Agenda item

Health and Wellbeing Board

4 January 2018

Walsall Vision for Emergency and Urgent Care

1. Purpose

1.1 To seek the views of the Walsall Health and Wellbeing Board to the vision for emergency and urgent care. This vision was developed by health and care lead officers to demonstrate our key aim for Walsall citizens.

2. Recommendations

2.1 To gain the Board's endorsement of the Walsall vision for emergency and urgent care.

3. Report detail

3.1 Colleagues from each of the main organisations responsible for health and care in Walsall attend the Accident and Emergency Delivery Board.

3.2 The Board has a remit across the health and care sector to improve the way in which citizens access and experience urgent care.

3.3 Over the last few months a number of improvement activities have been underway to help the Board and its member organisations improve the experience of our customers.

4. Implications for Joint Working arrangements:

4.1 There is a full System Recovery Plan appended to this report to highlight to the Board what they key areas of focus for improvement are. These are grouped under three main headings:

Attendance Avoidance
Patient flow (in the hospital)
Discharge pathways

4.2 Each of those elements has a key set of activities that the system leaders own and drive; these get monitored monthly at the Accident and Emergency Delivery Board

4.3 Many of these elements require greater understanding, cross over and synergies between teams and separate organisations.

4.5 One such example is that in Discharge Pathways, a new Integrated Intermediate Care Team is currently being established.

4.6 All of this aims to improve the customer's experience by better alignment and closer working across the system.

5. Health and Wellbeing Priorities:

5.1 The health and care system leaders are committed to the priority of

"creating a healthy and sustainable place".

Further, the vision for urgent and emergency care is designed to:

"improve healthy life expectancy"

and

"reduce inequalities".

Background papers

Vision (**Appendix 1**)

Microsoft Office
Word 97 - 2003 Docu

System Recovery Plan September 2017 (**Appendix 2)**

Microsoft Office
PowerPoint 97-2003 F

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frontline
we help you do things better

Appendix 1

Walsall Vision for ED and Urgent Care

Our aim is that citizens of Walsall live as healthy and productive lives as possible. If care is needed, then it should be provided as near as possible to your home and community.

Your home is for health, our hospital is here to support you. If you become ill, very often it is best for you not to be in hospital. There are other times of more serious illness when it is best that you are not at home.

At times, we recognise that you may need the services of our emergency department (ED) and urgent care services. Our ED facility is there to provide emergency services. It is your safety net. We want to do everything possible to help you avoid having to use this safety net.

Many different types of patients use our ED and urgent care services. We tailor our services to your needs. So if you are an elderly person living at home and have a fall, Walsall's ambulance, ED and social services will work with you and your family to get you mobile and back home as soon as possible. Spending too much time in hospital is not best for you or us.

If you are a younger person and have an accident, it may be of the kind that your GP or our urgent care services can treat. We'll aim to provide the necessary care and get you on your way as quickly as possible.

We are very aware of the risk in health care, and all our services will work together to manage and reduce risk. This includes you, in looking after your own health.

We provide a 24/7 ED and urgent care service. We aim for consistency and high quality outcomes. But we recognise, as you do, that there are challenges in providing, for example, very specialist services in the middle of the night. You therefore have the responsibility to use our services as they are intended to be used.

We work in partnership with all public services in Walsall to ensure that they are integrated, and that you don't see the joins between services. We will maximise the use of technology to help both you and us.

Technology will help us to join up our services and enable consistent and tailored care; it will help you to play a greater part in your own health and care. Your care plan will be shared across services so that we provide the right kind of care tailored to your needs in the right setting.

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Appendix 2

Walsall A&E Board Recovery Plan 2017/18

‘What steps need to be taken to ensure the system is fit for the purpose of delivering excellent unplanned care to the residents of Walsall and beyond, how will this improvement be delivered, and how do the local priorities and proposed actions align to regional and national actions and strategies?’

Authored by the A&E Board Operational Group on behalf of the Walsall A&E Board

Purpose of this document

This document sets out the recovery plan for the urgent and emergency care system in Walsall. The current system has consistently failed to deliver the national standard that 95% of patients attending A&E wait a maximum of four hours. The plan aims to improve performance to above England average (90%) by September 2017 and to 95% by the end of June 2018, and then to sustain this level of improvement. This requires the system to reduce daily breaches by 20 per day by the end of September 2017 and by 33 per day by June 2018.

The focus is on improving the overall health & wellbeing of the people of Walsall and, more specifically, the outcomes of them using the urgent and emergency care services that serve them

It sets out the current performance, with context, of the local health economy, the specific complications that are preventing the system performing at the expected level and the proposed actions that the system intends to implement to achieve the identified improvements required.

This document has been created to communicate to NHSE, NHSI and organisations delivering interventions in the Walsall health economy. It aims to articulate the A&E boards understanding of the challenges faced by the system, the critical thinking that has been applied to designing solutions to these key challenges and the detailed plans that are in place to deliver the agreed interventions aimed at delivering an improved health economy for unplanned care.

Whilst the document will set out the specific improvements required by the Walsall System the document also sets out the strategic alignment to national strategies

Contents

Contents (Continued)

Section 1 – Executive Summary

Executive Summary

The A&E Delivery Board is required to develop a System-wide Recovery Plan to achieve the 95% A&E 4 hour wait target by not later than September 2018 on a sustainable basis, with a milestone target to achieve 90% from September 2017 onwards.

The Board is supported by an Operational Group that has been focused upon three main work-streams: attendance avoidance; patient flow; and discharge pathways, and so the plan follows the same format. Each work-stream has its own governance arrangements. This in the form of separate arrangements for each element of attendace avoidance; the WHT Emergency Department Taskforce for patient flow; and the Joint Integrated Intermediate Care Steering Group for the discharge pathways.

The plan sets out 10 priority actions for achieving a recovery trajectory by reducing Emergency Department attendances, reducing emergency non-elective admissions; and reducing length of stay and thereby reducing excess bed days. Each priority action is the responsibility of one of the three work-streams.

The plan is focused upon recovering performance, but these actions will also have an impact on the finances of both the CCG and Walsall Healthcare Trust. The actions are listed below, and further work is currently underway to analyse and identify their predicted impact upon both performance and the potential financial savings.

The next two slides set out the 10 priority actions to be undertaken by the system in the coming months.

ATTENDANCE AVOIDANCE

1. Sustain increased referrals to rapid Response Service at 225 per month or more from the baseline in 2016/7 of 180 per month;

2. Redesign Community Respiratory Pathway. Expand the coverage of the current COPD Team to cover a wider range of respiratory conditions; ensure everyone diagnosed with a respiratory condition has a standardised plan for self-management and agree arrangements between Community Respiratory Team and Rapid Response Service to provide rapid response to people with respiratory conditions to prevent avoidable attendance at A&E;

3. Reduce ambulance conveyance via impact of enhanced clinical hub in NHS 111 to reduce referrals to WMAS for 999 call out, and to support ambulance crews with non-conveyance. NHS 111 clinical support for care homes. Co-ordinated partnership working to support High Frequency Users; focus on frail elderly

PATIENT FLOW

4. Sustain the number of same day discharges from the Frail Elderly Service in the Emergency Department at 230 or more from the baseline in 2016/17 of 200 per month;

5. Increase the number of patients supported by the Ambulatory Emergency Care (AEC) Pathway within the Emergency Department;

6. More effective streaming and triage process within the ED to ensure patients attending are channelled directly to Assessment Units, Frailty Service and Ambulatory Emergency Care Pathway thus by-passing A&E;

7. Continued work to embed SAFER and Red and Green approach at ward level with clinically led discharge. Listening in to Action programme to continue. Discharge Lounge and Bed Bureau to support increased patient flow;

DISCHARGE PATHWAYS

8. Reduce the number and length of stay of patients on the Medically Fit For Discharge (MFFD) list with an earlier start to discharge planning in the ED, and earlier discharge by increasing the percentage of patients discharged within 24 to 48 hours of entering the MFFD List;

9. Support the model of earlier discharge with more effective integration of intermediate care services;

10. Support the model of earlier discharge with increased therapy support for the ‘discharge home to assess’ model so that more patients are discharged home for their therapy treatment/ support instead of occupying a hospital bed.

Section 2 – High Level Overview

Current system situation

- **Primary Care –** Whilst the demographic of Walsall is typically more at risk from long term conditions which have a significantly higher prevalence than the national average these conditions are managed well by comparison to the national picture. Access to appointments is a concern but is not significantly worse than the national standard
- **NHS 111 –** Newly commissioned service delivered by Care UK from Nov 16. Clinical hub beginning to get established. Overall performance against KPIs encouraging
- **WMAS –** Impacted by unexpected peaks in conveyance creating handover delays at times, but performance against national service specification is high overall. Need to set a locally agreed target to reduce the actual number of conveyances
- **Integrated Urgent Care –** Good performance in the two UCC's with lower than planned activity in GP Out of Hours. Changes across whole system over the last two years has created a need to revisit the configuration of services and this is currently subject to public consultation
- **Community Health (admission avoidance)** – Locality based teams now established. Rapid Response team not yet reaching target of 225 referrals per month. Plan in place for this to achieve from September 2017. Plan in place for revised model of respiratory pathway from January 2018. Community Health provision contributes significantly to the management of LTC's and, as a result QoF performance

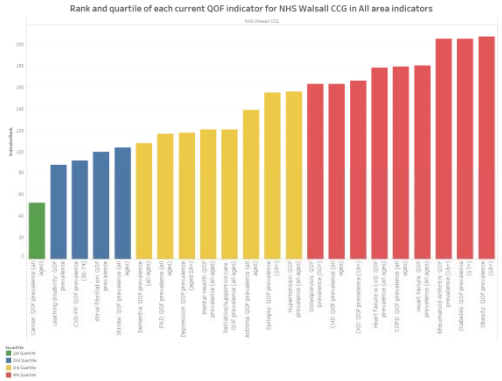
Current system situation (cont)

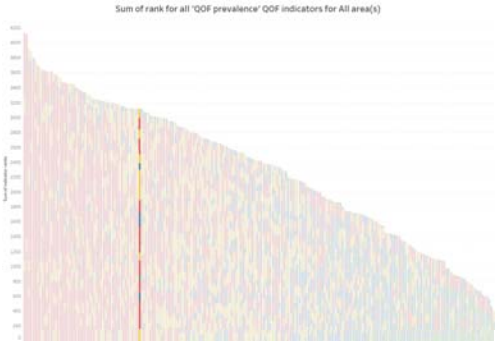
- **Acute Care** – Ability to meet 4 hr target is a significant challenge. In addition to achieving the 95% target, there is pressure to reduce the medical bed base to sustainable and safe levels. Intensive support has been aligned to patient flow which has had an impact, however the redesigned processes and new ways of working (e.g. Big Room) are not being consistently applied which is leading to performance being inconsistent. Recruitment of ED staff continues to be challenging. Implementation of SAFER Bundle and Red/Green Programme inconsistent at ward level.

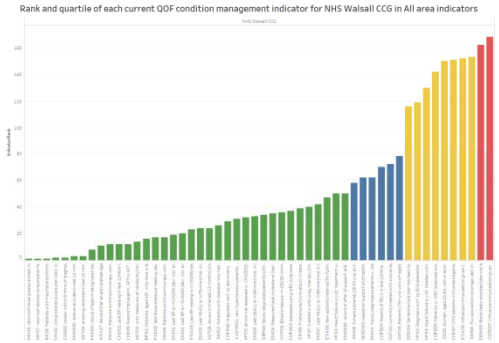
- **Community Health (supported discharge)** – Implementation of revised model of integrated hospital discharge and intermediate care underway from September 2017. Overall aim is for discharge within 24 to 48 hours of patient becoming medically fit for discharge (MFFD) with therapy assessment and treatment, CHC assessment, and social care assessment conducted out of hospital. The therapy element of this integrated pathway continues to be an issue. MFFD numbers have reduced from April 2017 to average 70 to 80 from previous average 120 to 130.

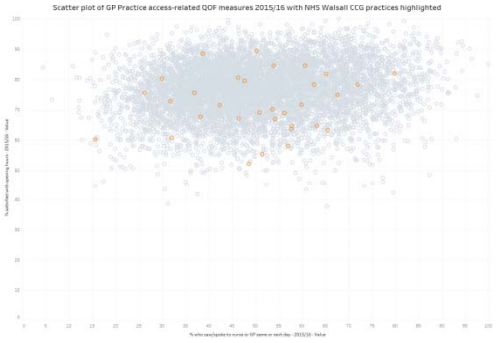
- **Social Care –** Capacity is not inhibiting discharge of patients from the acute setting for Walsall residents. Capacity has been steadily increasing with residential LoS decreasing as a result of new ways of working. Integrated pathways are not yet fully embedded, but implementation of revised model is underway. Therapy services are a significant challenge within social care settings.

