Lancashire County Council

Health Scrutiny Committee

Tuesday, 31st October, 2017 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Meeting Held on 19 September 2017**	(Pages 1 - 4)
4.	**Chair's Update**	
5.	**Winter pressures and preparations**	(Pages 5 - 50)
6.	**Report of the Health Scrutiny Steering Group**	(Pages 51 - 54)
7.	**Health Scrutiny Committee Work Plan 2017/18**	(Pages 55 - 64)
8.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	
9.	**Date of Next Meeting** The next meeting of the Health Scrutiny Committee is currently scheduled to be held on Tuesday 12 December 2017 at 10.30am at County Hall, Preston.	

Lancashire County Council

I Young
Director of Governance,
Finance and Public Services

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday, 19th September, 2017 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

County Councillor Peter Britcliffe (Chair)

County Councillors

J Purcell	M Iqbal
L Beavers	M Pattison
J Burrows	E Pope
Ms L Collinge	P Steen
G Dowding	S Turner
C Edwards	

Co-opted members

Councillor Wayne Blackburn, (Pendle Borough Council)
Councillor Glen Harrison, (Hyndburn Borough Council)
Councillor Tony Harrison, (Burnley Borough Council)
Councillor Colin Hartley, (Lancaster City Council)
Councillor Bridget Hilton, (Ribble Valley Borough Council)
Councillor Hasina Khan, (Chorley Borough Council)
Councillor Julie Robinson, (Wyre Borough Council)

The following speakers were welcomed to the Health Scrutiny Committee meeting:

From Healthier Lancashire and South Cumbria (STP Team):

- Dr Amanda Doyle OBE, GP and STP Lead;
- Neil Greaves, Communications and Engagement Manager
- Gary Raphael, Finance Director; and

From Morecambe Bay CCG:

- Andrew Bennett, Chief Officer

1. Apologies

Apologies were received from Councillors Roy Leeming and Matthew Tomlinson.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

County Councillor Lizzi Collinge disclosed a non-pecuniary interest for Item 4 as her post was funded by Lancashire Care Foundation Trust and her husband worked for NHS England.

3. Minutes of the Meeting held on 24 July 2017

Regarding Item 6 on the minutes – 'Lancashire and South Cumbria Sustainability and Transformation Partnership – Update on the work of the Local Workforce Action Board (LWAB)', Members enquired if a letter had been sent to the Secretary of State for Health and the Chairs of Health Education England and Health Education North West formally inviting appropriate representatives to attend a future meeting of the Committee to address the inequity of funding for medical under-graduate and post-graduate training in Lancashire and South Cumbria. The letter had not yet been sent as advice was being sought at an upcoming Health Scrutiny Steering Group meeting from Heather Tierney-Moore, Chief Executive of Lancashire Care Foundation Trust (LCFT).

Councillor Julie Robinson, Wyre Borough Council, informed the Committee her apologies had been omitted from the minutes of the Health Scrutiny Committee on 24th July 2017.

Resolved: That; subject to the above amendment, the minutes from the meeting held on 24 July 2017 be confirmed as an accurate record and signed by the Chair.

4. Next Steps on the NHS Five Year Forward View: Integrating Care Locally

A presentation was given on progress made since the Next Steps on the NHS Five Year Forward View was published on 31 March 2017 and the Sustainability Transformation Partnership (STP) for Lancashire and South Cumbria. A copy of the presentation is set out in the minutes.

In July 2017, Lancashire and South Cumbria was identified as advanced when NHS England compared STPs nationally. This demonstrated the strength of the collective efforts of organisations in the region to maintain and improve performance, and, provided a strong platform to build on.

There were key national priority areas for immediate delivery by the STP and the Accountable Care System (ACS). These were:

- Urgent & Emergency Care
- Mental Health
- Learning Disabilities

On transformation, priority areas to be looked at were:

- Primary Care
- Community Care
- Social Care
- Prevention
- Voluntary, Community and Faith Organisations

It was reported that growth monies would be used on all the above priority areas. However, on income for acute and specialised care, where most of the costs were incurred it was reported that this would remain the same.

It was noted that Lancashire and South Cumbria were not expecting a funding cut in health and care but were expecting around £345m in funding growth. It was projected that by 2020/21, Clinical Commissioning Groups would have a combined budget of £3.1bn and Upper Tier Councils would have a budget of £0.6bn for social care.

The STP would adopt the NHS RightCare approach looking at the best way to use resources with a focus on what was best for patients. RightCare benchmarked our health economies issues against places in similar economic areas and similar demographics. Delivery of efficiency savings within NHS providers was also being reviewed. Prioritised savings would be in areas such as surgical supplies and drugs, as well as reductions in the use of agency staff and staff sickness levels.

Involvement with Councillors, Voluntary, Community and Faith Sector and wider partners were a priority for the STP team. There was strong emphasis on developing the Communications and Engagement network. Local people would be involved through the Local Delivery Partnerships. There would be targeted public and patient engagement events taking place as the programme developed.

The Committee was informed that the STP Board was not a statutory body but the organisations within it were statutory. Whilst no organisation had a place on the Board as of right, all statutory organisations had signed up to it. The STP Board had an assurance role dealing with the sustainability of finances and performance against key targets as well as approving transformation plans. It was reported that a refresh of the STP would take place in approximately two months' time.

Members were informed that Partnership Board Engagement had representation from Health Education England and universities on it and dealt mainly with the transformation agenda.

Resolved: That;

i. The report be noted; and
ii. The Sustainability and Transformation Partnership Refresh be presented to a future meeting of the Health Scrutiny Committee in the New Year.

5. Health Scrutiny Committee Work Plan 2017/18

The Work Plans for both the Health Scrutiny Committee and the Health Scrutiny Committee Steering Group were presented to the Committee. The topics included were identified at the work planning workshop held on 20 June 2017.

In the October meeting of the Committee the topic of Winter pressures and preparations was to be discussed. It was suggested that this topic be reviewed after the winter season. This would be discussed at the Health Scrutiny Steering Group in March/April 2018.

Regarding the January 2018 meeting it was suggested that the topic of Adult Social Care, and, Public Health Budget Proposals be reviewed by the Steering Group. Members requested that these proposals come to the full Health Scrutiny Committee instead with the appropriate Cabinet Members invited.

Resolved: That the report and comments be noted.

6. Urgent Business

There were no items of Urgent Business

7. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will take place on Tuesday 31 October at 10.30am in Cabinet Room C (The Duke of Lancaster Room) at the County Hall, Preston.

I Young
Director of Governance, Finance and Public Services

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on Tuesday, 31 October 2017

Electoral Division affected: (All Divisions);

Winter pressures and preparations
(Appendices 'A', 'B' and 'C' refer)

Contact for further information:
Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (Overview and Scrutiny),
gary.halsall@lancashire.gov.uk

Executive Summary

Representatives from North West Ambulance Service and Lancashire Teaching Hospitals Foundation Trust (A&E Delivery Board) will attend the meeting to highlight the pressures they are likely to face during the forthcoming winter season and the preparations they have made.

Recommendation

The Committee is asked to:

i. Seek assurances on whether the Trusts are working together and whether the overall winter preparations put in place by the Trusts with a particular focus on patient safety, emergency preparedness and resilience are sufficient for the forthcoming winter season; and
ii. Formulate any further recommendations arising from the meeting to assist the Trusts.

Background and Advice

NHS England and NHS Improvement have pledged to be more aligned to better support local systems through the winter months and for the first time, 2017/18 has seen formal winter planning commencing from July. In a joint letter from NHS England and NHS Improvement dated 14 July 2017 (Gateway Reference Number 06969), Local A&E Delivery Boards were directed to submit by 8 September 2017, overall winter plans covering resilience arrangements from the start of December up to Easter 2018.

In developing winter plans, Local A&E Deliver Boards have been directed to prioritise the following aspects:
"

- Demand and capacity plans;
- Front door processes and primary care streaming;

Lancashire County Council

- Flow through the urgent and emergency care pathway;
- Effective discharge processes;
- Planning for peaks in demand over weekends and bank holidays;
- Ensuring the adoption of best practice as set out in the NHS Improvement guide: Focus on Improving Patient Flow" **(see Appendix A)**.

Local A&E Delivery Boards have also been directed to submit more detailed plans by 1 December 2017, setting out what resilience arrangements are in place to get them through the Christmas/New Year bank holiday and the highly pressured early January period. More information on what these plans should cover was provided at appendix 3 to the joint letter and is set out at **Appendix B** to this report. Appendices 1 and 2 to the joint letter on targets and expectations of Delayed Transfers of Care can be accessed from NHS England's website.

In addition to the requirements of Local A&E Delivery Boards, the Secretary of State for Health has been recommended to roll out the new Ambulance Response Programme to every ambulance service in England **(see Appendix C)**. The new operating model which seeks to address longstanding concerns such as inefficient 'multiple dispatching', long waits for 'non-urgent' patients and significant disparities between urban and rural response times will be live in all Trusts by this winter. "The key components of this new operating model are:

- Quicker identification of life threatening conditions using a pre-triage system;
- Introduction of new response times standards which cover every single patient, not just those in immediate need;
- A new dispatch model, giving staff more time to identify patients' needs; and
- A change to the rules around what "stops the clock", so standards can only be met by doing the right thing for the patient."

