NHS
Merton
Clinical Commissioning Group

Report to the Merton Clinical Commissioning Group Governing Body

Date of Meeting: 18th July 2013

Agenda No: 8.4 **ATTACHMENT 12**

Title of Document: Urgent Care Plan – St Georges	**Purpose of Report:** To Receive and Note
Report Author: Andy Smith Interim Director of Commissioning and Planning	**Lead Director:** Adam Doyle Director of Commissioning and Planning

Executive Summary:

- In response to the poor performance of A&E at the start of this year, NHS England (NHSE) required each host CCG of an acute trust with an A&E department to produce an urgent care Rectification & Improvement Plan (RIP)
- Attached is the plan for St Georges produced by Wandsworth CCG and submitted to NHSE in June 2013. Merton CCG have input into the plan.
- This plan will be developed and monitored by the newly formed Urgent Care Board consisting of all stakeholders in urgent care in the catchment area of St Georges.
- Epsom and St Helier NHS Trust Urgent Care Plan is expected to be available for review by the Governing Body at its September 2013 meeting.

Key sections for particular note (paragraph/page), areas of concern etc:
Whole document

Recommendation(s):
The Merton Clinical Commissioning Group Governing Body is requested to note the report.

Committees which have previously discussed/agreed the report:
Executive Management Team – June 2013

Financial Implications:
None

Other Implications: (including patient and public involvement/Legal/Governance/ Risk/ Diversity/ Staffing) None

Equality Analysis: NA

Information Privacy Issues: NA

Communication Plan: (including any implications under the Freedom of Information Act or NHS Constitution) NA

The Wandsworth, Merton, Lambeth and St George's Healthcare Trust Partnership – Urgent Care Improvement Plan 2013/14

Draft v0.7

Version Control			
Version	**Date**	**Author**	**Development/Edits**
0.1	22.05.2013	Kosar Parveen	Template prepared with headers/sub-headers and initial content suggestion
0.2	29.05.2013	Kosar Parveen, James Olweny, Iain Rickard	Template reviewed by Chief Officer, amendments added and final copy submitted to NHS England as 1st phase edition
0.3	06.06.2013	Kosar Parveen	1st phase edition developed further in readiness for phase 2 submission. Circulated to all partners for content
0.3	11.06.2013	Kosar Parveen	Phase 2 DRAFT submission circulated to all partners for content and amendment (CEOs and Directors)
0.4	16.06.2013	Lucie Waters	Edit
0.5	19.06.2013	Kosar Parveen	Amendments Added
0.6	19.06.2013	Graham MacKenzie	Chief Officer's Edit
0.7	25.06.2013	Kosar Parveen	Final Amendments Added

Document Approval	
Organisation/Board/Individual/Group	**Date**
Wandsworth CCG Management Team – 2nd phase edition template developed for circulation to partners	05.06.2013
All partner Boards agreement and sign-off of final plan as submission for phase 2	TBC

Contents

1. Introduction

This plan represents an overview of the initiatives and actions in progress by the Wandsworth, Merton, Lambeth and St George's Healthcare Trust Partnership, hereafter to be referred to as the 'Partnership' and the members of which are as follows:

- Lambeth Clinical Commissioning Group
- Merton Borough Council
- Merton Clinical Commissioning Group
- NHS England (Specialised and primary care commissioning)
- St George's Healthcare NHS Trust
- Wandsworth Borough Council
- Wandsworth Clinical Commissioning Group

These organisations are working in partnership to maintain and improve the performance and quality of the urgent care pathway for patients within the South West London region.

The plan has been prepared by the Partnership in response to both the generic guidance issued from NHS England, as well as the specific feedback received in response to the first submission made on 31st May 2013, where the Partnership were required to respond to four areas.

This second submission answers these four areas and has been developed with the involvement of Wandsworth Borough Council and Merton Borough Council, who are actively involved in improving the urgent care pathway for patients via strong community and hospital discharge work and plans.

At this stage (19th June 2013) the plan represents a second draft and focuses primarily on the immediate priority of sustaining performance against the A&E 4 hour operational standard throughout 2013/14 and the associated planning for the winter period ahead.

Based upon St George's recent performance we do not regard the Trust and local health economy as being in recovery in respect of the 4 hour A&E target. We do however recognise the importance of maintaining our strong collaboration across agencies to continue to both sustain and improve our local performance.

The final version of the plan will expand on the overall patient pathway for urgent and emergency care both within and outside the hospital environment and across the neighbouring boroughs and CCGs served by St George's, notably in Merton and Lambeth.

The finalisation of the plan and on-going implementation and performance management will be overseen by a newly established Urgent Care and System Improvement Board for St George's and the local health and social care economy, chaired by Dr Nicola Jones, Clinical Chair of Wandsworth Clinical Commissioning Group. The Board will be the primary local forum for the whole systems strategy, planning and partnership in relation to whole system sustainability, resilience and capability.

