Report to:	Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin, 2 March 2016

Title	Update on Winter Pressures and the Urgent and Emergency Care System
Purpose	To update the Joint Health Overview and Scrutiny Committee on work across the health and care system to improve urgent and emergency care and address winter pressures
Previously considered by	Shropshire and Telford & Wrekin System Resilience Group Joint Health Overview and Scrutiny Committee, 15 December 2015

Executive Summary

Health and care partners across Shropshire and Telford & Wrekin have worked together, with support from the national Emergency Care Improvement Programme (ECIP) to develop an updated Urgent and Emergency Care Recovery Action Plan aiming to improve patient experience and timely access to appropriate care.

A presentation on that work was made to the Joint Health Overview and Scrutiny Committee on 15 December 2015, highlighting four themes of work aiming to sustain improvement in urgent and emergency care:

A. The acute hospital focusing on delivering improvements in bed flow processes, ED efficiency and fully implementing ambulatory emergency care (AEC)

B. The community services and local authorities focusing on enhancing capacity and impact of integrated re-ablement teams to avoid admissions and speed up complex discharge

C. Commissioners focusing on driving greater throughput at treatment centres co-located at each site, and ensuring that demand management schemes are effective in reducing ED attendance

D. Collective effort focusing on managing complex medically fit patients with fewer delays, and implementing improvements to support and divert greater numbers of over 75 year old patients outside of acute hospital.

The demand for services, and the complexity of needs of our patients & communities, has remained high and at 10 February, system performance is 12% below trajectory.

Whilst some areas have shown improvement (Clinical decision maker breaches, DTOC lost bed days, Sunday discharges, ICS complex discharges) others are well behind plan (e.g. Urgent Care Centre / Walk In Centre streaming, admissions avoided remain, non-admitted breaches) and further remedial action is required.

A presentation will be made to the meeting outlining:

- the current position as at 2 March 2016
- progress, opportunities and challenges in each of the four themes of work

Enclosures:

- Annex 1: Summary position on whole system Emergency Care Recovery Action Plan as at 10 February 2016
- Annex 2: Emergency Care Improvement Programme System Concordat, 9 February 2016
- Annex 3: Reducing discharge delays: SATH partnership with Virginia Mason Institute, 28 January 2016
- Annex 4: Detailed position on whole system Emergency Care Recovery Plan as at 13 January 2016
- Annex 5: Emergency Care Improvement Programme Whole System Diagnostic

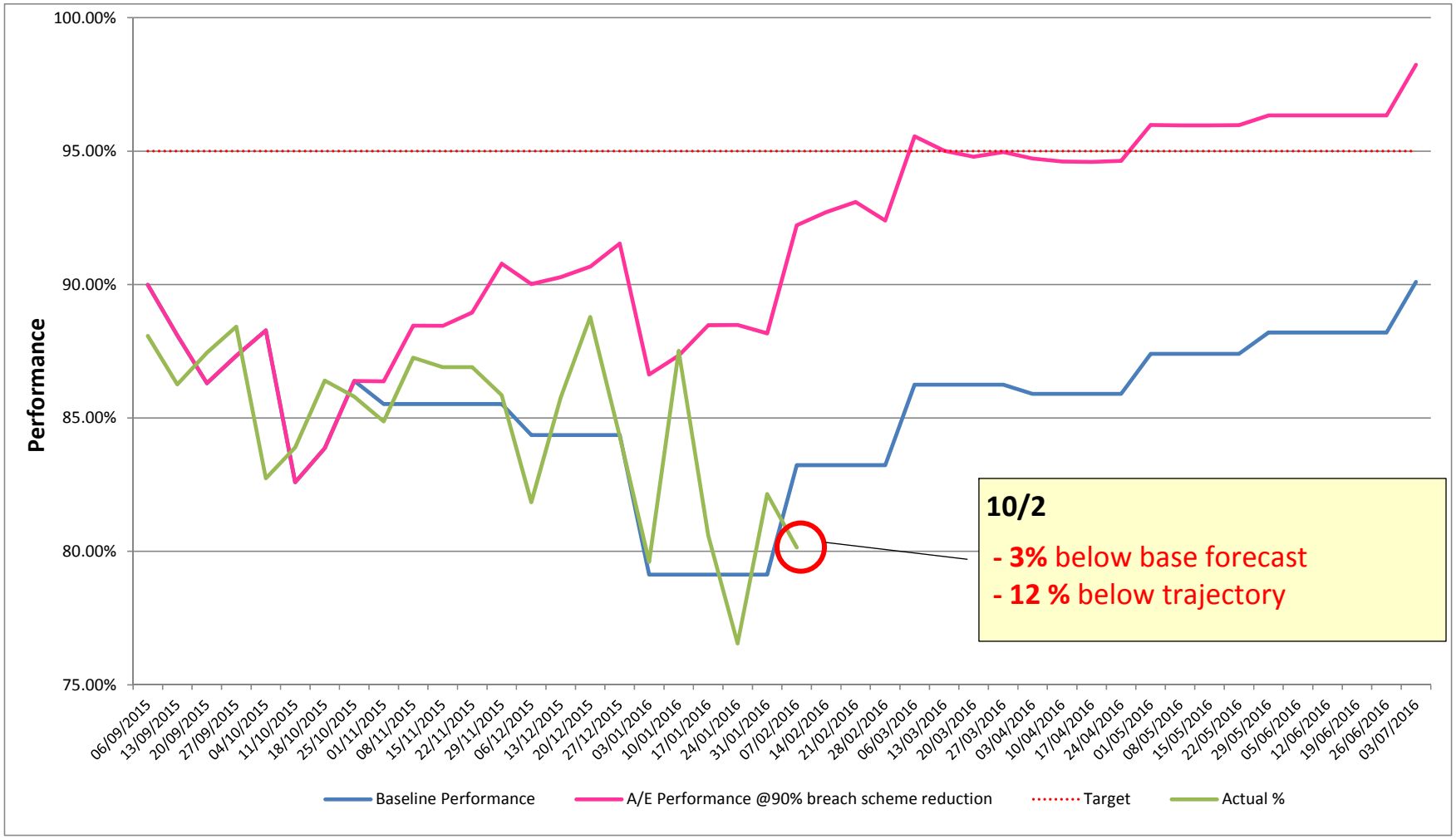
Update on Winter Pressures and the Urgent and Emergency Care System

Annex 1

Summary position on whole system Emergency Care Recovery Action Plan as at 10 February 2016

1. Performance against trajectory

Performance has fluctuated in relation to the forecast. Last week performance fell behind base forecast and was 12% behind the trajectory



Key headlines

Signs of improvement:

- Clinical decision maker breaches now c 0% for last 7 weeks
- DTOC lost bed days had been consistently low for 3 weeks (although showing increase from February)
- Sunday discharges rising on both sites for 3 weeks (although dipping again mid February)
- ICS complex discharges keeping pace with target

Areas for further action include:

- **UCC/ WIC numbers continue to be below potential streaming volume**
- **Admissions avoided remain consistent but below target**
- **Non admitted breaches remain high on both sites**

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 2

Emergency Care Improvement Programme System Concordat, 9 February 2016

Emergency Care Improvement Programme

Safer, faster, better care for patients

9th February 2016

David Evans
SRG Lead and Accountable Officer, Telford & Wrekin CCG

CC: Simon Wright Chief Executive Shrewsbury and Telford Hospital NHS Trust; Brigid Stacey Accountable Officer Shropshire CCG; Jan Ditheridge Chief Executive Shropshire Community NHS Trust, Paul Taylor, DASS Telford; Stephen Chandler, DASS Shropshire

Marianne Loynes, Monitor Regional Director (Midlands & East)
Paul Watson, NHS England Regional Director (Midlands & East)
Dale Bywater, NHS TDA Regional Director (Midlands & East)

Dear David,

Re: Emergency Care Improvement Programme (ECIP) - Concordat

Further to our recent discussions, we are writing to set out a formal concordat between yourselves and the Emergency Care Improvement Programme (ECIP). This concordat will be signed by leaders from each part of the system and the regional tripartite to demonstrate the overall commitment to the objectives set out.

Having now visited the system over the course of a number of weeks, undertaken diagnostic exercises and met with a number of key clinical, managerial and executive stakeholders, we would like to propose that the SRG prioritise the following five areas for action:

1. Development of a system wide vision for UEC and delivery of an effective communication strategy to cascade to all staff.
2. To enhance the Acute Frailty pathway and along with this develop a system wide vision for Frailty with an overall aim of enabling people to remain in their own home. When a hospital admission is required the acute pathway should allow them to return home in the most timely manner to avoid prolonged hospital stay.
3. To introduce the SAFER patient flow bundle across all bed based services in acute and community Trusts to ensure consistency across ward process. This needs to be outcome focused with agreed metrics that are monitored weekly.
4. Introduce Discharge to Assess across the health and social care system. This is the planning of post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This should be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this. Home with care needs to be urgently reviewed and a solution found to ensure domiciliary care is responsive to avoid hospital deconditioning or inappropriate transfer to a community bed based area.
5. To review opportunities to support resilience of the acute Trust EDs.

It is our view that focusing on these areas will help Shropshire, Telford & Wrekin SRG best improve the performance of their urgent and emergency care pathways, reduce waits and occupancy and so improve outcomes, including reducing mortality, for patients in their system.