Lancashire Teaching Hospitals Foundation Trust

The trust provides:

- A range of general hospital services to 370k people from Chorley, South Ribble and Preston areas;
- Several specialist services to 1.5m people across Lancashire and South Cumbria; and is
- The Regional Specialist Centre for;
    - Cancer (including radiotherapy, drug therapies and cancer surgery);
    - Disablement services (such as artificial limbs and wheelchairs);
    - Major trauma;
    - Neurosurgery and neurology (brain surgery and nervous system diseases);
    - Plastic surgery and burns;
    - Renal (kidney diseases); and
    - Vascular.

The Chair of the A&E Delivery Board for the Trust has been invited to attend the meeting to present to the Committee.

North West Ambulance Service (NWAS) NHS Trust

The Trust provides 24hr, 365 days a year accident and emergency services to those in need of emergency, medical treatment and transport across Greater Manchester, Cheshire and Merseyside and Lancashire and Cumbria. The Trust also provides:

- Non-emergency patient transport services to and from hospital;
- The NHS 111 Service to the North West Community; and
- An important role in advising patients and public about staying safe and healthy.

NWAS deals with more than one million emergency calls a year. Control centres are based in Manchester, Liverpool and Preston.

The Head of Service for the Cumbria and Lancashire area has been invited to attend the meeting to present to the Committee.

The Committee is asked to seek assurances on whether the Trusts are working together and whether the overall winter preparations put in place by the Trusts with a particular focus on patient safety, emergency preparedness and resilience are sufficient for the forthcoming winter season.

The Committee through identifying the pressures may wish to formulate any further recommendations to assist the Trusts.

For information, advice on how to keep well and where to get expert advice will be given throughout the winter and can be found on the stay well this winter website: https://www.nhs.uk/staywell/

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

N/A

Reason for inclusion in Part II, if appropriate - N/A

NHS Improvement

National priorities for acute hospitals 2017

Good practice guide: Focus on improving patient flow

July 2017

Produced in collaboration with and endorsed by:

Contents

Introduction

This guide outlines good practice in 10 areas that will improve patient flow.

The good practice is not new. It was recommended in Bruce Keogh's *Safer, Faster, Better: Transforming urgent and emergency care services in England.*[1] It features guidance from the Royal Colleges, the National Institute for Health and Care Excellence (NICE), specialist societies and from publications by the Nuffield Trust and King's Fund.

We know it works. Where implemented effectively by well-led teams using effective improvement techniques, hospitals have seen real benefits to patient outcomes and staff satisfaction. Hospital crowding reduces. Emergency departments (EDs) decongest. Mortality falls. Harm is reduced. Staff feel less pressured.

Implementing the good practice in all 10 areas will have a positive, cumulative effect on improving patient flow. Implementing it piecemeal will be much less effective.

This guide focuses on acute hospital care but should be considered within the context of collaboration and effective collective leadership across whole health and social care systems. While it captures and brings together existing good practice, implementation will need to be tailored to local circumstances. Therefore, we have taken a balanced approach and tried not to be overly prescriptive.

This guide is aimed at senior operational and clinical staff and especially medical directors, nursing directors and chief operating officers. Clinical teams will benefit from a concise guide that highlights priorities for patient care.

Together we can make a difference.

[1] www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

Why focus on patient flow?

The term ‘patient flow’ refers to the ability of healthcare systems to manage patients effectively and with minimal delays as they move through stages of care.

The consequences of poor flow are well known:

- EDs becomes crowded, stressful and unsafe[2,3]
- patients are admitted as ‘outliers’ to wards that are not best suited to manage their care, which may mean they have worse clinical outcomes[4]
- ambulatory care services, clinical decision units, even catheter labs and endoscopy units may fill with patients waiting for ward admission
- inpatients are shuffled between wards to make room for newcomers
- staff are overstretched and routine activities slow down dramatically
- clinical outcomes are measurably worse, particularly for frail older people, who suffer more harm events and may decondition due to extended periods in hospital beds[5]
- patients’ and carers’ time is wasted due to delays and slow care processes, and their experience is adversely affected.

Discharge delays and increased demand contribute to poor flow. Health and social care systems that have adopted best practice to improve flow find themselves much better able to cope with external pressures than those that have not.

Focusing on implementing good practice in the 10 areas in this guide will improve flow through your hospital.

Achieving good flow requires expertise and focus. Getting it right brings job satisfaction, reduces stress and improves patient outcomes.

[2] Carter EJ, Pouch SM, Larson EL (2014) *The relationship between emergency department crowding and patient outcomes: a systematic review* www.ncbi.nlm.nih.gov/pmc/articles/PMC4033834/

[3] Hoot NR, Aronsky D (2008) *Systematic review of emergency department crowding: Causes, effects, and solutions* www.annemergmed.com/article/S0196-0644(08)00606-9/fulltext

[4] Beckett D (2014) *Boarding: Impact on patients, hospitals and healthcare systems* www.acutemedicine.org.uk/wp-content/uploads/2014/11/Plenary-5-1030-Wrong-Place-Anytime-Why-Boarding-is-Bad-for-Patients-Hospitals-and-Healthcare-Systems.pdf

[5] Campbell CS *Deconditioning: The consequence of bed rest:* http://aging.ufl.edu/files/2011/01/deconditioning_campbell.pdf

Making it happen – principles of patient flow

Delivering change to improve patient flow is challenging and complex but of vital importance.

Six principles underpin good non-elective patient flow:

1. **Flow is a team sport** – patients often visit many different health and social care professionals and departments before, during and after their hospital stay. All organisations, departments and staff groups in and outside hospitals need to collaborate and act together – for example, through shared assessments and interventions to deliver effective and responsive patient care.

2. **Flow needs focus from the top** – there should be senior clinical and executive leads for flow who use live data to track flow across the hospital, identify unnecessary variation and troubleshoot where there are bottlenecks.

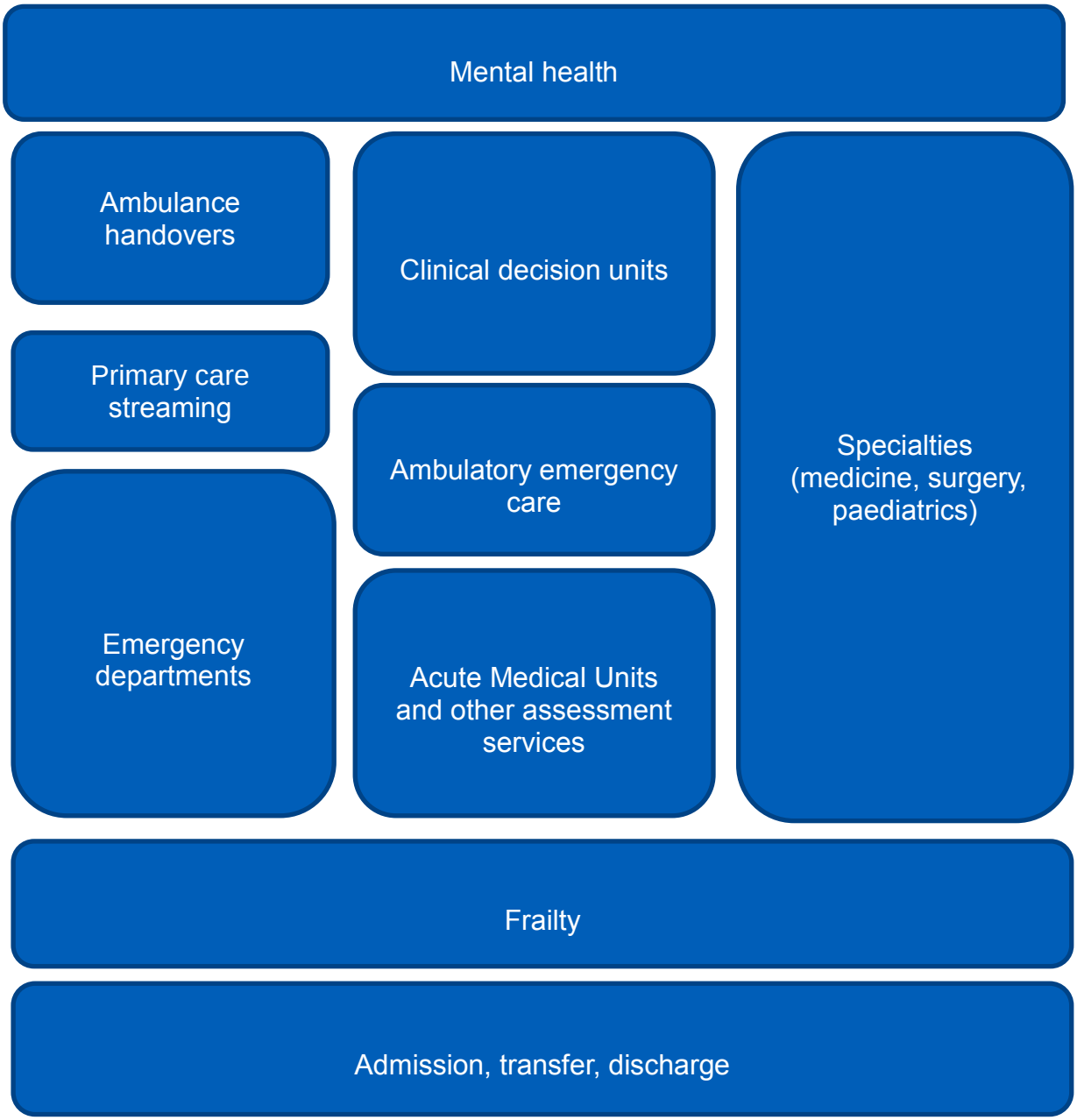
3. **Flow is seven days a week** – attendances and admissions occur relatively consistently through the week and so should reviews, transitions and discharges.

