Readiness for Winter and achieving the A&E 4 hour wait

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Context

Emergency Care Improvement Programme

System wide review and recommendations for action

Confirmed priorities to be addressed as

- Clear system wide vision
- Frailty
- SAFER
- Ambulatory Care
- Escalation (in & out of hospital)

NHS National A&E Plan

Creation of A&E Delivery Board / Replace SRGs Chaired by Trust CE

National focus on five priorities to be delivered locally

- Streaming in A&E
- NHS 111 Calls transferred to clinician
- Ambulance Response Programme
- Improved Patient Flow
- Improved Discharge

Included within

Included within

GP Alliance Actions

CWPT Actions

LA Actions

CCG Actions

UHCW Actions

Local A&E Delivery Plan

- **Home** first - No-one goes to hospital who should be managed elsewhere in the community.
- **Avoid** -No-one is admitted to hospital that doesn't have an acute hospital need.
- **Pace** - Admission through to discharge is effectively coordinated and managed, to ensure no-one waits more than 24 hours to leave hospital once medically fit for discharge.
- **Targeted** - On-going care and support resources are targeted at those patients whose needs cannot be met in other ways.

Performance and Current System Demand

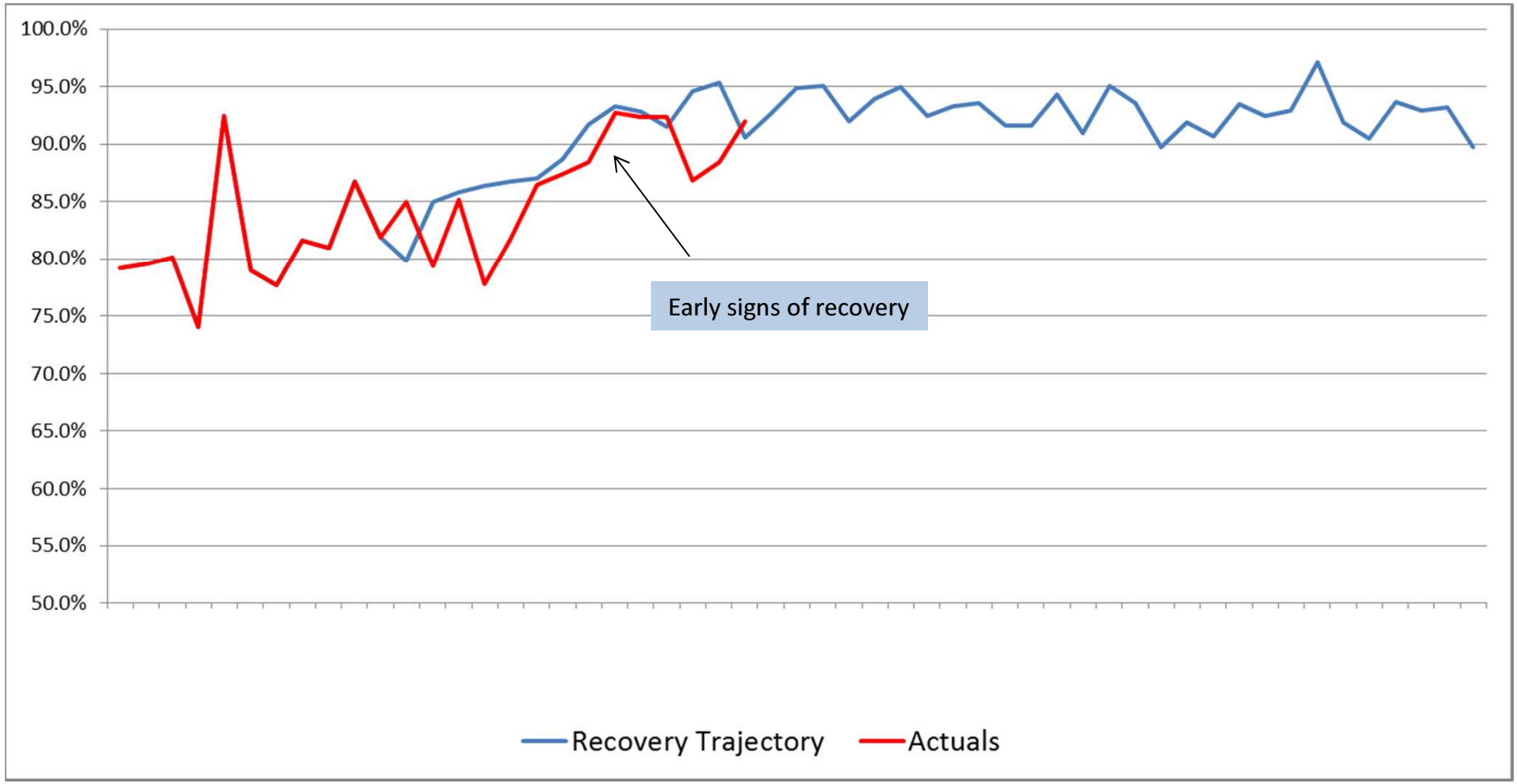
Performance

- Performance is below constitutional standard of 95%
- Local system pressures nationally recognised so the System Transformation Fund (STF)requires 92% in Q4
- Performance has risen since A&E Plan agreed

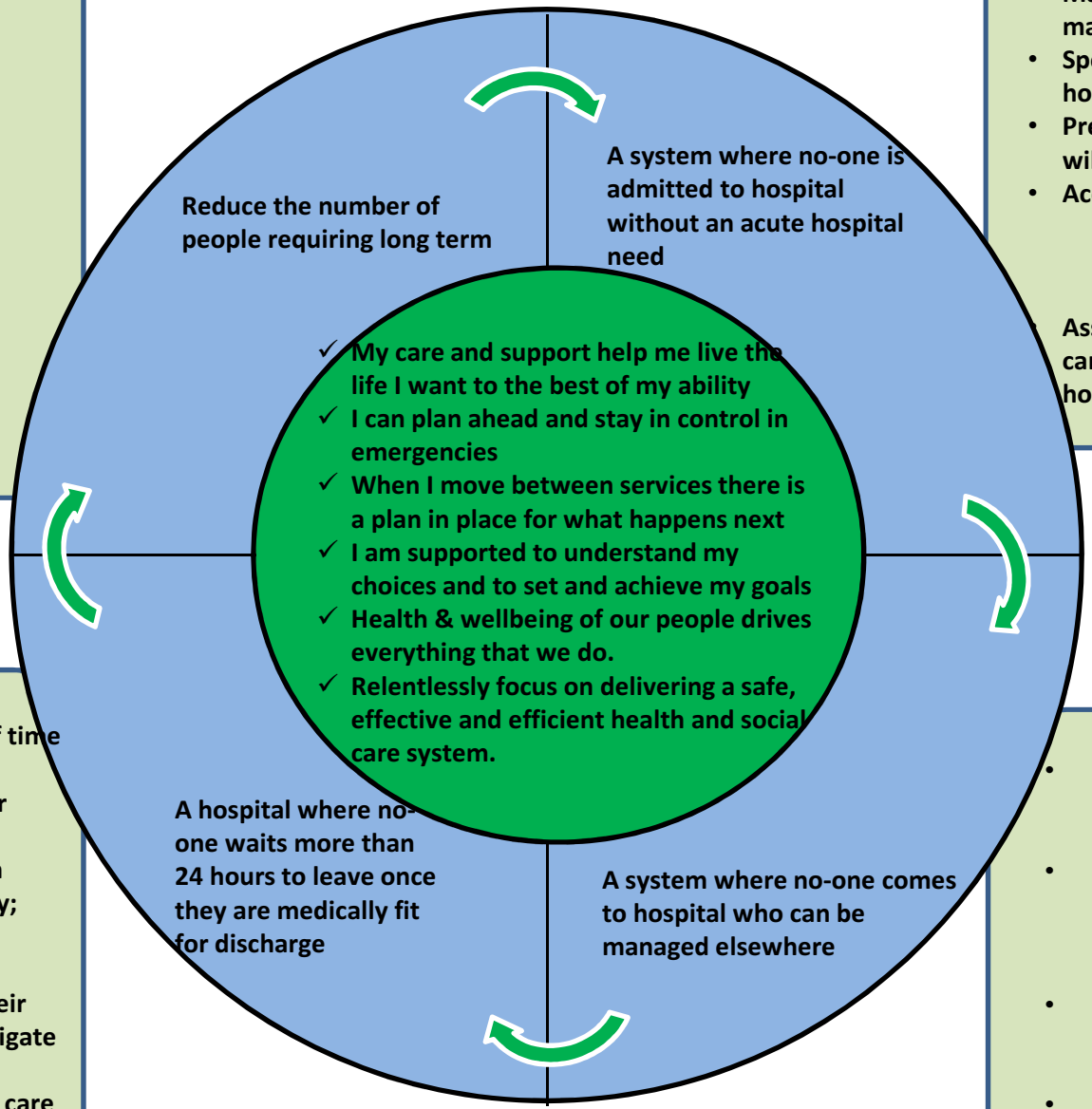
System Demand – What the data shows

- A&E Attendances have risen.
- Emergency admissions
    - Short stay admissions are up
    - Longer stay admissions are stable
- DTOC remains too high well above 3.5% target (actual 6.6% bed day lost in July 2016.)