As you are aware ECIST have provided support to this system ahead of the system's inclusion in ECIP. This concordat aims to formalise this support and establish the priorities for your system. These priorities along with the ECIP support package will be reviewed with you before 31st March 2016. We also recommend that the SRG use some granular improvement metrics to monitor progress. Some suggestions are included in the table below. In addition, the SRG should set itself an ambition to improve system performance against the 4 hour emergency care standard as this is a key barometer of system success and is linked to good patient experience and outcomes.

ECIP expects that the system should define its own goals for these improvement metrics and the ways it will gather and monitor the information. If you do not already have a PMO to support this, we recommend that you should put one in place.

Programme Aim	Improvement in patient care and making the system safer with: • Improvement in performance against the emergency care 4 hour standard • Reduction in daily and weekly variation in performance against the emergency care 4 hour standard • Reduction in mortality • An increase in the proportion of patients returning directly to their usual place of residence from hospital

Action	**ECIP Support**	**Suggested improvement metric**
1. UEC Vision	• ECIP onsite support for a minimum 1-2 days per week • ECIP intensive support managers allocated to sites across the system • Access to wider ECIP team including clinicians and social care • Access to website, all ECIP resources, webinars and events	Patient engagement and staff engagement, measured by surveys
2. Acute frailty pathway		Reductions in conversion rates of over 75s Reductions in length of stay for over 75s
3. SAFER		Reductions in stranded patients; Increased discharges before 10 am Improved reports from audits of board and ward rounds
4. Discharge to assess		Reduce LOS of frailty patients Reduce length of time it takes to get a care package
5. Support resilience of acute EDs		Reduction in non-admitted reaches

Support to develop and implement the work streams will be undertaken through a structured programme that will include on-site visits from the team specified in the table above. These may reduce in intensity over time as the work streams and projects mature.

We would also suggest that a formal review of progress with ECIP and the SRG be undertaken on a monthly basis to ensure we track progress and ensure delivery. To ensure

accelerated delivery of the support programme, we would also suggest that key members of the SRG meet ECIP weekly in the first instance to regularly establish progress against agreed actions, issues and next steps.

The following accountability will apply:

- The Trusts will remain accountable to the NHS TDA or Monitor for their performance, as applicable
- The CCGs will remain accountable to NHS England for their performance
- The Regional Tripartite will hold the system to account for overall delivery of this plan and the realisation of improvement in Emergency Care
- ECIP will provide a support function as set out above so that the SRG is in the best possible place to secure improvement

In summary, we would like to thank you for engaging with ECIP and inviting us to provide a more detailed review of the internal clinical processes within your system which has been the main focus of this concordat.

Yours sincerely,

Steven Christian
Head of Improvement
ECIP

Vincent Connolly
Medical Director
ECIP

Glen Burley
Senior Responsible Officer
ECIP

[Approved by]

Frances Shattock
Regional Director, Midlands & East
Monitor

Dale Bywater
Regional Director, Midlands & East
Trust Development Authority

Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS

Paul Watson
Regional Director, Midlands & East
NHS England

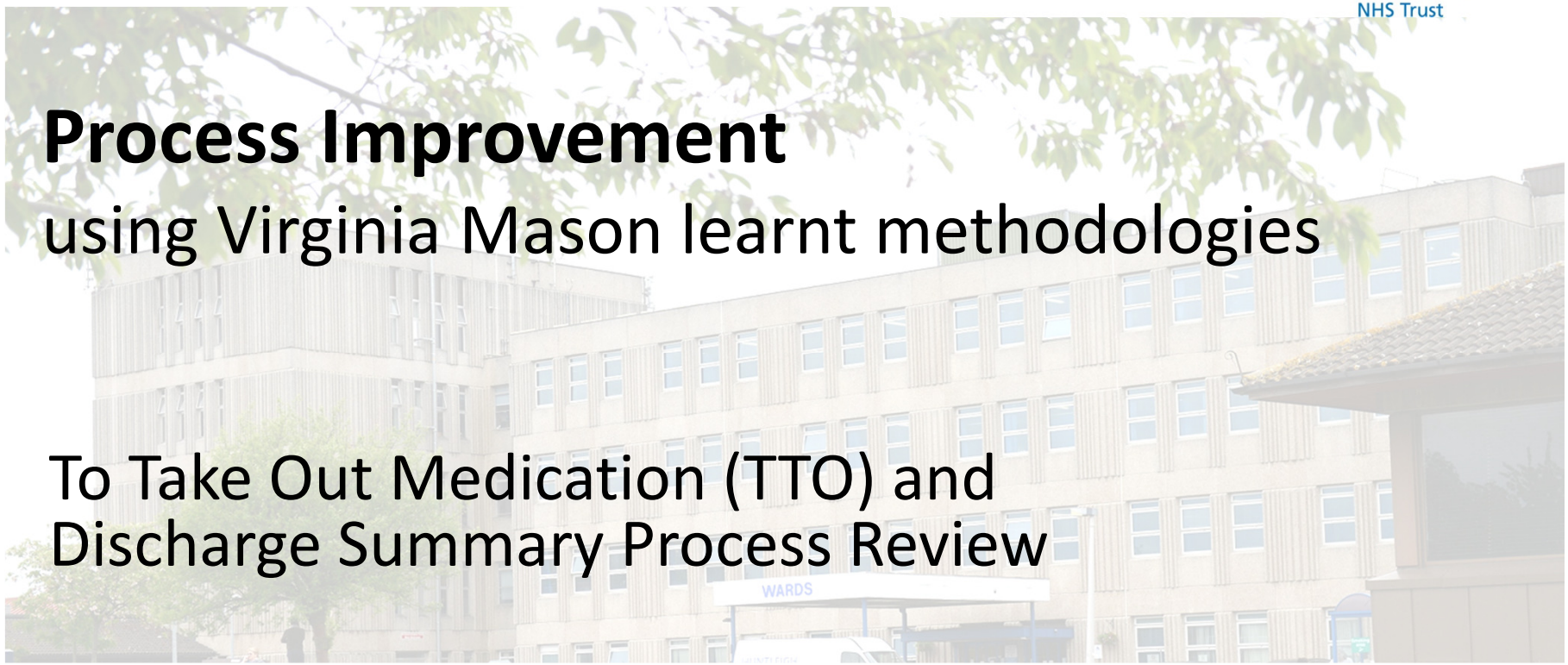
[Agreement from]

David Evans
Chair, Shropshire, Telford & Wrekin SRG

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 3

Reducing discharge delays through the SATH partnership with Virginia Mason Institute, 28 January 2016



Process Improvement

using Virginia Mason learnt methodologies

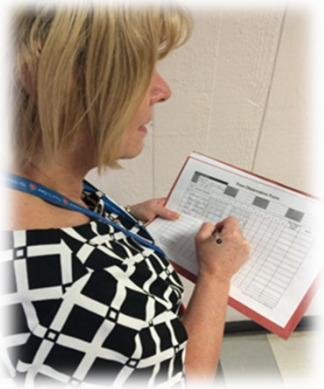
To Take Out Medication (TTO) and Discharge Summary Process Review

What is the problem we are trying to solve?

- Improvement & Transformation Team formed to focus on a key improvement for the Trust
- **Breaking the Cycle week** identified To Take Out Medications (TTOs) and Discharge Summary as priority
- Ward and Pharmacy teams fully engaged as key stakeholders
- Aim to reduce **turnaround time** of TTO **by half**

"We believe that a high number of discharges are delayed due to the process of producing TTOs and discharge summaries"

Improvement Methodology



- Provide current state information to stakeholders
- Ideas for improvement generated by teams
- Scientific method used to prove or disprove hypothesis
- Using Plan, Do , Study, Act (PDSA) cycles, experiment and measure improvement activity
- Review, adapt and retest ideas
- Encourage continuous improvement through many small local changes
- Support teams to make improvement by providing advice, guidance and facilitative resource
- Start small, think big

