BRIEFING NOTE

TO: Health and Social Care Scrutiny and Performance Panel

DATE: 24 September 2015

SYSTEM RESILIENCE FOR WINTER: MANAGING DEMAND FOR URGENT AND EMERGENCY CARE IN THE WALSALL HEALTH ECONOMY

1. Summary

1.1 As with many other places around the country, the urgent care system in Walsall has been facing unprecedented and increasing demand for A&E attendance and emergency admissions to hospital during the last few years. So it is important to ensure that there is support in the community to prevent avoidable admissions to hospital, and that hospital discharge planning arrangements are working well. To support these aims we have planned for the right amount of health and social care service capacity available for patients to be able to leave hospital in a timely manner, in order to provide the right care in the right place at the right time.

1.2 This report is to describe the arrangements for the coming winter period.

2. Recommendations

2.1 That the Health and Social Care Scrutiny Panel note the arrangements and associated risks to the health and social care economy for the forthcoming winter period.

3. Activity

A&E Attendances

3.1 The A&E department at Walsall Manor Hospital had 85,811 people attend during 2014/15. In addition approximately 25,000 patients attended the department with less critical conditions and were triaged to the Emergency Urgent Care Centre at the Manor Hospital run by BADGER. To date (August) in 2015/16 the department has had 32,076 attendances, with an additional 15,400 patients being triaged to the Emergency Urgent Care Centre i.e. a slightly smaller number than last year.

3.2 In 2014/15, 80% of A&E activity was for Walsall CCG patients and 9.8% of activity was for patients from the South Staffordshire CCGs.

Emergency Admissions to Hospital

3.3 In recent years we have seen significant increases in emergency admissions to Walsall Manor Hospital. In 2014/15, 28,664 patients were admitted as an emergency – an average of 2,387 a month. To date (September) in 2015/16, 11,937 patients have been admitted as emergencies.

3.4 81% of emergency admissions in 2014/15 were Walsall CCG patients. 11% of emergency admissions were patients of the South Staffordshire CCGs.

3.5 Average length of stay for emergency admissions has fallen from 11.4 days in 2014/15 to 8.3 days in 2015/16 (year to date).

3.6 Emergency admissions continue to rise although the rate of growth is slowing down. The annual increase in emergency admissions since 2012/13 is summarised below:

Annual growth in emergency admissions	
2012/13	+15%
2013/14	+7%
2014/15	+4%
2015/16 (to date)	+4%

This therefore amounts to a total 30% increase in the level of emergency activity following admission since the start of 2012/13.

4. Priority Work Programmes

4.1 Three high level work programmes have been identified as a priority for 2015/16. The aims of each, progress to date and plans for 2015/16 are as follows:

Staying Well at Home

4.2 There are three main elements that make up one overarching programme for the integration of community services and each element is interdependent on the others. The three main elements are;

- Redesign of community health services;
- GP case management of people over the age of 75 years;
- Moving to locality based multi-disciplinary teams carrying out planned prevention on those at most risk of admission, made up of community health services; primary care services; social care services and mental health services.

4.3 Supported by £1.8m investment from the CCG, the Walsall Healthcare Trust has been expanding its community services to provide more care at home in 2013/14 and 2014/15. The main elements of this programme are listed below.

1. Expanding Community Health Services: 30 extra additional community nurses have been appointed and the community teams have been re-organised into 5 localities each covering about 50,000 patients which are aligned with

primary care services. Following a pilot earlier this year in Darleston, the five localities will work closely with local GPs and social care teams to identify the most vulnerable patients in the area and work to support them to remain at home whenever possible. For instance, the community matrons are systematically reviewing every patient who have had 2 or more emergency admissions to hospital in a 12 month period and ensuring that there is a plan to care for them at home.

2. Rapid Response Team. The capacity of the Rapid Response Team has been expanded to enable them to care for more patients. Referrals have been at their highest of nearly 200 per month during January and February and are currently between 130 and 150 per month. These are preventing hospital admission for 80% of those referred to it. The scope of the team has been extended through the provision of medical support (a GP employed by the Trust) and therapy support, and there are plans to coordinate this service with the social care reablement.

3. Support for Nursing Homes. Experienced community matrons are working with nursing homes in the borough to ensure that we have plans for caring for their patients. As a result there has been a 63% reduction in transfers to hospital from the nursing homes. Additional resource to extend this to residential care homes has been agreed and this is underway.