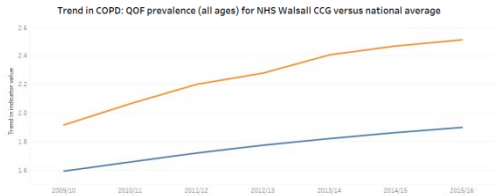
Self and Primary Care

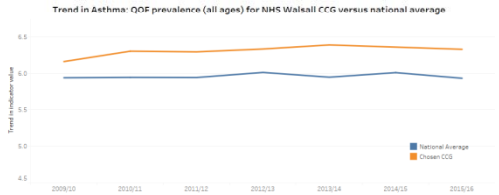








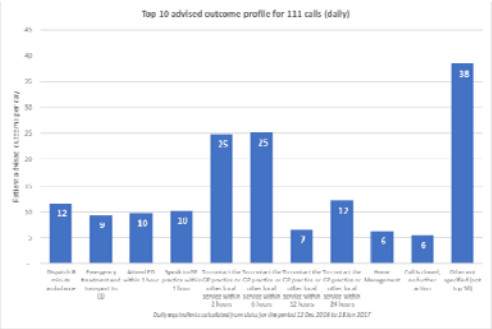


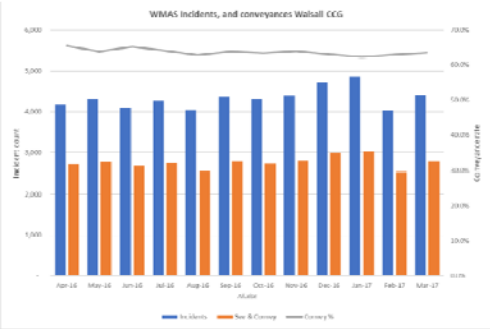


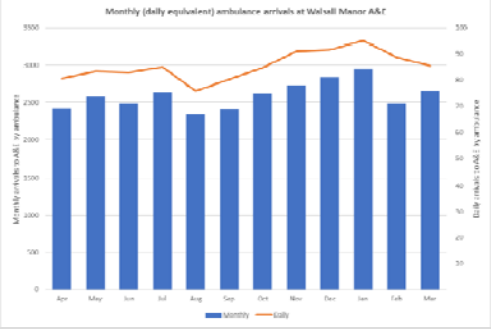
Self Care and Primary Care - Conclusions

- Disease prevalence in the Walsall population is close to the worst quartile nationally
- Walsall CCG performs better than the national median on 36 of 51 national indicators related to condition management outcomes. Condition management indicators are in the top few percentiles nationally.
- Walsall CCG's population is on average reasonably satisfied with GP Practice access when compared to other CCGs. There is no significantly worsening trend in relative terms.
- GP Practices perform reasonably well compared to national profiles in relation to access although there are a small number of outliers.
- Walsall CCG area has consistently higher prevalence of respiratory illnesses than national averages. The gap compared to that average has consistently risen in recent years.
- CONCLUSION: Improvements to self care and primary care in Walsall, whilst necessary and important in their own right, would not significantly affect ED performance

111 and WMAS


Top 10 advised outcome profile for 111 calls (daily)
12
9
10
10
25
25
7
12
6
6
38


WMAS Incidents, and conveyances Walsall CCG


Monthly (daily equivalent) ambulance arrivals at Walsall Manor A&E

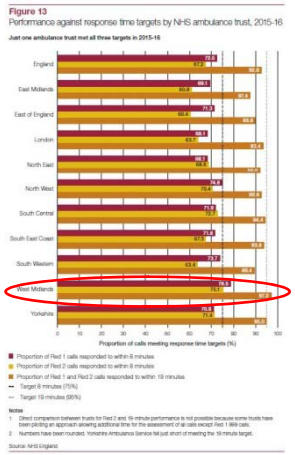


Figure 13
Performance against response time targets by NHS ambulance trust, 2015-16
Just one ambulance trust met all three targets in 2015-16
England
East Midlands
East of England
London
North East
North West
South Central
South East Coast
South Western
West Midlands
Yorkshire
Proportion of calls meeting response time targets (%)

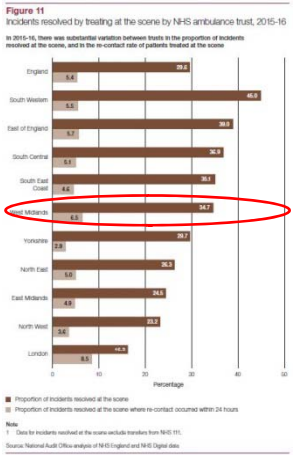
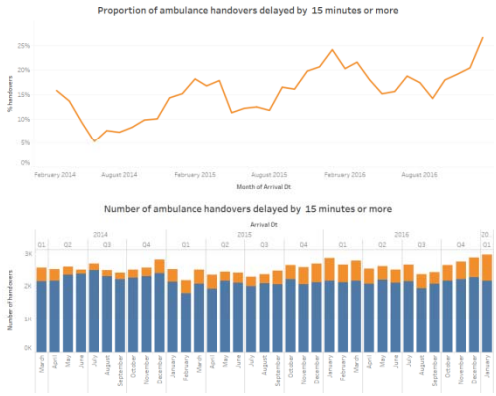


Figure 11
Incidents resolved by treating at the scene by NHS ambulance trust, 2015-16
England
South Western
East of England
South Central
South East Coast
West Midlands
Yorkshire
North East
East Midlands
North West
London
Percentage


Proportion of ambulance handovers delayed by 15 minutes or more
% handovers
Month of Arrival Dt
Number of ambulance handovers delayed by 15 minutes or more
Arrival Dt
Number of handovers

Ambulance Response programme

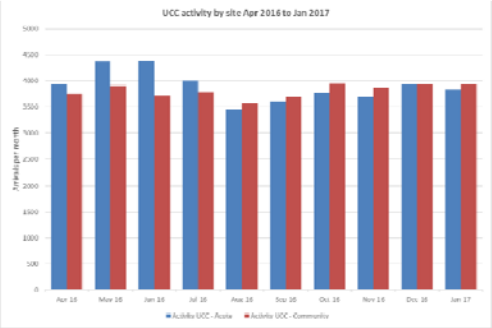
WMAS piloted the Ambulance Response Programme (ARP) and therefore all of the required changes in operational processes have been fully implemented across the West Midlands. WMAS have highlighted the following achievements following implementation of the ARP:

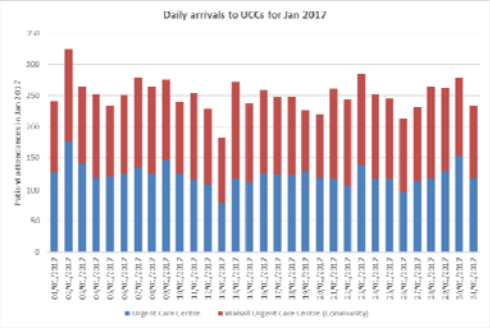
- A higher proportion of responses by ambulance compared to rapid response vehicles (RRV) from previous daily peak outputs of 215 Ambulances and 99 RRVs, to 310 Ambulances and 14 RRVs;
- Providing faster response to patients across all categories
- Ensuring priority patients such as Stroke cases get to hospital quicker
- 96% of resources now have a Paramedic on board and will 100% by Winter 2017
- RPI Reduced from 1.23 to 10.7 – saving nearly 100,000hours
- WMAS responding to +8% more demand (+69,000 incidents)
- WMAS utilising -4.5% less resource (-50,000 resources to scene)
- The number of patients transported to hospital has fallen from 62% to 60%
- Less Control / Dispatch staff required to handle a simpler model
- Wastage reduced by two-thirds in Paramedics on RRVs needing to travel with an Ambulance
- Total Fleet mileage reduced by 5%
- Total Fleet assets reduced, whilst the Emergency Ambulance Fleet has increased by +69
- Total number of Estate locations reduced 50% (+64)

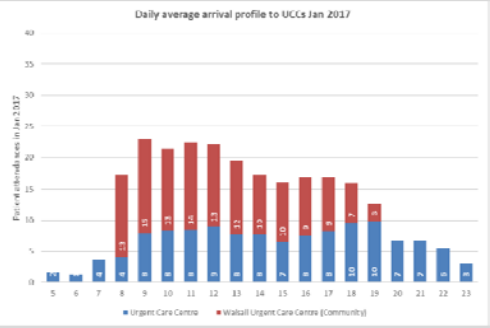
NHS 111 and WMAS Conclusions

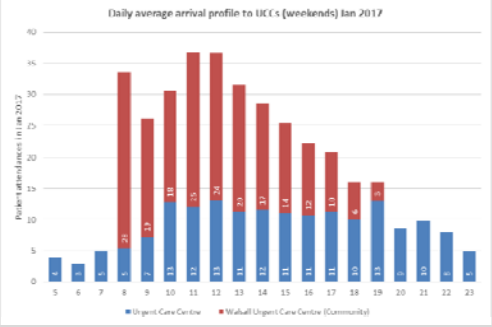
- Calls to NHS 111 from Walsall population average around 160 per day. Around half the activity (79 patients per day) are directed to their own GP after receiving advice over the telephone. One fifth (31 patients per day) who call NHS 111 are directed to A&E. The enhanced Clinical Assessment Unit (CAS) is expected to reduce referrals to WMAS and A&E of low acuity patients.
- Ambulance call outs have increased by 4.1% in four months from April 2017 compared to 2016. It's difficult to find an explanation for this. The % of call outs that have been conveyed has remained the same, but this means a higher number of ambulance arrivals. Unexpected peaks in ambulance arrivals causes problems in the ED because of lack of space for cohorting by HALO.
- The number and rate of 15+ minute handover delays for ambulances arriving at A&E at Walsall Manor have followed a seasonal pattern over recent years and has seen a consistently increasing trend since early 2015. There is a higher level of delays caused by unexpected peaks in the number of ambulances arriving.
- A small number of High Intensity Service Users(HIUs) create a disproportionate amount of conveyance. Plan in place to support HIUs from December 2017 resulting in reduced attendances.
- CONCLUSION: Impact of CAS in NHS 111 and ARP expected to reduce extent to which low acuity patients arrive at ED. More effective support to HIUs is expected to reduce ED attendance. Handover delays and peaks of ambulance arrivals are expected to continue.

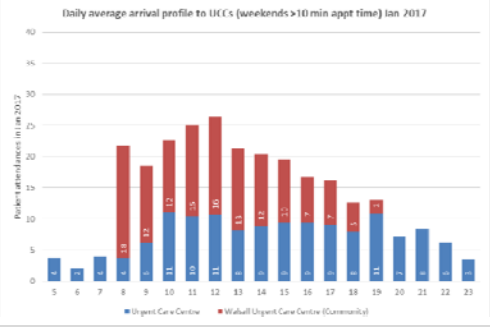
Out of Hours and Urgent Care Centres

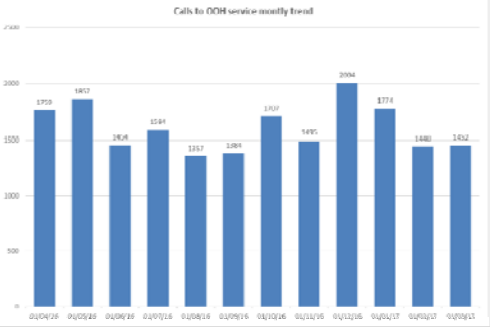








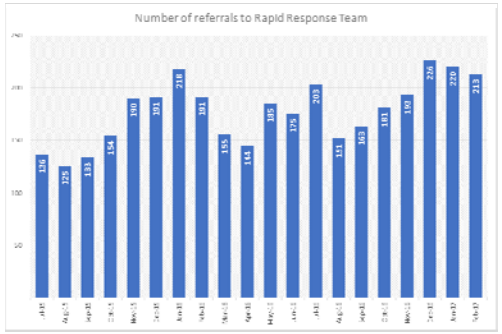


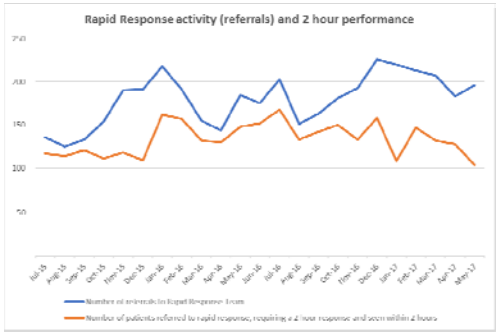


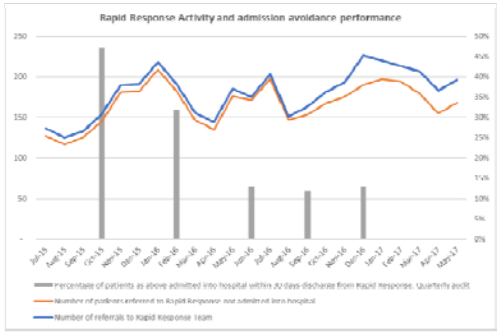
Out of Hours and Urgent Care Centres Conclusions

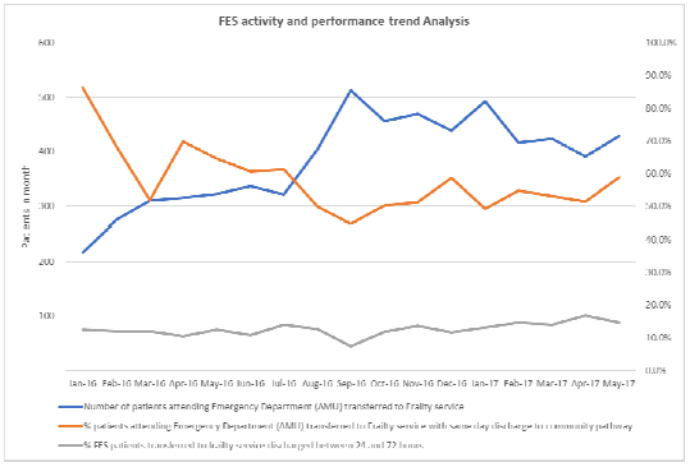
- UCC activity is relatively stable over time and consistent between the 2 UCC sites, equating to around 3,750 attendances per month for each. Daily activity is between 220 and 270 attendances per day and remains fairly evenly split between the 2 sites.
- 35% of Town Centre UCC activity has 10 min or less treatment time versus 18% for Walsall Manor UCC. The Town Centre UCC has 60% greater activity at weekends than on weekdays, whereas the Walsall Manor UCC weekend activity is just 34% higher weekends than weekdays.
- Weekend hourly attendances at the Town Centre UCC are 50% lower between 1pm and 8pm than they are 8am-12pm. On week days attendances are 30% lower pm than am.
- These statistics suggest there is both lower acuity and less urgency of attendances, underpinning the Town Centre UCC activity.
- OOH calls activity average 1,600 per month. No trend of change in volumes. OOH activity averages at 47 patients per day but varies significantly between weekdays (28 patients) and weekends (100 patients).
- Maximum activity (8-10 per hour) arises on weekend mornings and gradually reduces as the day progresses. Home visits spike at lunchtime weekends.
- CONCLUSION: There is effective streaming of urgent primary care patients away from A&E with some marginal room for more impact.

