: Ethnicity and Health http://www.parliament.uk/documents/post/postpn276.pdf

health – the lower a person's social position, the worse his or her health. This social gradient in health is starkly apparent in Rotherham with significant differences in life expectancy between our most and least deprived areas. Attempting to reduce this gap, by focusing on raising the health status of the poorest fastest, will contribute to local NHS priorities to reduce the potential years of life lost as a result of ill-health.

3.2 Central to *Fair Society, Healthy Lives* is the life course approach. It recognises that disadvantage starts before birth and grows throughout life; therefore, the actions to tackle inequality in health also need to start before birth and continue through childhood and adolescence, working age and into retirement and later life.

3.3 The report highlights six policy objectives:

- Give every child the best start in life (FSHL1)
- Enable all children young people and adults to maximise their capabilities and have control over their lives (FSHL2)
- Create fair employment and good work for all (FSHL3)
- Ensure healthy standard of living for all (FSHL4)
- Create and develop healthy and sustainable places and communities (FSHL5)
- Strengthen the role and impact of ill health prevention (FSHL6)

Our Health and Wellbeing Strategy has been developed with these as guiding principles; the priorities we have identified will each link to one or more of Marmot's policy objectives.

3.4 The *Children and Families Act 2014* sets out the challenge for radical reform of services for children and young people. It seeks to improve services for vulnerable children and ensure that all children and young people can success, no matter what their background. Support for young people with a disability or a special educational need now receive support up to the age of 25. The cross-Government policy for young people aged 13-19 (25 for those with a disability or special educational need) *Positive for Youth*, sets out a shared vision for how partnership working can support families and improve outcomes for young people, particularly those who are most disadvantaged or vulnerable.

3.5 The Coalition Government announced the Better Care Fund in 2013. It redirects funding into a local single pooled budget between clinical commissioning groups (CCGs) and local authorities to drive closer integration and improve outcomes for people with health and care support needs. Local plans for how the fund will be used must be agreed by the Health and Wellbeing Board and signed off by the CCG and local authority.

3.6 The development of the Health and Wellbeing Strategy has taken two further key national policy documents into account: the *NHS 5-year Forward View* (October 2014) calls for a radical upgrade in prevention and public health, and The Care Act (2015), which aims to give people more control over their care and help people stay independent for longer.

4.0 Health and wellbeing boards and strategies

4.1 Health and Wellbeing Boards were introduced in the Health & Social Care Act (2012) to ensure a more joined up approach to plan how best to meet the health and wellbeing needs of the local population and tackle inequalities in health. The boards are managed by local authorities and bring together representatives from NHS commissioners, public health, adult and children's services, Healthwatch and elected members as the statutory board members. In Rotherham, the Health and Wellbeing Board also has representatives from Voluntary Action Rotherham, our NHS providers (Rotherham NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust), South Yorkshire Police and other key partners.

4.2 The Health and Wellbeing Board uses data from the Joint Strategic Needs Assessment (JSNA) and refers to other borough-wide strategies in the development of a Health and Wellbeing Strategy. This sets the local priorities for joint action and will inform commissioning decisions for health and wellbeing.

4.3 As partners we invest many millions of pounds in Rotherham which influence health and wellbeing, through investment in the economy, transport, housing and community safety as well as health and social care services, where Rotherham Clinical Commissioning Group (CCG) and the Council invest over £530m. The Health and Wellbeing Board has the opportunity to influence and challenge this investment. The current and future limits on resource require us to work more collaboratively than ever, integrating our commissioning of services to ensure that every pound spent in Rotherham on health and care supports improvements in health and wellbeing and the reduction of health inequalities. The Health and Wellbeing Board can support collaboration and integration, and has a role in breaking down barriers between agencies, focusing on getting the most out of the whole system.

5.0 How the strategy has been developed

5.1 In developing the Health and Wellbeing Strategy our aim is to identify outcomes based on strong evidence, stakeholder and public feedback, and specific areas where the Health and Wellbeing Board could have the biggest impact. We have identified specific criteria for each outcome showing what we would expect to see in the long term if the strategy is successful.

5.2 Rotherham's JSNA and Pharmaceutical Needs Assessment (PNA) provide a comprehensive and rigorous analysis of the issues that need to be considered when planning for the protection and improvement of the health and wellbeing of the people of Rotherham. The JSNA identifies the current and future health and wellbeing needs of the population, including differences in life expectancy within and between communities and the impact of ill health on the quality of life

experienced by local people. It also recognises the importance of mental health and wellbeing, which is important for the resilience of individuals and communities, enabling people to take control of their health and health behaviours. The PNA outlines how pharmaceutical services can contribute to meeting the health needs of the population.

5.3 This Health and Wellbeing Strategy complements other local strategies:

- Rotherham CCG's Commissioning Plan
- Rotherham's Improvement Plan: *A Fresh Start*
- Children and Young People's Improvement Board Action Plan
- Better Care Fund plan
- Rotherham Economic Growth Plan
- Safer Rotherham Partnership Plan
- Rotherham's Local Plan
- Joint Commissioning Plan – Children and Young People
- Child Sexual Exploitation (CSE) Delivery Plan
- Emotional and Wellbeing Strategy

It adds value, capacity and resources to the current strategic priorities for the borough and reflects the priorities of local people and stakeholder organisations.

5.4 In drafting the strategy we have also taken into account views from stakeholder events with partners from the statutory and voluntary sectors within Rotherham and, via Healthwatch, from patients and the public. We have also considered the feedback from RMBC's Commissioner Roadshows. A consultation process for the draft strategy has also taken place; the timeline for this can be found at Appendix 1.

Table 1: Rotherham – at a glance[3] [to be presented as an infographic]

- The health of people in Rotherham is generally poorer than the England average
- Life expectancy for men and women is lower than the England average and is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham compared to the most affluent areas
- Rotherham's population is changing:
    - the number of older people is increasing and people will live longer with poorer health
    - our Black and Minority Ethnic community is changing, with a higher proportion of younger people and a growing Roma community
- Deprivation is higher than average and more than 11,000 children live in poverty

- 11,700 people in Rotherham are economically inactive (neither in work nor looking for a job or available for work) due to long-term sickness
- 9.6% of benefit claimants in Rotherham are claiming Employment Support Allowance, Incapacity Benefit or disability-related benefits.

[3] Public Health England (2015) *Health Profiles*

- 4060 people in Rotherham receive benefits due to their role as a carer
- Household incomes in Rotherham are lower than the Yorkshire and Humber and UK average
- 9% of homes are in fuel poverty with some localised rates near 24%

- Rotherham's breastfeeding rate is amongst the lowest in the region – contributing to levels of childhood obesity and paediatric hospital admissions
- 18.3% of mothers smoke during pregnancy. Smoking in pregnancy contributes to increased risk of stillbirth, low birthweight and neonatal deaths.
- 23.4% of children leaving primary school are obese.
- 5.9% of 16-18 year olds in Rotherham are not in employment, education or training, compared to 4.7% nationally
- 1550 people aged 15-24 in Rotherham were newly diagnosed with a sexually transmitted infection in 2013. This is a higher rate than the England average.

- Nearly 3 in 10 adults in Rotherham are obese (28.5%) – worse than the average for England
- 1688 hospital admissions in Rotherham during 2013/14 could be attributed to alcohol
- 35.1% of the Rotherham population are estimated to drink at a level that puts their health at risk, of which 8.9% (17,996 people) are causing themselves actual harm
- An estimated 18.9% of adults in Rotherham smoke
- There are nearly 500 smoking related deaths each year in Rotherham – significantly higher than the England average
- On average, one in four people will have mental health problems at some point in their lives.

Table 2: There have been some notable improvements in health and wellbeing in Rotherham over recent years[4]. Good progress doesn't mean, however, that we don't have more to achieve.

School readiness (children achieving a good level of development at the end of reception year) and GCSE achievement are now better than national averages.

The rate of under-18 conceptions in the borough has reduced and is now the same as the England average.

Smoking rates have been falling and we now have our lowest ever adult smoking rate. Smoking during pregnancy has reduced quicker than in any of our comparator local authorities following changes to how the service was delivered five years ago.

Rotherham's healthy weight framework to address overweight and obesity is recognised nationally as an example of best practice.

More people are having routine vaccinations and cancer screening in Rotherham than the national average.

[4] Public Health England (2015) *Health Profiles*

Rotherham's performance on opiate users leaving treatment successfully has improved significantly from being one of the lowest in the country to above the national average.

Excess winter deaths have seen a significant reduction and are now below the England average.

6.0 How we will use the strategy

6.1 The Health and Wellbeing Strategy places particular emphasis on a shared vision and leadership for improving health and care services. We will use the strategy to develop action plans that we are all signed up to, to hold each other to account and to use our resource collectively to deliver the best outcomes for Rotherham.

6.2 We have identified five key aims with associated objectives where we will look for improvement in order to demonstrate progress. This is not a final list of everything that the board and partners will do, but a set of the most pressing health and wellbeing priorities for Rotherham.

6.3 Health and Wellbeing Board members are responsible for a wide range of services that impact on health and wellbeing, and the board and strategy will also influence the direction of other strategies and plans, including planning and development, transport and economic growth. The Health and Wellbeing Strategy provides a framework for commissioning plans for the council and CCG and specifically for the development of the Better Care Fund proposals and for joint commissioning of services to ensure seamless, effective and efficient service delivery. The areas where the strategy will add weight include early help services, mental health and wellbeing, special educational needs and disability, 0-19 services, support for carers and young carers, housing and the local planning framework.

6.4 There is also an explicit relationship between the local and sub-regional partnership structures providing opportunities to influence wider determinants including air quality and economic investment.

7 Managing and monitoring the strategy

7.1 We will monitor progress on the strategy by focusing on the impact it will have on people's lives. We have identified a number of indicators and data sources for each aim that will help us measure progress.

7.2 We will establish a sub-group of the Health and Wellbeing Board that will act as an 'engine room' and make the strategy happen. It will ensure that the indicators we have selected are the best to demonstrate improvement and will seek out new guidance and evidence that could help us deliver the aims most effectively. The sub-group will have representation from Rotherham Healthwatch to help us ensure, through a process of managed public engagement, that we keep the needs of the Rotherham population at the heart of our work.

7.3 The major changes that are being sought in this strategy will take time and we expect to see gradual, but measurable, improvements.

7.4 The Health and Wellbeing Board will use its strategic influence with other key groups, such as Rotherham Together Partnership's Chief Executive Officers Group, to ensure that all partners are contributing to delivering the strategy through:

- Regular performance reports from the sub-group
- Publishing an annual 'healthcheck' on progress

8 Rotherham Health and Wellbeing Strategy Aims 2015-2018

8.1 We have identified five key aims for Rotherham that can best be tackled by a 'whole system' approach, where we need the involvement of the whole health and care system to achieve improvement. We have used five questions in selecting the aims:

- Is there more that can be done to tackle this issue?
- Is it an issue that is amenable to intervention?
- Is the delivery of this issue important to all partners on the Health and Wellbeing Board?
- Is it of strategic importance?
- Would this issue lead to considerable impact across the borough, or to one of our vulnerable target groups?

8.2 Each aim will be underpinned by a comprehensive action plan. There are a number of supporting principles that will apply consistently across these action plans:

- To reduce health inequalities we need to ensure that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest.
- Prevention of physical and mental ill-health should be our primary aim, but where it is already an issue, we should intervene early to maximise the impact of services for individuals and communities
- We will work with individuals and communities to increase resilience and enable people to better manage and adapt to threats to their health and wellbeing, using an asset-based approach that values the capacity, skills, knowledge, connections and potential within communities
- Integrating our commissioning of services wherever possible to support improvements in health and wellbeing and the reduction of health inequalities
- We need to ensure pathways are robust, particularly at transition points (e.g. from children and young people's services into adult services), to be sure that nobody is left behind
- All services need to be accessible and provide support to the right people, in the right place, at the right time

9. Aim 1: All children get the best start in life

9.1 Objectives:

- Improve emotional health and wellbeing for children and young people
- Improve health outcomes for children and young people through integrated commissioning and service delivery
- Ensure children and young people are healthier and happier

9.2 Why this is an issue?

9.3 All aspects of our development – physical, emotional and intellectual – are established in early childhood. Development in the early years (including in the womb) can have a lifelong impact on health and wellbeing, educational achievement and economic status. By placing an increased focus on health and wellbeing in those early years we hope that all Rotherham children will be able to fulfil their potential.

9.4 Early Help describes a range of interventions to identify and respond to individual needs and prevent these escalating into complex and costly issues at a later point. Delivered through partnership working across health and social care, and using a single assessment to target the early help offer, we will prevent the need for social care interventions and secure better outcomes for children, young people and their families. Early help spans a wide age range (0-19 years, or up to 25 years if the individual has a disability or special educational need) and has a critical role to play in the key transition points in a child's journey from dependence to independence.

9.5 We have, on average, more than 3,000 births in Rotherham each year and around 16,000 children aged 0-4 years. Too many of these children are not currently getting the best start in life.

9.6 The percentage of children living in poverty in Rotherham is higher than regional and England averages, with 11,320 children and young people aged 0-16 living in families whose income is less than 60% of median income (2012). Child poverty influences educational achievement (by the age of three, poorer children are estimated to be nine months' behind children from more wealthy backgrounds – and this gap continues throughout the educational stages) and health, with children in poverty almost twice as likely to live in poor housing and be affected by fuel poverty[5].

9.7 More than 500 babies are born every year in Rotherham to mothers who smoke or drink alcohol during pregnancy. These children are at significant risk of preventable health conditions and developmental delay.

[5] Child Poverty Action Group http://www.cpag.org.uk/content/impact-poverty

9.8 Breastfed babies have fewer chest and ear infections, fewer gastrointestinal problems, are less likely to become obese and therefore of developing obesity-related problems in later life, and are less likely to develop eczema. It is therefore a concern that fewer babies in Rotherham are being breastfed and for a shorter a time than the England average.

9.9 Rotherham has higher than regional and national average levels of tooth decay in both 3 and 5 year olds, with 3 year olds having the poorest oral health in South Yorkshire. The most common dental diseases (tooth decay and gum disease) can cause pain and infection and lead to tooth loss, disruption to family life and absence from education.

9.10 Rotherham Health and Wellbeing Board will:

- Work with Rotherham's Children and Young People's Improvement Board to maximise the health impact of their action plan
- Reduce the long-term ill-health implications of child poverty through supporting the implementation of Rotherham's Early Help strategy, working with families with multiple and complex needs.
- Engage with early years services in developing parenting skills and capacity, which will in turn support improvements in health and wellbeing in the early years
- Review and strengthen pathways to ensure services are delivering high quality interventions as required by the Healthy Child programme.
- Commission an integrated public health service for children and young people aged 0-19 that ensures a seamless pathway across key transitions and focuses the most intensive support on our most vulnerable children and young people.
- Ensure all pregnant mothers who smoke receive consistent specialist advice on the risks to the pregnancy and their baby and high quality stop smoking support for those who wish to quit.
- Ensure all new mothers receive accurate and consistent information and support to facilitate breastfeeding.

Table 3: Did you know?

In 2015 Broom Valley Community School won a Healthy School Good Practice Award for their oral hygiene campaign, which engaged staff, parents and children across the whole school. Practical sessions were combined with curriculum activity and presentations to parents. Parents have registered their children with a dentist and some children have attended their first dental appointment as a result of the campaign. Links with the oral health outreach team ensure parents who lacked confidence in making the changes receive additional support.

Healthy Schools Rotherham

10. Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood

10.1 Objectives:

- Reduce the number of young people at risk of child sexual exploitation
- Reduce the number of young people experiencing neglect
- Reduce the risk of self-harm and suicide among young people
- Increase the number of young people in education, employment or training
- Reduce the number of young people who are overweight and obese
- Reduce risky health behaviours in young people

10.2 Why this is an issue?

10.3 Whilst tackling inequalities in health needs focused action from the start of life and in the early years, the commitment needs to be maintained throughout childhood and adolescence. We need to provide good education and healthcare, and opportunities for good work and training in order to support young people to thrive. In common with all the priorities, whilst we need to ensure these are available for all children and young people within the borough, we must focus on those children and young people who are most vulnerable: those who are looked after, those with mental health problems, physical and learning disabilities and those from our most deprived communities.

10.4 This is a key period for developing individual resilience: developing a sense of purpose and self-esteem, becoming emotionally aware, taking responsibility for your own physical and emotional needs and being connected to others. Resilience enables children and young people to cope with the challenges they face and to contribute positively within their community.

10.5 The risk of child sexual exploitation (CSE) must remain at the forefront of all our plans. Health services can be well placed to identify early signs of exploitation and we must ensure that all staff have robust training in how to spot the signs and know how to respond. Young people who have been victims of CSE need access to high quality support for their emotional wellbeing.

10.6 Neglect, or the ongoing failure to meet a child or young person's basic needs, can have serious and long-lasting effects on physical and mental wellbeing. Young people who have been neglected are more likely to experience mental health problems including depression and post-traumatic stress disorder. In addition, these young people may be more likely to take risks, such as running away from home, using drugs or alcohol, or getting involved in dangerous relationships which, in turn, makes them vulnerable to sexual exploitation.

10.7 We must ensure that the Health and Wellbeing Board's work complements Rotherham's Children and Young People's Services Improvement Board action plan and contributes to the achievement of the vision for Children and Young People's Services.