4.4 There is a Local Enhanced Scheme (LES) with GP's to conduct a healthcare and medication review of all the over 75's registered with each practice. The development of the specification and delivery process was clinically led and managerially supported by the CCG. The funding for the scheme was based on £60 per patient, per practice at a cost to the CCG of £1.3m for a population of 21945 of over 75's in Walsall. The aim is to improve access to primary care for the over 75's who account for some of the avoidable admissions into WHT and as a result deliver an overall reduction in admissions and readmissions for this cohort of patients.

4.5 The realignment of Community Health Services to work more closely with primary care services is the start of the development of multi-disciplinary teams made up of these services, together with social care and mental health services. The plan is to share access to information systems in the various agencies to support joint assessment and case management and thus streamline support and reduce duplication. From early 2015 there has been pilot for integration between health and social care teams serving the West locality (Darlaston and Willenhall). This will be rolled out across the other teams during the autumn, with involvement of the community mental health teams for older people in Dudley Walsall Mental Health Partnership Trust to follow.

Rapid Emergency Assessment and Treatment

4.6 This will provide a multi-disciplinary frail older people's assessment service at the front door of the hospital to assess older people and wherever possible provide a package of support at home to avoid admission. Where it isn't safe for people to go home they will be cared for in specialised beds in Ward 29 which will provide overnight bed based care which is specifically designed to support frail elderly people – some with dementia – to be able to go home as soon as possible. The

multi-disciplinary team will include social care and mental health services as well as hospital clinicians, and will work closely with community health and the patients GP.

Getting Home Quickly and Safely

4.7 At any one moment in time, the throughput of patients in the hospital means that there are between 90 and 120 patients who are clinically stable and medically fit for discharge. It is important to ensure that hospital discharge planning is working in a way that minimises the length of time that these patients remain in hospital, and that where patients need further support in order to leave hospital, there is the necessary amount of support to meet demand.

4.8 There are fundamentally three ways that patients leave hospital: the majority will go home on their own or with family support; some others will need health and social care support to go home; and a minority are not able to go home safely and so need to go to an intermediate care or 'step down' bed (in care homes) where they can recover to the point where they can go home, or a multi-disciplinary assessment can be conducted as to whether they need to go in to a care home.

4.9 Work is underway to streamline and clarify hospital discharge arrangements by setting an expected date of discharge for each patient, early identification of patients who are ready for discharge, and increase the number of patients who are discharged before lunchtime. Discharge co-ordinators are assigned to each ward and there will be a single point of discharge co-ordination so that patients needing on-going care and support can be triaged to the correct pathway.

4.10 Each year there is joint working to establish the amount of health and social care services that will be needed to ensure that patients are not delayed in hospital because there is insufficient service availability. This is a complex process requiring a comprehensive understanding of the likely number of people who will be admitted to hospital – especially in the winter months – and the subsequent correct amount of the right type of health and care services outside of the hospital.

4.11 The System Resilience Group has examined the pattern of demand during last winter and concluded that with the work underway across the three high level programmes described above, including significant additional investment in community health services which has succeeded in avoiding some emergency admissions, the system will be able to meet demand with the same capacity as last year. This is 21 beds in the Council run intermediate care centre at Hollybank, 40 Discharge-to-Assess beds in Nursing Homes, 8 Intermediate Step Down beds at Richmond Hall and a flexibility to spot-purchase additional intermediate care beds in care homes to account for peaks in demand.

4.12 If the level of demand allows, then some of the beds in the Swift Ward at The Manor may be held vacant and used as an additional mechanism for flexing the available capacity at times of high escalation. The level of social care reablement to support patients who can go home with support will also remain the same as last year.

5.0 Risk Management

5.1 Clearly there is a risk of insufficient capacity if the level of increase in emergency admissions to hospital increases at a significantly higher level than planned by these arrangements. Financial constraints in both the NHS and the Council make it difficult to increase the level of capacity for this coming winter without there being confirmation by Government of additional funding. The financial contingency funds through the Better Care Fund have already been invested in preventative capacity in the Walsall Healthcare Trust, and the system will need to operate within the current financial constraints.

6.0 Conclusion

6.1 The funding for all of the initiatives described above has been incorporated in to the Better Care Fund which thereby supports integrated commissioning of these services, and promotes more integrated delivery of health and social care between primary care, community health, social care and mental health services. It is, however, early days and the system is operating under unprecedented financial constraints whilst demand in the form of emergency admissions to hospital and care home placements continues to rise.

6.2 The impact of the additional CCG investment in community health services and the planned additional CCG investment in older people mental health services must be to reduce the level of emergency admissions and care home placements in order for the system to meet demand during the forthcoming winter.

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