Shropshire, Telford & Wrekin
Integrated Care System

Urgent and Emergency Care Improvement Plan Priorities 22/23

Introduction

Shropshire, Telford & Wrekin
Integrated Care System

- Shropshire, Telford and Wrekin Integrated Care System(ICS) has developed its short to medium-term intentions for urgent and emergency care (UEC). With alignment to national priorities and addressing local population needs, the strategy sets out the improvements for 2022-2025.
- The Urgent and Emergency Care Delivery Board is responsible for the oversight of this strategy, reporting to the Integrated Care Board (ICB); collaborating with Place-based delivery partnerships and system partners to ensure delivery of improved care pathways and services. Implementation of the improvements will be linked to place-based partnerships serving the communities of Shropshire Telford and Wrekin.
- The ICS UEC Delivery Board will oversee the implementation of the UEC Strategy through its programme focused on:
  - Wider integration and system-wide reform
  - Transformation and improvement
  - Assurance – oversight of national and local performance standards
- Shropshire, Telford and Wrekin ICS will demonstrate compliance with implementation of the NHS Long Term Plan (LTP).
  - Providing a 24/7 urgent care service, accessible via NHS 111, which can provide medical advice remotely and if necessary, refer directly to Urgent Treatment Centres (UTCs), GP (in and out of hours), and other community services (pharmacy etc.), as well as ambulance and hospital services.
  - Implementing Same Day Emergency Care (SDEC) services across 100% of type 1 emergency departments, allowing for the rapid assessment, diagnosis, and treatment of patients presenting with certain conditions, and discharge home same day if clinically appropriate.
  - Focusing efforts to reduce the length of stay for patients in hospital longer than 21 days, reducing the risk of harm and providing care in the most clinically appropriate setting.
  - Working closely with primary and community care services to ensure an integrated, responsive healthcare service, helping people stay well longer and receive preventative or primary treatment before it becomes an emergency.
- NHS England published a UEC Recovery 10 Point Action Plan 2021 acknowledging that demand has returned to pre-pandemic levels. The ten key areas have been incorporated into the UEC strategy.
- Key priority for improvement is ambulance handover delays and reducing the time spent within Emergency Departments.

Shropshire, Telford & Wrekin
Integrated Care System

Context

Population

By 2043 there will be an estimated 589,330 people in STW

30% will be over 65 (currently 21%)

Geography

Across a total Area 3,487 sq km

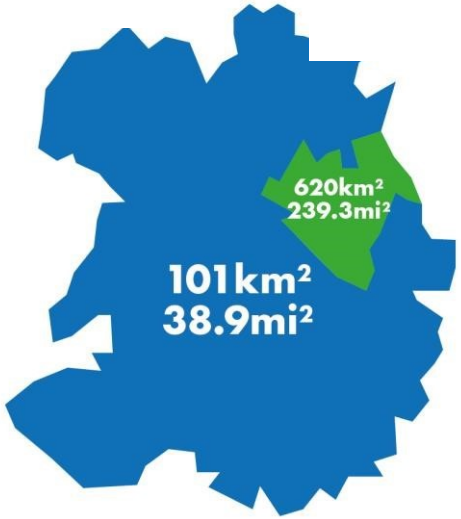
Shropshire is predominately rural 66%

Telford and Wrekin is predominantly urban

Across STW there are 88,000 people with a long term Limiting illness (18%)

Total Population 502, 990

By 2043
there will be an estimated
589,330 people in STW



People Per KM²/MI²

Shropshire, Telford & Wrekin
Integrated Care System

Case for Change

- The the current model of delivery is under pressure and is not sustainable. High demand is impacting on responsiveness, risk to patient safety and patient outcomes.
- The challenges regarding hospital flow have led to significant waits for admission in the EDs, with over 12-hour length of stay increasing significantly. At all acute hospital sites, increasing numbers of patients identified as medically fit for discharge and have No Criteria to Reside
- Ultimately, this results in ambulance handover delays at the Emergency Departments (EDs), where staff cannot accommodate incoming ambulance conveyances. Consequently, ambulances queue outside the EDs.
- At present, the turnaround time for ambulance handovers is amongst the worst nationally, with instances where patients have waited over 12 hours outside the hospital.

The demand for urgent and emergency care is high with a greater number of people seeking advice and assistance from urgent and emergency services. The number of attendances at Emergency Departments regularly exceed capacity.	The impact of the Covid pandemic requires covid and non-covid pathways; and agile operational delivery to respond to the demand. The Covid pandemic also presented an opportunity to include greater use of digital solutions in shared records, communication and treatments.
With pressure on Emergency Departments, the impact is also affecting ambulance handover efficiency with ambulances queuing and waiting longer outside Departments.	People recognise Emergency Departments as accessible and available locations to receive advice, reassurance, assessment and treatments. The introduction of NHS111 is encouraging people to seek advice and signposting to the most appropriate service for their need.
Patient experience of urgent and emergency care is variable.	National policy requirements support further reforms in urgent and emergency services: • NHS Long-term Plan • UEC 10-point Plan • 2022-23 Operational Plan requirements

UEC challenges

Shropshire, Telford & Wrekin
Integrated Care System

Vision for Urgent and Emergency Care

To create a responsive and affordable urgent and emergency system that meets the population's needs

Our Clinical Vision is that our patients receive the best healthcare and outcomes by ensuring:

- Our clinical teams have optimal time and resources to provide great care
- All patients are cared for in an appropriate and safe environment, with processes in place to minimise the risk of infection or other avoidable complications
- Information is enhanced by access to shared patient records
- No-one is admitted to our hospitals unnecessarily as community and Primary Care Network services can respond
- If patients need a stay in hospital, they are admitted quickly to the right bed to meet their clinical needs and when they are ready, they are discharged home without delay.