10.8 Educational development and attainment are generally good in Rotherham; more children achieve a good level of development at the end of reception year and more young people achieve 5 or more GCSEs at grades A*-C (including English and maths) than the England average. However, by age 16-18 our young people are beginning to struggle, with a higher number not in education, employment or training than the England average.

10.9 During adolescence young people become more independent. With this increasing autonomy they may experiment with risk-taking behaviours. They may try alcohol, tobacco and other substances, and may become sexually active. Modelled estimates suggest 10% of 15 year olds in Rotherham smoke regularly (daily or weekly), which is higher than the England estimate. Alcohol-specific hospital admissions for under 18s, however, are significantly better in Rotherham than the England average (29.1 per 100,000 under 18 year olds in Rotherham, compared to 40.1 per 100,000 for England).

10.10 Self-harm, when somebody chooses to inflict pain on themselves, might be used because people think it will relieve tension or anxiety or to help them gain control of issues that are worrying them. Research suggests that nationally around 10% of 15-16 year olds have self-harmed. Self-harm is more common in young women, although it is on the increase among young men. Self-harm can sometimes indicate that a young person may be at risk of suicide[6]. An awareness of the signs of self-harm and suicidal thoughts is essential if we are to be able to respond to these vulnerable young people quickly and effectively. There is further discussion of mental and emotional wellbeing for people of all ages in Aim 3.

10.11 Childhood is an important time in the development of obesity, as levels more than double between Reception (aged 4-5 years – 9.7% obese, similar to the England average) and Year 6 (aged 10-11 years – 23.4% obese, higher than the England average). There will be many contributing factors to this increase: lifestyle and diet choices of the children, their parents, their school, and the local environment. School stay-on-site policies have been shown to reduce the consumption of unhealthy food during the school day.[7]

10.12 In Rotherham we have a higher diagnosis rate of new sexually transmitted infections (STIs) than the England average. Care needs to be taking in interpreting this data, however, as higher diagnosis rates may not necessarily indicate that more young people have STIs than in other areas, but may reflect local services that are accessible and young people friendly.

10.13 Rotherham Health and Wellbeing Board will:

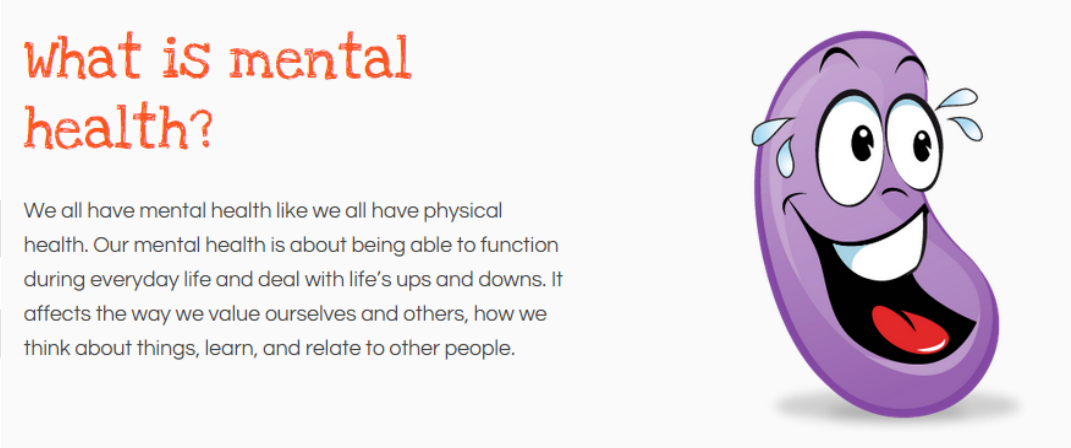
[6] http://www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm/what_self-harm

[7] Crawford et al (2012) A Feasibility Study to Explore the Nutritional Quality of 'Out of School' Foods Popular with School Pupils
http://www.gcph.co.uk/assets/0000/3539/Out_of_school_foods_report_-_final.pdf

- Work with Rotherham's Children and Young People's Improvement Board to maximise the health impact of their action plan
- Review and strengthen pathways to ensure services are delivering high quality interventions as required by the Healthy Child programme.
- Commission an integrated public health service for children and young people aged 0-19 that ensures a seamless pathway across key transitions and focuses the most intensive support for our most vulnerable children and young people
- Deliver on the actions in the Rotherham Sexual Health Strategy Delivery Plan
- Involve and engage young people with our work programme, for example through holding joint meetings with Rotherham Youth Cabinet
- Engage more closely with schools and colleges on the health and wellbeing agenda through cluster meetings, personal social and health education (PSHE) leads meetings and governor training and development

Table 4: Did you know?

mymindmatters.org.uk has been launched to provide information and support to children and young people, parents, carers and practitioners in Rotherham on mental health and emotional wellbeing. Taking a one-stop-shop approach, as well as separate sections for children (Wellbeenz) and young people, there is also information and practical advice for parents and professionals to ensure the whole community around the child or young person can respond appropriately and with confidence.



11. Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

11.1 Objective:

- Improve support for people with enduring mental health needs, including dementia, to help them live healthier lives
- Reduce the occurrence of common mental health problems
- Reduce social isolation

11.2 Why this is an issue?

11.3 Mental health problems can affect anybody at any age. It is estimated that one in four of us will suffer from mental health problems at some point in our lives. Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters by their mid-20s[8]. It is vital that positive mental and emotional wellbeing is a priority at every age. Therefore the actions identified within this aim apply across the life course.

11.4 Mental health problems are the biggest cause of illness and incapacity in the borough and are related to deprivation, poverty and inequality. People with long term mental health problems are also more likely to live in the most disadvantaged sections of society. Austerity and socioeconomic insecurity increase the risk factors for poor mental health[9], particularly for those on low income and those who face loss of income and/or housing. In Rotherham the underlying economic determinants of mental health are worse than the national average.

11.5 Communities that lack social support and social networks are less likely to experience positive mental health and wellbeing. For young people, the most common mental health problems are depression, anxiety and misuse of alcohol and other drugs, with one young person in ten experiencing some form of problem with their emotional and mental health in the course of a year. Older people are especially vulnerable to feelings of isolation as a result of the loss of friends and family, limited mobility or income that comes with age. Social isolation and loneliness is associated with mental health problems and can result in increased use of emergency healthcare and earlier admission to residential care. We need to ensure our communities are resilient communities, with the right services, facilities and infrastructure to enable people to confront and cope with life's challenges.

11.6 Another consequence of our ageing population is the increasing number of people living with dementia. By the age of 90, around 30% of people will be living with dementia. On average, people live for around seven years after the onset of symptoms and two years after diagnosis. Most people with dementia live at home, supported by family, neighbours, mainstream health

[8] The World Health Report (2001). *Mental Health – New Understanding, New Hope*. World Health Organisation, Geneva
[9] WHO (2011) Impact of economic crises on mental health

services and the community. The impact of dementia on carers' physical and mental health must also be taken into account.

11.7 In recent years suicide rates nationally have increased following several years over which there had been a steady decline. Locally Rotherham has also seen an increase in the number of death registrations classified as suicides/deaths of undetermined intent. These deaths fell sharply between 2008 and 2010 but have increased between 2010 and 2013. Rotherham's suicide rate for 2011-13 is virtually the same as the England average.

11.8 The latest suicide prevention strategy for England[10] and a recent report from The Samaritans[11] have both identified middle aged men, especially those from poorer socioeconomic backgrounds as one of the high risk groups who are a priority for suicide prevention. Our experience of suicide in Rotherham has tended to follow national trends.

11.9 Rotherham Health and Wellbeing Board will:

- Ensure our work embeds action to promote mental wellbeing, build individual and community resilience and prevent and intervene early in mental health problems
- Deliver on the actions in the Rotherham suicide prevention and self-harm action plan
- Identify, coordinate and promote initiatives to address social isolation, working in partnership with local voluntary, community and faith sector organisations
- Review and strengthen pathways between health and social care to ensure nobody can fall through gaps in the system
- Ensure all users of mental health services have equality of access to health services and behaviour change services to support them to live healthy lives
- Require all our mainstream health services to undertake mental health awareness training and to become dementia friendly services

Table 5: Did you know?

The Rotherham Less Lonely campaign aims to reduce social isolation for the borough's older residents through a range of activities. These range from lunch clubs to one-to-one befriending to providing transport for an older person to attend a social group.

Rotherham Less Lonely receives no statutory funding, but through partnership working with statutory and voluntary sector organisations and with support from committed volunteers it is making a real difference to many of the 4,000 people in Rotherham who said they feel lonely every day of their lives.
www.rotherhamlesslonely.org

[10] HM Government (2012) Preventing suicide in England: A cross-government strategy to save lives https://www.gov.uk/government/publications/suicide-prevention-strategy-launched

[11] Samaritans (2012) Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide.

12. Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing

12.1 Objectives:

- Reduce the number of early deaths from cardiovascular disease and cancer
- Improve support for people with long term health and disability needs to live healthier lives
- Increase the opportunities for participation in physical activity
- Reduce levels of alcohol-related harm
- Reduce levels of tobacco use

12.2 ***Why this is an issue?***

12.3 Life expectancy and healthy life expectancy in Rotherham are lower than average for both men and women. Within Rotherham, life expectancy is 9 years lower for men and 7 years lower for women in the most deprived areas of the borough compared to the most affluent areas.

Table 6:

2011-2013	Life expectancy at birth	Healthy life expectancy at birth
Rotherham men	78.1 years	57.1 years
England average	79.4 years	63.3 years
Rotherham women	81.4 years	59 years
England average	83.1 years	63.9 years

[this table will be displayed as a graph in the printed version, which demonstrates the gap in a visual manner]

12.4 This inequality in health leads to almost 7,000 years of life being lost each year in Rotherham through causes considered amenable to healthcare. This is almost 1,500 years more than might be expected based on the England average.

12.5 The main drivers of the excess years of life lost in Rotherham are problems of the circulation (principally stroke and ischaemic heart disease), respiratory disease and cancer. Tackling premature mortality will require a coordinated approach from all members of the Health and Wellbeing Board.

12.6 Our concern should not, however, be just about extending life: it should also cover the factors that contribute to healthy life expectancy. The difference in health life expectancy means that people in Rotherham develop poor health around 5 or 6 years earlier than the average for England. This disability burden has significant implications for public services locally, on the need for health and social care and for employment opportunities. This is because, on average, people in Rotherham will develop long term conditions around 8 years before the new state pension age of 67. This means more working age people living with

long term conditions such as heart disease, diabetes, dementia, chronic mental health disability and surviving after cancer treatment.

12.7 The actions we are recommending through the early years, childhood and adolescence will all contribute to increasing life expectancy and healthy life expectancy, but we also need to focus on those who are already in adulthood, or who may have already developed long term conditions. The link between good work and health is particularly important here: being in work is, in itself, good for physical and mental health, but for those people of working age who may have a long term condition, we need to ensure employers continue to support them to have a fulfilling working life. Economic growth within Rotherham will play its part in reducing health inequalities.

12.8 The risk of early death and disability from the three main contributors to the years of life lost in Rotherham can be effectively reduced by reducing levels of overweight and obesity, increasing levels of physical activity, not smoking, and limiting alcohol consumption. It must be recognised that individual behaviour change is difficult and needs support. A multifactorial approach that addresses all risk factors yields most benefit. This is because tackling multiple risk factors in individuals has a cumulative effect in reducing the chance of death. Screening programmes and health assessments such as the NHS Healthcheck programme provide early identification of certain conditions and can enable referral into effective treatment programmes.

12.9 We need to ensure that people who have a long-term condition or disability and those with mental health problems receive the **right care in the right place at the right time**. Too many people are admitted to hospital unnecessarily and are kept in hospital for too long as the services to support them on discharge are taking too much time to put in place. We need to increase access to health services in the community and to reduce the proportion of care that occurs in hospital. Work to support the most vulnerable to remain independent for as long as possible is required across health and social care, as is high quality support for their friends and family who provide unpaid care. The impact of the Better Care Fund should be felt most by these Rotherham residents.

12.10 People approaching the end of their life are entitled to high quality care, wherever that care is delivered. Good end of life care should be planned with the individual and the people close to them to ensure it is tailored to their needs and wishes and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support. We need to ensure that more people in Rotherham are able to exercise choice over their end of life care and the place of their death.

12.11 Rotherham Health and Wellbeing Board will:

- Ensure effective pathways are in place into screening and behaviour change services to help reduce premature mortality
- Ensure integrated commissioning and delivery across all health, social care and community organisations to deliver effective support for people with long term conditions, physical and

learning disabilities and mental health problems so that people receive the right care in the right place at the right time

- Support the delivery of Rotherham's Economic Growth Plan to increase the opportunities for residents to access good work, housing, transport and green space
- Actively participate in Rotherham's multi-agency strategy groups tackling the behavioural contributors to preventable ill-health to deliver quantifiable improvements in overweight and obesity and smoking prevalence

Table 7: Did you know?

Voluntary Action Rotherham runs a social prescribing service to help people with long term conditions access a variety of services and activities provided by local voluntary organisations and community groups. Funded by Rotherham Clinical Commissioning Group, the service sees staff from the health and voluntary sectors working with colleagues in social care to establish a coordinated care plan for people with long term conditions to improve quality of life and reduce the risk of hospital admissions.

www.varotherham.org.uk

13. Aim 5: Rotherham has healthy, safe and sustainable communities and places

13.1 Objectives:

- Develop high quality and well-connected built and green environments
- Increase the number of residents who feel safe in their community
- Reduce crime and antisocial behaviour in the borough
- Ensure planning decisions consider the impact on health and wellbeing
- Increase opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing

13.2 Why this is an issue?

13.3. As previously discussed, health is influenced by more than just the healthcare we receive. The physical environment in which we live, work and spend our leisure time and how safe we feel in our communities also impacts on health outcomes.

13.4 The quality of housing, the condition of streets and public places, noise, access to green space and levels of antisocial behaviour and crime contribute to inequalities in health. Tackling these wider determinants of health will also benefit the sustainability and economic growth agenda through the promotion of active travel, public transport, energy efficient housing and increasing access to green space, as well as supporting the other aims within this strategy. For example, through community regeneration programmes we can also help to reduce social isolation and increase community resilience.

13.5 A healthy economy leads to a healthy community; it offers good jobs, incomes and opportunities which increase aspiration and, therefore, health and wellbeing. Equally, healthy, resilient people are better able to contribute to their local community, secure a better job and be more productive in the workplace, supporting a healthy economy.

13.6 Planning decisions can have significant impact on health and wellbeing. Ensuring buildings and public spaces are designed in a way that enables people to be more physically active, or using planning levers to limit the growth of fast food takeaways, for example, can contribute to the broader effort to reduce growing levels of overweight and obesity. Encouraging a vibrant high street with diverse local and independent food traders can increase choice and access to healthy, fresh food for all. Planting regimes can reduce noise pollution from major roads and improve air quality for local residents. Rotherham's Local Plan has a clear objective to create safe and healthy communities and to engage health services in key planning decisions.

13.7 Poor housing costs the NHS at least £2.5 billion a year in treating people with illnesses directly linked to living in cold, damp and dangerous homes[12]. Cold homes and poor housing can have a negative impact on physical and mental health and wellbeing and may ultimately result in excess winter deaths. Associated health inequalities can occur across the life course, from early years through to the frail elderly population.

13.8 An increasingly older population, living longer with long term conditions and disability, will require more homes with adaptations to enable them to continue with a good quality of life and to maximise their independence.

13.9 Rotherham Health and Wellbeing Board will:

- Work in partnership to maximise the health impact of:
  - Rotherham's Local Plan
  - Rotherham's Housing Strategy 2013-2043
  - Rotherham's Economic Growth Plan
  - Safer Rotherham Partnership Plan
  - South Yorkshire's Local Transport Plan

13.10 Appendix 2 contains tables indicating how this strategy will complement other key borough-wide plans.

Table 8: Did you know?

Rotherham led the work to develop national guidance and resources around cold home: Winter Warmth England. Partners including the NHS, RMBC, emergency services and voluntary sector organisations worked together to ensure that older people whose health might be at risk due to a cold home receive clear, correct, consistent and useful advice and information from local services who support them.

www.winterwarmthengland.co.uk

[12] Local Government Association (2014). Healthy Homes, Healthy Lives http://www.local.gov.uk/documents/10180/5854661/L14+-+85+Housing+and+Health+case+studies_14.pdf/b4620ef6-87bc-4e12-964a-5cbd4433dd47

14. What we want for the future

14.1 We hope that this strategy will help to build the individual, community and economic resilience needed to enable Rotherham people to make positive choices that maintain and improve their health and wellbeing. Its delivery relies on a shared commitment from Health and Wellbeing Board members, but also from a wider range of partners – statutory and community organisations as well as individuals – to working collaboratively, shifting resources from treatment to prevention and focusing on improving the health and wellbeing of our most vulnerable communities the fastest.

14.2 The actions plans that will accompany this strategy will be living documents, regularly reviewed and updated in light of new and updated local strategies and national guidance. We will ensure that these plans also reflect ongoing feedback from Rotherham residents obtained through ongoing consultation with individuals and community groups.