2. Background and Context

Nationally there is immense pressure on the urgent and emergency care systems, notable as present during summer months and before expected additional winter pressures. In some areas of England this has had an impact on the achievement of the operational standard for A&E which is that 95% of patients must be admitted, transferred or discharged

within 4 hours. The A&E operational standard is designed to deliver patients' rights under the NHS Constitution.

In 'Everyone Counts: Planning For Patients 2013/14' NHS England reinforced the NHS Constitution commitment and as such have requested that those CCGs with hosting responsibilities for A&E departments on their patches produce *sustainable* plans; this is part of NHS England's approach to achieving CCG Assurance.

3. Executive Summary

The Partnership recognises the importance of multi-agency planning and coordinated preparation to maintain and improve the quality and performance of urgent care services for local patients. In particular we are committed to a collaborative and managed approach for addressing the additional pressures placed upon A&E during the winter season and other periods of high demand.

Our collaborative approach and range of service improvement initiatives within and outside of the hospital environment have supported St. George's to achieve the A&E four hour standard in 2012/13. An example of the approach of partners is the introduction of the primary care led Urgent Care Centre at St. George's in 2012, which has enabled a significant number of patients to be redirected from A&E to see their own GP on the same day.

This plan describes the initiatives and actions in place across all partners, to ensure that preparation is robust and processes are in place that can adapt to pressure surges as and when they arise. The detail of the range of initiatives in progress both within and outside of the hospital environment are summarised in the spreadsheet presented as Appendix 1.

A crucial element of our joint response will be complementary, integrated contingency arrangements to handle peaks in demand and unforeseen circumstances in conjunction with performance reports on key metrics, which will be used to monitor pressure in the system and identify areas requiring additional support to maintain performance.

The pressures posed by winter and other periods of high demand can be unpredictable. Whilst the A&E 4 hour standard at St George's was maintained at 95.3% for Type 1 and 96.0% for all types during 2012/13, there were episodes of challenging performance as a result of a multitude of factors including:

- The tendency towards a more complex/dependent case mix
- Reductions in timely discharge of patients, including delayed discharges and repatriations
- Peaks of unplanned staff absence due to sickness
- Increased demand for services due to higher levels of infection within the community
- Increased demand for emergency care in most specialities
- The consequent impact of a number of these on reduced elective capacity and potential ward closures

Extra demands on services during winter impact upon all parts of the NHS including primary care, ambulance and acute hospital services, such as accident and emergency, critical care, medical inpatient beds and social care. This plan and the preparation of all partners for the approaching 2013/14 winter are developed by the Partnership.

The finalisation of the plan and the on-going implementation and performance management will be overseen by a newly established Urgent Care and System Improvement Board for St George's and the local health and social care economy. The Urgent Care and System

Improvement Board will ensure that health and social care systems are prepared and coordinated to respond to the increased needs and/or service demands through the winter period and maintaining resilience during other periods.

4. Patient Journey Through the Emergency System – The 3 phases and associated actions to manage attendances

St. George's Healthcare NHS Trust has been identified as an exemplar site for service improvement and has been awarded funding, to carry out a wide range of service improvement projects based around Lean Methodology across the whole hospital system.

There have been a number of initiatives commissioned by partner organisations under the Quality, Innovation, Productivity and Prevention (QIPP) Programme, which have been audited and proven to reduce pressure on secondary care in terms of A&E attendances, emergency admissions, outpatient attendances and length of stay.

The QIPP projects include but are not exclusively limited to the Community Ward, Falls and Bone Health, GP Referral Management, Admissions Avoidance for Harmful and Hazardous Drinkers, the Urgent Care Centre and Self-management programmes for patients with Long Term Conditions. It is anticipated that these projects will reduce A&E attendances, and we will be able to directly attribute a reduction of 6000 A&E attendances, 1000 admissions, 1100 occupied bed days and a potential increase of 500 out-patient appointments to these schemes. The QIPP plans are all three year plans which commenced this in 2012/13 and we expect the full benefits in 2013/14 and 2014/15 onwards.

Both Wandsworth and Merton Social Services Departments are top quartile performers nationally for Delayed Transfers of Care (DToC). Performance reports for 2012/13 show that for social services only DToC, that Wandsworth Borough Council was ranked 16th and London Borough of Merton was ranked 21st out of the 152 boroughs.

Wandsworth Social Services have the lowest delayed transfer of care rates in London for non-health related reasons. Even when health related reasons are added, Wandsworth remains in a strong position (fourth within London). There are a number of successful initiatives currently running (provision of step-down, non-acute nursing beds) which have been piloted (24 hour live-in care) which has been audited and proven to have significantly reduced length of stay and re-admissions. Routinely, Social Services successfully expedite transfers of care through integration of staff into the STAR team at St. George's, the Intermediate Care Bed Based Team and the Community Ward. Additionally, social care staff are involved in the assessment and development of care packages for patients at a very early stage in the discharge planning process.