Good UEC is defined as…

- Patient focused
- Based upon good clinical outcomes
- A good patient experience
- Timely care and Right the first time
- Available 24/7 to the same standard

Objectives

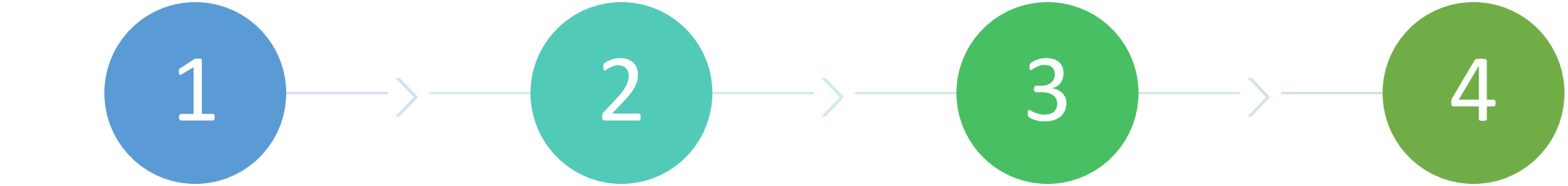
Reducing health inequalities – The impact of health inequalities is recognised in the demand for UEC services and steps are taken to address improvement in population health outcomes.

Reducing unwarranted variation in access to care – people have access to the same quality and timeliness of UEC services regardless of where they live or visit in the area.

Improving outcomes from UEC– emergency services are available to respond and treat life-threatening events, and urgent care services for illnesses and injuries that require prompt attention.

Strengthening clinical and financial stability – services are organised so that they are clinically safe, sustainable and financially efficient.

STW UEC Improvement Plan Review development process



Look back on progress and identify learning

- Operational Group discussion In February
- Feed in National expectations regarding Planning round requirements for 22/23

Further review/priority setting

- Review group to identify key themes and discuss priorities and operational planning issues
- Further discussion on priorities at Op Group on the 16th March.

UEC Delivery Board discussion/agreement to priorities

- Discuss and agree outputs from the process
- Support further work to develop more detailed action plans

Development of Programme/Workstream Delivery Plans

- Develop Programme delivery plans/sub workstream plans
- Agree reporting programme and PMO arrangements to measure and track delivery progress

National Context : Operational planning guidance (22/3)

D. Improve the responsiveness of urgent and emergency care and community care

Keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments and minimising ambulance handover delays.

- System leaders should continue to transform community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay.
- Systems are therefore asked to:
  - Reduce 12-hour waits in EDs towards zero and no more than 2 per cent.
  - Minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards:
    - eliminating handover delays of over 60 minutes
    - 95 per cent of handovers take place within 30 minutes
    - 65 per cent of handovers take place within 15 minutes.

National Context : Operational planning guidance 22/23

D2. Transform and build community services' capacity to deliver more care at home and improve hospital discharge

- **Virtual wards**

Systems are asked to complete comprehensive development of virtual wards by December 2023. By December 2023, NHSEI expects systems to have completed the comprehensive development of virtual wards towards a national ambition of 40–50 virtual wards per 100,000 population. Up to £200 million will be available in both 2022/23 and 2023/24 to support the implementation of systems' plans for this goal.

- **Urgent community response**

Maintain full geographic rollout and continue to grow services to reach more people extending operating hours where demand necessitates and at a minimum operating 8am to 8pm, 7 days a week in line with national guidance

- **Anticipatory care**

Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for anticipatory care.

- **Enhanced Health in Care Homes**

Ensure consistent and comprehensive coverage in line with the national framework.

- **Community service waiting lists**

Systems must develop and agree a plan for reduction of community service waiting lists and ensure compliance of national sitrep reporting.

- **Hospital discharge**

As outlined in the H2 2021/22 planning guidance, the additional funding for the Hospital Discharge Programme will end in March 2022

- **Digital**

Ensure providers of community health services, including ICS-commissioned independent providers, can access the local care shared record as a priority in 2022/23, to enable urgent care response and virtual wards.

UEC Improvement Plan 22/23

- The vision for urgent and emergency care in STW remains that it is focused on continuing to transform our services into an improved, simplified and financially sustainable 24 hour/7-day model; delivering the right care, in the right place, at the right time for all our population.
- The STW UEC Improvement Plan will focus on three specific work stream areas:
  - Pre-Hospital
  - Hospital Improvement and Flow
  - Discharge
- The plan has been developed following a review of the 21/22 UEC Improvement Plan and incorporating learning from winter 21/22 and the Covid19 pandemic response
- The review work has been led by the UEC Operational group.

