THE QUALITY OF URGENT AND EMERGENCY CARE IN

Airedale, Wharfedale, Craven & Bradford


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 – in 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.

Background to the review

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, which 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 (UECN), 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, 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 and 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 experiences of care. We describe the quality of urgent and emergency care for these specific conditions, and more generally, in our findings.
This report records the findings of the review of the quality of urgent and emergency care (UEC) in Airedale, Wharfedale, Craven and Bradford. It focuses on the experiences and outcomes for people within the geographical boundaries of the Bradford and Airedale 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 care across a local area, as part of our future methodology.

We provide 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 Bradford & Airedale 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 Bradford & Airedale Urgent & Emergency Care SRG locality profile. This section presents analyses that were part of the locality profile produced in March 2016 for use by CQC’s fieldwork team; only certain data used has been refreshed.

BRADFORD & AIREDALE SYSTEM RESILIENCE GROUP

The Bradford & Airedale SRG is part of the West Yorkshire Urgent and Emergency Care Network.

Bradford and Airedale SRG consists (as at 29 February 2016) of a range of organisations, including:

1. Source: The CQC data warehouse.

- 3 clinical commissioning groups (CCG): Bradford City CCG, Bradford Districts CCG and Airedale, Wharfedale and Craven CCG
- 2 local authorities: Bradford Metropolitan District Council and North Yorkshire County Council
- Bradford Health and Wellbeing Board
- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Bradford District Care NHS Foundation Trust (includes community and mental health services)
- Yorkshire Ambulance Service NHS Trust
- 99 GP practice locations cover the Bradford & Airedale SRG
- Local Care Direct (GP out-of-hours service)
- 248 adult social care locations are within the Bradford & Airedale SRG area (all residential and community-based services).
Background of the locality and System Resilience Group

Figure 1. GP practice and acute hospital locations, incl. CQC ratings up to 29/02/2016

West Yorkshire Urgent & Emergency Care Network (which includes Bradford & Airedale SRG) is one of eight Urgent and Emergency Care vanguards nationally. The SRG will work in conjunction with the vanguard to build on progress already made in transforming primary, community and acute care services in the local area.

CURRENT CQC INSPECTION RATINGS FOR PROVIDERS WITHIN THE SRG

We have included CQC ratings for the NHS trusts that we have inspected:

- Bradford Teaching Hospitals NHS Foundation Trust: requires improvement
- Yorkshire Ambulance Service NHS Trust: requires improvement
- Bradford District Care NHS Foundation Trust overall rating: good
Background of the locality and System Resilience Group

- Bradford Royal Infirmary’s ‘urgent and emergency services’ were rated requires improvement overall and for the safe and responsive key questions; the other key questions were not rated.

- Airedale NHS Foundation Trust: requires improvement (both overall and for emergency and urgent care)
  - Airedale General Hospital’s ‘urgent and emergency services’ were rated good overall and for all five key questions.

At the time of our visit for this review, most of the GP and adult social care locations within the SRG area were yet to be rated, but the majority of those rated so far have been rated good. See figure 2 for GP and social care ratings (based on data available in February 2016).

Figure 2: GP practice locations and adult social care service ratings in Bradford & Airedale SRG locality

<table>
<thead>
<tr>
<th>Not rated</th>
<th>Inadequate</th>
<th>Requires improvement</th>
<th>Good</th>
<th>Outstanding</th>
</tr>
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<td>56%</td>
<td>4%</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>locations</td>
<td>248</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| GP practice | 64% | 35% |
| locations   |     |     |
| 99           |     |     |

Note. These values were accurate as of March 2016.

BRADFORD & AIREDALE SRG POPULATION AND USE OF URGENT AND EMERGENCY CARE (UEC)

The sociodemographic composition of an SRG locality is relevant to the provision of UEC. Factors such as the age composition of the population, the number of people living with long-term conditions, deprivation, whether areas are rural or urban, and alcohol-related admissions within the Bradford & Airedale SRG are discussed below.
Background of the locality and System Resilience Group

Age

The age structure of a population has been linked to UEC use, particularly young children and older people, as they tend to use UEC services more than other age groups. For example, older people are more likely than younger people to be admitted to hospital if they attend A&E. More than 80% of emergency department attendances by older people are linked to long-term conditions. As well as older people, young children also tend to use UEC services more than other age groups. For young children, the trend is an increase in very short-term admissions for common infections, 28% over the last decade. There are many reasons for the rise, but it is recognised that achieving good communication and coordination between UEC services supports early diagnosis and treatment of acute illness, which can sometimes avoid a hospital admission.2

Bradford and Airedale SRG has a large proportion of young adults and children, with the proportion of the population aged under 10 at 14.3% compared with the England average of 11.9%. The proportion of the population over the age of 65 is lower than the England average. While these age structures are true for the SRG as a whole, it is recognised that there is a large variation within different CCG areas of the Bradford & Airedale SRG.

Figure 3: The GP registered age population structure in Bradford and Airedale, 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. Often these people lack support to self-manage their conditions, which can increase the risk of exacerbations, resulting in hospital admission. As the proportion of the population living with long-term conditions in the Bradford & Airedale SRG is mostly similar to that seen across England, it is expected that the SRG should have similar levels of avoidable admissions for these conditions as the rest of England. However, rates of avoidable admissions may be affected by factors such as the higher than average levels of diabetes in both Bradford City (9.2%) and Bradford Districts CCGs (7.6%) compared with the England average (6.2%).

Deprivation

NHS England describes how deprivation is linked to increased use of GP and A&E services, with more complex conditions often seen in more deprived areas. Public Health England describes a mixed picture, with deprivation scores (2015) for Bradford City in the most deprived 10% and Bradford Districts in the top 20% of most deprived CCGs nationally, whereas Airedale, Wharfedale and Craven CCG is in the 5th decile (top 50%) of deprived CCGs. Figure 4 shows the Index of Multiple Deprivation (IMD) score, with the most deprived areas in darker shades. The sub-urban areas on the outskirts of Airedale and Bradford show the least deprivation, whilst rural and particularly inner-city areas, including the urban areas of Bradford and Keighley, show the greatest rates of deprivation.

Rurality

Bradford & Airedale has two disparate regions: Bradford is a very densely populated urban region with only 6.9% of the population living in rural areas, whilst rurality in Craven is 60% compared with the England average of 17.6%.\(^6\) 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.\(^7\)

In rural areas such as Craven, this could add pressure on ambulance services to meet target response times due to the large geographic area covered and inaccessibility of some areas.

