

THE QUALITY OF URGENT AND EMERGENCY CARE IN

South Warwickshire



Report on pilot assessment activity: 22 to 26 February 2016

November 2016

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Published November 2016

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Introduction

There is considerable evidence about quality and safety in urgent and emergency care systems and what needs to change. NHS England is leading improvement and reform of urgent and emergency care through a series of initiatives, including Vanguard sites, which are testing new models of care. The eight Vanguard sites aim to improve the coordination of urgent and emergency care services and reduce the pressure on A&E departments.

CQC is also supporting improvement and innovation in urgent and emergency care by building on our current approach to regulating these services, which looks at individual providers. We are testing how we can assess the quality of urgent and emergency care across a local area(s). This involves looking at how well providers work together within a local system.

We are working with local and national stakeholders to develop an approach for inspecting urgent and emergency care that reflects the changing policies and structures in this area, including the drive for further integration.

We piloted the approach in two areas of the country – South Warwickshire and in Airedale, Wharfedale, Craven & Bradford. We have published a report on the quality of urgent and emergency care for each area (setting out the findings from the pilots) and a locality profile providing relevant contextual information on the locality, its demographics and health and care performance and activity metrics.

This review was conducted under Section 48 of the Health and Social Care Act 2008, which permits CQC to review the provision of NHS healthcare, including how clinical commissioning groups arrange healthcare and how local authorities arrange the provision of adult social care services.

As part of the review we explored:

- how urgent and emergency care services function across the system, with a particular focus on coordination and communication between providers
- how the system leadership (local commissioners, local authorities and the local health and wellbeing board) ensures that urgent and emergency care services in their patch are of high quality and are safe and effective
- the outcomes for people who receive urgent and emergency care – whether they receive the right care at the right time, as well as people's experience of urgent and emergency care.

To direct the focus of the review, we used a standard set of questions that directly relate to the five key questions we ask of all individual services, to look at what safe, effective, caring, responsive and well-led looks like in each locality.

We assessed urgent and emergency care in a locality. At the time of activity, a locality was defined as the area covered by a single System Resilience Group (SRG). SRGs are forums where all partners across the local health and social care system come together to undertake regular planning of how local urgent and emergency care services are delivered. They are newly-formed structures that sit under regional Urgent and Emergency Care Networks (UECNs), and ensure the effective delivery of urgent and emergency care in their localities, in coordination with an overall urgent and emergency care strategy agreed through the UECN.

SRGs are chaired by a senior leader from the clinical commissioning group(s) (CCG) who sits on the group. All local providers, commissioners, and social care organisations are represented on the group to enable the system as a whole to develop and agree plans.

Since our fieldwork for this review, NHS England has announced that A&E Delivery Boards will replace SRGs.

How we carried out the pilot

The inspection team was led by a Care Quality Commission (CQC) inspector. The team included three clinical specialist advisors and two additional inspectors from CQC.

We gathered information both during and before the visit to each locality by using information requests, reviewing documentation, holding interviews, focus groups and visits. Where possible we met and spoke with people who had used urgent and emergency care services. This approach provided evidence that could be checked and confirmed in several ways.

The review looked at the quality of urgent and emergency care generally, but during onsite activity we also tracked 10 individual cases of patients who used urgent and emergency care services because they were either:

- over 65 years old and had experienced a fall, or
- a febrile (feverish) child under five years old.

This helped us to understand people's experience of accessing and moving through the urgent and emergency care system in the locality. We acknowledge this is a relatively small test group, but wanted to test the effectiveness of tracking patients through the system as a method to understand people's

Introduction

experiences of care. We describe the quality of urgent and emergency care for these specific conditions, and more generally, in our findings.

This report

This report records the findings of the review of the quality of urgent and emergency care (UEC) in South Warwickshire. It focuses on the experiences and outcomes for people within the geographical boundaries of the South Warwickshire System Resilience Group and reports on how UEC functions in the area and how the leadership of the system manages and supports this.

Please note that the fieldwork findings described in this report were part of the pilot work to develop a methodology, as described above. As we are still developing this methodology, and were only able to include a limited sample of providers within areas, we do not intend for this report to be a definitive picture of the performance of the System Resilience Group. Under Section 48, we are required to publish our findings where we have carried out a review. We have developed this report to test how we may publish our findings, on the quality of UEC across a local area, as part of our future methodology.

We have provided a number of recommendations that are based on our findings in the area and that set out the changes we believe should be considered to facilitate and drive improvements for a more effective and efficient UEC system. We will be evaluating the effectiveness of these recommendations in driving improvement within the UEC system.

Note: Where we use the term *significant* in this document, it means statistically significant. Details are available in South Warwickshire SRG's data profile for the locality, which we have published alongside this report.

Background of the locality and System Resilience Group

This section provides contextual information on the System Resilience Group (SRG) locality, its demographics and health and care performance, and activity metrics. Further information is available in the South Warwickshire Urgent and Emergency Care System Resilience Group locality profile. This section presents analyses that were part of the locality profile produced in February 2016 for use by CQC's fieldwork team; only certain data used has been refreshed.

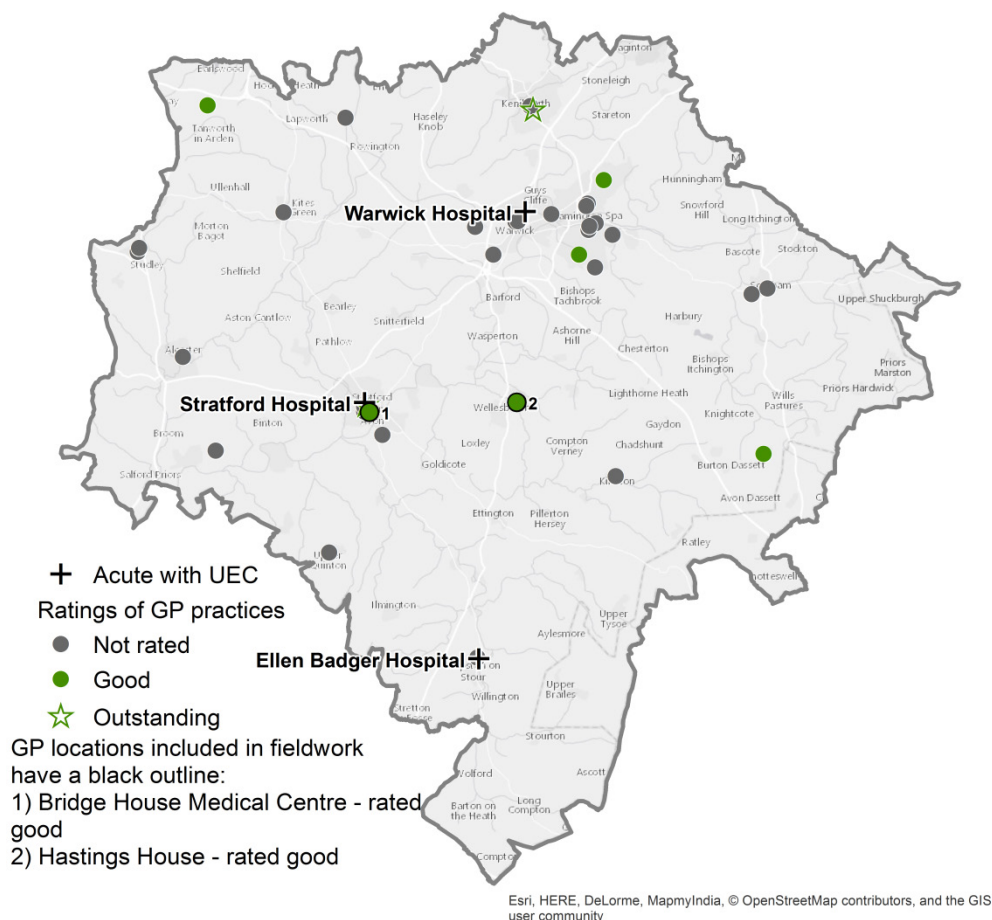
SOUTH WARWICKSHIRE SYSTEM RESILIENCE GROUP

The South Warwickshire SRG is part of the West Midlands Urgent and Emergency care Network.

South Warwickshire SRG consists (as at 29 February 2016) of a range of organisations, including:

- South Warwickshire Clinical Commissioning Group (CCG)
- Warwickshire local authority
- South Warwickshire NHS Foundation Trust (including four hospitals, figure 1 includes acute locations with urgent and emergency care services)
- West Midlands Ambulance Service
- Care UK Warwickshire (GP out-of-hours service)
- Healthwatch Warwickshire
- Vocare (operating the NHS111 service for the wider region)
- Coventry and Warwickshire Partnership Trust (main provider of mental health services)
- 38 GP practice locations covering South Warwickshire CCG's primary medical services
- 124 social care services in the South Warwickshire CCG area (all residential social care locations and community based adult social care services).

Figure 1: GP practice locations and acute hospital locations, including CQC ratings up to 29 February 2016

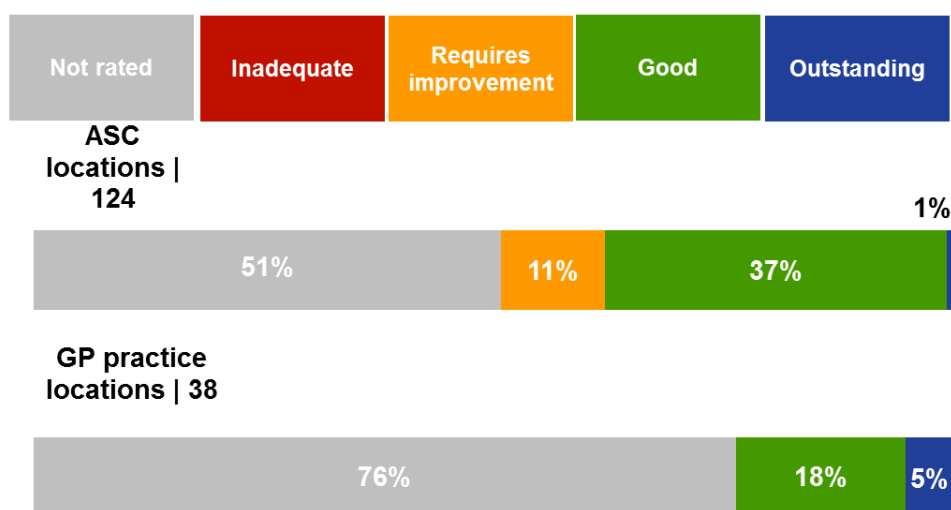


CURRENT CQC INSPECTION RATINGS FOR PROVIDERS WITHIN THE SRG

Most providers within the SRG area are yet to be inspected, but the majority of those rated so far have been rated either good or outstanding (figure 2).