UEC Operational Group reflections/look forward

Headlines

- UEC improvement is now seen as a critical system issue with a high degree of 'common purpose'
- Ambulance handover delays, ED Flow and effective discharge remains a significant system issue.
- Ensuring sufficient outflow/alignment of community services remains a key challenge.
- Securing improved acute capacity and flow is a high priority although there is an underlying shortfall in overall capacity across the system (beds/community resource)
- Capacity and Demand work has progressed and extended to look at community capacity as well as in-hospital
- Establishing same day emergency care for medicine and surgery (new estate and workforce)
- Single point of access pilot has made an encouraging start and can be built on
- Overall-need to sharpen areas of focus for 22/23 and ensure we robustly track progress

Pre-hospital

- Alternatives to hospital admission : build additional community capacity and be more stretching in relation to current schemes-coverage & expanding urgent 2-hour crisis response services
- Need to better measuring performance of pre-hospital services
- Develop overall pathway/s modelling (pre-in-post hospital setting)
- Integration of frailty response with primary/community services
- MPFT Hospital avoidance service

Hospital improvement

- Preventing crowding in ED
- Explore redirection opportunities
- Creation of the Acute Floor at RSH site
- Develop and implement direct access pathways
- Addressing demand and capacity gap which will remain after modular ward in place
- Improvements in Acute Discharge processes and hospital flow

Discharge

- Improvements in acute ward processes, discharge earlier/weekends and resolving MFFD levels as a system wide priority
- Maximize use of Virtual Wards
- Reset and Transformation of care sector capacity

Cross-system issues

- Review of ageing well summit actions
- Further workforce modelling needed to set out workforce requirements
- Development of performance dashboards for subject areas/monitoring against new standards
- Demand and capacity modelling; predicting when will demand will exceed capacity
- Use of Improvement tools to help us plan and improve flow

STW UEC Priority Transformation Programmes (22/23)

Pre-Hospital

Screening, redirection and reducing Ambulance delays

Single Point of Access (SPA) development (alternatives to ambulance conveyance to ED)

111 Improvements

New direct access pathways

Enhanced provision for high intensity users

Redesign of Pre-hospital Integrated Urgent Care:

Development and commissioning of new model of care

Hospital Improvement

Enhanced capacity and reconfiguration

Acute medicine footprint (PRH/RSH),
ED refurbishment
32 bedded ward, Trauma/Frailty assessment, Vulnerability suite

Improving Flow

ED redirection/ Acute discharge processes incl failed discharges/patient journey facilitators/integration of therapies
Maximise the impact of discharge facilities

Direct access pathways

Trauma/Frailty & SDEC e-referrals

Compliance with new ED standards

Discharge

Appropriate system discharge provision

Develop joint commissioning strategy for P2/P3 community capacity/market development

Review of re-ablement care

Enhanced integrated discharge team (7 Day working/TOM)/alignment with community services

Improving Flow

implementation of MADE action plans, DTA model development/criteria led discharge/FFA review, revised pathways

Linked Programmes

Local care programme

Enhanced 2-hour crisis response coverage/A2HA

Virtual Ward rollout (COVID/Resp/Frailty/other)

Enhanced care In care homes

Anticipatory care model development

Workforce

System demand and capacity modelling

Mental health (Adults and CYP)

Primary care development

Place based integration

Digital development

22/23 UEC Improvement Plan : NHSE 10 Point Action Plan

Action	Link to UEC plan
1. Supporting 999 and 111 services	Improving 111 services and the reduction of ambulance delays is supported via the pre-hospital workstream. Contractual performance monitoring for both services is reported monthly and via the UEC dashboard.
2. Supporting primary care and community health services to help manage the demand for UEC services	This is supported via the pre-hospital workstream. Primary Care transformation is a linked programme of work to the overall UEC plan, acknowledging the key interdependencies between service areas.
3. Supporting greater use of Urgent Treatment Centres (UTCs)	Supported via the pre-hospital improvement workstream and its links to 111 improvements as well the re-configuration of UTCs in line with demand.
4. Increasing support for Children and Young People	The UEC Improvement Plan focusses on all age service improvement, including CYP. This is part of the systems development of integrated health and social care plans for CYP. It will be monitored through ICS CYP monitoring board.
5. Using communications to support the public to choose services wisely	Communications for the UEC programme will form part of the wider Comms and Engagement strategy of the ICS with a system-wide focus to ensure contribution from all strategy partners, representation from local people and communities, gathering meaningful intelligence and using these insights to inform decision making and quality governance.
6. Improving in-hospital flow and discharge (system wide)	This is supported via all UEC plan workstreams via SPA, alternative pathways and SDEC, improving hospital flow and discharge planning to ensure improved patient experience.
7. Supporting adult and children's mental health needs	The UEC agenda for children and adults in the ICS is overseen by the multi-agency Mental Health, Learning Disability and Autism (MH, LD & A) Operational Board, led by the ICS Senior Responsible Officer for MH, LD & A. Progress from the mental Health Crisis Care operational work group is fed into the system UEC Group and Board to inform and support the work of the wider UEC agenda.
8. Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response	Systems are expected to fully implement national IPC guidance across all areas of activity and ensure good surveillance/assurance/risk assessment of IPC practice. This is monitored by the Infection Prevention and Control team.
9. Reviewing staff COVID isolation rules	The impact of covid isolation guidance across the ICS footprint is monitored to enable mitigations to be taken across all workstreams and as a system work to protect urgent care and also elective and cancer demand.
10. Ensuring a sustainable workforce	This is supported across all workstreams, such as SDEC and working with the local domiciliary and care home market to develop ICS led response to workforce shortages. Workforce development is set out in the system Workforce Plan