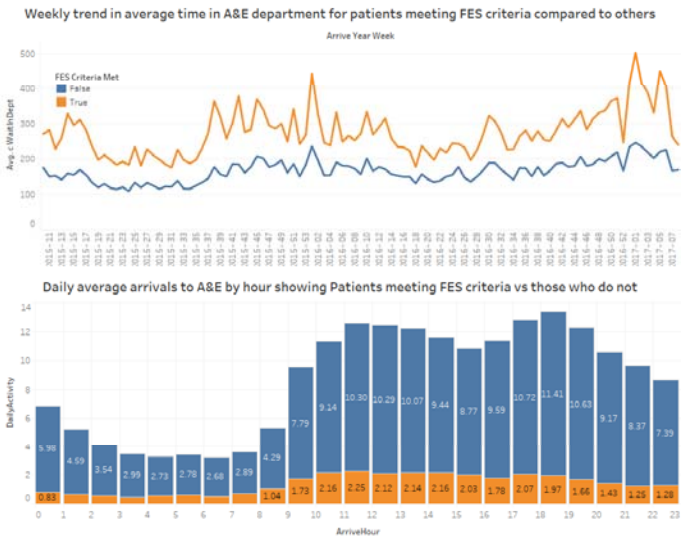
Demand Management







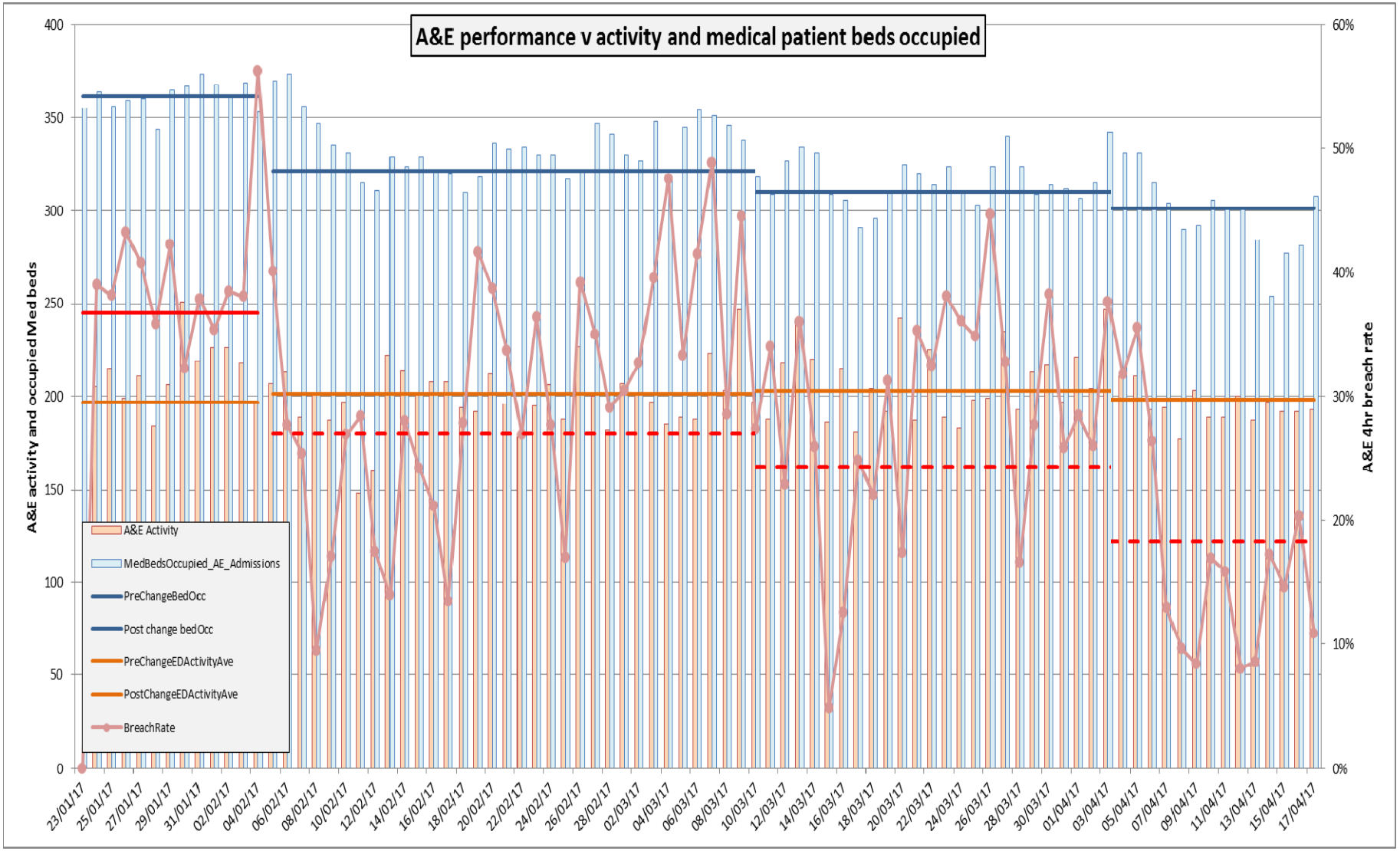




Demand Management Conclusions

- Referrals to the Rapid Response Service (RRS) follow a seasonal trend. Referrals are 18% higher than the equivalent than in the previous year, currently receiving around 210 referrals per month and aims for a two hour response time. As activity has risen, a lower proportion of referrals have been seen within this target timescale so triage system implemented to agree longer response times with GP's for some patients.
- The proportion of referrals to RRS that were subsequently admitted within 30 days of intervention has reduced to 12.5% from a high of circa 50%.
- In the early stages of Frail Elderley Service (FES) introduction activity trended at around 300 referrals pcm. Its currently in excess of 400 pcm and regularly exceeded 450 pcm over the winter. The % of same day discharges to a community pathway and the % 24-72 hour discharges have both been relatively consistent at around 55% and 15% respectively.
- Average total time in department (TTOD) is 275 minutes for patients 70+ with 3-5 triage score, compared to 167 minutes for others. These patients account for just under 17% (35 patients per day) of total activity but 25% of total time in department.
- Streaming more patients who meet FES criteria directly to a clinically appropriate setting could deliver a significant improvement in 4 hour performance.
- CONCLUSION: RRS and FES are supporting significant numbers of frail elderly and so the potential impact of further work on these services on ED performance is limited.

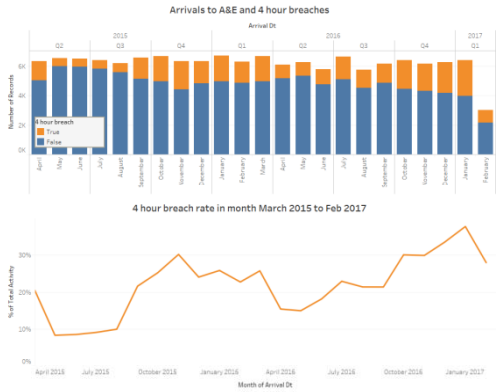
Attendance at Emergency Department

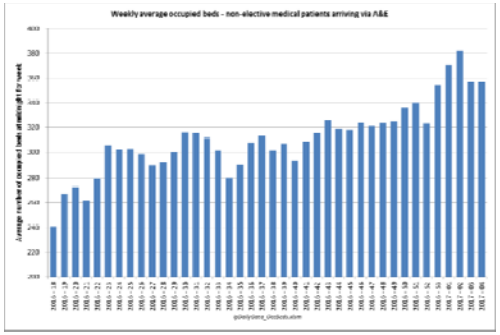


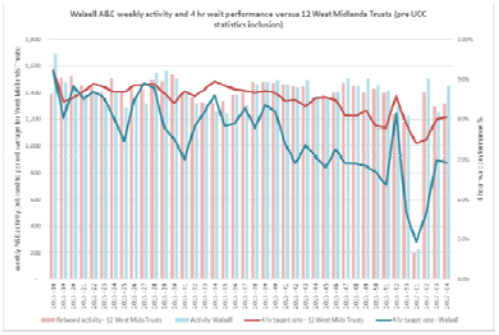
Attendance Conclusions

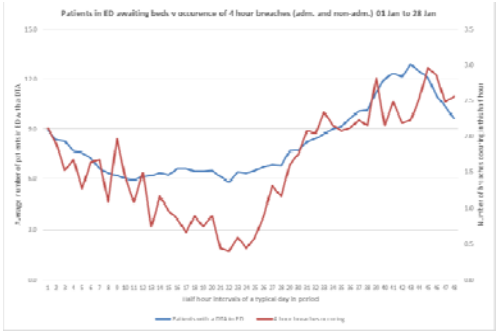
- There is no direct correlation between daily attendances and daily breaches.
- When compared to the West Midlands Trust average, the post intervention period saw a reversal of the earlier decline relative to peers without being driven by relative changes in activity. This brought Walsall 'back to the pack' in terms of A&E 4 hour performance.
- Performance is shown to slip back soon afterwards albeit not to Jan 2017 levels. So while the Trust shows it can implement these approaches in the short term, they have not been fully embedded into standard process.
- CONCLUSION: Continuing to work on reducing attendance is a necessary and important work-stream but will not in itself impact on the level of performance

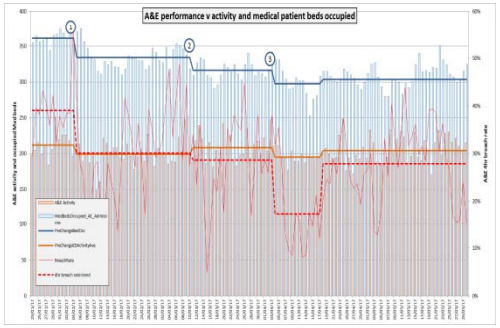
Acute provision

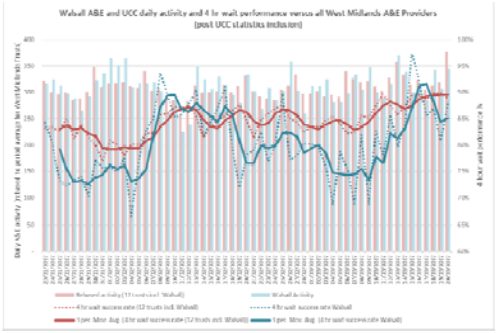




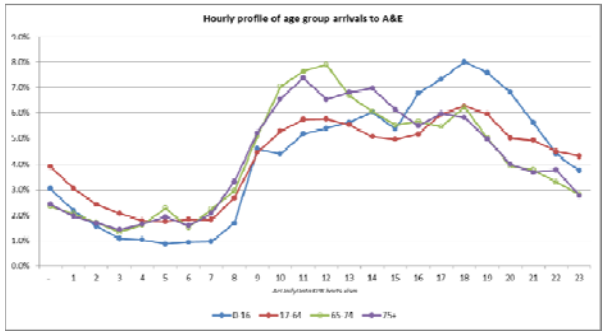


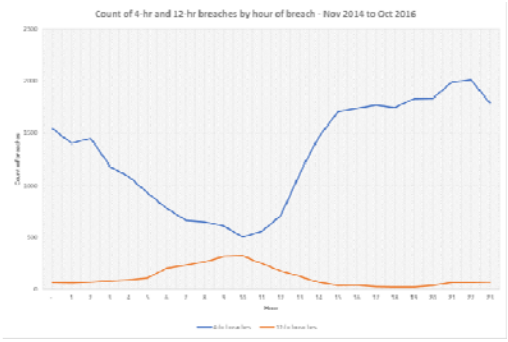


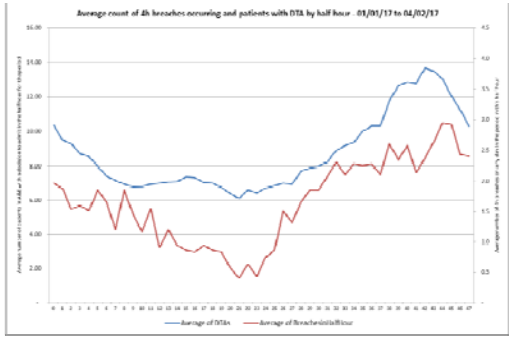


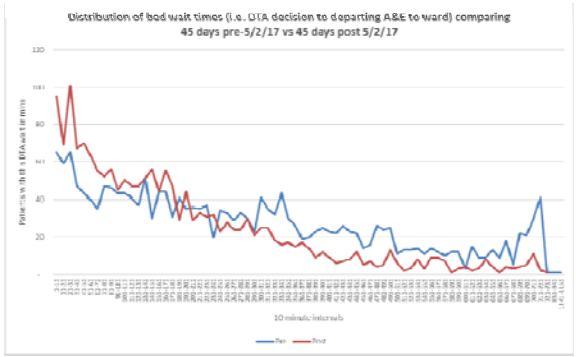


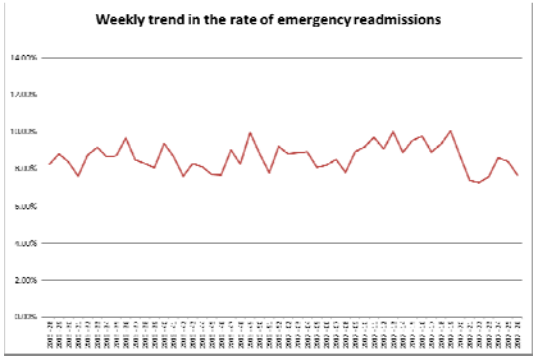
Acute Provision (Cont)