4.1 Patient journey PRIOR to A&E – Managing A&E Attendances

A range of best practice programmes are in place to support management of demand:

- Self-Management programmes
- Integrated community care, End of Life Care (avoidance of inappropriate admissions for this group of patients) and falls prevention, management and bone health for frail and elderly patients
- Support for carers
- Enhanced management of patients with long term conditions in primary and community settings - including COPD, Diabetes, Heart Failure and Coronary Heart disease, including specialist training for practice nurses to deliver this

- Community Ward with input into MDT from Senior Health Consultant, Specialist Nurses, Advanced Nurse Practitioner and Social Care to manage complex cases in community more effectively
- Local Enhanced Services to support A&E including enhanced GP access, action plans to reduce A&E attendances and promote joint working with secondary care
- Re-configuration of GP Out of Hours community clinics at Brocklebank and Balham Health Centres
- Using NHS 111 as an alternative to A&E and Urgent Care and to manage the flow of patients into A&E

4.2 Patient journey THROUGH the hospital – Pathways and Capacity

St George's Healthcare NHS Trust has a noted programme of process transformation:

- Partnership working with London Ambulance Service to avoid handover delays and understand flows of patients into A&E
- Improvement project at St. George's to widen the provision of ambulatory care services
- Improving flow through the Urgent Care Centre by reviewing triage processes and skill mix
- Improving flow through A&E by ensuring robust pathways are in place for patients with specialist conditions and that regular reviews are carried out by AMU and Specialty Consultants
- Managing capacity by reviewing bed availability, discharge planning and flexing bed capacity between urgent and elective patients during business as usual and times of surge
- Ensuring provision of services for specific groups of patients, including sick children and patients with mental health, alcohol and substance abuse issues
- Acute Coronary Syndrome pathway
- Heart Failure and Atrial Fibrillation pathways in development
- Integrated information management systems to facilitate working between health organisations and with social care

4.3 Discharge and out of hospital care using the framework set out in *Delivery of the A&E 4 hour operational standard (Gateway 00062)*

All partners are working collaboratively on effective and efficient discharge arrangements:

- Ensuring robust models for discharge planning, including removing bottlenecks in patient flows, ensuring accommodation is available for patients awaiting discharge and that all mechanisms are in place for discharge (Prescriptions, Transport, etc.)
- Working to agreed length of stay targets for specialties and minimising delays in transfers of patients to social care.
- Providing step-down capacity in the community settings to facilitate discharges and prevent re-admissions.

5. Urgent Care System Improvement Board

The Partnership has developed an 'Urgent Care & System Improvement Board'.

5.1 The remit of the Board will be to ensure that:

- Clinical and senior leadership is maintained across the health and social care system to consider the drivers for and responses to, increases in urgent care demand.

- There is a long term commitment to continuous improvement ensuring that high level focus continues as well as an integrated approach across CCGs, health and social care, commissioners and providers, leads to sustained improvement in quality, performance and affordability in the medium to long term.
- Through shared analysis and data review, there is a common understanding of the barriers to improved performance and agreement on the priority actions.
- There is a clear delivery programme with effective monitoring of the implementation and evaluation of the impact.
- Resources to support urgent care performance are identified and managed on a collaborative basis across the health and social care economy, including oversight of the use of the 70% funding retained from the excess urgent care tariff.
- Links the work on Urgent Care and integrated approaches to care out-of-hospital to the SW London Strategy Programme 'Better Services, Better Value' (BSBV) to ensure that trajectories for urgent care are met.

5.2 Membership

The Urgent Care and System Improvement Board will bring together all the members of the Partnership as follows :

1. Lambeth Clinical Commissioning Group (LCCG)
2. Merton Borough Council
3. Merton Clinical Commissioning Group (MCCG)
4. NHS England/London/South Area Team/Primary Care (NHSE)
5. NHS England/London/Specialised Commissioning (NHSESp)
6. Royal Marsden NHS Foundation Trust – community provider arm (RMH)
7. St George's Healthcare NHS Trust/integrated acute and community (SGH)
8. Wandsworth Borough Council
9. Wandsworth Clinical Commissioning Group

Colleagues from other agencies e.g. South West London and St George's Mental Health Trust, London Ambulance Service, Lambeth Council, may be invited to attend the Board when relevant to the issues under discussion.

Discussion has been held with the Chief Executive of London Ambulance Service as to the best way to service the Board: this may be easier to judge following Board direction on the priorities for action arising from the first Board meetings.