Current State Value Stream Map

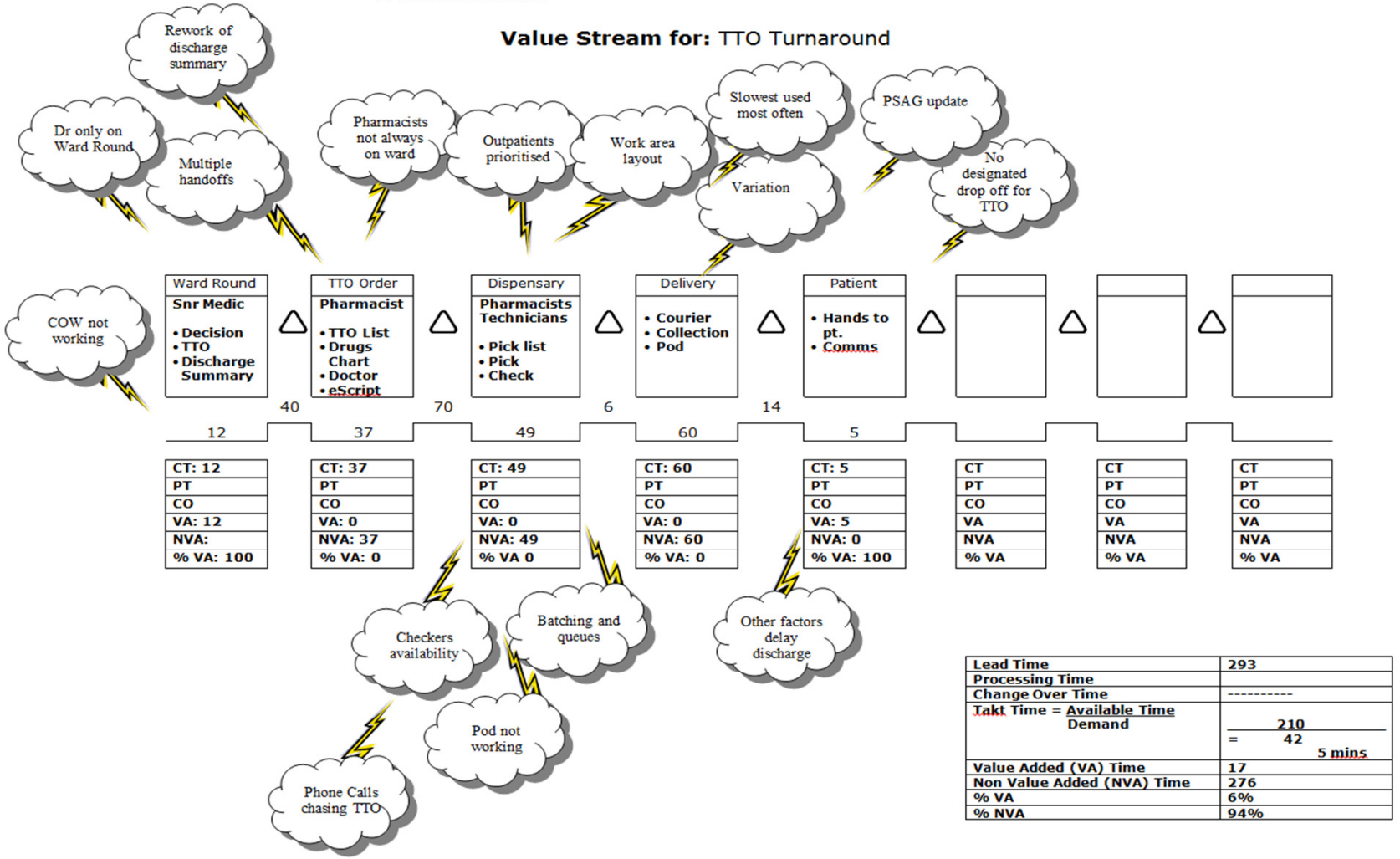
The Shrewsbury and Telford Hospital NHS
NHS Trust

Process Boundaries
From: Patient declared fit to leave
To: Patient receives TTO

☒ **Current State**
❑ **Future State**

Author: Nick Holding
Date prepared: 14/10/15

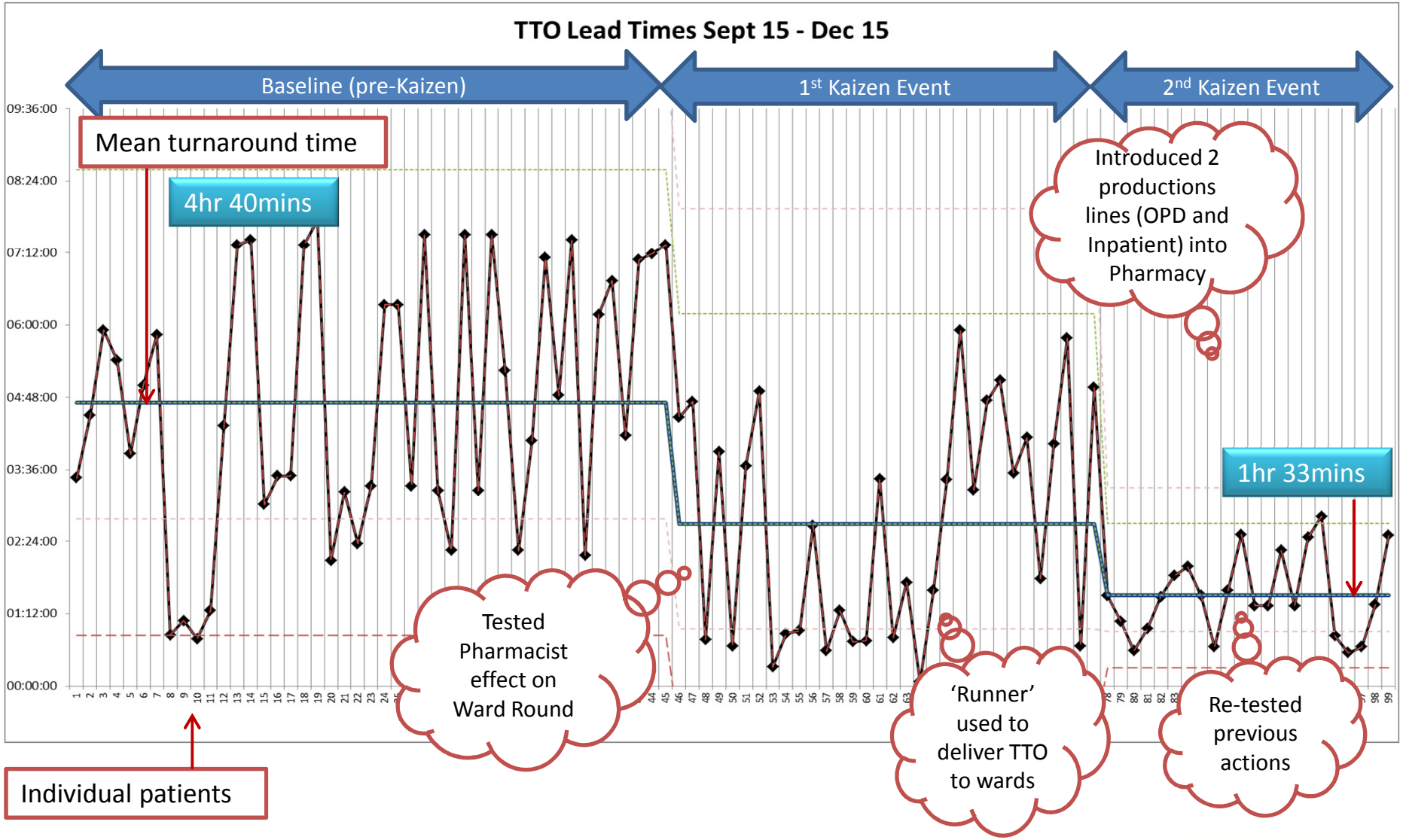
Value Stream for: TTO Turnaround



Lead Time	**293**
Processing Time	
Change Over Time	----------
Takt Time = Available Time / Demand	210 / 42 = 5 mins
Value Added (VA) Time	**17**
Non Value Added (NVA) Time	**276**
% VA	**6%**
% NVA	**94%**

TTO Turnaround Times

The Shrewsbury and Telford Hospital NHS
NHS Trust



Source. Sema, eScript, Pharmacy dept docs & direct observation

Improvement and Transformation

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Summary

The Shrewsbury and Telford Hospital NHS
NHS Trust

- **Overall TTO lead time reduced by 67% (3hours)**
- **Patient TTO delays reduced by on average 10 hours per day (1 ward)**
- **Potential release of approx. 300 hours per day of bed usage time, across inpatient areas (USC & SC)**
- **Earlier discharge time**

- Used Virginia Mason methodologies
- Care Groups identified TTO and Discharge Summary process as area of focus, following Breaking the Cycle week
- Collected real time current state data
- Working with operational teams, ran a number of improvement events to test ideas using PDSA cycles over 3 months

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 4

Detailed position on whole system Emergency Care Recovery Plan as at 13 January 2016

