Health Scrutiny and Performance Panel
19 September 2013

Agenda Item No.

9.

Surge Plan: Winter 2013/14 -
Sustaining and improving A & E performance

Ward(s) All

Executive Summary:

Over the past year the local health and social care system has worked closely to develop services and close links between organisations to assist in improving and sustaining urgent care services across Walsall. This plan has been prepared by Walsall CCG and has the support of our partners. It has been structured to give details on

- Assurance from NHS England and Regional Office
- What the activity data tells us about A & E performance
- Progress and achievements winter 2012/13 and Q1
- Governance arrangements
- Plan and actions for surges in demand this winter 2013/14

Reason for scrutiny:

To provide assurance that's plans are in place to manage surges in demand this winter for urgent access to health care

Recommendations:

That:

The report be received for information of OSC

Background papers:

None

Resource and legal considerations:

None

Citizen impact:

Urgent care access

Environmental impact:

None

Performance management:

N/A

Equality Implications:

N/A

Consultation:

All stakeholders involved in drawing up the plan

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Walsall Health Economy

Surge Plan

Winter 2013/14

Walsall Health Economy

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STAR – Service Transformation and Redesign Team that is primarily clinical and undertakes care pathway redesign

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Sustaining and improving A & E performance

1 Introduction

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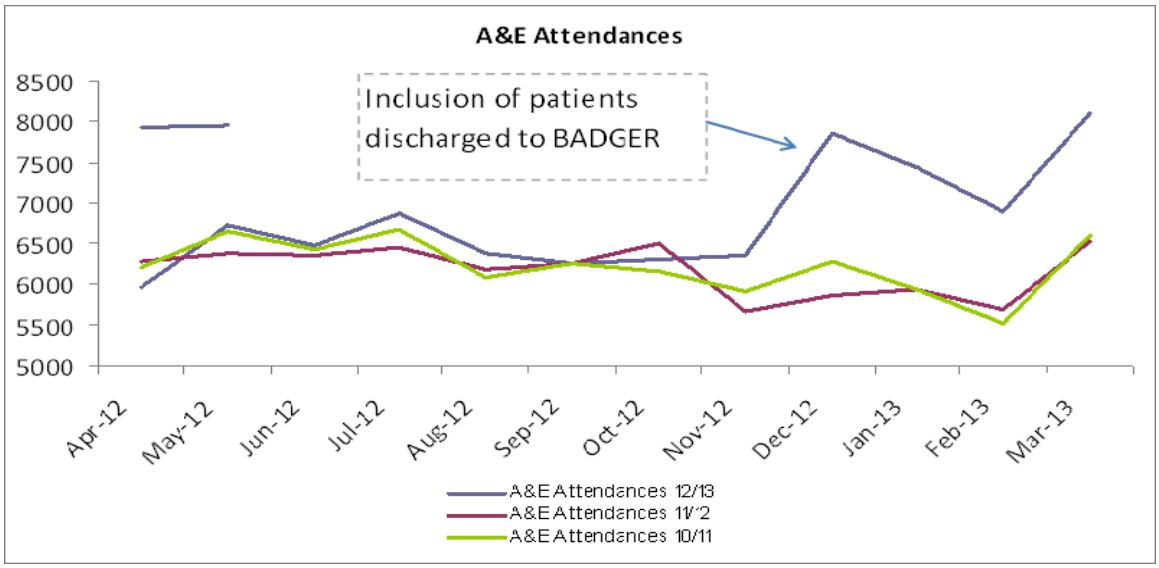
2. Area Team Feedback and CCG Assurance Response

The Health Economy's Plan has now been fully assured by NHS England and the Regional Office

3. What the data tells us about A & E Performance

3.1 A & E Attendances

Overall A&E attendances are broadly stable (excluding counting changes) but based on information from WHT there is evidence of an increase in complexity and an increase in attendances by Staffordshire residents.

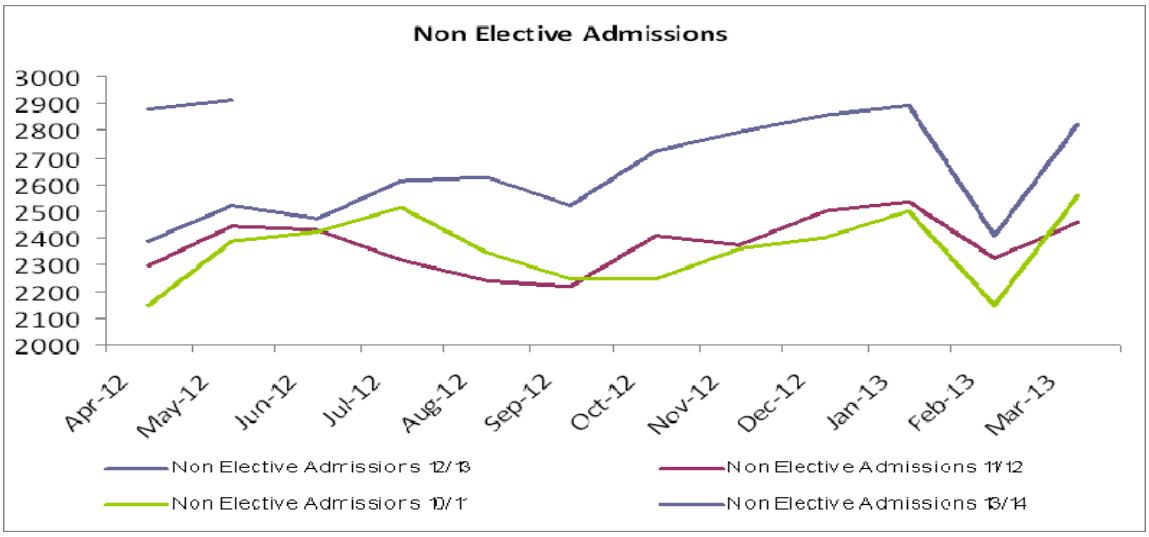


Key points to note:

- 81,600 attendances in 2012/13 (NB counting change in December 2012).
- Less than 1% increase in attendances compared with 2011/12 (excluding counting change).
- This pattern has continued in the first months of 2013/14.
- Based on information provided by WHT 42% of 2012/13 attendances were categorised as major or intermediate compared with 33% in the previous year and Staffordshire activity has increased.

3.2 Emergency Admissions

Based on data provided by WHT Emergency admissions to the hospital have risen significantly in the last 12 months and created significant pressure on hospital bed capacity.



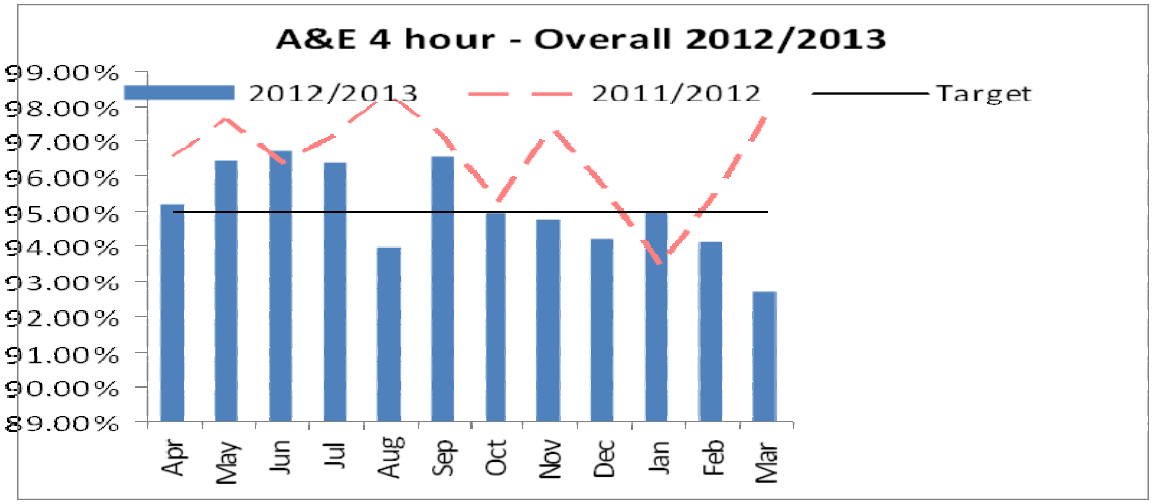
Key points to note and based on information provided by WHT:

- 31,600 emergency admissions to hospital last year.
- Admissions rose by 15% in 2012/13 compared to the previous year (2011/12)
- Admissions have continued at this higher level in the first months of 2013/14 year.
- Walsall residents account for most of WHT activity with Walsall activity increasing by 9%.
- Staffordshire residents account for 10% of emergencies but this activity has increased by 40%.

- The CCG needs to determine the reasons why emergency admissions are increasing. It will do this in collaboration with WHT, Public Health and with Commissioning Support Unit support. We will be using comparative / benchmarking data to inform this review.

3.3 The 95% 4 Hour Wait Target

Across the year 95% of A&E patients were treated within 4 hours although performance fell below this level in our busiest months due to waits for beds.