UEC Priority Transformation Programmes (22/23)

Shropshire, Telford & Wrekin Integrated Care System

Programme workstream plans: [STW UEC Tranformation Programme Summary V3.01.xlsx]

Pre-hospital

Senior Responsible Officer: Sam Tilley

Aim(s)
Screening, Redirection and Reducing Ambulance Delays: The Pre-Hospital Programme aims to ensure that all parties within the pre-hospital system are working collaboratively (through a bi-weekly working group), in line with agreed priorities, to deliver services addressing key national, system and patient needs. There is wide recognition that the urgent and emergency care system requires people to be treated in the right place, at the right time and with the right care for their needs. In Shropshire, the intention is to utilise alternative provision to improve outcomes for patients by offering early identification and preventative interventions to avoid a hospital attendance/admission, as well as appropriate use of other UEC services and considering alternatives to ambulance conveyance to ED.
Development and Commissioning of new model of care: We want to develop, agree and implement new approaches to meeting patients' physical and mental health urgent and emergency care needs. We must ensure people receive the most clinically and cost effective model of care and that our urgent and emergency care services deliver maximum value in terms of outcomes, quality and efficiency.

Workstreams	Owner
Single Point of Access development	Nicky Wilde
111 Improvements: > UTC/ED > Bookable Slots, Primary Care	 Sara Biffen Emma Pyrah
New Direct Access Pathways: > SDEC > Community direct access	 Sara Biffen Sam Townsend
Anticipatory Care	Sam Townsend
Enhanced Provision for High Intensity Service Users (HISU)	Sharon Clennell
Re-design of pre-hospital Integrated Urgent Care	Sam Tilley

UEC Priority Transformation Programmes (22/23)

Shropshire, Telford & Wrekin
Integrated Care System

Hospital Improvement

Senior Responsible Owner: Sara Biffin

Aim(s)	Workstreams	Owner
Enhanced Capacity and reconfiguration To ensure the capacity and estate we have is used to maximum effect and to ensure the most efficient service with the best outcomes for our patients is achieved	Acute medicine footprint (PRH/RSH)	Laura Graham
	ED refurbishment	Rebecca Houlston
Improving Flow To ensure patients are able to move through the hospital in the most efficient way, that supports their care needs and results in care taking place in the right place, at the right time, with the molst appropriate team	Improving the impact of discharge facilities	Laura Graham
	Failed discharge learning and improvements	Trevor Hubbard
Direct Access Pathways To reduce over crowding in A&E and delays in ambulance handovers allowing patients to receive care as quickly as they need it and in the right setting, avoiding A&E	ED redirection/acute discharge processes	Laura Graham & Rebecca Houlston
	Direct access pathways - trauma/frailty & SDEC e-referrals	Laura Graham & Lisa Challinor
	Learning from MADE events	Trevor Hubbard

UEC Priority Transformation Programmes (22/23)

Shropshire, Telford & Wrekin
Integrated Care System

Discharge

Senior Responsible Owner: Michael Bennett

Aim(s)	Workstreams	Owner
Appropriate system discharge provision and improving flow: To consider short and long term requirements for both health and social care to further progress, integrate services and ensure systems are fit for purpose for the future social and health care system. A whole system transformation is required in order to develop a preventative rather than reactive approach and instead a reablement/enabling model to ensure better outcomes for the client and a reduction in the need for long term care, moving away from bedded provision models of care to support at home.	Develop a joint commissioning strategy	Sarah Bass, Laura Tyler and Brett Toro-Pearce
	Review of reablement care	
	Enhanced integrated discharge team	
	Review and implementation of: MADE action plans, DTA model development/criteria led discharge/FFA review, Independence at home - technology offer Revised pathways	