Current Performance – April 2016 to Sept 2016



System Vision



- Increasing the amount of time people spend at home through early intervention, prevention and recovery
- Preventing and delaying the onset of frailty
- Helping people to move through care pathways more effectively

- Common principles to care Identify frailty and manage/care Maintain independence and maximise this at home
- Specialist outreach from hospital
- Presumption that the patient will go home
- Access to
  - packages of care
  - results out of hospital
  - to what patients need

Assumption that 90% of this care can be given away from hospital

- Reducing the amount of time spent in hospital
- Helping patients recover their independence (Maximise and maintain independence – mobility; nutrition; continence; personal care; ADLs)
- Involving patients in their care to not over-investigate and / treat)
- Common approaches to care wherever the patient is cared for

- "I am supported to understand my choices and achieve my goals"
- Delivering integrated and seamless services which improve the coordination and continuity of care for patients
- Increasing the number of frail people being identified who need support
- Ensuring a safe and effective alternative to acute hospital care, 24/7

A&E Plan – in summary

Home first - No-one goes to hospital who should be managed elsewhere in the community.

- **CWPT** – Single point of Access, Urgent Primary Care Assessment, Integrated Neighbourhood Teams, Urgent Primary Care Turnaround. ***Modelled weekly impact 96 reduction in A&E attendances, 35 avoided admissions***

- **CCG** – High Intensity Users including Care Home Enhanced Support, Transformation of End of Life Care, Dementia Care (including Admiral Nurses), Long term Conditions & MH, Communications Campaign. ***Modelled weekly impact 35 reduction in A&E attendances, 8 avoided admissions***

- **GP Alliance** – GP Enhanced Hours. ***Modelled weekly impact 5 reduction in A&E attendances***

- ***WMAS –*** Electronic Patient Record. ***Modelled weekly impact 25 reduction in A&E attendances, 5 avoided admissions.***

- ***SWFT*** - Rugby Falls Pathway, Integrated Neighbourhood Teams – Rugby, Urgent Primary Care Turnaround – Rugby. ***Modelled weekly impact 12 avoided A&E attendances, 12 avoided admissions.***

A&E Plan – in summary

Avoid -No-one is admitted to hospital that doesn't have an acute hospital need.

- **UHCW** – ED - Initial Triage, ED- Protect Minors Stream / Non-Admitted Pathway , Pathway development i.e. abdominal pain, Establish Frailty Unit on W21. ***Modelled weekly impact already accounted for in Home First schemes as these are enabler schemes to redirect work flow.***

- ***GP Alliance -*** Integrated Neighbourhood Teams/GP in ED/Primary Care Frailty pathway, ***Modelled weekly impact 5 avoided admissions.***

Pace - Admission through to discharge is effectively coordinated and managed, to ensure no-one waits more than 24 hours to leave hospital once medically fit for discharge.

- **UHCW** – SAFER implementation, Increased discharge in the morning, embed IDT model, 7 day therapy service across Medicine, Surgery and Rugby St Cross , improve quality and frequency of Board reviews - introduction of red & green days (ECIP supported). ***Modelled weekly impact doesn't affect demand, but increases flow and reduced breaches improves A&E performance by 4%.***

- **Coventry City Council** - Home based re-ablement for community access extra 150 hours from September, ***Modelled weekly impact a 0.4% improvement in A&E performance.***

A&E Plan – in summary

Targeted - On-going care and support resources are targeted at those patients whose needs cannot be met in other ways

- **CCG** – Community Support for re-ablement and assessment of ongoing needs (including CHC D2A improved Utilisation), amended to include case management of D2A pathway 3 – ***Initial Modelled weekly impact 2 avoided admissions, but as D2A embeds then will impact significantly on DTOC numbers and into improved A&E performance.***

Some of the mentioned schemes also formed part of a 90 day Frailty programme that was a joint initiative across all organisations, to focus on the care of frail people in crisis. This work involved agreement as to a Discharge to Assess model, the development of the frailty pathways in hospital and in the community, GPs within the emergency department.