The Urgent Care and System Improvement Board will be chaired by Dr Nicola Jones, the Clinical Chair of Wandsworth CCG. Membership will comprise senior representatives of each of the organisations at Clinical lead, Chief Officer or Director level. There will be a high level of clinical leadership and engagement on the Board both from within the Trust and from commissioning organisations.

5.3 Key Tasks and Responsibilities

The key tasks of the Urgent Care and System Improvement Board will be to ensure that the full range and responsibilities of an Urgent Care Board are fulfilled, with a focus on longer term sustainability, through ensuring:

- Each of the partner arrangements has strong 'Risk and Issues Management' plans in place and the Board will oversee these plans

- Leadership capacity and expertise is in place to manage urgent and emergency care issues within the health economy
- Leadership capacity and expertise is in place to undertake rapid data review and share findings with key stakeholders
- Identification and agreement on key priorities to achieve sustained improvement
- Resources are in place (senior leadership, external support, commissioned capacity) to accelerate proposed improvements
- Effective programmes are in place to deliver sustained improvement, holding partners to account for delivery of each part of an integrated approach
- Learning from programme delivery and performance information is shared across programmes, and a further programme of continuous improvement
- The impact of successes and challenges in integrated working are considered and to propose new ways of facilitating integrated care are proposed
- Relating outcomes of the programme work streams to the BSBV modelling assumptions, engage the BSBV team as appropriate.

5.4 Performance Management

The Board will monitor performance across the urgent care system using a dashboard of metrics covering all elements of the system. Agreement of metrics will be a key task of the first Board meeting, but is expected to include the following metrics:

Whole System Urgent and Emergency Care Metrics

PRIOR TO A&E	
% Cat A ambulance performance (8 minutes)	Currently available via UNIFY & NHS England – London Region
Ambulance Conveyance rates	Available weekly via NHS England – London Region
LAS usage of ACP resources	TBC
Ambulance handovers >15 minutes	Available from HAS system via CSU and in weekly NHS England – London report.
Primary Care Access measures	24 & 48 hour access targets. Availability of data TBC as may no longer be routinely measured. No. of appointments available to be booked by UCC.
GP Out-of-Hours performance	Provision and uptake of out-of hours service.
111 Service Performance measures	Data available via UNIFY: Calls answered, calls transferred to clinician, call-backs
HOSPITAL SYSTEM	
St. George's 4hr Type 1 Performance	Available daily via CMS
UCC Performance	UCC activity available monthly via SUS. UCC subject to same 4 hour wait target as main ED.

UCC Adult and Paediatric split	UCC activity available monthly via SUS and can be analysed by age or patient category.
% patients seen in 4 hours at Type 3 services	Data for Minor Injuries Unit at QMH available monthly via SUS.
A&E Department Attendances	Available daily via CMS
A&E Admissions (total)	Available daily via CMS
GP Admissions	Emergency admissions from GPs available via SUS
Mental Health 4hr breaches	Available daily via CMS
MIU Attendances (Type 3)	Data for Minor Injuries Unit at QMH available monthly via SUS.
St. George's Bed Occupancy	Available daily via CMS
Non-elective length of stay	Available monthly via SUS
Zero Length of Stay Admissions	Available monthly via SUS
Readmission rates	Available monthly via SUS
Mortality rate.	Available via Public Health by disease area. However, may only be available annually.
DISCHARGE & OUT OF HOSPITAL	
GP-Led Health Centre Attendances	Data should be available from identified centres.
Crisis Response Times	Available from Mental Health Trust
Intermediate Care Measure	Requirements to be defined around capacity
Community Care measures	Requirements to be defined around capacity
Discharges from St. George's by time of day	Available from St. George's (If currently compiled and published)
Delayed Transfers of Care	Available via UNIFY
Community bed occupancy	Could be supplied by Community Bed Providers
Care Homes data	Requirements to be defined around capacity
Disposition to institutional care	Available via SUS

5.5 Programme of Work and Board Structure

The programme of works are at present being agreed across the Partnership and as such the following workstreams are currently in draft form. There may possibly be *two distinct* or *three distinct* areas of work based on the following three workstreams;