Pre-hospital

Workstream	Project Area	Milestones What do we want to achieve?	Outputs How will we show this?	Key benefits What are the expected benefits?
Single Point of Access	**Falls**	A falls service that supports all patients across Shropshire and Telford: 24/7 with a 30min response on average; Falls pick up service for non-injured fallers to reduce pressure on 999 services; Integrated and collaborative service with close links to community and UCR team; Predict prevent, react and respond	Reduction in ambulance call-outs for falls Reduced admissions for falls Care closer to home	Improved service for patients in Shropshire and Telford. Reduction in time patients spend on the floor post-fall. Focus on prevention and supporting patients to stay well at home.
	Welsh Ambulance	To implement with WAS/SDOC SDEC referrals through the SPA.	Increase in referral numbers through SPA Reduction in ED, A&E attendance	Use of alternative pathways Consistent approach for SDEC referrals across all specialities and stakeholders
	Switchboard	Netcall telephony rollout	Rollout of Netcall (June 22) Reduced waiting times - CCC/SPA Efficiency of call handling time Improved flow through switchboard - time savings	Improved patient experience Improved experience for healthcare professionals Ease of access Increased telephone capacity for SaTH and CCC/SPA
	Frailty	Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for anticipatory care. - Proactive and preventative approach for those living with frailty or long term conditions - Use of a frailty register and co-ordinated approach to caring for those with frailty	Frailty register Reduction in admissions for LTC Increase Rockwood scoring Increased use of Respect and advance planning	LTC Advanced care planning Frailty register increase Preventive management community resource Increase Rockwood scoring in the community Advanced care planning and respect forms End of life registered
	UCR	UCR team to provide a responsive and holistic service by: - Offering short term interventions, typically lasting under 48 hours, in response to a crisis - A consistent response across the whole county and equity of access for patients - Minimum operating time 8 am-8 pm seven days a week - Accepting referrals from 111/999/GP/self/carer/ED - With a 'no-wrong-door ethos' - Submitting full and accurate data returns to CSDS - 70% seen within 2- hours - Work with the council to provide TEC/pendant alarms - Accurate DoS profiling - Work with the virtual ward provision for admission avoidance - Aligned with other UEC such as 999/111/Primary Care/hospital discharge teams - Support admission avoidance and early discharge models - Co-ordinated through a single point of access (aspirational: integrated with local CAS/co-ordination hub) - Utilising remote consultation software when appropriate Supported by VW, older adult MH services, NTs, planned care, social care, re-ablement, and diagnostics. Workforce development	70% seen in 2- hours ≤ Increase in 111 referrals Increase in 999 referrals Increase in SPA referrals Reduction in catheter care attendances to the Acute Monitored via SPA weekly metrics: - Hospital admissions - SDEC referrals - Care home referrals - NHS 111 referrals	Reduction in category 3 conveyances in the older population to A&E - reducing the burden on these services and 999. More patients treated in the community and through Home First approach. Improved experience for patients.
	Admission Avoidance	Increased use of social prescribing and voluntary sector organisation support to ensure wider needs of patients are met	Increase in referrals to a range of local non-clinical services Reduction in A&E attendance	Allows individuals to take greater control of their health and wellbeing Reduction in health inequalities Individuals are able to access more appropriate services and have an active part in their care
New direct access pathways	**SDEC**	In line with national guidance, continue to develop core services mandating medical and surgical SDECs - 12 hour access, 7 days a week, including the development and monitoring of all direct access pathways	Increase in zero length of stay metrics	Capacity increase for same day emergency care of patients

Pre-hospital

Workstream	Project Area	Milestones What do we want to achieve?	Outputs How will we show this?	Key benefits What are the expected benefits?
111 Improvements	**UTC ED bookable slots 111 Service provision**	To provide a consistent service for patients across Shropshire and Telford for urgent presentations which supports the functioning of A&E to treat emergency presentations: - Consistent and clear communication - Services aligned with demand - Bookable and appropriate slots - Utilising virtual consultation where appropriate Increasing capacity within NHS 111 to ensure the service is the credible first option for patients, enabling their referral to the most appropriate care setting by: - Providing a responsive service - Providing booked appointments wherever possible - Raise awareness of the NHS 111 First initiative with the public	Increase in UTC activity referrals Reduction in non-urgent presentations to ED Reduction in type 1 referrals Increase in booked appointments Improved response/call back times	Reduction in type 1 attendances and improved patient experience. Ensuring patients are seen in the most appropriate place for their needs. Improved flow through ED and appropriate triage to reduce wait times and length of stay Improved patient experience through 111
	Primary Care	To have a convenient service for patients to access Primary Care in hours when needed: - Bookable via NHS 111 - Aligned with and accessible, if possible, to SPA - Supports Right Care, Right Place agenda	Reduction in standard and non- urgent presentations to A&E % searched and booked appointments	Patients utilising Primary Care through planned care appointments - in hours Reduction in inappropriate A&E attendances Increase patient satisfaction
	A-ted	NHSEI tool Admission alternatives: What is profiled on the DoS; what is commissioned; what is the reality Pathway reviews and forward plan	A-ted score Increase in referrals to alternative pathways	A simple, easily understandable, pragmatic scoring framework to measure, evaluate and offer a degree of comparability of the availability and accessibility within local health and social care systems that provide alternative services, other than ED attendance and subsequent admission. Identifies gaps in the DoS and missed opportunities
	Healthwatch	Review of patient feedback and findings following Healthwatch survey, part 2. Ensuring consistent and accurate information is available for all services in the county. Engaging service users in service design. Targeted initiatives to reduce inequalities.	Patients feedback, awareness and satisfaction levels. Improved patient awareness of UEC services and satisfaction levels Improved 111 call handling performance metrics Reduction in A&E walk in attendances	Improved awareness and communications for patients on available services Access to right care, first time Reduction in A&E unheralded attendances
	MIUs	To provide a consistent service for patients across Shropshire for the treatment of minor injuries: - Consistent and clear communication - Services aligned with demand - Bookable service - Utilising virtual consultation where appropriate (aspirational) - No wrong door policy - Review of X-ray provision	EAS >95% Total attendances Conveyance/deferral rates	Reduction in type 1 attendances and improved patient experience. Ensuring patients are seen in the most appropriate place for their needs.
	Care Homes	Continue to build on the work already undertaken in this area to strengthen support for the people who live and work in care homes through: - Collaborative working with health and social care - Enhanced PC support - MDT approach - Falls prevention and rehabilitation - High-quality end of life care - Education and awareness of alternative pathways to 999	Increased use of UCR Reduced ambulance call-out Discharge flow to care homes	Better integration between care homes, primary care, community and hospital services to improve health outcomes and experiences of care home residents. Reduction in the use of UEC services for care home residents through proactive and preventive practices.

