Item 4

Report of the Executive Director Core Services and the Executive Director Health and Adult Social Care & Place Director, Health and Care Barnsley, South Yorkshire Integrated Care Board (SY ICB), and the Health and Care Partnership to the Overview and Scrutiny Committee (OSC) on 29 April 2025

Managing the Demand on Urgent and Emergency Care (UEC) Services in Barnsley

1.0 Background

1.1 This paper is to provide the Overview and Scrutiny Committee with an update and overview of the proposed Urgent and Emergency Care (UEC) programme of work across Barnsley Place Partnership. This work will commence in April 2025. It is anticipated that the programme will run for a minimum of two years.

1.2 The ambition of this programme of work is to ensure Barnsley Health and Care partners:

- Achieve the national performance standards in relation to UEC, such as 78% of all patients attending the Emergency Department (ED) to be admitted or discharged within 4 hours of arrival to the ED (also known as Accident and Emergency, or A&E), Category Two ambulance calls (Category Two calls are deemed as emergency calls) to achieve a category 2 average mean response time of under 30 minutes (although the national response target is usually 18 minutes), and ambulance handovers at ED to take 15 minutes.
- As a partnership, we move to a more proactive and anticipatory approach to health and care management, for the population of Barnsley, reducing the need for urgent, or unplanned care services as people's care is known and better managed in general practice and community services.
- Health and care services to better link with, and involve, local voluntary, community and social enterprise services as part of more bespoke offers to the population.
- Improve the population of Barnsley's health and wellbeing outcomes.

1.3 The UEC programme of work includes six projects which are listed here:

- Working with General Practices (GPs) to improve on the day/same day access into general practice for urgent care needs (minor illness and minor injury)
- Developing and implementing a collaborative approach to better supporting and managing 'high intensity users' who frequently access services, using the Core20PLUS5 principles to this work
- Develop a local Clinical Assessment Service (CAS), building on the current model of RightCare Barnsley (RCB)
- Develop a Transfer of Care Hub at the front door to ED, supporting re-direction away from the ED where an alternate service will better meet the needs of the individual
- Input into the creation of Community/Neighbourhood Hubs, offering more bespoke needs using the Core20PLUS5 principles to the different cohorts who all make up the Barnsley population, better meeting people's needs and better recognising the wider determinants of health, and the impact these can have on an individual's health and wellbeing.
- Review the flow in, through and out of the hospital, including looking at admission and re-admission rates and reviewing the discharge process and opportunity for more robust multi-disciplinary decision making at the earliest opportunity, to support timely discharges to the right setting.

1.4 More detail around these six projects will follow in this paper (please see Section Three below).

2.0 Background

2.1 UEC remains a political and much scrutinised topic nationally. NHS England publish regular strategies and policies on how to improve UEC performance and improving patient experiences and outcomes. The

most recent and relevant NHS England publications that this programme of work is based on includes (and can be found in Section Five of this report):

- The newly published 2025/26 Priorities and Operational Planning Guidance
- The Lord Darzi's Independent Investigation into the NHS in England
- Guidance and recommendations from the 'Getting It Right, First Time' team
- Primary Care Recovery Plan-Modernising General Practice (2023-2025)
- Urgent and Emergency Care Recovery Plan (2023-2025)

2.2 NHS RightCare was launched in 2015. This was the beginning of the ethos fundamental to the UEC agenda of ensuring patients received the right care in the right place, by the right clinician, first time. This ethos/philosophy is what still drives the UEC agenda today, as it is agreed nationally, that there is an issue of too many people choosing to access the ED when their clinical needs meant they could have been dealt with in the community setting (such as by their GP, or other community health or care professional).

2.3 In 2022, the UEC Board requested support from NHS England to run an audit on alternative services as to where patients could have been seen for their clinical needs instead of the ED. The findings from this audit led to system partners doing some focused work on considering options around implementing 'something' at the front door of ED, to manage the lower acuity (conditions that are less severe and not immediately dangerous). Such options included having a GP hub in ED, a co-located Urgent Treatment Centre (UTC) adjacent to the ED and creating a multi-disciplinary decision-making unit within ED to support re-directing patients elsewhere. This work ceased in July 2024 as there were concerns around the potential additional costs and workforce requirements and uncertainty of how these options would be financed.