14.3 If you would like to get involved in the delivery of this strategy, please contact:

Public Health: Alison Iliff	Alison.iliff@rotherham.gov.uk	01709 255848
Policy and Partnerships: Michael Holmes	Michael.holmes@rotherham.gov.uk	01709 254417
Rotherham CCG: Ian Atkinson	Ian.atkinson@rotherhamccg.nhs.uk	01709 302000

Table 9

Aims	Objectives	Indicator bundle	Reporting mechanism	Frequency of reporting
1. All children get the best start in life *Link to Marmot policy objective FSHL1*	• Improve emotional health and wellbeing for children and young people • Improve health outcomes for children and young people through integrated commissioning and service delivery • Ensure children and young people are healthier and happier	Free school meals Yr 3 upwards	Department for Education Pupil Census (data source: schools via DfE COLLECT data management system)	Termly
		Breastfeeding a) % of all mothers who breastfeed their babies in the first 48hrs after delivery b) % of all infants due a 6-8 week check that are totally or partially breastfed	a) PHOF 2.02i (data source: NHS England) b) PHOF 2.02ii (data source: NHS England)	Quarterly
		Children aged 5 years with one or more decayed, filled or missing teeth	CHIMAT Child Health Profile (data source: National Dental Epidemiology Survey)	Annual
		School readiness a) % children achieving a good level of development at the end of reception b) % children achieving the expected level in the phonics screening check	PHOF 1.02i and 1.02ii (data source: 1.02i DfE EYFS Profile statistical series; 1.02ii DfE Teacher Assessments: Phonics screening check statistical series)	Annual
		Low birth weight of term babies	PHOF 2.01 (data source: Office for National Statistics)	Annual

2. Children and young people achieve their potential and have a healthy adolescence and early adulthood *Links to Marmot policy objectives FSHL1, FSHL2*	• Reduce the number of young people at risk of child sexual exploitation • Reduce the number of young people experiencing neglect • Reduce the risk of self-harm and suicide among young people • Increase the number of young people in education, employment or training • Reduce the number of young people who are overweight and obese • Reduce risky health behaviours in young people	% 16-18 year olds not in education, employment or training	PHOF 1.05 (data source: Department for Education)	Annual
		Number of education, health and care plans (EHCPs) a)Number of new EHCPs b) Number of transferred EHCPs c) Total number of EHCPs	Department for Education Statements of SEN and EHC plans statistical release (data source: annual SEN2 data return)	Annual
		Emotional wellbeing of looked after children: Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31 March.	PHOF 2.08 (data source: Department for Education)	Annual
		Reduced suicide and self-harm: a) Hospital admissions caused by unintentional and deliberate injuries (0-14 and 15-24 years) b) Hospital admissions for mental health conditions (0-17 years) c) Hospital admissions as a result of self-harm (10-24 years)	a) PHOF 2.07i and 2.07ii (data source: PHE Knowledge and Intelligence Team (South West)) b) CHIMAT Child Health Profile (data source: Hospital Episode Statistics) c) CHIMAT Child Health Profile (data source: Hospital Episode Statistics)	a) Annual b) Annual c) Annual
		Number of health assessments for looked after children completed within recommended timescales	RMBC CYPS monthly report (data source: RMBC CYPS and RCCG)	Monthly

		Number of children and young people presenting at risk of CSE	RMBC CYPS monthly report (data source: RMBC CYPS social care database)	Monthly
		Number of children and young people presenting with neglect	RMBC CYPS monthly report (data source: RMBC CYPS social care database)	Monthly
		School attainment a) key stage 2 b) key stage 4 c) progress between KS2 and KS4	Department for Education (data source: national curriculum assessments for KS2 and KS4)	Annual
3. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life *Links to Marmot policy objectives FSHL3, FSHL4, FSHL5, FSHL6*	• Improve support for people with enduring mental health needs, including dementia, to help them live healthier lives • Reduce the occurrence of common mental health problems among adults • Reduce social isolation	Social isolation a) % of adult social care users who have as much social contact as they would like b) % of adult carers who have as much social contact as they would like	a) PHOF 1.18i / ASCOF 1Ii (data source: Adult Social Care Survey) b) PHOF 1.18ii / ASCOF 1Iii (data source: Personal Social Services Survey of Adult Carers in England)	a) Annual b) Biennial (next scheduled 16/17)
		Suicide rate	PHOF 4.10 (data source: Public Health England, based on ONS source data)	Annual
		Excess under 75 mortality rate in adults with serious mental illness	PHOF 4.09 (data source: HSCIC)	Annual
		Estimated diagnosis rate for people with dementia	PHOF 4.16 (data source: HSCIC)	Annual

		Rate of domestic abuse incidents recorded by the police per 1,000 population	PHOF 1.11 (data source: Crime Statistics, Focus on Violent Crime and Sexual Offences. ONS)	Annual
		Social care-related quality of life a) Service users b) carers	a) ASCOF 1A (service user) (data source: Adult Social Care Survey) b) ASCOF 1D (carer) (data source: Survey of Adult Carers in England)	a) Annual b) Biennial (next scheduled 16/17
4. Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing *Links to Marmot policy objectives FSHL3, FSHL4, FSHL6*	• Reduce the number of early deaths from cardiovascular disease and cancer • Improve support for people with long term health and disability needs to live healthier lives • Reduce levels of alcohol-related harm • Reduce levels of tobacco use	Potential years of life lost considered amenable to healthcare	NHSOF 1.1 (data source: Primary Care Mortality Database via Health and Social Care Information Centre)	Annual
		Proportion of older people (65+) still at home 91 days after discharge into rehabilitation	Better Care Fund metric. ASCOF 2Bi (data source: Adult Social Care Short and Long Term Return (ASC-SALT))	Annual
		Non-elective first finished consultant episodes	Better Care Fund metric (data source: Unify 2, MAR Commissioner, Department of Health)	Monthly
		Delayed transfers of care from hospital per 100,000 population (number of days delayed)	Better Care Fund metric (data source: NHS England)	Monthly
		Emergency readmissions within 30 days of discharge from hospital	Better Care Fund metric (data source: The Rotherham NHS Foundation Trust via Secondary Uses Service (SUS))	Monthly

		Permanent admissions of older people (aged 65+) to residential and nursing care homes, per 100,000	Better Care Fund metric ASCOF 2A part 2 (data source: Adult Social Care Short and Long Term Return (ASC-SALT) and ONS)	Monthly
		% deaths not in hospital	End of Life Care group local metric (data source: ONS)	Quarterly
5. Rotherham has healthy, safe and sustainable communities and places *Links to Marmot policy objective FSHL5*	• Develop high quality and well-connected built and green environments • Increase the number of residents who feel safe in their community • Reduce crime and antisocial behaviour in the borough • Ensure planning decisions consider the impact on health and wellbeing • Increase opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing	Fuel poverty	PHOF 1.7 (data source: Department for Energy and Climate Change)	Annual
		Fear of crime	South Yorkshire Police Q5 (data source: Your Voice Counts Survey)	Annual
		Proportion of service users who feel safe	ASCOF 4A (data source: Adult Social Care Survey)	Annual

Behaviour change indicator bundle that impact across the life course and upon all aims		Overweight and obesity a) % of children aged 4-5 classified as overweight or obese b) % of children aged 10-11 classified as overweight or obese c) % adults classified as overweight or obese	a) PHOF 2.06i (data source: HSCIC - National Child Measurement Programme) b) PHOF 2.06ii (data source: HSCIC - National Child Measurement Programme) c) PHOF 2.12 (data source: Active People Survey, Sport England)	Annual
		Alcohol use a) Number of people in tier 3 alcohol treatment services aged under 18 b) Number of people in tier 3 alcohol treatment service aged 18+	Public Health England Adult Alcohol Statistics and Young People Statistics (data source: National Drug Treatment Monitoring System)	Quarterly
		Smoking prevalence a) % women who smoke at time of delivery b) Smoking prevalence at age 15 – current smokers and regular smokers c) Prevalence of smoking among persons aged 18 years and over	a) PHOF 2.03 (data source: HSCIC) b) PHOF 2.09i and 2.09ii (data source What About YOUth (WAY) Survey) c) PHOF 2.14 (data source: Integrated Household Survey)	a) Quarterly b) Annual c) Annual

		% of people using outdoor space for exercise/health reasons	PHOF 1.16 (data source: Natural England: Monitor of Engagement with the Natural Environment (MENE) survey)	Annual

List of abbreviations:

PHOF: Public Health outcomes Framework

NHSOF: NHS Outcomes Framework

ASCOF: Adult Social Care Outcomes Framework

PHE: Public Health England

HSCIC: Health and Social Care Information Centre

ONS: Office for National Statistics

CHIMAT: Child and Maternal Health Intelligence Network

FSHL: *Fair Society, Healthy Lives*

Appendix 1: Draft strategy consultation timeline

20 July*	Draft circulated to Health and Wellbeing Strategy Task and Finish Group
27 July	Informal consultation with Rotherham Clinical Commissioning Group and Rotherham Together Partnership Chief Executive Officer Group
3 August	Circulated to Health and Wellbeing Board and other partners for comments
17 August	Discussed at RMBC Senior Leadership Team
31 August	Draft discussed at Local Children's Safeguarding Board
7 September	Draft discussed at advisory cabinet
28 September	Final report signed off at Health and Wellbeing Board

* all dates indicate week commencing

Enough is enough

As leaders of organisations representing different parts of the community we are committed to working together to build a bright and prosperous future for Rotherham.

We are very concerned at the ongoing impact of repeated marches and demonstrations on our community, on our town centre and our businesses.

The people of Rotherham have shown much forbearance but understandably are increasingly fed up of these intrusions which leave people feeling unsafe in their own town. This has been exacerbated by the recent tragic and unprovoked attacks on residents on our streets.

We want to find peaceful ways to ensure the safety of all our community. We want all residents to feel safe and welcome on our streets.

We are not complacent about the failures of the past and we are committed to working together to right those past wrongs.

We want to see justice for the victims and survivors of child sexual exploitation in Rotherham and their families. But the repeated protests, largely by people from outside our area, do not further this aim. Instead they are holding our town back.

We encourage all residents and businesses in Rotherham to support each other in promoting a positive image of Rotherham and its prospects and to discourage confrontational activity which detracts from this.

So enough is enough. We are launching together an online petition to draw the Government's attention to the strength of feeling in Rotherham; that we have tolerated these marches and demonstrations for long enough and that Government needs to find a way to halt their frequency.

We hope that residents will sign up to the petition and that they will encourage their friends, colleagues and neighbours to do the same so that we can speak with one voice, together.

The petition can be found at **www.rotherham.gov.uk/enough**

Signed:

Cllr Chris Read – Leader, Rotherham Council and Chair, Rotherham Together Partnership

Sarah Champion MP

Rt Hon Kevin Barron MP

Rt Hon John Healey MP

Chief Superintendent Jason Harwin, Borough Commander

Rev. Canon David Bliss – Rotherham Minster

Rev Mgr. Desmond Sexton – Catholic Parishes of St Mary and St Gerard's

Saghir Alam OBE – Rotherham Council of Mosques

Sithule Moyo – Mama Africa Rotherham

Ted Ring – Churches Together in Rotherham

Rev Joanne Archer-Siddall – Rotherham & Dearne Valley Methodist Church

Khalida Luqman – Tassibee

Janet Wheatley – Voluntary Action Rotherham

Almas Abbasi – Rotherham Diversity Forum

Andrew Denniff – Barnsley & Rotherham Chamber of Commerce

Azizzum Akhtar – Rotherham Ethnic Minority Alliance

Jayne Senior – Rotherham CSE Survivors Steering Group

Parveen Qureshi MBE – United Multicultural Centre

Dr Julie Kitlowski and Chris Edwards – Rotherham Clinical Commissioning Group

Louise Barnett – The Rotherham NHS Foundation Trust

Kathryn Singh – Rotherham, Doncaster & South Humber NHS Foundation Trust

Mary Jacques and Steve Ruffle – Rotherfed

Phil Shillito – South Yorkshire Fire & Rescue Authority

Zanib Rasool MBE and Jamie Noble – Rotherham United Community Sports Trust

Martin Harrison – Dearne Valley College

Richard Williams – Thomas Rotherham College

Roger Burman – Rotherham Secondary Schools

Donna Humphries – Rotherham Learning Communities Strategic Management Group

Gill Alton – Rotherham College

www.rotherham.gov.uk/enough

Discussion with scrutiny committee colleagues – Mid and South Yorkshire, Bassetlaw and North Derbyshire

12 October 2015

Why are we working together?

What have we been doing?

Our geography

The detail: critical care for stroke patients

What next?

Why?

SAFETY

What?

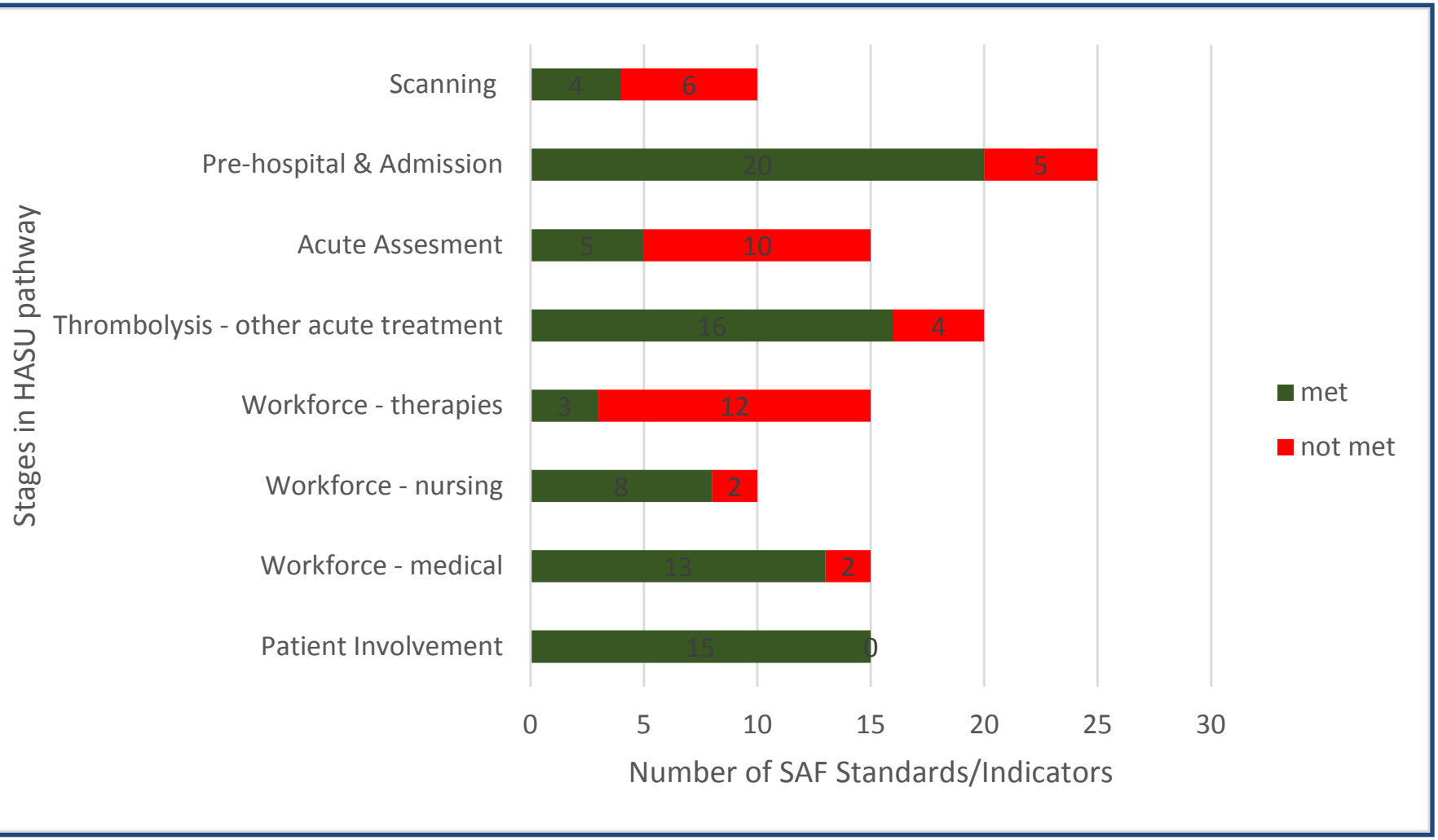
Strategic review

Where?