4. **Flow is about case mix** – use analytical tools to understand the acuity of patients attending the ED and how this varies across the day and the week. Use this information to match resources to demand.

5. **Flow needs patient input** – pathways and individual patient journeys should be regularly reviewed with patients to appreciate where flow is being blocked, see things from their perspective and improve processes and systems.

6. **Flow needs to be maintained at times of pressure** – systems will come under significant stress. Tried and tested escalation processes should be implemented when they do, to protect assessment and short stay wards, clinical decision units, ambulatory emergency care and acute assessment services. Escalation should be meaningful and the whole system needs to act to relieve pressure where it occurs.

The 10 areas for focus



Ambulance handovers

Outcome

Patients arriving by ambulance enjoy a seamless handover to an ED without delay, supported by the transfer of patient information from the ambulance service to the hospital.

Core principles

- EDs should accept handover of patients within 15 minutes of an ambulance arriving. Leaving patients waiting in ambulances or in a corridor supervised by ambulance personnel is unacceptable.
- On arrival or at the time of initial assessment, patients on trolleys should be assessed for their suitability to be transferred to wait in a chair. 'Fit to sit' assessments help release ambulances to respond to the next call.
- The clinical assessment of patients arriving by ambulance should start within 30 minutes of their arrival at an ED.
- Clinically stable patients referred to an ED by a GP should go directly to an assessment service to be assessed by the clinical team within 30 minutes of arrival.
- Escalation plans must be triggered when objective measures indicate the system is under significant pressure. Plans may include:
  - **Cohorting**, where patients are placed in an area of the ED not usually used for assessment or waiting, should be used as a temporary measure with a clear plan for de-escalation. Cohorting is safest when applied after assessment to ensure departments are fully aware of the patients and their risks. Areas used for cohorting must have appropriate equipment and facilities to maintain patients' privacy and dignity at all times. Escalation plans should include how the extra nurse staffing required for any cohort area will be met.
  - **A full capacity protocol (FCP)**, as recommended by the Royal College of Emergency Medicine (RCEM),[6] should be used to balance the risk to patients when EDs are crowded and there is no available space in which to assess patients. Patients requiring inpatient care are moved out of the

[6] RCEM (2015) *Tackling emergency department crowding*, p20 www.rcem.ac.uk/docs/College%20Guidelines/5z23.%20ED%20crowding%20overview%20and%20toolkit%20(Dec%202015).pdf

ED or assessment units to an inpatient ward area. This is achieved by, for example, a ward caring for one extra patient until a bed becomes available elsewhere for that person following discharge of another patient. The FCP should be de-escalated as soon as practically possible. Repeated use of the FCP should prompt a thorough review to ensure that all escalation steps are effective. Protocols should include appropriate safeguards, based on patient acuity and condition – for example, frail older patients and those with a national early warning score (NEWS) of >3 should be excluded.

- Deploying **ambulance managers** (sometimes termed 'HALOs') or additional acute resources to help manage the hospital–ambulance interface and release ambulances quicker to respond to the next emergency. This is essential to reduce the risk faced by unassessed patients waiting 'at scene' for an ambulance.

To learn more

- ECIP guide to reducing ambulance handover delays
  https://improvement.nhs.uk/resources/reducing-ambulance-handover-delays/
- RCEM initial assessment of ED patients guidance
  www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf
- Papers on the FCP:
  - www.sciencedirect.com/science/article/pii/S0196064409002388
  - http://altarum.org/health-policy-blog/full-capacity-protocol-simple-changes-can-transform-a-hospital
  - http://info.medicalreimbursementinc.com/ef1/files/2128/ED_Overcrowding%20(Full%20Capacity%20Protocol).pdf
  - www.crd.york.ac.uk/crdweb/ShowRecord.asp?ID=12012015320

Primary care streaming

Outcome

Patients attending EDs with conditions more suited to assessment and treatment in primary care are streamed to a co-located primary care service.

Core principles

- Hospitals should set clear criteria to support patient streaming to primary care services.
- Redirecting patients to other sites requires specific safeguards to ensure it is both appropriate and safe, and that the off-site service has accepted the patient.
- Clinical streaming should always be performed by a trained ED clinician (usually a nurse).
- Streaming should be performed as soon as possible and always within 15 minutes of the patient's arrival. For this to be achieved, capacity must be planned to meet variation in demand on an hour-by-hour and day-by-day basis, not based on average demand.
- Demand and capacity should be analysed to determine the staffing profile, model and opening hours of the primary care service (in local circumstances where primary care attendances are very low, a primary care stream may be inappropriate or be integrated into the 'minors' stream).
- Clinical liaison between the ED and the primary care service must be regular and effective. Joint governance is a fundamental requirement. Monthly governance meetings should consider the operational effectiveness of the streaming process and primary care service together with all risk reports and incidents.
- A clear process must exist for patients requiring ED assessment to be transferred back promptly to the ED from the primary care service. These cases should be discussed at monthly governance meetings and protocols modified where appropriate.
- The four-hour A&E standard applies to all patients streamed to a co-located primary care service.

Emergency departments

Outcome

All patients receive timely assessment and clinically appropriate, high quality care in the ED.

Core principles

- All patients attending an ED should be streamed at the front door by a trained ED clinician (usually a nurse) to the most appropriate area and clinician.
- Streaming involves taking a brief history and performing basic observations if appropriate. This information may also be used to support triage prioritisation within streams if required.
- Streaming should include calculation of an early warning score (for example, the national early warning score (NEWS) for adults or paediatric equivalent for appropriate patients). Early warning scores should form part of the assessment of acuity but streaming decisions should not be based on them alone.
- The ED should prioritise the assessment and treatment of the sickest patients including:
  - those presenting with time-critical and potentially life-threatening conditions
  - frail older people at risk of admission
  - vulnerable patients including children, people with learning disabilities and those at risk of self-harm.
- The ED further streams patients to:
  - resuscitation
  - majors
  - low acuity/less serious injuries (‘minors’)
  - co-located primary care
  - fast track pathways (eg fractured neck of femur, acute abdomen)
  - other services in the hospital including ambulatory emergency care (AEC), assessment services and rapid access outpatient services.

  - normal place of residence, following risk assessment and with appropriate follow-up care and liaison and information sharing with primary and community care services.

- ED staffing should be planned so that capacity meets hourly, daily and seasonal variations in demand, rather than average demand, including that from specific patient groups such as children, frail older people and people with mental healthcare needs. There should be routine analysis of demand at a detailed level to support workforce planning.
- A senior doctor of ST4 grade (or equivalent) or higher should be present 24/7. Best practice is to deploy consultants to manage each of the functions of the ED, including overall command and control; resuscitation; rapid assessment and treatment (RAT); and the clinical decision unit (CDU).
- The deployment of advanced clinical practitioners in emergency departments is strongly encouraged (they may come from a range of professional backgrounds including nurses and allied health professionals – for example, paramedics and physiotherapists), together with pharmacists and clinicians from other specialties where appropriate.
- ED layout should be reviewed regularly to ensure that it supports flow.
- GP referred patients should go direct to the relevant assessment service, and not the ED, unless they are clinically unstable.
- Internal professional standards[7] or local agreements should be made with specialty departments across the wider hospital to provide rapid assessment, treatment and decision-making in the ED when requested.
- Acutely unwell people with frailty should be identified at the front door and appropriately assessed by clinicians competent to identify the most appropriate care pathway for these patients. The use of well-evidenced frailty assessment tools is encouraged (for example, the Rockwood Clinical Frailty Scale).
- Patients should only be admitted if their needs cannot be met by AEC or other pathways (for example, primary care).
- Close liaison with, and the direct support of, emergency medicine by in-taking specialties is essential. Site-specific rules should be agreed that set timescales, expectations and processes for how EDs can access specialist services, particularly during periods of escalation.

[7] https://improvement.nhs.uk/uploads/documents/internal-professional-standards-RIG.pdf

To learn more

- *Safer, faster, better: good practice in delivering urgent and emergency care* section 14 /www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
- Guidance on initial assessment in ED: www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf
- Guide to internal professional standards: https://improvement.nhs.uk/uploads/documents/internal-professional-standards-RIG.pdf
- Using safety checklists in emergency departments: www.health.org.uk/sites/health/files/Bristol%20final%20report_website%20version_0.pdf
- Fast track pathways: Laparotomy bundle: http://onlinelibrary.wiley.com/doi/10.1002/bjs.9658/full

Mental health

Outcome

Patients presenting to EDs or on inpatient wards with mental health and related physical conditions receive compassionate care from all staff. Skilled assessments and interventions by an all-age liaison mental health team (including alcohol specialists) are available seven days a week to maximise safety, optimise patient experience, and reduce avoidable admissions and procedures and inpatient length of stay.