2.4 Despite this work in 2022-2024 not resulting in any tangible outcomes or outputs such as a 'new' service being implemented, it was instrumental in supporting partnership working and consideration of what is needed to reduce low acuity patients accessing the ED. It also reflected the difficulty of undertaking transformation when it meant moving existing resource across system partners, as there was no 'new' funding to implement proposed changes and enhancements. The discussions also highlighted the importance of ensuring that any solution did not add more activity into the system or simply shift activity (like for like) from one building/service to another building/service. The solutions must instead have a more proactive and anticipatory approach, better meeting the person's needs earlier, reducing the need for people to access urgent care services. This aligns with the ethos of 'right care, right place, right time, right clinician'. This approach also recognises there is a year-on-year increase in attendance to the emergency department of over 5%.

2.5 In 2024/25, various pilots were implemented to test new approaches to collaborative working, to support the reduction of patients attending the ED. One pilot had the GP Out of Hours (GPOOH) service working alongside the Assisted Living Team, the Night-sitting service and the Urgent Community Response (UCR) Team 8pm-8am. The latter three services were co-located with the GPOOH service (Priory Campus). This collaborative working saw improved relationships between the four services and enabled an integrated crisis/urgent intervention team to offer, for referrers, patients, family members and carers alike when requesting out of hours support. This saw timelier responses and quicker interventions, supporting patients to remain at home, reducing the need for patients to be conveyed (and potentially admitted) into hospital.

2.6 Between September and November 2024, a pilot tested the impact of having a Specialist Paramedic in Urgent Care (SPUC) from Yorkshire Ambulance Service (YAS) co-locating with RCB between the hours of 8am-8pm. RCB is a single point of access service and receives referrals from a variety of sources including GPs, community teams, hospital and the ambulance service. The team is a combination of administrators and clinical staff, who receive calls, and help navigate healthcare professionals to services both in and out of the hospital. RCB aims to support admission avoidance by helping healthcare professionals to ensure patients are on the most clinically appropriate care pathways, only being referred/told to go to ED when clinically necessary.

2.7 During the pilot, the SPUC was co-located in the same room as clinicians from RCB, supporting multi-disciplinary working, and logged in (remotely) to YAS systems, able to view calls in the Barnsley area, and work collaboratively with RCB clinicians to review and signpost work away from an ambulance

conveyance, to clinically appropriate alternate responses (such as an onward referral to other community teams e.g. UCR and respiratory teams). This pilot reviewed 281 incidents and provided an alternative ambulance response to 66% of incidents reviewed. 24% of the 281 cases were passed to community teams, 63% of the cases were dealt with by the paramedic themselves, and 13% were changed from an ambulance conveyance to a Hear and Treat (H&T) clinical consultation by a paramedic. These alternative responses saved approximately 270 hours of ambulance time.

2.8 Barnsley Hospital have also invested in its workforce within the ED, recruiting their own GP workforce to deliver the 'GP Streaming' service (for the low acuity/primary care type presentations that 'walk in' to the ED). The hospital has also invested in a dedicated workforce who deal with the 'lower acuity major' patients (slightly higher acuity than primary care but not requiring an emergency response). Investment has also gone into the paediatric service, expanding the service to operate between 7am and midnight now, rather than a 12-hour service. This investment is to support the delivery of the four-hour performance by being able to better stream all those attending ED, with dedicated workforce in place to deal with each 'type' of clinical acuity.

2.9 General practices across Barnsley are maximising the Additional Role Reimbursement Scheme (ARRS) funding, enabling practices to enrich their teams with additional clinical and non-clinical roles, such as Physician Associates, Nurse Associates, Phlebotomists, Pharmacists, Social Prescribers, Health and Wellbeing Coaches and Care Coordinators. These roles are providing additional capacity equating to 173.8 Full Time Equivalent across Barnsley, mainly delivering clinical and direct care roles.

2.10 In 2024, nationally, NHS 111 was extended to provide additional help to those in mental health crisis. This development means that patients are now able to access urgent mental health support directly by contacting NHS 111, and by selecting the mental health option, can be put through to a local mental health crisis line, managed by partners. The extension to the NHS 111 service is for those people who are experiencing a mental health crisis and require urgent medical advice.