- 95% of A&E patients treated across the year (2012/13) within 4 hours.
- 6 months last year when WHT did not meet this standard
- Q1 has now been confirmed as 95.06% at WHNHST (all types).
- The first 2 weeks of July have also been good, at 96.6% and 97.31% (despite the two highest attended weeks of the year so far). This puts YTD at w/e 14/7/13 at 95.32%
- Based on information provided by WHT the largest cause of over 4 hour waits were delays for admission to a hospital bed caused by the increase in emergency admissions.
- In the national A&E survey 76% of patients reported overall high levels of satisfaction – in line with previous years and majority of trusts nationally.

The forward trajectory for the 95% 4 Hour Wait Target is given below. This shows projected and actual performance to 21 July 2013. It covers Q1 and Q2 with the forward trajectory for Q3 and Q4 to be finalised with the requirement that they will meet 95% in each of these quarters.

Week Ending	Trajectory	Actual	Standard
07/04/2013	95.0%	95.68%	95%
14/04/2013	96.0%	91.79%	95%
21/04/2013	96.0%	92.66%	95%
28/04/2013	96.0%	93.06%	95%
05/05/2013	95.0%	95.02%	95%
12/05/2013	95.9%	95.50%	95%
19/05/2013	95.9%	97.46%	95%
26/05/2013	95.9%	93.61%	95%
02/06/2013	95.9%	96.49%	95%
09/06/2013	95.9%	94.40%	95%
16/06/2013	95.9%	96.88%	95%
23/06/2013	95.9%	94.71%	95%
30/06/2013	95.9%	98.44%	95%
07/07/2013	95.9%	96.60%	95%
14/07/2013	95.9%	97.32%	95%
21/07/2013	95.9%	96.96%	95%
28/07/2013	95.9%	93.62%	95%
04/08/2013	95.0%	91.30%	95%
11/08/2013	95.0%	96.86%	95%
18/08/2013	95.0%	95.39%	95%
25/08/2013	95.0%	92.51%	95%
01/09/2013	95.9%	94.48%	95%
08/09/2013	95.9%	96.39%	95%
15/09/2013	95.9%		95%
22/09/2013	95.9%		95%
29/09/2013	95.9%		95%

3.4 Commissioning Support Unit (CSU) analysis

The CCG is a full and active member of the area Urgent Care Board. This Board commissioned the CSU to undertake an A & E activity analysis of all member CCGs and produce benchmarking analysis. This showed that the trend in increased A & E attendances was consistent across all CCGs but that emergency admissions were higher for Walsall which may be accounted partially by the mid staffs cross boundary drift. In order to understand this issue in more detail the CCG is commissioning the CSU to undertake further analysis of emergency admissions and in addition is undertaking further local analysis as well.

We are also accessing intelligence from the CSU on the impact of Urgent care initiatives – “Reducing Unplanned Admissions – Rapid Literature Review” - and have used this to inform our local impact analysis and management of risks.

3.5 Summary

What the data shows is that there is increased pressure on A & E, increased emergency admissions and therefore a risk to achieving the 95% 4 hour wait target although Walsall did achieve the 95% target for 2012/13 and in Quarter 1 2013/14. These pressures can affect the operation of other acute care pathways and increase costs but the CCG, Walsall MBC and WHT are working hard to address these risks through collaboration and partnership working.

3.6 Key points arising from analysis of recent urgent care activity

- Increases in ambulance conveyances
- Increases in A&E attendances- Less than 1% increase in attendances compared with 2011/12 (excluding counting change).
- Increase in admission rates from A&E department, assumed to be due to increased acuity of patients –an increase of 15% in 2012/13 compared to the previous year (2011/12)

3.7 Key findings in relation to the Emergency Department

WHT have reported considerable progress in implementing recommendations of the various external reviews including WMQRS (Oct 2010), SHA appreciative Enquiry (March 2012), PCT Trust visit (July 2012), ECIST (April 2012 and January 2013) and also records the current state of play in implementing locally the recommendations of the CQC Investigation into University Hospitals Morecambe Bay NHS Foundation Trust and the standards relating to workforce, training and competency arrangements in A & E. The CCG is seeking assurance that all the recommendations of the ECIST reports have been implemented in full.

The WHT A&E Improvement plan has been submitted by WHT to the NTDA for approval. It is understood that NTDA have reviewed and approved, but the Trust are awaiting final confirmation.

3.8 Key findings in relation to non-elective inpatient activity

There are higher Emergency admissions from the 30 to 55 age group

Significant numbers of emergency admissions are respiratory, gastro-intestinal and cardiac related, although other conditions that are a precipitating cause include gynaecological, diabetes and paediatric related admissions.

4. Winter 2012/13 Evaluations and Lessons Learned

4.1 Collaborative working and learning from others

Walsall CCG has worked collaboratively on urgent care issues with the other Black Country CCGs for some time via a range of groups including the Black Country Urgent Care Group. We are also participating in the Black Country Ambulance

Commissioning Group to ensure that Ambulance issues have the attention that they need and the link back to the CCG.

The Black Country Urgent Care Group offers a mechanism for sharing good Practice (such as the Frail Elderly Pathway in Walsall) and to allow work to be shared and replicated as appropriate to the local situation across the Black Country.

The Black Country recent collaborative initiatives include:

- GP in a car scheme (WMAS)
- Falls Car (WMAS)
- These schemes are being reviewed and undergoing final evaluation when they ended at the end of Quarter 1 2013/14. There will be a decision following the review of the schemes as to whether they will be recommissioned. Winter sharing best practice event in March 2013.

In addition, a development to support the senior managers/executives on call, both in hours and out of hours, technology is being developed to streamline the recording of information which will not only provide a robust evidence trail to support any root cause analysis, but also provide a structured approach to ensuring a smooth transition between in hours and out of hours when issues have arisen. This technology will be in the form of an iOS App to run on Apple devices (iPad, iPhone) which will be accessible to both commissioners and providers. The app accesses local secure server storage to present a single version of live working documents to all parties. Instantaneous live updates can be added and all activity is recorded for review purposes. This will be piloted in Wolverhampton with the option to roll out across the Black Country in time for winter pressures.

4.2 Walsall CCG initiatives 2012/13

A wide range of initiatives have been funded and implemented by the CCG to support the efficient and safe flow of patients through the emergency care system. These are described below.

4.3 Communications between partners

There were **daily conference calls** involving all partners 7 days a week and at times of peak pressures All Partners agreed to meet morning, lunchtime and afternoon. These were of real benefit and provided opportunities for all to assure and challenge respective contributions to managing winter pressures and agree actions.

4.4 Pre admission/admissions avoidance/diversion schemes

4.4.1 GP Practice Urgent access appointment slots

Walsall CCG commissioned a pilot LES from January to April 2013, to fund additional opening hours, to enable practices to have the capacity to see more patients than their existing surgery capacity and contractual arrangements enabled. This LES was developed to address inappropriate attendances at A&E and provide additional capacity to cope with patient demand. Originally, the service was commissioned from January – March 2013, with a total of 46 practices from Walsall CCG signed up to the service; the LES was later extended to the 30th April, with 3 practices opting out beyond March 2013.

The LES provided practices with a payment of £570 per 3 hour weekly session provided. This session cost was designed to cover a range of Clinical skills which could have included a GP, Nurse Practitioner or Practice Nurse appointment. The main requirement to signing up to the pilot LES, was for the practice to demonstrate that they had provided additional urgent access to patients at times when patients may have sought other alternative health services such as the A&E department at Walsall Manor Hospital. To meet this requirement, the LES Service Level Agreement requested practices to submit monthly evaluation information and endeavoured to undertake a 25% telephone survey of those patients accessing this service between January and April 2013. The submitted monthly claim forms detailed:

- The number of additional/urgent appointments offered per month and the actual number of appointments accessed
- How many patients, in the opinion of the practice, were diverted from inappropriately attending A&E
- How many of the patients seen were urgent/non urgent

The details of the evaluation suggests that on average, of the appointments offered, 64% of the appointments were accessed. The access percentage rate across practices ranged from 9.2% to 100%. Some practices managed to fill all of their appointments slots; however 37% of the practices filled less than 50% of their appointment slots. It is also worth noting that the information collected did not include DNA rates, which may have further reduced the overall number of appointments accessed per practice.

A telephone questionnaire for patients was devised and clinically validated, before it was sent out to practices to complete. Practices were requested to undertake a telephone questionnaire with 25% of the patients who accessed the additional/urgent appointment service and 1105 responses were returned from 40 GP practices. The summary of the results were as follow:

- 16% of patients who responded to the telephone survey say they would have gone to A&E, if an urgent appointment had not been available at their practice.
- If an urgent appointment had not been available, proximity and having the opportunity to have access to a same day appointment, were considered the main reasons to why patients would have used the Urgent Care Centre or Walk in Centre instead.
- 93% of patients agreed that having access to urgent appointments would improve their experience of healthcare in the future.
- A number of patients suggested that this service should continue, but that this kind of appointment should only be offered to patients who need to be seen by the **doctor urgently**

4.4.2 PNHs and Care Homes

Walsall CCG also commissioned additional block capacity in one of our local PNHs as well as spot purchasing in other PNHs on a framework agreement, totalling some 50 beds at times of high pressure.