1. Admissions
2. In hospital processes
3. Discharge processes/procedures, as detailed within Section 6.1

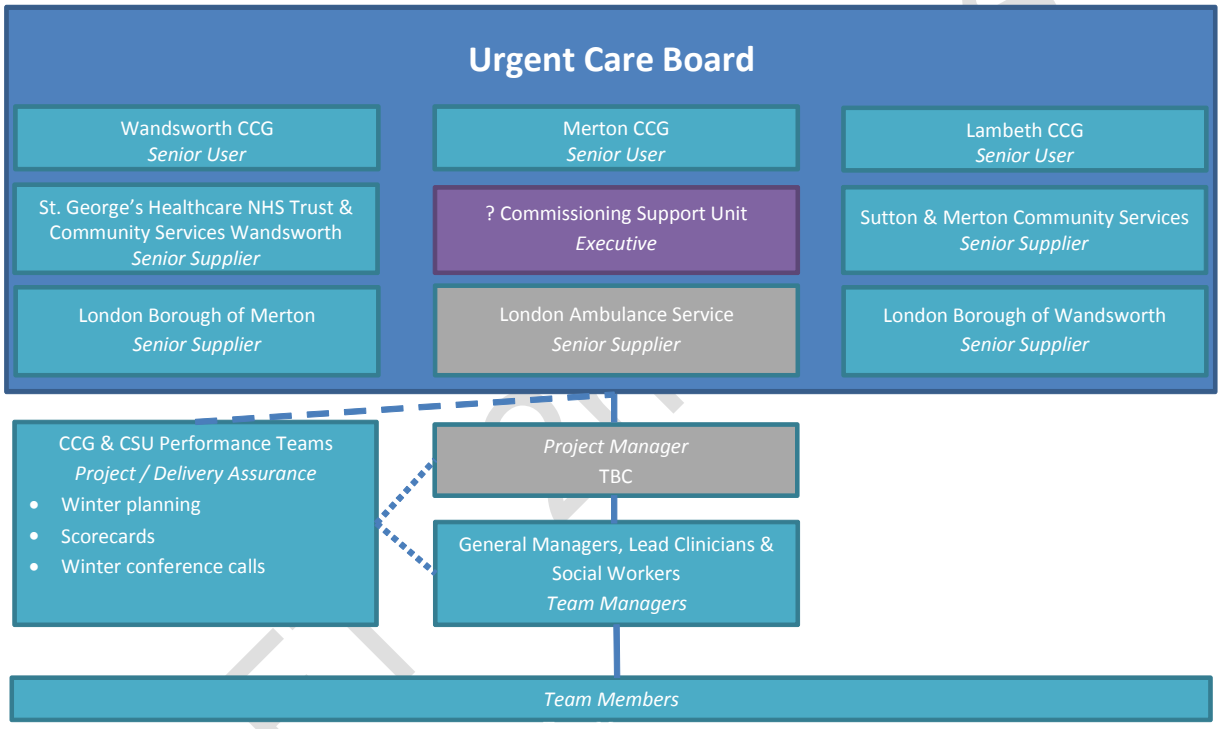
Alternatively the Partnership may decide that there will be two distinct programmes of work, as follows:

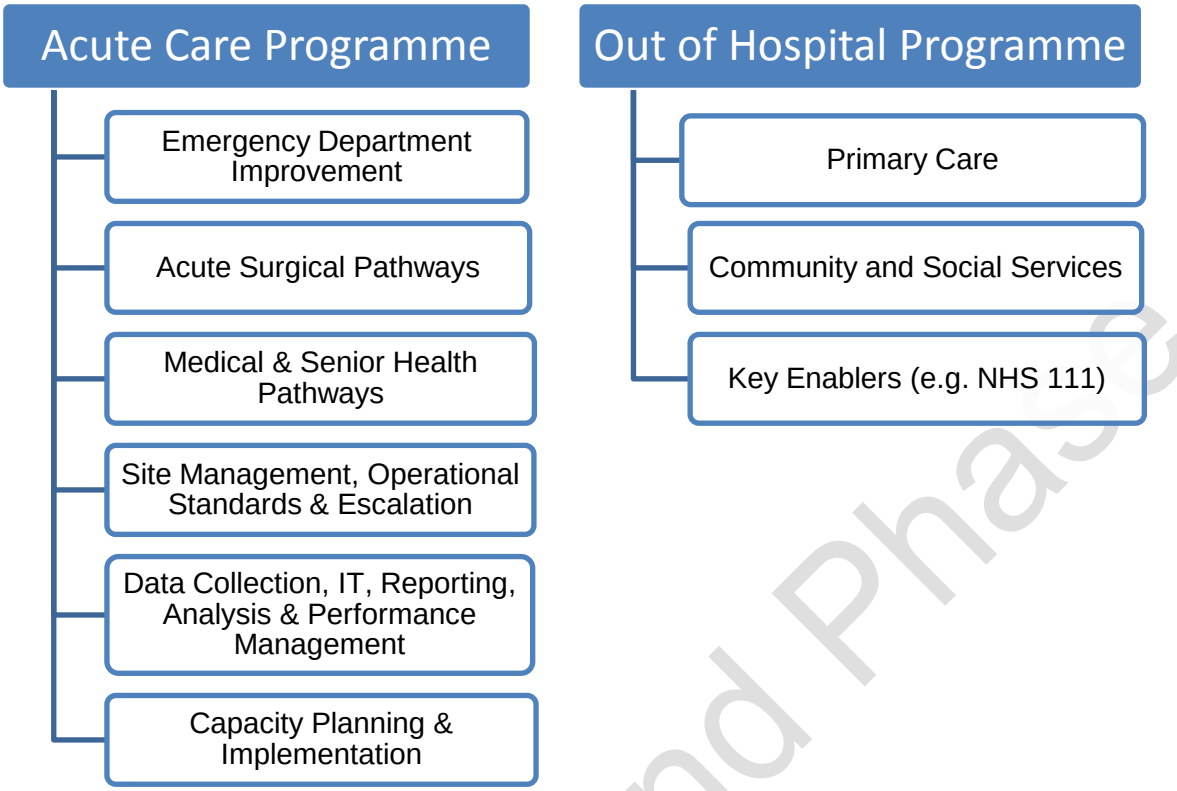
1. Acute hospital based care
2. Out of hospital Services