3.0 Current Position

3.1 The issue that the programme of work is aiming to improve, is that activity across the health and care system continues to increase year on year, with people living with ill-health for longer. The acuity of people's clinical needs is also increasing. This may be a result of the covid era, with people not able to access more timely care, and/or being scared to access services, combined with health and care services being slower to respond to patient's needs due to the back logs that covid created and workforce reductions. There is also the possibility that people are now more reluctant to get help with a health and care concern, only accessing services when they feel it is impacting them significantly, missing opportunities to keep the illness/condition at a more manageable level.

3.2 Activity across the health and care landscape is increasing. Key headlines:

- 1.75% increase in patients registering at a GP over the past three years
- 19% increase of appointments delivered across general practice from Q1 22/23 to Q1 24/25
- 25% increase of same day appointments across general practice from Q1 22/23 to Q1 24/25
- General practices have maintained the workforce levels (with a slight increase in GPs in this last quarter (Q3 24/25)
- ED attendances are on the increase, with April 2024 up from April 2023 by 10% and May 24 up from May 23 by approx. 6%. Year to date (as of August 2024) attendees to the ED are up by 5.4% based on plan.
- ED faces significant challenges at the beginning of the week with attendances at 300+ on a Monday for 49/52 weeks in the year across 2023/4, with similar patterns consistent throughout 2024/25 thus far. The average attends for a Monday range between 291 – 343, with a peak of 397 in September 2023.
- Community services such as the UCR are exceeding their targets of a 70% two-hour response rate (over 90% of the services responses are delivered within the two-hour period), and carry a significant case load, keeping people in their own home or community setting, and keeping patients away from hospital where feasible.

- ED four-hour performance has been poor over the winter period, receiving scrutiny from NHS England, in part due to the volume of people attending ED. However, performance has improved in March.
- The response times for YAS Category Two calls for Barnsley for the year to date is 29 minutes 20 seconds.
- The average handover time for YAS at Barnsley ED (year to date) is 21 minutes and 54 seconds.
- YAS 999 call handling remains very good, with an average call answer time of 4 seconds during February, with a year-to-date position of 5 seconds.
- YAS 'hear and treat' rates, (where a clinician is able to provide treatment and advice over the phone and an alternative, more appropriate service is identified) remains good, with performance at 16.3% of calls in February, an increase of 0.3% on the previous month.
- YAS delivery of the NHS 111 service has continued to see improvements in call response times and the service received 140,292 calls in February. The average call answer time in February was just over 30 seconds, with 96% answered within a minute.

3.3 The ethos of the transformational work that is underway is to continue to build upon the work that has already been done, making pilots a key part of 'business as usual', to ensure that across Barnsley we continue to improve alternative pathways to ED. This also means educating health and care professionals on what these alternate pathways or services we have, here in Barnsley, as well as members of the public. A key principle of this transformation work is to make unplanned care planned care, at the earliest opportunity by having a stronger prevention and pro-active approach to care, using collaborative working to bolster faster, multi-disciplinary clinical and professional decision making, optimising patient care and better managing patients' care needs. This ultimately should mean less people attending ED, as their health and care needs are better managed in their own home or community setting.

3.4 More detail on each of the six transformation projects are detailed here:

Project One - 'Working with General Practices to improve on the day/same day access into general practice for urgent care needs (minor illness and minor injury)'

3.5 This project will involve initially working with general practices whose patients are high users of the ED. This will explore why the patients may be accessing ED as opposed to their own practice, and influencing the practices to consider if they could offer an improved same day/on the day offer (such as amending how they structure their appointments and clinics, reviewing what skill mix they have available and looking at potential ways to improve this), and are ensuring their access model into their practice is user-friendly for their patients (such as a combination of digital access alongside telephone access and face to face access). This work will also involve patient communications, to try and myth bust the 'can't get an appointment at my doctors' and to encourage patients to contact their practice first, when they have a minor illness or injury, instead of going to the ED.

3.6 Expected outcomes to this project is to ensure same day access for minor illness and injury conditions are improved, specifically at the practices where they may not have had the best offer for their patient demographics. Another outcome will be that ED will see a reduction of ED attendances who are streamed to the GP streaming service, as patients are accessing their own registered practice more, due to the improvement work and improved ability in accessing their practice. The outcomes of this will be reduced activity in ED, so more likelihood of the four-hour performance target being met.