Ongoing work in is train now to embed into place a clear Discharge to Assess pathways, with jointly agreed standard operating procedures and targets. A point prevalence survey was undertaken to assess the level of need for each pathway, and used to set out future requirements.

The following slides are some examples of the actions in place from the A&E Plan

Home first - No-one goes to hospital who should be managed elsewhere in the community. The CWPT Offer for Frailty

- CWPT deliver a suite of services to prevent hospital admission; Intermediate Care (Fast Response), UPCA, Frailty, District Nursing.

- In 2015/16 419,000 patient contacts across the community contract.

- Launch of Integrated Neighbourhood Teams in April 2016, a co-ordinated care model for planned care in the community designed around 3 GP neighbourhoods in Coventry designed to reduce acute hospital admissions.

From 1st September

- Single Point of Access with One phone number
- Urgent referrals ONLY via one phone call to enable effective discharge from UHCW and to avoid admissions via WMAS.
- To enable professionals to facilitate the right care for urgent referrals, helping to prevent avoidable hospital admissions. This will ensure patients can access high quality care, as quickly and easily as possible.
- Streamlining of the patient care pathway preventing multiple referrals, ensuring the patient receives the right service at the right time.
- This service will be provided by a senior clinician 7 days a week, 8am-8pm.

CWPT Patient Pathway - Example

This is Bob. He is 85 years old and lives at home with his wife Mabel who has dementia. Bob has diabetes and high blood pressure and is prone to UTIs.

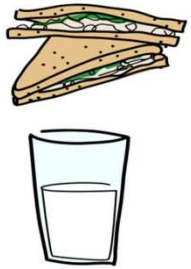
JANUARY 2016

Bob is feeling unwell. He visits his GP who decides that he needs a nursing and care package to remain at home. The GP contacts Intermediate Care (Fast Response Service), who arrange this.

Intermediate Care provide a four hour response.

Four visits a day are made to Bob's home to help with personal care (meals, fluid intake and to check on mobility).

The team also check the clinical system to identify any dementia intervention required from CWPT and communicate this accordingly.



MARCH 2016

Bob feels really unwell and dials 999.

The paramedics assess Bob and conclude that it is cellulitis which can be treated at home and he does not need to be taken to hospital.

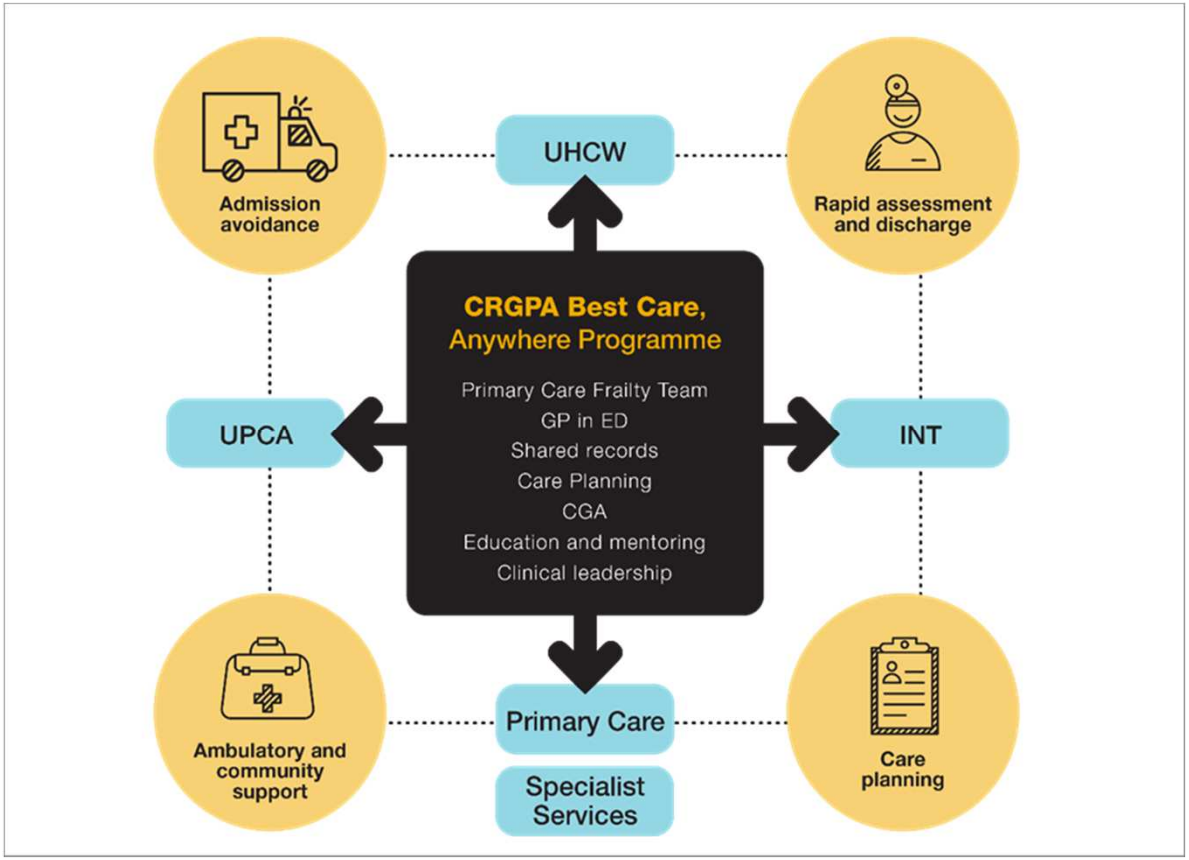
The paramedic calls CWPT Single Point of Entry (SPE). They speak to a clinician who accesses the clinical system and arranges to review Bob to keep him at home safely.