Pre-hospital

Workstream	Project Area	Milestones	Outputs	Key benefits
		What do we want to achieve?	How will we show this?	What are the expected benefits?
Positive Lives Service (HISU)	**New contract implementation and monitoring**	Implementation of new contract from 1st Oct 2022 for Shropshire county. Contract and quality monthly meetings tbc and contract monitoring arrangements to be arranged Enhanced provision for high intensity users (positive lives services)	Reduction in A&E attendances KPIs to be confirmed once contract awarded	Supported self management through social prescribing and community based support Personalised care and support plans Shared decision making between patients and healthcare professionals Equity of access for all patients
Redesign of Pre-hospital integrated urgent care	**Development of new model of care**	Undertake a detailed review of all components of pre-hospital urgent care services: GP out of Hours Service, Care Co-ordination Centre, Minor Injuries Units and Urgent Treatment Centres Determine feasibility and options for more sustainable integrated urgent care offer.	Review of key data, eg. ED/A&E attendances, ambulance response and journey times, patient travel times, current operating hours of existing services Case for change Options papers	Addressing gaps/inequity in service provision and health inequalities Exploring the potential for alternative sources of local urgent treatment advice and guidance in a range of settings Consider improvements in patient and colleague experience, avoiding duplication and ensuring a more efficient deployment of resources.

Hospital Improvement

Workstream	Project Area	Milestones	Outputs	Key benefits
		What do we want to achieve?	How will we show this?	What are the expected benefits?
Enhanced capacity and reconfiguration	Acute Medicine footprint	Creation of: - An enlarged Acute floor and re-introduction of Acute Medical ~Assessment Area - Direct admissions pathway from GP & Ambulance service within Acute medicine, T&O and oncology - Direct access pathways to free up A&E capacity	Move ward 22 Respiratory to ward 24 (22 July 22) Move AMU from ward 29 to ward 22 Respiratory (29 July 22) Works to ward 23 to create direct oncology admission area (31 August 22) Move ward 22 T&O to ward 29 (16 September 22) Trauma direct admissions pathway operational (23 September 22) Works to ward 22 T&O to create new AMU (28 October 22) New Acute Floor operational (excluding 8 monitored beds) (9 November 22) 8 monitored beds open (determined by workforce recruitment & training (7 July 23 at latest)	Improved flow with in the Emergency Department Improvement in patient experience and delivery of UEC measures
	ED refurbishment	Reconfiguration of RSH Floorplan to improve flow in A&E, creating a C&YP area, learning disabilities room, additional assessment bays and Fit to Sit areas.	Development of Mental Health/ Fit to Sit Assessment area and vulnerability room	Improvement in patient experience and delivery of UEC performance measures Improvement in patient flow, including paediatrics and CYP area
	Increase impact of discharge facilities	Improve use of discharge lounges to facilitate pre 12 discharges across both sites	Golden patient to transfer to discharge lounge by 9am Pull model to discharge lounge using non clinical staff to facilitate Afternoon planning meeting to prepare for next day discharges Pre booked transport in place	Reduce Ambulance Handover delays Reduce waits in ED Improve flow through the Hospital Reduce LoS (reduction to LOS post MFFD to target of 60 by end of July)
	Creation of an enlarged 32 bedded ward	Creation of an enlarged surgical ward	New modular ward 37 complete for occupation creating 32 new spaces to support elective recovery programme	Improve surgical flow - and work towards elective recovery programme metrics.