Wakefield
Barnsley
Doncaster
Sheffield
Rotherham
Buxton
Worksop
Chesterfield

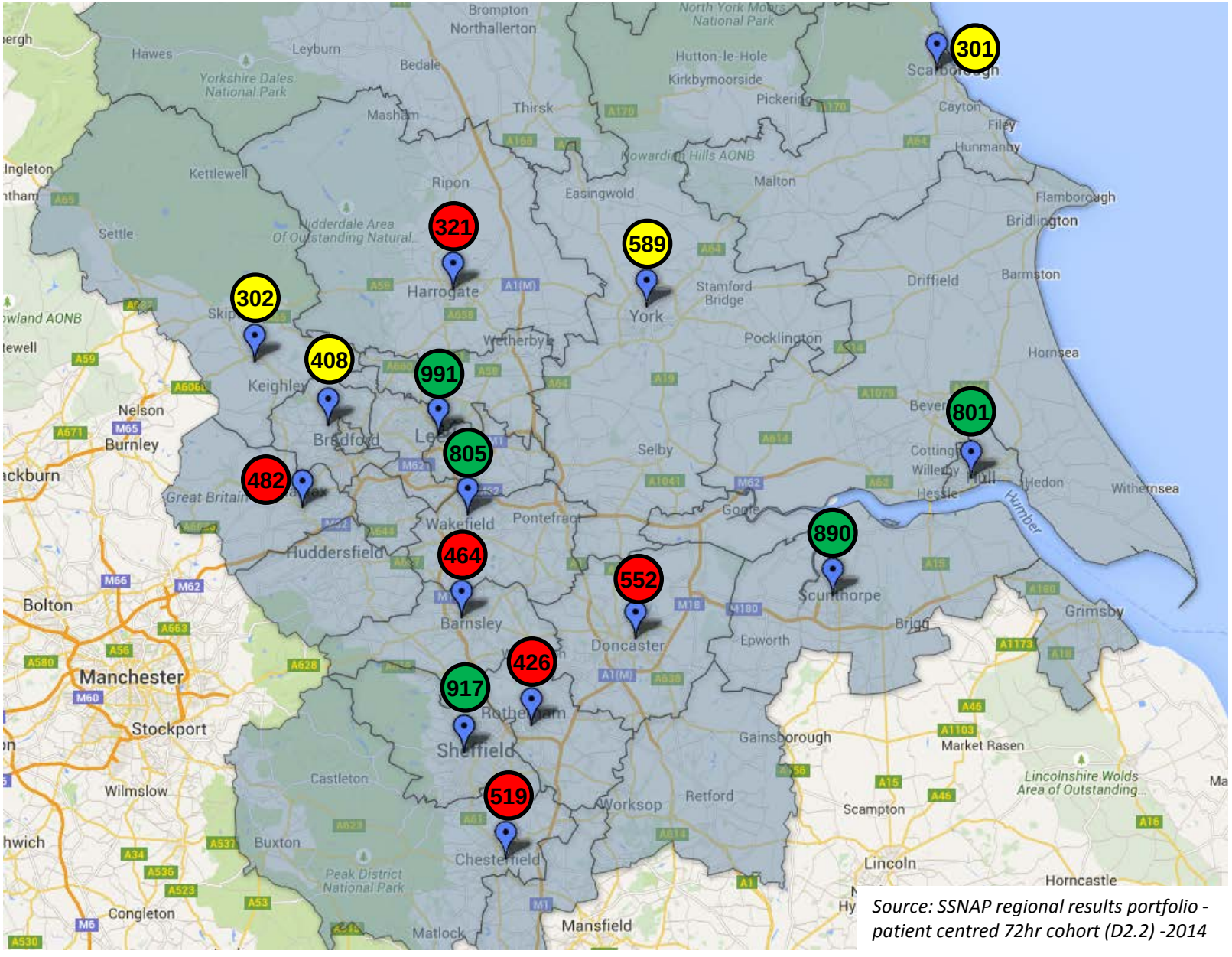
The case for change: stroke

Why?


Scanning
Pre-hospital & Admission
Acute Assesment
Thrombolysis - other acute treatment
Workforce - therapies
Workforce - nursing
Workforce - medical
Patient Involvement
4
6
20
5
5
10
16
4
3
12
8
2
13
2
15
0
Stages in HASU pathway
0
5
10
15
20
25
30
Number of SAF Standards/Indicators
met
not met


· Wakefield
[HASS]
[HASS]
· Barnsley
· Doncaster
[HASS]
[HASS]
Sheffield ·
· Rotherham
[HASS]
· Buxton
· Worksop
Chesterfield ·
[HASS]

Number of strokes by Unit (2014)



Source: SSNAP regional results portfolio - patient centred 72hr cohort (D2.2) -2014

What's the evidence?

Manchester & London

Improved quality

Fewer deaths

Much greater chance of survival

What next?

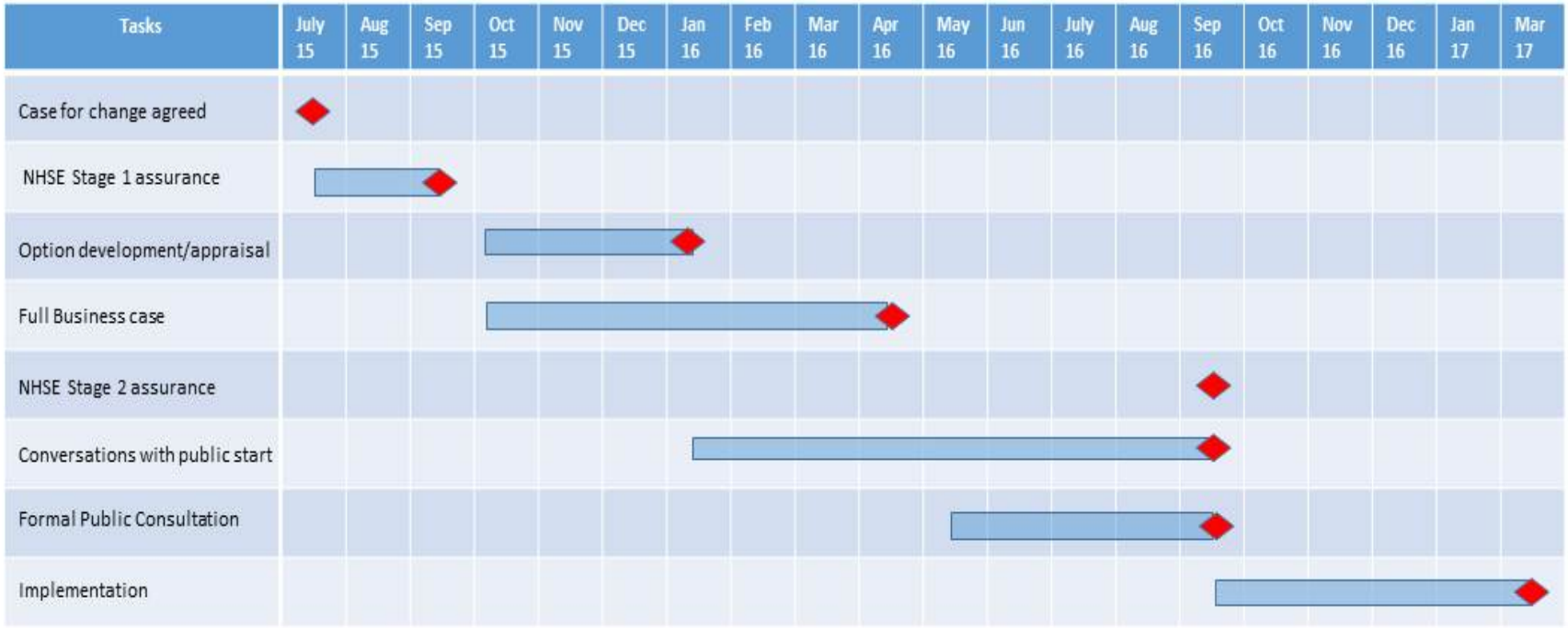
Conversations with communities

Develop the options

Develop a business case

Timelines

Stroke - High Level Project Timeline



Key

Milestone - task complete

How can we work together?

Presentation Notes:

Meeting of WT OSC and AOs
12 October 2015, 15:30 – 17:30, Oak House Rotherham

Objectives:

1. Share work so far
2. Agree how we can work together
3. Gain support for join OSC
    a. Agree how we will achieve that – shared paper requesting support to each OSC
4. Agree when we will next come together
    a. Timeline would indicate January 2016

Simple presentation focussing on:

WHY:

- A big challenge for the NHS today is improving care at the same time as more and more people are using its services. **Rising demand**
- A significant factor is people are living longer and expectations of patients and the public are rising. Technology and how care is delivered is also improving. **Aging population rising expectations**
- We want to ensure that the quality of services remains high and that new and improving standards can be implemented. **Quality & Standards**

- We know that for some services, there won't be enough trained and experienced doctors, nurses and healthcare staff in the future to be able to provide care in the way that it is now and this is challenging our ability to meet standards. **Workforce**
- Our patients access services across many geographical boundaries to access the full range of services from primary care and community services to complex specialised services. **Shared Pathways**
- We also know that how services are currently provided is complex and not always designed in the best way for patients. **Complexity**
- With the way we currently provide services the NHS costs more than there is money to run it. **Less money**
- All these factors mean the NHS of the future has to be different and to improve care we need to work together. **Transformational change**

WHAT:

- Working together across mid and south Yorkshire, north Derbyshire and north Nottinghamshire is one of the ways we are making sure our local **NHS stays safe**, available and **close to people.**
- NHS organisations across the region have agreed to work together to make sure that our services and hospitals in particular continue to provide **high quality care** to our residents within the funding available
- Eight clinical commissioning Groups and NHS England have established a collaborative partnership of commissioners called Working Together, to collectively plan and manage change to **improve services**. Over the past 18 months the foundations have been put in place to enable us to be able to both mange and coordinate change on this scale and also enable us to start to effective have discussion.
- A strategic programme of work is established which is responding to the significant challenges facing the delivery of services across this geographical area.

- A similar partnership has also been established comprising the seven acute hospital providers across the same geographical area and there is close working between the two collaborations. This collaboration has been successful in gaining **Vanguard status** to develop new models of care and support **viable smaller hospitals** through sharing resources and developing a **joint clinical strategy** to deliver care across the geography.
- The collaboration enables **coherent and consistent service planning**, commissioning and provision across the patch, including alignment on quality and safety, ensuring that quality standards are met
- Enables us to **sharing limited resources** and effort
- To-date we have been working with our partners to developing our understanding of the issues facing a small number of our services where working together would improve quality, outcomes and experience of our patients.
    - Medical and surgical specialties of ENT, OMFS and Ophthalmology
    - Stoke and acute cardiology services
    - Children's services
    - Urgent and Emergency care
- We have agreed a strategic outline case for change for those areas where the impact is likely to be wide-spread.
- We recognise the significant work locally, regionally and nationally and the complexity this brings to efforts to improve our health and care services. We are currently undertaking a **Strategic review** across our health and care system will help to inform future priorities and our collective response to the **NHS FYFV** for collaboration to respond to current challenges and make improvements for our populations to inform how services are provider across our geography.

WHERE

- Working together across mid and south Yorkshire, north Derbyshire and north Nottinghamshire is one of the ways of making sure the local NHS stays safe, available and close to where people live.

Case for Change for Stroke

Background:

- 2846 stokes pa
- Across 5 centre in WT and 15 across Y&H

Why

- Consist evidence from Stroke Sentinel Audit show clear room for improvement and feedback from national clinical director for stroke that services are mediocre and need to be reviewed.
- Evidence that HASS units need to see between 650 and 1500 strokes per year to provide optimal care
- 3/5 of HASU centres admit less than 600 strokes per annum. (relationship between performance and min. 600 admissions) this is 10/15 centres across Y&H
- There is a shortage of medical & therapy staffing in all provider organisations due to the inability to recruit to established posts
- Unsustainable medical rotas – 4/5 (WT) and 13/15 (Y&H) have less than 6 consultants, and 6/15 have less than 4 consultants
- Door to needle times of over 1 hour and above national average in most cases.
- Low thrombolysis rates across many providers
- Not achieving 1 hour scanning. National average 45 mins.

- A number of Hyper-acute Stroke Services/Units are in close proximity to each other

- Gaps in Early Supported Discharge

Experience from elsewhere

- London and Manchester saw significant improvements both in mortality and morbidity. More stroke patients survived and their recovery was quicker and they were left with fewer complications as a result of their stroke.

Map of HASU

- Map showing 5 Units in South Yorkshire
- Map Showing 15 across Y&H

What next

- Start to engage more widely with communities
- Develop the options for the future service model and full business case
- Key milestones in the timeline
    - January 2016 draft options
    - May 2016 Consultation on option

END

Commissioning Standards Integrated Urgent Care – Ltr from Dame B Hakin

Dear Colleague

Commissioning Standards Integrated Urgent Care

Further to my letter of the 3 July 2015 regarding the commissioning of a functionally integrated 24/7 urgent clinical assessment, advice and treatment service, the Commissioning Standards have now been published. This brings together NHS 111, GP out-of-hours and clinical advice under a single commissioning framework. They are intended to support commissioners to deliver the transformation of urgent care services as set out in Sir Bruce Keogh's Urgent and Emergency Care Review and more recently the Five Year Forward View.

The Standards have been developed following widespread engagement through a variety of routes with a range of stakeholders, which have included the Urgent and Emergency Care Review roadshow events undertaken over the summer months with commissioners and providers.

I would like to thank everyone who took part in the workshops and discussions, and for the part you have played in developing these Standards.

The standards are built on evidence and what is known to be best practice. Elements of the standards will be aspirational at present; however it is envisaged that as Integrated Urgent Care services evolve and become established then the standards will be further enhanced and revised on an annual basis.

To access the Commissioning Standards please click on the following link http://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf.

Dame Barbara Hakin
National Director: Commissioning Operations

NHS England

Commissioning Standards Integrated Urgent Care

September 2015

Information Reader Box (IRB) to be inserted on inside front cover for documents of 6 pages and over, with Publications Gateway Reference number assigned after it has been cleared by the Publications Gateway Team. *Publications Gateway guidance and the IRB* can be found on the Intranet.

Commissioning Standards

Integrated Urgent Care

Version number: 1.0

First published: September 2015

Classification: OFFICIAL

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

Foreword

NHS 111 is already a vital service in helping all people with urgent care needs get the right advice in the right place, first time. Many patients requiring urgent healthcare access this through their GP practice and we expect that this will remain the first point of contact for the majority of patients in the future. However, for those patients who are unable to access their own GP – because the practice is closed or they are away from home for example, NHS 111 will be the primary route to urgent care services. This free to use number is available across England, 24 hours a day, 365 days a year with call volumes now exceeding 1 million per month.

These standards build on the success of NHS 111 and will help to deliver the benefits for all patients set out in the Urgent and Emergency Care review led by Sir Bruce Keogh. The intent is to enable commissioners to deliver a functionally integrated 24/7 urgent care service that is the 'front door' of the NHS and which provides the public with access to both treatment and clinical advice. This will include NHS 111 providers and GP Out-of-hours services, community services, ambulance services, emergency departments and social care.

Some parts of the NHS are already a long way towards functional urgent care integration, but elsewhere there remain areas that have entirely separate working arrangements between NHS 111, Out-of-hours and other urgent care services. This makes accessing urgent advice and treatment very confusing for a large number of patients.

These new Commissioning Standards have been developed in widespread consultation with commissioners and providers, and have taken into account the public feedback received during the earlier stages of the Urgent and Emergency Care Review. They are intended to support commissioners in delivering this fundamental redesign of the NHS urgent care 'front door'. The standards are built on evidence and what is known to be best practice; however, it is envisaged that as Integrated Urgent Care services evolve and become more established then these standards will be further enhanced and revised on an annual basis.

NHS England will continue to work with Commissioners in supporting them with the implementation of the Urgent and Emergency Care Review, within which Integrated Urgent Care will be essential.

Dr Amanda Doyle

Chief Clinical Officer,
NHS Blackpool CCG

Professor Keith Willett

National Director for Acute Episodes
Care, NHS England

1 Introduction

1.1 Current arrangements

NHS 111 is now available across the whole of England, making it easier for the public to access urgent healthcare services when they need medical help fast. It is free to use and directs all people to the right local service first time, or gives health advice that is best able to meet their needs. NHS 111 has been critical to improving the delivery of urgent and emergency care services, ensuring that all patients receive convenient care and close to home.

Out-of-hours GP services give patients treatment and advice for medical problems that are not life-threatening, but where the patient cannot wait to attend their own GP practice.

The current Out-of-hours period is:

- the period beginning at 6.30pm on any day from Monday to Thursday and ending at 8am on the following day.
- the period between 6.30pm on Friday and 8am on the following Monday.
- Good Friday, Christmas Day and bank holidays.

Out-of-hours does not include any period where for example a GP practice closes during contracted hours. Should a GP practice close during contracted hours, it is the practice's responsibility (including financial responsibility) to ensure appropriate cover is provided at such times.

Since February 2014, the commonest route for people to access Out-of-hours GP services is to call NHS 111. However, amongst the public, knowledge about the availability of GP Out-of-hours services is poor:

"The most recent GP patient survey found that over 40 per cent of respondents did not know how to contact an Out-of-hours GP service. The survey found that around a quarter of people had not heard of Out-of-hours GP services. Awareness among certain groups, including younger people and black and minority ethnic citizens, was lower than among others."[1]

In some areas of England, people can also still call a designated Out-of-hours GP telephone line.

The way Out-of-hours GP services are provided varies across the country. Services differ in the number of GPs employed, the use of call takers, the number of cars available for home visits, and the use of other clinical staff to support GPs.

[1] National Audit Office – Out-of-Hours GP Services in England HC439 9th September 2014

On 1st April 2013, CCGs became responsible – by virtue of directions given by NHS England – for commissioning Out-of-hours primary medical care services.

The only exception to this is for the small number of practices that have retained contractual responsibility for providing Out-of-hours primary medical care services (i.e. those that remain 'opted in' and who continue to contract or provide the service themselves). Although NHS England has responsibility for managing contracts with these practices, CCGs have responsibility for carrying out some functions on its behalf, for example to support the monitoring of quality for Out-of-hours Services.