The clinician reviews Bob and adjusts the treatment and care package. If Bob had not been known to CWPT, a full health and social care assessment would be carried out and a package of care put in place.

Had Bob's daughter taken him directly to A&E, the A&E medics would have also accessed the CWPT SPE and the same process would have taken place. Bob would not have been admitted to hospital. .

If it had been after 8pm, A&E would contact WM Fire Service, who would facilitate the patient's return home. This would include an urgent safe and well check (water, food, risk assessment).

Avoid -No-one is admitted to hospital that doesn't have an acute hospital need. GP Alliance Best Care



Coventry and Rugby's GP Access Fund Programme 'Best Care, Anywhere'

The vision of the programme is to provide an integrated solution; improving primary care access and ensuring continuity of care through integrated pathways, a shared and new primary care workforce and interconnecting technology between patients and clinicians.

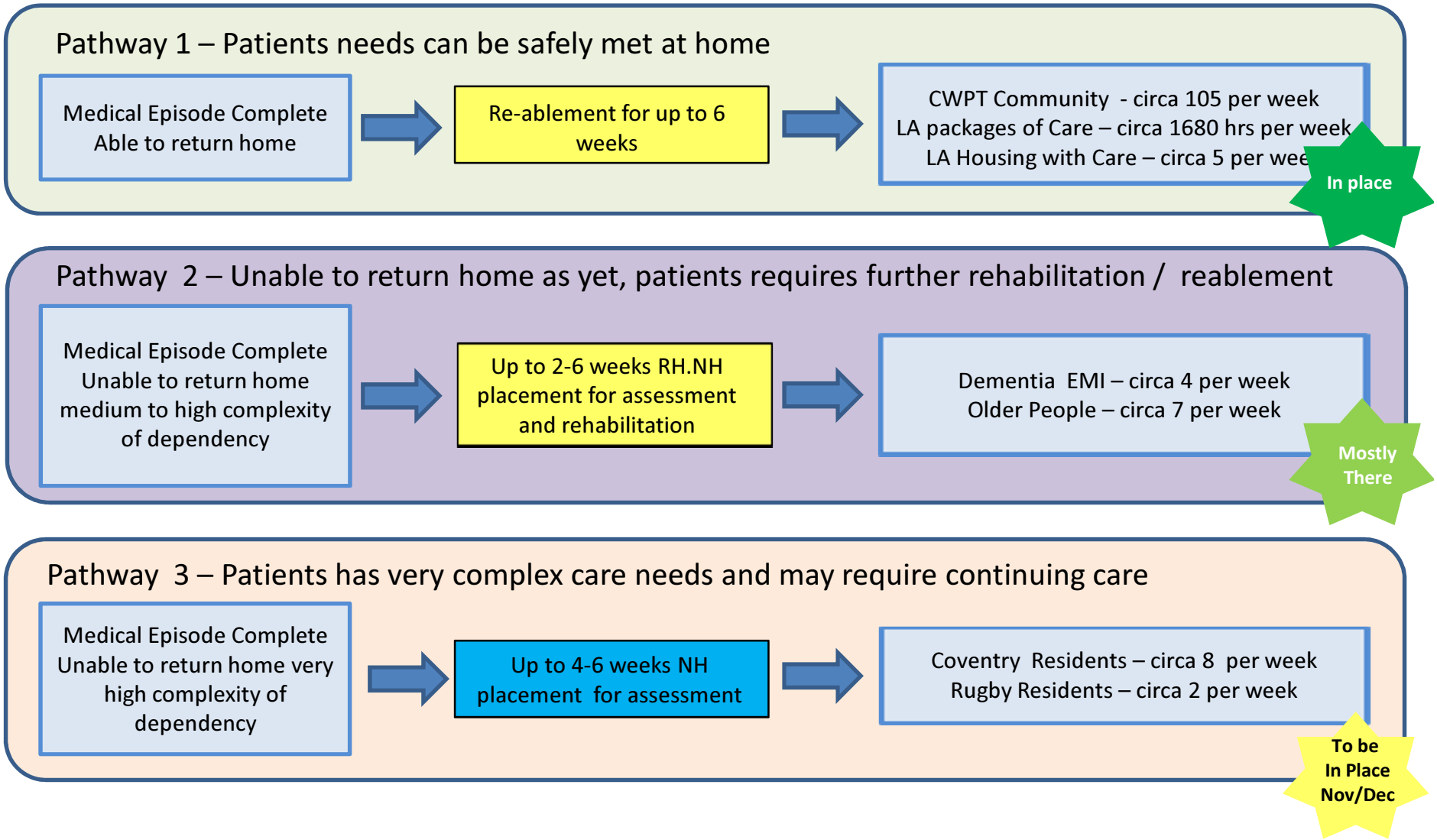
The GP-led Primary Care Frailty Team focuses on the older patient population with Coventry and Rugby's first GP-led multidisciplinary team of primary care specialists who provide discharge and care planning for frail patients and manage their care with a proactive, community-based focus.