- South Warwickshire NHS Foundation Trust has been rated as requires improvement overall.
- Warwick Hospital's urgent and emergency care services were rated as good overall, with the following ratings for the five key questions:
 - safe – rated requires improvement
 - effective, caring and well-led – rated good
 - responsive – rated outstanding.
- Care UK Warwickshire has been rated as good across all key questions.

Figure 2: GP practice locations and adult social care service ratings in the South Warwickshire SRG locality



Note: these values were accurate as of February 2016.

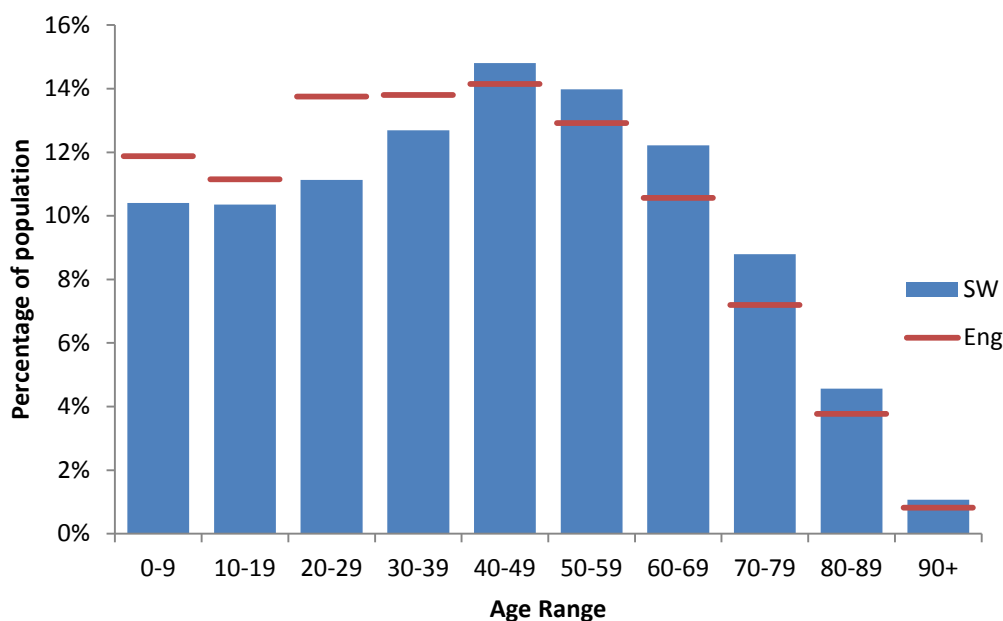
SOUTH WARWICKSHIRE SRG POPULATION AND USE OF URGENT AND EMERGENCY CARE

Age

South Warwickshire has a larger percentage of older people than the England average.

The age structure of a population has been linked to UEC utilisation, particularly young children and older people. South Warwickshire's age trends are not significantly different from the England average for the proportion of population under five or over 65 years, but the area does have a higher percentage (approximately 3.5%) of older people than average (ages 65+).

Figure 3: The GP registered age population structure in South Warwickshire, against the national average



Source: HSCIC – GP registered population, April 2015

Long-term conditions

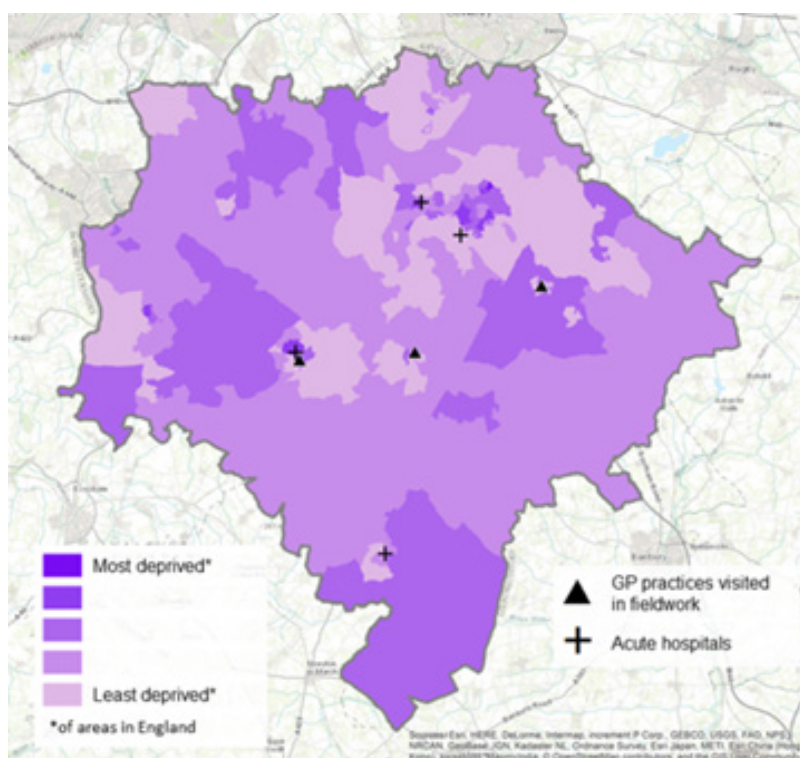
As more people live into old age, many more are living with a long-term condition, such as asthma or diabetes. Often, these people can lack support to self-manage their conditions, which can increase the risk of exacerbations, resulting in hospital admission. The prevalence of long-term conditions in South Warwickshire is similar to that seen across England for conditions such as asthma and diabetes. South Warwickshire CCG could therefore be expected to have an average number of admissions.¹

Deprivation

NHS England describes how deprivation is linked to increased use of GP and A&E services, with higher complexity conditions often seen in more deprived areas. Public Health England describes the overall deprivation in 2010 of Warwickshire local authority as one of the 20% least deprived local authorities in England. Figure 4 shows the Index of Multiple Deprivation (IMD) score by Lower Layer Super Output Area (LSOA), with the most deprived areas in South Warwickshire in darker shades. Rural and inner-city areas around Warwick and Stratford show higher rates of deprivation.

1. The King's Fund, *Avoiding hospital admissions: What does the research evidence say?* (2010).

Figure 4: South Warwickshire CCG Population IMD Score by LSOA, 2015



Source: Gov.UK - English indices of deprivation 2015

Rurality

In South Warwickshire, 43% of the population live in rural areas compared with the England average of 18%. A King's Fund study found that rural areas tend to encounter fewer avoidable emergency admissions than more urban areas, for conditions such as asthma.²

Other factors

Alcohol is one of the most significant factors affecting demand for A&E services. Alcohol-related chronic conditions, intoxication and secondary effects of alcohol abuse, such as injuries from alcohol-related violence, contribute to approximately 35% of A&E attendances nationally. Alcohol-specific hospital admissions in South Warwickshire are significantly below the average across England, although this is showing a rising trend.

2. The King's Fund, *Avoiding hospital admissions: What does the research evidence say?* (2010).

CURRENT DEMAND FOR UEC SERVICES IN THE AREA

Overall, South Warwickshire has lower numbers of A&E attendances and admissions from July 2014 to June 2015 than expected, based on the age and gender of the population.³

- There has been a 1.7% increase in emergency attendances between July 2013 to June 2014 and July 2014 to June 2015, which is larger than the England average of a 0.7% increase.
- Year-on-year change indicates a 3.3% decrease in emergency admissions from 24,738 admissions between July 2013 and June 2014, down to 23,915 admissions between July 2013 and June 2014; compared with an increase (2.6%) observed across England.

3. Based on Hospital Episode Statistics.

What people in the locality say about services

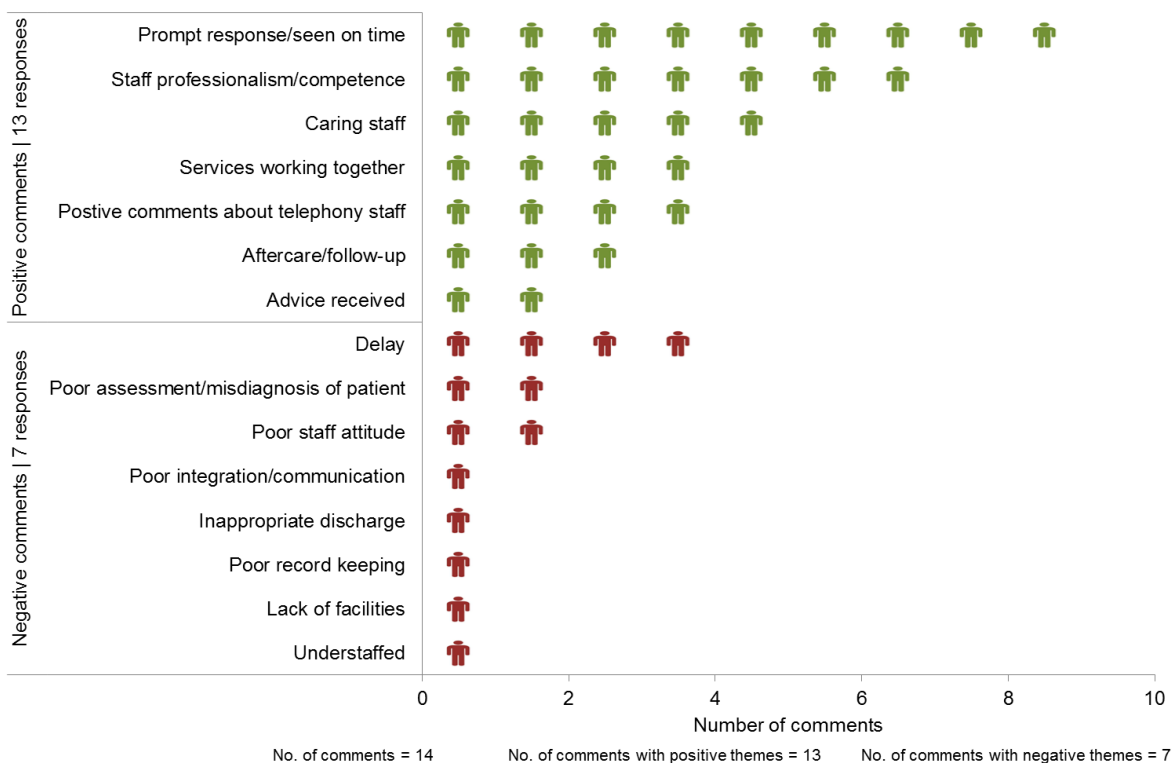
We received good verbal feedback during fieldwork. In addition, we received 17 surveys and comment cards that were completed by people from the Warwickshire area. Fourteen of those contained free-text replies to questions about their good and poor experiences of using urgent and emergency care services. The narrative below sets out this feedback. As we only received a very small number of responses to the surveys and comment cards, the narrative does not aim to interpret or suggest reasoning behind patterns, but to provide information about general themes and findings that appeared.