Hospital Improvement

Workstream	Project Area	Milestones What do we want to achieve?	Outputs How will we show this?	Key benefits What are the expected benefits?
Improving Flow	ED redirection/acute discharge processes	Redirection being piloted at PRH	Evaluation of ED re-direction and imrproved discharge processes at PRH	Improve patient flow and experience
	Failed Discharge learning and improvement	Bring forward discharges to earlier in the day to reduce bottlenecks in the EDs	POD meetings twice daily to facilitate discharges SHOP model and SAFER standards embedded Transport pre booked Afternoon huddles in place and effective	Improvement in UEC performance measures
		Eleiminate failed discharges due to lack of systems and processes	Ensure POD agenda includes specific plans for discharges, plans for timely use of the discharge lounges, plans for all complex patients identified for discharge by the Integrated Discharge Team (IDT) and a review of failed discharges from the previous day. Implement further meetings throughout the day to review progress, escalate and resolve issues, and to receive assurance of forward plans for patients with imminent discharge dates. Review current and planned practice against ECIST focussed site management model self-assessment tool. Implement further meetings throughout the day to review progress, escalate and resolve issues, and to receive assurance of forward plans for patients with imminent discharge dates.	Improvement in UEC performance measures
		Increase numbers of Fact Finding Assessments (FFAs) completed within 2hrs of decision to discharge	Complete FFAs within 24hours of patient becoming MFFT	
		Reduce daily numbers of aborted transport journeys related to patients not being ready for discharge Increase number of patients discharged before noon and before 5pm Reduce daily numbers of failed discharges	Plan MADE events in advance for the rest of the year, supported by follow-up learning events and plans to embed good practice into daily management.	Reduce Ambulance Handover delays Reduce waits in ED Improve flow through the Hospital Reduce LoS
Direct access pathways	Trauma/frailty & SDEC e-referrals	Create Trauma and Frailty assessment area	Increase number of referrals to SDEC by extending the operating hours	Improve UEC measure and patient experience
	Enhancing direct access pathways		Direct access #NOF pathway Direct access oncology pathways	Improve UEC measure and patient experience

Discharge

Workstream	Project Area	Milestones	Outputs	Key benefits
		What do we want to achieve?	How will we show this?	What are the expected benefits?
Joint commissioning stategy	Community capacity	Short term, urgent requirement to model community capacity and configuration to meet beg Jul target date and funding. Long term planning to consider needs across the geographic areas, demographic complexities, target and at risk groups.	Feasibility matrix for short term requirement Community capacity reviews for long term planning	Evidence based approach to future planning, consistent joint approach to service provision across all geographic areas and systems
	SDA	SDA draft plan 22/23 to be considered in line with ICS action plans and programme of work to be planned, ensuring sufficient resources in place to lead change well. SDA terms and references on roles and the right health funding to support programme work.	SDA reporting to UCB with right system representatives included.	Strong focus on community at home outcomes for people A single SDA that will support the local population, and has the right partners in place Addresses system gaps, implements clear pathway flows and understands JSNA and population placed based outcomes Future plans can be easily mobilised and are agile
Review of re-ablement care	Enhancement of service	Short and long term plans to consider enhancement and strengthening service provision across Shropshire and Telford Review of future recruitment needs and capacity increase, winter priorities considered Review current models and look at other approaches and options with partners Home first approach	Reablement (step up and down) as a core offer Patients feedback, awareness and satisfaction levels.	A single reablement offer across our system, focused on home first.
Enhanced integrated discharge	Target Operating Model	Review of our current TOM and funding offer. The review will look at current approach and benchmark our approach against others.	7 day working as a TOM is set out within a robust ICS/B.	System will operate within a clear TOM A 7 days TOM that is fully supported by partners.
	Alignment with community services	Community support services review to consider alternative triage options. CHC offer to support individuals who have ongoing healthcare needs	Reduction of walk-in's at A&E Patients feedback, awareness and satisfaction levels	Ensuring patients are seen and supported in the most appropriate way and place for their needs. Improved flow through A&E

Discharge

Workstream	Project Area	Milestones What do we want to achieve?	Outputs How will we show this?	Key benefits What are the expected benefits?
Improving flow	**MADE**	Implementation of MADE planning to support improved patient flow across the system, recognise and unblock delays challenge, improve and simplify complex discharge processes.	Collection of real-time information on individual patients, clear escalation process to reduce delays.	Unblock delays and simplify processes across the whole system. Free up beds and increase flow as part of an escalation process. Reduce length of stay. Safe and timely discharges.
	DTA model	Review DTA model to determine cost implications and options for alternative models being used	Clear analysis framework set against other models	Greater understanding of cost implications across the system Alternative offers fully considered to ensure best models in place across the system and geographical area
	Criteria led discharge	Discharge Goals (Outcomes) Review to include simple discharges and OT hospital input (preparing patients for home). Clinical decision making and interface with MDT decision making. System Discharge BCP Tactical Planning – forward look at pressures over key times of the year.	Discharge flow outcomes framework.	Patients are supported, with clear goals (outcomes), supporting home first approach and smooth discharge flow. Greater support to the entire system, focused on people getting home, in a timely and effective way - right place first time, every time
	FFA review	Review of all current models to consider costs implications, beds capacity reviews, assessment pathways and preventative/provider offers A single assessment, that supports clear pathway flows Removing any duplications in process/ pathway	Clear pathway flows	Improved local approach across all partners
	Independence at home	Digital and community technology / wearables – that supports independence at home review – local offer	Supports pathway zero and pathways 1/2	Supports people to remain safe and well at home.
	Internal processes	To consider processes for FFAs, non medically fit and ready for discharge approach, Transport, TTOs	Supports all improving flow approaches	Improved local approach across all partners, effective working across health and social care systems
	Pathways	Review & monitor high impact / performance matrix driving current pathways, with a clear focus also on zero activity and in seeking the right health funding to support each pathway longer term	Improvements to current matrix - Pathways: 0/1/2/3	Effective working across health and social care system Improved support for pathway zero