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

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abuse, such as injuries from alcohol-related violence, contribute to approximately 35% of A&E attendances nationally. In 2014/15, the three CCGs all show different rates, with Airedale, Wharfedale and Craven CCG being the only of the three not to be significantly worse than the England average (374 admissions, per 100,000).\(^8\)

In Bradford specifically, the population is ethnically and culturally diverse with a significant proportion of the population speaking English as a second language. Additionally, a significant proportion of the population had migrated to the Bradford and Airedale area from other countries. Some patients from other countries and cultures were unaware of how to access urgent and emergency care other than through accident and emergency services.

**CURRENT DEMAND FOR UEC SERVICES IN THE AREA**

Overall, Bradford and Airedale CCGs had similar numbers of A&E attendances to what would be expected based on the age and gender of the population.\(^9\)

- When comparing the year covering July 2013 to June 2014 and July 2014 to June 2015, all three CCGs showed an increased number of emergency attendances. Bradford City had the biggest increase in attendances (2.4%). All three CCGs had a greater increase in the number of attendances from 2013/14 to 2014/15 than the England average, which showed a 0.7% increase.

- Bradford City CCG had a significantly higher number of emergency admissions from July 2014 to June 2015 (12,116) and July 2013 to June 2014 (12,247) than would have been expected (8,996 and 8,880 respectively).

- Airedale, Wharfedale and Craven CCG was the only CCG with an increased in the number of emergency admissions from 2013/14 to 2014/15 (1.4% increase). Admissions in Bradford Districts CCG decreased by 1.7% and Bradford City CCG by 1.1%. Across England for the same period, the number of emergency admissions through type 1 A&E increased by 2.6%.

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9. Based on Hospital Episode Statistics.
What people in the locality say about services

We received good verbal feedback during fieldwork. We spoke with 19 patients by telephone and 37 patients in person. These patients had used the urgent and emergency care system at their GP surgery, the walk-in centre, the out-of-hours service, the ambulance service, the hospital A&E department or a combination of these services. This included people who lived in each of the three clinical commissioning groups (CCG) areas that make up the SRG and included a range of people from a diverse ethnic background. We contacted local voluntary and statutory organisations (see Appendix C) to ask them for any information they held about patient opinions of urgent and emergency care services with the area. We did not receive information from all of the organisations we contacted.

- All the people we spoke with were aware of NHS 111, GP services and their local A&E department. Very few people knew about the ‘Pharmacy First’ scheme that was running in the local area. (This scheme gives patients the option of visiting their local pharmacist for self-care advice for common health conditions such as coughs, colds or earache, with the aim of reducing pressure on primary care services.)
- People knew that if they needed immediate medical attention, they could call 999.
- The people we spoke with told us that there were occasions when it was very difficult to get appointments with GPs.
- Some patients told us that because of difficulty accessing appointments they no longer tried to get GP appointments, choosing to either call NHS 111 or attend the local A&E.
- Patients were on the whole very happy with the care or treatment they or their child had received. They said when they had needed to call an ambulance to attend the local A&E department it had arrived in a timely manner.
- When patients had used the NHS 111 service, they found that there were a lot of questions to answer, which often took some time. A number of patients expressed frustration that they had been offered a call back from a clinician within a specific time frame, but had waited longer than the time frame given. It was noted that the patient experience referred to a whole pathway and that the waiting time may include a number of clinicians.
- Patients praised the staff who cared for them when accessing the urgent and emergency care system. They said they were treated with dignity and respect by kind and caring staff.
Summary of findings

We saw evidence that the providers we visited delivered safe services and were monitoring events such as serious incidents and complaints to ensure that safety was a priority in the system. Organisations showed us their logs of complaints and serious incidents and actions taken as a result. Lessons were learned, but communicating these to staff in other organisations could be improved to demonstrate openness and willingness to share best practice. We were told it was the role of the West Yorkshire Quality Surveillance Group to ensure that this information was disseminated. Services worked within national guidelines and this was audited locally within organisations to ensure compliance. Staff were appropriately qualified and experienced.

We saw evidence that the providers we visited worked together to provide joined-up care for people, but there were challenges and barriers to this working as effectively as it could, including sharing patient information, which could be improved. All providers in the area were under pressure, for a number of reasons as set out in this report, including:

- Yorkshire Ambulance Service failed to meet the Red 1 and Red 2 (75%, eight minute targets) for the two 12-month periods between June 2013 and June 2015.10
- Patient survey results to the specific questions around access to GP appointments in Bradford City and Bradford Districts clinical commissioning groups (CCG) were worse than the England average. Patients in Airedale, Wharfedale and Craven reported similar levels of access to GP appointments as the England average.11

There were problems in the locality with demand versus capacity. For example, staff at one walk-in centre told us that demand for the service vastly outweighed the appointments available during the evening. However, organisations were proactively working to address these issues, with GP practices offering the maximum number of appointments available, including urgent same-day services to patients, and organising their clinics in different ways to make sure they were more accessible.

10. NHS England, Ambulance Quality Indicators. The Trust’s performance was 71.3% for Red 1 calls and 71.6% for Red 2 calls in the year period running up to fieldwork (March 2015 to February 2016).
Patients received treatment from caring and dedicated staff. Patients’ dignity was preserved and staff respected and involved patients in decisions about their treatment. If patients needed emotional support, this was available from a number of sources.

Organisations were able to provide examples of how they provided support to people, including taking account of the needs of people in vulnerable circumstances such as older and disabled people. The GPs we visited told us of similar schemes they had to support patients who attended A&E frequently, and often inappropriately, or who had frequent unnecessary GP appointments. In addition, the mental health trust, MIND and the local authority had worked together to introduce a single point of access for patients who were suffering from an acute mental health episode.

All of the health professionals and organisations we spoke with acknowledged a need to raise awareness within the general population of the variety of services available and to educate people about the alternatives to A&E, NHS 111 for example. However, we saw no evidence that the SRG had developed a plan to address this. The SRG had an urgent and emergency care strategy for the locality and was part of a vanguard programme, which was delivering the objectives of the strategy. All board members of the System Resilience Groups (SRG) were engaged with the strategy and were keen to provide joined-up care and treatment in a coordinated way across the locality. Numerous pilots and initiatives were taking place in the locality to improve the quality of care and promote good outcomes for people. As many of these were still in the pilot stage, they had not yet been fully evaluated or rolled out widely across the SRG.

Despite having a strategy, we saw little or no evidence of a joined-up plan of initiatives across the locality to address the challenges and issues identified. However, the SRG told us that the plans are picked up through New Models of Care in Airedale, Wharfedale and Craven and by the Urgent Care Board in Bradford. Also, some staff felt that there was a disconnect between front line staff and the SRG (including the CCGs). They felt the SRG needed to be more engaged with the front line.
Recommendations

Leadership and governance

- System resilience group (SRG) members should take responsibility for ensuring that frontline staff have a good understanding of its role as part of a strategy to increase involvement of and consultation with staff. This will assist in the healthy flow of information throughout the system including escalation of risk and concerns, and will help to implement SRG-led strategies and ways of working.