Figure 5 provides a summary of the frequency of these different positive and negative themes identified in responses. Overall positive themes were seen more consistently, with prompt response and staff professionalism and competence being the most frequently seen responses.

A few of the more common negative comments included long delays in treatment, poor assessment or misdiagnosis, and poor attitude of staff. For example: "Poor response [from staff] to my self-harm scars".

What people in the locality say about services

Figure 5: Positive and negative themes about experiences of urgent and emergency care



Awareness of and contact with services

Most respondents indicated they were aware of which service to use in the first instance, with only a small proportion indicating they did not know how to contact the service or did not know which service to contact.

In general, respondents were both aware of and had contact with a range of services when they or someone known to them experienced an urgent medical problem. None of the respondents had any contact with pharmacies during their urgent medical problem.

Overall experience

Overall, the small number of respondents reported reasonable satisfaction with accessing and overall experience of urgent and emergency care as well as moving between services.

However, there was variation in people's satisfaction. The following sections include specific quotes from patients, covering access to and experience of urgent and emergency care services.

1. Access to services

The promptness of response or ease of contacting the service was praised by survey respondents, for example:

“The response was fast and competent and the attitude of all the agencies concerned made a traumatic occasion much more manageable”.

2. Moving between services

Some responses included comments about services working well together, and positive comments about aftercare and follow-ups.

“On behalf of my wife and in response to my 999 call, a locally available Paramedic arrived at my home within 10 minutes, handed over to an Ambulance crew and arrived at Warwick Hospital A&E by approximately 9pm. [...] Following the operation ... and post-operative treatment, my wife was moved for 5 weeks convalescence at a care home in Stratford-on-Avon and eventually home, under joint NHS / WCC social services teams. Final referral to our GP...”.

3. Staff

Several respondents praised the professionalism and/or competence of the staff they spoke to or saw, the caring or compassion of the staff, or referred to having received helpful advice.

“...Two paramedics were excellent, professional and caring”

“Clear advice, explanation of why I needed to move.”

4. Other comments

Two people commented on delays, including one who stated:

“A&E staff forgot I was there and after 4 hours I enquired re seeing Nurses or Dr and was told I had been seen according to their records, which was strange and disappointing”.

Summary of findings

Of the individual providers that we visited, we saw that they had safe practices in place and worked and communicated well together. Individual providers monitored safety well and worked with each other to investigate incidents. There was a serious incidents learning forum to enable sharing of learning from serious incidents across the whole of Coventry and Warwickshire. However, the individual providers that we visited did not feel that learning from incidents was shared across the urgent and emergency care system by the SRG.

We found that, overall, individual providers were providing effective services and had systems to monitor outcomes.

- West Midlands NHS 111 service performs significantly better than other providers, with fewer calls abandoned.⁴
- Patients' experiences of out-of-hours GP services in South Warwickshire were similar to the England average.⁵
- West Midlands Ambulance Service achieved the 75% target for Red 1 calls responded to within eight minutes (77.9%) and was significantly higher than England average (72.8%). However, the CCG highlighted that performance within their local CCG area was worse than the wider area.⁶
- The year-on-year performance of South Warwickshire NHS Foundation Trust on the four-hour A&E waiting target of 95% decreased significantly from 96.4% to 93.8% between October 2013 and September 2015.⁷

We observed many examples of effective joint working between providers and a number of innovations to support patients with urgent care needs. However, it was difficult to analyse trends for the urgent and emergency care system in South Warwickshire or to compare its outcomes with other localities, as no formal system-wide outcome monitoring data was available.

We found that the public were not always clear on which service to access outside of normal working hours, and that some patients were not always correctly directed to the appropriate service when first accessing the urgent and emergency care system. Communication across providers was on the whole

4. NHS 111 minimum data set Oct 2014 to Sept 2015. **The service's abandonment performance was 0.9% in the year period running up to fieldwork (March 2015 to February 2016).**

5. NHS England, GP Patient Survey, July to Sept 2014 and Jan to Mar 2015.

6. NHS England, Ambulance Quality Indicators Oct 2014 to Sept 2015. **The Trust's performance was 78.7% in the year period running up to fieldwork (March 2015 to February 2016).**

7. NHS England, A&E waiting times – all department types. **The Trust's performance was 95.4% in the year period running up to fieldwork period (March 2015 to February 2016).**

effective and improved use of electronic records was helping this. However, there were still some areas where this could be improved further, notably communication between GP out-of-hours and NHS 111 services with GPs. We saw evidence that pressures on some services (especially community services) were affecting other services, but we saw many examples of initiatives to reduce this impact.

Patients and relatives we spoke with during this review provided generally positive feedback about the care and compassion they received across the urgent and emergency care system.

We found evidence that the urgent and emergency care system was responsive to many of the needs of the local population, particularly older people. However, some providers felt that the needs of younger age groups had not been met as effectively as those of older people.

The SRG has an urgent care strategy for South Warwickshire. This is incorporated into the CCG's broader strategy. The SRG has also prioritised local initiatives, for example, Community Emergency Response Team (CERT).

Individual providers reported frustration that the SRG was too focused on the performance of the acute trust and performance targets in general, rather than improving system integration.

Recommendations

Leadership and governance

- The SRG should continue to develop and share a clear vision and set of values for the system to which all members are signed up to. It should be aligned with the Urgent and Emergency Care Network's vision and values.
- The SRG should encourage and support cross-organisational working with clear and agreed local protocols in place.
- The SRG should implement an effective governance framework to support the delivery of the strategy. This framework should include all health and social care providers and relevant voluntary groups within the system.
- The SRG should continue to embed its quality and performance frameworks to hold commissioners and providers to account and facilitate whole system performance dashboards (including patient and carer experience data) that help to identify pressure points in the system and prioritise themes for action.

Workforce and capacity

- The SRG should ensure that the system in place is effective enough to monitor current capacity across the system, facilitating effective communication across providers and safer working. This information should be used to actively review local capacity issues to support effective planning and delivery across the South Warwickshire locality.
- Providers should review how they can ensure safe staffing levels by making the best use of staff and/or recruitment to their services.

Quality of care

- The SRG should actively review themes from concerns and complaints relevant to urgent and emergency care, and share learning across the system.
- All providers should regularly attend the monthly SRG meetings to facilitate shared learning and generally improve communication across the system.
- Improved information flows and access to systems should be used as an opportunity to improve collaborative working. A shared electronic patient record system should be implemented across the urgent and emergency care system to enable all providers to access, read and make records, to support them to deliver effective care and treatment and facilitate communication between them.

Access

- Commissioners should make sure that the Directory of Services system is complete, accurate and up to date to ensure that providers safely refer patients to the most appropriate service for their needs.
- The SRG should support a formal review of services available outside of normal working hours, to ensure that hospital, primary, community and social care services can work in a coordinated way and to minimise barriers to discharge from the acute trust.
- The SRG should continue to actively promote urgent health and social care services outside of hospital, especially outside of normal working hours, to help people with urgent care needs to get the right advice in the right place, first time.

Meeting the needs of the population

- The SRG should take a more active role in planning urgent and emergency care delivery in line with the needs of its population. It should proactively engage with the public and all staff across the system and gather feedback to help shape and improve the system and delivery of services. It should use audit and activity data to understand the main factors associated with increased use of services in the locality and the characteristics of the local population to help plan and deliver services.
- Local commissioners should review how they routinely conduct comprehensive needs assessments of the local population to determine commissioning priorities for developing urgent and emergency care services for all groups of people – in addition to older people.
- The SRG should design services that are population-orientated and address the needs of different people and groups in the locality, and that are co-designed, person-centred, and evidence-based. Local voluntary groups should be included in the design process.

Partnership working

- Commissioners and providers should work together to ensure that contractual arrangements encourage and drive collaborative working between providers.
- To develop joint strategies, and minimise organisational barriers, the SRG should continue to facilitate cross-organisational joint working between SRG members, including the social care and voluntary sector. SRG members should be willing to move away from individual institutional cultures and work towards a common understanding of what matters locally.

What does SAFE look like in this locality?

SUMMARY

Individual providers monitored safety well internally and worked with each other to investigate incidents. There was a serious incidents learning forum to enable learning from serious incidents to be shared across the whole of Coventry and Warwickshire. However, individual providers were hampered by not having an effective single data system (or series of compatible systems) to monitor capacity and quality across the whole urgent and emergency system. We found that the currently available data systems did not adequately support providers to ensure that urgent and emergency care was delivered safely, for example by responding to surges in demand.

Despite the lack of an effective single data system, the System Resilience Group (SRG) felt they had oversight of the needs of the local population and actively planned for surges in demand across the urgent and emergency care system. Throughout our visit we were not reassured that this was the case.