1.2 Integrated Urgent Care

Around the country, commissioners have adopted a range of models for the provision of NHS 111, Out-of-hours and urgent care services in the community. In some areas a more comprehensive model of integration has been implemented. Some parts of the NHS are already a long way towards urgent care integration, but elsewhere there remain areas that have entirely separate working arrangements between NHS 111, Out-of-hours and other urgent care services. This position is entirely understandable given the way that primary care, Out-of-hours and NHS 111 services have evolved; but it no longer fully meets the needs of patients or health professionals.

The need to redesign urgent and emergency care services in England and the new models of care which propose to do this are set out in the Five Year Forward View (5YFV). The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided, improving out of hospital services so that we deliver more care closer to home and reducing hospital attendances and admissions. We need a system which is safe, sustainable and that provides consistently high quality. The vision of the Review is simple:

- For those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

1.3 Vision

The core vision for a more closely Integrated Urgent Care service builds upon the success of NHS 111 in simplifying access for patients and increasing the confidence that they, local commissioners and the public have in their services.

The offer for the public will be a single entry point - NHS 111 - to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership.

Central to this will be the development of a 'Clinical Hub' offering patients who require it access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. The clinicians in the hub will be supported by the availability of clinical records such as 'Special Notes', Summary Care Record (SCR) as well as locally available systems. In time, increasing IT system interoperability will support cross-referral and the direct booking of appointments into other services.

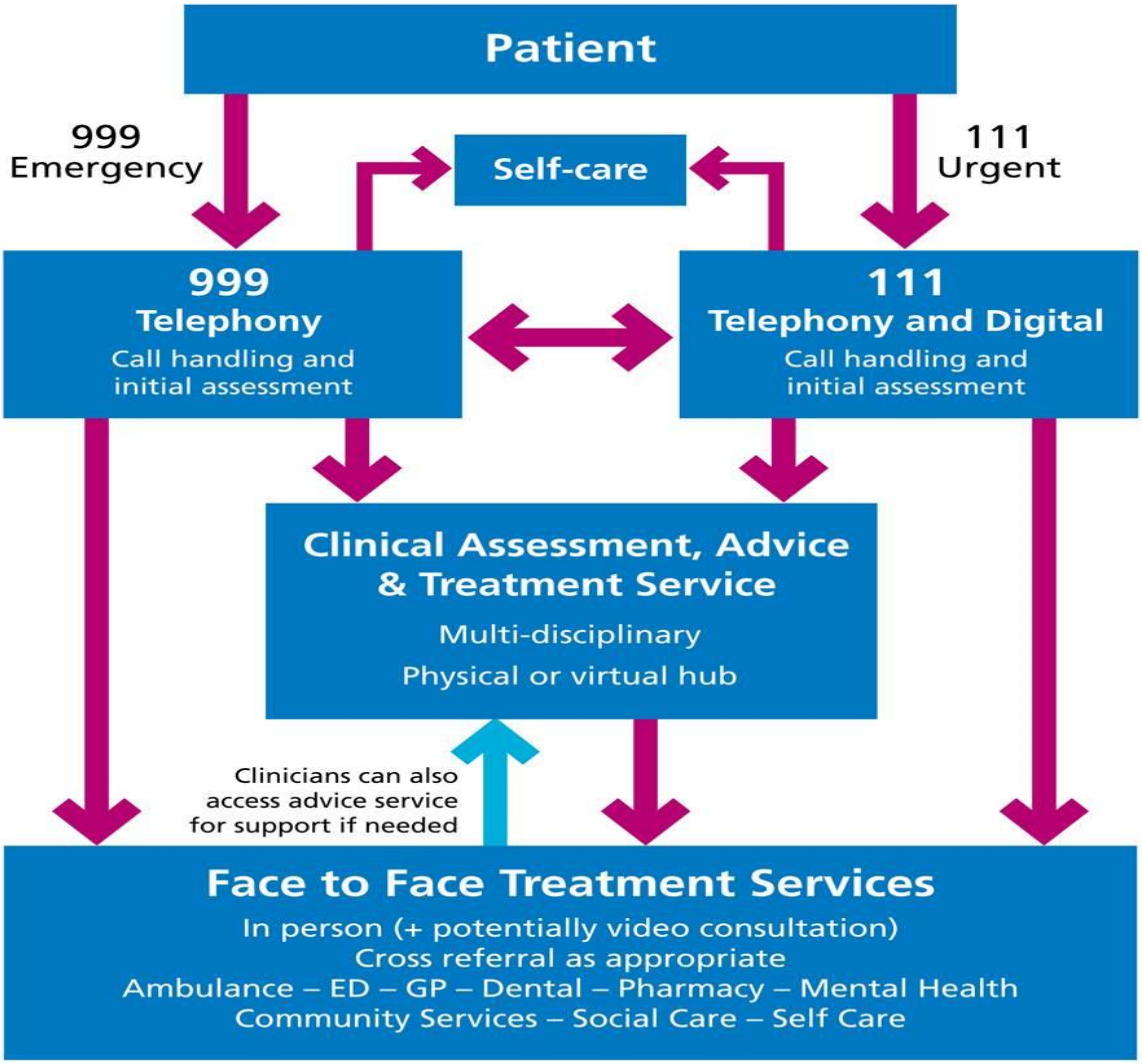
A plan for online provision in the future will make it easier for the public to access urgent health advice and care. This will increasingly be in a way that offers a personalised and convenient service that is responsive to people's health care needs when:

- They need medical help fast, but it is not a 999 emergency.
- They do not know whom to contact for medical help.
- They think they need to go to A&E or another NHS urgent care service.
- They need to make an appointment with an urgent care service.
- They require health information or reassurance about how to care for themselves or what to do next.

Put simply:

"If I have an urgent need, I can phone a single number (111) and they will, if necessary, arrange for me to see or speak to a GP or other appropriate health professional – any hour of the day and any day of the week"

Shown diagrammatically, a functionally integrated urgent care service:



An Integrated Urgent Care service, supported by an Integrated Clinical Advice Service (Clinical Hub) will assess the needs of people and advise on or access the most appropriate course of action, including:

- Where clinically appropriate, people who can care for themselves will be provided with information, advice and reassurance to enable self-care.
- Where possible people will have their problem dealt with over the phone by a suitably qualified clinician.
- People requiring further care or advice will be referred to a service that has the appropriate skills and resources to meet their needs.
- People facing an emergency will have an ambulance dispatched without delay.

- 999 will continue to provide an emergency service whilst 111 will take all calls requiring urgent but not emergency care.

1.4 Benefits

Commissioners are responsible for the measurement and delivery of the intended benefits for an Integrated Urgent Care service. The list below describes the anticipated benefits to patients, commissioners and providers as identified in the Urgent and Emergency Care Review:

For Patients:

- Increases the patient's and/or their family/carer's awareness of the service and publicise the benefits of 'phoning NHS 111' as a smart call to make.
- Improves public access to urgent healthcare services 24/7.
- Makes it clear how all patients or their family/carer can access and navigate the urgent and emergency care system quickly, when needed.
- Provides all patients and/or their family/carer with information and options for self-care, and support them to manage an acute or long-term physical or mental condition.
- Improves all patients' care, experience and outcome by ensuring the early input of a senior clinician in the urgent and emergency care pathway.
- When required, makes the onward referral increasingly seamless e.g. through direct booking of appointments at a wider range of urgent care services.
- Increases public satisfaction and confidence in the NHS.
- Measures the quality and experience of patient care and act upon these assessments to ensure continuing service improvement.

For Health Professionals:

- Provides consistently high quality and safe care.
- Is simple and guides good, informed choices by patients, their carers and clinicians.
- Provides access to the right care in the right place, by those with the right skills, the first time.
- Promotes the appropriate and effective sharing of relevant patient information across and between services.
- Improves decision making through access to records.

For Commissioners:

- Is efficient and effective in the delivery of care and services for patients.
- Increases the efficiency and productivity of the urgent care system, eradicating overlap and duplication in service provision and clinical time.
- Drives the improvement of urgent and emergency care services.
- Creates an opportunity to reduce high acuity referrals; improving system impact.

2 Commissioning Standards

2.1 Purpose

This document sets out the Commissioning Standards for a functionally Integrated Urgent Care service in England which will provide the public with 24/7 access to urgent clinical assessment, advice and treatment. The standards detailed throughout this document have been jointly developed between CCGs, providers, NHS England and a wide range of stakeholders and take account of public feedback received during the Urgent and Emergency Care Review.

The standards describe the core requirements and quality metrics for an Integrated Urgent Care service.

However, all Out-of-hours providers, including those GP practices that retained responsibility for Out-of-hours services under the GP contract (i.e. did not opt out of responsibility for Out-of-hours services under the 2004 contract) are currently required to meet the quality requirements set out in '*National Quality Requirements in Out-of-hours Services'* published on 20 July 2006. These requirements are currently described in legislation *(SI 2015 no196 section 8)* and NHS England will work with the Department of Health to consider whether, and how, amending them. In the meantime, a companion publication describing a proposed suite of new metrics and key performance indicators (KPIs) for the functionally integrated service will be published alongside these Commissioning Standards. In time, these new metrics and KPIs will be incorporated into further iterations of this document.

The intent is to describe best practice in supporting commissioners and providers to deliver these standards and ensure that all patients can depend upon receiving the same high quality service wherever they live or access urgent health care in England.

The standards have been informed by:

- The Five Year Forward View.
- The Urgent and Emergency Care Review.
- Learning and Development Phase 1 Pilots.
- Commissioners.
- Patient and the Public insights.

Crucially, in its 2014 report on: *"The performance, oversight and assurance arrangements, and integration of Out-of-hours GP services"*, the ***National Audit Office*** recommended that:

"In taking forward its vision for urgent and emergency care, NHS England should support and incentivise clinical commissioning groups and other bodies to integrate. If the vision is to be realised consistently and cost-effectively, the NHS will need guidance and sometimes central direction. Specifically, NHS England will need to: understand how patients flow through the system; identify and disseminate good practice; support clinical commissioning groups, possibly financially, to align existing urgent care contracts; and address perverse incentives in national payment and performance management frameworks."

The intent is to describe achievable best practice in supporting commissioners and providers to deliver these standards and ensure that all patients can depend upon receiving the same high quality service wherever they live or access urgent health care in England.

2.2 Audience

The primary audience for this document is clinical commissioning groups and providers of NHS 111 and Out-of-hours services as the responsible organisations in the performance of local urgent care systems. Clinical commissioning groups should be aware that it will be of considerable importance to work with local providers, and should ensure that they are involved in the development of local delivery plans.

2.3 Roles and responsibilities

The full roles and responsibilities are outlined within **Annex A**.

Commissioners are responsible for the procurement of an Integrated Urgent Care service in line with the service standards described throughout this document.

Annex B provides a useful self- assessment tool for commissioners to use as a guide to the level of integration towards new clinical standards for an integrated 24/7 urgent care and clinical advice service. It can be used at Clinical Commissioning Group, System Resilience Group or Urgent & Emergency Care Network levels.

2.4 Local commissioning specifications

This document constitutes the ***national standards*** to deliver a 24/7 urgent clinical assessment, advice and treatment service (Integrated Urgent Care). Commissioners may wish to enhance these in delivering their local

specifications and to ensure that they are comprehensive and appropriate in meeting the needs of their local population.

It also gives commissioners and providers an outline of current developments and further improvements to the service offering that are highlighted as explanatory notes within the document.

Commissioners should take account of these standards and separate supporting procurement guidance when commissioning 'Functionally Integrated Urgent Care' services.

Commissioners must have robust plans to ensure that the newly commissioned functionally integrated urgent care services fully realise the available financial savings at the local healthcare economy level and that these savings are realised at the same time as any new costs are brought on stream. When evaluating these potential savings commissioners should include all costs and savings across the whole healthcare economy that are borne by CCGs, NHS England, or any other organisation with delegated authority to commission healthcare locally.

Commissioners should assure themselves that any savings realised from the newly commissioned services are not offset through commissioning of unnecessarily duplicated services elsewhere in the urgent and emergency care system (for example through ambulance services, urgent care centres or locally commissioned general practice enhanced services).

Additionally, when commissioning new services commissioners should ensure that there is sufficient flexibility built into the new contracts that the risk of future duplication of commissioned services is mitigated. In particular, contracts should allow for the possibility of longer in-hours general practice provision consistent with the development of seven day services, and the possibility of a future shift between telephony and digital access to 111 services.

NHS England is seeking to publish a financial modelling tool to support commissioners in understanding the whole system potential cost and to circulate a summary at CCG level comparing the costs prior to September 2015 of 111 and GP Out of Hours services.

2.5 Joint working arrangements

2.5.1 Lead Commissioner Arrangement

As identified in the Urgent and Emergency Care Review it is critical that NHS 111 services are considered as part of the Urgent and Emergency Care Network[2]. As such the Network would be the most appropriate level for agreeing how a service such as an integrated service should be commissioned.

The lead or co-ordinating commissioner arrangement should be considered, in which commissioners serving a wider area are brought together to commission an integrated service. This has been shown in a number of areas to be an effective model for engaging with providers (particularly those that deliver services over an area covering a number of CCGs) and to effect strategic change.

2.6 Collaborative Provider Management

Commissioners should continue to promote a healthy and diverse provider market. It is envisaged that both large and small providers will have an important part to play in delivering a successful and Integrated Urgent Care service. Providers will need to collaborate to deliver the new investment required in technology and clinical skills, and to ensure that services are aligned. It is for this reason that commissioners should consider using the procurement process to encourage current NHS 111 and Out-of-hours organisations to collaborate or work within a lead provider arrangement, to deliver the standards for an Integrated Urgent Care service.

In doing so, commissioners will need to ensure that the current provider market continues to be developed and is not destabilised in any way. There should be many opportunities for any qualified provider to meet these new service standards in collaboration with other providers. ***To be clear, NHS England has no expectation that any organisations should merge.***

2.7 Payment approach for Integrated Urgent Care

NHS England and Monitor recognise that current forms of payment for urgent and emergency care (UEC) services may create a barrier to coordination and collaboration and that a new approach to payment may play a valuable role in enabling a networked model of care.

[2] http://www.nhs.uk/NHSEngland/keogh-review/Documents/Role-Networks-advice-RDs%201.1FV.pdf

The document: Urgent and emergency care: a potential new payment model outlines potential payment options and provides guidance on how to approach developing and implementing one possible new payment approach locally to support UEC service reform. In addition, it recognises the need to allow local areas the freedom to develop alternative approaches should they better fit their local needs.

We have now drafted a document which builds on this guidance, looking specifically at NHS urgent and emergency care telephony assessment and advice. We have outlined one suggested payment approach that is consistent across providers and encourages coordination in providing behaviour to provide the best patient care.

Local areas can use this document as a basis for planning. The options described are at a development stage, and will be further developed and tested with a small number of local areas during 2015/16. Updated versions of this document will be published as we learn from this work and how it informs refinement of the payment design, including how the proposed payment approach will work alongside other payment models.

This document can be found at: https://www.england.nhs.uk/ourwork/pe/nhs-111/resources.

3 Standards of Delivery

3.1 Access

- Central to Integrated Urgent Care will be a 24/7 free to call number (111) that gives patients and the public easy and swift access to urgent care.
- Patients and the public should be enabled to access Integrated Urgent Care via alternative routes to the telephone; i.e. digital online platforms.
- Warm transfer of patients should be facilitated between organisations with the avoidance of re-triage whenever possible and appropriate.
- Commissioners should ensure access to a range of multidisciplinary clinical expertise and services in addition to nurses and paramedics. We expect that the clinical hub (physical or virtual) will be the source of this expertise.
- Whilst it is not recommended, it is acknowledged that alternative routes of telephone access to the urgent care system may be in place to reflect current local arrangements, e.g. provision of extended access primary care services. Commissioners should ensure that these are both absolutely necessary and within the scope of Integrated Urgent Care governance arrangements and that adequate signposting and transfer occurs if a patient calls 111.

3.2 Assessment

- Patients calling 111 will speak first to a health adviser who will use an accredited clinical assessment tool to assess and triage symptoms.
- Where local alternative routes of access are available (i.e. direct access via local Out-of-hours telephone numbers) commissioners should assure themselves that initial call handling and assessment also occurs using a locally agreed clinical governance process.
- Patients with complex problems needing to speak to a clinician will be identified quickly and transferred to speak to the appropriate clinician. It is advised that commissioners work together with providers and clinical governance leads to identify and utilise safe and effective process for this purpose.
- Safeguarding alerts, Special Patient Notes, including End-of-Life Care Plans and recent contact history, will be available at the point of access to ensure appropriate assessment of need. In addition, as a minimum the Summary Care Record will be available to all clinicians, with a commitment

to widen access to other relevant patient records (e.g.) – virtually or in a face to face setting.

- Integrated Urgent Care will have the capability to make an electronic referral to the service that can best deal with a patient's needs as close to the patient's location as possible.

- Integrated Urgent Care should aim to book face to face or telephone consultation appointment times directly with the relevant urgent or emergency service whenever this is supported by local agreement.

  As networks and federations of GP practices develop, patients may be offered an alternative practice-based appointment within their GP network

3.3 Treatment & Clinical Advice

- Red ambulance or equivalent dispositions are to be dispatched without re-triage. This is not intended to prevent health advisers in NHS 111 seeking clinical advice during a call, nor to prevent enhanced clinical assessment by the 999 service which does not delay dispatch.