Each programme and workstream will have a designated SRO as well as a clinical lead.

The diagram below is an indicative draft version only and the Partnership will be agreeing the full structure at subsequent meetings.

Urgent Care and System Improvement Board – DRAFT Board Structure





5.6 Terms of Reference

The draft terms of reference will be agreed during the initial meetings of the Urgent Care and System Improvement Board.

6. Urgent Care Improvement Plan

The plan provides assurance to NHS England and evidences the strong performance of the South West London regions A&E departments.

The Urgent Care Improvement Plan details the three key stages of the patient pathway through the A&E and urgent care system and focusses upon improvements which can be made at each stage of the journey detailed as follows.

1. The patient journey prior to A&E
2. The patient journey through the hospital
3. The patient journey at point of discharge and out of hospital.

The section on prior to A&E covers improved provision for the needs of elderly and frail patients; ensuring appropriate care is provided in a community setting for patients with long term conditions; providing sufficient capacity in the Community Ward; improving access to General Practice to divert patients from A&E and ensuring sufficient surge capacity in out of hours and NHS 111 services.

The hospital system section considers improved joint working between St. George's and London Ambulance Service to improve the patient handover process and better understand patient flows into A&E; Provision of a range of ambulatory care services to appropriate patients to reduce A&E attendances and emergency admissions; Improving

efficiency of patient flows through the Urgent Care Centre and away from A&E and ensuring there is sufficient skill mix in the Urgent Care Centre to provide for as many groups of patients as possible; Improving patient flows through A&E by establishing pathways for patients with complex conditions; Ensuring there is sufficient senior medical cover in A&E to make treatment decisions and prevent admissions where possible; Ensuring that there is sufficient bed capacity and discharge planning in place to accommodate elective and non-elective patients during business as usual and the winter period and that there is provision for specific groups of patients with complex needs, including children, those with mental health issues and alcohol and substance misusers.

Finally, the Discharge and Out of Hospital section details how bed management processes can be improved to allow the Trust to predict bed usage, balance elective and emergency admissions and ensure that all patients are accommodated in the appropriate parts of the hospital; Discharge planning is examined to ensure that any bottlenecks are reduced as much as possible and that resources such as transport and packages of care are provided for patients leaving hospital; Delays in transfers of care are as minimised through discharge planning soon after admission and liaison with Social Services and other providers; Sufficient medical cover is provided on specialty wards and that there is support from Community Services Wandsworth to minimise avoidable and admissions and delayed transfers of care.

6.1 Emergency Care Intensive Support Team (ECIST) – Local Services Report

We are expecting ECIST to hold a series of workshops on urgent care to which all members of the Partnership will participate in. All CCGs are expected to include the findings of their ECIST report in their final winter plans, due later in the year.

7. Performance Overview

7.1 Current Position – Overview of Performance & Plans for 2013/14

A&E Performance at St George's is continuing to improve. At the end of April 2013, St George's weekly average is above the 95% operational standard for Type 1. The YTD position also shows that the Trust is on track to meet its annual 95% standard. There has also been a significant improvement in the ambulance handover times with no 60 minute breaches reported during May 2013 and relatively small numbers of patients waiting over 30 minutes.

The A&E department has recently undergone a full scale refurbishment and modernisation, and was officially opened by Dame Ruth Carnall, Chief Executive of NHS London in January 2013. This improved a number of areas including:

- The children's emergency department which has been expanded to include a new space for a combined walk-in and minor Paediatric injuries service
- A new Paediatric majors area where children with more serious injuries are treated
- A new Paediatric Assessment Unit, which is a short stay area for children who need short stay observation or are awaiting investigations, but do not need to be admitted
- The Clinical Decision Unit (CDU) has been expanded creating more capacity, and has been kitted out with improved facilities which mean a better patient experience. The CDU is for those who require planned investigation and treatment for a period of no more than 24-36 hours
- Additional space for the Urgent Care Centre (UCC) which provides treatment for minor illnesses and injuries like strains, bites, burns, infected wounds or chest infections

- A new reception, waiting room and triage area

St George's is working on plans to increase inpatient bed capacity at the Tooting site to ensure they are able to respond to peaks in demand for emergency admissions. A winter ward will be opened for the winter period in 2013, and an additional 15 extra inpatient beds are also due to be opened in December 2013. This is to ensure there are sufficient inpatient beds available for patients being admitted through A&E, whilst the trust continues to deliver elective work. Furthermore six extra general critical care beds are due to open in the last quarter of the 2013/14 financial year.