Providers told us that their organisations had processes to learn from significant events, but that learning from incidents was not always shared across the urgent and emergency care system. They felt that the SRG could develop its role in ensuring that learning from incidents was shared across the system.

DETAILED FINDINGS

What is the track record on safety across the urgent and emergency care system?

We found there were several barriers to safe systems across the South Warwickshire locality, including the inability to review the track record on safety across the urgent and emergency care system. Different computer systems were being used by providers which made it difficult to monitor safety consistently across the urgent and emergency care system.

After our visit, we were told by the SRG that a system was in place to log and monitor current capacity across the urgent and emergency care system. However, we found this system was not effective as communication across the system about current capacity was variable. A number of services commented on how the GP out-of-hours service sometimes signposted patients

What does SAFE look like in this locality?

inappropriately to services that did not have capacity to see more patients, because of a lack of information. Furthermore, NHS 111 staff felt that the service was understaffed at the weekend, when some reported feeling unsupported and under pressure.

Providers identified a number of areas where communication across the system could impact on the safe delivery of services. Staff we spoke with at NHS111 reported delays in identifying the most appropriate service options for patients due to a lack of updated information on their local directory of services (DOS).⁸ Providers stated there was insufficient resource devoted to DOS to keep it updated. NHS 111 also reported a recent increase in demand, despite fewer clinicians being rostered, which meant that their 60-second response rate could not always be achieved.

Emergency department attendance documents, which noted reasons for attendance and any treatment provided, were sent through daily by fax to GP practices and scanned promptly by GP practices to be followed up as required by GPs. This ensured that the safety of individual patients, moving through different parts of the system, was monitored. From the GP practices we visited, we were told potential risks to individuals were managed by practices offering automatic same-day appointments to children needing to see a GP and adults requesting emergency appointments were offered same-day appointments where this was deemed necessary or in the following days where appropriate.

We saw that individual providers carried out induction training and Disclosure and Barring Service (DBS) checks on staff so potential risks to individual people were managed and some providers required staff to complete a probationary period. Individual providers had their own mandatory training records to ensure that staff kept up to date to support them in providing safe, appropriate care to people.

How is safety monitored?

The SRG held weekly strategic conference calls with providers, commissioners, the local Healthwatch and the local authority to review demand and address any issues. Clinical leads reviewed only the most significant issues affecting patient safety at system level. Responding to less significant safety issues was primarily an operational issue to be dealt with at individual provider level. We found that individual providers had good internal systems and processes in place to monitor safety at their own sites but were not clear about what should be discussed at SRG level.

Individual providers identified a safety lead to investigate incidents internally. However, we saw evidence of joint root cause analysis investigations across

8. The directory of services (DOS) is a central directory which provides NHS 111 call handlers with real time information about services available to support a particular patient.

What does SAFE look like in this locality?

providers such as the acute trust, NHS111 and the ambulance service. We found that individual providers shared lessons internally after action plans had been put in place. We were told by individual providers that they would only take information to the SRG if they felt they needed to be escalated.

NHS 111 carried out monthly audits of approximately 3% of all NHS 111 calls. Daily data collection was reviewed every fortnight at an operational meeting with the Clinical Commissioning Group (CCG) to review outcomes and any emerging trends. The service also held monthly meetings regarding clinical issues to see how it could improve.

Are lessons learned and improvements made when things go wrong that involve more than one provider or service in the urgent and emergency care system?

Individual providers had robust systems to monitor and review safety. There was a serious incidents learning forum to enable sharing of learning from serious incidents across the whole of Coventry and Warwickshire. However, the individual providers that we visited did not feel that learning from incidents was shared across the urgent and emergency care system by the SRG. Providers did have processes to notify other providers if concerns raised were about more than one service. None of the providers we spoke with told us about clear opportunities to share any of this learning across the urgent and emergency care system. However, providers did report services “pulling together when things went wrong” and this was usually done through a conference call.

The local Quality Surveillance Group⁹ kept an overview of trends arising from complaints and significant events and put in place action plans when needed. Complaints were discussed at SRG meetings, but attendance was variable. The SRG was keen for all providers to attend meetings to share learning, including the ambulance service even though the service received few complaints.

Individual providers were able to demonstrate how lessons learned internally had led to improvements within their services. The acute trust shared an example where learning from the winter pressures had led to an increase in consultant staff; GP practices explained that they received daily discharge and attendance summaries from A&E, GP out-of-hours service and NHS111, which were checked daily and they shared learning within their practices, but it was not clear what learning was shared across the system.

We found that some providers were unwilling to freely disseminate learning when things went wrong as they were concerned about the impact on their future

9. A Quality Surveillance Group acts as a virtual team across a health economy, bringing together organisations and their respective information and intelligence (gathered through performance monitoring, commissioning, and regulatory activities), working to safeguard the quality of care that people receive.

contract. This posed a barrier to an open, transparent culture and shared responsibility and learning.

How well are actual and potential risks to individual people and the urgent and emergency care system anticipated and planned for in advance?

We saw that the SRG actively reviewed the effectiveness of the system based on performance in the previous year. This included looking at what worked well and what did not work so well when planning for future services.

Commissioners and providers worked together to address pressures on individual providers, such as cold weather spells. During winter, every two weeks, the SRG examined whether the system was coping with added demand. Contracts were reviewed regularly by the CCGs to monitor providers' performance and, if required, action plans were agreed.

We were told by the SRG that there had been joint discussions and general agreement across providers, about the key challenges for the SRG to address. Delayed transfers of care¹⁰ from the acute trust into supported care facilities (i.e. care homes) was seen to be a significant issue for the South Warwickshire urgent and emergency care system as it meant staff were unavailable to treat other patients with greater needs (such as patients with an urgent or emergency care need). As a result, the SRG was considering how to focus on improving capacity in social care settings. We saw that the local authority was taking steps to improve the flow of patients who required residential, nursing and home care following urgent and emergency care. The initiative looked at restructuring business processes, with 90 providers in scope, with the objective to take some pressure away from the urgent and emergency care system. It is anticipated to take two to three years to achieve.

Across providers, staffing was altered to reflect additional demand as a result of, for example, major events, seasonal fluctuations and holidays. We found there were systems in place to plan staffing for different providers during periods of additional demand. This work was driven by individual providers to meet their targets. Individual providers felt that this was not effectively overseen by the SRG. However, after our visit we were told by the SRG that "all SRG partners shared plans for meeting additional demand at monthly SRG meetings". In response to potential changes in staffing levels, and/or increased demand, staffing arrangements were in place for individual providers. For example, the GP out-of-hours service wanted to increase staffing on its rota, in response to increased demand. The provider carried out a capacity and demand review and the audit results were used to manage the rotas

10. A 'delayed transfer of care' occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care but is prevented from doing so.

What does SAFE look like in this locality?

accordingly in response to increased demand, preventing other parts of the urgent and emergency care system from being affected.

The ambulance service continually monitored its activity on its IT system and liaised with the acute trust in real time if there was increased demand on the service or capacity issues. These arrangements would ensure appropriate responses at key points of the system should staffing issues arise. NHS 111 had informed us that it had forecast demand on an ongoing basis (weekly), but the service was finding it difficult to rota sufficient staff for weekend shifts and overnights.

We were informed by the acute trust that there had been surges in demand across the service (year-on-year between July 2013 and June 2015 the number of emergency attendances [Types 1-4] increased by 1.7% to approximately 175 per day)¹¹ the cause of which was unclear. The acute trust undertook a “Perfect Week” activity, involving trust staff, to understand current capacity and agree service standards. Winter pressures, festivals and bank holidays seemed well planned for by increasing staffing levels, but it was difficult to respond at short notice to the demand created by an unexpected volume of patients. The trust introduced isolation pods to cope with norovirus after a particularly difficult winter in 2014/15 and was linked to other hospitals around it, as part of its escalation policy, where it could call for help from other hospitals if demand required this. In addition, the ambulance service could supply extra staff to the hospital if it was “stretched” to help care for patients.

Of the providers that we engaged with across the South Warwickshire locality, all of them had carried out winter planning. The SRG had asked providers to complete their own plans and bring these to SRG meetings. Providers confirmed that winter planning was provider-led rather than system-led. As part of its winter planning, the ambulance service had identified risks to the service and put in place plans to mitigate them, for example, they were conscious that the South Warwickshire geography was its biggest challenge and posed a risk to people in rural areas with an urgent or emergency care need requiring ambulance response. In response to this, the ambulance service employed first responders in cars to navigate rural areas and help reduce emergency department admissions. The ambulance service had also developed plans for responding to major incidents and was invited to meetings with the Local Health Resilience Partnership to be included in all relevant exercises and initiatives. GP-led schemes such as the Over 75s programme also contributed to the management of fluctuations by avoiding hospital admission.

11. Hospital episode statistics (HES).

What does EFFECTIVE look like in this locality?

SUMMARY

We saw many examples of providers working in ways that supported patients in accessing urgent and emergency care effectively. In many cases, providers had developed services that helped reduce demand in other parts of the system (for example alternatives to A&E attendance). We also saw examples of how initiatives to support patients who did not have an urgent care problem assisted the urgent and emergency care system to work effectively. For example, services to support patients being discharged from inpatient beds helped avoid delayed discharges which in turn facilitated timely admission of patients from A&E to inpatient wards.

It was difficult to compare outcomes with other areas, given the current lack of formal system-wide outcome monitoring data. We saw evidence that pressures on some services (especially community) were impacting on other services but we saw many examples of initiatives to reduce this impact. We found the public were not always clear on the appropriate service to access outside of normal working hours, and that some patients were not always correctly directed to the appropriate service when first accessing the urgent and emergency care system.

We found communication across providers was on the whole effective and improved use of electronic records was helping this. However, there were still some areas in which this could be improved further, notably in GP out-of-hours (OOHs) and NHS 111 communications with GP practices.

DETAILED FINDINGS

Are people's urgent and emergency care needs assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance, ensuring people get the right advice/care/treatment, in the right place at the right time?