The PHN service was commissioned in December 2012 at Parklands court Nursing Home with 10 general beds within Harrison and Collins House, 15 Residential Dementia beds within Samuel House and access to Challenging behaviour beds within Elmore House. Criteria were agreed and a process map developed for access and communication across Acute Hospital, IDT and Parklands. The service continued throughout April May and June 2013, but with reduced capacity

Evaluation of Parklands Nursing Scheme has shown benefits in having this capacity available to manage surges in demand over the winter period, and key learning points from an evaluation of the service commissioned will shape the specification for the service if it is commissioned in the future. The key learning points include:

- Patients and families have fed back that the transition arrangement has meant a smoother discharge pathway, with all aspects planned and resourced appropriately. Patients largely required simple assessments and care packages establishing to allow a return home, however thresholds of expectation regarding independent care vary between social care and health, sometimes impacting discharge arrangements.
- Whilst there has been no therapeutic input, patients have been encouraged to build on their existing self care skills to maximise their independence. This will be reviewed in any potential future schemes
- Nursing assessments completed on the ward were variable in consistency and quality, this will be considered in the future and training support be put in place.
- Complex discharge with social care input have created some delays, processes will require review and streamlining, however reablement pathways worked well.

- Medical cover has been provided by WALDOC as the patients GPs do not often in reach into Parklands. This has mostly been effective but has posed problems with consistency of the attending GP.
- Medication has at times been incomplete or less than 14 days supply sent on discharge. This has led to discussion with the wards and pharmacy to ensure that 28 days of medication is sent to cover the time within the step down bed and return home. The patients GP has supported the provision of medication should it exceed the 14 days. The supply of other items (e.g catheter equipment, stoma equipment, continence products) has also been problematic, at times involving staff having to fetch items from the wards. This has led to a prompt / discharge checklist being developed, which would be implemented under any other scheme commissioned
- The home has been incredibly flexible and supportive, understanding the nature of emergency escalation. This has been crucial and should be fostered with any other potential provider going forwards, however historically patients from Swift Discharge Suite have had a more comprehensive discharge plan to support care going forward, and this should be explored.

4.5 Hospital front end, admission and inpatient stay

4.5.1 A & E triage system

WHT operates a **triage system at the front end of A & E.** Although 2 providers offer urgent care services under 2 contracts the urgent care pathway is integrated and designed to ensure that activity is triaged to the most appropriate service. Currently there is a commissioned service with a joint contract for the GP Out of Hours service and the operation of the EUCC (Emergency and Urgent Care Centre) at the Manor Hospital. This service accepts patients triaged by WHNST staff from A&E, future provision of triage is anticipated to be by the EUCC provider Badger, which is hoped to increase the number of patients from A&E.

4.5.2 WHT senior management team actions

Hourly tracking systems, opening extra bed capacity and proactive management of the clinically stable list i.e. patients who were medically fit and capable of being discharged. Other specific initiatives included:

- Medical Staff – During the winter period **WHT recruited to its 6 Acute Physicians posts** which enabled extended cover of Acute Medical Unit until 8.00pm week days with additional ward rounds at weekend. A&E expanded its Consultants workforce to 6 which provided cover until 10.00 pm week days from 8.00pm and additional middle grade cover was provided out of hours. Consultant weekend ward rounds were also maintained throughout this period with an additional evening AMU ward round by on call Physician.

- **Geriatrician review in A&E** – Additional Frail elderly nursing cover linked to elderly care team was provided during the winter months for A&E with A&E GP support.

- **Intermediate care HIT squad into AMU** – Over the winter months WHT put in a discharge coordinator in AMU, Linked community matrons into IDT to pick up admissions from known case load through the flagging system together with increasing FEP support. This level of support has been well received by AMU and the Trust is looking to further develop this approach in 2013/14. In addition more community support was put in place to facilitate early discharge with a particular focus on IV therapy pathways.

- **Pharmacy, portering and diagnostic support. -**Additional Support Services were put into place to ensure clinical functions are fully supported at times of peak pressure such **as extended Pharmacy, portering and diagnostic support.**

- **Additional Trauma theatre sessions** were provided over the winter months and elective activity reprofiled to ensure ability to meet emergency surgical demand.

- Diversion pathways to redirect avoidable demand away from A & E.

- Local Social services also **revised their assessment process** which meant that patients could be discharged to interim placements much sooner and their full assessment done in the community rather than continuing to block a hospital bed.

4.6 Discharge Capacity/Post admission

Walsall Councils reablement service is currently set up to support people over the age of 18 who are suitable for reablement within their own homes, and have a care plan to demonstrate they need such support. The service was reconfigured from a historical home care service; the maintenance cases were reviewed and support externally sourced during 2010 and 2011 to enable a smaller service which could then concentrate on supporting step up and step down reablement and therapy sessions. Initially the service was set up to support approximately 25-30 new service users each week, but was also dependent on a similar number being reviewed for a longer term package by an alternative provider.

Social services reablement and social workers were pivotal throughout the entire winter period. We found that OOAs admissions were very challenging and on some occasions delayed discharges were the result of social workers from surrounding areas not coming into WHT in a timely fashion, but more a reflection of their capacity to do this rather than anything else. WHT always proactively managed such cases through the Integrated Discharge Team, and Walsall Social services were always fully involved and proactive in discharge planning arrangements to home, residential and private nursing home placements where required.

5. Governance and the Urgent care Board

Governance for Urgent Care is currently managed via the Unscheduled Care/Urgent Care Programme Board, whose membership comprises a wide range of clinical expertise, including Acute and Community clinicians, Local Authority - social care and

inclusion representatives, CCG executive and clinical leads, Out of Hours provider, West Midlands Ambulance, Mental Health and Public Health. CSU Urgent Care lead also attends to represent views on partner organisations across the Black Country.

The current work of this Programme is to provide system wide leadership to the LHE in Walsall; set strategic direction for transforming the emergency and urgent care system; and monitor progress against agreed actions and evaluate outcomes. We have reviewed the effectiveness of this group and are revising its TOR to enable us to better focus on the following areas:

- Collectively agree those actions that will improve the immediate situation within the emergency and urgent care system in Walsall with a view to ensuring achievement of the 95% target by the end of Quarter 1
- Ensure quality and safety is maintained within the local emergency and urgent care system
- Evaluate current initiatives and agree/commission robust actions to manage the forthcoming winter period
- Set out plans for transforming the system longer term
- Ensure the effective coordination between the local system and the wider emergency and urgent care network across the wider Health economy, BSol and Black Country.

Future membership will include CEs from the CCG and the WHCT and Director of Adult Services and Inclusion, Walsall MBC, who will collectively lead this agenda and will ensure the mobilisation of individual resources and capacity.

The Chair of the Urgent Care Board will ensure effective coordination between local actions and those of the wider emergency and urgent care system e.g. Black Country

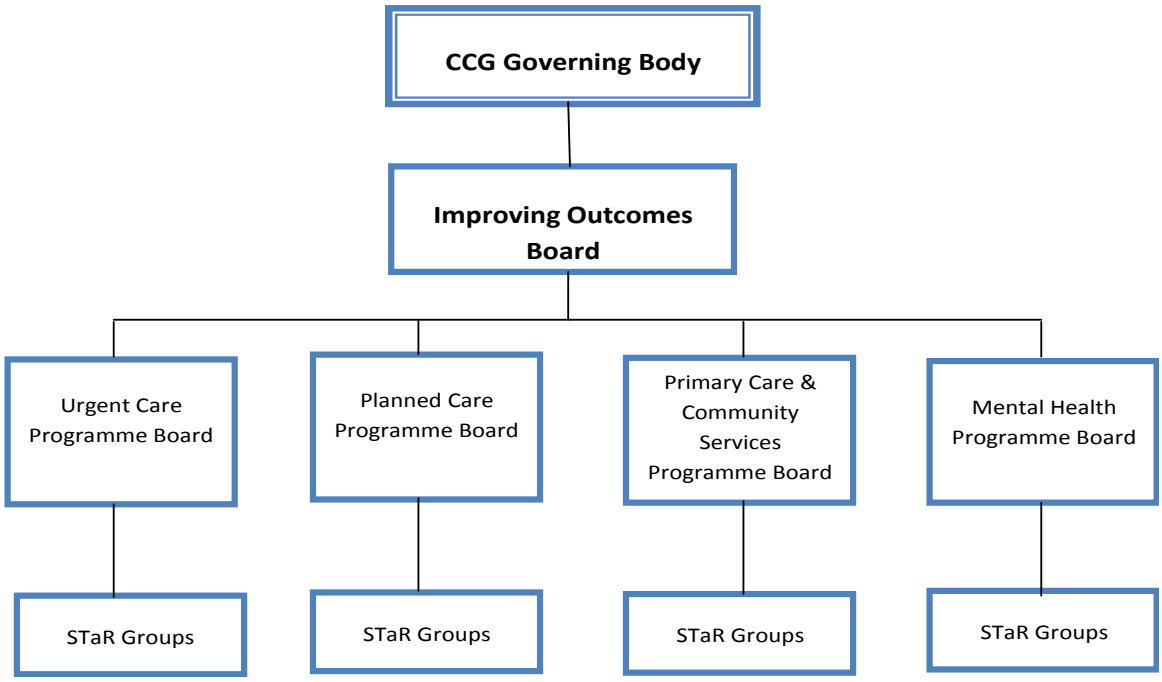
The work for the coming year has been confirmed as analysis of current patterns of patient flow, review of current provision across Walsall including Walk in Centres and our Emergency and Urgent Care centre, improved GP Access in Primary Care, Winter/Surge planning, Out of Hours services and A&E activity and review and updating the risk register.