Pace - Admission through to discharge is effectively coordinated and managed. UHCW – SAFER

S - Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A - All patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.
F - Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.
E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
R – Review. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

- ADN Ops x2 with responsibility for compliance
- Tiger Teams to drive forward implementation
- Audit and review
- Improved Quality of Ward and Board Rounds
- Internal Communications Campaign

Targeted - On-going care and support resources patients whose needs cannot be met in other ways – CCG / LA Discharge to Assess



Progress

- Alternative Community pathways are in place – need to embed and ensure optimal utilisation, supported by joint CQUINs with providers to promote use of alternative suitable pathways.

- Frailty Pathway operational, with defined Standard Operating Policies, supported by GP Alliance GPs in ED. All 65+ attenders at ED assessed for frailty, and if identified as frail then a Comprehensive Geriatric Assessment is started within 2 hours and management plan put in place.

- Internal work at UHCW supported by ECIP on improving internal processes, i.e. implementation of SAFER.

- Discharge to Assess, appointment of 2 Case Managers for Pathway 3 made, reviewing existing CHC patients in D2A capacity, will focus on ensuring all pathway 3 patients are Discharged from Hospital within 48 hours maximum, and ensuring reassessment within 6 weeks of discharge to ensure flow – capacity to be increased in next two months. Joint workshop held with all partners 4th October.

Governance

A&E Delivery Board Coventry and Rugby
Chaired by Prof Andy Hardy, UHCW Trust CE
CE/CAO/Director representation from CCG/ LAs / CWPT as well as NHS E and NHS I representation

Nationally set mandate to cover compliance to the mandated improvement initiatives:-

- Streaming at the front door;
- NHS 111 – Increasing the number of calls transferred for clinical advice';
- Ambulances – DOS and code review pilots; HEE increasing workforce;
- Improved flow – 'must do's that each Trust should implement to enhance patient flow; and
- Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models.

Key responsibilities

- To lead A&E improvement and sustainability;
- To develop plans for year round system resilience and ensuring effective system wide surge and escalation processes exist;
- To support whole-system planning (including with local authorities) and ownership of the discharge process;
- To participate in the planning and operations for local ambulance services;
- To participate in the planning and operations of NHS 111 services including oversight of local DOS development;
- To agree how resources are deployed for maximum benefit of the system;
- To work within the Coventry and Warwickshire STP footprint & UEC Network to deliver the UEC Strategy