Individual providers followed legislation, standards and evidence-based guidance relevant to their services to ensure people got the right advice, care and treatment in the right place at the right time:

What does EFFECTIVE look like in this locality?

- all providers followed relevant national guidance such as NICE guidelines
- providers participated in clinical audit and had systems in place to implement learning from audits
- providers worked to achieve standards applicable to their individual service, for example, the ambulance response times.

Individual providers took account of national policy initiatives, providing a range of urgent care services outside of hospital and providing better support for people to self-care, this facilitated movement through the urgent and emergency care system.

There were a number of initiatives to support effective working in the locality as a whole. We saw that patients in South Warwickshire had access to a range of locations where they could receive urgent and emergency care and advice and there were initiatives to provide the most appropriate care for patients, including alternatives to A&E attendance or hospital admission. The acute trust provided ambulatory care clinics (emergency service offering same day care to patients with acute medical conditions) where patients who did not require admission to hospital could be assessed and treated with early return to their home. GPs were able to refer patients to the ambulatory care clinics rather than traditionally to inpatient hospital services; patients could also be referred by the emergency department. The acute trust had also established a short-stay acute frailty assessment unit for older people requiring urgent and emergency care where prompt assessment by a multidisciplinary team of specialists for older people meant those suitable for treatment outside of the acute hospital could be identified.

A Community Emergency Response Team (CERT) had been established to provide emergency response to patients who may not require acute hospital admission and to patients being discharged earlier from the hospital. This ensured that people received the appropriate response whilst preventing unnecessary hospital attendances. We also saw that ambulance staff were able to refer to GP practices or alternative providers, such as GP out-of-hours or walk-in centres, if inpatient assessment was not felt to be required.

The acute trust had made improvements to patient flow through the hospital, which meant patients were able to be handed over from the care of the ambulance crews to the hospital in a timelier manner. Whilst the acute trust did experience delays, none had extended to over 60 minute breaches for the first two quarters of 2015/16.¹² Patients attending South Warwickshire NHS Foundation Trust A&E responded similarly to the England average when asked

12. Source: South Warwickshire NHS Foundation Trust - Integrated Performance Dashboard, Oct '15

What does EFFECTIVE look like in this locality?

how long did you wait with the ambulance crew before your care was handed over to the A&E staff?¹³

In line with best practice, major trauma patients were transferred to the specialist centre in Coventry to ensure patients received the appropriate treatment and better outcomes. The ambulance service had breached its red and amber response time targets¹⁴, which the service had identified and was undertaking work to address.

How are people's care and treatment outcomes monitored across the urgent and emergency care system and how do they compare with other SRGs?

Although the SRG had collated data from different providers into a dashboard, we did not see any formal monitoring across the urgent and emergency care system as a whole. Providers told us that they did not feel there was a system-led process to monitor outcomes for patients across the system.

Performance and patient outcomes across the system should be monitored by the SRG. However, we were told by some providers that the SRG was too heavily focused on the acute trust's performance rather than other services or the system as a whole.

We found that individual providers had their own policies and dashboards for monitoring outcomes, for example, while we were in the area the acute trust was carrying out an audit of patient flow for people aged over 75 through the hospital from the emergency department to discharge. However, providers were unsure what dashboards other providers were using or what they were monitoring.

How well do different components of the system work together to deliver effective urgent and emergency care and treatment?

We saw some good examples of joint working between providers across the system. Most of the GP practices that we visited felt that the GP out-of-hours services worked well with them, ensuring people received urgent and emergency care and treatment outside normal surgery hours. Also, a particular strength in the system, identified by GP practice staff, were the direct telephone lines to the trust for admissions to the hospital, gynaecological issues and psychiatric admissions.

13. A&E Patient Experience survey covering the period January 2014 – March 2014.

14. Emergency 999 calls are prioritised into categories to ensure that the most life threatening cases receive the quickest response. 'Red' calls have nationally set targets to ensure seriously ill patients and those requiring urgent attention receive the appropriate response; 'Amber' and 'Green' calls, which have locally agreed targets, are less urgent.

What does EFFECTIVE look like in this locality?

There was good practice between providers across the system, especially within normal working hours, for acutely unwell patients. We saw evidence that the GP practices and the ambulance service worked well and had a dedicated telephone number to communicate with each other.

Patient experience

Y, an adult over 65, fell in the garden at a friend's house and sustained a head injury. They called 999 and felt they received an immediate response from the first response team, who tried to stop the bleeding and called for an ambulance, which came within 30 minutes. Y was taken to the emergency department of the hospital and was swiftly admitted to the ward.

A copy of the treatment card was sent to the GP and all treatment was provided in a timely manner. Y was discharged from hospital three weeks later. As she needed equipment at home this was arranged through the GP and Age UK, and was available on her return from the hospital.

Y's family were pleased with the care received; they felt that all the services worked together and were very organised.

The ambulance service had a Strategic Operations Centre (SOC) and hospital turnaround desk, which worked with commissioners and acute trust staff in the management of hospital turnaround for ambulance crews. Other arrangements were also in place to support effective handovers, such as a nurse at the acute trust who routinely met ambulance crews at the hospital front door and the SOC and Hospital Ambulance Liaison Officers (HALOs) ensuring ambulance resources were able to respond to patients out in the community without delay. HALOs were particularly effective during times of high demand for the hospital and worked in partnership with the emergency department practitioners to provide clinical care to people waiting, on trolleys, to be admitted. HALOs were able to liaise directly with hospital site managers and the role had been well received.

We saw evidence of different providers and agencies jointly carrying out frequent reviews of pressures and blockages in the system, and taking a multi-agency approach in addressing key issues such as:

- a joint managerial post with the local authority to oversee community services
- a joint local authority and acute trust Winter Planning Group, which focused on addressing the barriers in the urgent and emergency care system

What does EFFECTIVE look like in this locality?

- an ambulatory care pathway, which allowed staff to quickly diagnose and treat patients with acute medical problems who would not require an overnight stay; urgent care providers could refer patients with common conditions and illnesses, reducing variation and simplifying the pathway for patients and staff.

A number of providers including the ambulance service had a hotline to, and worked jointly with, the police service; staff told us this felt reassuring. We spoke with a community health visitor who explained that they had very good links with hospital staff. One health visitor told us they would like to see an increase in community pharmacists to support people with medicines management and prevent admissions.

Staff at the local voluntary group, Springfield MIND, told us that they worked in partnership with the community mental health trust (CMHT), in particular if a person's mental health was deteriorating towards an urgent situation. They were able to communicate with GPs directly, and if necessary, the police for advice and support. They felt that the effectiveness of communication depended on the relationships in place and this often worked best at senior manager level of local providers. However, staff from a number of other voluntary groups that we spoke to told us that they did not always feel part of the wider urgent and emergency care system and had little interaction with other services like the police and mental health services.

Outside of normal working hours, we found evidence that the different components of the urgent and emergency care system in South Warwickshire did not work as effectively together. The SRG recognised that the system could appear fragmented and there were delays in some patients reaching the most appropriate destination for their needs.

Patient experience

C is the mother of a child under five years of age who had a fever, and experienced two seizures. On the first occasion, C rang 999 and a first responder arrived very quickly and the child was promptly taken to the emergency department of the acute trust by ambulance. The child was assessed and transferred to a ward and discharged early the next morning.

On the second occasion, C rang NHS 111 after her child experienced another short seizure and a GP out-of-hours appointment was arranged. A GP out-of-hours receptionist directed the family to the emergency department. The child waited for four hours before being seen in another area of the hospital and discharged.

What does EFFECTIVE look like in this locality?

C described a positive experience of the ambulance service on the first occasion. She felt NHS 111 was appropriate for advice but described a negative experience, both in terms of the high volume of questions she was asked and the incorrect advice to attend the GP out-of-hours service as she was then redirected to the emergency department. C also described a negative experience of the emergency department on both occasions, with long waiting times and insufficient explanations of the child's problem, treatment and follow-up plan.

The family have raised a formal complaint about this directly to the trust and have indicated they would prefer to access services at another hospital if possible.

We saw how capacity exceeding demand in one part of the local healthcare system could affect other sectors. Community services such as the re-enablement team, which helps people regain independence after an illness, could not always meet all demand. Care and nursing homes did not always have the capacity to receive patients from the acute trust, and did not take patient referrals at weekends. The limited capacity of community services affected the acute trust's ability to discharge patients from inpatient beds, which in turn could lead to delays in admitting patients to inpatient wards from A&E.

Patient experience

P's mother is aged over 65 and experienced a fall. P had attended the emergency department with his mother on a Sunday afternoon and felt the process worked very smoothly. An ambulance had arrived promptly and his mother was taken into the emergency department (ED).

The ED was busy and P and his mother waited for 1.5 hours; the wait was explained to them and doctors gave a clear explanation of what was happening. His mother was admitted overnight and this was explained to them both.

P felt confident in the clinicians; staff had a calm professional manner and he felt his mother's dignity was respected.

His mother's GP had also received information about the attendance.

On discharge from the ED, P's mother was to be transferred into a nursing home to receive re-enablement services. P and his mother waited a few days for an available place in the nursing home and P felt he had to keep chasing staff to try to find out when his mother would be transferred. As a result of the delayed discharge, P's mother lost confidence in her mobility.

What does EFFECTIVE look like in this locality?

The system was being proactive in moving healthcare out of hospital settings and closer to people's homes. As well as the local authority's initiative to combat delayed transfers of care, the CERT was also supporting discharges from the hospital with interventions at care homes. In addition, a Discharge to Assess (D2A) service enabled patients to be discharged earlier from acute inpatient wards by coordinating care in alternative settings. The trust worked with the local authority, NHS Continuing Healthcare¹⁵ (NHS CHC) and the local clinical commissioning group(s) (CCG) to set up the service. The service was facilitated by assessment between health and social care, in-house re-enablement and rehabilitation, and care co-ordinators to support patients and their families throughout the discharge process. The trust felt these internal processes were producing more effective services and enabled it to improve A&E performance despite rising demand.