- Green ambulance dispositions may be subject to enhanced clinical assessment within Integrated Urgent Care before an automated referral is sent to the local ambulance service. This process must be agreed by commissioners, clinical leads and providers as safe and robust, with appropriate governance/escalation in place, and the impact on local performance and incidents must be regularly reviewed.

Evidence: *There have been* ***32,000 fewer green ambulance referrals*** *from London 111 since the start of enhanced clinical assessment of Green ambulance dispositions in November 2014 –* ***approximately 800 per week.***

- Commissioners should assess the potential benefits and consider if Emergency Department (ED) dispositions should be subject to early clinical assessment within Integrated Urgent Care. Referral of patients from Integrated Urgent Care to the ED should include the use of electronic messaging and opportunities to book patients directly into the ED should be explored.

- Ambulance services should have the facility to electronically transfer patient details to Integrated Urgent Care for early clinical assessment if the call is assessed as a green disposition rather than being required to deal with the call themselves.

- Self-care should always be considered as an option when treating and offering advice to those contacting the service. In addition to this there may be the option of tertiary sector involvement and in time the possibility of linkage with social care systems that would support an individual in their own home.

3.4 Advice and Referral

- The Directory of Service (DoS) will hold accurate information across all commissioned acute, primary care and community services and be expanded to include social care. The advantages of being able to contact social care support through the 111 telephone number offer significant benefits - specifically in relation to home support / carers etc. (Further detail of the DoS is included in 4.4).

- The Directory of Services should reflect locally commissioned schemes and services, especially those intended to utilise independent contractors such as community pharmacists as appropriate alternatives for minor ailments and urgent repeat medication. Commissioners must assure themselves that arrangements are in place to ensure that entries are accurate and up to date. Health advisers need to be confident in referring or signposting callers to these services, where available.

Evidence: *A Pharmacy Urgent Repeat Medication scheme was commissioned for winter 2014/15, resulting in 1,084 fees claimed by community pharmacists as at the end of May. This represents one third of urgent repeat prescription activity; although it reduced pressure on GP Out-of-hours providers and EDs, the rate of referral to community pharmacists is being increased through better processes and improved health adviser confidence. In a survey of 469 patients using the scheme, in answer to the question 'Where would you have gone if this service was not available?'*

- *41% would have gone to A&E or urgent care centre*
- *39% would have gone to GP Out-of-hours*
- *19% would have gone without their medicines*
- *7% would have gone on to contact own GP*

- An accredited search tool should be available to allow clinicians across all Integrated Urgent Care settings to search the DoS [Access to Service Information] direct. For appropriate staff, this should be permitted outside the approved clinical algorithm software, where considered safe and appropriate.

Evidence: *A Directory of Services search tool is being deployed across a range of urgent care settings to provide access to GP bypass numbers and locally commissioned services, especially those designed to support care in the community (e.g. falls teams).*

- To ensure adherence to these national standards, all providers, or combinations of providers, must commit to adherence to the service specification and contractual framework on patient disposition options and shared clinical advice, recognising that the initial part of the assessment accessed via 111 is a national service.

- There should be clear governance in place, informed by audit of service selection, to ensure regular review of services returned from the Directory of Service [Access to Service Information] and their relative priority especially across borders with neighbouring CCGs.

3.5 Integrated Care Advice Service (or 'Clinical Hub')

To support effective Integrated Urgent Care it is recommended that commissioners include an "urgent care clinical advice hub" in specifications. To improve working relationships, dialogue, and feedback, some of the clinicians that make up this hub should be physically co-located. For clinical specialisms and care expertise which is consulted less frequently it may be more appropriate to make arrangements to contact an individual who is off site through the creation of a "virtual urgent care clinical hub".

Commissioners will want to consider maximising the utility of the 'clinical hub' e.g. The Clinical Hub should serve two purposes: to provide clinical advice to patients contacting the 111 or 999 services, as well as providing clinical support to clinicians (particularly ambulance staff such as paramedics and emergency technicians) to ensure that no decision is made in isolation. It could also support the wider Urgent Care Network (for example nursing and residential homes and other emergency services such as the police, for use in street triage). We would encourage the joint commissioning and establishment of hubs and at an appropriate scale – avoiding overlap and duplication. Over time additional methods of communication and support (for example video-consultation) should be explored to further increase the effectiveness of the clinical hub.

The exact mix of clinicians and other urgent care staff in the integrated urgent care clinical hub, and their seniority, should be specified in contracts/service arrangements and dictated by a careful assessment of local needs and the

UEC network design. Usually they will include one or more of each of the following professionals:

- Specialist or advanced paramedics with primary care and telephone triage competences.
- Nurses with primary, community, paediatric and/or urgent care experience.
- Mental health professionals.
- Prescribing pharmacists.
- Dental professionals.
- Senior doctor with appropriate primary care competences.

Additional competency areas that may require provision include: midwifery, paediatrics, hospital specialists, occupational therapy, third sector organisations, alcohol and drug services, palliative care nurses, social care, housing and others depending on local need. Wherever possible individuals working in the clinical hub should be based in that community, and be familiar with local services and practice.

3.6 Improving Referral Pathways

3.6.1 Referral Rights

In addition, and in order to help facilitate an improved flow of patients and information within the UEC system, all registered health and social care professionals within physical and mental health (referred to in this document using the general term “clinicians”), following telephone consultation or clinical review of a patient, should be empowered, based on their own assessment, to make direct referrals and/or appointments for patients with:

- The patient’s registered general practice or corresponding Out-of-hours service.
- Urgent Care Centres.
- Emergency Departments in Emergency Centres and in Emergency Centres with Specialist Services.
- Mental health crisis services and community mental health teams.

- Specialist clinicians, if the patient is under the active care of that specialist service for the condition which has led to them accessing the urgent and emergency care system.

Urgent & Emergency Care Networks may wish to define the exact referral pathways available to each professional working within their network. Further guidance is available in the document: *Improving Referral Pathways between Urgent and Emergency Services in England - Advice for Urgent Care Networks.*

3.6.2 Referral Mechanism

Referral of patients between urgent care services is best facilitated by transfer of electronic messages. Detailed guidance is available in the Inter-operability Standards

3.6.3 Post Event Messaging

Commissioners must ensure that a post event message (PEM) is sent to the registered GP in-line with previous guidance from GP Out-of-hours national quality requirements and NHS 111 inter-operability standards. Commissioners should note that there are considerable opportunities to streamline the format and content of the PEM using the receiving GP system and by working with local NHS 111 providers. The community website https://posteventmessaginginfo.readthedocs.org provides some useful guidance on these matters.

Although considerable work has already been undertaken to improve the PEM and to reduce the number of duplicate PEMs sent we continue to work with the clinical decision support system (CDSS) supplier to improve this further.

4 Supporting Standards

4.1 Access to Records

- Clinicians within the Integrated Urgent Care service must have access to relevant aspects of patients' medical and care information, where the patient has consented to this being available.

- This must include knowledge about patients' contact history and medical problems; so that the service can help patients make the best decisions. Patients with special notes or a specific care plan must be treated according to that plan and, where patients have specific needs they must be transferred to the appropriate professional or specialist service.

- Access to important patient information through the existing Summary Care Record (SCR) service, and from other local systems that may be in place, must be available to all clinicians working in the Integrated Urgent Care system along with the necessary training to use it appropriately. Commissioners should ensure that Integrated Urgent Care service providers remain engaged to develop wider sharing of records across the health care system, including the enrichment of SCRs with additional information by GP practices for appropriate patient groups.

Explanatory Note: SCRs with additional information will include reason for medication, significant medical history and procedures, patient preferences (e.g. communication and end of life) and immunisations.

- Commissioners need to ensure that providers adhere to the Data Protection Act in relation to access to records. It may be beneficial that the 'Permission to View' (PTV) question for clinical records is asked by the call handler during the initial stage of the patient's encounter with the Integrated Urgent Care service. The response to this question should be captured and stored in the system, and passed through technical interfaces onto any further system and/or organisation that will be responsible for direct patient care during the episode.

  Explanatory Note: Call handlers are not expected to view the SCR only to capture the patient's consent at the beginning of the call. This removes the need for clinical staff having to ask the question whilst attempting to treat the patient.

- The SCR will be developed to allow the creation of 'flags' which will signal the presence of key information held within the enhanced SCR or on other, locally determined, systems. It is intended that these flags will be presented at a point in the call flow that will allow for appropriate action e.g. routing directly to a clinician, without the requirement for a full triage by the health advisor.

- **In time, we expect that the SCR will be developed as a strategic solution to ensure that the presence of care plans and special notes can be identified and accessed.**

- **We recognise the need to work with providers, commissioners and system suppliers to create additional interoperability standards and develop an interoperability roadmap by March 2016 to support more advanced models of integration and access to records.**

4.2 Business Continuity

- All Integrated Urgent Care commissioners should require through the NHS standard contract that providers have arrangements in place so that in the event of fluctuations in demand, technical failure or staff shortages they can invoke contingency and continue to provide an acceptable level of service to the population. It is vital that the service remains safe for patients at all times.

- It is suggested that a collaborative provider-to-provider relationship, where possible geographically separated, would be a pragmatic approach to this. If providers are looking at implementing this approach then this should be undertaken in conjunction with NHS England and the commissioner, so if required any changes that may be required to telephone call routing can be delivered. Any arrangement of this sort must have clear agreement regarding how much activity could be potentially transferred to the support provider.

- Commissioners and providers should be aware of their responsibilities to support disaster recovery in the event that another service provider is unable to take calls due to some catastrophic event. In these circumstances, the NHS 111 National Contingency would be invoked and all commissioners and providers would be expected to accept an appropriate proportion of calls in order to maintain national patient safety. The proportion of calls will be determined by the amount of activity each provider routinely experiences. Neither funding nor performances penalties should be applied to the receiving call handling service in this situation. The commissioner should seek to establish retrospectively whether the catastrophic event was within the failing parties control and constituted a breach, or whether it should be classed as “force majeure”.
- The National Contingency policy is detailed in a separate document (https://www.england.nhs.uk/ourwork/pe/nhs-111/resources/). The capacity of Integrated Urgent Care services should be sufficient to meet call volume and fluctuations in demand, in line with the National Quality Requirements. Providers must ensure they plan their resources in relation to historical demand and ensure that any current trends in demand are also taken into account. Integrated Urgent Care providers must ensure that their capacity planning is conducted in liaison with other healthcare providers who may be affected by their outputs (e.g. out of hour’s providers, ambulance services, ED departments).

4.3 Clinical Decision Support System

Integrated Urgent Care service providers must ensure that health advisers and non-registered clinicians use accredited clinical assessment tools/clinical content to assess the needs of callers; this is a mandatory requirement. For registered clinicians local commissioners will need to determine the use of any CDSS based on the scope of practice, competences and educational level of clinicians concerned. In addition, the provider of the service must ensure that they adhere to any licensing conditions that apply to using their system of choice. This must include the ability to link with the wider urgent and emergency care system. Commissioners should also ensure that providers deploy any relevant CDSS upgrade/version, associated business changes, training and appropriate profiling changes to enable Access to Service Information (DoS) within any specified deployment windows for the chosen system(s).

4.4 The Directory of Services (DoS)

The Directory of Services (DoS) provides access to service information, which is a critical element of NHS 111 service provision. As patients should be able to

access a wide range of services via NHS 111, access to service information may be provided from the DoS and additional sources. Commissioners must ensure that resource and infrastructure is in place to provide accurate and relevant access to service information to Integrated Urgent Care providers.

Commissioners therefore:

- Need to enable the addition of services from social care, mental health and third-sector services to improve accessibility for patients to these services.
- Should ensure that expert resources are available to engage with all services in order to effectively maintain and update systems providing access to service information. This involves regular, routine updating of services for accuracy, profiling, ranking and the addition of new services where appropriate. These activities must be undertaken in line with the Clinical Decision Support System (CDSS) licence requirements, and commissioners should work with their providers to plan and agree the timing of CDSS version upgrades and consequent changes to service profiling.
- Should ensure that resources employed to maintain service information are at an equivalent grade to other areas, are sufficiently senior and are supported by a local governance model with clear reporting structures from the local level through to national reporting and oversight.
- Must ensure that adequate resource is allocated to testing of service information returns to the NHS 111 service following profiling changes and/or CDSS upgrades. This testing should include clinical sign off against defined scenarios and must respond to service improvements identified during live operations or as a result of improvement initiatives, such as context sensitive ranking of results.
- Should ensure that service information collected from social care, mental health and the third sector is assured as being consistent with the data collected from NHS services and therefore maintains clinical safety for patients being signposted to those services. The access to service information for services within and outside the NHS should be completed without duplicating data across directories where possible.
- Should work with services and the Integrated Urgent Care provider to ensure that "follow up" information is available to the person calling the Integrated Urgent Care service by (for example) text message or e-mail confirmation of details of the service that the patient has agreed to attend.
- Must engage with annual data quality audits to ensure that service information is maintained to an agreed quality standard.

- Should ensure that regularly updated Standard Operating Procedures are in place for managing the day-to-day access to service information, business continuity in the event that service information cannot be accessed, and approaches to handling calls where access to service information does not correctly link to the CDSS. Where national initiatives provide solutions to continuity of access to service information, commissioners must work with their providers to support these initiatives. Operating procedures should also enable the capture of feedback from Integrated Urgent Care Service staff relating to improvement of access to service information.

4.5 Clinical Governance

Each Integrated Urgent Care service must ensure that clinical governance arrangements are in place to assure the clinical safety of the whole patient pathway, not just the initial call handling service phase of 'Integrated Urgent Care'. These arrangements are underpinned by strong relationships and partnership working between all providers involved in the patient pathway so that issues can be identified and service improvements made. They are based on an open, transparent and multi-agency approach to clinical governance.

The following is suggested good practice for Integrated Urgent Care clinical governance;

1. The appointment of a local Integrated Urgent Care clinical governance lead (CGL). This lead should be appropriately skilled and suitably experienced for the role.
    - The CGL role involves the development of relationships across the whole urgent and emergency care network, and the individual should be clinically credible in order to work effectively in this complex environment.
    - The CGL will be responsible for holding the provider to account for clinical standards.
    - The CGL must have clearly defined links to the regional and national NHS clinical governance structures, particularly the local system resilience groups and urgent and emergency care network.
    - A minimum expectation is for the lead to have at least two days a week to dedicate to this role. Where the geography, service utilisation and complexity of service are greater, more capacity may be required.

2. A local clinical governance group, under strong clinical leadership and with clear lines of accountability to the commissioners of the integrated urgent care service, working alongside and closely with the contracting team. The local governance group should bring together the Integrated Urgent Care Service providers with all the NHS and social care providers to whom patients may be referred, enabling all to develop a real sense of ownership of their local service.

   More detailed guidance on the role of local clinical governance groups, including model terms of reference and membership is available in the companion document 'Integrated Urgent Care Clinical Governance available at https://www.england.nhs.uk/ourwork/pe/nhs-111/resources

   ***NB.** Clinical Governance advice and a revised toolkit to encompass the new Integrated Urgent Care service, based on the old NHS 111 CG model, will be available ASAP.*

3. Clarity about lines of accountability within the Integrated Urgent Care service.
4. A policy setting out the way in which adverse and serious incidents will be identified and managed, ensuring that the clinical leadership of the Integrated Urgent Care service plays an appropriate role in understanding, managing and learning from these events.
5. Clear and well publicised routes for both patients and health professionals to feedback their experience of the service, ensuring prompt and appropriate response to that feedback with shared learning between organisations.
6. Regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional insight into the quality of the service.
7. Regular review of the 'end-to-end' patient journey, with the involvement of other partner organisations, especially where outcomes have proved problematic.
8. Provision of accurate, appropriate, clinically relevant and timely data about the integrated urgent care service to ensure that it is meeting these Commissioning Standards.

4.6 Future Workforce

As part of the wider Urgent and Emergency Care Programme, NHS England, Health Education England and key stakeholders are presently working together

on a number of key areas, these include:.

- Integrated Urgent Care health advisers and the integrated urgent care call-centre based ‘tele’ workforce.
- GP fellows in emergency and urgent care.
- Advanced practitioners from nursing, paramedics, pharmacy, podiatry and physiotherapy.
- Emergency Medicine fellows.
- Physician Associates.
- Non-medical prescribers.
- Independent prescriber pharmacists.
- Paramedics.

The national NHS 111 (Integrated Urgent Care) Workforce Development Programme has been setup to identify the urgent care workforce requirements for the future; to define the optimal composition, scope of practice, competences and associated development needs. The Programme will deliver outcomes up until 2017/18, however in the interim commissioners and providers must be clearly sighted on quality, composition and competence of the existing workforce.

The clinical workforce will be comprised of generalist clinicians (paramedics, nurses and GPs) who have specialised skills and competences in remote and telephone assessment and management, supported by specialised clinicians from a range of professions cover specific clinical areas, including mental health, dental health and paediatrics.

Commissioners must ensure that services are commissioned for quality and must ensure that there is a clear understanding of the continuous quality systems (including appraisal and feedback) for staff to compliment robust and high quality personal development at recruitment and this must not be limited to solely audit systems, such as used with the CDSS systems.