- The SRG should ensure that it is actively working in conjunction with the Bradford Digital 2020 Board (through the Integration and Change Board) to develop an information governance framework. This will facilitate communication between providers to resolve current issues about sharing and accessing patient-specific information through the shared patient electronic record. Providers should adhere to the framework to improve communication about individual patients.

- Providers should ensure that individuals who report serious incidents or concerns receive feedback on the action taken. The SRG should take a lead in encouraging providers to do this.

- The SRG should lead a more coordinated way of recording the various initiatives being piloted within individual organisations. This will manage demand and workload, and enable results and learning to be shared across the system to encourage system-wide initiatives. Evaluation activity should include monitoring the impact of these initiatives on the locality as a whole.

Workforce and capacity

- The SRG should implement an effective system to monitor current capacity, for example across the system, facilitating effective communication across providers. This information should be used to actively review local capacity issues in real time to support effective planning and delivery across the Airedale, Wharfedale, Craven and Bradford locality.

- Once a system is in place to monitor capacity, the SRG should develop and implement a strategy to ensure that capacity across the urgent and emergency care system is used efficiently, making the best use of resources.
Recommendations

Quality of care

- The SRG should encourage primary and secondary care providers to develop shared policies for common health conditions to support consistent clinical judgements. This will help to manage patients consistently and in line with best practice across the whole urgent and emergency care system.

Access

- Commissioners and care providers should ensure that the local Directory of Services is complete, accurate and continuously updated to ensure that people can be safely referred to the most appropriate service to meet their urgent and emergency care need.

- The SRG should support a coordinated approach to improving the general public’s knowledge, awareness and confidence in the urgent and emergency care services available and the types of health conditions that each can treat.

- The SRG should actively work with schools to raise awareness of the appropriate urgent and emergency care services to use when children are unwell so that they can pass this information on to parents and enable children to get the right advice, in the right place, first time.

Partnership working

- Commissioners should continue to support collaborative working between existing providers and partners to deliver services.
SUMMARY

The individual organisations that we visited within the System Resilience Group (SRG) had systems to monitor the safety of the services they provided. Each had responsibility for reporting any concerns to the SRG. Where incidents or safety concerns involved a number of organisations, there was a process to ensure that investigations took place and that all relevant parties were involved throughout the process, including receiving feedback. We found there was good communication at relevant clinical commissioning group (CCG) committees, but front line staff felt disengaged from these discussions.

There were pressures in the system, such as the demand for primary health care services exceeding capacity. These affected the system as a whole and had the potential to affect the safety of patients. However, CCGs and the SRG were aware of these pressures and were looking at different ways to address them, such as through the use of NHS 111 and a variety of pilot initiatives.

DETAILED FINDINGS

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

Due to the variety of systems that different organisations used for monitoring safety across the SRG, getting a picture of the overarching track record on safety was not straightforward. However, each organisation we visited was able to offer assurance about its safety record and we saw evidence that provision of safe care was important to all organisations. For example, each organisation had processes to ensure that staff had the appropriate qualifications and experience for their role. All employees had undergone Disclosure and Barring (DBS) (formerly known as CRB) or enhanced DBS checks and there were induction processes in place. Checks were in place to ensure that staff were competent to fulfil their roles; there were also systems in place to supervise staff and ensure that they received an annual appraisal. Staff were able to access training relevant to their roles and responsibilities. Where staff required a professional registration, checks had been carried out to ensure that their registration was current.
We identified some concerns in primary care about urgent care capacity. This was not only at GP practices, but also at the appointment-based walk-in centre where demand for available appointments has not been met. Senior managerial staff from the CCGs and SRG told us that a shortage of GPs was a particular issue within the Airedale, Wharfedale, Craven and Bradford locality, though patients could also see practice nurses and advanced nurse practitioners for some urgent care needs. Other sources of urgent and emergency care in primary care included the NHS 111 service and Pharmacy First.

How is safety monitored?

The organisations we visited within the SRG had systems in place for reporting, recording and investigating incidents. Incidents were analysed to look for trends and learning points and action was taken when these were identified. Incidents were discussed at various governance, safety and risk meetings held both by individual providers and CCGs. The CCGs also escalated any issues to the SRG through regular engagement meetings. The SRG was in the process of developing a dashboard for use across the West Yorkshire urgent and emergency care system.

Some staff told us that they encountered the same issues repeatedly and felt that, although information was escalated within the CCG, they were unsure about any action taken beyond this. Some staff felt that the integrated working meetings were more focused on giving staff operational information than discussing learning from incidents, concerns and complaints or about receiving and acting on feedback. Operational staff told us that they received feedback about incidents they were directly involved in, but rarely received feedback about incidents across the wider locality. This did not help wider system learning.

The CCGs had introduced a facility on their intranet for staff to report a concern or highlight an issue about a service. None of the GP practice-based staff we spoke with had used the system and not all were aware of it.

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?

The different organisations that we visited within the SRG (the acute trust, ambulance service, general practitioners and primary care out-of-hours providers) all told us that there was a system for sharing information about incidents that involved multiple organisations. Safety and incidents were discussed at a number of levels – within each organisation, at a clinical commissioning group level and by SRG. Where a number of different organisations were involved, a lead was identified to carry out investigations,
What does SAFE look like in this locality?

root cause analysis and feed back to others involved. We saw some meeting minutes as evidence of this.

Internal Quality Groups undertook overarching monitoring of serious incidents that occurred within providers in the SRG area. Clear information was presented on lessons learned and how the learning would be shared with others, which included dissemination through the provider’s internal governance and meeting structures. However, staff told us where they reported serious incidents or concerns they were not given feedback on actions taken.

The clinicians we met with across a number of organisations told us about new initiatives they had introduced to manage demands on their services, or as a response to incidents or complaints. However, these were specific to providers rather than across the locality.

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

Staff and managers told us that recruiting and deploying appropriately trained staff was a key challenge to delivering safe care and treatment and overall quality of care within the urgent and emergency care system. Staff mentioned that capacity within general practice, the out-of-hours service and A&E departments were key challenges. Capacity issues in one part of the system affected patient flow in other parts. For example, we were told that the process of discharging patients from inpatient beds was not always completed early enough to free beds for patients awaiting admission from A&E. We were told that the resulting delays in patient flow affected service provision for the rest of the day.

Some practitioners told us that the urgent and emergency care system could be risk averse, increasing demand on services. There was a perception that patients who contacted one service were sometimes then directed to another service for investigation or treatment when this was not always clinically necessary.