Linked Programmes

Shropshire, Telford & Wrekin
Integrated Care System

Local care programme • Enhanced 2-hour crisis response coverage/A2HA • Virtual Ward rollout (COVID/Resp/Frailty/other) • Enhanced care In care homes • Anticipatory care model development	• Maintain full geographic rollout and continue to grow services to reach more people, extending operating hours where demand necessitates. • Systems development of virtual wards by December 2023 towards a national ambition of 40–50 virtual wards per 100,000 population. • Consistent and comprehensive coverage in line with the national framework through a whole system, collaborative, proactive approach that is centred on the needs of individuals, families and staff. • Plan for AC from 2023/24 by Q3 2022, will be in line with forthcoming national operating model for anticipatory care. Proactive and preventative approach for those living with frailty or long term conditions.
Workforce	Ensuring a long-term plan for the workforce is in place across the UEC workstreams through workforce modelling to set out clear workforce requirements.
System demand and capacity modelling	Demand and capacity modelling to predict when will demand will exceed capacity using predictive analytics and single data resource to form core of ICS and to enable routine capture of all key data items. Key UEC and system pressure metrics is reported to gold and silver command.
Mental Health (Adults and CYP)	The UEC agenda for children and adults is overseen by the multi-agency Mental Health, Learning Disability and Autism (MH, LD & A) Operational Board. The mental Health Crisis Care operational work group, formally accountable to the MH, LD & A Operational Board, feeds progress and outputs into the system UEC Group and Board to inform and support the work of the wider UEC agenda.
Primary Care development	Primary Care Development will ensure delivery of national and local plans, with the key focus on GP Access and delivering the requirements of the PCN DES. Assurance will be via the Primary Care Commissioning Committee.
Place based integration	Ensuring system plans match the ICS ambition and improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, enhance productivity and value for money, support broader social and economic development and reflect national NHS priorities.
Digital Development	Two way mechanism required to ensure alignment to digital agenda and support identification of the digital requirements of the various UEC workstreams, gain agreement on feedback processes and ensure whole system alignment.

UEC Core Standards Bundle - metrics

The below are the currently known metrics, current reporting and caveats/restrictions

Service Area	Measure	Data source	Currently reported	Caveats /restrictions
Pre Hospital	Response time for Ambulances	WMAS	Yes – Cat 1 and 2	Target driven metric – in UEC CORE indicators dash
	Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances	WMAS	% of Total WMAS cases for STW conveyed is reported	No Target. Consistently reported. A better measure would be the % of cases that are conveyed that are taken to alternative location to ED – in UEC CORE indicators dash
	Proportion of contacts via NHS 111 that receive clinical input	NHS111	Yes - % of total 111 cases triaged that receive CAS Input	This includes cases warm transferred and call back by any health professional within the 111 CAS. – in UEC CORE indicators dash
A&E	Percentage of Ambulance Handovers within 15 minutes	WMAS	Yes	Based on Cases conveyed to PRH/RSH hospital – utilising the Handover time reported by WMAS – in UEC CORE indicators dash
	Time to Initial Assessment - percentage within 15 minutes	SATH	Yes	Reported but will have improved capture with new EPR system – in UEC CORE indicators dash
	Average (mean) time in Department - non-admitted patients	SATH	Yes	– in UEC CORE indicators dash
Hospital	Average (mean) time in Department - admitted patients	SATH	YES	– in UEC CORE indicators dash
	Clinically Ready to Proceed	SATH	NO	This will not be available until the new EPR system is introduced – No Confirmed timeframe known
Whole System	Patients spending more than 12 hours in A&E	SATH	YES	Currently in the SATH TAB of UEC. Will be moved to be in Core indicators tab
	Critical Time Standards	SATH	NO	See Next TAB. These are in development

Critical time standards - CTS

The Critical Time Standards (CTS) are being developed on these principles:

- The highest priority patients will get high-quality care with specific time-to treatments, with proven clinical benefit.
- A focus on evidence-based clinical interventions that should be commenced within one hour of a patient's arrival in an acute hospital (by any route, not just via ED).
- Clinical audits show that there is the potential to save many more lives by focusing all hospitals on treating killer conditions within the first hour of treatment.
- We have developed, and are testing, evidence-based measures to support early intervention in stroke, STEMI heart attack, acute physiological deterioration (RAPID) and major trauma.
- National performance in these pathways has improved dramatically in recent years, with an additional 600 patients surviving major trauma in 2016/17 compared with the previous year, and a 19% increase in survival since the inception of major trauma centres in 2012/13. There also has been a reduction by more than half in the 30-day mortality rate for hospitalised stroke, which has fallen from 27% in 1998 to 17% in 2010 and 13.6% in 2015/16.
- Whilst some of the data needed to drive improvement in care in these is routinely collected, further work is underway to enable routine capture of all key data items.
- We are introducing the ability to capture NEWS2 scores through ECDS and are working with clinical audit teams to enable accurate and timely return of key data that will support local teams to challenge and improve their performance.
- We continue to work with clinical leaders to finalise the CTS standards, including the appropriate thresholds, and will make more information available in due course. In parallel, we are developing proposals for future developments in CTS, including a focus on paediatric care and how we can develop the RAPID standard to capture key interventions required in respect of other presenting conditions such as asthma.