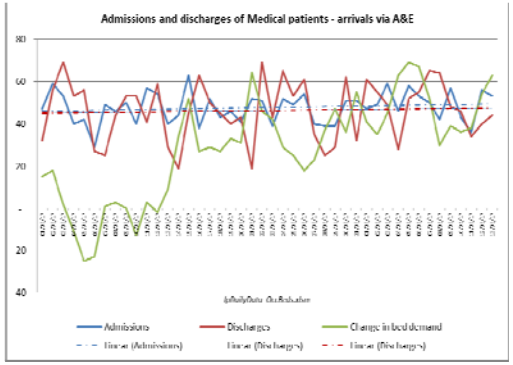




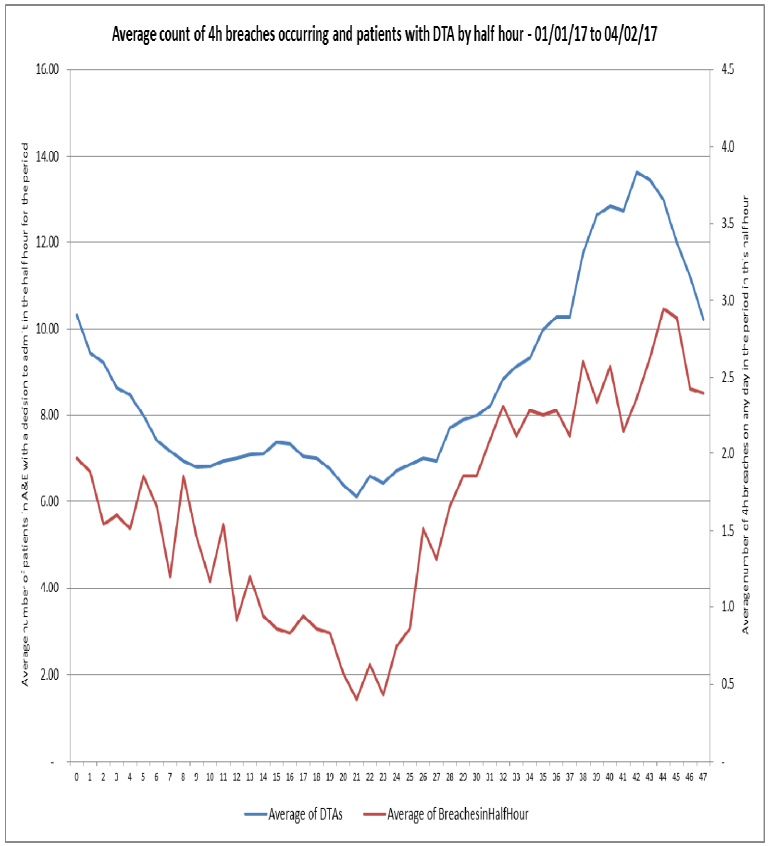


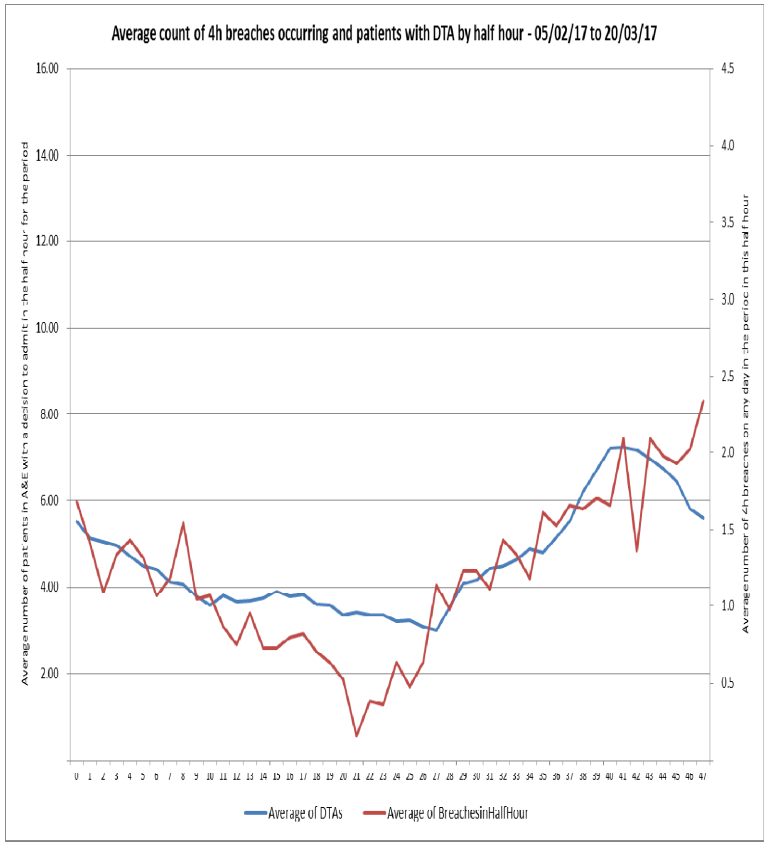




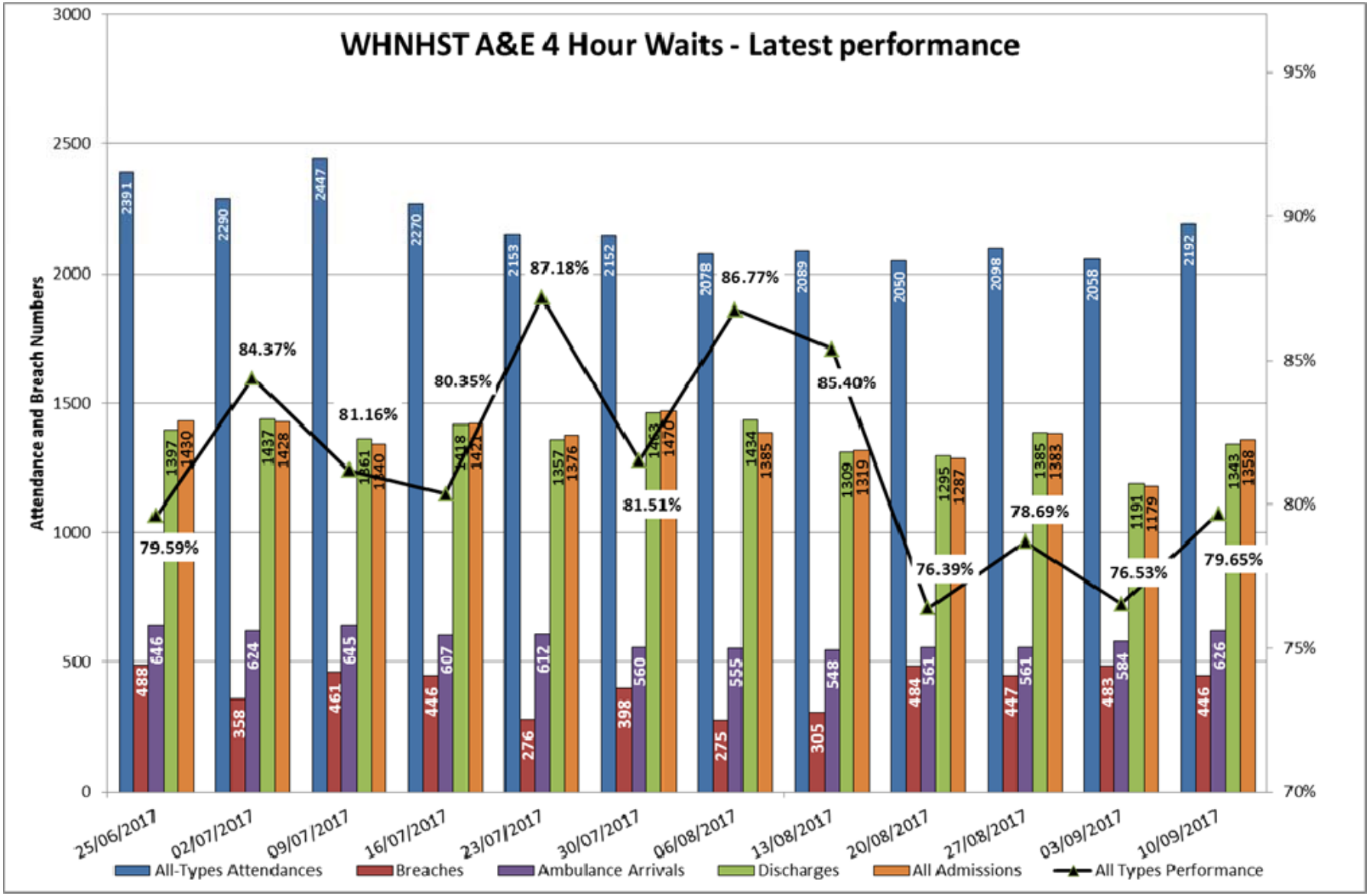


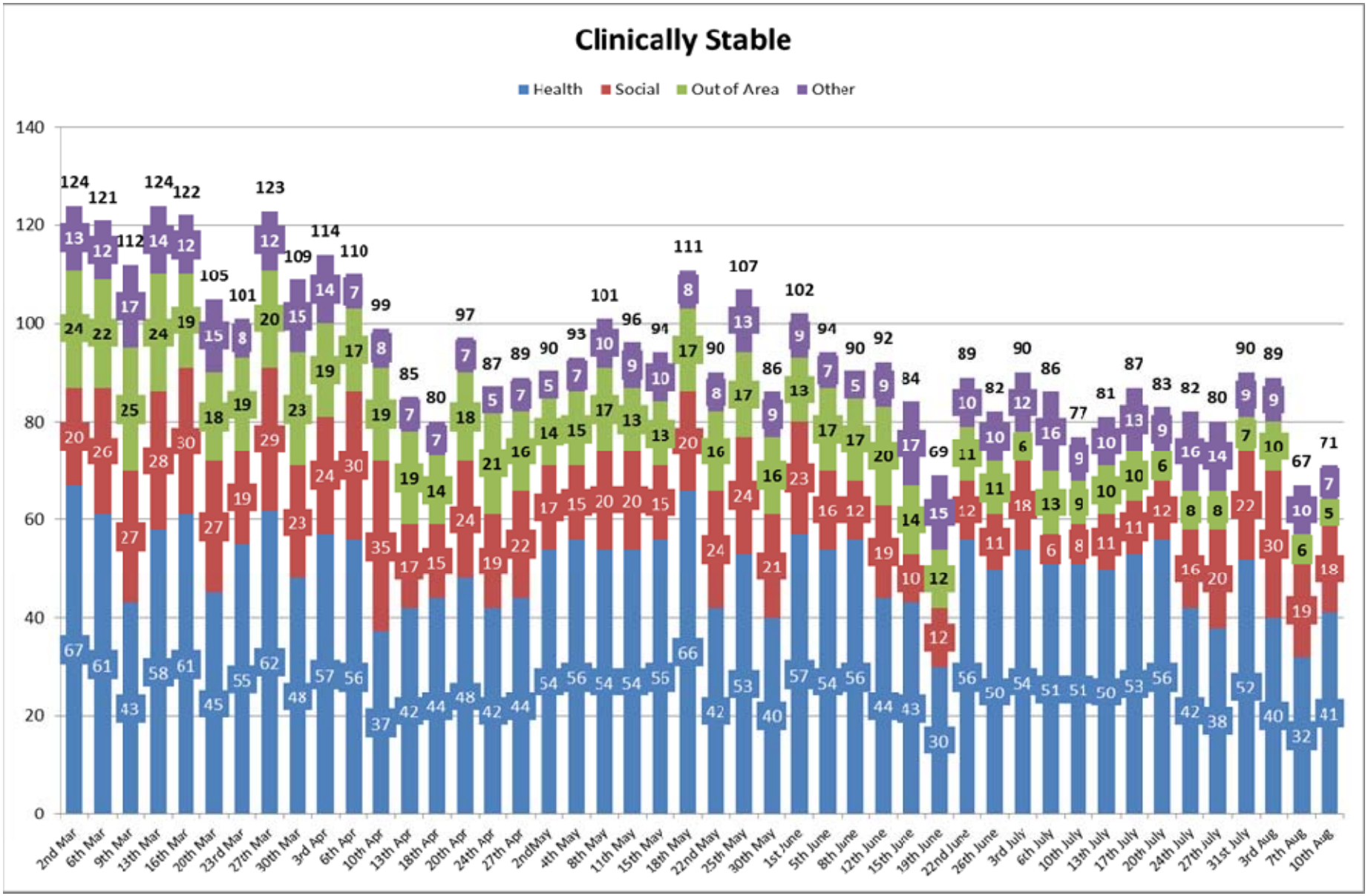
These graphs (on the same scale) show the impact of the big room approach on the number of people in the ED waiting for a bed and the impact of this on breaches