Staff told us that patients sometimes used the urgent care system to obtain a second opinion on issues that did not necessarily require urgent care. For example, if GPs felt that antibiotics were not clinically appropriate, patients sometimes attended A&E to request them, even if their clinical condition was unchanged. We spoke with one patient attending A&E who told us that this was the reason for their attendance.

The telemedicine scheme operated by Airedale NHS Foundation Trust supported care for people living in care and nursing homes. Staff at the scheme told us a third of care and nursing homes in the SRG area are signed up to the scheme, which provides residents with video consultation if they become unwell
What does SAFE look like in this locality?

or are involved in an accident such as a fall. We were told that this had been successful in significantly reducing A&E attendances and reducing strain on the urgent and emergency care system. The trust told us that the percentage of A&E attendances from people in care or nursing homes involved in the scheme had dropped by 69% and admissions dropped from around 45% to 12% since the introduction of the telemedicine scheme. Local CCGs had recently entered into a contract to ensure that all care and nursing homes within the SRG area would be covered by the scheme in the near future. The trust had received positive feedback about the effectiveness of this scheme from a number of agencies, such as the local authority and care homes. The Yorkshire and Humber telehealth hub partnership had become a top rated European reference site in England for good practice and innovation in the field of telehealth. We have since been told that up to June 2016, the coverage of the scheme has increased to 94% in Airedale, Wharfedale and Craven and 99% in Bradford.
What does EFFECTIVE look like in this locality?

**SUMMARY**

On the whole, patients received evidence-based care that was appropriate to their health care needs. There were systems to ensure that patients received treatment from suitably qualified and experienced staff. The organisations we visited had processes to ensure that staff had the skills and knowledge to meet the needs of patients. The effectiveness of patient care was monitored by all of the member organisations of the System Resilience Group (SRG) through Patient Related Outcome Measures (PROMS), and clinical audit.

Demand on services was affected by patient choice, which was driven by people’s perceptions about the availability of appointments and knowledge of the services available, including which service was the most appropriate for their healthcare needs.

On the whole, member organisations worked well together to ensure that patient care was effective. There were examples of multi-disciplinary and multi-agency working, such as between social care, voluntary organisations and mental health services. However, there were issues around the sharing of information and access to patient records. Although many organisations shared an electronic patient record system, access by all relevant health care organisations to all patient information was still proving to be problematic because of concerns about data protection and confidentiality. There was a reluctance to share the complete clinical record among all healthcare providers even when they all used the same electronic record system. Resolving this issue would help to ensure that patients receive the most appropriate care that meets their specific needs.

Additionally, there was a feeling among front line staff that organisations failed to recognise the impact on other organisations of referring patients inappropriately, or failing to access the Directory of Services (DOS) to find the most appropriate service.

**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?**

We found that each organisation used the relevant national or international evidence-based guidelines to deliver care and treatment. For example, the A&E
What does EFFECTIVE look like in this locality?

department worked within National Institute for Health and Care Excellence (NICE) guidelines and the ambulance service used nationally recognised triage tools to determine the correct care pathway for each patient. These tools were being constantly adapted to help improve the effectiveness of the care. For example, NHS pathways, used by the NHS 111 service to triage patients, were being continuously refined by service providers and by using information from the DOS. Staff reported that these systems had improved markedly over time since the service provider commenced the contract three years ago.

Although it was clear that patients were receiving evidence-based care, this was not always provided by the service best placed to meet their needs. For example, people with minor illnesses such as coughs and colds sometimes attended A&E when their needs could have been met by a pharmacy or NHS 111.

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

Each organisation produced performance dashboards in line with national guidance, such as waiting time targets, response times or targets. These were monitored by the CCGs, the SRG and by other organisations. Clinical audits and measures of compliance against policy or guideline standards also assessed the quality of care and patient outcomes. Some organisations used Patient Related Outcome Measures (PROMS) to monitor patient outcomes.

A number of providers, and the CCGs, used end-to-end reviews to assess and monitor people’s care and treatment outcomes. These involved tracking a patient’s experience through the urgent and emergency care system to determine whether appropriate decisions were taken and good outcomes achieved. These were often done in response to specific safety-related incidents, particularly at CCG level, but were also used by individual providers to audit staff actions, particularly in the investigation of outliers. For example, the 111 service monitored the decisions made by its call handlers. If a call handler had an unusually high percentage of requests for an ambulance, this would be classified as an outlier. An investigation would then be undertaken to check whether the call handler had asked the prescribed questions and followed the prescribed pathways.

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

Staff told us that some improvements were needed to the working relationships between providers within the urgent and emergency care system. They said key challenges included the need for a more robust exchange of information, and ensuring that consistent and good quality clinical decisions were made across
What does EFFECTIVE look like in this locality?

the system. For example, if all parties were able to access important patient-specific information such as previous medical history or current medications, it would help clinicians to make better decisions about patients. It would also help to have a consistent system-wide approach to managing specific health conditions, such as thresholds for prescribing antibiotics, based on best practice.

Staff reported that there was a good working relationship between the necessary care providers when people were discharged from hospital, for example, in providing intermediate care at local care and nursing homes or use of re-enablement community services to provide homecare to people as part of a programme of rehabilitation.

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

The majority of organisations in the SRG used the same system (SystmOne) to manage patient information. In theory, this meant that all health care professionals could access information at the same time about the health conditions and current treatments that patients were receiving. However, in reality organisations had not been able to agree consistent access rights to patients’ electronic records, due to concerns about patient confidentiality. The result was that not all health care professionals could access information about patients that could help them to make decisions about treatment and care needs. Additionally, some other providers within the area did not have access to SystmOne. This was a potential challenge to the delivery of effective care.

GPs told us that more clinical information in discharge letters from A&E and after acute admissions would be helpful in providing follow-up care.
What does CARING look like in this locality?

SUMMARY

We spoke with patients and relatives who had used a variety of different services, including GPs, the NHS 111 service, walk-in centres, the ambulance service and A&E. The vast majority were complimentary about the care and treatment they received.

Patients received treatment that respected their dignity from compassionate and caring staff. They were involved in discussion about their care needs, able to ask questions and were given emotional support when this was appropriate.

DETAILED FINDINGS

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

People consistently told us that they were treated with kindness and compassion by staff when using the urgent and emergency care system. People were particularly pleased with the compassion shown by staff at the ambulance service. Some people reported feeling that urgent care problems were not always taken seriously when they rang the GP to make an appointment.

From the discussions we had with staff of all disciplines and in all roles, it was clear that they were caring and compassionate. Staff worked hard within sometimes difficult situations to deal with patients’ requests and needs to the very best of their capacity and capability.

We spoke with patients and their relatives, both in hospital and by telephone, about their experience of A&E and the ambulance service. They told us that staff were kind, patient, caring and compassionate.