We were told about the barriers to effective joint-working across the system, including outdated information on the DOS system, which caused obstruction in communication across the system. This was a particular problem for the NHS 111 service when trying to identify the appropriate service for patients. GPs told us that they wanted a closer working relationship between in-hours GPs, the out-of-hours GP service and the NHS 111. It was felt that there was a more direct relationship between GPs and the minor injury unit located at the trust.

Several providers, including the GP practices and ambulance service, also told us that feedback from the SRG, including the CCGs, tended to focus on an individual provider's performance indicators and targets, rather than issues affecting the whole healthcare system. We found an appreciation across providers that capacity in the system was tight with little ability to flex during a surge in demand. At the same time, however, there appeared to be reluctance from providers to escalate to the SRG that they were struggling with capacity for fear of financial penalties or a risk of jeopardising their bid for future contracts.

How does the system ensure effective and appropriate management of key information?

Although handover of information from ambulance to hospital was generally felt to be good, and a special patient notes (SPN)¹⁶ system between GP out-of-hours and GP practices worked well in ensuring information was shared in a timely way (as and when required), several providers told us about difficulties with the communication of key information about patients across services. GP practices told us it was sometimes difficult for the practice to read hand-written

¹⁵. NHS Continuing Healthcare is a free package of care, which is arranged and funded solely by the NHS, for individuals outside of hospital who have ongoing health care needs.

¹⁶. Special patients notes are notes that can be attached to new, or existing, patients to alert or highlight any specific care requirements, long term care plans or any other item of useful information for the patient.

What does EFFECTIVE look like in this locality?

notes from the emergency department and GP out-of-hours service. NHS 111 and GP out-of-hours reports contained all the questions they asked of patients and patients' responses rather than a concise summary. The ambulance service and GP practices reported that key information would be buried among unnecessary text that set out the whole of the patient's journey. The ambulance service felt there could be a better transfer of information to ambulance crew from GPs at times to ensure all essential medical history was known, as they could not access GP records.

Several providers felt that better use of information technology could improve communication between providers – the technology was sometimes available but not always used. GP practices felt it would be more effective if all providers across the urgent and emergency care system could access summary care records as everyone could readily access key patient information, such as allergies. This would ensure a consistent approach when people moved between providers. The SRG told us about a scheme where six GP practices, within the system, were working with the acute trust on admission avoidance and, as part of this, were streamlining their electronic records systems. As a result, communication across these providers had improved, with their systems effectively being able to “talk to each other”; particular feedback from consultant geriatricians was positive with regards to improved communication for frail elderly patients. The ambulance service was to implement an electronic system in South Warwickshire, which was planned for completion across the West Midlands by September 2016

What does CARING look like in this locality?

SUMMARY

Patients and relatives reported that urgent and emergency services in South Warwickshire were caring and compassionate. We did hear of some isolated experiences where some patients were dissatisfied, but in most of those cases, there were still elements of the patient's journey through the urgent and emergency care system that provided a positive caring experience.

The SRG tried to involve people in the design of services as much as possible. This included patient representatives as SRG members

Facilities did exist for patients who didn't speak English as their first language and we found patients and relatives were actively involved in their care.

DETAILED FINDINGS

Are people treated with kindness, dignity respect and compassion while they receive urgent and emergency care and treatment?

It was evident that the SRG members we engaged with demonstrated a caring and compassionate culture. When asked what was good about their care, people told us:

"Compassion and how quickly 111 grasped the importance and urgency of my situation. Awestruck basically by how well it worked."

"Called ambulance after my wife collapsed. It arrived in about five minutes. Two paramedics were excellent, professional and caring."

A number of providers were using pictorial guides for patients with a learning disability and all staff had received training in equality and diversity. One of the providers we met explained that while their staff did not have specific training about people's cultural needs, they did receive emails reminding them of cultural festivals and the potential impact this could have on services.

An interpreting service was available across the locality, which all providers could access for patients whose first language was not English. The South Warwickshire area had a Roma community (who spoke Romanian as a first language) and we spoke with the British Red Cross who provided support and advocacy services to this community. Staff felt that interpreting services were not

What does CARING look like in this locality?

always accessible, but were able to share an example of a patient, whose first language was not English, receiving very good care, including a rapid response from the ambulance service, admission to hospital and discharge home within two days. In addition, a British Sign Language (BSL) interpreting service was also available across the system for people with a hearing impairment.

Providers that we spoke with provided positive feedback about each other. Individual providers' patient survey results and Friends and Family Test¹⁷ results showed high patient satisfaction rates at provider level; this could be translated into a positive experience across the urgent and emergency care pathway. Additionally, patients responded better than the England average when asked if they had enough privacy during their A&E treatment at South Warwickshire NHS Foundation Trust.¹⁸ We met with patient participation group (PPG)¹⁹ members at the GP practices we visited, who spoke very highly about the practices in the review.

Are people who use urgent and emergency services and those close to them involved as partners in their care?

The SRG tried to involve people who used the urgent and emergency services as much as possible in the development of the services. Furthermore, there were two GP patient reference groups (PRG) in the locality. These were groups of practice staff and patients (made up of members of PRGs) with an interest in health and social care issues who wanted to get involved in decisions about the range and quality of services provided and over time, commissioned by their practice. Some of the issues raised needed to be dealt with on a wider basis, by practices or groups working together.

The CCG had a public and patient participation group (PPG), which included a representative from each GP PRG across the locality. By establishing a network, the PPPG could influence issues that had a wider commissioning impact, as well as sharing good practice and ideas. The PPPG met approximately eight times a year and had expanded in the last year as more GP practices had established PRGs. In addition, two patient representatives of the SRG were representatives for each PRG.

We heard positive feedback from patients and relatives about their involvement in their care.

17. The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment across the NHS. The FFT is rolled out across most NHS services, including community care, hospitals, mental health services, GP practices, emergency care, patient transport and more. This reference is referring to the A&E FFT results.

18. A&E Patient Experience survey covering the period January 2014 to March 2014.

19. GP patient participation groups (PPGs) enable GP teams to be proactive in providing services that truly reflect what patients want and need.

What does RESPONSIVE look like in this locality?

Summary

We saw extensive evidence of initiatives by the System Resilience Group (SRG) and providers to meet the needs of older people and to improve their access to care. The SRG had worked in partnership with NHS providers, social care providers and AGE UK to improve services for older people. Social care and community services were being integrated to facilitate multidisciplinary assessments and joint working.

However, many of the providers reported that the system was too focused on older people and did not pay as much attention to other vulnerable groups, such as young children. Providers told us that the system was not very effective in assessing the needs of the local population and developing initiatives that improved access to the system for all populations groups.

DETAILED FINDINGS

Are services across the urgent and emergency care system planned and delivered to meet the needs of people?

The SRG felt that individual providers communicated well between themselves to help plan and deliver services that met the needs of people within South Warwickshire.

At the time of our visit, the SRG was in the process of setting objectives for its engagement strategy 2016 to 2018. We were told that the local Healthwatch was the main channel for feedback about whether people's needs were being met. A listening event for the general public had been held in autumn 2015, but this was poorly attended.

The SRG told us that they used a wide range of local demographic information to help plan services across the system, for example, using Right Care²⁰ information to determine priorities and shape commissioning intentions.

20. Right Care is a programme designed to increase the value from the resources allocated to healthcare and directly address variations in spend, activity and outcomes in three ways: improved clinical involvement in commissioning, stronger patient involvement through shared decision making, and supporting commissioners to understand whether the level of variation needs addressing.

What does RESPONSIVE look like in this locality?

However, most of the providers we spoke to felt that the SRG could do more to ensure responsiveness across the system. We saw that individual providers extensively planned for services that reflected the needs of the local population. However, a number of providers felt the system was not proactively facilitating a joined-up approach to planning coordinated urgent and emergency care services that took account of all urgent care needs across the locality. The SRG told us that seven-day working is regularly discussed at the Warwickshire Cares, Better Together Integration Board. This is also attended by the clinical commissioning group (CCG) with frequent engagement between stakeholders.

The SRG had identified that access to community services for frail elderly patients was an important issue for the South Warwickshire locality, which had a large older population group. The CCG had invested £1.4million on services for this population group and we saw evidence of a number of initiatives across the system to try to respond to this older population group, including:

- A frailty pathway developed by the trust, which aimed to ensure that frail older people were identified early and assessed by a geriatrician. The pathway encouraged early planning for community services from the start of hospital admission and wards providing intermediate care were converted into additional geriatric assessment units so that all patients once transferred here were managed on the correct ward without further transfers before discharge.
- A dedicated 'Over 75 Care Coordinator' role, which was developed by the CCGs to facilitate timely assessment, encourage forward planning, share patients' expected date of discharge and information on complexity with community services, patients and their relatives. GPs across the locality told us that the role was invaluable and had helped reduce unplanned admissions.
- Closer links between GPs and nursing homes, with a named GP accountable for people's care to ensure continuity of care for older people and to try to reduce unnecessary admissions to hospitals.
- A key service for older people, provided by the local voluntary group, Age UK, involving accompanying them home after a visit or admission to the emergency department, and assessing fall hazards in the home.

In addition, we were told after our visit that the Arden Mental Health Acute Team (AMHAT) offered a psychiatric and risk assessment service in acute healthcare settings, such as the A&E department or wards of local hospitals. This ensured timely care and treatment for patients who had acute mental health issues, when they attended physical healthcare settings, such as hospital. As of December 2015, the service had extended to further support people with mental health needs. The SRG told us that they are conducting a system-wide campaign promoting self-management, pharmacy and NHS 111 to ensure that the urgent and emergency care services are planned and delivered to meet people's needs.

Do urgent and emergency care services take account of the needs of different people, including those in vulnerable circumstances?

There was limited evidence of the system taking account of the needs of different groups of people and planning and delivering services accordingly. We saw that the community service was working with the local authority on pathways for people with disabilities, dementia and end of life care, where people would require multidisciplinary assessment and a period of residential care and nursing support.