Core principles

- People presenting with a mental health crisis need to be assessed in an environment that is quiet, safe and supportive. While waiting for assessment and treatment, to reduce their distress and during the assessment itself, patients should have access to a bespoke mental health assessment room.[8]
- People thought to have a mental health condition should be triaged by compassionate staff trained in line with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2017 recommendations, as adverse attitudes increase the risk of repeat self-harm and suicide. Particular attention should be given to providing a compassionate response to those groups who report poorer experiences of ED and are at much higher risk of suicide, including those diagnosed with personality disorders and those who self-harm. Care should be provided in line with NICE guidance CG16 for the short-term management and prevention of recurrence of self-harm.[9]
- The initial priority is to assess any significant physical health needs, including delirium; overdose; self-harm injuries or self-injuries incurred by people with dementia or alcohol-related conditions; cardiovascular disease, diabetes, chronic obstructive pulmonary disease, liver and other conditions common in people with psychoses. ED staff should refer to the liaison mental health team as soon as they believe its involvement is necessary. As these teams include the necessary expertise in caring for people with co-morbid mental and physical health problems and they work in parallel with medical teams, they should be proactively involved in the person's treatment and be ready to provide mental health input within 60 minutes or less of the person being able to be seen. If undue delays in the pathway are to be avoided, this should be more than a request to be notified when the person is declared 'medically cleared'.

[8] www.rcpsych.ac.uk/pdf/Standards%204th%20edition%202014.pdf
[9] www.nice.org.uk/guidance/cg16

- A multidisciplinary liaison mental health team that includes a consultant liaison psychiatrist should be available 24/7.
- The liaison team identifies those at risk of suicide or self-harm or who may have mental health co-morbidities, including people with long-term physical conditions and the large population of older people in acute hospitals among whom a high prevalence of undetected dementia, delirium and depression is likely.
- People who are intoxicated and experiencing mental health problems:
    - should be assessed and given appropriate support. All hospitals should have access to a drug and alcohol liaison service, which is either part of a liaison mental health team or provided through another model, such as an alcohol care team
    - should be kept safe physically and assessed clinically as having sufficient mental capacity to receive mental healthcare
    - should be assessed for transient suicidality or psychosis, in which cases the liaison mental health team should provide interventions
- ED and liaison staff must understand and comply with the Mental Health Act and the Mental Health Act Code of Practice to reduce delays. Protocols are needed for access to rapid Mental Health Act assessments by s12 doctors and social care teams if required and liaison teams should include psychiatrists approved under s12 of the Act. This includes protocols with police services for escort of patients detained under s136 of the Act or for those not detained to EDs.
- An appropriate area should be provided for patients to wait in while transport for admission to a psychiatric service or other follow-up action is arranged.
- Acute hospital staff should have access to an up-to-date NHS111 Directory of Services (DoS) and primary care social prescribing directory, to enable faster onward referral to appropriate community services.
- By the time of discharge, those having experienced a crisis should have been appropriately assessed, an urgent and emergency mental health (UEMH) care plan or follow-up care accepted and scheduled, or advice/signposting provided.
- For people with mental health needs and dementia on acute hospital inpatient wards, early involvement of liaison teams including embedded social care and housing expertise will improve discharge planning and co-ordination, resulting in shorter lengths of stay and reduced general hospital readmissions for adults and particularly older adults.

- People who are known to mental health services and also frequent attenders should have a co-produced care plan in place, including an advance decision crisis plan of the actions to take to manage a crisis, as well as arrangements to support the patient to share that plan safely with ambulance, ED and other staff.

To learn more

- *Achieving better access to 24/7 urgent and emergency mental health care – part 2: Implementing the evidence-based treatment pathway for urgent and emergency liaison mental health services for adults and older adults – guidance*
  www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf
- *Safer, faster, better: good practice in delivering urgent and emergency care* section 16
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
- The College of Emergency Medicine (2013) *Mental health in emergency departments*
  www.rcem.ac.uk/docs/RCEM%20Guidance/CEM6883-Mental%20Health%20in%20ED_Toolkit.pdf

Clinical decision units

Outcome

Patients who can be discharged following a short period of observation, investigation or treatment are managed in an appropriate short stay area outside the ED.

Core principles

- All hospitals should have a facility that enables same-day emergency care in a non-inpatient setting. Clinical decision units (CDUs) and ambulatory emergency care (AEC) services are both effective models. Hospitals may decide to have both depending on the model of emergency care, but this is not essential.
- CDUs should be supervised and led by a consultant and staffed by multidisciplinary teams including clerical staff and allied health professionals.
- Open 24 hours a day or to match the known demand profile.
- Co-located with or close to the ED, with access 24/7 to key diagnostic services, such as pathology and radiology.
- Governance should include medical, nursing and allied health disciplines.
- Decisions should be made as soon as a patient's results become available and should not be contingent on a ward round process.
- CDUs must not be used for patients waiting for admission as part of 'escalation' when the hospital is under pressure.
- CDU criteria should be balanced and co-ordinated with those of AEC and acute frailty services to avoid unnecessary duplication.

To learn more

- The College of Emergency Medicine (2011) *Emergency medicine operational handbook: The way ahead*, pp32-33 www.rcem.ac.uk/docs/Policy/The%20Way%20Ahead_Final%20Dec%202011.pdf

Ambulatory emergency care

Outcome

Patients being considered for emergency admission are rapidly assessed and, where appropriate, streamed to AEC, where they are diagnosed and treated on the same day, without overnight admission where possible. Hospitals introducing AEC should aim to convert a third of their adult acute medical admissions to ambulatory care episodes.

Core principles

- All patients other than those who are clinically unstable should be considered for AEC as the preferred option.
- AEC should be available at least 14 hours a day, seven days a week to receive patients directly from the ED and primary care.
- Where possible, the AEC facility should be close to the ED. AEC should be available for patients with medical, surgical or gynaecological problems.
- Selection of patients for AEC should be maximised by:
  - AEC clinicians undertaking regular board rounds with ED staff to identify patients
  - displaying a list of common AEC conditions in the ED to help identify appropriate patients for AEC
  - giving the AEC team access to the ED board to spot patients
  - allowing automatic referral from ED for appropriate patients.
- There should be immediate access to a senior doctor who is responsible for agreeing the case management plan for each patient.
- The timeframes for initial assessment and medical review in AEC should be similar to those in the main ED.
- Patients should have access to diagnostics within the same timeframe as other emergency patients.

- The AEC facility should have a combination of consulting rooms, treatment trolleys and chairs for patient assessment. Patients should be kept ambulant as the default.
- AEC must not be used for patients waiting for admission as part of 'escalation' when the hospital is under pressure.

There should be agreed and shared clinical governance of AEC between the ED and other relevant departments in the hospital, particularly the CDU and assessment services. This should set out the roles and responsibilities of the different functions and seek to ensure that assessments and other processes can be shared.

To learn more

- *Safer, faster, better: good practice in delivering urgent and emergency care,* section 15 www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
- *The directory of ambulatory emergency care for adults* www.ambulatoryemergencycare.org.uk/uploads/files/1/BAAEC/AEC%20Directory%202016%205th%20edition.pdf.pdf
- Providers can refer to the Royal College of Physicians *Acute care toolkit 10: ambulatory emergency care* to assess what proportion of admissions could be converted from inpatient to AEC: www.rcplondon.ac.uk/projects/acute-care-toolkits
- www.ambulatoryemergencycare.org.uk/

Acute assessment

Acute Medical Units (AMU)

Outcome

Patients with acute medical conditions are assessed and their treatment begun by a multi-professional acute medical team. Patients are referred from the ED or primary care. Following initial assessment and treatment, patients are either discharged from the acute medical unit (AMU), or transferred to a specialty ward appropriate for their condition, usually within 72 hours of arrival.

Core principles

- AMUs must be consultant-led, with a core team of acute physicians supported by specialty physicians.[10] They must be available 24/7.
- AMUs should aim to receive clinically stable GP referred patients directly, not via the ED.
- AMUs should have a dedicated multidisciplinary team that includes nurses (with appropriate nurse-to-patient ratios), allied health professionals (for example, physiotherapists and occupational therapists) pharmacists and discharge co-ordinators as appropriate.
- AMUs should have ready access to in-reach services to support patient care and early discharge, including inpatient specialist doctors, specialist nurses, social workers and allied health professionals, for example, speech and language therapists and dieticians.
- AMUs should include dedicated assessment wards and ring-fenced short stay beds. Service design should conform to the recommendations of the Royal College of Physicians 2007 Acute Care Taskforce.
- AMUs should have direct access to the hospital executive team to foster collaborative working, especially during periods of peak demand.
- Communication and handover rotas should be used to promote continuity of care. There should be regular 'board rounds' and core acute assessment service multidisciplinary team 'huddles'.

10 https://cdn.shopify.com/s/files/1/0924/4392/files/acute_medical_care_final_for_web.pdf?1709961806511712341

- Patient discharge processes, including establishing an expected discharge time and date, should start as soon as the patient arrives on AMU as part of the initial assessment process.
- As a quality marker of acute medical assessment services, specific pathways should have standardised processes (for example, a sepsis pathway, an acute kidney injury pathway).
- There must be close working between clinicians and managers to optimise flow through the AMU, for example avoiding delays in discharges and transfers to wards. To efficiently admit patients from ED to AMU, the AMU should run at between 85% to 90% bed occupancy.

To learn more

- *Safer, faster, better: good practice in delivering urgent and emergency* care section 18.4 www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
- Royal College of Physicians (2007) *Acute medical care*, https://cdn.shopify.com/s/files/1/0924/4392/files/acute_medical_care_final_for_web.pdf?17099618065117123 41
- *Acute care tool kits:* www.rcplondon.ac.uk/projects/acute-care-toolkits
- *Seven-day services clinical standards:* https://improvement.nhs.uk/documents/768/Clinical_standards_revised_Feb_2017_FINAL_for_publication_QvpPj1X.pdf
- Effectiveness of acute medical units in hospitals: a systematic review: https://academic.oup.com/intqhc/article/21/6/397/1797926

Acute surgical and specialty assessment

Outcome

Patients are rapidly assessed and their treatment begun by acute assessment services following referral from the ED or primary care, and either discharged or admitted to a ward that is appropriate for their condition.