Significant demand and capacity planning, at a specialty level, has been undertaken by St George's and will be a key input to the Urgent Care and System Improvement Board. The Urgent Care Board will ensure that consideration of 2012/13 bed base, learning from 2012/13 and projections for 2013/14 are inputs to early Board meetings, to inform winter planning.

The local actions and initiatives by Wandsworth CCG, St George's Healthcare Trust and partner agencies across the urgent care pathway, both within and outside the hospital environment are summarised in Appendix 1 attached to this report.

The main areas of action are profiled against the three stages of the urgent care pathway in Section 4 from p5 onwards.

7.2 Reflections from 2012/13

In recent years, numbers of patients attending A& E at St Georges has risen from 100,522 in 2007/08 to 120,836 in 2011/12 – a 20% increase in activity over a 5 year period. However, attendances in A&E started to reduce from July 2012 when the Tooting Walk-In Centre (TWIC) closed, and the Urgent Care Centre then opened in October 2012. Attendances have remained lower each month from July 2012 onwards and are lower than the numbers of attendances experienced from April 2012 to June 2012.

Between 2011/12 and 2012/13 St George's saw a drop of approximately 15,500 attendances, comparing the A&E with TWIC attendances to A&E with UCC attendances. Implementing the UCC has enabled the trust to better manage the flows of patients attending A&E at any one time, and to give patients the most appropriate care for their clinical condition. Additionally St George's and CCGs have been working together to ensure that patients for whom A&E may not be the most appropriate care setting are redirected back to Primary Care.

Whilst the attendance numbers have been reducing, there has been a shift in the type of case mix presenting from a lower proportion of the "minors" type and a higher proportion of patients with a higher acuity, which require emergency admission.

Partner organisations were involved in developing the local 2012/13 winter plans as well as health system surge planning arrangements, in partnership with all key stakeholders within the wider health and social care community.

The 2012/13 winter planning process built on winter plans from previous years and took into account the lessons learnt from 2011/12. Planning assumptions for potential winter demand at St George's Healthcare Trust were considered using the latest position on underlying demand for activity and potential growth from 2011/12 baseline for emergency admissions. Bed capacity, incorporating both acute and community service, levels of occupancy and average lengths of stay were also factored into the modelling.
There was no indication from the historical analysis of the infection data that the levels of Norovirus in the health community would be any different from the previous year.

The attendance levels and admissions at the Trust for most of the winter 2012/13 were within expected levels, but there were days where levels spiked above plan, impacting on performance. The pattern of attendances across the week remained a mirror image of the previous year, with Monday showing as the day of the week which consistently has the most attendances. The Trust was below the 95% for type 1 in November, December, February and this can be correlated to the increased levels of acuity, resulting in longer lengths of stay, delays in transferring care, including repatriations to other hospitals and intermittent loss of beds due to Norovirus outbreaks. Another contributory factor was the potential need for more inpatient beds at the Tooting site for emergency admissions. Whilst the volume of available beds within the Trust was at a lower level than in previous years, additional beds were opened to cope with pressures.

Performance in Q4 was assisted by additional winter funding to support the Trusts remedial plans to improve patient flow and recover performance during periods of peak demand. Performance was monitored and managed through weekly conferences calls against emergency and urgent care standards including A&E wait times and ambulance handover.

The 2012/13 year-end achievement against the A&E 4 hour standard was 95.3% for type 1 and 96.0% for all types.

7.3 Winter Planning 2013/14

The Department of Health highlights eight key areas that are vital to ensuring all services and winter planning arrangements across local health and social care systems are well coordinated, responsive and resilient:

1. Ambulance handover times
2. Operational readiness
3. Out of hours arrangements
4. NHS/Social Care joint arrangements to prevent/avoid admissions and facilitate early discharge
5. Links between the London Ambulance Service, Primary Care, CCG's and NHS Trusts
6. Critical care services
7. Preventative measures
8. Communications

Measures are being actively taken to manage risks associated with each of these key areas and to ensure mitigation strategies are included in plans across the whole health economy.

An evaluation of the effectiveness of the winter planning process and allocation of additional funding during 2012/13 is being carried out. The CCGs will work with its health and social care partners to ensure that the lessons learnt from winter 2012 are built into the 2013/14 plans to enhance a whole system resilience capability. The overriding objectives for 2013/14 are to maintain safe, high quality services for patients, including the effective management of infection, Emergency Department access, ambulance turnaround times, urgent and other elective treatments. The plans for 2013/14 will not simply be designed to last just a few months, but will be an integral part of a long-term local strategy and the commissioning of responsive services that meet patient need.