In the NHS Friends and Family Test in 2014/15, Airedale NHS Foundation Trust A&E department had a similar satisfaction score (89.1% recommended the service) to other A&E departments (87.5% England average) and showed
similar performance from 2014 to 2015. Conversely, Bradford Teaching Hospitals NHS Foundation Trust showed significantly worse satisfaction levels (69.9%) and showed significantly lower satisfaction with the amount of information that was given to them during treatment.

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

Patients we spoke with told us that they felt involved in decisions about their care and treatment. Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for. We saw that patients were advised about what to do if symptoms recurred or got worse.

People told us that staff respected their choices and views. For example, one patient told us that ambulance staff had respected his decision not to attend hospital after a fall.

Individually, each organisation we visited had processes to engage with people who used their services and received feedback from patients.

Do people who use services and those close to them receive the support they need to cope emotionally with their care, treatment or condition?

From discussions we had with staff at a number of organisations in the System Resilience Group (SRG), including the local authority, the ambulance service and GP practices, we were told about a number of initiatives in place to support people’s emotional needs. The ambulance service had a team who worked with patients who frequently called the service (daily, often multiple times), often inappropriately. The team worked with the patient, other health providers and sometimes voluntary organisations to develop an action plan and appropriate support for the patient.

Action plans to support people during difficult times, when they believed they needed to see a GP urgently, were put in place by a multidisciplinary team that included specialist nurses, primary care practitioners and hospital staff.

For people who had mental health support needs, the local authority and MIND, a mental health charity, had developed a place called The Sanctuary. People in the locality who needed support with their mental health needs could access the service fairly easily as an alternative to attending the local A&E department.

12. NHS England, FFT (A&E FFT test; August 2014 – July 2015). Airedale NHSFT performance was 93.2% in the year period running up to fieldwork (March 2015 to February 2016). Bradford Teaching Hospitals NHSFT performance was 71.0% in the year period running up to fieldwork (March 2015 to February 2016).

What does CARING look like in this locality?

There was also support for patients with mental health needs who attended the A&E department through on-site, on-call psychiatric services.

The two Bradford clinical commissioning groups had funded a project to provide a tele-coaching service to support patients to manage their chronic conditions through Local Care Direct (GP out-of-hours provider), who provided staff for the walk-in centres, and Turning Point, a voluntary organisation. The aim of the project was to support patients with their long-term conditions, thereby reducing their need to access primary care (or possibly secondary care) services. Patients were supported with practical advice to improve their physical and mental health. However, the initiative ended in 2014 and we did not see any evidence of any evaluation activities to understand how well the project had worked.
What does RESPONSIVE look like in this locality?

Summary

We found evidence that the urgent and emergency care system was responsive to the individual needs of specific patients, such as people with a mental health need or a physical or learning disability. There were support services such as interpreters for patients who needed additional support to access healthcare. However, we also found evidence that primary care services were finding it difficult to meet the needs of the local population as a whole due to the demand being placed on services such as GPs, walk-in centres and the NHS 111 service. There was also additional pressure on secondary care and the ambulance service as a consequence, as patients chose to bypass primary care and go directly to secondary care services.

The System Resilience Group (SRG) recognised the demand and capacity problems and was willing to find alternatives within the budgetary constraints to address these issues. The relationships between SRG members were maturing and organisations were no longer competing to provide services, preferring to work in collaboration; this was viewed as a positive step.

DETAILED FINDINGS

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

In general, patients’ feedback about their experiences of getting in-hours appointments with GPs in Bradford City and Bradford Districts clinical commissioning groups (CCG) was worse than the England average. For example, in the 2015 GP Patient survey, 58.6% of respondents in Bradford City CCG, and 67.7% of respondents in Bradford Districts CCG, were able to get an appointment, compared with the England average of 76%. In Airedale, Wharfedale and Craven CCG, 74.8% of patients said they were able to get an appointment to see or speak to someone, similar to the England average.¹⁴ A significant proportion of the patients we spoke to told us that it was not always easy to get an appointment at short notice, an urgent face-to-face GP appointment.

What does RESPONSIVE look like in this locality?

appointment, or to speak with a GP. Patients felt frustrated and their perception was that there were never enough GP appointments.

One surgery we visited told us it struggled to cope with the demand from patients who wanted same-day appointments. The rate of A&E attendances, by the practice’s population, was also higher than the CCG average.

Another surgery we visited operated a walk-in appointment system each morning with pre-bookable appointments limited to the afternoon. Data showed that the success of getting an appointment at this practice was better than the CCG and national average and showed that the rate of A&E attendances from this practice was 10% better than the CCG average.

Staff and patients told us that there were some capacity issues with services. For example, we were told that the GP out-of-hours services at the walk-in centre had insufficient appointments for the demand on the service.

The SRG was aware of the problems patients faced in accessing GPs. They were additionally aware of the impact this was having on other services such as NHS 111, walk-in centres, out-of-hours services and the local A&E departments. Additionally, the SRG acknowledged that there were significant problems in recruiting GPs to work in Bradford and the surrounding areas. The SRG had commissioned some research into the reasons for the high demand for GP services. This showed that patients preferred to see a GP rather than use pharmacy services unless they wanted to collect prescriptions or buy over-the-counter remedies. Patients also had a high desire for quick reassurance and resolution, which made them to want to access a GP quickly.

Yorkshire and Humber NHS 111 had shown a consistent decline in performance between October 2013 and September 2015. This decline was shown by an increase in the percentage of calls that were abandoned by the caller after 30 seconds of waiting for an advisor, from 1% of calls offered from October 2013 to September 2014 to 1.9% of calls offered from October 2014 to September 2015. In addition, the percentage of calls answered within 60 seconds fell from 95.6% of answered calls in October 2013 to September 2014 to 92% of answered calls in October 2014 to September 2015. Additionally, there was a reduction in the number of people who were recommended to attend primary or community care services, such as the locality’s falls team, which could support patients without the need for unnecessary admission to

15. NHS 111 Minimum Data Set. The service’s abandonment performance was 2.1% in the year period running up to fieldwork (March 2015 to February 2016). The service’s 60 second answer performance was 88.4% in the year period running up to fieldwork (March 2015 to February 2016).
What does RESPONSIVE look like in this locality?

hospital. However, the drop in performance was in the context of increased demand above the contracted activity levels.

Only Airedale NHS Foundation Trust achieved the 95% target for people discharged or admitted from A&E within four-hours between October 2014 and September 2015. When asked about their experience at A&E between January and March 2014, the time patients spent in A&E at Bradford Teaching Hospitals NHS Foundation Trust was similar to the England average and better than average for those attending Airedale NHS Foundation Trust.