The Winter/Surge Planning Group, consisting of GP clinicians, Acute Trust, WMAS, Mental Health, Local Authority, and Regional Capacity Management Team will be the STaR (Service Transformation and Redesign Team) which develops the Surge plan and provides recommendations to the Board. The aim of the group is to ensure there is an urgent care system that meets the patients' needs, provides quality services and reduces the demand for A&E services to support the target. The remit of the Programme Board, following the recommendations in the Improving A&E performance Gateway 00062, will also include:

- Sign off/ratification of the A&E Recovery Plan
- Oversee the implementation and monitoring of progress against the plan.

- Using the dashboard under development in the CSU, and work undertaken locally, the group will undertake further diagnostics
- Develop proxy metrics (in consultation with Performance colleagues) for agreement by the programme board. All associated measures are being drawn together as a programme scorecard and will be monitored via the board, including all performance and CCG outcome indicators and constitutional NHS Measures

The Urgent Care Board has a robust reporting structure within the CCG to ensure that all issues are escalated and managed at the appropriate level:



To ensure robust communication, across all Urgent Care networks in the surrounding area, representatives from the Programme Board are also active members of the Black Country Urgent Care collaborative Board with the Accountable Officer attending these meetings and the CFO deputising in her absence. This forum enables to sharing of best practice, and ensures a consistent approach to Urgent Care systems across Birmingham, Solihull and the Black Country. Following a recent meeting with South staffs commissioners, it was agreed that either a separate group, or extended membership would be required to plan for any changes in service delivery at Mid-Staffs and acknowledge the increasing cross boundary drift into Walsall and Wolverhampton from Cannock and surrounding areas.

6. Surge/Winter: Planning and Actions for 2013/14

6.1 Introduction

We are taking a whole system approach to our action plan which follows the patient journey from home, primary care/ urgent care system, A/E attendance and then flow through hospital followed by early discharge and re-ablement at home. The plan is an iterative process, with some areas requiring further development and also prioritisation of initiatives. We are undertaking an impact assessment of the health economy plan to assess the level of risk this winter and to ensure that our plans mitigate the risks identified, as well as to help aid the prioritisation of schemes in terms of deliverability for this year. The work is underway for this and we anticipate this being available in next few weeks for review by the Urgent Care Board

6.2 Public, Patient and Staff Engagement

Walsall CCG is currently working with the Communications and Engagement Department within Central Midlands CSU and other CCG partners and providers to develop the Winter Plan for 2013/2014. The final planned activity is still to be formally signed off.

Walsall CCG has a number of communication methods that it will utilise dependent upon the situation and the urgency. Some examples of these are as follows:

Description	Audience	Method
General health updates/winter campaigns	General Public/ CCG Members/CCG Staff	Internet/Extranet, CCG newsletters, AO update, social media
On-going health campaigns (Choose Well, Flu)	General public	General media (newspaper/radio/etc), social media, internet, CCG newsletters
Alert of pressures on the system/closure of wards	CCG Members/CCG Staff	Direct e-mail to each recipient, extranet, AO update
Disease specific outbreak	General Public	General media (newspaper/radio/etc), social media, internet, CCG newsletters
Disease specific outbreak	CCG Members/CCG Staff	Direct e-mail to each recipient, extranet, AO update
Closure of services	General Public	General media (newspaper/radio/etc), social
Closure of services	CCG Members/CCG Staff	Direct e-mail to each recipient, extranet, AO update

The communications team commissioned by Walsall CCG provide a 24/7 media support service to ensure that the CCG is fully informed of any changes in the current health provision and any factors that could affect service provision.

The communications campaign will support people with information re management of self-limiting illnesses and making good choices about which parts of the healthcare system they need to use such as primary care/WIC centre rather than attend at A/E.

6.3 Primary care

Enhanced surgery opening Hours

As reported earlier in 3.4.1 the CCG will further develop this service with a view to commissioning this service again. The specification will be modified to take account the learning from the patient evaluation.

Review of primary care A & E Attendance's data and action proposed

We are working with the top 10 practices with highest A& E attendance rates to identify support.

The CCG is working with CSU on two related areas the first is development of an urgent care dashboard which the CCG will use to identify areas for improvement and track performance and secondly taking forward key pieces of strategic analysis to review community services and acute bed modelling. We are also using the levers in the contract to drive up performance with a performance improvement notice being issued to WHCT in Q1.

Enhanced Services: risk stratification DES

NHS England offered all GP practices the opportunity to provide four new enhanced services for 2013/14. Areas Teams offered three of the new schemes directly and the CCG were required to offer the *'Risk Profiling and Care Management Scheme'* to GP practices on behalf of NHS England.

The aim of the enhanced service is to encourage GP practices to undertake risk profiling and stratification of their registered patients, work within a local multi-disciplinary approach to identify from the list produced, those patients who are seriously ill or at risk of emergency hospital admission and to co-ordinate with professionals the care management of those patients identified who would benefit from more active case management.

In the absence of an electronic risk profiling tool, for 2013/14, each GP practice will be required to access the MICS system on a quarterly basis to predict patients who are at risk of becoming seriously ill or are at significant risk of emergency hospital admission,

applying a criteria of: those patients who are over the age of 75, have co-morbidities and are frequent A&E attendees.

The GP practice will work with the community nursing team to assess the list produced to identify those patients in significant need of active case management. Due to resource/capacity limits, a cap of 5% of the registered patient list or maximum of 30 patients for active case management will be applied.

The GP practice will meet with the community nursing team on a minimum quarterly basis to achieve a shared and integrated approach to the case management of each identified patient to improve the quality of care and reduce their individual risk of emergency admission.

The GP practice will be required to submit an agreed audit template to evidence they have met the requirement of the local specification.

The CCG will use completed templates to assure NHS England that the enhanced service specification has been met to enable them to make payments to participating GP practices.

The CCG will evaluate and report the impact of the scheme on A&E attendance in Walsall to the CCG Operational Group. 60 out of 62 practices have signed up to this NES.

GP Practice QOF productivity scheme

The Quality and Outcomes Frameworks (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. Contractor participation in QOF is voluntary. The Quality and Productivity (QP) domain requires practices to undertake an internal practice review and an external peer review of secondary care referrals (first outpatient activity), emergency admissions and accident and emergency attendances.

QP Indicators 4, 5 & 6 Emergency admissions requires practices to internally explore reasons for emergency admissions with reference to available pathways. There is external peer review with other contractors to compare data on emergency admissions and agree with the group areas for commissioning or service design improvements.

QP Indicators 7, 8 & 9 Accident & Emergency attendances requires practices to internally consider whether access to clinicians in the contractors' premises is appropriate in light of the patterns on accident and emergency attendance. There is external peer review with other contractors to compare data on accident and emergency and agree an improvement plan for implementation by Contractors.

The CCG have worked in partnership with NHS England and agreed three care pathways for emergency admissions review. The agreed pathways and rational are:

COPD: is a common disabling condition with a high mortality and increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. The pathway links to CCG Health Outcomes Indicators and Improvement Ambitions for 2013/14 as follows:

- Under 75 mortality rate from respiratory disease
- Health related quality of life for people with long term conditions
- Proportion of people feeling supported to manage their condition
- Unplanned hospitalisation for asthma, diabetes, and epilepsy in under 19s
- Emergency admissions for acute conditions that should not normally require hospital admission

Heart Failure: represents the only major cardiovascular disease with increasing prevalence and is responsible for dramatic impairment of life, carries a poor prognosis for patients and is very costly for the NHS to treat (second only to stroke). Many heart failure patients will be diagnosed following specialist referral or during hospital admission. The pathway links to CCG Health Outcomes Indicators and Improvement Ambitions for 2013/14 as follows:

- Under 75 mortality rate from cardiovascular disease
- Health related quality of life for people with long term conditions
- Proportion of people feeling supported to manage their condition
- Emergency admissions for acute conditions that should not normally require hospital admission

Diabetes: is a progressive, long term condition and is one of the most common endocrine diseases affecting all age groups with over 1 million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. There are a substantial number of patients with diabetes who remain undiagnosed and a number of patients receiving treatment with an incorrect diagnosis of diabetes. Prompt detection and treatment of diabetes complications can lead to a reduction in important health outcomes such as end stage renal failure and cardiovascular morbidity and mortality. The pathway links to CCG Health Outcomes Indicators and Improvement Ambitions for 2013/14 as follows:

- Under 75 mortality rate from cardiovascular disease
- Health related quality of life for people with long term conditions
- Proportion of people feeling supported to manage their condition

- Unplanned hospitalisation for asthma, diabetes, and epilepsy in under 19s
- Emergency admissions for acute conditions that should not normally require hospital admission

All of the three pathways link to the CCG Quality Premium measures and data analysis shows that there high levels of admissions where these disease areas are the precipitating cause.

The benefits to the CCG of GP practices taking part in the QOF QP will be through their involvement with the three pathways and group recommendations for commissioning and service redesign improvements, and agreeing and implementing accident and emergency attendance improvement plans.

GP practices will be able to access urgent care through the MICS hosted by the CSU and will conduct an internal review within the practice. The GP practice are expected to participate in an external peer review group with other contractors who are members of the same CCG to compare data with that of other contractors and to agree areas for commissioning or service redesign improvements, and improvement plans.