Project Two: Developing and implementing a collaborative approach to better supporting and managing 'high intensity users' who frequently access services, using the Core20Plus55 principles to this work

3.7 This project will focus initially on patients who access a service frequently (usually five or more times within a 12-month period) such as ED, general practice, and YAS, who live in the more deprived areas of Barnsley (Index of Multiple Deprivation (IMD) 1 initially). The project will link with community assets and services already in place to understand from these individuals what the barriers are (either real and/or perceived) as to why they are accessing urgent and emergency care services so frequently, and to ascertain if perhaps their reasons are more social needs. Work can then be done to better connect these individuals into the services and community groups that may better meet the wider determinants of health needs. This approach means this project will be very tailored, to ensure the needs of the diverse

population of Barnsley are better met, rather than a one size fits all approach. This project will also offer awareness raising to the public, on when and how to access healthcare services and encourage awareness and understanding on self-care, health promotion, and what is available in their local community to help support them with their health and care needs.

3.8 Expected outcomes of this project is to reduce the volume of high intensity users across Barnsley, alongside reducing the number of times these individuals access various services. Another outcome is for these cohorts of the population to have better connections with local voluntary and community services, better meeting their social needs and wider determinants of health. This will improve their health and wellbeing. The outcomes of this will be reduced activity in ED, so more likelihood of the four-hour performance target being met.

Project Three: Develop a local Clinical Assessment Service (CAS), building on the current model of RightCare Barnsley.

3.9 This project will build on the success of the co-located GP OOH service with UCR, night sitting service and assisted living service pilot (as detailed in section 2.5) and the SPUC in RCB pilot (as mentioned in Section 2.6 and 2.7), building up a larger multi-disciplinary team (MDT) of health and care professionals to determine the most appropriate pathway for a patient based on their clinical needs. The aim is to broaden this team to include having (for example) GP representation, mental health specialist, social workers, UCR and paramedics working on the CAS 24/7. This wide team of health and care professionals will give a broader and more holistic view to patients' health and care needs and sharing information. The project will involve communications to health and care professionals, encouraging them to use the service when they have any queries about what pathway a patient needs to go on/which service may be the most suitable based on the health and care needs.

3.10 The outcomes of this project will be an increased use in appropriate alternatives to ED, and therefore a reduction of people attending ED. It will improve awareness of services available for health and care professionals to refer/signpost a patient into, and it will improve patient outcomes as they are receiving care in the most appropriate place, by the appropriate clinician, within the appropriate timescales for their needs. It will also reduce the 'spike' of demand services often see when 'in hours' services open, as the CAS aims to be in operation 24/7, giving timely responses to those contacting the service. The outcomes of this will be reduced activity in ED, so more likelihood of the four-hour performance target being met.

Project Four: Develop a Transfer of Care Hub at the front door to ED, supporting re-direction away from the ED where an alternate service will better meet the needs of the individual.

3.11 This project is similar to the CAS as described above, in the fact it will have a multi-disciplinary skill mix of health and care professionals, who work at the 'front door' of ED, so when a patient has accessed ED, the MDT can determine what service may better meet the patient's needs, and encourage the patients to go to that service as opposed to waiting in the ED.

3.12 The outcomes of this will be reduced activity in ED, so more likelihood of the four-hour performance target being met. It will support the 'right care, right place, right time, right clinician' ethos. A further outcome will be improved patient awareness of where to go in the future, as their understanding and education of services will be improved.

Project Five: Input into the creation of Community/Neighbourhood Hubs, offering more bespoke needs using the Core20PLUS5 principles to the different cohorts who all make up the Barnsley population, better meeting people's needs and better recognising the wider determinants of health, and the impact these can have on individual's health and wellbeing.

3.13 This project will link with the wider Neighbourhood Health approach to improving people's health and wellbeing and reducing health inequalities (an agreed shared priority in the Barnsley Place Plan 2025-2030) and consider how to better use and maximise the community assets available, such as the Community, Voluntary and Social Enterprise (VCSE) organisations and community networks to help the public, improve their awareness on health promotion and self-care. The work will also support better understanding of the barriers (real and perceived) that different cohorts of the Barnsley population experience, in managing their health and care needs and accessing services, which result in people accessing urgent and emergency care. The core 20PLUS5 principles will be applied to this work, focusing

on the most deprived pockets of the population of Barnsley. By understanding the barriers people face with their health and care needs, bespoke and improved community hub offers can be established, that support people keeping healthy and well, reducing the need for people to access urgent and emergency care services. Equally, when people do need to access such services, they have improved awareness of what is available for them to access.