The CCGs had led some work to help people understand which services were the most appropriate to use to meet their needs. The Pharmacy First scheme gave advice and treatment about long-term conditions, self-care and healthy lifestyles without the need to see a GP. The objective was to reduce the number of patients using services inappropriately, thereby reducing pressure on the system.

From the discussions we had with many staff at all levels, we found there was a lack of a coordinated approach to help patients understand the various urgent and emergency care services available within the region.

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

We asked the organisations we visited to tell us how they took account of the needs of people who used services, including those in vulnerable circumstances, such as older people, those who are disabled and young people. Each organisation was able to show us examples of how they supported people. For example, the acute trust and GPs had ready access to interpreters. This meant that people whose first language was not English were able to understand treatment advice. Organisations had a suite of policies and standard operating procedures to ensure that patients with mental health needs, or physical or learning disabilities received the correct support. Staff received training to ensure they could support patients in the correct way.

There were support services such as community-based specialist nurses to support people identified as having a long-term condition, or who were vulnerable due to physical or mental health conditions. The role of these staff was to help patients to reduce their need for unplanned care. For example, the

16. NHS 111 Minimum Data Set. The service’s abandonment performance was 2.1% in the year period running up to fieldwork (March 2015 to February 2016).

17. NHS England, A&E waiting times. Airedale NHSFT performance was 95.6% in the year period running up to fieldwork (March 2015 to February 2016). Bradford Teaching Hospitals NHSFT performance was 94.0% in the year period running up to fieldwork (March 2015 to February 2016).

mental health trust, MIND and the local authority had worked together to introduce ‘First Response’, a single point of access for patients who were suffering from an acute mental health episode. Health professionals could refer patients to the service, which was open daily between 6pm and 1am. First Response offered an alternative to attending an A&E department to people with mental health problems.

The GPs we visited told us of similar schemes they had to support patients who attended A&E frequently, again, often inappropriately, or who had frequent unnecessary GP appointments.

On the whole, services took patients’ needs into account, although some people told us that the system needed to offer more flexibility in certain circumstances. For example, some parents of young patients reported being offered out-of-hours GP appointments at times they considered inconvenient (including very late at night, or very early in the morning) as they had other children to consider and were unable to attend appointments without taking these children out of bed late at night.

The CCGs were conscious of the challenges of meeting the needs of their diverse and changing local population. In Bradford specifically, the population was ethnically and culturally diverse with a significant proportion of the population speaking English as a second language. Additionally, a significant proportion of the population had migrated to the Bradford and Airedale area from other countries. Some patients from other countries and cultures did not know how to access urgent and emergency care other than through accident and emergency services.

The population of Bradford also had a higher number of children and young people than the England average, which created a high demand for services for that age group.

The needs and expectations of people using the services had led to increased demand on services. People who needed the urgent and emergency care services were often unaware of the different levels of care and support available, which led to increased demand for GPs and at A&E. All the health professionals and organisations we spoke with acknowledged a need to raise awareness within the general population of the variety of services available and to educate people about the most appropriate services to access. Staff felt that more could be done to work with organisations such as schools and nurseries to improve the awareness of teachers and parents about what action to take if children were unwell, preventing the inappropriate use of services and ensuring that children received the right advice in the right place, first time.
Can people access urgent and emergency care and treatment in a timely way?

People in the Airedale, Wharfedale, Craven and Bradford area could access urgent and emergency care in a number of ways. Patients were assessed using a nationally-recognised tool and, depending on the urgency and severity of the illness of the patient, an ambulance would be dispatched to attend within a specified target time frame. Alternatively, patients could call for an urgent GP appointment within normal hours, call NHS 111 for medical advice or in an emergency call for an ambulance on the 999 number. In addition, patients could attend an urgent care centre for an urgent appointment, attend an out-of-hours GP appointment, or attend their local A&E department. For all three CCGs, the percentage of patients describing their experience of out-of-hours GP services as good or very good ranged from 63.3% to 69.6%, which is similar to the England average (68.6%). However, patients in Bradford City CCG were less satisfied with how quickly they received out-of-hours care, with only 55.3% reporting it was about right compared with 65.1% in England, generally, and 58.9% and 59.5% in Airedale, Wharfedale and Craven CCG and Bradford Districts CCG.19

A similar proportion of patients at both Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust reported waiting under 60 minutes to be examined by a doctor or nurse after first arriving at the A&E department when compared to the all-England responses.20 Between October 2014 and September 2015, 95.7% of A&E patients at Airedale NHS Foundation Trust and 94.6% at Bradford Teaching Hospitals NHS Foundation Trust were discharged or admitted from A&E within four hours against a national target of 95% (the England average was 91.8%).21 The median total time in A&E for all patients was 187 minutes at Airedale NHS Foundation Trust and 165 minutes at Bradford Teaching Hospitals NHS Foundation Trust. Both of these were above the England average of 124 minutes.22

Yorkshire Ambulance Service showed significant deterioration in its eight-minute target response time of 75%, achieving 70.8% Red 1 and 70.1% of Red 2 calls responded to within eight minutes in 2014/15. However, performance was similar to the England averages (72.8% Red 1 and 69.1% Red 2).23 The rurality of some of the locality areas created challenges for the ambulance

19. GP patient survey.
21. NHS England, A&E waiting times. Airedale NHSFT performance was 95.6% in the year period running up to fieldwork (March 2015 to February 2016). Bradford Teaching Hospitals NHSFT performance was 94.0% in the year period running up to fieldwork (March 2015 to February 2016).
23. NHS England, Ambulance Quality Indicators. The Trust's performance was 71.3%, Red 1 and 71.6%, Red 2 in the year period running up to fieldwork (March 2015 to February 2016).
service in meeting its target response times. This was mainly due to the
distances travelled and the type of roads on some rural routes. Adverse
weather conditions were also a contributory factor. The ambulance trust had
improved provision by using community first responders, who as volunteers
worked in partnership with the ambulance trust to provide vital lifesaving
treatment in the first few minutes of an emergency.

There was one walk-in centre within the SRG area, which was located
independently from the A&E departments. We were told that demand for this
service vastly outweighed appointments. Commissioners tried to balance the
supply of walk-in centre appointments to reduce pressure on A&E while also
trying to manage the number of people taking up walk-in centre appointments
unnecessarily, when they could attend their GP practice, albeit with a short wait
for an appointment.

All the GPs we spoke with told us that they offered the maximum number of
appointments available, including urgent same-day services to patients. They
also told us of the different ways they organised their clinics and different types
of appointments, such as, telephone appointments to manage demand and
prevent patients from using services unnecessarily such as A&E. One of the
practices we visited also operated a walk-in service in the morning. Despite this,
patients’ feedback about their experiences of getting in-hours appointments with
GPs in Bradford City and Bradford Districts CCGs was significantly worse than
the England average, with 58.6% and 67.7% respectively able to get an
appointment to see or speak to someone compared to the England average of
76.0%. Patients’ feedback in Airedale, Wharfedale and Craven CCG was similar
to England, with 74.8% reporting they were able to get an appointment to see or
speak to someone.