Emergency Care

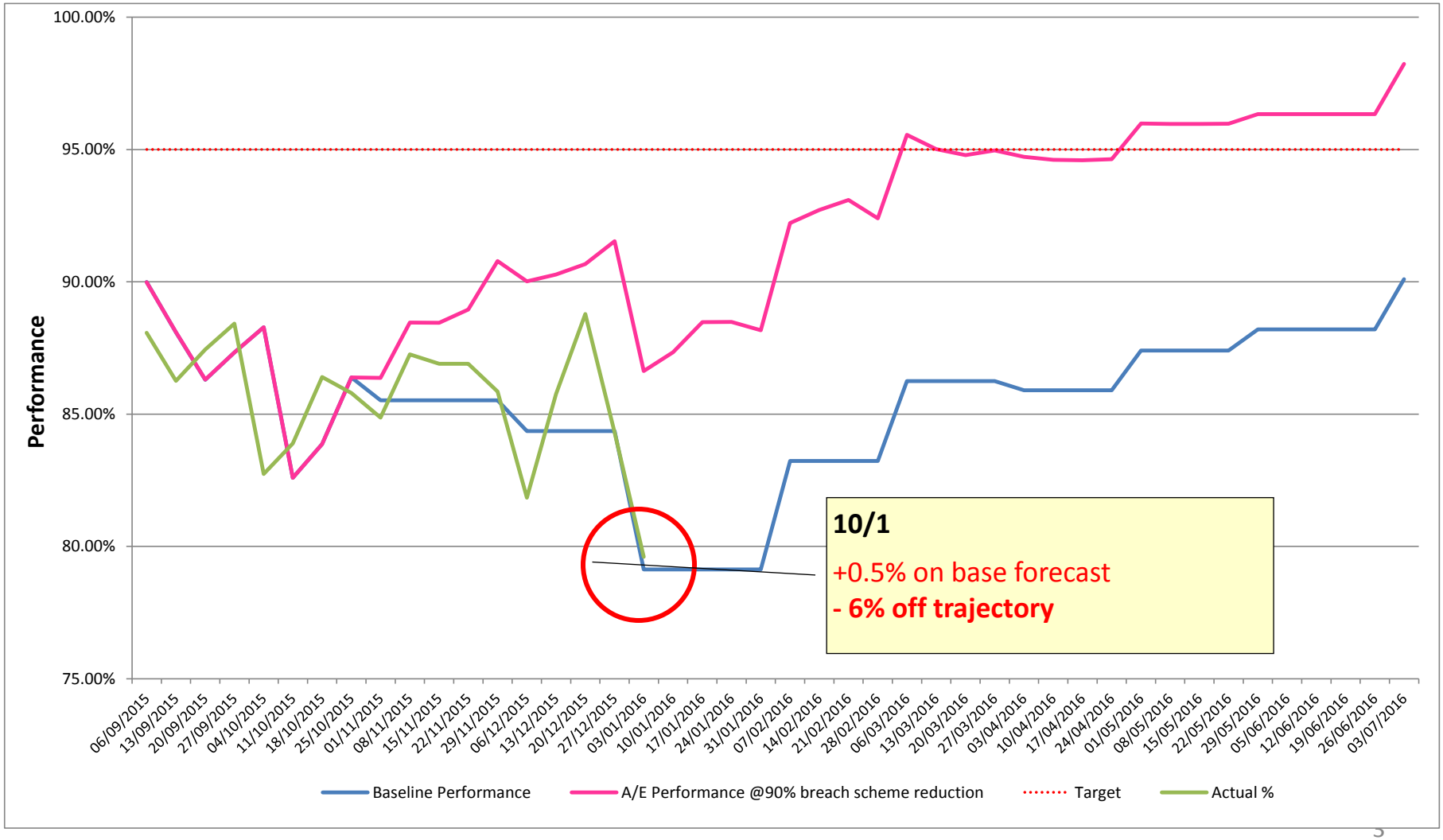
Recovery Action Update

January 13th 2015

CONTENTS

1. Performance against trajectory

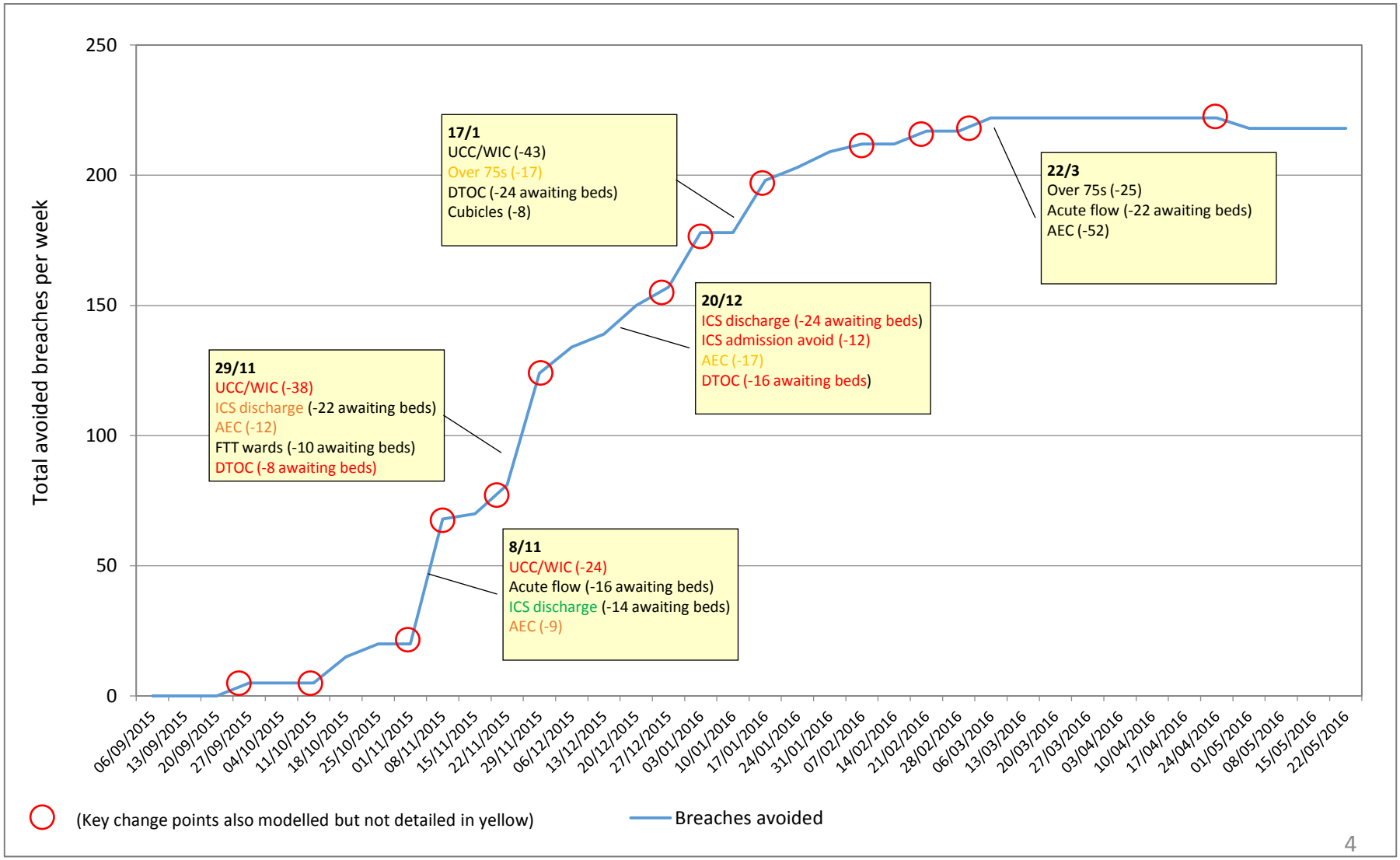
Performance has tracked close to forecast base performance. It dipped to 82% on the 13th Dec but rose sharply to 88.8% w/e 27th Dec. Performance at the start of the New Year is better than previous years (plus 6%) but fell back to -4% vs 2015 in w/e 10th Jan.



1. Breach trajectory tracker

Key actions off track/ late –

1. UCC/ WIC streaming; 2. Complex discharge/ DTOC; 3. AEC & ICS activity rates



2. Key actions required

Gaps and mitigating actions

1. Streaming patients to UCC/ WIC

   - Delays in agreeing streaming process and capacity have constrained opportunities to divert demand at the front door
   - Streaming and additional funded resources to support this are now in place from w/e Dec 27 and very early signs of increased activity
   - PRH are using diverts back to GPs, and there is agreement to jointly monitor on a daily basis

2. Admission avoidance & complex discharge through ICS

   a. Admission avoidance rate at 33% of forecast
      - Care Coordination Centre to be used as well as SPR as point of AA referral
      - 8-8pm service hours in place from Jan 4

   b. Complex discharge rate is c30% of forecast
      - Care capacity uplift expected from Jan 18
      - All existing and new referrals for care being reviewed to ensure appropriateness and potential to profile care needs accordingly

2. Key actions required

Gaps and mitigating actions

3. Utilising AEC to avoid ED/ admissions

- Unit throughput data outstanding – escalated and data to be provided ahead of SRG Jan 15
- Current operational pressures mean that the AEC has been disrupted by the need to bed patients when hospital full.
- Pathway development work continues on track

4. Reduction in delayed transfers

- Reduction in numbers of delayed patients after Christmas (zero at PRH), however first week in Jan saw a stepped increase
- Daily operational processes and grip enhanced following COO meeting Dec 18. Strengthened further by daily command and control meetings within the acute
- Additional commissioner presence in daily hub meetings to support additional challenge and pace of action/ decision making
- ECIP led workshop on improving complex discharge management being confirmed

2. Key actions required

Gaps and mitigating actions

5. Internal flow improvements

   - Day of discharge initiative mapped and 3 areas of focus to reduce TTO lead time are being piloted, with an evaluation planned for end of Jan.
   - SAFER and Exemplar Ward project are being piloted on 2 wards and baseline metrics being collected.
   - Nursing Director lead to work with ECIP on supporting pace of roll out and embedding progress

6. Non admitted breaches

   - Cubicles installed at PRH, process changes to be delivered and impact starting to feed through from Jan 13

7. Over 75s Admission Avoidance Scheme

   - Funding approved and signed off by SRG through winter monies
   - Delay in formal sign off from WMAS has meant that recruitment and induction has been delayed – scheme live date slipped from Jan 4 to beginning of Feb
   - Option to launch with clinical lead providing cover for shifts to be explored

3. Next steps

What we need to do now -

1. Ensure close monitoring
    - Recovery metrics circulated across system weekly - COO's to receive, discuss and action at their weekly meeting
    - SRG & SRG Core Group to receive updates
2. Detailed line by line review of all plans
    - Session being arranged for all action owners to present their plans to PMO/ Chair of UCWG
    - Mid term projects to be scoped and potential impact on recovery to be quantified
3. Maximise the impact of support from ECIP
    - Local lead to join weekly COO meeting & plan of support to be aligned to each priority area and mapped to end of March
4. Remain committed to delivery of trajectory in March
    - Stock take of progress to date and what it means for delivery – refresh breach impact timing
    - Ensure daily operational grip maximises current performance
    - Deliver existing actions on time and bring forward where possible mid term impact

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 5

Emergency Care Improvement Programme Whole System Diagnostic

Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS

ECIP – Whole System Diagnostic – Shrewsbury & Telford Local Health Economy

Summary

A whole system review was undertaken between the 9th and 12thNovember 2015. The acute trust that formed part of the whole system review is Shrewsbury and Telford Hospitals NHS Trust (SATH). The Trust was in full support of the review and the preparatory work leading up to our visit.