The workforce will require support from commissioners and Local Education and Training Boards to innovate and develop practice, particularly around the introduction of specialist and advanced level practice clinicians and the Health Advisors. Focus on the development of 'tele' competencies, including an understanding of the CDSS systems and ensuring that they safely manage patients in the telephone environment is required for ALL groups of staff, from GPs to paramedics and nurses and strategies must be in place to ensure that

all staff who practice have the correct competencies and are supported in developing these.

The wellbeing, mental health and future careers of the Integrated Urgent Care workforce are very important; commissioners and providers must ensure that there are mechanisms in place to have a clear understanding of these issues and systems and processes in place to manage them - including exit interview data, an understanding of the rates of attrition for each group and a clear process to ensure value is added from collecting this data.

Prior to these outcomes being available, the workforce should meet the following, minimum requirements, adapted from the NHS 111 Commissioning Standards 2014.

Providers and commissioners should always ensure that they undertake employment checks in accordance with the guidance set out by the NHS Employers, which includes relevant criminal records checks. Examples can be found at: http://www.nhsemployers.org/case-studies-and-resources/2014/07/eligibility-for-dbs-checks-scenarios

4.7 Staff working in Integrated Urgent Care

4.7.1 Health Advisers (Call Handlers)

Workforce training and development must be led by trainers with experience of working within the NHS 111 and/or other telephone triage areas and training and supervision must be provided by a multi-professional workforce, comprising senior health adviser call handlers and clinicians (nurses or paramedics). Newly trained staff must not deliver training and development when a new service is ‘stood up’ without support from more experienced trainers. The focus must be on quality that translates into positive patient experience, and enhanced patient safety.

All staff involved in handling calls in Integrated Urgent Care must undertake training that covers the following areas:

- Compliance with the licence requirements of the relevant Clinical Decision Support Software (CDSS).
- How to interact with urgent care services.
- The use of Directory of Services.
- NHS values and behaviours.
- Delivering excellent, compassionate, customer-focused service.

- Level 2 Safeguarding.

The above should only serve as an indicator and commissioners may wish to specify minimum educational standards and competences over and above these minimum standards. Supernumerary supervisory and clinical staff must be available at all times to support and supervise health advisers. The procedures for seeking clinical advice and the handover protocols from a call handler to a clinician must be simple and clear with voice recording of all interactions.

4.7.2 Clinical staffing model

The basic principles applying to non-clinical staff should be applied to the clinical staffing model.

Commissioners should consider how increased or faster access to clinical advice should be secured for their population. This should be in line with any recommendations from their clinical quality group and include how clinicians access patient records and how they ensure safe timely handover of patient care.

Patient safety must be assured at all times, and clinicians must have the necessary competence, knowledge and skills to operate in roles within the system, including a core level of knowledge of the CDSS systems with which they interface.

Within the Integrated Urgent Care contact environment, clinicians will perform a dual function, providing both direct patient contact, and also clinical supervision and support of the non-registered staff working within the environment – the commissioning arrangements must facilitate this and recognise that clinicians employed within this function will not always be providing direct patient contact. There is also an opportunity to consider the rotation of staff through providers in urgent care to increase skills, whilst, of course, acknowledging the very specific skills required to give tele-advice.

Explanatory Note: Pilots and evaluations of different clinical models are on going and will inform future standards. Initial pilots are focused on access to GPs, but future pilots will include a full range of clinical professions including nursing, pharmacy and mental health. Formal assessments of different models will use operational research techniques in order to establish what is most cost effective.

4.7.3 Training of clinical staff

All clinical staff must be trained in line with the Clinical Decision Support System used in the operational service; however their practice must not be restricted to solely operating within the scope of the CDSS, instead their practice must include the necessary specialist competences and capability to work safely and effectively within the urgent and emergency care environment.

Explanatory Note: Currently it is acknowledged that there may be the need to develop specific educational modules for clinical staff to undertake that will increase their knowledge and improve patient outcomes. NHS England in partnership with stakeholders is undertaking a piece of work to evaluate this and any recommendations will appear in later versions of the commissioning standards.

4.7.4 Medicines and Poisons training

NHS 111 is now the primary user of the National Poisons Information Service (NPIS) to support the handling of accidental poisoning and overdose calls in urgent care. Toxbase is the recognised web based resource to support clinicians handling toxic ingestion calls and supporting decisions about self-care.

Feedback from NPIS and the Toxbase service indicates that training of clinicians working in urgent care contact centres is essential to support safe decision making and managing patients who can be advised to stay at home or need to attend Emergency Departments for clinical assessment.

The eToxbase learning module should be a minimum requirement training for all clinicians supported by additional medicines and eBNF training in the context of therapeutic overdose.

Further Information can be found at https://www.toxbase.org/.

4.7.5 Staff continuous audit and improvement

Health advisers and clinicians (including GPs) must undergo a continuous process of audit in line with the requirements of any clinical decision support system (CDSS) licence and as specified in this document. This must be a process that not only identifies where specific staff have gaps in skills and knowledge but also must allow for continuous improvement of all staff. The audit process should identify key areas where either additional training, modifications to existing training or feedback to software providers are needed.

The audit process itself should be quality assured; as a minimum there should be both internal and external review of auditors.

The audit and development process outlined for health advisers above should be adapted to meet the needs of clinicians and applied in an equally rigorous and systematic way.

Audit by clinicians is preferable to reflect the wider assessment role provided by these individuals, and should reflect the competences within the RCGP Out-of-hours audit toolkit.[1]

Continuous improvement must not be restricted to CDSS audit, but as described earlier, be around appraisal, feedback, mentoring and development – the focus should be on supported, self and system directed learning and improvement to enhance quality, experience and safety.

4.8 Repeat caller service

As a result of the tragic death of Penny Campbell in 2005, the Department of Health issued Directions requiring all GP Out-of-Hours services to ensure that any health professional assessing a patient's needs in the Out-of-hours period would have access to the clinical records of any earlier contact that patient (or their carer) may have recently made with the service.

Thus, where a patient (or their carer) calls the Integrated Urgent Care service 3 times in 4 days, the 3rd call should only be assessed by the health adviser to determine whether or not an ambulance is required. If the outcome is not to send an ambulance, then the call must result in a "Speak to GP within 1 hour" disposition and the GP must be alerted to the fact that this is the 3rd time in 4 days that the caller has made contact with the Integrated Urgent Care Service, and they should therefore complete a thorough re-assessment of the patient's needs. The GP should be sent details of all 3 calls.
The host software system will have to be able to identify where a caller has called twice before within 4 days, so that it can then flag this third call in such

a way that when it is answered by the call adviser, the outcome described above is achieved.

None of this should apply to that small minority of people who regularly make repeated calls to the same service, where the service will have made separate arrangements to respond appropriately to those calls, nor should it apply where there is an agreed care plan for the particular patient (e.g. palliative care, long term conditions etc.). The host software system will therefore also need to be able to identify these callers so that the Integrated Urgent Care Service can respond appropriately to their needs.

Providers should monitor compliance with the above requirement and report on any exceptions in a way that can be audited.

4.9 Interoperability

Interoperability within the Integrated Urgent Care environment is detailed in the Interoperability Standards https://www.networks.nhs.uk/ The standards define the technical standards that must be used for the transfer of data where applicable, to and from NHS 111 application systems and the applications that integrate with NHS 111 service providers.

The following outcomes are required for all services:

- All Integrated Urgent Care applications must connect directly with the SPINE and have followed the Common Assurance Process with the ability to perform an advanced trace to obtain patients NHS Numbers.
- All applications must connect with the Summary Care Record to ensure access to patient records is achieved as a minimum.
- Integrated Urgent Care services must submit and retrieve data from the National Repeat Caller Service.
- Services must be capable of receiving inbound messaging that can be directed to the variety of clinical skill sets to support the online platform and also offer potential integration with 999 should that be a local requirement.
    - Integrated Urgent Care services must follow the IM& T assurance toolkit https://www.networks.nhs.uk/
- Commissioners must ensure that providers use approved software systems.

The following outcomes have flexibility in the approaches to how they are commissioned from a technical perspective:

- All Integrated Urgent Care services must be able to book in either an integrated manner, or using Interoperability Standards.

- All services must be able to dispatch ambulances in either an integrated manner locally, or using Interoperability Standards when dispatching to a separate application or Out of Area 999 service.
- Integrated Urgent Care services must be able to determine where patients are being referred or transferred to and transmit the data for all services and all 999 services.
- It is recommended that there should be a technical requirement to provide a text or email to patients to confirm direct bookings/appointments across the UEC system.
- NHS England will be working with commissioners, providers and system suppliers to develop interoperability standards and an interoperability roadmap by March 2016.

4.10 Online Platform

An online channel for Integrated Urgent Care is currently being developed. If rolled out nationally it is envisaged that it will provide a standardised mobile and online platform that local urgent care (NHS 111) services can use to enable a digital access channel for their populations.

It will be underpinned by accredited clinical decision support but redesigned for online access directly by the patient. There will be key points in the online process where patients are directed to a telephone interface with local services or in time web/video chat as these are become available. The platform has been designed specifically so that the questions the patient has already answered are made available directly to the health adviser or clinician within the urgent care service.

There remain detailed implementation and change management implications. It is critical the platform is clinically safe, operationally efficient and simple to use. NHS England will be working with industry experts and Integrated Urgent Care services in London and across the West Midlands to refine and test the service. It is expected that this stage of development will conclude during 2016.It is possible that the platform will be available for use in 2017.

Commissioners should include the development and use of the online platforms as a vital part of their agreements with service providers. It is acknowledged that at this time with a developing service this cannot be definitely specified. Therefore regular updates on progress will be provided on this development to keep commissioners as informed as possible.

4.11 KPIs & Metrics

Commissioners should ensure the data required to populate the Integrated Urgent Care Minimum Data Set (MDS) is collected. This data should comply with current metrics in line with the MDS Provider Specification.

The current data collection is derived from the existing Out-of-hours National Quality Requirements (NQRs) and the NHS 111 Minimum Data Set (MDS), however NHS England is working in close collaboration with providers and commissioners to establish a new suite of metrics for Integrated Urgent Care that will replace the NQRs and NHS 111 MDS.

The result will be the creation of a revised set of data items for the proposed Integrated Urgent Care model aligned to the quality framework categories of efficiency, safety and patient experience. Within this framework, the new MDS will be grouped under the integrated delivery elements of access, assessment, advice and treatment.

The intention will be to establish a data capture that facilitates three levels of functionality:

1. Appropriate for commissioners to answer any data query they may have.
2. Appropriate for monthly submission to NHS England for publishing.
3. Appropriate for summary dashboard.

The finalised data collection will be taken through the Standardisation Committee for Care Information (SCCI) and Burden Advice and Assessment Service (BAAS) run by the Health and Social Care Information Centre and will be subsequently mandated. This document remains in development – Https://www.england.nhs.uk/ourwork/pe/nhs-111/resources/.

Longer term development work will continue through the Urgent and Emergency Care Review to set system wide metrics responsible for tracking patient outcomes as well as service performance. Commissioners should ensure that Integrated Urgent Care providers comply with these metrics once agreed.

4.12 Telephony

Commissioners must ensure the following:

- Calls to the NHS 111 number must be received on specific direct dial in (DDI) numbers that are devoted to 111, enabling the calls directly to Integrated Urgent Care to be counted. It is no longer regarded as appropriate to forward calls to 111 from GP practices or legacy Out-of-hours numbers. A better approach is to play an announcement asking callers to hang up and redial 111. There are normally 3DDI numbers (primary, secondary and tertiary). The DDI numbers cannot be “non-geographic” numbers, such as 0300; they must be a landline number.
- Integrated Urgent Care services must have reliable telephony provision that allows calls to be networked across all the call centres directly receiving 111 calls in their contracted area. In the event of the loss of call answering at any one location, calls can then be sent to other centres.
- Integrated Urgent Care services must have telephony systems that provide management information as defined in the Integrated Urgent Care Minimum Data Set.
- Groups (specifically users of BSL who are using the 111 BSL translation service) it will be necessary to warm transfer a caller to the Integrated Urgent Care service, as they cannot be called back.
- Recorded announcements must be compliant with the Integrated Urgent Care Brand Guidelines.[5]
- All inbound and outbound calls to Integrated Urgent Care must be recorded. Calls from adults must be retained for 8 years and calls from or about children must be retained until their 26th birthday. (This requirement is currently under review and the retention time is likely to be substantially reduced but no decision has yet been made).
- Integrated Urgent Care providers are required to ensure that systems are in place to comply with regulation concerning child protection and vulnerable adults.

- In order to cope with the very high level of demand that occurs on some days there must be at least three times the number of lines available compared to the maximum number of advisers. In addition there must be sufficient “IVR ports” so that calls will go “off hook” (answer acknowledged) within 5 seconds of a call being presented. This is normally done by playing a message (see above). Calls that do not go off hook rapidly are played a message asking the caller to try again. The playing of this message is recorded nationally.

- If there is a call to 999 which is not of an emergency nature then the name and number can be sent electronically to the appropriate Integrated Urgent Care centre who will call them back. It is not currently legal to forward a 999 call from an ambulance service to another organisation which is not an ambulance service.

- Calls to Integrated Urgent Care that need an emergency response are sent to the ambulance service electronically. The ambulance service should then treat them as if they had dialled 999.

- 111 providers can if they wish use a local facility to spilt off dental, pharmaceutical, repeat callers, health care professionals and other groups. This should be done on the telephony platform of the provider.

- Integrated Urgent Care providers should have local contingency plans in place for partial or full failure of their service. This could be forwarding of their calls to another provider. Often such arrangements are reciprocal.

- As a last resort, NHS England can invoke national contingency. Calls are then forwarded to all other providers. All providers are required to accept national contingency calls in the event of it being invoked.

- Different organisations who are working collectively within the Integrated Urgent Care system may wish to operate on a single telephony platform to make it easier to manage voice communications between different organisations, and to provide comprehensive telephony reports.

- Further requirements and information about Integrated Urgent Care telephony can be found in the “NHS 111 Telephony Guide” which is updated on a regular basis. This can be found at: https://www.england.nhs.uk/ourwork/pe/nhs-111/resources

4.13 Patient experience

Commissioners should ensure NHS 111 providers have a systematic process in place to regularly seek out, listen to and act on patient feedback on their experience of using the service, ensuring that they deliver a patient centred service. This must include:

- Clear and well-publicised routes for both patients and health professionals to feedback their experience of the service.
- Provide prompt and appropriate responses to that feedback.
- Regular surveys of patient and staff experience (using both qualitative and quantitative methods) to provide additional insight into the quality of the NHS 111 service.
- Systems in place to collate, aggregate and triangulate feedback from a range of sources such as complaints, surveys, social media and online resources including NHS Choices; www.nhs.uk or patientopinion.org.uk.
- The whole patient feedback process needs to be fully transparent whilst recognising confidentiality. It is important that commissioners adopt an approach that allows users to see the diverse views and experiences of other patients and service users and the responses made by the service.

4.14 Procurement

It is for commissioners to decide what services to procure and how best to do this within the framework of the regulations. This includes deciding whether services could be improved by providing them in a more integrated way, by giving patients a choice of provider to go to, and/or by enabling providers to compete to provide services.

It is clear that both larger and smaller providers will have an important part to play in delivering a successful and fully integrated service. To achieve this integration and delivery of the revised commissioning standards, providers will need to collaborate to deliver the new investment required in technology and clinical skills, and to ensure that services are aligned. It is for this reason that commissioners should consider using the procurement process to encourage NHS 111 and Out-of-hours organisations to collaborate or work within a lead provider arrangement, to deliver the specification for the Integrated Urgent Care service.

Further guidance to support the procurement of Integrated Urgent Care has been developed and is available via the following:
https://www.england.nhs.uk/ourwork/pe/nhs-111/resources

ANNEX A

Integrated Care Advice Service roles:

Dental

Dental pain without injury remains one of the highest reasons for calling NHS 111. NHS England is responsible for commissioning all NHS dental services and CCGs will need to work with NHS England Area Teams to ensure that dental services are commissioned in local areas.

The dental case mix needs to be managed by suitably trained dental professionals, which may include dental nurses trained in triage. This will usually be once anything requiring urgent ED attendance has been ruled out by a clinical algorithm – see next section. Ideally there would be the capability to book treatment slots direct with dental treatment providers. To maximise efficiencies, this clinical group would need to be able to refer cases to/receive cases from pharmacists and Independent Prescribers within the Multidisciplinary Assessment Service. In addition, the use of Interactive Voice Response (IVR) should be considered where it could be used to improve the patient experience.

Management and Referral of callers with dental symptoms:

- The provider will need to manage callers with dental symptoms to NHS 111 using a clinical decision support system in use for the overall service.
- During normal working days (excluding public holidays), these callers will be referred to services returning from the DoS between the hours of 0800 and 1800.
- Between the night time hours of 1800 in the evening until 0800 the following morning, calls will be handled by NHS 111 and directed through the DoS and sent to the Dental Assessment Service via ITK including an encounter report.
- Callers who are not physically within their home area boroughs at the time of their call will be managed through the CDSS and the DoS at all times.
- The provider must ensure that clinical staff receives suitable training on the management of callers with dental symptoms in order to appropriately refer or manage cases that cannot be referred to another service.
- The provider will be expected to provider a call log extract in relation to dental cases.

- Where a caller with dental symptoms is identified as a frequent caller the provider will need to have processes in place to identify these cases and manage them outside of the CDSS through a clinical advisor.

- The provider should ensure that all clinical staff working in the service have received training on Toxbase or its equivalent to ensure that analgesia overdose can be identified and managed amongst these callers.