Models may vary but all assessment services adhere to similar principles. AMUs may be co-located with surgical and non-medical specialities in combined assessment units or ‘emergency floors’.

Core principles

- Acute assessment services are consultant led and available in accordance with demand patterns, ideally 24/7 where patient volumes justify it.
- As a minimum, a specialty trainee (ST3 or above) or a trust doctor with equivalent ability, is available to see/treat acutely unwell patients at all times within 30 minutes and is able to escalate concerns to a consultant.
- An initial patient assessment should start within 15 minutes of arrival.
- Acute assessment services should aim to receive clinically stable GP referred patients directly, not via the ED.
- Acute assessment services should have a dedicated multidisciplinary team that includes qualified nurses (with appropriate nurse-to-patient ratios), allied health professionals (for example, physiotherapists and occupational therapists), pharmacists and discharge co-ordinators as appropriate.
- Acute assessment services should have ready access to diagnostics and in-reach services to support patient care and early discharge.
- Patient discharge processes, including establishing an expected discharge time and date, should start as soon as the patient arrives on an acute assessment ward.

To learn more

- Standards for short stay paediatric assessment units: www.rcpch.ac.uk/system/files/protected/news/SSPAU%20College%20Standards%2021.03.2017%20final.pdf
- Standards for unscheduled surgical care (see section 1.6.3 surgical assessment units) www.rcseng.ac.uk/-/media/files/rcs/about-rcs/regional/rcs_emergency_surgery_2011_web.pdf
- *Safer, faster, better: good practice in delivering urgent and emergency care* section 18.4 www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

Frailty

Outcome

Frail patients are identified as soon as they present to the ED or directly to assessment services, and receive specialist, high quality, person-centred care on the non-elective pathway. They are discharged without delay when their acute care is complete, with the right level of support to continue their recovery and rehabilitation in their own home.

Core principles

- Frailty should be identified and measured at the front door using an evidence-based assessment tool (for example, the Rockwood Clinical Frailty Scale).
- There should be a multidisciplinary team that is competent to deliver holistic assessment and management of older people (through comprehensive geriatric assessment).
- The frailty pathway should be embedded in processes in the ED, AEC, CDUs, AMUs and on specialty wards.
- Patients with frailty should be actively involved in their care and the provider able to demonstrate shared decision-making/patient-centred care. Patients should be routinely asked what is most important to them and their responses clearly documented.
- Hospitals should be aware of what happens to patients with frailty who leave their service. This is a central part of providing care to these patients.

To learn more

- *Safer, faster, better: good practice in delivering urgent and emergency care*, section 22
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
- British Geriatrics Society (2012) *Silver Book*
  www.bgs.org.uk/silverbook/campaigns/silverbook
- The Health Foundation (2013) *Improving the flow of older people*
  www.health.org.uk/sites/health/files/ImprovingTheFlowOfOlderPeople_casestudy_1.pdf

Specialties

Outcome

Patients on hospital inpatient wards receive person-centred, compassionate and skilled care. They are admitted promptly to, and remain on, the right ward to meet their needs. They, and where appropriate their families, are involved in decisions about their consultant-led care and achieve outcomes that are personally relevant to them without exposure to avoidable delays or harm. They are discharged without delay when their acute care is complete, with the right level of support to continue their recovery and rehabilitation.

Core principles

- Specialties should use simple rules to standardise ward processes and minimise variation between individual clinicians and between clinical teams. This may include implementing the SAFER patient flow bundle and Red2Green days (see Appendix 1) and routinely using ward round checklists.
- Daily senior medical review should be normal practice seven days a week. A senior doctor should assess the progress of every patient, in every bed, every day on a board or ward round. Delays and obstacles to treatment or discharge should be discussed and addressed. A second, afternoon board round or huddle is considered best practice to progress care plans, particularly in the first 48 hours after a patient's admission.
- Ward rounds should always include an appropriately senior nurse and other members of the multidisciplinary team.
- Actions should be undertaken in real time whenever possible (requesting tests, writing discharge prescriptions, etc) not at the end of ward rounds.
- Continuity of care is essential. The Royal College of Physicians' *Future Hospital Commission* report (2013)[11] states that continuity of care for patients should be co-ordinated and delivered by a single consultant-led clinical team. As far as possible, the provision of care to any single acutely ill patient should be confined to a single ward or adjacent wards to facilitate continuity of care by the same team on successive days. Once the patient has left the hospital, continuity of care from a single team should be the case for successive clinical contacts with hospital-based services for the same

[11] www.rcplondon.ac.uk/projects/outputs/future-hospital-commission

index clinical problem (for example, follow-up in the community, outpatient department or AEC centre).

- All patients should have a consultant-approved care plan containing clinical criteria (both physiological and functional) for discharge and an expected date of discharge, set within 14 hours of admission.
- Patients considered at high risk (eg patients with a predicted mortality of ≥10% using an appropriate specialty risk-scoring mechanism) must be discussed with the consultant and be reviewed by a consultant within four hours if the management plan remains undefined and/or the patient is not responding as expected.
- Morning discharges should be maximised to reduce ED crowding, to allow new patients to be admitted early enough to be fully assessed and for their treatment plan to be established and started. Of a day's discharges, 35% should leave wards by midday. Activities associated with discharge should be prioritised by specialty teams.
- From the time of admission, all patients should know:
  - What is going to happen to them today?
  - What is going to happen to them tomorrow?
  - How well do they need to be before they can leave hospital?
  - When can they expect to leave hospital?
- Hospitals should ensure that patients are admitted to the right ward to meet their needs and are only transferred to another ward for sound clinical reasons. This is particularly important for frail patients.
- Requests for diagnostic tests and specialty review should routinely be completed on the same day and always within 24 hours.
- All patients with a length of stay over six days ('stranded patients') should be reviewed by the multidisciplinary team to determine the reason for any delays and to ensure that an appropriate discharge plan has been developed.

To learn more

- Royal College of Physicians (2015) *Ward rounds in medicine: principles for best practice* www.rcplondon.ac.uk/projects/outputs/ward-rounds-medicine-principles-best-practice

- *Safer, faster, better: good practice in delivering urgent and emergency care* section 24 www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
- The Royal College of Physicians (2013) *Future Hospital Commission* www.rcplondon.ac.uk/projects/outputs/future-hospital-commission
- ECIP rapid improvement guide to setting expected dates of discharge and clinical criteria for discharge https://improvement.nhs.uk/resources/rapid-improvement-guide-expected-date-discharge-and-clinical-criteria-discharge/
- Seven-day services standards www.england.nhs.uk/wp-content/uploads/2017/02/clinical-standards-feb17.pdf
- Emergency surgery: standards for unscheduled care www.rcseng.ac.uk/-/media/files/rcs/about-rcs/regional/rcs_emergency_surgery_2011_web.pdf
- Health Foundation (2013) *Improving patient flow: How two trusts focused on flow to improve the quality of care and use available capacity effectively* www.health.org.uk/sites/health/files/ImprovingPatientFlow_fullversion.pdf

Admission, transfer, discharge

Outcome

Patients are discharged as soon as they no longer benefit from acute hospital care. In most cases, discharge is to a person's usual place of residence.

Core principles

- Therapy and social work teams should work at the front of the acute care pathway, routinely collecting information on how patients have been managing at home before becoming acutely unwell.
- On admission, the expectation should be that people will be discharged to their usual place of residence, with additional support if required, and assessment of their longer term needs undertaken there rather than in hospital.
- A clear clinical care plan must be set for all patients within 14 hours of admission, which includes an expected date and time of discharge that are linked to functional and physiological criteria for discharge.
- There should be a strong focus on 'simple' discharges. The SAFER patient flow bundle and 'Red2Green days' tools should be used routinely to ensure the most appropriate care for patients on all hospital wards (see Appendix 1).
- Board rounds should take place on all hospital wards each morning. The multidisciplinary team should review the clinical plan (including the discharge elements) on the board rounds and any decisions communicated to the patient.
- Duplication of assessment should be minimised using trusted assessors, building on the functional information collected on admission (see below).
- There should be a single point of access for health and social care to support 'discharge to assess'. Integrated discharge teams should be linked to an integrated intermediate tier of local services.

To learn more

- *Quick guides: discharge to assess*
  www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

- *Quick guide: supporting patients' choices to avoid long hospital stays*
  www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf

- *Safer, faster, better: good practice in delivering urgent and emergency care* section 20
  www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

- *Utilising the 8 high impact interventions to assess our local system: Improvement in discharge management & planning*
  http://londonadass.org.uk/wp-content/uploads/2016/04/Utilising-the-8-high-impact-interventions-to-assess-our-local-system-.pdf

Appendix 1: The SAFER patient flow bundle and Red2Green days

The SAFER patient flow bundle

SAFER is a practical tool to reduce delays for patients in adult inpatient wards (excluding maternity).

The SAFER bundle blends five elements of best practice. It is important to implement all five elements together to achieve cumulative benefits. It works particularly well when it is used in conjunction with the **Red2Green** days approach.

When followed consistently, length of stay reduces and patient flow and safety improve.