Patient experience

S is the mother of a child with a history of seizures.

She felt the ambulance service was very responsive when they needed it and
quickly took her son to the local A&E department to be checked over.

She described the wait in A&E to be very good and said in the past they have
had to wait four or five hours for medical staff to respond.

S felt it was not easy to get a same-day GP appointment, as they needed to ring
at 8am, often the lines were busy and they could either not get connected or
there were no appointments.

Instead, S would ring the NHS 111 service, which she found more responsive
and their advice to be good.
People spoke positively of their experience after discharge from hospital, for example, praising the responsiveness of staff in supplying equipment to help them live independently and the council’s homecare service, which provided support and enablement following hospital admissions through illness or incidents, such as, falls.

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

Each organisation we spoke with had systems and processes to deal with complaints from the public. Patients’ complaints and concerns were managed at a local level, by individual organisations. Staff told us that if they received a number of complaints about a service other than their own, they would feed these concerns back to the relevant organisation. When complaints about care or treatment spanned a number of organisations, one provider was identified to co-ordinate and lead on the complaint and provide a single access point for the complainant.

All the organisations we met with had public engagement strategies. Some had a patient forum, some asked patient representatives to attend board meetings and some used patient stories to illustrate patient experience of using services.

Some staff told us that frequently when people were passed between services, often after making initial contact through NHS 111, they were not clear where to direct their complaints and could direct them to the wrong provider, which staff would then have to sort out.

Most of the patients we spoke with told us that they hadn’t made any formal complaints about the services they received. However, they told us that if they needed to complain formally, they would not hesitate to do so. Most of the complaints patients told us about, were dealt with locally, for example, by reception staff or medical staff.
What does WELL-LED look like in this locality?

SUMMARY

The System Resilience Group (SRG) had an urgent and emergency care strategy for the locality. As a vanguard site, significant work was being undertaken to ensure that the provision of urgent and emergency care in the Airedale, Wharfedale, Craven and Bradford locality was effective, efficient and responsive to patient needs. We found that those in leadership roles had a wealth of experience and were from diverse professional backgrounds.

However, we did find that a number of areas appeared to lack coordination. Although the communications team and public health team coordinated engagement with the public, we were told that there was no overarching public engagement plan in place to specifically improve the population’s awareness and confidence in the variety of services available and which health conditions they could treat. During our visits, we heard about many local initiatives to manage pressures on services. However, we found that there was little or no coordination of these initiatives across the locality. We felt that this was a missed opportunity to share good practice and learning in terms of solutions to the same challenges providers were facing as well as a more effective use of resources.

Some staff felt that there was a disconnect between front line staff and the SRG (including the clinical commissioning groups (CCG)).

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’s vision was “a simple to navigate, sustainable and customer-focussed high quality urgent and emergency care system, providing 24/7 access that ensures patients are seen by the most appropriate health professional at the right time in the right setting.”

The aim of the SRG’s urgent and emergency care strategy (2015-19) for the locality was “a sustainable urgent and emergency care system that meets the needs of the people of AWC and Bradford, where all parts of the system
function cohesively, are integrated with the wider health and social care economy, make best use of, and are deliverable within, the resources available to deliver improved quality and patient experience."

Seven key objectives were identified as being important to help deliver the SRG’s vision, these were:

• to improve patient experience
• to make primary care the first port of call for urgent care needs
• to increase people’s confidence in taking responsibility for their own health
• to reduce the number of times people need hospital-based care
• to deliver high quality and responsive hospital-based emergency care through dedicated major emergency/emergency care centres and diagnostic facilities
• to reduce the need for hospital admission through alternative, community-based services
• to improve patient outcomes.

The SRG was a part of the West Yorkshire Urgent and Emergency Care Network vanguard programme, which was delivering the objectives of the strategy. All board members of the SRG were engaged with the strategy and were keen to provide joined-up care and treatment in a coordinated way across the locality. The relationships between SRG members had begun to mature as each organisation understood their position and role in the system. For example, organisations had started to collaborate on projects, rather than compete with each other when additional finance for projects became available.

Staff and managers in the urgent care system were able to give us examples of numerous pilots and initiatives taking place in the locality to improve the quality of care and promote good outcomes for people. As many of these were still in the pilot stage, these strategies had not yet been fully evaluated or rolled out widely across the SRG in order to assess their overall success. It did not appear that they were coordinated in any way by the SRG.

Managers said that access to services across the locality was inconsistent and that work was being undertaken to help streamline access to services across the area. This would help to ensure that people who live in different areas have access to the same services. Streamlining work between CCGs was also being undertaken to promote more joint working.

One GP practice we spoke with told us that it had reduced attendance at A&E by 10% by taking a targeted approach to patients who were frequent attendees at A&E. Staff had worked with these patients to create action plans to help them to manage their health conditions. Through care plans, patients understood the
What does WELL-LED look like in this locality?

Best action to take if they were feeling unwell or needed support. Staff understood the needs of the population and used a more holistic approach to people’s health and social needs. Other support services were involved such as community nurses, district nurses and specialist nurses, as well as other allied health professionals. At the time of our visit this again was a pilot and not widespread.

The challenge for the SRG and its member organisations was to evaluate the impact of individual pilot projects and ensure that where successful, these are supported and rolled out to all appropriate organisations.

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

Some organisations we spoke with told us that they had a voice in the SRG. However, front line staff told us that the SRG was separated from the daily operations of health care in the region and needed to be more engaged with what happened at the frontline. Operational staff were more concerned with their immediate working environment and the daily responsibilities that came with their jobs.

There was a perception from some primary care providers that secondary care and acute care was given more priority than primary care during discussions at the SRG. However, all those who attended SRG meetings that we spoke with thought that the SRG was an open forum where honest discussions were held in order to promote quality care for patients across both primary and secondary care.

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

The membership of the SRG included a number of individuals representing provider organisations in the region. These individuals came from a range of professional disciplines and had a vast joint experience of working in health and social care. This joint experience, along with mutual respect, openness and honesty, appeared to facilitate productive and meaningful discussions at SRG level that were taken back to provider organisations to develop into working practices.

At a local level, we found management were clear about the services they had responsibilities for, with a good understanding of the services and an appreciation of the key challenges that faced the system.
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?

Quality was measured in a number of different ways. Individual organisations robustly monitored serious incidents and other quality outcomes and shared results where appropriate with other SRG members. Each CCG held regular governance and safety meetings to discuss the quality of the services it commissioned. As a number of services were commissioned across a larger geographical area, such as ambulance services, a lead CCG was also responsible for contract monitoring of these services.