However, as mentioned above, the system had a very strong focus on the needs of older people. The CERT service provided ambulatory care for frail older people so they did not need to attend the emergency department, and the ambulance service was supplying defibrillators to nursing homes and training on how to use them. A number of providers, including GP practices and staff from the voluntary sector confirmed that the system was mainly focused on meeting the needs of older people, possibly to the detriment of other vulnerable groups, such as people with mental health issues and very young children. Voluntary sector mental health agencies, such as MIND, the mental health charity, told us they did not always feel part of the urgent and emergency care system and had little interaction with health and care services.

Staff at the British Red Cross told us that the Roma community frequently encountered long delays in getting equipment and adaptations fitted in trailers and temporary accommodation. They also told us that there were also isolated cases where this community found it difficult to access urgent and emergency care services, such as interpreting services.

Can people access urgent and emergency care and treatment in a timely way?

Generally we found that people could access urgent and emergency care and treatment in a timely way.

The SRG had identified the need to improve waiting times for patients who needed care in the emergency department. As a result a number of cross-provider initiatives had been put in place including a seven-day palliative care service in the community to avoid unnecessary hospital attendances and the opening of a new planned admissions unit in a different area to the emergency department. In addition, to support patients to access urgent and emergency care in the community, an ambulatory care pathway had been implemented across the system, which permitted several urgent care providers, including GPs, to allow patients to access acute hospital care. This facilitated timely access, fewer hospital admissions and greater patient satisfaction.

We were told that there were difficulties accessing certain clinical specialities in South Warwickshire, such as neurosurgery, where GPs reported being unable

What does **RESPONSIVE** look like in this locality?

to refer patients directly, so patients had to attend the emergency department, which could affect timeliness of care. Eye trauma services were located at the specialist clinic in Coventry, in line with best practice, but could again affect the timeliness of care. Also, ambulances took trauma patients to the specialist trauma centre in Coventry. This is consistent with best practice in trauma management, but did mean that ambulance travel times were longer, which could affect response times for subsequent calls.

While the majority of patients we spoke with reported positive experiences of the ambulance service responding rapidly to the initial call, we did hear from some patients who occasionally experienced difficulties due to lapses in communication between services.

Patient experience

D is an adult over 65 who fell down the stairs and injured her ankle. She had difficulty bearing weight on her injured ankle but did not seek immediate help as she did not want to worry anybody. At 7am the following morning, D's son rang her GP as the pain was increasing. A home visit was arranged and the GP agreed to arrange an ambulance to take her to hospital as soon as possible.

D's son became concerned as the ambulance had not arrived after 3.5 hours. The call was upgraded to a 999 call and an ambulance arrived at 8:01pm, arriving at hospital at 8.33pm.

D explained that she waited in a chair at the hospital until 9pm when a nurse told her the x-ray department had closed. She waited in the A&E department until 12.34am when she was moved to the observation bay. She was told she would be staying overnight so she could be x-rayed in the morning. She had an x-ray at 7am the following morning and was discharged at 10am with some paracetamol and told to see her own GP if her pain continued.

Notes: D waited for 5.5 hours from assessment by the GP to the ambulance crew arriving. D's relative was not informed by the GP about how long the ambulance would be.

There was a long wait between the onset of pain and treatment.

D was happy with the treatment from the GP and the ambulance service, despite the long wait for treatment. The communication at the outset could have been better to manage the patient's expectations.

What does RESPONSIVE look like in this locality?

We also noted that the predominantly rural geography posed particular challenges when accessing ambulance services in South Warwickshire. The ambulance service covered the whole West Midlands region and some providers reported that ambulance availability could be an issue. It was difficult to isolate specific data for this review as the ambulance service's governance data related to the wider area, rather than just South Warwickshire.

However, the ambulance service's track record in meeting turnaround and response targets at the acute trust was generally good in facilitating timely transfers of care and preventing congestion at the acute trust's front door. Where there were delays, this was usually because of the large rural area and the distances the ambulances had to cover. The service had implemented robust systems to investigate any delays. The ambulance service worked well with both GP practices and GP out-of-hours service, and referrals were appropriate.

Hospital Ambulance Liaison Officers (HALOs) were available and responsible for the effective and efficient management of patient flow and ambulance turnaround times. Ambulance staff felt HALOs worked well to reduce periods of stress in the emergency department, even though the non-urgent ambulance wait times were not always conveyed to patients. Ambulance crew and HALOs worked together, managing patients on trolleys, to reduce both the length of time people waited to be admitted to the emergency department as well as the length of time the ambulance itself was out of action. Emergency paramedics were also able to prescribe to reduce admissions.

We heard frequent positive feedback about the timely way in which patients were seen in urgent and emergency care settings.

Communication to tell people about available local services and how to access the right healthcare quickly was variable. We spoke with NHS 111 operators who commented that there was no effective way of informing patients when urgent appointments at GP clinics were filled. Patients also told us that they were confused about what service options were available to them (not including A&E) outside of normal working hours and said there was a need for more information about these services. This was again echoed at our meeting with the local Healthwatch.

How are people's concerns and complaints listened and responded to and used to improve the quality of urgent and emergency care?

Each individual provider investigated patients' complaints internally, and we saw that there was learning from the complaints at provider level. We saw evidence of GP practices and the acute trust coming together to investigate individual serious incidents at root cause analysis (RCA) meetings. Providers told us that

What does **RESPONSIVE** look like in this locality?

learning from incidents and complaints did not seem to be shared across the system. There were internal pathways in place within providers to disseminate learning from concerns and complaints affecting more than one organisation, and these were shared with the commissioners. Several providers felt the SRG could do more to facilitate system-wide learning from incidents. The SRG, on the other hand, felt that they did hear about complaints but that their role was to be involved with complaints that were about the 'system' rather than the concerns of individual providers, and this would happen where patients complained to the CCG directly.

What does WELL-LED look like in this locality?

SUMMARY

We found examples of good leadership in the urgent and emergency system, both in individual services and supporting cross-system working. However, even though the organisations that made up the System Resilience Group (SRG) demonstrated good leadership within their own organisations, we found that the SRG as a body was not yet providing effective leadership consistently. Some innovative system-wide initiatives had been successfully implemented. However, two and a half years after its inception, the SRG had not yet developed a clearly articulated vision for the system, which was described as a 'work in progress', even though it was agreed that 'joined up' urgent and emergency care was the locality's priority. The SRG had developed a local Urgent Care Plan and Strategic Plan. Patient engagement was discussed at SRG level, but there was poor attendance at workshops.

Individual providers, and the local authority, reported frustration that the SRG did not actively facilitate joint working across the system and was perhaps too focused on the performance of the acute trust and performance targets in general rather than system improvements. A number of providers felt the SRG meetings were not very inclusive, and did not feel part of an open decision-making process.

DETAILED FINDINGS

Is there a clear shared vision and a credible strategy to deliver high quality urgent and emergency care and promote good outcomes for people?

The SRG believed that over the two and a half years of its existence, it had developed a set of values in the way it worked together. Although these values were not formally written down, they informed strategies to improve the urgent and emergency care system. The SRG was revising its terms of reference and would be writing a standard set of values for the SRG.

The SRG did not think that there was a clearly articulated vision for the system that all providers had signed up to. However, it generally agreed that the priority for the locality was 'joined-up' urgent and emergency care. Although individual providers had not officially signed up to this priority, they had invested time in the system to make sure it was effective to meet the needs of the local people

What does WELL-LED look like in this locality?

and were working collaboratively where possible. The SRG described development of its vision as a 'work in progress'; it had led a workshop on the future vision for urgent and emergency care within the locality, but not all providers were able to attend this. SRG meetings were felt to be generally well attended by GP practices, the acute trust and the local authority, but less attended by the ambulance or NHS 111 provider, which had weekly telephone discussions.

We saw evidence that the clinical commissioning group (CCG) had developed a local Urgent Care Plan and 2016-20 Strategic Plan. The CCG attends the local Integration Board, Warwickshire Cares, Better Together and the Arden Urgent Care Network. Information is then fed back to the SRG through this route.

How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality urgent and emergency care?

Although the SRG's priority for the system was to improve joint working, individual providers and the local authority reported frustration that the SRG did not actively facilitate joint working across the system and was perhaps too focused on the performance of the acute trust and performance targets in general, rather than system improvements.

The acute trust felt it had a voice on the SRG and was listened to, but other providers did not feel as involved in the SRG. The local authority felt it had tried to work in partnership with other organisations across the system, particularly with the acute trust, but felt that the SRG meetings did not give sufficient time for meaningful dialogue or developing solutions. The local Healthwatch told us that the SRG was inclusive and that if concerns were raised they were discussed at meetings. However, some providers, such as NHS 111 and the ambulance service, told us they felt the SRG meetings were not very inclusive and they did not feel part of an open decision-making process, which could in turn mean that SRG decisions were not necessarily representative of all providers in the area. The SRG told us that attendance at SRG meetings by a number of individual providers was poor, and it had chased providers several times on behalf of the CCG and SRG.

The SRG agreed that it had concentrated on the pathway between primary care and the acute trust and acknowledged that there was an opportunity for better working relationships between all members of the SRG. The SRG felt that there were some barriers to integration and working well as a system, such as organisational boundaries, some providers' reluctance to work outside their usual responsibilities and individual contracts, which were restrictive. However, the system had been successful in bringing about system wide initiatives that challenged this traditional way of working, including the Discharge to Assess (D2A) service.

What does WELL-LED look like in this locality?

The ambulance service was being commissioned by three CCGs to cover the West Midlands region. The service was finding it difficult to operate consistently across the wider urgent and emergency care system as each CCG operated differently, with different objectives. There were also geographical restrictions. The ambulance service told us that it had, on numerous occasions, advised the CCGs that a single vision and approach would benefit the whole system, including providing some efficiencies in hospital avoidance. We saw no evidence that the CCGs had taken this forward.

We found that financial considerations were also somewhat of a barrier to a shared vision for urgent and emergency care as a number of providers felt that the CCGs had more authority than the rest of the SRG (for example the local authority and Healthwatch) to influence change as the CCG held the budget for health services. Some GP practices felt that the system did not provide enough money to primary care. The SRG also told us they wanted the system to move to working 24/7 but were concerned that this was unaffordable.