The SAFER patient flow bundle rapid improvement guide
https://improvement.nhs.uk/resources/safer-patient-flow-bundle/

Red2Green bed days

Red2Green bed days are a visual management system to assist in the identification of wasted time in a patient's journey and reduce length of stay. It is applicable to inpatient wards in both acute and community settings.

The approach is used to reduce internal and external delays in conjunction with the SAFER patient flow bundle.

It is not appropriate for high turnover areas such as EDs, assessment units, CDUs/observation units and short stay units where using Red and Green on an hours/minutes basis may be more appropriate.

The Red2Green rapid improvement guide
https://improvement.nhs.uk/resources/rapid-improvement-guide-red-and-green-bed-days

Red2Green video
www.youtube.com/watch?v=Dc-b6GclTq4

Appendix 2: Trusted assessment

'Trusted assessment' simplifies assessment processes and increases the speed of patient discharge from hospital.

- Many local health systems have introduced 'trusted assessment' or 'generic assessment' where one person or team is appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols.
- Trusted assessment should be carried out by a trusted assessor who is authorised to undertake defined assessments for a range of different health and care provider organisations (normally care homes, home care services, NHS trusts and local authorities) through a single process.
- Organisations intending to carry out trusted assessments and those that will provide the care (for example, private-sector residential provision) must co-design and agree a streamlined and simple assessment process for trusted assessors to follow. Some local organisations may not agree to the use of trusted assessment.
- Patient experience and feedback should be used in the design of the trusted assessment process. Feedback from patients going through the process should be regularly collected to review and improve the process.
- There must be a clear and rapid route for challenge and escalation of problems/issues by any organisation for placements that are unsuitable for a person's needs. The aim should be to resolve any disputes on the day they arise.
- A competency profile for the trusted assessor must be agreed by all organisations.
- The costs and funding of the trusted assessment model should be agreed by all local partners. In some models, offering trusted assessments does not add to cost because existing staff are supported to carry them out. Often these are staff who are already collecting the necessary information, or much of it, as part of their routine work.
- There should be a clear analysis of the number and types of assessments that may be suitable for a trusted assessment model, the impact this should have on reducing length of stay and delayed transfers of care (DToCs), and an agreed ambition for the system. Metrics tracking the number of assessments done by trusted assessors, the number of satisfactory transfers and the locations patients are transferred to should be collected on a

monthly basis and the impact on length of stay and DToCs regularly reviewed.

- Arrangements should be captured in a memorandum of understanding between the relevant organisations that have signed up to the trusted assessment model, likely to include local authorities, clinical commissioning groups, NHS trusts and NHS foundation trusts, care home and home care providers, that explains the agreed trusted assessment model in a local system.

To learn more

- *Rapid Improvement guide to trusted assessors* https://improvement.nhs.uk/uploads/documents/ECIP_RIG_Trusted_assessors_March2017.pdf
- South Warwickshire's trusted assessment form has enabled direct referral to reablement without the hospital social work team's involvement: www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/18-south-warwickshire-trusted-assessment-form.pdf
- East and North Hertfordshire Care Home Vanguard is piloting a trusted assessor model and has developed the 'complex care premium' which is paid to the care home for residents who have 'complex needs' www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/19-en-herts-trusted-assessment.pptx

Appendix 3: Coming soon

The **emergency flow improvement tool** is an online resource that presents a range of indicators illustrating flow through a trust from arrival to discharge.

This flow tool is provided as an improvement aid rather than a performance tool, allowing trusts and their stakeholders to visualise their data and prompt questions about where demand, pinch points and blocks are occurring in their system.

Each time series graph has been processed against six statistical process control (SPC) rules to highlight common cause (expected) and special cause (unexpected) variation. A benchmarking feature shows how a trust compares to all others.

The tool will be made available to trusts in September 2017 through the Model Hospital portal.

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This publication can be made available in a number of other formats on request.

 Publication code: IG 31/17

Appendix 3 – winter plan requirements

All local A&E delivery boards are required to submit comprehensive winter plans (covering from 01 December up to Easter). In addition to any local initiatives already planned or underway, this should cover the following key themes:

Wider system preparation

- Ensuring that good practice in patient flow is embedded across all parts of the emergency patient pathway, not just in isolated departments or wards. Refer to the Keogh Review's Safer, Faster, Better (2015) and the Good Practice Guide: Focus on patient Flow (2017).
- Collaborating with ambulance services and primary care to monitor illness patterns in the local community and weather changes that may affect specific patient cohorts. Escalate early in anticipation of demand surges, not in response to them.
- Focus on supporting care homes and the 350,000 older people who live in them including:
    - Assessing compliance with the BGS Guide on Care Home Medicine (more information available here)and addressing any gaps that are identified
    - Implement the principles of the 'red bag scheme' (see NHS E new care models website) across care homes ensuring that residents details, vital health information, supplies of medicine, and a change of clothes accompany residents who are admitted to hospitals.
    - Consider commissioning a tele-health service similar to the Airedale model to reduce 999 calls & ED attendances for care home residents

Front door

- Focus on processes in A&E departments to prevent avoidable breaches, particularly amongst 'minors' and non-admitted patients referred for specialist assessment. Effective and adequately resourced command and control is essential.
- Ensure there is a clear process for primary care referrals (including OOH) to acute specialities to bypass ED. There should be alternatives to immediate referrals, including 'hot' clinics.
- Ensure EDs have sufficient clinical input from surgical and clinical specialties

Flow

- Implement the **SAFER Patient Flow Bundle on every ward**. Implementing SAFER reduces stranded patient numbers and reduces deconditioning that results from prolonged hospital stays
- **Monitor and manage 'stranded patients**'. Use 'mini-MADE' (Multi-agency discharge events) events early when stranded patient numbers rise, rather

than as an urgent measure during escalation. It is essential to identify the number of stranded patient that should trigger the mini-MADE.

- **Monitor and manage occupancy levels**, with regular reporting to boards

Discharge

- **Implement the *Eight High Impact Changes for Managing Transfers of Care***
- **Ensure that health and social care 'discharge capacity'** (workforce, beds, equipment, funding) is modelled so it can meet daily demand, including variation, across the whole of winter.
- **Commission additional home-care packages now to support 'discharge to assess'.** Systems that have done this find that CHC delays and social care DToC's are reduced. This additional capacity can be realised before winter and used for surge.
- **Implement a 'placement without prejudice' process**. When a patient has been identified as potentially requiring CHC, he/she is discharged to an appropriate environment out of hospital while the assessment and decision is made. A local agreement should exist between the CCG and local authority specifying which party will initially pay for the care or placement. If CHC is agreed, the costs should be met by the CCG backdated to the date of discharge.
- **Use the trusted assessor guide**, which NHS Improvement will publish imminently, designed to support hospitals, primary and community care and local councils deliver trusted assessment as a key part of the High Impact Change Model described in Chapter 2 of the Five Year Forward View Next Steps document.

Better planning for peaks in demand over weekends and bank holidays

- **Demand and capacity planning needs to have been conducted and tested before the end of October**. This will help local systems to work together more closely to meet workforce demands during peak periods and avoid outbidding each other for locums working during the winter period.

Appendix C

Professor Sir Bruce Keogh
National Medical Director
Skipton House
80 London Road
SE1 6LH

Jeremy Hunt
Secretary of State for Health
By email and hard copy

13 July 2017

Dear Jeremy,

Ambulance Response Programme

In recent weeks we have seen countless examples of the outstanding work done by the ambulance service in the most tragic of circumstances, from the response to terrorist attacks in London and Manchester to the devastating fire at Grenfell Tower. The extraordinary response to these terrible events came on top of the everyday heroics by paramedics that save countless lives day in, day out across the country.

We have also marked the 80th anniversary of the introduction of the 999 emergency telephone number. The ambulance service has changed beyond recognition during this time, from little more than vehicles transporting patients to hospitals, often staffed by volunteers, to the “mobile hospital” model we see today.

It is a timely reminder that the NHS is constantly evolving and, as leaders of the NHS, we must always ensure that we move with the times – supporting staff to provide the best possible service to our patients, rather than putting obstacles in their way.

Yet, in the case of the ambulance service, it has become increasingly obvious that we have failed to keep up. Since the mid-1970s most aspects of the service have changed beyond recognition: a large number of responses now focus on the frail elderly rather than traditional medical emergencies, half of all calls are now resolved by paramedics without the need to take patients to hospital, and for specialist care the focus of the ambulance service is increasingly on getting patients to the *right* hospital rather than simply the nearest. Over the last four decades, however, the service has remained organised around an eight minute response time target.

Amidst all of this change that standard has become an anachronism, with anxious callers placed into outdated categories that are no longer fit for purpose. Half of all calls are classed as urgent with an 8 minute response time target – but one that has to be met in only 75% of cases. The other half of calls are deemed non-urgent with no national response target at all. Response times for that second group of patients have, unsurprisingly, doubled in some trusts in the last two years alone.

For those covered by the 8 minute target the system is equally dysfunctional. Ambulance staff are given just sixty seconds to decide what resource each patient needs. While this may have worked many years ago, it is hopelessly unsuited to modern medicine. A stroke patient, for example, will gain little benefit from a paramedic on a motorbike when what they need is an ambulance that can rapidly convey them to a specialist treatment centre.

There is also the problem of "hidden waits" for those patients needing urgent hospital treatment. At present, the clock is "stopped" by the arrival of the first vehicle, not the arrival of the vehicle that the patient actually needs. A quarter of all patients who require hospital treatment have the clock stopped by a vehicle – often a motorbike – which is in fact incapable of taking them anywhere. There are few better examples of hitting the target and missing the point.