Shrewsbury and Telford Hospitals NHS Trust provides acute hospital services, including urgent and emergency care, critical care, general medicine including elderly care, emergency surgery, elective surgery, paediatrics, maternity care and a range of outpatient services. Urgent and emergency (UEC) services are provided across two sites with Emergency Departments (ED) at Shrewsbury Royal Hospital and the Princess Royal Hospital in Telford. Shrewsbury and Telford Hospitals NHS Trust is a non-foundation trust. The Trust employs over 5,000 staff.

SATH provides acute treatment and care for a catchment population of around 500,000 people in Shrewsbury, Telford and Mid Wales. The hospital provides healthcare to the population covered mainly by two Clinical Commissioning Groups, Shropshire CCG and Telford and Wrekin CCG. Each CCG was invited to engage in the process. Shropshire Community Health Trust is the community provider in this system and was a key part of the diagnostic visit. Shropshire County Council and Telford and Wrekin are the two Local Authorities.

The whole system review comprised of the following:

1. An Acute Walkthrough of the patient pathway across SATH's urgent and emergency care system, on both sites. The visiting team met with clinical and managerial staff involved in leading and delivering services across the internal pathways.
2. Structured interviews with providers and commissioners outside Acute Trust.
3. A visit to two of the community hospital facilities in Whitchurch and Bridgnorth as well as recovery beds managed by an independent provider.
4. Discussions with Integrated Care Service (ICS) and discharge planning / admission avoidance teams in Telford and Shropshire.
5. A whole system event to present findings and initiate discussion to develop solutions.

Acknowledgements

We would like to thank the teams and individuals we met for their openness and willingness to be challenged.

The visit, with the co-operation of all the staff we met, has allowed us to make a number of observations, which we have developed into 'high impact' priority recommendations.

We wish to assure all concerned, in particular the teams we met, that in our evaluation we have acted independently and trust that observations and recommendations will be viewed in a constructive manner by all concerned.

The ECIP review was conducted by:

- Dr Jyothi Nippani (ECIP Clinician)
- Dr Mitton Ruparelia (ECIP GP Clinician)
- Steve Christian (ECIP Cluster Head of Improvement)
- Elizabeth Sargent (ECIP Clinical Lead for Integration, Health and Social Care)
- Glynnis Joffe (Social Care Lead)
- Karen Campion (ECIP Intensive Support Manager).

Evidence Base – Case for Change

As a starting point, it is essential that everyone across the system understands that poor patient flow leads to a reduction in high quality care, and therefore the requirement to make improvements at pace.

Research into poor patient flow (resulting in crowded Emergency Departments and high bed occupancy) has established links with a number of adverse patient outcomes and evidence suggests:

- For patients who are seen and discharged from an A&E, *the longer they have waited to be seen*, the higher the chance they will die during the following 7 days (Guttmann et al, 2013).

- The longer a patient spends in the Emergency Department (ED), the longer they stay in the hospital (Liew et al, 2003).

- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Giles et al, 2004).

- Delays in transfer from ED to higher dependency units increase mortality and length of stay (Chalfin et al, 2007).

- Once a hospital is over 90% bed occupancy it reaches a tipping point in its resilience (Forster et al, 2003).

- Lowering levels of bed occupancy is associated with decreased in hospital mortality and improved performance on the 4-hour target (Bowden et al, (2015).

The key national factors associated with deterioration in 4 hour standard performance

The Economic Team at Monitor have completed analysis to determine the key factors at a national level for the deterioration in performance (figure 1).

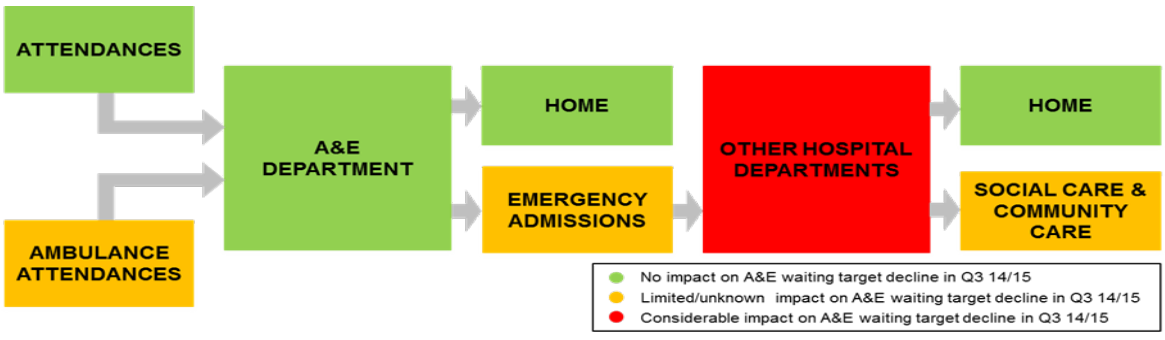


Figure 1 - Drivers of the A&E performance challenges in 2014/15

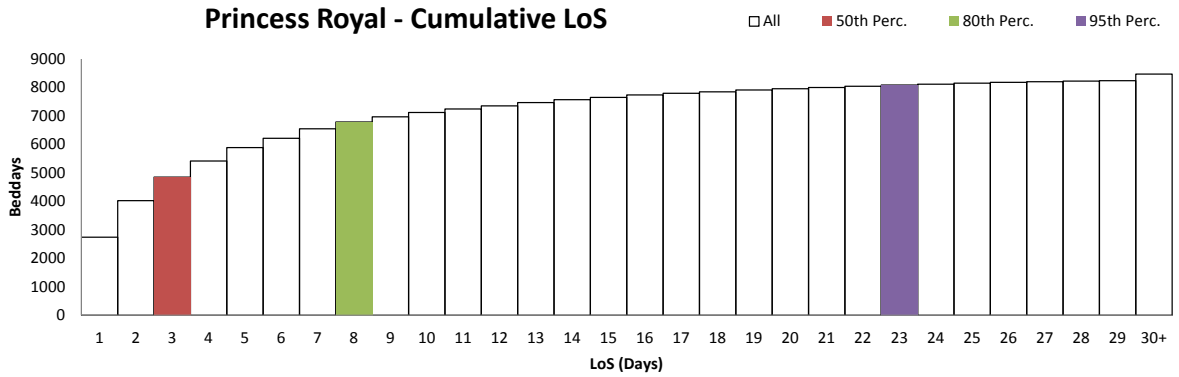
The findings show that the most important cause of the decline was a reduction in acute Trusts' ability to absorb an increase in admissions from EDs. This, in turn, was a result of Trusts running at very high occupancy rates of 90% or above. The data indicates that factors potentially contributing to blockages at other stages in the patient pathway had either a minor or no impact on actual delays. Therefore measures taken by Trusts to improve patient flow through hospital departments other than ED are likely to be highly effective in avoiding another sharp decline in 4 hour standard performance this winter.

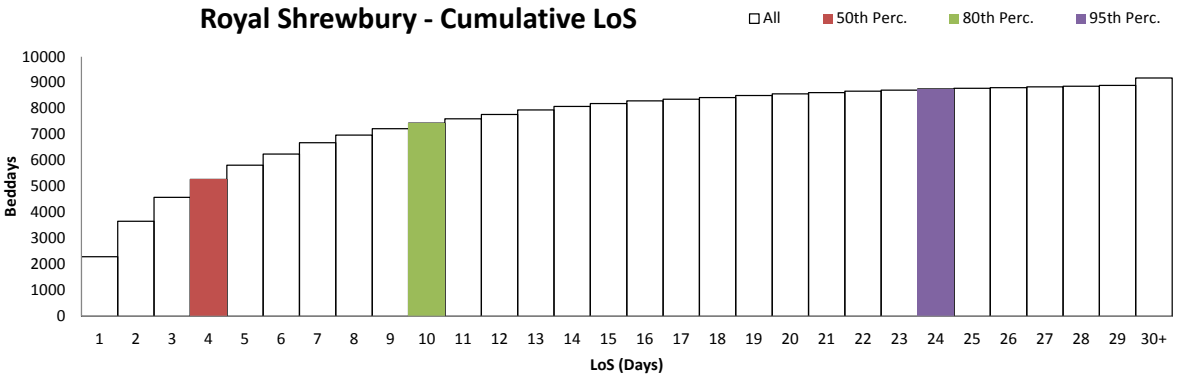
Based on the findings from the analysis (national context) and our observations across the whole system review, the report will detail 8 high impact priorities recommendations that if delivered we believe will improve the system's resilience and ability to achieve the 4 hour standard. However, more importantly, they will improve patient experience and mitigate any potential harm factors arising from the known evidence based risk factors associated with poor patient flow and ED crowding.

Key Information from ECIP Data Pack – Length of Stay

The data suggests that the key focus point for the system will be to drive improvement in Length of Stay (LoS) across the acute Trust. To flag early, this can only be achieved through a whole system approach and working together under a shared vision.