Does the leadership have the skills, knowledge and experience to deliver effective care and treatment?

The SRG and provider-level staff we met with appeared to be open and approachable. However, some providers did not always want the SRG to know if they were struggling as this could adversely affect their contracts so they dealt with issues on their own, rather than always reporting them.

Do system wide governance arrangements ensure that responsibilities are clear and that quality, performance and risks are identified, understood and managed within the urgent and emergency care system?

We saw some examples of governance arrangements across the urgent and emergency care system, including some shared protocols between providers for specific conditions and scenarios relevant to urgent and emergency care. The CCGs had a clinical governance and quality committee, which monitored these processes. In addition, the SRG's clinical review group worked well with the acute trust.

Individual performance was reported to the SRG through dashboards and issues regarding performance were discussed with providers. We heard that some providers felt that the focus was on waiting times and there was little discussion on patient experience.

One barrier to effective governance across the system was the use of different information management systems across the system. The SRG was aware that guidelines had been issued by NHS England about facilitating the compatibility of systems but this had not yet been put in place.

What does WELL-LED look like in this locality?

Due to the reconfiguration of services, stroke, heart and trauma patients were automatically conveyed to University Hospital Coventry, by-passing Warwick Hospital, and therefore increasing the job cycle time and depleting resources intended for the county. Resources were reviewed on a daily basis with the local team through a conference call to identify the position for the day and actions required for the days ahead to ensure that downtime was kept to a minimum.

The ambulance service and the trust held quarterly meetings, up until late 2015, to discuss performance, but these had stopped. The ambulance service also engaged with the Warwickshire Health Overview and Scrutiny Committee, who had created a task and finish group for quality reports and met quarterly. The first meeting took place on 17 December 2015.

Local managers of individual providers regularly reviewed the quality of urgent and emergency care services and this information was discussed in senior management team meetings. As the data was usually two to three months behind, any required actions were delayed. The acute trust's roll-out of the electronic version of the patient record would improve this position but there were delays with receiving data from other hospitals that were beyond the acute trust's control.

How are the public and staff engaged and involved?

Patient engagement was discussed at SRG level through the public and patient participation group. Individual GP practices also had patient reference groups that were also used as a voice of feedback. However, it was noted that they were not always representative of the whole community. Some of the individual providers, including the acute trust and GP practices, provided newsletters for their patients with up-to-date information. Individual providers had their own satisfaction surveys to ensure that public and staff were engaged and involved.

A number of providers felt that there was no effective public engagement across the system because although workshops were organised, there was little to no attendance.

How are urgent and emergency care services continuously improved and sustainability ensured?

The SRG had implemented, or was developing, a number of innovative initiatives and new models of care to improve flow through the system, including:

What does WELL-LED look like in this locality?

- a seven-day community specialist palliative care service, which was providing 24/7 nursing care in line with evidence-based guidance to prevent unnecessary hospital attendances
- developing a three-year project to link a GP practice with a nursing home, ensuring continuity of care and reduced admissions
- a specialist over-75s care coordinator, who would perform thorough assessments
- local voluntary group initiatives, such as Age UK's service to accompany people home after an emergency department visit or admission, and assess fall hazards in the home.

All the individual providers we engaged with were aiming for better services and driving improvements for people. However, they felt they were constrained by budgets and commissioning restrictions. For example, some providers felt that if they were seen not to be meeting targets, it could lead to losing their contract which could in turn have a knock-on effect on innovation. It was clear that funding was limited and providers felt discouraged from developing innovative services because the money was not available.

We were advised by the SRG that the acute trust had a low response to the NHS Friends and Family test. The commissioners and the acute trust were monitoring this to look at new and innovative ways of encouraging responses. Several initiatives had been introduced to increase feedback and continue improvement and learning, including GPs observing A&E, completing mystery shopper type exercises and attending different public engagement events. A further initiative was the use of 'Health Champions' – trained volunteers who could motivate and empower people and communities to improve their health and wellbeing using their ability to relate to people and often their own particular life experiences. The SRG recognised that further work was required to ensure effective communication and engagement with this group.

Next steps

We will evaluate this pilot assessment approach, carried out as part of our review, and make recommendations to CQC on how it should be implemented to enable CQC to assess and report on the quality of urgent and emergency care systems in the longer term.

We expect the SRG to consider this report and the recommendations, including how the establishment of A&E delivery boards can help deliver the recommendations.

As part of our evaluation, we will continue working with the two pilot areas to gather their feedback on how the process and recommendations can be best used to drive improvement within the urgent and emergency care system.

Learning from the review will also feed into the development of CQC's strategy for 2016 to 2021, which focuses on a wider approach to regulating new models of care for populations across local areas.

Acknowledgements

We would like to acknowledge the contributions of the various stakeholders who have worked in co-production with CQC to develop the approach. Their involvement and support has been greatly appreciated at every stage.

We would also like to thank the System Resilience Group, and its members, for their support and involvement in the review.

Appendix A: Scope of the review

Why are we doing this review?

Our 2016 to 2021 strategy document *Shaping the Future*, sets out our plans on taking forward further work on Integration, Place and Pathways – this is about considering how we look at the quality of urgent care beyond individual providers.

Our more recent document, *Building on Strong Foundations*, sets out a possible future scenario in how we can take this forward, '*Looking at the quality of care for populations and places*'. This would mean we could continue to develop approaches to assess quality beyond the performance of specific providers, for example, following people's individual experiences of care across different services, and assessing the quality of care that people receive in a particular place.

We are considering how we look at the quality of urgent care beyond individual providers as part of this work.

There is already considerable evidence about quality and safety in urgent and emergency care systems and what needs to change. As a result, there is a national drive, led by NHS England, to reform urgent and emergency care (see the NHS England publications: the Urgent and Emergency Care Review, the Five Year Forward View) and implementation has already begun through the Vanguard approach. These changes are due to be embedded by 2017.

We need to ensure that our inspection approach reflects these changing policies and structures taking place as well as aligning to our overall approach to integrated care.

Appendix B: Detailed methodology

Engagement work carried out

In developing the assessment approach, we have worked with various stakeholders to ensure that it reflects the changes in urgent and emergency care policies and structures.

We have worked with an internal and external reference group, which has included CQC inspectors and a range of stakeholders including NHS England and the Royal College of Emergency Medicine.

We have also worked in co-production with local stakeholders in the pilot areas to gather learning on how the approach should work in practice.

Overview of methods

We piloted a range of methods that enabled us to look at integrated urgent and emergency care within a system.

We developed data profiles for each pilot area based on existing available data, including information from our own inspections of urgent and emergency care services in the areas.

We used an assessment framework to interview key people that made up part of the SRG and providers, to understand how the system functions and their role within it.

One of the methods used to understand people's experiences of urgent and emergency care services was case tracking patients that fall into one of two groups: over 65s who have experienced a fall, and under-fives with a fever, testing integration and communication throughout the system.

To understand how we can most effectively gather and understand people's experiences we also tested different approaches in the two pilot areas:

South Warwickshire

- online webform to gather individual experiences of care
- inspection team-led focus groups to gather experiences of urgent and emergency care services from people who are seldom heard or /vulnerable because of their circumstances.

Appendix B: Detailed methodology

Airedale, Wharfedale & Craven and Bradford:

- written request for existing evidence about people's experience of urgent and emergency care services held by local organisations
- inspection team interviews with:
 - statutory organisations that represent people who use services
 - voluntary and community groups that represent the two pathways
 - voluntary and community groups that represent people who are vulnerable because of their circumstances

Appendix C: SRG and provider information request forms

SRG information request

SRG name:	<insert SRG name>
Lead contact name:	
Lead contact tel. no:	
Information required: (where possible for urgent & emergency care only)	Please provide summary below - or attach relevant document/s: (please state if relevant to urgent & emergency care only)
A copy of your urgent and emergency care strategy	
A summary of multi-agency serious incidents / adverse events received within the last 12 months, action taken and learning shared	
A copy of your workforce strategy	
Arrangements/ protocols in place showing joint working including for major incidents	<i>Please summarise or attach protocol</i>
A summary of how you have monitored the quality of urgent and emergency care/treatment and services within the last 12 months / how is performance assessed	

Appendix C: SRG and provider information request forms

<p>A summary of action plans following findings from public engagement and progress</p>	
<p>A summary of how you address urgent care mental health needs</p> <p>(local arrangements / protocols for responding to patients detained by the police under s136 of the MHA)</p>	
<p>A summary of multi-agency complaints received within the last 12 months, themes, action taken and learning shared</p>	
<p>A self-assessment of how you work within your local urgent and emergency care system under the five key questions; safe, effective, caring, responsive and well-led.</p>	<p><i>Please consider;</i></p> <ul style="list-style-type: none"> <i>-strengths & weaknesses</i> <i>-good/outstanding areas</i> <i>-actions taken to address weaker areas</i> <i>-innovation/awards</i>

PROVIDER information request

Location:	<insert location name>
Lead contact name:	
Lead contact tel. no:	
Information required: (where possible for urgent & emergency care only)	Please provide summary below - or attach relevant document/s: (please state if relevant to urgent & emergency care only)
A summary of multi-agency serious incidents/adverse events received within the last 12 months; action taken and learning shared	
Staffing levels within the last 12 months, including; -WTE -vacancies -sickness rates -turnover	
Arrangements/ protocols in place showing joint working including for major incidents	<i>Please summarise or attach protocol</i>
A summary of how you have monitored the quality of urgent and emergency care/treatment and services within the last 12 months / how is performance assessed	
A summary of how you address people's needs in the following areas; -vulnerable people -seldom heard people -hard to reach groups -mental health	
A summary of multi-agency complaints received within the last 12 months; themes, action taken and learning shared	
A self-assessment of how you work within your local urgent and emergency care system under the five key questions; safe, effective, caring, responsive and well-led.	<i>Please consider; -strengths & weaknesses -good/outstanding areas -actions taken to address weaker areas -innovation/awards</i>

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