Most worryingly, the target can increase response times and cost lives. Multiple vehicles are often dispatched to the same patient in a race to "stop the clock". When calls where a patient's needs only become known after the one minute has elapsed are factored in, one in four ambulances dispatched are now stood down before they reach the scene. Every year hundreds of thousands of patients fail to get an immediate response because ambulances are dispatched in this wasteful and illogical manner. Correcting this anachronism would free up to fifteen thousand ambulance responses every week.

These criticisms are not new. They have been highlighted by the National Audit Office, by the Health Select Committee, and by countless paramedics and ambulance staff. So when I wrote to you in 2015, I said that we were determined to finally tackle this problem. I commissioned the Ambulance Response Programme (ARP) – an independently evaluated trial to test new ways of working for the service, led by Professor Jonathan Benger and Professor Keith Willett.

Over the last 18 months the ARP has covered over 14 million calls, testing a new operating model and new set of targets. Further details are annexed to this letter, but in summary this new system would:

- Change the dispatch model of the ambulance service, giving staff slightly more time to identify patients' needs and allowing quicker identification of urgent conditions.
- Introduce new target response times which cover every single patient, not just those in immediate need. For the most urgent patients we will collect mean response time in addition to the 90th percentile, so every response is counted.
- Change the rules around what "stops the clock", so targets can only be met by doing the right thing for the patient.

The results have been impressive. The trial has demonstrated that, should these changes be adopted nationally:

- Early recognition of life-threatening conditions, particularly cardiac arrest, will increase. Based on figures from London Ambulance Service, it is estimated that up to 250 additional lives could be saved in England every year.
- Up to 750,000 patients every year would receive an immediate ambulance response, rather than joining a queue.
- The differences in response time between patients living in rural areas and those in cities would be significantly reduced.

All of this has been achieved with no patient safety or adverse incidents attributed to the ARP in those 14 million calls.

Given this comprehensive and compelling evidence, I am writing to you formally to recommend the roll out of the Ambulance Response Programme to every ambulance service in England. Patients across the country deserve to benefit from the significant improvements seen in the trial areas, from ambulances reaching cardiac arrests in London 30 seconds faster to the one minute improvement on stroke responses in the West Midlands. These changes, together with ambitious new clinical standards for heart attack and stroke patients, will end the culture of "hitting the target but missing the point." They will refocus the service on what actually counts: outcomes for patients.

These trials, the most extensive ever conducted, have provided us with an unrivalled evidence base for these changes. They also come with the strong endorsement of every expert organisation we have spoken to – whether the Royal College of Emergency Medicine, the Stroke Association, or the College of Paramedics.

If these recommendations are accepted then we intend to fully implement these new standards by the beginning of winter 2017, a little over six months before the NHS's 70th birthday. As we inevitably use this moment to reflect on both the achievements and challenges of the NHS, I am confident that the ambulance service would approach this landmark in a much stronger position to continue its remarkable work even more effectively.

Yours sincerely,

Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director
NHS England

Annex 1 – Changes to the current national standards

Changes to triage questions

The “Nature of Call” system introduces three standardised pre-triage questions to increase the early recognition of cardiac arrest. Based on London Ambulance Service figures obtained by Sheffield University, it has been estimated that up to 250 additional lives will be saved in England every year.

Changes to clinical standards

To ensure the ARP changes drive improved clinical outcomes, we will be introducing a new set of clinical indicators.

For serious **heart attack** patients, who have specific ECG changes, we will measure the proportion of patients that receive definitive treatment (balloon inflation during angioplasty at a specialist heart attack centre) within 150 minutes of making a 999 call. We expect 90% of patients to meet this standard by 2022.

For **stroke patients**, we will measure the proportion of patients that complete their pathway of care (thrombolysis where appropriate, or first CT scan for those where it is not) within 180 minutes of making a 999 call – again with an expectation that 90% of patients will meet this standard by 2022, up from an estimated 75% of stroke patients currently completing their pathway of care within that timeframe.

Changes to dispatch practices, call categorisation and clock start/stop definitions

A comparison of the current operational standards and new operational standards is shown below.

Current standards

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Red 1	3%	75% within 8 minutes	The clock starts at the point the call is connected to the ambulance service	The first ambulance service-dispatched emergency responder arriving at the scene of the incident
Red 2	47%	75% within 8 minutes	The earliest of: •The problem being identified •An ambulance being dispatched •60 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident
Green	50%	No national standard	The earliest of: •The problem being identified •An ambulance response being dispatched •60 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident

Proposed standards

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 3	34%	120 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance, service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 4	10%	180 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

Health Scrutiny Committee
Meeting to be held on Tuesday, 31 October 2017

Electoral Division affected: (All Divisions);

Report of the Health Scrutiny Steering Group

Contact for further information:
Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (Overview and Scrutiny),
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Executive Summary

Overview of matters presented and considered by the Health Scrutiny Steering Group at its meetings held on 27 September and 11 October 2017.

Recommendation

The Health Scrutiny Committee is asked to receive the report of its Steering Group.

Background and Advice

The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Labour and Independent Groups.

The main functions of the Steering Group are listed below:

- To act as the first point of contact between Scrutiny and the Health Service Trusts and Clinical Commissioning Groups;
- To liaise, on behalf of the full Committee, with Health Service Trusts and Clinical Commissioning Groups;
- To make proposals to the full Committee on whether they consider NHS service changes to be 'substantial' thereby instigating further consultation with scrutiny;
- To develop and maintain its own work programme for the full Committee to consider and allocate topics accordingly;
- To invite any local Councillor(s) whose ward(s) as well as any County Councillor(s) whose division(s) are/will be affected to sit on the Group for the duration of the topic to be considered;

It is important to note that the Steering Group is not a formal decision making body and that it will report its activities and any aspect of its work to the full Committee for information.

Lancashire County Council

Meeting held on 27 September 2017:

1. **Improvements to Mental Health Services in Lancashire**
   A report was presented on planned changes and improvements to mental health services in Central Lancashire and Pennine Lancashire areas. The report set out the background to the changes, the future model of care and key milestones achieved since 2006. Details on future provision by locality was also provided.

   The Steering Group recommended that this matter be referred to the full Committee for its meeting scheduled for 12 December 2017.

2. **Action on Screening and Immunisations across Lancashire**
   This matter was referred to the Steering Group by Health and Wellbeing Board. The report provided an overview of programmes, key data, examples of projects to address uptake along with a high level action plan.

   It was agreed that:

   i. A further report on childhood immunisations be presented to a future scheduled meeting of the Steering Group on
      a. progress made with primary care (low uptake, large waiting lists and support to improve uptake and opportunistic immunisations),
      b. data cleansing exercise and new childhood information system and latest assessment of the figures,
      c. update on the Pennine Lancashire Childhood Immunisation Group and
      d. revised communication materials for parents; and
   ii. A report on the seasonal flu vaccinations programme be presented to a future meeting of the Health Scrutiny Committee.

3. **Committee Enabling**
   The Chair raised concerns in relation to the current functioning of the Health Scrutiny Committee and its Steering Group. The start time of the full Committee meetings was also discussed. Consideration was also given to the request for the scrutiny of the Adult Social Care and Public Health budget proposals to be considered by the full Committee and not the Steering Group.

   The Steering Group agreed that:

   i. A report on the proposed revised purpose of the Steering Group be presented at a future meeting of the Steering Group for consideration and subsequent referral to the full Committee to agree;
   ii. The budget proposals from the relevant Cabinet Member portfolios for Adult Social Care and Public Health be considered by the Health Scrutiny Committee at its meeting on 23 January 2018.

Meeting held on 11 October 2017

1. **Health and Wellbeing Board - Update**
   A verbal update on the Health and Wellbeing Board was provided to the Steering Group.

   The Steering Group recommended that a memorandum of understanding be drafted on a future working relationship between the Health Scrutiny Committee and the Health and Wellbeing Board taking into account the existing informal arrangements in place.

2. **Implementation of the Care Act 2014 within secondary mental health services in Lancashire**
   The Steering Group considered a referral that had been received on the above matter.

   It was recommended that responses to all of the points raised in the referral be provided to a future meeting of the Steering Group at the earliest opportunity.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

N/A

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny Committee
Meeting to be held on Tuesday, 31 October 2017

Electoral Division affected:
(All Divisions);

Health Scrutiny Committee Work Plan 2017/18
(Appendix 'A' refers)

Contact for further information:
Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (overview and Scrutiny),
gary.halsall@lancashire.gov.uk

Executive Summary

The Plan at Appendix 'A' is the work plan for both the Health Scrutiny Committee and its Steering Group.

The topics included were identified at the work planning workshop held on 20 June 2017.

Recommendation

The Health Scrutiny Committee is asked to

i. Note and comment on the report; and
ii. Accept the recommendations made by the Steering Group at its meeting held on 27 September 2017 to refer the report on improvements to mental health services in Lancashire for consideration by the Committee at its next scheduled meeting on 12 December 2017.

Background and Advice

A statement of the work to be undertaken and considered by the Health Scrutiny Committee and its Steering Group for the remainder of the 2017/18 municipal year is set out at Appendix A which includes the dates of all scheduled Committee and Steering Group meetings. The work plan is presented to each meeting for information. The Committee will note that the Health Scrutiny Committee work plan has been aligned to the Sustainability and Transformation Partnership's Governance meetings and priority areas.