NHS111

NHS 111 is fully implemented in the area. Activity is reported on a daily basis and the contract reviewed on a monthly basis. All complaints/patient queries that are Walsall specific are being responded to in a timely manner via the agreed governance route, there have been no serious untoward incident related to NHS111 in Walsall.

Actions from A & E data analysis including Long term conditions

Diabetes

http://www.hscic.gov.uk/searchcatalogue?productid=11321&q=%22National+Diabetes+Inpatient+Audit%22&sort=Most+recent&size=10&page=1#top

The hyper link above links to a copy of the National Diabetes Inpatient Audit 2012 report which evidences that at the time of the audit 19.4% of inpatient beds were occupied with patients with diabetes (as a diagnosis- 75 in total) which in terms of prevalence puts WHT towards the upper quartile compared nationally, of which over 90% were unplanned admissions, a steady increase year on year from 2010, however it is important to stress that of these, 62.7% were admitted for other medical reasons (co morbidities) and this is an area the CCG is examining further to better understand why these patients are attending A&E and subsequently being admitted.

In relation to the outcome indicators and local priorities aligned to diabetes the STAR (Service Transformation and Redesign Team) have agreed the following;

- Local Priority 3 Self care management- extending access to DESMOND and alternate structured education programmes
- C2.5 structured education, currently a business case is being developed to secure funding for the XPOD programme for self management/prevention for people with Type 2 diabetes and those who are pre diabetic or who may be at risk of developing diabetes including those with gestational diabetes
- C2.4 Nine care process, although overall we are making progress against each of the criteria overall the one area we need to address is is retinopathy screening, increasing attendance by even a small % will massively increase overall % against this indicator. We will be seeking the support of the Area Team screening lead to address this issue.

Whilst on their own none of these contribute significantly to the winter plan, increasing awareness and confidence in supporting patients to manage their own condition will address non elective attendances in the longer term.

In the short term, we are looking to roll out the Hypo-alert service with WMAS, Dudley are currently piloting the project and an evaluation will be published shortly. There is keen interest across the BCC urgent care collaborative to adopt this project. The associated business case will be presented to the CCG in September for its support. The aim is to address patients presenting to WMAS with a hypo, so that instead of patients being transferred to A&E, the community diabetes team will liaise with the patient and if necessary undertake a home visit, however we would still be looking to better understand patients who have diabetes but who are presenting to A&E with another medical reason and pending the initial results of this, will be an agenda item either via the appropriate planned STAR or as part of unscheduled care commissioning.

Gynaecology

CCG analysis shows an increase in emergency admission trends particularly for maternal disorders predominantly related to pregnancy and pregnancy with abortive outcome by some 30-50%. We believe that the activity is pregnancy related PV bleeds, women with a gestation of less than 20 weeks, in PBR terms are considered to be Gynaecology patients and not Obstetric patients therefore different treatment codes may be used, hence the trend.

NICE guidance prohibits pregnant women that are bleeding going directly to an EPAU, at booking (6-10 weeks) women should be given appropriate advice/guidance on what to do if they bleed (which is very common) This is potentially not happening, and consequently we are seeking some assurance from WHT so that we can better understand the pathways for these patients. In the interim NICE have issued new guidance for consultation in regards to pain and bleeding in early pregnancy which discusses EPAU's (pg 11 section 1.5) stating: Dedicated early pregnancy assessment

services should accept self-referrals from women who have had a previous ectopic or molar pregnancy. All other women with pain and/or bleeding should be assessed by a healthcare professional before referral to an early pregnancy assessment service.

The Obstetrics and Gynaecology STAR (Service Transformation and Redesign Team) are therefore reviewing the pathways and we are looking to implement changes to address this non elective activity/trend.

Paediatrics

There are 3 sub working groups to the STAR each looking at the following;

- Asthma, is one of the outcome indicators (2.3) for the CCG. CCG analysis shows the trend for emergency admissions is increasing year on year. Whilst the DOH are producing guidelines on the management of Asthma, we are considering joint funding for an Asthma specialist community nurse. This post will be a vital element to addressing both the short term and long term trends in emergency admissions. In the interim WHT is working with GPs to address those with higher than average admission rates in particular. The CCG outcome indicator analysis also shows a growing trend in emergency admissions for children with acute bronchiolitis, this pathway is being reviewed by the STAR group to better understand why this is the case.

- Urgent Care, the publication of both the Collegiate emergency standards and RCP 'Back to Facing the Future', have provided this sub group with a steer in addressing urgent care pathways starting with a self-assessment against the standards with the intention to agree immediate, short term and longer term solutions. The immediate term solutions will look to be implemented as part of the winter readiness plans.

- Community, looking to develop wrap around services around the unwell child including admission avoidance and facilitating discharge home. We are currently reviewing the Hospital at Home service with the community paediatric team who have also extended access to their service to include weekend cover to include better understanding of workforce skills and skill mix. . An evaluation of the original service 2010 provides real evidence as to how this service impacts on admission avoidance and reducing LOS. Again this group will look to identify immediate, short term and longer term solutions in readiness for winter planning, in particular fully implementing the H@H service as it was originally intended.

End of Life - The CCG is developing an OBC for a hospice at home service in addition to this we are also developing a service specification. The financial and activity assumptions are currently with the finance team for confirmation but it is anticipated that pending advice from Alan Turrell on AQP process, and confirming support from the CCG, we will be looking to advertise/procure and implement the service by

December 2013. This looks to address capacity within existing services to support patients to die at home, the initial analysis suggests emergency related activity and LOS for these patients will reduce on average by 10% overall.

6.4 Community based services - Out of hospital care

Community Nursing and Therapy Services Redesign

The Community Services Service Transformation Team is currently working on a redesign of existing community services, which will re-align nursing and therapy teams to GP practices, and using a risk stratification approach, the teams will work proactively to manage those most 'at risk' to avoid an admission. In some respects risk stratification tools have not delivered the benefits expected, so the approach is planned to be more flexible, using the expert knowledge of the practice regarding their own patients, and encouraging a much more collaborative approach. Social care input remains crucial.

This work will take into account existing structures and staffing level, assessing the potential impacts of the requirements of the cost improvement programme. It is hoped that elements of this service will be in place from September 2013, however it is anticipated that there will be a full year effect in terms of training, development and embedding of a new model. To that end, it is not anticipated that this will deliver the full impact envisaged in winter 2013 /14, but it will still have a positive effect on demand management and the self-management of patients with long term conditions.

Commissioning additional community beds

Part of this year's plan will be to commission up to a maximum of 25 step down beds (the "Parklands" Model). Following the evaluation of the service in winter 2012 /13 there will be a revised specification, and a procurement process and contract awarded to the preferred provider. The aim remains to improve flow of acute patient beds and provide a 7-14 day facility for patients to move back into the community while finalising discharge arrangements.

Initially managed from within IDT then supported by Social Worker and FEP Lead Nurse

Based on the evaluation of the service for winter 2012 / 13, the specification and operational management of this provision will be revised so that it includes the following:

a) A case manager in place to ensure that the patients are progress chased and discharge plans are met.
b) Robust discharge plans in place with identified key workers who are able to continue to work with the patient and family and remain in close contact with the case manager.

c) Ward staff will need to be able to identify patients who fit agreed criteria and supply a robust comprehensive nursing assessment to the commissioned Provider alongside the discharge plan.
d) To prevent patients exceeding the length of stay criteria there needs to be an agreement for speedy social care assessment and processing through the funding system.
e) Communication with the case manager needs to be through an agreed format with comprehensive single patient held notes being maintained and shared.

Clinical wrap around for nursing homes

Clinical Wrap around Team was developed and may be commissioned again this winter. This involved the development of regular ward rounds (x2 sessions per week) in order to clinically review patients and put in place management plans to support the on-going clinical management of patients in nursing homes and to improve communication methods between Independent Provider, Acute and Community services to enhance patient care and transfer of information with a preventative element across nursing home residents. The project ran from 1st December 2012 to 31st March 2013 and involved working with four nursing homes within the Borough and aligned to two GP surgeries. The consists of GP representing each Practice, Frail Elderly Pathway Nurse, Nursing home link and Proposal for Secondary care sessional support from elderly care physicians.

Outcomes:

Between Dec-Feb 410 reviews have taken place:

- December = 167
- January = 135
- February = 108

Over 63% of reviews were recorded as due mainly to a Respiratory Condition.

37% of reviews were recorded as due mainly to symptoms of a UTI.

Of the 19 reported deaths, 89% were recorded as being in preferred place of care i.e.: within the nursing home.

GPs report significant reduction in urgent call outs from homes.

Homes reporting greater confidence and competence in the management of patients with LTC and EOL, with evidence of the use of clinical protocols and GP proforma in place. Data being collected which suggests a reduction in inappropriate admissions for this period of those patients reviewed as part of this project.

Frail Elderly Pathway

NHS policy is to support older people in their own homes and to prevent avoidable emergency admissions to hospital. Intermediate care and reablement services are currently operating across the Borough and have a successful record in supporting people to remain in their own homes. The aim of the frail elderly pathway (FEP) is to provide care for this patient group in their home, where possible, including care homes, in order to reduce the unnecessary use of acute hospital beds by achieving as good or better outcomes in patients' health, well-being and quality of life

The pathway adopts the concept of a 'virtual ward – plus' with an integrated care pathway covering three components; urgent care, acute care and post acute care; addressing the physical, mental and social needs of the frail elderly. The CCG is commissioning services in all of these areas of the urgent care pathway and are described in the following sections.