Not only does this reduce the burden on the ED department and free up cubicles for assessment it removes patients from an area of known risk to a much safer environment on a ward


WHNHST A&E 4 Hour Waits - Latest performance
Attendance and Breach Numbers
3000
2500
2000
1500
1000
500
0
95%
90%
85%
80%
75%
70%
25/06/2017
02/07/2017
09/07/2017
16/07/2017
23/07/2017
30/07/2017
06/08/2017
13/08/2017
20/08/2017
27/08/2017
03/09/2017
10/09/2017
2391
488
646
1397
1430
79.59%
2290
358
624
1437
1428
84.37%
2447
461
645
1361
1340
81.16%
2270
446
607
1418
1422
80.35%
2153
276
612
1357
1376
87.18%
2152
398
560
1463
1470
81.51%
2078
275
555
1434
1385
86.77%
2089
305
548
1309
1319
85.40%
2050
484
561
1295
1287
76.39%
2098
447
561
1385
1383
78.69%
2058
483
584
1191
1179
76.53%
2192
446
626
1343
1358
79.65%
All-Types Attendances
Breaches
Ambulance Arrivals
Discharges
All Admissions
All Types Performance


Clinically Stable
Health
Social
Out of Area
Other
140
120
100
80
60
40
20
0
2nd Mar
6th Mar
9th Mar
13th Mar
16th Mar
20th Mar
23rd Mar
27th Mar
30th Mar
3rd Apr
6th Apr
10th Apr
13th Apr
18th Apr
20th Apr
24th Apr
27th Apr
2ndMay
4th May
8th May
11th May
15th May
18th May
22nd May
25th May
30th May
1st June
5th June
8th June
12th June
15th June
19th June
22nd June
26th June
3rd July
6th July
10th July
13th July
17th July
20th July
24th July
27th July
31st July
3rd Aug
7th Aug
10th Aug

Acute Provision Conclusions

- Data analysis has examined the overall pattern of breaches and the cause of breaches, and then the relationship between the level of attendance, occupancy of cubicles, the number of patients in the ED with a DTA, and the level of emergency admissions, with the level of performance.
- A&E performance is more sensitive to the number of patients with a DTA occupying cubicles than to increases in activity, with 6 patients with a DTA occupying cubicles appearing to be a 'tipping point'.
- The level of performance during July and August is well below trajectory with additional causes including closure of beds in wards 12 and 14, and staff shortages.
- Peaks of demand continue to impact on the level of performance in line with the above analysis, particularly higher than predicted ambulance arrivals.
- More consistent delivery of the 'Big Room' principles in the Operations Centre would accelerate patient flow and thereby contribute to an improvement in performance.
- More consistent delivery of the SAFER and Red/Green Programmes would accelerate patient flow and thereby contribute to an improvement in performance.
- CONCLUSION: the overall level of performance has not improved in line with the recovery trajectory and greater focus is needed within the ED and the inpatient wards to maintain the flow of patients so that the level of 4 hour breaches is reduced as set out in this recovery plan.

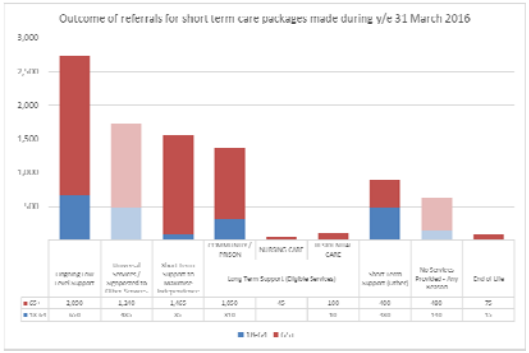
Acute Provision Conclusions

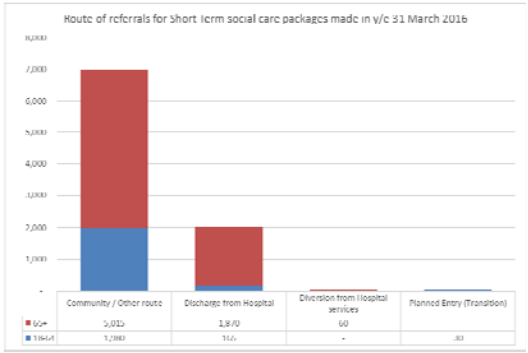
CONCLUSION:

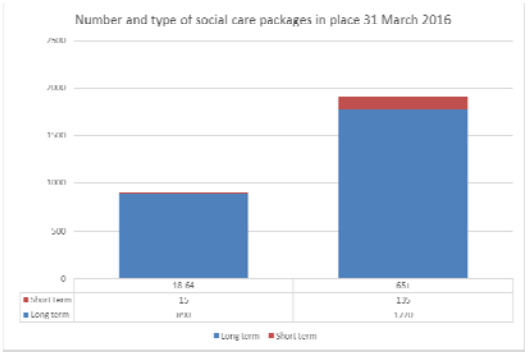
Individual community demand management schemes can each show that they have had an impact on reducing attendance at the ED, and the 7 day ambulatory and frailty pathway can also demonstrate that there are higher numbers of patients using these pathways thus reducing the level of admissions. There has been a significant reduction in the number and length of stay of patients MFFD and this has allowed the closure of the beds in

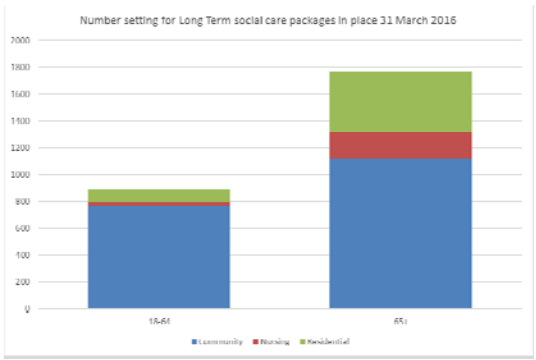
The WHT Winter Plan sets out the planned arrangements for winter 2017/18. This sets out further initiatives and arrangements for opening additional capacity. However, the overall level of performance has not improved in line with the recovery trajectory and greater focus is needed within the hospital to maintain the flow of patients so that the level of 4 hour breaches is reduced as set out in this recovery plan.

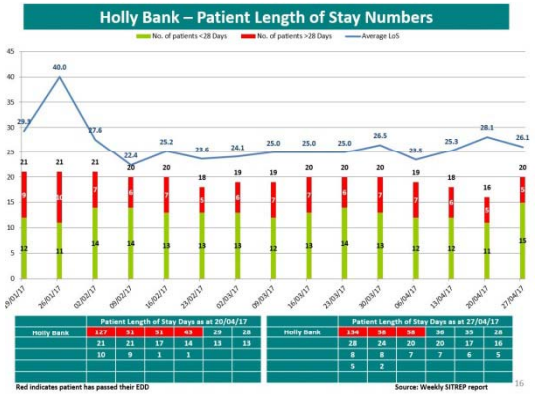
Social care

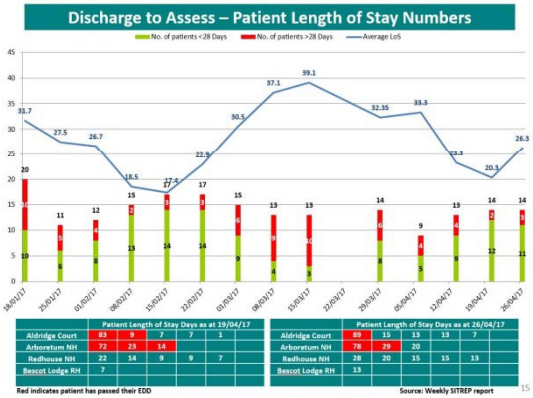

Outcome of referrals for short term care packages made during y/e 31 March 2016


Route of referrals for short term social care packages made in y/e 31 March 2016
Community / Other route
Discharge from Hospital
Diversion from Hospital services
Planned Entry (Transition)


Number and type of social care packages in place 31 March 2016
Long term
Short term


Number setting for Long Term social care packages in place 31 March 2016


Holly Bank – Patient Length of Stay Numbers
No. of patients <28 Days
No. of patients >28 Days
Average LoS
Patient Length of Stay Days as at 20/04/17
Patient Length of Stay Days as at 27/04/17
Red indicates patient has passed their EDD
Source: Weekly SITREP report


Discharge to Assess – Patient Length of Stay Numbers
No. of patients <28 Days
No. of patients >28 Days
Average LoS
Patient Length of Stay Days as at 19/04/17
Patient Length of Stay Days as at 26/04/17
Aldridge Court
Arboretum NH
Redhouse NH
Bescot Lodge RH
Red indicates patient has passed their EDD
Source: Weekly SITREP report

Social Care Conclusions

- Capacity is, on a consistent basis, not inhibiting discharge of patients from the acute setting who are ‘in area’.
- Capacity has been steadily increasing with residential LOS decreasing as a result of new ways of working.
- Integrated pathways are not yet fully embedded and working well.
- In addition to the challenge in Community Health therapy services are a significant challenge within social care setting.
- CONCLUSION: Social care capacity is not currently inhibiting patient discharge. Further work to embed integrated pathways will future proof against planned increased demand for social care.

Section 3
Priority Actions for Improvement

Priority Actions – Templates

The following templates set out at a high level for each of the ten priority actions:

- the problem being addressed
- the actions
- progress to date
- impact in terms of A&E breach reduction
- risks and mitigation
- due dates

Each work-stream is expected to ensure there are completed templates for each action.

Operational Group to oversee implementation and report on progress to A&E Delivery Board

ATTENDACE AVOIDANCE

1. Sustain increased referrals to rapid Response Service at 225 per month or more from the baseline in 2016/7 of 180 per month;

2. Redesign Community Respiratory Pathway. Expand the coverage of the current COPD Team to cover a wider range of respiratory conditions; ensure everyone diagnosed with a respiratory condition has a standardised plan for self-management and agree arrangements between Community Respiratory Team and Rapid Response Service to provide rapid response to people with respiratory conditions to prevent avoidable attendance at A&E;

3. Reduce ambulance conveyance via impact of enhanced clinical hub in NHS 111 to reduce referrals to WMAS for 999 call out, and to support ambulance crews with non-conveyance. NHS 111 clinical support for care homes. Co-ordinated partnership working to support High Frequency Users; focus of frail elderly

PATIENT FLOW

4. Sustain the number of same day discharges from the Frail Elderly Service in the Emergency Department at 230 or more from the baseline in 2016/17 of 200 per month;

5. Increase the number of patients supported by the Ambulatory Emergency Care (AEC) Pathway within the Emergency Department;

6. More effective streaming and triage process within the ED to ensure patients attending are channelled directly to Assessment Units, Frailty Service and Ambulatory Emergency Care Pathway thus by-passing A&E;

7. Continued work to embed SAFER and Red and Green approach at ward level with clinically led discharge. Listening in to Action programme to continue. Discharge Lounge and Bed Bureau to support increased patient flow;

DISCHARGE PATHWAYS

8. Reduce the number and length of stay of patients on the Medically Fit For Discharge (MFFD) list with an earlier start to discharge planning in the ED, and earlier discharge by increasing the percentage of patients discharged within 24 to 48 hours of entering the MFFD List;

9. Support the model of earlier discharge with more effective integration of intermediate care services;

10. Support the model of earlier discharge with increased therapy support for the ‘discharge home to assess’ model so that more patients are discharged home for their therapy treatment/ support instead of occupying a hospital bed.

Priority Actions Templates

Action 1: Increase attendance avoidance via Rapid Response Service

Owner: Donna Chaloner (WHT Community Health Services)

Problem to be solved:

Increase referrals to RRS by changing skill mix, calibrating capacity to demand, and increasing capacity.

Improve the extent to which a referral to RRS does prevent an avoidable attendance at A&E via appropriateness of referrals

Actions:

- *Change skill mix by appointing lower grades to conduct care planning and freeing up more clinical nurse time for assessment*
- *Ensure rota's match with the changing pattern of referrals through the day and the week*
- *Work with other pathways(i.e. respiratory) to provide rapid response for lower acuity cases and thus free up RRS to work with higher level of acuity*

Progress:

- Appointment of lower grades underway
- Work rota's have been changed to calibrate with demand though the day and the week.
- See next slide for progress with respiratory pathway. This to provide a possible model for adoption by other pathways

Intervention:

Lower grades to free up more senior clinical grades for assessment and clinical intervention

Rota's changed so that higher level of capacity at times of peak demand

Respiratory Team to carry out some rapid response for lower acuity cases

Impact:

Referrals to RRS to increase from current average circa 210 per month to average 225 with 80% avoidance of A&E attendance.

Reduction in attendance by 1 frail older person per day

	Apr	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*
Daily Breach Reduction	*0*	*0*	*0*	*0*	*0*	*1*	*0*

How we will measure progress

No of referrals to RRS per month.