The 8 high impact priority recommendations are focused on initiatives aimed at improving Length of Stay at the acute hospitals. From our observations, we believe that driving the 'basics' should be the focus. We strongly believe that there are opportunities for the system to 'left shift' percentile performance in LoS and therefore support improvement in bed occupancy; and as a result deliver resilience against the 4 hour standard.





The graphs above provide the percentile Length of Stay performance for both acute Trusts at SATH. Whist we don't have a national standard we advise systems that good practice is to work towards the below percentile LoS targets. This is performance we have observed in high performing systems across the NHS.

LoS Percentiles – High Performing Systems		
50th	80th	95th
2	7	21

'High Impact' Recommendations

As a result of our visit, ECIP has identified the 8 high impact recommendations that we believe provide the greatest marginal gains for improvement across UEC and as a result the 4 hour standard. We have purposively focused our attention on specific priorities (rather than a wide range of initiatives) to ensure the improvement remains focused and realistic in terms of delivery.
Later in this report we will identify what we believe from these recommendations are immediate key short term priorities for the system to deliver. However we will continue to work with the health economy over time to deliver all 8 High Impact Recommendations.

1. Development of a system wide vision for UEC and delivery of an effective communication strategy to cascade to all staff.
2. Maximise Ambulatory Care models at Acute Trust to prevent unnecessary overnight hospital stay – this should include support from community rapid response and linking with DARRT service.
3. To enhance the Acute Frailty pathway and along with this develop a system wide vision for Frailty with an overall aim of enabling people to remain in their own home. When a hospital admission is required the acute pathway should allow them to return home in the most timely manner to avoid prolonged hospital stay.
4. To review the current model of care in Acute Medicine.
5. To introduce the SAFER patient flow bundle across all bed based services in acute and community Trusts to ensure consistency across ward process. This needs to be outcome focused with agreed metrics that are monitored weekly.
6. Introduce Discharge to Assess across the health and social care system. This is the planning of post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This should be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this. Home with care needs to be urgently reviewed and a solution found to ensure domiciliary care is responsive to avoid hospital deconditioning or inappropriate transfer to a community bed based area.
7. To review current processes in managing escalation (i.e. review the effectiveness of frequent teleconferences).
8. To review opportunities to support resilience of the acute Trust EDs.

It must be noted that we observed many aspects of good practice and observed hardworking, committed individuals across the system. The report is focused on further opportunities to complement existing efforts.

1. Leadership and development of a system wide vision

Throughout our visit we did not see any evidence of a shared agreed vision for UEC across the whole health and social care economy. Whilst recognising the significant challenges across the system,

relationships between system Executive teams and senior operational managers did not appear to be that of trusted colleagues. It seems that unacceptable behaviours particularly when the system is under pressure have become normalised, there appeared to be a culture of blame.

This does not mean that there is not a 'can-do' attitude and we met staff across the whole health and care system who were leading on improvement work linked to patient flow. However some members of staff reported a lack of Executive presence and support for their work .The frequent changes in the Executive team in recent years at the acute Trust specifically has not helped with this. The recent appointment of the new CEO at the acute Trust and the Shropshire CCG Accountable Officer brings about an opportunity to develop system leadership, which is positive.

When we spoke to staff across the system it was consistently described to ECIP that the system has a poor track record of sticking to sustainable change, moving on to a new initiative before evaluating and developing the previous service improvement ideas. This is evidenced for example by previous work on the SAFER bundle and Comprehensive Geriatric Assessment at the front door, that was `leading edge ' improvement work at that time bringing significant gains to patients, which for reasons that could not be described on our visit was not sustained. Executive leaders must harness the values and enthusiasm of clinical and operational staff across the health and social care economy.

Recommendations:

- The System Resilience Group (SRG) needs to set a vision for UEC across the health and social care system and communicate that to all levels of staff.
- Executives across the SRG should set shared principles across each improvement initiative and take responsibility in creating a culture of continuous improvement across the system. Across each high impact priority whilst a provider organisation will be responsible, it is paramount that partners engage and work together to find solutions to optimise the recommendations being proposed.
- The system leaders agreed that it would be helpful to develop a set of values and behaviours to underpin the vision and principles. They agreed that these should be developed jointly and allow them to hold each other to account as change is progressed. ECIP could provide support to facilitate this.
- The system leaders need to spend dedicated 'personal' development time as a strategic leadership group. This is something that the ECIP team could help with and facilitate.
- Develop leadership across all levels from the frontline up. The acute Trust in particular had individuals with great ideas and didn't need ECIP to inform 'what good looks like'. The system and providers need to explore change management initiatives to engage the workforce to encourage individuals to be inspired and motivated to lead the change / improvement required.
- System leads must agree the high impact priorities, sponsor each initiative and commit.
- We recognise the challenges the system has in recruiting however it was not apparent that in attempting to tackle this issue the system has approached this as a collaborative. We would advise HR leads from across the system to meet and formulate a recruitment and retention plan to support resilience across UEC.

2. Ambulatory Emergency Care (AEC)

The AEC units at SATH require development to increase the number of emergency patients being referred to AEC, prior to decision to admit into hospital. It is essential that the Trust has one understanding of the purpose and principles of AEC, and this is understood by all service stakeholders, including patients.

We met enthusiastic and inspiring clinical champions for the service across both sites, although they did appear frustrated by barriers being encountered on a daily basis. For example, a clinician overseeing one of the AEC units described a situation, experienced on the day of our visit, whereby a patient was identified as suitable for same day discharge through a process driven AEC approach (and not experience an admission to an inpatient bed). The clinician required a 'next day' MRI scan and a speciality outpatient appointment to deliver such outcome for the patient. The systems were not in place to enable the plan to convert into action, and as a consequence the likely scenario was admission to hospital. The AEC clinician did pursue and not accept initial barriers from clinical support teams and after personal perseverance the right outcome for the patient was reached, and the patient was discharged from the AEC in a safe manner. The process was not timely for the patient nor was it a good use of resources for a clinician to 'chase' the necessary requirements from clinical support teams. Whilst this is a stand-alone example it was 'real time' and the clinical teams we met could describe numerous examples. The process should be systematic and not operator dependent.

Recommendations:

- All patients referred as an emergency (from GP and ED) should be considered for AEC management as a first line unless they are clinically unstable. The number of patients being directly referred to AEC from ED and GP needs to form part of the daily performance reports that are accessible to all clinical and managerial leads. The aim should be to deliver a process were the AEC facility is accommodating at least 35% of the current medical take.
- The time frames for initial assessment and medical review in the AEC facility should be similar to those in the main ED. This should be monitored and reported internally.
- The DAART and community service should be reviewed to ensure clarity of function and consideration of how services fit / support with the development of the AEC and acute frailty services.
- The AEC service should be available for a minimum of 12 hours per day 7 days per week but not overnight.
- Given the recruitment challenges, Advanced Care Practitioners (ACPs) should be pivotal in delivery of the service.
- A weekly project group to deliver continual evaluation and development of the units should be set up with Executive support. The service leads of the units across sites should meet regularly to share learning and experiences. It is appropriate for each site to have different approaches to a model of care (for example different approaches in work force due to availability). However, the principles should be consistent.
- The project group should engage all support service functions (within the hospitals and across community services) to ensure capacity is available to promote 'same day' discharge from AEC. It was not evident that the community services have actively engaged in seeking to understand how they can support this critical function to avoid hospital admission.

3. Acute Frailty Pathway

It was unclear when the Comprehensive Geriatric Assessment (CGA) for patients takes place. There is no frailty pathway. The underpinning aim should be to complete the CGA as soon as possible in the patient journey. CGA is a multidimensional inter-disciplinary diagnostic process to determine the medical, psychological and functional capabilities of a frail older person in order to develop a co-ordinated and integrated plan for treatment and long-term follow up. Effective implementation has been shown to reduce admissions for the over 75s by 33% and for those who are admitted, length of stay is reduced. A 'front door' therapy process to capture the pre admission functional level is a key element of the Acute Frailty pathway.

There is no frailty team although there is the basis of a frailty service available at both ED sites, predominately led by an enthusiastic therapy team with some community rapid response capacity at limited times of the day. The specialist geriatric resource supported a front door service in the past, but this has not continued due to workforce constraints .

We encourage Acute Frailty teams to work towards the following good practice principles:

- Establish a mechanism for early identification of people with frailty (find the patients on arrival)
- Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour (do the same thing to them every time, urgently)
- Set up a rapid response system for frail older people in urgent care settings
- Adopt a "Silver phone" system (nationally, why do trauma, stroke, STEMI, septic patients get an urgent standard response but frail patients do not?)
- Adopt clinical professional standards to reduce unnecessary variation
- Define and manage 'stranded patients' (Patients in hospital 7 days and over)
- Strengthen links with services both inside and outside hospital
- Put in place appropriate education and training for key staff
- Develop a measurement mind-set
- Identify clinical change champions
- Identify an Executive sponsor and underpin with a robust project management structure

Recommendations:

- The frailty pathway from patients presenting to the ED to discharge requires urgent review and focus. Whilst the therapy team have maintained a front door service, this needs to be supported by a multi-disciplinary response including Geriatricians with agreed professional standards and outcome measures. The review would need to include delivery of a front door assessment model, utilising all members of the multidisciplinary team including general practitioners with special interests, skilled nursing and therapy staff. To support this, we have specialist clinical resources available who could complete a comprehensive 'deep dive review' to ascertain a baseline (gap analysis) and provide practical advice and support to develop current pathways of care.
- Arrangements should be made to include social services, community health services and the voluntary sector in facilitating admission avoidance as part of the service.
- The FFA form is an early functional assessment, which has recently been implemented at the Telford site. This could be used as the assessment notification for both community health and social care services from the front door and would follow the person through their hospital stay. Further functional assessment would then be made when the patient is back in their usual place of residence.