The frail elderly pathway is predominantly delivered by the intermediate care team, and more detail around development of this service can be found below.

Intermediate care team :"virtual ward" and bed based services: Hollybank House & Richmond Hall

Intermediate care teams provide a short term rehabilitation service following illness or accident., The population this service usually serves is aged over 60, but younger adults considered on an individual basis. The service is provided **in the person's own home wherever possible**. Where this is not possible the service has intermediate care beds in a local nursing home and a joint unit run in collaboration with Social Care and Inclusion:

- Hollybank House is a 21 bedded unit currently staffed and owned by the Local Authority with in-reach and support provided by ICT
- Richmond Hall – 15 beds in private nursing home supported by ICT.

The intermediate care team forms a service which promotes faster recovery from illness, avoids inappropriate hospital admission, supports earlier discharge from hospital, avoids the need for long-term care and maintains independence. The ICT Team manages community based Diversion pathways, which include

- DVT pathway
- Cellulitis pathway
- Rapid Response as part of the frail elderly pathway

DVT Pathway

The DVT pathway is designed to accept referral, primarily from GP's but with some community and hospital referrals. It is used for patients with suspected DVT, assessed against recognised criteria. Patient has a d-dimer test in community with an ultrasound

diagnostic if required in community. Confirmed DVT will be managed with Clexane, in line with guidance by ICT in Community

Cellulitus Pathway

The cellulitus pathway is designed to accept referral, primarily from GP's, but with some community and hospital referrals. It is used for patients with confirmed or suspected cellulitus and patient is assessed by ICT nurse against national standards. Confirmed diagnosis is managed with IV antibiotics by ICT, supported by District Nursing.

Rapid response / Frail Elderly Pathway

The team respond to urgent community referrals (from GP's, WMAS, Community Nurses or Social care) within 2 hours. This service aims to provide a top to toe assessment and maintain the patient in their own home. This is further strengthened by a GP based at the Swift community unit at the hospital, and a frail elderly team who actively 'turn around' patients at A&E. The nurses and social workers who are part of this team are also able to access short term 'step up' community beds in Swift.

As part of the plan for winter 2013 / 14 the rapid response service will be further enhanced by the support of a Consultant Geriatrician from the 1st September 2013 – this will be run as part of the winter initiative, with a view to embedding if successful. This is further supported by a local re-design of reablement services, which will allow for increased flexibility for frail elderly patients, both on discharge (to speed the discharge pathway) and to 'step up' to a community frail elderly community bed. WHT and Commissioners have worked closely with Local authority to help with these developments, which will be closely aligned to the integrated intermediate care unit (Hollybank House). There are plans for further integration which will be detailed later in this paper as future developments

A further part of the plan for winter 2013 / 14 is to strengthening intermediate care staffing and their links to Community matrons, but also to revisit the matron in-reaching in A & E, in order to divert admissions where appropriate and safe to do so as well as the ICT 'hit squad'.

SWIFT Ward - Step up and Step down beds

Patients will be admitted to the unit from community settings (Step up admissions) or from hospital settings (step down admissions)

The step down and step up function will be supported by a range of professionals from both health andsocial care and will include therapy input 7 days per week. Attention to the mental health needs of patients is an integral part of the service.

Admission criteria is agreed for the unit; Swift Ward is not currently perceived as acute hospital bed stock, (patients are 'stepped down' into SWIFT prior to discharge home,

where appropriate or ‘stepped up’ from community avoiding a hospital admission). In addition the CCG are working with Social Care to strengthen intermediate care and discharge pathways

The CCG also aims to review the designation of some of the beds on SWIFT Ward to strengthen the ability of GP’s to admit directly to the GP who manages the unit.The intention is to ensure that the following are promoted as central to the service:

- Patients are managed more appropriately as a ‘community’ patient and avoiding a hospital stay
- Reduction in LoS and a swift return to home, with a focus on maximised independence
- Community admission for stabilisation, observation and diagnostics if required. Patient is ‘managed’ by the unit’s GP and care transfers directly back to patients own GP
- Reduction in unnecessary readmissions

Rapid Discharge Support for Living at Home Service

The purpose of the Rapid Discharge Support for Living at Home Service is to provide care staff within 2 hours of receiving a referral for vulnerable adults who have been assessed by as eligible to receive this service in their homes. The aim is to support patient who may be in a ‘crisis’ situation, but not requiring a hospital in-patient episode. Referrals are predominantly made by Community Intermediate care team or the dedicated Frail Elderly nurses based at the acute Trust. This service was commissioned initially for one year, and commenced in January 2013. The service is currently being evaluated, but has already proved helpful in the discharge process and supporting the frail elderly pathway. If evaluation proves as positive as the anecdotal evidence, the contract has a clause to allow for an extension to support winter 2013 /14 with a view to recommission the service for the future.

The service currently provides a carer, who will meet the service user at their home and will monitor their health and wellbeing as detailed in the service user’s care and /or support plan for a period of up to 48 hours in order to:

- Prevent unnecessary hospital admissions
- Observe their ability to manage and/or maintain their own safety, health and well-being following discharge from hospital
- Assess the need for statutory services
- Avoid delayed discharge

Referral to Sevacare is for a short term / 48 hour package only; social care pick up patient care beyond that point to assess for their on-going need This patient group will generally require on exit from Sevacare one of the following:

- No on-going needs (temporary observation / stabilisation)

- Reablement
- Long term PoC
- Assessment for final long term destination

Spot Purchase Beds

Spot purchase beds are made available when patients require ICT bed based services, but no beds are available. There is robust criteria and a 'gatekeeping' process to ensure that all patients will be appropriately managed as per the Intermediate care teams normal philosophy.

6.5 Hospital Based service

Emergency and Urgent Care Centre

The EUCC will continue to be part of demand management in A&E. The function of the EUCC is to provide a safe, easily accessible primary care service with in and out-of hours with out-of-hours call handling and GP home visit service. The service must provide appropriate advice, information, reassurance and treatment to patients seeking urgent and immediate help at the Emergency & Urgent Care Centre and via the call handling service outside routine opening hours. EUCC will also triage patients from A&E to the EUCC to divert appropriate activity into a primary care service.

Integrated Discharge Team

Simple discharge is generally managed by ward based staff, whilst complex discharge is managed by IDT. The funding for IDT historically tripartite and the sources were Walsall Community, Walsall Acute and Social Care and Inclusion. Multi-disciplinary integrated discharge planning of patients is essential to ensure that they are discharged safely to a community setting most suitable for their individual needs and in accordance with the Community Care (Delayed Discharge) Act 2003. The monitoring of delayed discharges shows that the team manages the process in a timely and effective manner:

			Apr-13	May-13	Jun-13
A18	Delayed transfers of care to be maintained at a minimal level	In month %	0.44%	1.10%	1.20%

Patients discharged or transferred to any other ward, department or service provider or to a patient's new or usual place of residence from Walsall Healthcare NHS Trust will always be carried out in a safe and appropriate manner, with consideration to the patients' individual needs and those of their family and / or carers

Utilising the appropriate sources of information from health and social care agencies involved in the patients care, prior to admission enables the patient to be discharged to an environment which is conducive to their particular needs and ensures optimum clinical and social outcomes. Decisions to transfer/discharge a patient are made as early as possible during their care pathway.

WHNHST Actions

Actions that WHT has taken/completed/ intends to take to address the current issues in the year 2013/14 are summarised below:-

- Early morning consultant ward rounds - Impact: Daily senior review of patients to take place at 08:00/08:30 hours
- Improve early discharge planning by introducing early morning board rounds (Impact: Free up bed capacity earlier in day and improve multi-disciplinary discharge planning)
- Social worker – to assess patients requiring Social Service input (Impact: Improved management of complex patients and reduction in LOS)
- Identify roles of Discharge Co-ordinator and Increased Discharge Coordinator hours (impact: Improved discharge planning)
- Communications – ensure effective communication to staff to increase awareness

In addition to these WHNHST have plans in place to utilise the 70% funding as outlined in section 8. They have also committed to an A&E improvement plan and are progressing on an ambitious development programme.

WHT plans for 7 day working

Specific actions WHNHST have taken toward 7 day working includes:

- Weekend ward rounds
- Increased A&E consultant presence at weekends
- Additional acute physicians to cover AMU 7 days a week.
- Increased weekend pharmacy cover
- Increased discharge co-ordination and social care input at weekends.

Workforce and Cost Improvement Programme (CIP)

Walsall CCG have expressed concern that the CIP has impacted on community staff, specifically Podiatry, Speech and Language therapy, Physiotherapy and district and community nursing. WHNHST have identified a plan for investment into community nursing, but this may leave a gap in therapy services. To better understand this issue, WHNHST have undertaken a review of therapy services, the results of which are anticipated in the very near future.

WHNHST have assured the CCG that the CIP has not adversely impacted on quality of workforce within the community – as with any Cost improvement plan within the trust they will be subject to an internal quality impact assessment review post implementation.