Risks

Unable to increase capacity of RRS

Unable to change role of current COPD Team to support people with wider range of respiratory conditions and conduct some rapid response

Priority Actions Templates

Rationale	Due Dates:	Mitigations:
With rapidly provided specialist tailored support to frail people in their own homes it is possible to reduce avoidable attendances at the A&E, and thus reduce breaches.	*Implementation: September 2017* *Outcome Impact: September 2017*	Transfer more capacity in to RRS from other parts of Community Health Services Agree plan for current Community COPD Team to become wider Respiratory Team providing some rapid response.

Priority Actions Templates

Action 2: Respiratory Pathway **Owner: Donna Chaloner (Community Health Services)**		
Problem to be solved: *Ensure that people with a respiratory condition are identified and diagnosed in primary care* *Ensure that everyone diagnosed with a respiratory condition has a care plan to manage any exacerbation so that they can avoid an attendance at A&E* *Ensure that patients with a respiratory condition who do attend A&E are supported in line with their care plan and where appropriate avoid a hospital admission*	Actions: • To develop standardised care plans for self-management of respiratory conditions; • The current Community COPD Team to have a wider role with people with respiratory conditions and work with primary care to ensure that everyone diagnosed with a respiratory condition has a standardised care plan for self-management; • That the Respiratory Team has capacity to provide rapid support at times of exacerbation to avoid attendance at A&E; • To ensure that the Emergency Department can access the care plans of patients who attend who have respiratory condition and support them accordingly;	Progress: • Work is underway with current clinicians in the community and hospital settings to redesign the pathway for people with respiratory conditions to deliver on these actions; • Three workshops have been held to analyse data from the Right Care Programme and involve current clinicians in pathway redesign; • A new service specification has been agreed and a Management of Change consultation is underway with relevant staff in WHT

Priority Actions Templates

Intervention:

To promote self-care and personal responsibility through the use of the agreed standardised care plan and the use of self-care resources;

Ensure timely access to a respiratory specialist nurse and/or therapist in a community setting in accordance with NICE guidelines and local criteria for services;

To support the home care of patients with exacerbations of respiratory diseases and minimise avoidable admission/ readmission to hospital;

Ensure that patients with a respiratory condition who do attend A&E are supported in line with their care plan and thereby avoid a hospital admission where appropriate.

Impact:

Reduction in attendance at A&E of people with respiratory conditions by 20% from a baseline established in first quarter of 2017/18. 12 people with respiratory conditions attending the Emergency Department every day. This would be a reduction of 2 to 3 people every day, leading to a reduction in breaches of 1 a day.

	Sept	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*
Daily Breach Reduction	*0*	*0*	*0*	*0*	*0*	*0*	*1*

Number of people diagnosed with a respiratory condition, COPD, Asthma, and Bronchy …

Number of people diagnosed with a respiratory condition with a care plan for self-management

Number of patients supported by the Respiratory Team

Number of rapid responses by the Respiratory Team

Number of attendances at A&E of people with respiratory conditions

Risks:

Difficulty getting patients and clinicians to adopt different working practice

Difficulty getting data to provide evidence that changed working practice will be better

Current staffing levels and skill mix in community and in hospital do not match requirements for changing working practice

Difficulty getting different parts of the system to work together more effectively

Priority Actions Templates

Rationale:	Due Dates:	Mitigations
The current service is focused upon people with COPD to the exclusion of people with other respiratory conditions, and the current practice of supporting people to self-manage their respiratory condition is ineffective. Extending the scope of the current COPD Team will mean that more people with respiratory conditions will be supported with self-management of their condition. Implementing and monitoring a process of more effective standardised care plans for self-management will mean that more people do not attend the Emergency Department when there is an exarcerbation. When people do attend the ED, establishing a more effective clinical response will prevent an admission Where people do get admitted, establishing a more effective clinical response will reduce the length of stay.	Extend role of current community COPD Team from January 2017 Establish a more effective system of self-management via standardised care plans from January 2017 Establish more effective clinical pathways in the ED and in hospital from January 2017.	Work with clinicians so that they determine how to change current clinical working practice Public and patient engagement exercise to support people with respiratory conditions to self-manage more effectively based on a revision of standardised care plans Bring clinicians from primary care, community and hospital together to work in partnership to revise the respiratory pathway Review current staffing levels and skill mix to calibrate current resources to deliver the changed clinical working practice

Priority Actions Templates

Action 3: Reduce Ambulance Conveyance to Hospital **Owner: Andy Rust (CCG Urgent Care Lead)**		
Problem to be solved: *Increasing numbers of ambulance call-outs and conveyances to hospital*	Actions: • *Reduce referrals to the ambulance service from NHS 111 – direct transfer each way between 111 and 999* • *Ambulance crews access to clinical hub via *5* • *Increase ambulance referrals to the Rapid Response Service* • *Optimise the functionality of the Electronic Patient Record* • *Frailty Screening Tool – FES used as point of contact by ambulance crews* • *Community Alarm cases have care plan* • *High Frequency Users to have care plans – ambulance crews access care plans via EPR* • *CQINN* • *Care Home Support to reduce conveyance via *6*	Progress: • NHS 111 working with WMAS to allow call transfers between 111 and 999 • * 5 and * 6 available from May 17 – plan to increase take-up underway • Plan for frailty screening, increasing referrals to RRS, and advice to crews from FES in development • Plan to optimise EPR in development • Plan for HFU's complete by June 17 with implementation by Sept 17 • CQINN? • Plan for community alarm recipients to have care plan to avoid conveyance in development – joint working between WMBC and WMAS

Priority Actions Templates

<table>
<tr>
<td>Intervention:

• Some 999 calls to be transferred to 111 clinical hub via *5
• WMAS have access to care plans for avoiding conveyance of a higher number of people i.e. Community Alarms and HFU's
• Increase referrals from WMAS to RRS
• Establish advice line from FES
• Use EPR's to access care plans
• Increase calls to *6 from care homes</td>
<td>Impact:

2% reduction in ambulance conveyances from baseline of April 16 – March 17 (-2 ambulances per day)

<table>
<tr><th></th><th>Jun</th><th>July</th><th>Aug</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>Daily Breach Reduction</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
</table>
How we will measure progress
1. No of NHS 111 Red Flag call to 999
2. No of conveyances from care homes
3. No of ambulance conveyances to ED</td>
<td>Risks:

• Capacity in FES and RRS acts as constraint on extent of support to reducing conveyance
• Interoperability of systems between Care UK and WMAS for transferring calls between 111 and 999
• EPR unable to access care plans
• Unable to reduce HFU's attending A&E
• Care homes reluctant to use *6
• WMAS crews reluctant to use *5</td>
</tr>
<tr>
<td>Rationale:

Improved support from NHS 111 clinical hub, RRS and FES for ambulance crews will reduce conveyance

Supporting ambulance crews to access care plans will reduce conveyance</td>
<td>Due Dates:

Implementation: December 2017

Outcome Impact: December 2017</td>
<td>Mitigations:

• Increase capacity for supporting ambulance crews in FES and RRS
• Technical solution for call transfers between 111 and 999
• EPR to register those patients who do have a care plan via NHS Number
• CCG commission HFU's business case for reducing attendance
• Training for care homes and ambulance crews on *5 and *6</td>
</tr>
</table>

Priority Actions Templates

Actions 4 to 6: Reconfiguration of Pathways through the Emergency Department **Owner: (Ruchi Joshi)**		
Problem to be solved: Rising attendance at the Emergency Department is leading to an increase in plus four hour waits, and a subsequent failure to meet the 95% A&E wait target.	Actions: • More effective integration of A&E Triage with Primary Care Streaming • Direct referral from integrated triage/streaming process to Frailty Service with increase of further 12 referrals per day. • Direct referral from integrated triage/streaming process to Ambulatory Service with increase of further 13 referrals per day. • Increase direct referrals to medical and surgical assessment units • Decrease in paediatric triage cases referred to PAU	Progress: • WHT Business Case for reconfiguration of ED referral pathways in final stage of development, to be signed off by WHT • Planning for more effective integration of A&E Triage with primary care streaming to be complete July 2017 • Capital bid for improvement to ED Reception Area in progress • More detailed plan for Ambulatory Pathway incorporated in above • More detailed plan for Frailty Service incorporated in above • More detailed plan for PAU in development

Priority Actions Templates

<table>
<tr>
<td>Intervention:

• Single reception point for patients attending ED with reduced ‘double handling’ between A&E Triage and primary care streaming
• More patients by-pass A&E by being referred directly to medical and surgical assessment units, frailty service, and ambulatory pathway
• Fewer patients triaged to PAU
• Ward 29 reconfigured to provide combined ambulatory and frailty pathways</td>
<td>Impact:

Reduction of 45 patients per day attending A&E leading to reduction of 15 four hour breaches per day.
<table>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td></tr>
<tr><td>Daily Breach Reduction</td><td>0</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td></tr>
</table>
<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan 2018</td><td>Feb</td><td>Mar</td><td>June</td></tr>
<tr><td>Daily Breach Reduction</td><td>8</td><td>8</td><td>8</td><td>9</td><td>12</td><td>15</td></tr>
</table>
</td>
<td>Risks:

Unable to gain support for change in clinical practice needed to deliver reconfiguration of pathways
Reconfiguration not able to be achieved within budget
Integration of A&E Triage with primary care streaming constrained by resources in Urgent Care Services due to outcome of decision by CCG on future service configuration
Capital bid for improvement to ED Reception area unsuccessful</td>
</tr>
<tr>
<td>Rationale:

By directing more patients straight to medical and surgical assessment units, the frailty service or ambulatory pathway there will be fewer patients attending A&E and a subsequent reduction in four hour breaches.</td>
<td>Due Dates:

Phased increase of referrals to frailty service and ambulatory pathway from May through to September 2017 delivers reduction in breaches</td>
<td>Mitigations:

• Clinical engagement with ED staff
• Plan to be within acceptable financial parameters
• Start engagement between WHT ED, Primecare and CCG on configuration of integrated A&E Triage and primary care streaming
• Continue reconfiguration of ED within current reception area environment</td>
</tr>
</table>

Priority Actions Templates

Action 7: Patient Flow **Owner: Phil Thomas Hands**		
Problem to be solved: To maintain a more rapid flow of patients through the inpatient wards so as to minimise lengths of stay and thereby ensure there is sufficient capacity to meet the level of demand for inpatient beds from the Emergency Department.	Actions: Implement SAFER Bundle effectively and consistently in all inpatient wards Implement the programme of Red and Green Days effectively in all inpatient wards Utilise the discharge lounge effectively to maintain patient flow Ensure the wards support the Bed Bureau effectively by following the principles set out by the 'Big Room' approach.	Progress: A Listening into Action Programme was implemented from September 2016 as a means of engaging clinicians at ward level of the importance of implementing the SAFER bundle. This has led to a level of implementation in most wards, but there is a need to for embedding a higher level of consistency of implementation. A Red and Green whiteboard approach has been established as an exemplar of good practice in Ward 14. A plan for this level of practice to be spread across all inpatient wards needs to be implemented. The discharge lounge is open, but at times has been under-utilised. A simulation of running the Bed Bureau in accordance with the principle sswet out in the 'Big Room' was supported by the Capacity Support Team in February 2017, and the Bed Bureau adopted this practice from that point. However, the principles of

Priority Actions Templates

<table>
<tr>
<td>Intervention:

More direct clinical leadership to ensure effective implementation of SAFER and Red and Green.

Wards to identify patients suitable to go to the discharge lounge before 9.00am each day.

More robust clinical and managerial leadership of the bed management process in the Bed Bureau.</td>
<td>Impact:

Extra capacity generated from earlier discharge leads to reduction of medical patients and beds in the system, resulting in reduction of 10 breaches per day in A&E.

<table>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td><td>Sep</td><td>Oct</td></tr>
<tr><td>Daily Breach Reduction</td><td></td><td></td><td>1</td><td>3</td><td>6</td><td>7</td><td>8</td></tr>
</table>

<table>
<tr><td></td><td>Nov</td><td>Dec</td><td>Jan 2018</td><td>Feb</td><td>Mar</td><td>June</td></tr>
<tr><td>Daily Breach Reduction</td><td>8</td><td>8</td><td>8</td><td>8</td><td>10</td><td>10</td></tr>
</table>
</td>
<td>Risks:

There is insufficient clinical engagement to ensure full commitment to implementation of these programmes.</td>
</tr>
<tr>
<td>Rationale:

Increasing patient flow will lead to reduction in delays which in turn will reduce lengths of stay releasing more bed capacity.</td>
<td>Due Dates:

More effective implementation to start from June 2017 with a phased increase in impact through to September</td>
<td>Mitigations:

Stronger clinical leadership to ensure full engagement</td>
</tr>
</table>

Priority Actions Templates

Actions 8 to 10: Discharge Pathways / Integrated Intermediate Care **Owner: Lloyd Brodrick**		
Problem to be solved: An assessment of the current Intermediate Care Pathways, supporting both discharge from hospital and admissions avoidance, has highlighted numerous weaknesses, including: 1. Over reliance on bed based models for discharge 2. Patients not 'directed' to the appropriate Intermediate Care Pathways (inconsistent compliance with pathway entry criteria) 3. Over provision of Intermediate Care Service, typically due to unnecessary delays to 'exiting' the Intermediate Care service 4. Silo working across health and social care teams 5. Misalignment of resources to meet the patient needs in a community setting 6. Inconsistent ward processes, including unreliable EDD and inadequate compliance to SAFER principles resulting in delays to identify patients with complex discharge needs The numerous weaknesses combined has resulted in fragmentation, misalignment of priorities and synchronisation of resources across health and social care teams. This has resulted in increased costs and reduced overall Intermediate Care capacity. In essence, the current 'System' does not consistently support timely and responsive discharge of patients that require additional health and / or social care support needs with obvious ramifications impacting the resilience of the 'System'.	Actions: Single team taking an MDT approach to identify needs, support patients and monitor against patient goals. Streamlined processes to identify patient needs and make a referral via a single point of access for all Intermediate Care Service pathways Earlier discharge from hospital, ideally when the patient is deemed medically fit for discharge liberating bed capacity at the hospital Implement model of integration of intermediate care Implement model of community based therapy services	Progress: MDT's in ED and at ward level currently being trialled – additional funding for sustained roll out has been identified Plan for integration of intermediate care complete and to be implemented from September 2017 Plan for development of community based therapy services underway – aiming for completion of plan and implementation from September 2017

Priority Actions Templates

Intervention:

Discharge majority of patients within 24 to 48 hours of MFFD

Ensure sufficient capacity in intermediate care discharge pathways

Ensure sufficient community based therapy services to support the new discharge model

Impact:

Reduction in number and length of stay of patients on MFFD from average of 110 with average8 days LoS to average of 60 with 4 days LoS. This creates additional capacity in inpatient beds that will reduce delays of patients awaiting admission to an inpatient ward.