3.14 The outcomes of this project (and the wider Neighbourhood Health model) will be improved understanding for how people can look after their own health and wellbeing better, with improved knowledge of what is available within their own community/area and connections to support them keep well, including the wider determinants of health which are critical and underpin people's health and wellbeing. Therefore, a shift to more anticipatory and pro-active care, reducing the pressures on urgent and emergency care services. Health inequalities will reduce as bespoke and focused hubs will be developed, that reflect specific and differing needs, of the different pockets of the community that make up Barnsley.

Project Six: Review the flow in, through and out of the hospital, including looking at admission and re-admission rates and reviewing the discharge process and opportunity for more robust multi-disciplinary decision making at the earliest opportunity, to support timely discharges to the right setting.

3.15 This project will focus on the internal processes within the hospital, considering the patient flow in, through, and out of the hospital. It will include reviewing (using the 'Criteria to Admit' tool) if all admissions into a hospital bed are necessary, with potentially reducing the number of admissions if deemed that perhaps at times patients are admitted when they don't clinically need to be. Discharge processes will also be reviewed, to ensure there is a robust, multi-disciplinary clinical and professional decision-making, at the earliest opportunity to ensure patients are discharged as soon as it is clinically appropriate, and into the right setting, with the right care needs in place. For example, ensuring social workers are involved in the discharge discussions at the very beginning, alongside the hospital staff. Reviews will also take place to see if more people can be discharged earlier, for example before 5pm, and even noon, to improve their experience.

3.16 The outcomes from this project will see potentially less people admitted, allowing the hospital to have more 'flow' as it is less full of patients, and an improved timely and more comprehensive discharge process. Patients will therefore spend less time in hospital than is clinically necessary, be discharged to the right place, with the right support in place based on their health and care needs. This work will also see a reduction of re-admissions post-discharge, as care needs are being met, supporting people to recover and recuperate.

3.17 It is anticipated that all the six projects will reduce activity going into the ED, supporting the ED to better meet the four-hour performance target. The projects will also improve knowledge and awareness across the health and care professionals about alternate services and pathways that patients can be referred/signposted into, that better meet the patients' needs. This supports the right time, right place, right clinician, first time ethos.

3.18 The transformation work also aligns to the Neighbourhood Health approach to care, as set out by the new Labour Government, adhering to the principles of prevention not treatment, and care closer to home. The work also supports the move to better proactive and anticipatory care for the population of Barnsley, improving people's health and wellbeing thus reducing the need to access urgent and emergency care services. The work aligns to other priority areas of work within Barnsley, such as Ageing Well, and Primary Care, as these also share the fundamental principle of needing to be better in preventing illness, better proactive and anticipatory management of long-term conditions and health needs and improving patient education and awareness of how to keep healthy, and how to self-care more.

3.19 Each project will undertake an Equality, Quality Impact Assessment to ensure there are no equality or diversity issues in any of the proposed projects. The projects all need to operate within existing financial parameters, there is no additional funding to deliver these. This is where collaboration and partnership working are key, as partners can see where the activity may flow differently, and the funding mechanisms must follow, to enable the change to occur.

3.20 The UEC Programme Board will have oversight of all the projects and seek assurance from the project leads regarding project delivery, progress, achievements of milestones and key deliverables. The Board will support in risk mitigation when risk has been escalated. The project groups have been set up, with clear proposals and scopes developed.

4.0 Future Plans & Challenges

4.1 The challenges this suite of projects will face is when decisions need to be made regarding changing funding flows, to support any transformation and change to pathways/ways of working. Barnsley system partners, as all other systems across the country are working in the context of significant financial challenges with no additional national funding available to support the transformation and improvement work planned. Significant elements of any new models would ideally require a period of double running to enable the impact to begin to be delivered, and activity begin to reduce as desired enabling the reduction of costs and transfer of funding to the more proactive, anticipatory model of care and this is unlikely to be possible.

4.2 However, the UEC Board have agreed the six projects, and the Integrated Care Board (ICB) have engaged with all partners collectively (such as at Place Committee and Partnership Group meetings) and individually (such as partner executive boards) and all partners have agreed to the projects, their scope, and implementation. Therefore, any challenge that may occur once the projects are fully underway can be discussed at the UEC Board, with escalation as required to the Health and Care Place Partnership Board to overcome these together in the spirit of the common purpose and shared ambition that has been agreed, and the improvement that needs to be delivered.