4. Acute Medicine – Variation in AMU

The model of Acute Medicine suffers from a lack of standardised processes. The variation that each team /individual is allowed to bring is too great. AMUs can suffer from this as the senior medical staffing changes frequently (often daily) due to the requirements of a GIM rota and a reliance on drawing from the wider medical consultant team. There is, however, an opportunity to run a short project describing what good looks like for the team delivering the medical take and we advise that SATH, led by Medical Director, undertakes this work, using the apparent nursing teams' frustrations and knowledge to inform medical teams. The SHOP (sick, home, others, plans) model is a way to conduct AMU ward rounds that go to where the patients' needs are. The consultants should see the

sick patients first, followed by those patients who can go home, taking the actions required for them to be discharged. As with AEC, help from other clinical teams and diagnostics needs to mirror ED.

Recommendations:

- Meet as a senior management team (Executive sponsors and clinical leads) to determine the vision for Acute Medicine and commit and work towards the following good practice principles:
  - An average length of stay of 12 hours.
  - All patients with a daytime admission should be reviewed by a consultant within three hours. Evening admissions should be reviewed within three hours by a senior doctor, and a have a 'consultant delivered review' the following morning.
  - Consultants should provide ward cover in blocks of more than one day to provide continuity of care and be present seven days a week and into the late evenings. This will reduce delays and improve outcomes.
  - Consistent speciality in-reach for every patient requiring specialist care should be available five days a week working towards seven days when workforce allows.
  - Short stay beds should be available as part of a wider acute medical unit and should have adequate resources to provide care for patients with an anticipated length of stay of up to two midnights. Patients on the short stay unit should have a face-to-face consultant review twice daily, seven days a week. It was felt that SATH has progressed in this however it is dependent on locum Consultant time and therefore perhaps not a sustainable model and warrants review for a sustainable approach.

5. Ward Processes – Implement SAFER patient flow bundle

We attended and observed inpatient and community ward 'board rounds'. It was immediately apparent there are significant opportunities to improve patient flow across the ward process in both the acute and community environments. We observed high levels of variation in approach. Across our visit we experienced pockets (e.g. ward round approach in respiratory at the acute Trust) of excellent practice. However, this was not consistently applied.

When speaking to staff on the wards the following points were highlighted as current challenges:

- A lack of systematic use of expected date of discharge (EDD).
- A process that encourages sequential planning and acceptance of internal / external waits and delays.
- An acceptance that Board Rounds are not action-focussed and do not hold all members of the MDT to account. The team emphasised that there is variation in Consultant and other MDT daily input / attendance.
- We didn't observe a ward round, but staff we met described a traditional method and that in the main key tasks are still batched until the end of the round which create delays to patient flow.
- Assessment services do not have agreed response standards that are monitored, acted upon and if necessary escalated in a timely and consistent manner.
- Whilst informed that daily senior consultant review of every patient is in place, it could not be evidenced across all areas.

Recommendations:

- We recognise that ward processes can be complex. A good approach to managing complexity is to develop and use simple rules. We would encourage a focused effort in the implementation of the national SAFER patient flow bundle (appendix 1) across all providers

of bed based services. All the principles must be adhered to in a consistent manner to deliver good outcomes for patients. The successful implementation of a patient flow bundle approach requires 'buy-in' at all levels, including all members of the executive team. We have helped a number of Trusts implement the SAFER patient flow bundle and believe this is an area of focus that both the Trust and the system must prioritise and support. The trusts will want to refer to the Ward Round in Medicine Guidance (RCP and RCN 2012)

We would expect the successful implementation of a patient flow bundle to deliver:

- Improved daily patient reviews by decision makers.
- Improved average daily discharge times.
- Earlier time of transfer from assessment units to specialty beds.
- A reduction in the number of unsatisfactory discharges.
- A reduction in the number of delayed patients awaiting sub-acute care.
- Increasingly standardised behaviours across all disciplines.
- Increased ward level 'ownership' and accountability.

6. Interface and Discharge Planning

We recognise the good work that has taken place across the health and social care economy on the development of the Integrated Care Service (ICS) when we met the team in Shropshire. We observed blurred professional boundaries within the teams and good use of skill mix – *the ICS is one of the best examples of this kind of working that we have seen.*

We observed the work teams have been implementing on discharge to assess (D2A) and heard a clear view that community hospitals should be for patients with registered nursing needs and possibly CHC 'potential' patients awaiting assessment as they recover from acute admission. It was acknowledged by most that rehabilitation and reablement should be at home, not in a bed.

Our concerns were around patients who will be placed in the extra beds that are opening over winter as part of the system's resilience plan which the acute trust are putting in place to mitigate against the shortage in domiciliary care capacity. This pathway would not be in the best interests of patients. We understand that there are older people in residential and nursing home beds opened last winter to increase capacity at short notice who are still there awaiting assessment of their onward care needs.

However, the action learning on a ward at the Royal Shrewsbury following our visit also found that some patients, who were waiting for a community hospital bed, could in fact be discharged to their own home, and of the small number that were actually able to leave the hospital needed far less care than their acute based assessments had suggested. The greatest percentage of patients that were highlighted as being able to go home with the Integrated Community Services were then unable to go due to lack of planning within the acute trust.

Far too many decisions about long term care and onward care generally are being made in hospital with no belief amongst hospital staff that home first could work. The CHC pathways are not right with confusing paperwork and far too much of the process happens in the acute hospital setting.

There have been some recent changes in the way the interface teams work at Telford. Social workers are now in a hub with community health professionals available to support patients on their pathway home as needed. Again this did not appear to have filtered through to front line staff in advance of the change, causing uncertainty and a lack of understanding at the front line. It appears that the discharge teams hold most of the decision making in relation to patients that are deemed to have complex needs. The wards described being disempowered in terms of managing discharge.

There appeared to be significant delays in discharge due to availability and provision of equipment.

Staff shared with us some risks around capacity in home based care, which is provided by the private sector. A recent procurement exercise has been undertaken by the joint commissioner with the council and provision should increase from the 1st December 2015. We did not observe assurance that this would be in place and it was not clear who would be responsible for ensuring the commissioning is robust and will deliver. This was a significant concern for system resilience, given the lack of assurance provided at the time of our visit. The system could not articulate a mitigation option, which places greater risk on the reliance of bed based options. This is not in the best interest of patients when home must be the default position.

We also attended the Medically Fit for Discharge meetings at both sites, which involved large numbers of staff in meetings that have no clarity of purpose and are not action focused. Staff attending did not appear to have the necessary detail to pass onto colleagues present.

Patient/family choice was also highlighted as an issue. Clear expectations are not set with families early in the admission. Although we were told that letters had been developed to support the process, communications appeared only to be used by the time the patients had reached the latter part of their stay in hospital. We can share examples of simple information to set expectations with patients on their admission.

Every patient and where appropriate their carers should expect answers to the following four questions to be available to them every day.

- What it wrong with me?
- What is being done to fix it?
- What do I need to be able to do to go home and has anyone asked me?
- When can I go home?

On discharge patients should also know>

- What support will I receive and from whom?
- What can I expect and what should I do if I am worried about something that is happening to me?

Ideally there will be single number that they can ring and we would suggest that the existing Care Coordination Centre is ideal for this purpose.

The system appeared much weaker on prevention of admission before arrival at hospital, although we were impressed by the patient centred services for respiratory patients. We observed excellent practice from Rapid Response although they had limited nonclinical support and appeared to spend large amounts of time trying to source care packages. There is a brokerage service to support this; we were told that this sometimes became quite a bureaucratic process although it should help. We suggest that there is a conversation between ICS and the Council led brokerage team in Shropshire to understand the issues.