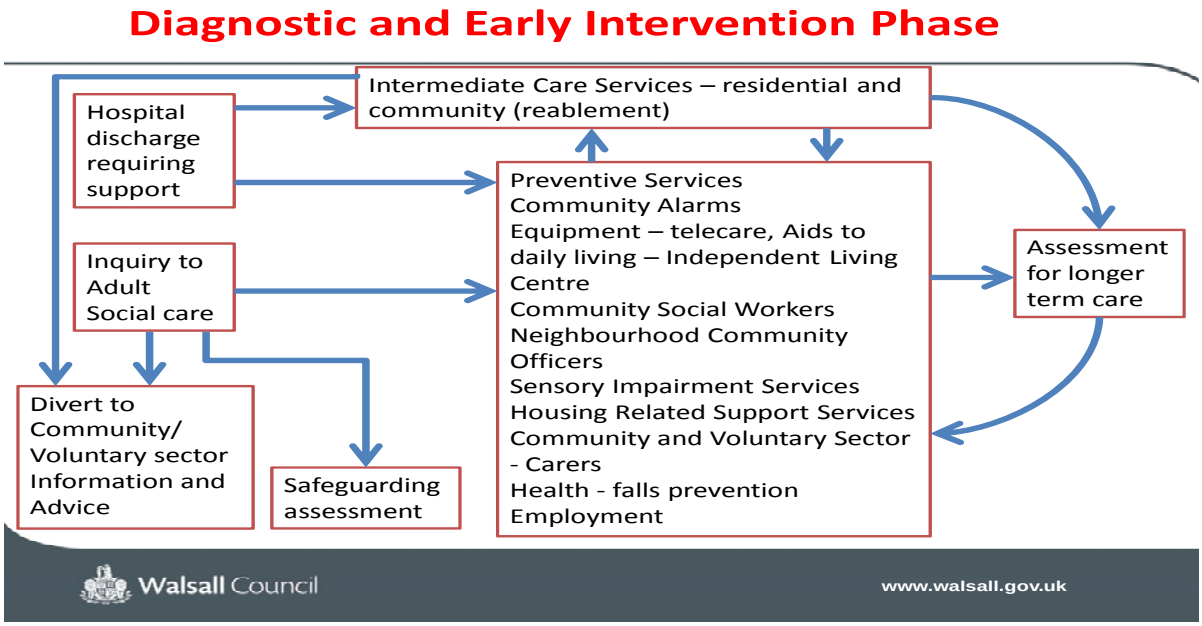
The CCGs unscheduled care programme Board work programme includes other Urgent care transformation projects being taken forward where WHT are pivotal members

6.6 Voluntary sector engagement

The CCG will be working with Walsall Council Voluntary Services to strengthen the links with the voluntary sector and engagement of this sector at a GP practice and or locality level. This will include but not limited to Age Concern and the Alzheimer's Society

6.7 Local Authority and Social Care (also see section 4.6)

The Council have amended their operating model for adult social care by putting a much stronger emphasis on the role that prevention and early intervention can make as part of the offer that people in Walsall should receive before they are assessed as being eligible for longer term care and support.



All the evidence (supported by Government Policy for the last two decades) indicates that people wish to stay in their own homes as far as is possible and in older age face declining years surrounded by family and friends. Over the last decades services have been developed to maximise, restore and rekindle independence and self confidence, to work with citizens to recover the independent life style that they would want rather than prepare them unwittingly for a risk free and unnecessary dependency on institutional type provision.

Over the last 12 months the demand has seen a shift from relatively simple packages of care to more complex sub acute patients. People are entering the service (usually as part of a discharge pathway, but also on a step up from community) with more support needs and a slower reablement pathway. This has affected the service in two ways; firstly, supply has been limited based on increased numbers being referred and protracted lengths of stay. Secondly, the intensity of some of the sub acute packages which can often require four calls a day 7 days a week initially and quite intense input over the reablement process.

Social Care and Inclusions EDMT approved an increase in the carers' baseline from 67 workers to around 100 giving the team a better staffing ratio and the opportunity to take on addition cases. The go live date is September 2013 and this expanded service should see an increases throughput of cases on a weekly basis from 25-30 to 50. There is also the opportunity to flex up higher as the council have a partnership with its internal agency and external domiciliary care agencies to supply extra staffing at times of need. All cases will be screened at discharge (or in the community on a step up basis) for Telecare which should also reduce interventions.

In addition to this the councils assessment and care management teams are looking at reformatting their operating plan. The intention is to move back complex assessments to a point where people are about to enter a complex pathway rather than over assessing in the hospital which is not the appropriate place. A multi-disciplinary MDT will be activated in the hospital and the community to ensure cases are stepped up in terms of the community or stepped down/exited quicker from the hospital. The reablement and ICT teams will then accept patients with minimal contact assessment and overview and it will be up to the interim services to assess more thoroughly ready for the person's exit into the community, this should assist with a quicker discharge as one of the symptoms of ineffective discharge is the waiting for social work assessments.

In addition the Neighbourhood Community officers will team up with Community social workers as a pre-front end service to try and identify people who need interventions to prevent admission. This team of around 30 staff will be able to support the virtual ward model as well as link in with the 9 GP/Community Health teams around the borough. The Council contact centre and community alarms service are being reunited with the response service which will aid early interventions with people who may fall or be

starting to become vulnerable (due to health or social reasons) the response team can then refer into reablement or ICT/FEP for a step up service to prevent admission.

The formal assessment of people will then begin more thoroughly at the point they are due to exit reablement or Intermediate Care services. A review will be held with a social worker to determine whether the person can be exited without formal care arrangements or whether they need a more complex assessment. This is the point a statutory social work assessment will happen with a package being delivered by an external provider.

6.8 West Midlands Ambulance Service

WMAS are looking to improve HALO coverage by pooling the current hours of the Black Country HALO's. This is hoped to provide wider coverage for up to 16 hrs per day at surge times, 7 days per week. With the 'hours pool' the Acute Trusts A&E departments will receive better availability and access to a HALO within budget. The HALO's will continue to work with the A&E department to maintain excellent working relationships and to further guide with the use of the patient release times and understanding the flow within the departments. It is also believed that with increased knowledge of each department there is greater resilience from the team.

The HALO's will also be assisting with the work on frequent service users (FSU) with an MDT approach in an aid to reduce the number of 999 calls and attendances to A&E. As part of the CQINN the CCG will support this with West Midlands Ambulance Service by targeting patients who are high users of services, along with other services such as the police. The main aim is to identify high users and empower and encourage them to better manage their care and reduce the demand they place on these agencies. There is also work on end of life registers (as part of a 2 year project) that is aimed to support peoples end of life care plans.

In addition to this HALO's will also be supporting the use of the DoS with operational staff and working with the DoS lead to identify any issues raised by operational staff. Also the HALO's will work with the ED Dr's to complete confirm and challenge with the crews to allow learning, should any of the patients be identified as not appropriate for ED; this learning is taking place as a case study for the identified crews.

WMAS still strives to improve the hear and treat, see and treat and see and convey rates to ensure that patients are treated in the right setting first time. There is training being undertaken by paramedics on the community paramedic schemes to give them additional diagnostic skills to allow them to complete a more detail assessment of patient and treat or refer to the most appropriate service. The Trust has a Black Country cluster divert process that is managed by the Strategic Operations Cell (SOC) that helps to improve the flow of patients in the Black Country.

GP in a car – provided by WMAS

By utilising a GP led referral car to attend to lower category green 2 calls targeting in particular those patients with chronic co morbidities with a view to managing these patients within the community without the need to transport to an acute site. They have been able to do this due to their experience and skill set in managing this type of patient within primary care with this they would also be able to achieve a shorter on scene time than that of traditional WMAS staff.

The service evidenced a reduction in the number of patients attending an acute trust which would lower the demand at the front door, therefore improving the turnaround of ambulances which would then put resourcing back into the system to help manage demand.

Falls car - provided by WMAS

As above, the rationale was to utilise the appropriately skilled staff to answer 999 calls for a fall. The FALLS3 asset came into operation on 10th December 2012. Since then (up to 03/03/2013) the resource has made 413 responses and significantly reduced A&E conveyance of these patients

These schemes are being reviewed and undergoing final evaluation when they ended at the end of Quarter 1 2013/14. There will be a decision following the review of the schemes as to whether they will be recommissioned for winter 2013 / 14.