4.3 Another potential challenge is the timescales as this transformation programme is a long-term programme, initially two years in duration, but likely may take longer, due to the complexities of this involving multiple partners across the health and care system, as well as the public and community assets such as the Voluntary, Community and Social Enterprise organisations. There is also the risk of national change, both in the structure of the NHS and the Department of Health and Social Care, and in strategies and policies which have yet to be published (such as the new Health and Care Plan) which may disrupt work and/or change the focus; however, the projects will adapt to any such requirements.

5.0 Invited Witnesses

The following witnesses have been invited to the session to answer questions from the committee:-

- Katy Calvin-Thomas, Executive Director, Adults & Place Health, Barnsley Council and South Yorkshire Integrated Care Board
- Kate Parker, Portfolio Lead – Transformation & Delivery, Place (Barnsley), NHS South Yorkshire Integrated Care Board
- Michael Wright, Managing Director, Barnsley Hospital NHS Foundation Trust (BHNFT)
- Gill Stansfield, Deputy Director of Operations, South West Yorkshire NHS Foundation Trust (SWYPFT)
- Jacqueline Howarth, Service Manager, RightCare Barnsley
- James Barker, Chief Executive, Barnsley Healthcare Federation
- Adam Layland, Director of Partnerships & Operations South Yorkshire, Yorkshire Ambulance Service (YAS)
- Councillor Jo Newing, Cabinet Spokesperson, Adults & Place Health, Barnsley Council

6.0 Possible Areas for Investigation

Members may wish to ask questions around the following areas:-

- What change management principles will you be adopting to ease the transition for partners, workers, and for residents?

- To what extent are the missed targets in A&E down to processes and systems? What needs to be put in place to effectively support change?

- What feedback has been received from service users and staff on the pilot projects and how have they been involved in shaping plans?

- Why were those specific projects identified as the way forward and what evidence and considerations have been taken into account when designing the projects so that the models are sustainable and fit for the future?

- Were any alternative projects or models evaluated? If so, why were they discounted?

- Are there any contingency plans in place for the potential failure of any of the six projects, and if so, what are they?

- What are the key milestones and what needs to be done to ensure the project progresses at pace?

- How will the new model impact on patient safety? Will it improve or is there a risk that potentially serious issues may be missed?

- How does the social care sector and the ambulance service fit in with the changes? What is likely to be the impact?

- What do you expect the challenges to be in relation to access and equity? Are there any specific sections of the community that are likely to be disproportionately affected?

- What is the strategy for communicating the plan to the general public? How can patients determine the most appropriate care for themselves?

- What does success look like and how will you monitor and measure risks and success?

- What can Elected Members do to best support this work?

7.0 Background Papers and Useful Links

- Urgent and Emergency Care Recovery Plan (2023-2025) NHS England » Delivery plan for recovering urgent and emergency care services – January 2023

- The newly published 2025/26 Priorities and Operational Planning Guidance NHS England » 2025/26 priorities and operational planning guidance

- The Lord Darzi's Independent Investigation into the NHS in England Independent Investigation of the National Health Service in England

- Guidance and recommendations from the 'Getting It Right, First Time' team Further Faster Handbook - UEC December 2024.pdf

- Primary Care Recovery Plan-Modernising General Practice (2023-2025) NHS England » Delivery plan for recovering access to primary care

8.0 Glossary

A&E	Accident and Emergency
ARRS	Additional Role Reimbursement Scheme
BHNFT	Barnsley Hospital NHS Foundation Trust
CAS	Clinical Assessment Service
ED	Emergency Department
GP	General Practice/Practitioner
GP OOH	General Practice Out of Hours Service
H&T	Hear and Treat
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation

MDT	Multi-Disciplinary Team
RCB	RightCare Barnsley
SPUC	Specialist Paramedic in Urgent Care
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
UEC	Urgent and Emergency Care
UCR	Urgent Community Response
UTC	Urgent Treatment Centre
VCSE	Voluntary, Community and Social Enterprise
YAS	Yorkshire Ambulance Service

9.0 Officer Contact

Jane Murphy/Anna Marshall, Scrutiny Officers, Scrutiny@barnsley.gov.uk

16 April 2025