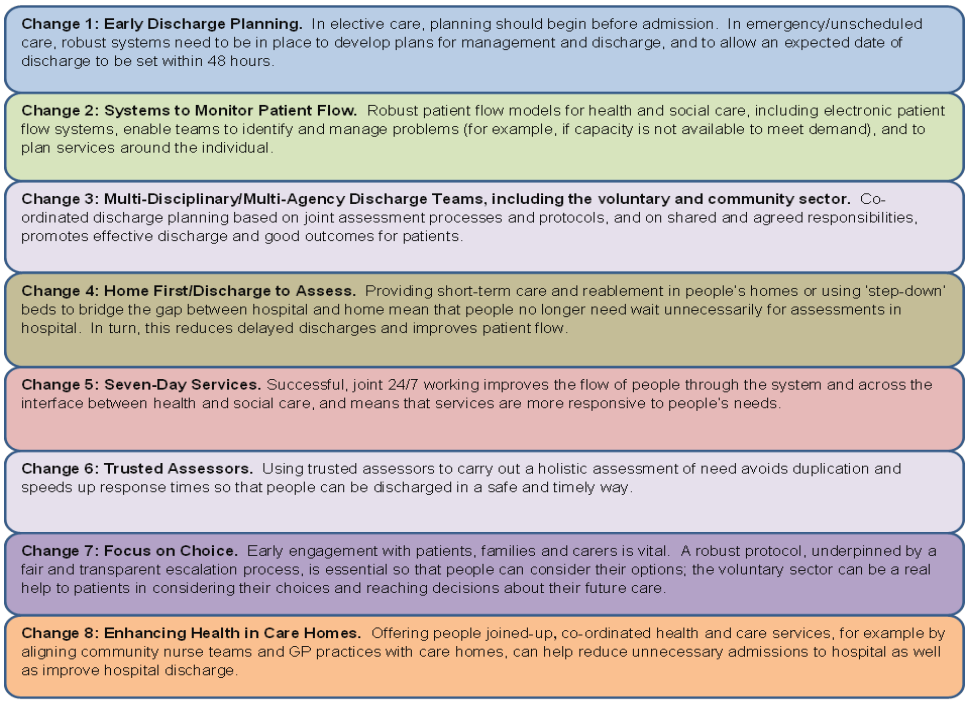
The IDT teams based around GP practices are not as advanced as we usually experience. This is particularly related to the management of patients who may require admission in the future or indeed are frequent attenders. The recent changes in the way community matron's work may bring some improvement. There appears to be a gap of focused medical support keeping patients at home in the community. Admissions from Nursing and Residential homes should be looked at specifically as the evidence base shows that this is an area where prevention of admission can have a significant impact.

The therapists across the community services may be better placed in the ICS team, which is currently struggling with lack of therapy support. It was also not clear what value the Single Point of

Access added and this will require evaluation by the SRG alongside the potential to use the Care Coordination Centre.

Recommendations:

Last winter, the Helping People Home Team (DH, DCLG, LGA, ADASS and NHS England) provided support and challenge to local systems experiencing high levels of delayed discharges.
Their work with 45 economies across England highlighted the importance of working across whole systems to ensure smooth patient 'flow' through health and care services. The work highlighted a number of interventions that were key to supporting improved performance that are listed in the table below. Our priority recommendations are focused on using this framework.



- Early discharge planning should start with Expected Date of Discharge, which should be picked up in the SAFER work stream.
- The ICS should capture unmet need and all referrals for discharge should go through them whether health or social care using the FFA. We are aware that this is work in progress and encourage its introduction as possible.
- There should be a focus on behaviour to drive a 'think home first' system wide approach – the system is currently still too reliant on bed based solutions. This should be led by the system leaders and form part of the vision for UEC.
- The delays in providing equipment needs to be reviewed and understood.
- Delays in provision of equipment should be reviewed

- The MFFD meetings should be reviewed to ensure they are fit for purpose with a view to moving the discussions back to the ward teams.

- The functions of Single Point of Referral should be reviewed, developing possible links with Care Co-ordination Centre

- Robust plans need to be in place to ensure increased domiciliary care is delivered in Shropshire by 1st December 2015.

- All organisations should work together to develop a model that introduces patient information regarding the choice policy at the beginning of the acute episode. This model should be comprehensively communicated with all staff. In many sites, we have seen a positive effect in using welcome cards, ticket home or patient passport concepts to inform the patient and family of next steps.

7. Escalation

We would recommend that the system review the overarching system escalation plan and processes to manage heightened pressures. Many areas are struggling with escalation given that operating at a red/black level has been normalised. There is a need to calibrate the system in order to introduce an effective system wide escalation.

Recommendation:

- The current operational process in managing heightened escalation needs to be reflected upon and an evaluation of the outcomes being delivered through the teleconference meetings should be completed and discussed at the next SRG. From our observation, these processes are not managed appropriately and are causing dysfunctionality in the system thus leading to fractious relationships between providers and commissioners. This is significant enough to impact on patient care. This must be resolved as an urgent priority, working to the principle that such processes are to support the system to address difficult challenges.

8. Emergency Department – Workforce

The trust is struggling with the resilience of the Emergency Departments due to significant number of consultant vacancies. The team described current pressures as unsustainable, particularly across the Consultant on-call rota. If the Trust has not previously, we advise that College support is requested for advice and guidance. The ECIP team has College colleagues as part of our enhanced offer to systems and we would be happy to arrange a facilitated session with the Trust's ED team to review current challenges and explore opportunities that have been borne out by work undertaken / recommended by the College.

Recommendations (to assist not completely resolve):

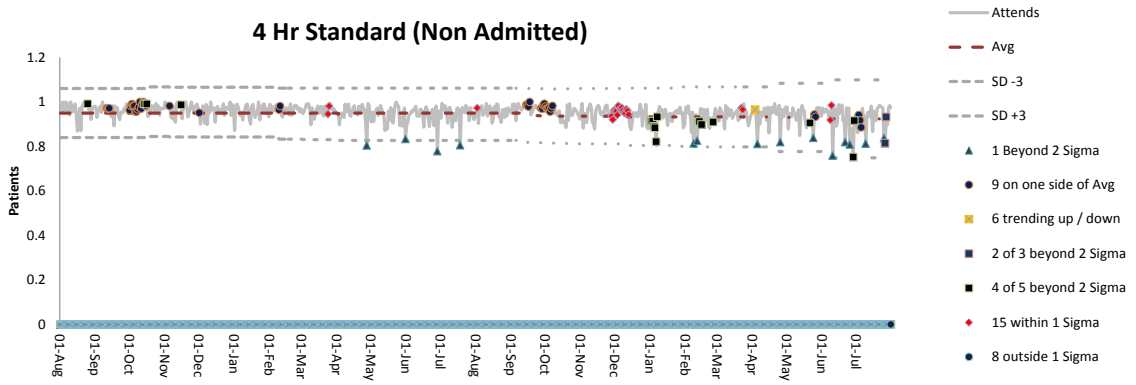
<u>ED Review Clinics</u>

- We were made aware that ED review clinics run 5 days per week across sites. This is unusual, as most EDs no longer run such clinics. The question should be asked, what can be managed in community and alternative plans sought prior to winter to release the ED senior clinical resource to care for on the day unplanned emergency presentations?

Enhance the level of ANP / ENP workforce in ED

- It was encouraging to see the ED utilise the ENP / ANP roles following recent investment. It is apparent that further opportunities are available to enhance this workforce and it would be in the Trust's best interest, given challenges in recruitment across other senior decision making roles in ED, to review options to increase pace to bring additional ENP / ANPs on line. This would also support addressing performance variation across the Princess Royal ED non-admitted pathways' where it was reported that the pathway is causing issues in performance. The Trust should be aiming for at least 98% of patients being seen, treated and discharged within 4 hours across the non-admitted pathway. This needs to be continually monitored locally to understand issues and identify resolution.

Princess Royal Non Admitted 4 Hour Standard Performance:



Urgent Care Centre at Royal Shrewsbury

- We are supportive of the introduction of a co-located UCC. However, from observation and talking to clinical staff the unit is not being maximised (in terms of levels of activity that could be streamed as an alternative to ED). The streaming process needs to be reviewed at the front door. The principles of good practice that underpin a co-located ED/UCC are well described in our Safer Faster Better document. We would encourage you to make reference to this in the future development of the front door model. We would be very happy to arrange a workshop that involved commissioners, acute, primary care and UCC staff to design the most effective model for SATH and wider system.

Priority Recommendations

Of the 8 recommendations above we would wish to highlight the 5 short term priorities for the heath economy to initially focus on and these are listed below: -

- Leadership and the Development of a System Wide Vision
- Ward Processes and the SAFER patient flow bundle
- Ambulatory Emergency Care
- Interface and Discharge
- ED

Next Steps

We hope that this report has been useful. We welcome any feedback on the content/accuracy. We would like to formally thank those involved in our visit for their time and constructive discussions.

Future Support

As you are aware, we have assigned Karen Campion, Intensive Support Manager, to be your ECIP support going forward and Karen will start working with you in December 2015. It is essential we agree what support you would like from our enhanced team function to enable you to make the improvement at pace but in a sustained manner.

It must be noted that the arranged visit was stepped down at the request of the system due to the Virginia Mason visit at the Acute Trust scheduled to take place on the same week (unknown to ECIP at the time). The system requested that the visit to be reinstated at short notice which we gladly supported and assembled a team to conduct the review. Based on the short notice planning, it must be acknowledged that the system did not setup all requested meetings with key stakeholders. For example, we did not meet 111 or WMAS service leads as requested within our initial itinerary. The ECIP support is an offer that will be in place to the system up to 31 March 2016 (as a minimum). Therefore if the system feels that the initial visit did not cover a particular aspect of the UEC pathway we will commit to a visit to review this particular part of the pathway. The report does however focus on the 'high impact' priorities that the ECIP team feel that if delivered, will provide the greatest marginal gains to improve performance across the system. Whist the above highlights that some aspects of the pathway were not reviewed we did however get excellent exposure to services and staff, and remain confident that of our 'high impact' priorities should be the focus for system leads to deliver rapid and sustained improvement across UEC.

We were encouraged by the positive discussions that took place on 7th December with ECIP and system leaders particularly on the issues of leadership and the development of a system vision. We look forward to working with you over the coming months

Yours Sincerely,

Steve

Steve Christian
Head of Improvement
ECIP
Mobile: 07769 135279
E Mail: Steven.Christian@nhs.net

Karen

Karen Campion
Intensive Support Manager
ECIP
Mobile: 07917438415
E Mail: karencampion@nhs.net