	Apr	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*
Daily Breach Reduction				*1*	*2*	*3*	

	Nov	*Dec*	*Jan 2018*	*Feb*	*Mar*	*June*
Daily Breach Reduction	*3*	*3*	*3*	*3*	*4*	*5*

Risks:

Ward staff do not adequately identify and document patient needs as part of standard ward practices. Unreliable EDD (patient discharge not consistent with EDD) will prevent ICS services organising post-discharge support pre-discharge

Delays in agreement to support partnership budget for integrated service

Decommissioning Holly Bank without access to alternative pathways results in increased length of stay in hospital

High risk averse culture of ward staff, especially therapy, may result in delays to referring to ICS thereby increasing the length of stay

Effort required (e.g. to ensure appropriate performance management mechanisms are in place) and lead-time to contract and utilise private sector market to provide 'support' staff to 'deliver' the intermediate care plan

Delays / hindrance to the Management of Change required to consolidate disparate teams, realign structure, roles / responsibilities and transition to seven-day service

Inadequate transformation support to assist ICS leadership facilitate the required process.

Priority Actions Templates

Rationale:	Due Dates:	Mitigations:
Increased bed capacity via reduction in length of stay. The proposed scenarios and accompanying financial benefits are: 1. Realisation of benefits to liberate **21 beds p.a**. IF the Trust has high transformation capability 2. Realisation of benefits to liberate **16 beds p.a**. IF the Trust has moderate transformation capability 3. Realisation of benefits to liberate **11 beds p.a**. IF the Trust has low transformation capability 4. Improved utilisation of therapy staff by significantly reducing 'Assess to Discharge' with staff reallocated to other therapy activities Improved value-for-money reduction of care costs cost per patient enabled by discharge home being the default pathway and reduced length of stay in hospital. Improved staff satisfaction Improved patient outcomes	Trialling of aspects of the model currently underway as forerunner. Implementation of the full model for integration from September 2017	ICS referral will be 'actioned' when the patient is medically fit or ready for discharge. Wards will be provided with the required data set and supported to collate the identified patient needs into a referral by IDT staff. BCF and/or Social Care will provide additional funding required to staff the proposed ICS model. Review of Holly Bank services to determine the required 'capabilities' across various pathways to minimise LOS in a hospital setting. Trust leadership, including therapy, involved in the 'design' of the proposed ICS service model. Engagement with professional leads / managers to demonstrate interdependencies across programmes and benefits to patients of being treated in the most appropriate environment. Early engagement with social care market and leverage contract management practices from other areas Early engagement to gain support from professional leads / managers re proposed ICS design and restructure plan. HR expert guidance re consultation and transition to new structures and roles / responsibilities.

Section 4

Self Assessment Against NHS Forward View for Urgent and Emergency care

NHS Forward View - Summary

The Next Steps on the Five Year Forward View for Urgent & Emergency Care was published March 2017. It outlines progress on the ambitions set out in the Five year forward view since its original publication in October 2014, defines what still needs to be achieved over the next two years, and how this will be achieved. It also outlines priorities for the service specifically in 2017/18 as follows:

- Deliver financial balance across the NHS
- Improve A&E performance
- Strengthen access to GP & primary care services
- Improve cancer and mental health services

The Plan notes the progress made in urgent and emergency care over the past three years, then outlines the key deliverables for urgent and emergency care in both 2017/18 and 2018/19. These deliverables are a mix of actions for both for local organisations and national bodies to deliver. They are:

- Before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours (up from 85% currently being delivered)
- The majority of trusts will have to meet the 95% standard in March 2018
- The NHS overall returns to the 95% standard within the course of 2018

The following slides provide an overview of the specific deliverables and the position of Walsall health and social care economy against each one.

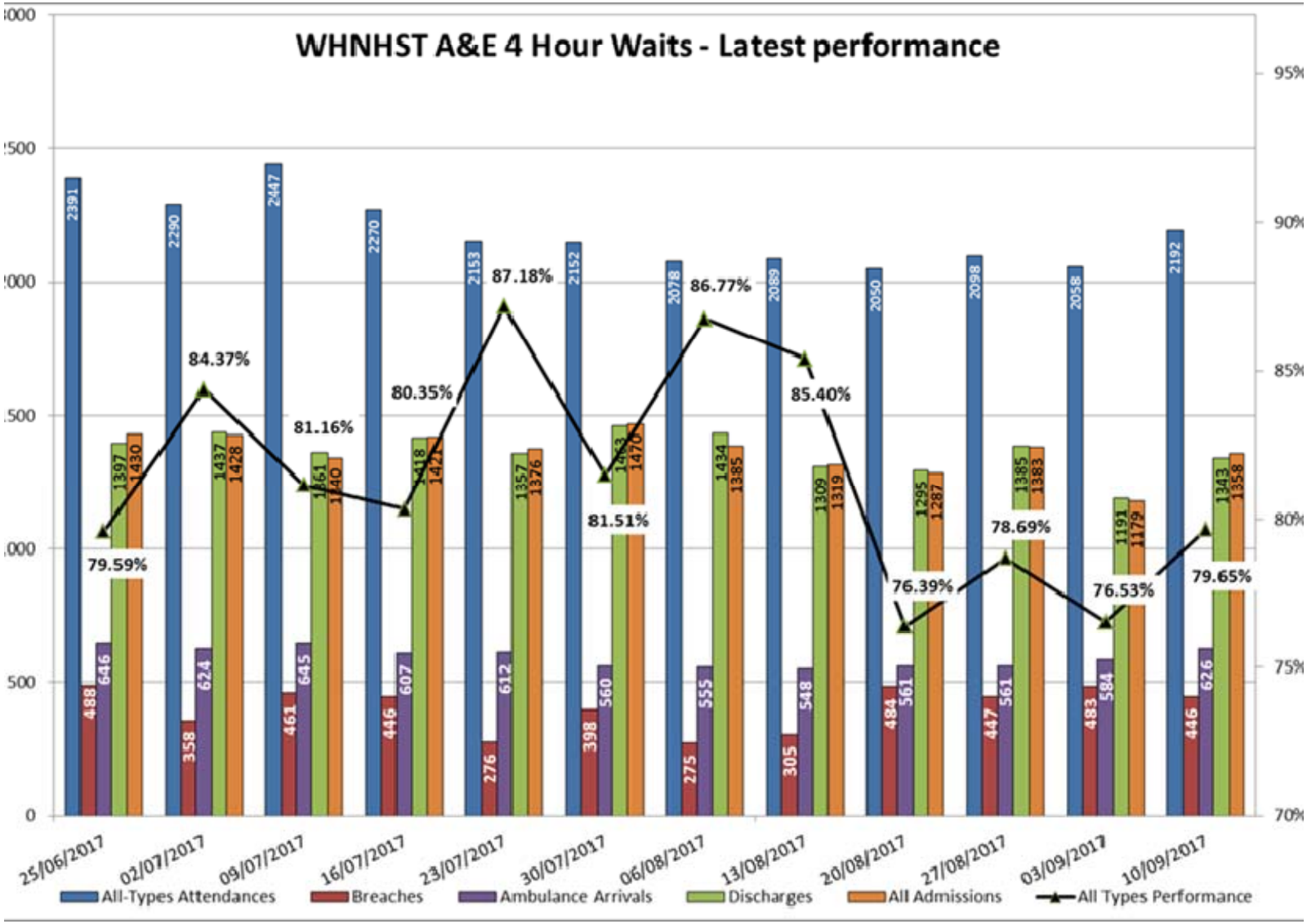
Next Steps on the Five Year Forward View Commentary on Key Deliverables for 2017/18 and 2018/19

Ref	Deliverable	Commentary	RAG
1.	Every hospital must have comprehensive **front-door clinical streaming** by October 2017, so that A&E departments are free to care for the sickest patients, including older people.	Clinical streaming for primary care patients to go to the Urgent Care Centre (UCC) is currently in place. An enhanced model based on combining primary care streaming with ED Triage is currently being planned as part of the plan for the reconfiguration of the Emergency Department. This is in part dependent upon the outcome of the current planned CCG consultation on the future of the UCC's.	
2.	By October 2017 every hospital and its local health and social care partners must have adopted good practice to enable appropriate **patient flow**, including better and more timely hand-offs between their A&E clinicians and acute physicians, 'discharge to assess', 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities.	This is a 'mixed bag' with elements being addressed in different work-streams i.e. • some hospitals (i.e. New Cross) have arranged for acute physicians to work directly in A&E thereby reducing hand offs. Space constraints make this difficult to achieve within the current ED in the Manor; • discharge to assess and trusted assessor arrangements with streamlined continuing health care processes are being addressed by the plan to increase the number of patients who are discharged within 24 to 48 hours of being declared clinically stable; • Seven day discharge capability is constrained by a number of factors i.e. costs associated with deployment of clinical staff at ward level at week-ends to conduct ward rounds, and arrange medication and transport; and constraints in the social care market to accept patients in care homes at week-ends.	

3.	Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for **delayed community health and social care**. They need to: - ensure that the extra £1 billion provided by the Chancellor for investment in adult social care in the March budget is used in part to reduce delayed transfers of care, thereby **helping to free up 2000-3000 acute hospital beds** – the equivalent of opening 5 new hospitals – and regularly publish the progress being made in this regard.22 - ensure that 85% of all assessments for continuing health care funding take place out of hospital in the community setting, by March 2018. - Implement the High Impact Change Model for reducing DTOCs, developed by the Local Government Association, the Association of Directors of Adult Social Care Services, NHS Improvement and NHS England.	The Recovery Plan submitted in March 2016 was based upon the High Impact Change Model for reducing DTOCs, developed by the Local Government Association, the Association of Directors of Adult Social Care Services, NHS Improvement and NHS England. The development of the Project 500 work-streams was also based upon this, and the development of the Recovery Plan for 2017/18 will take this forward. A local plan for the social care funding provided by the March Budget to deliver a reduction in beds has been agree. Walsall's contribution to the target of reducing beds by 2,000 to 3,000 is 10 to 15 beds. 85% of assessments for continuing healthcare to take place out of hospital will be achieved by end of March 2018, via the plan to increase the number of patients who are discharged within 24 to 48 hours of being declared clinically stable.	
4.	Specialist **mental health care in A&Es**: 24-hour 'core 24' mental health teams, covering five times more A&Es by March 2019, than now. The service will be available in more than a quarter of acute hospitals by March 2018 and reach nearly half by March 2019, compared with under one-in-ten today.	Update requested	
5.	Enhance **NHS 111** by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2018, so that only patients who genuinely need to attend A&E or use the ambulance service are advised to do this. GP out of hours and 111 services will increasingly be combined. By 2019, NHS 111 will be able to book people into urgent face to face appointments	The West Midland NHS 111 service is currently reporting over 30% of calls receiving clinical assessment. The GP Out of Hours Service in Walsall is accessed via NHS 111. Booking of face to face appointments in the Urgent Care Centres is currently constrained by the Adastra booking system. Once this technical issue is resolved then Primecare has indicated a willingness for this to go ahead.	

6.	NHS 111 online will start during 2017, allowing people to enter specific symptoms and receive tailored advice on management.	The ASK NHS App is now available to the public for uploading.	
7.	Roll out **evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.**	Additional funding for improved access to primary care will be allocated to Walsall CCG from April 2018 and the CCG is currently developing its plan for implementation by April 2019.	
8.	Strengthen support to **care homes** to ensure they have direct access to clinical advice, including appropriate on-site assessment.	There is currently wrap around medical and nursing support to the nursing homes in Walsall and this has led to reduced conveyance.. Direct access for residential homes to clinical advice via NHS 111 CAS is now available.	
9.	Roll-out of standardised new **'Urgent Treatment Centres'** which will open 12 hours a day, seven days a week, integrated with local urgent care services. They offer patients who do not need hospital accident and emergency care, treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine. We anticipate around 150 designated UTCs, offering appointments that are bookable through 111 as well as GP referral, will be treating patients by Spring 2018.	The UCC at the hospital is largely compliant with the specification for a UTC. Timing for total compliance with the specification for an UTC is subject to the outcome of the current formal consultation on the future of the UCCs.	
10.	Working closely with the Association of Ambulance Chief Executives and the College of Paramedics, implement the recommendations of the **Ambulance Response Programme** by October 2017, putting an end to long waits not covered by response targets. Actions taken will be subject to the results of evaluation and approval from Ministers.	WMAS has implemented the ARP.	