6.9 Mental Health

Children's Mental Health Developments

For children's services work is underway to manage those children with MH issues who may find themselves on a paediatric ward due to no other facilitates being available or a timely assessment response being forthcoming – this service (tier 3+/home treatment) will aim to prevent children with behaviour or MH problems being admitted to the Acute hospital and avoid those who fall between CAMHs specialist services and tier 4 secure with a service at home (BC to be developed)

Work is also underway to jointly look at Maternal MH from pre pregnancy (for those known to have MH issues) through to the post-partum stage and beyond for those with psychosis – this aims to reduce the escalation of MH during pregnancy, alleviate the fear for women who stop taking medication during pregnancy who then develop major illness after birth and to follow women with psychosis up to one year following birth – this also has major impact on social and adult development for those children who go on to develop attachment disorders etc due to not bonding with mother or not being part of the developing family (BC to be developed

The CCG have commissioned an online psychological therapies service for children and adolescents which can be referred to by clinicians or staff – this may prove useful

to pass onto those who have self-harmed etc who do not need to be admitted for physical reasons but may need some support in conjunction with CAMHs or if they don't meet the CAMHs criteria for level 3 specialist services – www.kooth.com

There is also a helpline available for parents and carers of children with behaviour or MH issues and can be accessed via www.youngminds.com

Adult Mental Health Developments

Adult Psychiatric liaison – an increase in resources was granted to the MH trust to increase the delivery of this service to 7 days a week however not fully 24/7 – the MH lead has commissioned Wolverhampton University to undertake an independent evaluation of the impact of this increased resourse to identify any possibility of the effectiveness of 24/7 provision – this report should have concluded in May however due to data difficulties this has not yet been finalised (Business Case to be developed dependent on the outcomes of the evaluation)

CRHT (Crisis Resolution/home treatment) a service scorecard has been developed to measure the effectiveness of this service which provides out of hours crisis response. The scorecard measures areas such as response times <4 hours etc – the MH commissioner will be undertaking and evaluation of the current provision and present the finding s to the IOB for Oct/Nov for decision on the future method of commissioning this service

There is also an online psychological therapies service that can be accessed – this service provided two levels of support on is via self referral to peer support and help 24/7 and can be accessed by using your Walsall postcode if you are registered to a Walsall GP – the second referral route is via a professional referral via bigwhitewall pro – all clinicians can access this service and can be issued with a password upon request from the MH commissioning team – the BWW pro offered real time face to face online counselling and there is no waiting times – this service can be accessed via www.bigwhitewall.com

7. Future Commissioning Plans – beyond winter 2013 / 14

7.1 Review of Urgent Care Access

Locally a contract was awarded for a co-located APMS practice and a walk in centre in Walsall town centre. The contract was awarded in March 2009 on a five year basis for both the 'walk in' element and an EAPMS practice. The GP practice element of this service has since relocated to The Wharf family practice, and the service is a now solely providing a GP led walk-in-centre. The contract is due to expire in March 2014. Although there is a clause which allows for up to a further 5 year roll over period, It is felt that the current service should be reviewed to understand the activity going through the walk-in-centre and describe how that will fit in the wider urgent care model required for the health and social care economy.

Aims of the project:

1. Review the activity currently being provided through the WiC to provide evidence of the reasons people attend the WiC
2. Ensure that patients utilise future services appropriately rather than accessing alternative services which could have been dealt with at their GP practice.
3. Provide value for money by making sure that The Walk-in Centres doesn't duplicate the services already offered by local GPs, the EUCC or commissioned Out of Hours (OOH) services (including 111)
4. Ensure future provision is an integral part of a single streamlined pathway with consistent and joined up acute, primary care, social care and community components
5. To develop an options appraisal with a preferred option, that has been developed as part of a robust stakeholder engagement process

A STaR has been established to begin this project, which is anticipated to deliver an options appraisal for consultation in July 2013.

7.2 Integrated Care

Following the publication of Gateway document ref 00079 *Integrated Care and Support: Our Shared Commitment,* Walsall CCG, WHNHST and Dudley and Walsall Mental Health Partnership Trust and Walsall Adult Social Care and Inclusion Directorate submitted a bid for pioneer status for an integrated care pilot. The four organisations, regardless of the success of the bid, have committed to proceed with pilot as outlined.

The two objectives of the vision are:

- Keep people at home as long as possible
- Swift return home following episode of bedded care

To keep people at home as long as possible an integrated team will be created comprising the competences of primary care, acute, mental health, secondary and social care to combine with a range of other skills from other partners. This team will utilise tools such as the single point of access and risk stratification using a range of health and social care data sets to understand the individual needs of people and provide the services which enable them to stay at home.

To deliver the first objective, there are three components of our new model of service:

- a Single Point of Access for health and social care
- co-ordinated locality teams
- pragmatic use of risk stratification

The second component of the new model of service, that of swiftly and safely transferring people back to their own homes following an acute episode of care, requires a coherent and efficient team, comprising skills of hospital discharge and social care, linking with the wider, co-ordinated locality teams, to agree with people the packages of care they most need at home. Through the SPA, there will be a menu of packages of services ranging from at the most intense, hospital based intermediate care beds through to at the least intense, 'reablement' which is available within 24 hours of request and provided for a specified duration of days e.g. four days.

The Integration Board will explore the best ways of ensuring that the range of health and social care workers who work in the community alongside GPs in Walsall can be better integrated and ensure a single care pathway for older people. The co-location of staff; the development of a single point of access; the development of "virtual wards" (linked to risk stratification"); linked-workers attached to GP practices; shared service models e.g. Intermediate Care (under a single manager); the creation of care coordinator posts; and other options will all be explored to ensure that we produce the best outcomes for older people in Walsall. (Pioneer bid attached to submission).This will continue to build on existing work, but developing fully integrated teams in community.

8. Use of 70% Funding

WHT is increasing bed capacity by 82 beds following the opening of wards 12 & 14 and the increased bed numbers located within elective care. The additional investment results in an additional 93.29wte posts (75.59wte nursing and 6.00wte medical) with the balance of funding utilised for hotel services, clinical support services and discharge co-ordination. This includes the staffing of 82 extra beds and associated hotel services costs.

The initial planned investment is £3.2m, with the Trust securing support from Walsall CCG of £2m which will be met from the emergency threshold adjustment built into the 2013/14 contractual agreement. The Trust will fund the additional £1.2m from internal resources and will invest in additional A&E workforce to support increased activity for the winter period. The level of increased financial investment supporting the urgent care plan is summarised by organisation in the table below:

Walsall CCG - Surge Plan 2013/14	**Funding Stream**				
	Emergency Threshold Adjustment	**Contribution from Walsall Hospitals**	**Contribution from CCG 2% non recurrent funds**	**Local Authority**	**Total**
	£m	**£m**	**£m**	**£m**	**£m**
Walsall Healthcare NHS Trust Response Increase bed capacity by 82 beds with consequent increased staffing support equivalent to 93.29 wte	2	1.2			**3.2**
CCG Response Procure an additional 20 beds within the Intermediate Care Sector			0.6		**0.6**

Increase access to Primary Care			0.7		**0.7**
Local Authority Increase in intermediate care staffing				0.5	**0.5**
Total	**2**	**1.2**	**1.3**	**0.5**	**5**

The CCG through the use of the potential non recurrent Winter Pressures allocation would seek to provide further resilience through the increased use of spot purchase beds and additional intermediate care support as summarised below.

Walsall CCG - Surge Plan 2013/14	**Potential use of additional Winter Pressures allocation**	**Narrative**
CCG Procure an additional 20 beds within the Intermediate Care Sector via spot purchase	**£m** 0.6	Increase potential bed stock by 20 beds
Local Authority/CCG Increase in Intermediate Care staffing	0.5	Increase intermediate care support to facilitate earlier discharge
Total	**1.1**	

9. Conclusion and next steps

Walsall Health Economy is committed to delivering high quality, safe and integrated care. As demonstrated in this recovery plan much has been done to ensure the Quality of urgent and emergency care services and achieve the 95% 4 hours wait target for 2012/13 and for Q1 in 2013/14 (TBC). We have set out specific initiatives that we commissioned and provided in 20121/3 and in quarter 1 that we believe have enabled us to achieve key winter performance targets and at the same time deliver a safe and quality emergency and urgent care system. We have also set out a range of specific actions/services that will be commissioned for tackling winter 2013/14 .All partners are committed to strategic and operational improvement of the urgent and emergency care pathway.

The plan has many elements but in addition to those services that are already commissioned though the main provider contracts and the 70% winter tariff funding the CCG we continue to work on the following core elements as a priority in the coming weeks

1. Completing the impact assessment , quantification of any residual gap and agreement of a further contingency/resourcing plan if required

2. Strengthening Primary Care by enhanced practice opening hours for urgent access
3. QOF QP scheme
4. Risk stratification DES
5. Working with the top 10 practices with highest A& E attendance rates to identify support
6. Primary care development and training
7. Communications campaign involving patients and staff
8. Develop community nursing and therapist teams supporting GPs
9. LTCs care pathways work
10. Strengthen Primary Care facing aspects of frail elderly pathway (FEP) to include GPs working with Acute Consultants to access advice re preventing admission and support at home
11. Rolling out nursing home wrap around services that were was piloted last year for GP Consultant ward rounds and GP review of patients in nursing homes to avoid hospital admission.
12. Review of UC pathway including EUCC, OOH and WIC services
13. Strengthen intermediate care services commissioned
14. Parklands Nursing home block commissioning of beds (as a model) will be used as a contingency scheme. We will look to strengthen and look at why re-admissions from the nursing homes are so high and look to enhance the referral criteria for this service.
15. We will review and strengthen the SWIFT ward arrangements from its original purpose to include GP admission rights.
16. We will explore with the Acute Trust the potential for additional beds over and about those that are being funded through the Winter tariff.
17. We will be reinvigorating a locality based nursing teams model aligned to GP practices

Most of these elements are short term ie over the next 3 to 6 months but there will be parallel work looking to integrated approaches to the provision of urgent care to overcome the barriers that exist and deliver on the principles that are set out in the national review of Urgent care services.

The UC Board will be responsible for overseeing this programme and holding to account those organisation's responsible for taking these forward