Steering Group Referral

At its meeting on the 27 September 2017, the Steering Group considered a report from Lancashire Care Foundation Trust on improvements to mental health services in Lancashire, which set out planned changes for both the Central and Pennine

Lancashire areas. The Steering Group agreed that this matter of service reconfiguration be referred to the full Health Scrutiny Committee for consideration at its meeting scheduled for 12 December 2017. The Committee is therefore asked to accept this referral.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

N/A

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny – Work plan 2017/18

Date to C'ttee	Report	STP Governance Meeting Workstream*/Priority area**	Lead Officers (including STP SRO)	Outline reasons for scrutiny/scrutiny method
24 July	STP Workforce – Scrutiny Inquiry Day Report	Workforce*	CC Steve Holgate, former Chair of the Health Scrutiny Committee	To formulate recommendations from the report and to determine who to circulate to.
	Update on the Local Workforce Action Board	Workforce*	Heather Tierney-Moore and Damian Gallagher, LCFT	Update on the work of the Board.
	Chorley Hospital Emergency Department mobilisation	Workforce*/Hospitals** and Urgent Care**	Karen Partington, Mark Pugh, LTHFT	Update on the mobilisation of the Emergency Department and recruitment issues
19 Sept	Next Steps on the NHS Five Year Forward View – Sustainability and Transformation Partnerships; Accountable Care Systems and Local Delivery Plans	-	NHSE North, Healthier Lancashire and South Cumbria, Fylde and Wyre CCG, Morecambe Bay CCG,	Overview of the next steps on the NHS five year forward view and update on the Accountable Care System.
31 Oct	Winter pressures and preparations (A&E)	All	Heather Tierney-Moore (AEDB), Derek Cartwright, NWAS, Paul Simic, LCA, LTHFT? Tony Pounder, LCC	Overview of pressures and preparations (adults/acute trusts/mental health)

Appendix A

Updated: 17 October 2017

Date to C'ttee	Report	STP Governance Meeting Workstream*/Priority area**	Lead Officers (including STP SRO)	Outline reasons for scrutiny/scrutiny method
12 Dec	Improvements to Mental Health Services in Lancashire	Care Professional Board*	Steve Winterson, LCFT	Report on planned changes for both the Central and Pennine Lancashire areas
	Suicide Prevention	Care Professional Board* Mental Health**	Dr Sakthi Karunanithi and Chris Lee, Public Health	To ensure effective implementation of the (local authority) suicide prevention plan
23 Jan 2018	Adult Social Care – and Public Health Budget Proposals	-	Tony Pounder, Dr Sakthi Karunanithi and Neil Kissock	Budget proposals from the following Cabinet Members: • Graham Gooch – Adult Services • Tbc – Health and Wellbeing
	Delayed Transfers of Care	Care Professional Board*	Tony Pounder, Sue Lott, Mike Kirby, LCC (All Trusts? – LTHFT, ELHT etc; & BwD Borough Council, Blackpool Council and Cumbria CC) Paul Simic, LCA	i. Overview and update on DTOC and discharge policies - Development of joint approach to DToC with NHS providers across the STP footprint. Health and Wellbeing Board to receive update on 14 November 2017; or ii. Review of Supporting Patients to Avoid Long Hospital Stays Policy and Funding Framework
5 March	Public Health - Life expectancy	Care Professional	Dr Sakthi Karunanithi	Overview of Life Expectancy, causes,

Appendix 'A'

Date to C'ttee	Report	STP Governance Meeting Workstream*/Priority area**	Lead Officers (including STP SRO)	Outline reasons for scrutiny/scrutiny method
		Board* Prevention**		prevention and self-help work, key service issues, challenges and opportunities
	Learning disabilities (Calderstones)	Care Professional Board* Health and social care**, Mental Health**	Mersey Care NHS Foundation Trust, NHS England Charlotte Hammond, LCC?	Update on Specialist Learning Disability Services
17 April	Skin cancer awareness	Care Professional Board* Prevention**	Sofiane Rimouche, LTHFT, Dr Sakthi Karunanithi CCGs	Raising awareness, prevention

Requested topics to be scheduled:

- STP Refresh (after December 2017)
- Community mental health; early intervention and prevention (Chris Lee, Public Health)

Referrals from Steering Group to the full Committee to be scheduled:

- Immunisations – childhood and seasonal influenza (Sakthi Karunanithi, LCC, Jane Cass, NHS England)

Updated: 17 October 2017

Potential topics for the Committee and its Steering Group:

- Data sharing
- Dementia awareness
- Care Home Quality
- Lancashire Safeguarding Adults Board – Annual Report (Sept/Oct).

Appendix 'A'

Health Scrutiny Steering Group – Work plan 2017/18

Date to C'ttee	Report	Lead Officers	Outline reasons for scrutiny/scrutiny method
4 July 2017	i. Royal Preston Hospital – bid for new primary care front end at Emergency Department and Urgent Care Centre (A&E) ii. WLCCG – Termination of singe handed GP contract iii. FWCCG – Improving health services in Kirkham and Wesham	i. Stephen Gough and David Armstrong, NHS England – Lancashire ii. Jackie Moran, WLCCG iii. Kate Hurry and Andrew Harrison, FWCCG	i. Unique bid for capital – need to identify appropriate funding stream to expedite and assist with overall A&E function ii. To receive updates on progress – wider concerns around single handed GPs in Lancashire iii. Overview of the proposals – concerns also raised by local councillor
27 Sept	i. Proposal for a Central Lancashire Mental Health Inpatient Unit ii. NHS England – 'Childhood Immunisation Performance Report for Lancashire, and Associated Action Plan	i. Steve Winterson, LCFT ii. Jane Cass, NHS England, Sakthi Karunanithi, Director of Public Health	i. Overview of proposals ii. To receive a report on Childhood Immunisation Performance for Lancashire and associated action plan to identify and address reasons for the downward trend of low uptake for screening, vaccinations and immunisations across Lancashire, how this will be monitored, targets met and timescales.
11 Oct	i. Health and Wellbeing Board (HWB) – Update ii. Implementation of the Care Act 2014 within secondary mental health services in Lancashire	i. Sakthi Karunanithi, LCC ii. Charlotte Hammond, LCC	i. Update on HWB Partnerships/Lancashire Health and Wellbeing Strategy ii. To receive referral made to scrutiny and to determine how the Steering Group wishes to proceed.

Updated: 17 October 2017

Appendix 'A'

Date to C'ttee	Report	Lead Officers	Outline reasons for scrutiny/scrutiny method
15 Nov	i. General service updates on Adult Social Care ii. Suicide Prevention iii. Update on the completion of the new primary care front-end at Royal Preston Hospital iv. VirginCare – Community Health and Urgent Care Services Contract	i. Tony Pounder, LCC ii. Chris Lee, Public Health, LCC iii. Stephen Gough and David Armstrong, NHS England – Lancashire iv. Jackie Moran, WLCCG	i. To receive general service updates and to prepare for January 2018 Committee meeting on DToC ii. Preparations and key lines of enquiry for Committee meeting scheduled 12 December 2017 iii. Update – briefing note/attendance at meeting iv. Update on contract awarded to private provider
6 Dec	i. Implementation of the Care Act 2014 within secondary mental health services in Lancashire ii. Better Care Together iii. Your Care, Our Priority; or iv. Together A Healthier Future	i. Charlotte Hammond, LCC, and LCFT ii. Morecambe Bay CCG iii. Peter Tinson, Fylde and Wyre CCG iv. Mark Youlton, East Lancashire CCG	i. Awaiting responses to a referral made to scrutiny in relation to a Section 75 Agreement ii. Update on the Bay Health and Care Partners LDP and outcomes of Trust Boards in relation to integrated hospital community and primary care services (Integrated Care Communities ICC). iii. Update on the Your Care, Our Priority LDP and Multi-speciality Community Providers (MCP) iv. Update on the Pennine Lancashire LDP
10 Jan 2018	i. Quality Accounts for Trusts ii. Our Health, Our Care Local Delivery Plan (LDP)	i. Steering Group and Healthwatch Lancashire	i. To formulate responses to requests from Trusts on their Quality Accounts ii. Outcome of clinical process mapping work

Updated: 17 October 2017

Appendix 'A'

Date to C'ttee	Report	Lead Officers	Outline reasons for scrutiny/scrutiny method
		ii. Jan Ledward, Mark Pugh and Sarah James GPCCG + CSRCCG	from the Solution Design Events and the LDP programme
7 Feb			
14 Mar			
11 Apr	LCC Adult Social Care Winter Plan	Tony Pounder, Sue Lott, LCC	Review the effective/robustness of the 2017 plan
16 May			

Topics referred by the Committee for Steering Group's action:

- Chorley Hospital Emergency Department mobilisation and Urgent Care Centre Performance (GTD)

Potential topics for Steering Group:

- West Lancashire LDP
- Pharmacies and prescriptions – volume of returned medicines and disposal of same, failure to collect, patient medicine reviews, change to current practice
- Low priority prescribing – consultations across CCGs - update
- Update from NWAS

Updated: 17 October 2017

- Capital investments across Lancashire
- Lancashire Care Association – update on Registered Care Managers Network (RCMN) – Paul Simic, CEO
- Delegation - To formulate objectives and intended outcomes for a delegation to lobby central government on the inequity of funding to address recruitment and retention issues in Lancashire