Section 5
Current Performance


WHNHST A&E 4 Hour Waits - Latest performance
95%
90%
85%
80%
75%
70%
0
500
1,000
1,500
2,000
25/06/2017
02/07/2017
09/07/2017
16/07/2017
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30/07/2017
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13/08/2017
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81.16%
80.35%
87.18%
81.51%
86.77%
85.40%
76.39%
78.69%
76.53%
79.65%
All-Types Attendances
Breaches
Ambulance Arrivals
Discharges
All Admissions
All Types Performance

Comparative Performance

	Monthly			3 Monthly			YTD		
	Jul-17	Jul-16	Difference	May 17 - Jul 17	May 16 - Jul 16	Difference	Apr 17 - Jul 17	Apr 16 - Jul 16	Difference
4 hour waits	82.30%	85.80%	-3.50%	82.99%	88.80%	-5.81%	83.67%	89.28%	-5.61%
Attendances All Types	10217	10665	-4.20%	30249	31255	-3.22%	39887	41165	-3.10%
Attendances Type 1	6461	6629	-2.53%	19175	18655	2.79%	25184	24732	1.83%
Type 1 Emergency Admissions via ED	2068	1881	9.94%	6101	5506	10.81%	7910	7263	8.91%
A&E Emergency admission conversion rate	32.01%	28.38%	3.63%	31.82%	29.51%	2.31%	31.41%	29.37%	2.04%
Ambulance attendances	2633	2626	0.27%	7836	7662	2.27%	10392	10162	2.26%
Ambulance Attendances Subsequently admitted	1286	1256	2.39%	3808	3647	4.41%	5042	4815	4.71%

Comparative Performance

	Monthly			3 Monthly			YTD		
	Aug-17	Aug-16	Difference	Jun 17 - Aug 17	Jun 16 - Aug 16	Difference	Apr 17 - Aug 17	Apr 16 - Aug 16	Difference
4 hour waits	79.5%	86.7%	-7.2%	82.4%	87.3%	-4.9%	82.90%	88.80%	-5.9%
Attendances All Types	8875	9245	-4.0%	29113	29982	-2.9%	48762	50410	-3.3%
Attendances Type 1	5397	5747	-6.1%	18119	18151	-0.2%	30581	30479	0.3%
Type 1 Emergency Admissions via ED	2012	1759	14.4%	6123	5417	13.0%	9922	9022	10.0%
A&E Emergency admission conversion rate	37.28%	30.61%	6.7%	33.79%	29.84%	3.9%	32.44%	29.60%	2.8%

Current and Comparative Performance - Conclusions

- The level of performance to week ending 10 September was just under 80% and this makes it very difficult to achieve the 90% trajectory target for the month of September.
- One of the reasons for this more challenging level of performance is the closure of wards 12 and 14 which has resulted in there being 50 to 60 fewer medical beds available (the precise number depends upon whether an individual bay remains in use in ward 14)
- A more realistic target for September will be 85% and the trajectory graph has been adjusted to reflect this.
- All types of attendance (Type 1 A&E and Type 3 UCC) are comparatively lower compared to 12 months ago, but within this trend there has been a slight rise in Type 1 attendances.
- Emergency admissions have increased resulting in a rise in the conversion rate (the percentage of attendances where there is an admission)
- The same pattern is repeated for ambulance attendances where there has been a slight rise in overall attendances and in the percentage that were admitted.
- The analysis provided earlier in this plan highlights that the main actions that need to be achieved in order to reduce the level of 4 hour breaches and this improve performance are in the patient flow work-stream.

CONCLUSION: Further more intensive action is required to accelerate patient flow through the Emergency Department, Assessment Units and Inpatient Wards. This is being supported by a reduction in medically fit for discharge patients which in turn is being supported by unimpeded flow to social care reablement services. Further operationalisation of the integrated model of hospital discharge and intermediate care will also support patient flow.

Recovery Trajectory

As stated in the introductory “Purpose of this Document”, this plan aims to improve performance to above England average (90%) by September 2017 and to 95% by the end of June 2018, and then to sustain this level of improvement. This requires the system to reduce daily breaches by 20 per day by the end of September 2017 and by 33 per day by June 2018.

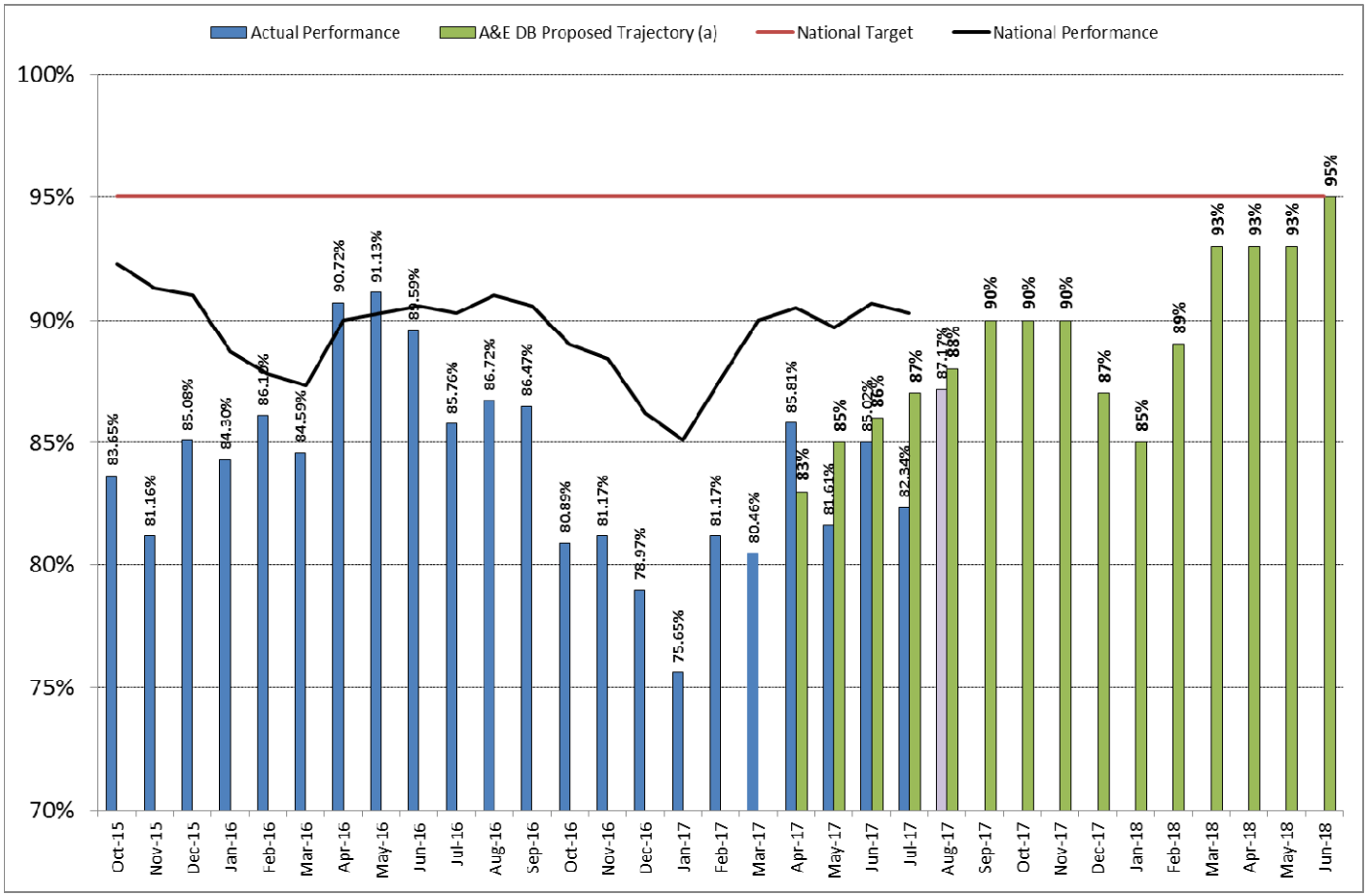
For each of the priority actions an impact on the level of performance has been calculated and the total impact has to be equal to a reduction of 33 breaches per day. In summary, this is achieved across the work-streams as follows:

- Community Demand Management schemes are planned to reduce breaches by 3 per day
- Admission avoidance in the Emergency Department are planned to reduce breaches by 15 per day
- Increasing patient flow through the inpatient wards will are planned to breaches by 10 per day
- Discharge Pathways and Integrated Intermediate Care are planned to breaches by 5 per day.

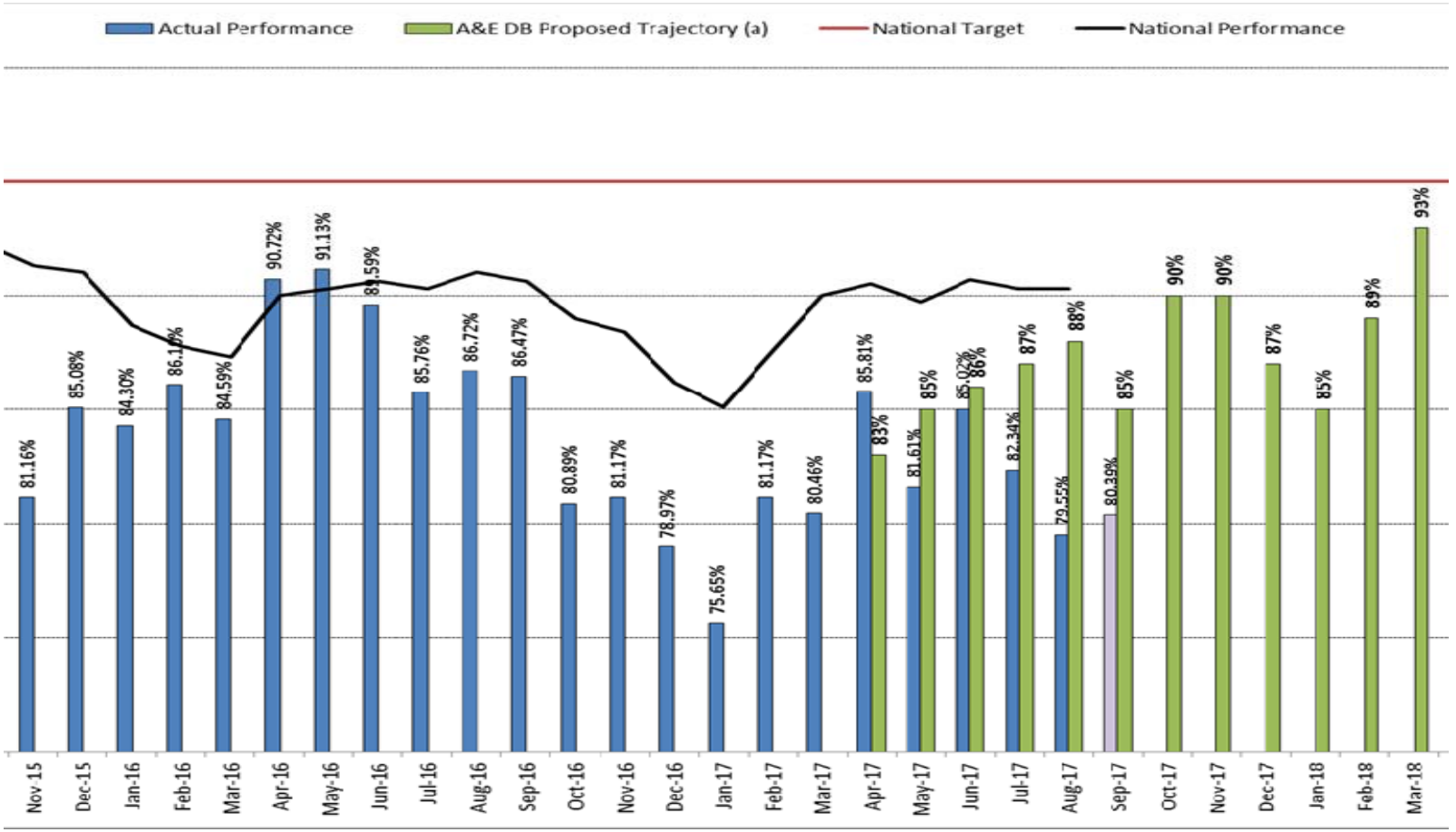
The timing of the impact of these changes is set out in each of the priority action templates resulting in a recovery trajectory as set out in the following table.

CONCLUSION: The national target of 90% A&E four waits in A&E for September 2017 is by now unlikely to be achieved in Walsall. The second graph illustrates a trajectory for September of 85%.

Revised Trajectory with 90% in Sept



Revised Trajectory with 85% in Sept



CONCLUSION

- The diagnostic concludes that the majority of impact required to reduce 4 hour breaches in the Emergency Department at the Manor Hospital will be delivered by actions to accelerate patient flow through the hospital and out in to the discharge pathways.
- Given the current level of performance, further more intensive work will be needed within the hospital to achieve the planned recovery trajectory, supported by implementation of the revised model of integrated hospital discharge and intermediate care