End-to-end reviews were a common audit tool used by services within the SRG area. This involved case tracking a patient’s experience of using services from the start of their patient journey to the end. This provided rich qualitative data to the organisations involved.

GPs told us they would like to be more engaged with the CCG’s decision making and that practices were working in silos and developing their own areas of good practice. This was a missed opportunity to share and develop positive ideas together.

Some specific services such as the telemedicine initiative had not yet been subject to robust evaluation, or clinical audit to ensure that the appropriate clinical decisions had been made for people who had used the service, because initiatives were in the early stages. The scheme was based on an earlier, small evaluation of the telemedicine scheme in 2012, which had shown a positive impact on reducing inappropriate admissions from care homes by 6% and unnecessary attendances at emergency departments by 14%. Although an overall evaluation of the current initiative had not yet taken place, data gathering and analysis was planned for the coming months to determine the overall impact of the telemedicine installations across Airedale, Wharfedale, Craven and Bradford on non-elective admissions, emergency department attendances and blue light transfers.

Some staff were frustrated that problems they identified with the urgent and emergency care system were not always effectively addressed, particularly where the identified problem concerned the coordination with other providers. For example, staff told us a persistent issue was inappropriate referrals to the limited walk-in centre appointments. NHS 111 and walk-in centre staff had repeatedly fed this back to their service managers to share with other services, but staff saw no significant change or decrease in inappropriate referrals.

Staff in some services said that other types of urgent and emergency care services lacked an understanding of what their service offered.
What does WELL-LED look like in this locality?

How are the public and staff engaged and involved?

The SRG’s strategy was written following engagement with Healthwatch, patients and the wider general public. The strategy stated that one of the critical factors to its success was engaging with the public and patients. The SRG did this in number of ways and had clear links with hard to reach groups and other interested parties such as carers and local voluntary organisations.

Individual organisations such as CCGs, acute health trusts, the ambulance trust and primary care providers all had patient engagement strategies to enable them to gather patient views about how services were configured, planned for the future and delivered. All the organisations we visited told us that it was important to listen to patients to ensure that the services being delivered best met patient needs. Organisations engaged with patients in a number of different ways. For example, some held patient and carer panels, youth panels and reader panels where patients reviewed patient information for readability. Other organisations issued patient questionnaires that used qualitative and quantitative questions, some in real time while the patient was still in the hospital. Others held focus groups and engaged with patients through managing concerns and complaints. It was unclear how the information collected from the different organisations was shared at SRG level.

There was a West Yorkshire Quality Surveillance Group and Bradford also had a People’s Board that discussed health issues in and around the Bradford area. The local Healthwatch organisations were active and regularly engaged with patients and providers.

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

The SRG members had a general understanding of the challenges faced by organisations and the SRG area as a whole. With this in mind, they were working to coordinate their approaches to the provision of urgent and emergency care within the Airedale, Wharfedale Craven and Bradford area. The vanguard scheme was one of the key drivers of this as it was looking at the efficiency and effectiveness of the entire system.

All were focused on the provision of the best quality of care for patients within the budgets available. Individual organisations had looked at innovative ways to try to ensure sustainability although many of these innovations were in their early stages or were only pilots. Only time will determine whether these innovative approaches have achieved their aims to provide sustainable, good quality care for patients.
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 system resilience group 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: Local voluntary and statutory organisations

4 Women @ The Bridge
Able All, Bradford People First
Age UK Bradford and District
Age UK North Craven
Bradford Action for Refugees
Bradford and District Disabled People’s Forum, Local council - engagement lead, Health and Wellbeing Board
Bradford and District Older People’s Alliance, Bradford and Airedale National Childbirth Trust (NCT)
Bradford City Centre Project, Bradford Cyrenians
Gypsy Liaison Service, AWARE
Keighley and Crave People First
Local Alzheimer’s (Bradford)
Local Alzheimer’s (includes Craven), Carers Resource
Local Healthwatch
MESMAC (Gay Men’s Project, working with gay men, bisexual men and men who have sex with men)
NHS Complaints advocacy
Overview and Scrutiny Committee
SOUND (for lesbian, gay, bisexual and transgender young people)
Wharfedale National Childbirth Trust (NCT)
Appendix D: SRG and provider information request forms

SRG information request

<table>
<thead>
<tr>
<th>SRG name:</th>
<th>&lt;insert SRG name&gt;</th>
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<tbody>
<tr>
<td>Lead contact name:</td>
<td></td>
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<tr>
<td>Lead contact tel. no:</td>
<td></td>
</tr>
<tr>
<td>Information required:</td>
<td>Please provide summary below - or attach relevant document/s:</td>
</tr>
<tr>
<td>(where possible for urgent &amp; emergency care only)</td>
<td>(please state if relevant to urgent &amp; emergency care only)</td>
</tr>
<tr>
<td>A copy of your urgent and emergency care strategy</td>
<td></td>
</tr>
<tr>
<td>A summary of multi-agency serious incidents / adverse events received within the last 12 months, action taken and learning shared</td>
<td></td>
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<tr>
<td>A copy of your workforce strategy</td>
<td></td>
</tr>
<tr>
<td>Arrangements/ protocols in place showing joint working including for major incidents</td>
<td>Please summarise or attach protocol</td>
</tr>
<tr>
<td>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</td>
<td></td>
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</tbody>
</table>
## Appendix D: SRG and provider information request forms

| A summary of action plans following findings from public engagement and progress |  |
| A summary of how you address urgent care mental health needs (local arrangements / protocols for responding to patients detained by the police under s136 of the MHA) |  |
| 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. | Please consider;  
- strengths & weaknesses  
- good/outstanding areas  
- actions taken to address weaker areas  
- innovation/awards |
## PROVIDER information request

<table>
<thead>
<tr>
<th>Location:</th>
<th>&lt;insert location name&gt;</th>
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<td>Lead contact tel. no:</td>
<td></td>
</tr>
<tr>
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<td>A summary of multi-agency serious incidents/adverse events received within the last 12 months; action taken and learning shared</td>
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<tr>
<td>Staffing levels within the last 12 months, including:</td>
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<td>- vacancies</td>
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<td>- sickness rates</td>
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<td>- turnover</td>
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<tr>
<td>Arrangements/ protocols in place showing joint working including for major incidents</td>
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<tr>
<td>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</td>
<td></td>
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<tr>
<td>A summary of how you address people’s needs in the following areas;</td>
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<tr>
<td>- vulnerable people</td>
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<td>- seldom heard people</td>
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<td>- hard to reach groups</td>
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<td>- mental health</td>
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