- The provider shall ensure that all staff are trained in dental trauma identification and management.

- The provider shall make contact with the Dental Assessment Service via a telephone by-pass number where indicated.

- The provider shall co-operate with NHS England, commissioners and providers with the end to end review of dental cases.

- The provider will need to communicate with NHS England, commissioners and providers in order to manage any incidents, serious incidents and complaints; this includes liaising with other dental providers.

Evidence:

In London, approximately 1750 callers per week with urgent dental problems are being routed away from 111, and potentially ED and UCCs, to the Dental Hub (winter resilience Dental Nurse Triage service) via IVR. Patient feedback for the Hub is generally positive, especially for the overnight service. There have been instances of patients who have gone to ED with an urgent dental problem, seen the posters to call 111 and had a positive outcome via the IVR. Patients appreciate being able to access expert advice overnight.

Patient Experience Feedback:

Experiences are positive overall, callers would use the service again and satisfaction was high, although service seemed variable in terms of call handler helpfulness and outcome. The service helped callers gain an awareness of services in local area, especially useful for a caller who had just moved to the area. Improved outcomes – evidence that callers would have accessed A&E, minor injuries clinics or walk-in centres if had not been able to use the service. One caller had recently come out of rehab and may have relapsed without 111. Other callers said they would have just put up with the pain.

Mental Health

- In order to drive further improvements across the wider health economy, Commissioners need to ensure that mental health services have the same strategic focus as cancer and diabetes. (Five Year Forward View; Mental Health Access and Waiting Time Standards, Urgent and Emergency Care Review, Parity of Esteem Programme).

- Engagement with users and people with lived experience has highlighted that there is more to do to deliver parity of esteem for mental health callers in NHS 111. Urgent Care commissioners need to work jointly with Mental Health commissioners to design the most appropriate range of services to be connected with Integrated Urgent Care, this should be considered across all areas of mental health but in particular the responses to crisis. Ultimately, Integrated Urgent Care services should be adhering to the Mental Health Crisis Concordat principles.

- Commissioners should seek to establish that the Integrated Urgent Care service is staffed by competent call handlers who are appropriately trained in mental health care, and who are supervised and supported by qualified clinicians. Service user feedback should be obtained to ensure that patient experience in this area is improving.

- Clinicians within the Integrated Urgent Care service must have access to relevant aspects of patients' mental health crisis record in line with the section on access to record detailed in section 4.1 below.

- Networks of support and service user defined recovery outcomes should be included, be reviewed regularly and kept up to date, particularly following any crisis presentation, admission or significant change in an individual's circumstances. They should also identify factors which could potentially precipitate a crisis and what steps can be taken to reduce the likelihood of a crisis in such circumstances.

- Commissioners will want to ensure that the Directory of Services hold's accurate information across all acute, primary care and community services and is expanded to include health based places of safety, NHS commissioned services, (third sector / independent) social care and services for homeless people. (Mental Health Access and Waiting Time Standards, Urgent and Emergency Care Review).

- All commissioned services should be profiled with regards to their capacity status to enable faster access to services, reduce the risk of suicide / adverse events, as well as to maximise productivity of all agencies dealing with mental health crisis. (National Suicide Prevention Strategy).

Commissioners should ensure that their Integrated Urgent Care provider has chosen clinical decision support system is capable of safely aiding the assessment of callers in need of mental health care and / or advice in line with CQC safety standards.

Pharmacy

Pharmacists in the clinical hub:

Experience has shown that where pharmacists have been working in NHS 111 contact centres they can make a significant contribution to the efficiency and quality of care handling a specific case mix of calls including:

- Medicines enquiries.
- Health information enquiries.
- Requests for urgent repeat medication.
- Medicines advice for minor illness.
- Poisons and accidental overdoses.
- Contraception advice.

Pharmacists have been working in the Yorkshire Ambulance Service (YAS) NHS 111 service since 2013 focusing on support at weekends and surge times. A recent review of their activity has shown:

- Call centre pharmacists add value with shorter call lengths for medication calls and are able to provide more specialist advice to patients than general trained nurses and paramedics.
- Pharmacists are able to work as part of a multi-disciplinary team to advise NHS 111 staff and 999 clinical teams.
- Clinical Pharmacists can be trained to multi-task in various roles e.g. Floor Walking, working from a queue of calls, advising on repeat medication needs and managing risk.
- Because of utilising the skills and knowledge of pharmacists, there are fewer onward referrals.

The YAS pharmacy team is set to build on the experience and develop a more integrated approach using the pharmacists to work throughout the week in the evenings and weekends.

As part of the Winter Resilience plans for 2014/15, a Pan London Pharmacy Hub was established in one of the NHS 111 provider contact centres at London Central and West (LCW) Unscheduled Care Collaborative. The Pharmacists worked Saturdays

and Sundays 9am to midnight taking medication calls that came directly via locally arranged interactive voice recognition (IVR) for London. The calls were initially answered by a call handler who screened out any acute symptomatic patients and then the callers were advised a pharmacist would call them back within 2 hours. Invariably the pharmacist called back within 1 hour with the hub handling an average of about 100 calls each day staffed by one pharmacist available at any one time and two at peak times. The pharmacists were able to close 95% of all the calls themselves and any referrals were most often to contact GP Out-of-hours to request a prescription.

Plans are underway to develop the pan London pharmacy hub as part of an integrated clinical advice team that can support a wider range of calls that come via the usual NHS 111 route and via the IVR at peak times. Supporting call handlers to manage the repeat prescription requests will be an important part of the activity so that patients can be referred on to community pharmacy or GP Out-of-hours services where appropriate.

Referral to community pharmacy and Urgent Repeat Medication:

Guidance is available for NHS 111 and GP Out-of-hours providers to support the referral of patients to community pharmacy to access urgent repeat medication supplies.

http://www.england.nhs.uk/wp-content/uploads/2015/03/rept-medictn-guid-nhs111.pdf

Local commissioning arrangements may enable referral to Pharmacy Urgent Repeat Medication (PURM) services. Examples of local schemes include:

Pan London

Nearly 500 pharmacies registered to take referrals from NHS 111 since December 2014 with over 170 pharmacies actively supplying medicines. Referral process to pharmacies via NHS Mail ensures pharmacies receive call details and SLA has been in place for pharmacists to call patient within 30mins of referral. NHS 111 providers have used a call from 111 to warn pharmacies an email has been sent.

An average 35% referral rate from NHS 111 with 28% going through to complete a supply has been achieved. On Saturdays referral rate reaches 50% but midweek drops down to 20%.

7% of all referrals resulted in no medication supply due to:

- controlled drugs being requested- referred back in to GP Out-of-hours directly.
- pharmacist assessed patient and agreed supply not required and referred back to in-hours GP for routine appointment.

- patient did not come to collect medicines.

In London an exit survey of patients (489 responses) showed:

41% would have gone to A&E if 111 had not sent them to pharmacy

39% would have tried to contact GP Out-of-hours direct

19% would have gone without their medicines

North East of England

In November 2014 NHS England Cumbria, Northumberland and Tyne and Wear and Durham, Darlington and Tees Area Teams, which are now combined as part of NHS England North, working across Cumbria and the North East, commissioned the pilot of an NHS Community Pharmacy Emergency Repeat Medication Supply Service.

http://medicines.necsu.nhs.uk/pharmacy-emergency-repeat-medication-supply-service-permss/

The pilot was supported across 14 CCGs and has shown a 35% referral rate compared to GP Out-of-hours. They referred call data directly to pharmacy via the Pharmaoutcomes pharmacy IT system. Health advisors entered the call data directly in to the Pharmaoutcomes web based system to be viewed by the receiving pharmacy.

An evaluation of the service by Durham University has shown patients reported that the service was easy to access; they were clear on the pharmacies to which they were directed and what to take with them. The majority were referred to pharmacies within 10 minutes travelling time, and most patients would keep a better check on their medication supplies to prevent a reoccurrence in the future. The general high satisfaction with the service was reflected in the high reported acceptability of the patients towards accessing community pharmacy in the future for medication related issues and minor ailments.

West Yorkshire

West Yorkshire has a commissioned PURM scheme that uses NHS Mail to refer from NHS 111 to local pharmacies. An evaluation of the 2014/15 service has shown to be very effective at reducing demand on other parts of the urgent care system.

http://www.cpwy.org/pharmacy-contracts-services/research-evaluation/evaluations.shtml

The NHS 111 provider YAS achieves a higher referral rate from NHS 111 primarily as this service has been in place for longer and they have pharmacists in the contact centre streaming the calls at weekends directly to community pharmacies taking out the calls where controlled drugs are required.

Key learning:

- Call handlers/health advisor trusting the process and accepting disposition – education programme required to encourage referral.
- Move to a model where the patient is advised to call the pharmacy direct once the email has been sent instead of the 111 provider calling the pharmacy to encourage patient to attend pharmacy and reduce call-handling time for 111 providers.
- Use of locums at weekends by pharmacies – particularly extended opening pharmacies – need to ensure all pharmacy staff briefed about process and ready to accept referral.
- DoS entries optimised for opening times and **all** SG/SD codes for repeat medication - urgent and routine to ensure capture weekend and bank holidays.
- Stakeholder engagement with local pharmacy groups and CCG medicines management leads to embed and support on going service.

Minor illness/injury:

Work is underway to develop a minor illness/injury DoS template that can be used to map community pharmacy services to primary care assessment end points. This will support the signposting of patients to alternative services that can be delivered locally. Community pharmacists are well placed to assess patients for minor conditions and in some areas local commissioners have commissioned the provision of “over the counter medication” on the NHS to support self-care. Referral to community pharmacy from NHS 111 using NHS Mail has been used in West Yorkshire to encourage patients to access community pharmacies as an alternative to GP Out-of-hours and in hours GP services.

http://www.cpwy.org/pharmacy-contracts-services/research-evaluation/evaluations.shtml

Electronic messaging to community pharmacy:

Best practice for referring a patient to community pharmacy is to use ITK messaging. A pharmacy specific message needs to be identified for urgent care referrals but in the meantime it is technically possible to use the GP out of hours message to send a case to community pharmacy if appropriate interoperability has been achieved. NHS Mail is currently being used successfully to message pharmacies directly using the DoS to support identification of the pharmacy NHS Mail address.

Prescribing:

Commissioners will need to decide where they wish prescribing to be undertaken as part of any urgent service. This will require allocation of appropriate prescribing budget and designation of prescribing codes for the service.

GPs and non-medical prescribers can work together to support best practice particularly for the prescribing of antibiotics, pain relief and palliative care medicines. Access to the patient's medication record held in the Summary Care Record (SCR) or GP care record is essential to support safe prescribing.

Integrated Urgent Care should be working towards incorporating the use of the electronic prescription service (EPS) and access to the EPS Tracker to support on-going patient care.

Further information about EPS can be found at http://systems.hscic.gov.uk/eps

ANNEX B

Roles and Responsibilities

Clinical Commissioning Groups (CCGs) are responsible for:

- Commissioning Integrated Urgent Care as an integral part of the urgent care system according to national requirements and standards.
- Providing NHS England with evidence that they have undertaken a robust procurement with an appropriate assurance process.
- Assuring NHS England that they have a contingency strategy in place should the chosen provider fail to deliver the Integrated Urgent Care service as contracted.
- Monitoring the impact of Integrated Urgent Care on local services so that over/under utilised services are identified and improvements to the urgent care system are made.
- Ensuring the effective mobilisation and operational delivery of an Integrated Urgent Care service that serves the CCG population, either directly or via joint commissioning arrangements.
- Performance managing the contract against agreed metrics and KPIs.
- Reporting on the quality, benefits and performance of Integrated Urgent Care services.
- Ensuring that Access to Service Information (formerly DoS) is fully up to date with the availability of local services and the agreed referral protocols with service providers.
- Ensuring that the summary care record, special patient notes and end of life care records are up to date and available to Integrated Urgent Care services.
- Ensuring clinical governance of Integrated Urgent Care as an integral part of the urgent care system. This will ensure the quality, safety and effectiveness of the service, leading to people experiencing continuity of service.
- Publicising Integrated Urgent Care locally.
- Local stakeholder communications and media handling.
- Ensuring that business continuity and disaster recovery procedures are in place in the event of disruptions to the provision of the Integrated Urgent Care service locally.

- Meeting the public sector Equality Duty

Networks are responsible for:

- Creating and agreeing an overarching, medium to long term plan to deliver Integrated Urgent Care aligned to the objectives of the Urgent and Emergency Care Review.
- Designating urgent care facilities within the network, setting and monitoring standards, and defining consistent pathways of care and equitable access to diagnostics and services for both physical and mental health.
- Making arrangements to ensure effective patient flow through the whole urgent care system (including access to specialist facilities and repatriation to local hospitals).
- Maintaining oversight and enabling benchmarking of outcomes across the whole urgent care system, including primary, community, social, mental health and hospital services, the interfaces between these services and at network boundaries.
- Achieving resilience and efficiency in the urgent care system through coordination, consistency and economies of scale (e.g. agreeing common pathways and services across SRG boundaries).
- Coordinating workforce and training needs: establishing adequate workforce provision and sharing of resources across the network.
- Ensuring the building of trust and collaboration throughout the network’spreading good and best practice and demonstrating positive impact and value, with a focus on relationships rather than structures.

SRGs are responsible for:

- Developing a plan to deliver Integrated Urgent Care to support the 'high impact interventions' as agreed by the national tripartite.
- The translation and delivery of network service designations and standards to match the local provision of services. This will usually be achieved through the development of written plans and protocols for patient care, agreed with all 3 stakeholders, and adapted from national templates. High priority plans will relate to high-volume and undifferentiated conditions, where there are strong precedents for ambulatory and community-based patient management.

- Ensuring a high level of clinical assessment for the patient, in or close to their home, and ready access to diagnostics where required. This will be particularly important in more remote and rural communities, in which the role of smaller hospitals will be developed and strengthened.
- The development and utilisation of “clinical decision-support hubs” to support the timely and effective delivery of community-based care.
- Establishing effective communication, information technology and data sharing systems, including real-time access to an electronic patient record containing information relevant to the patient’s urgent care needs.
- The delivery of local mental health crisis care action plans to ensure early and effective intervention to prevent crisis and support people who experience mental health crisis.
- Ensuring the effective development and configuration of primary and community care to underpin the provision of urgent care outside hospital settings 24/7.
- Achieving accurate data capture and performance monitoring.

NHS England is responsible for:

- Monitoring the performance of Integrated Urgent Care and compliance with national requirements, quality and performance standards.
- Monitoring the impact of Integrated Urgent Care with the urgent care system.
- Assuring that CCGs are managing their responsibility for quality and safety.
- Commissioning and management of Integrated Urgent Care national telephony infrastructure and IT systems including repeat caller service, NHS Pathways and Access to Service Information (formerly DoS).
- Liaison with Ofcom over the use of the 111 number.
- Accreditation of Integrated Urgent Care Clinical Decision Support System(s)
- National communications and media handling.
- Ownership of and development of the Integrated Urgent Care (111) brand, core values and guidelines for usage.
- Ownership of the Integrated Urgent Care Commissioning Standards and governance of any changes.
- Identifying and sharing lessons learned and good practice across local areas.

- Meeting its legal duties on equality and on health inequalities
- Assuring national business continuity and CCG's contingency arrangements for managing unforeseen surges in demand.
- Approving key decisions, plans, deliverables and any changes to the Integrated Urgent Care service design.
- Overseeing interdependencies with related initiatives and programmes outside the scope of Integrated Urgent Care.
- Assuring that the interests of key stakeholder groups are represented.
- Providing a formal escalation point for the NHS and other stakeholders for issues and concerns relating to Integrated Urgent Care.
- Periodically providing assurance to the NHS England Board.
- Supporting CCGs' re-procurements of Integrated Urgent Care contracts and the transition of services from their current state to any new provider.

ANNEX C

Clinical Model: Self-Assessment Tool

This self- assessment tool can be used as a guide to level of integration towards new clinical standards for an integrated 24/7 urgent care and clinical advice service. It can be used at CCG, SRG or U&EC Network levels.

Clinical Standard				
At the heart of the Integrated Urgent Care (IUC) system will be a 24/7 NHS 111 access line working together with 'all hours' GP services.				
Additional clinical expertise available in IUC call centre, via IVR or via warm transfer (e.g. Pharmacy, dental, MH and GPs).				
Enhanced Clinical assessment of green ambulance dispositions				
Direct booking from Integrated Urgent Care into Emergency Department				
Direct booking from IUC into GP and GP Out-of-hours				
Direct booking from IUC to Community services & 'fast response' multi-professional community teams				
Special Patient Notes (SPNs), End-of-life care plans & crisis plans to be available at the point in the patient pathway which ensures appropriate care				
Integration via joint management of patient pathways & capacity by NHS 111 and GP Out-of-hours				
DoS to hold accurate information across all acute, primary care & community services, and to be expanded to include social care				
All providers working with IUC demonstrate integration by joint working to manage UEC patient pathways & capacity				
Enhance patient experience by early identification of call that would benefit access of clinical adviser not pathways				
Ambulance services pass green disposition back to the appropriate Clinician/Clinical Hub within IUC				

Key	
✓	Clear and fully aligned vision for integration
±	Partial alignment to national vision
×	Ambition is not currently consistent with national ambition.