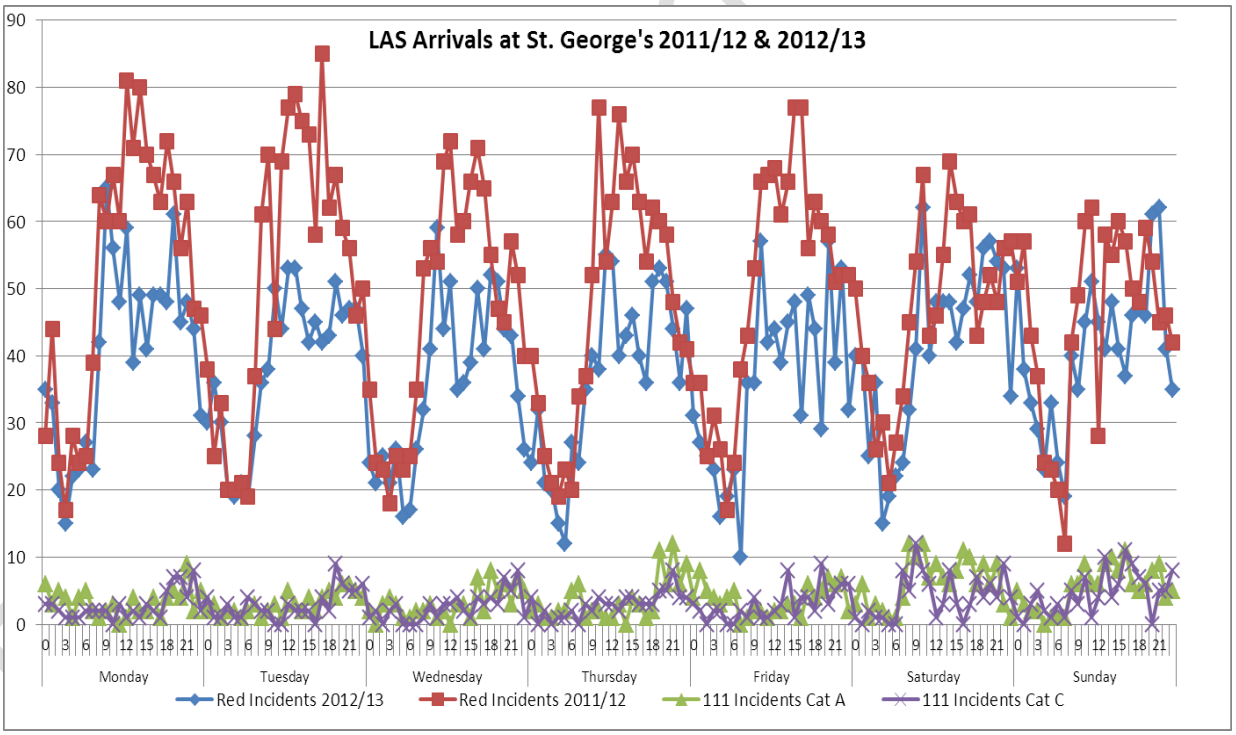
The 2013/14 winter plans aim to assure continuity and successful response of essential services at times of high demand and to enable effective contingencies to be initiated on a planned and managed basis. They will be constructed in the context of the need to ensure sustained performance across the whole system. The Partnership will work together

through the Urgent Care System Improvement Board to ensure the whole health economy understands and addresses the identified pressure points.

Winter pressure management is provided by the South London Commissioning Support Unit on behalf of the CCGs in South London. The main information flows / communication channels in use to manage risks and issues are as follows:

- Daily reporting of performance against the 4 hour target.
- Daily reporting of capacity pressures via CMS. The CMS system provides a score reflecting the severity of pressures on bed and A&E capacity. Increasing scores trigger increasing levels of escalation and management.
- Weekly exception reports produced by Trusts not meeting 95% target for a particular week. These reports detail the nature and magnitude of pressures and actions proposed to address them.
- 2 x weekly conference calls. One between acute trusts, CCGs, CSU, NHS England, LAS and others to summarise weekly performance and agree actions to address any issues identified. Second conference call between CSUs and NHS England.
- Feedback provided from weekly conference call to CCG Exec / Management Teams.

7.4 Performance Graphs



LAS Arrivals at St. George's

The graph above breaks down ambulance arrivals at St. George's A&E department by type and hourly, over a typical week and compares 2012/13 activity with 2011/12.

Summary

Overall, the numbers of 'peak' incidents are lower in 2012/13 than in 2011/12. The reduction in arrivals is most noticeable during normal working hours, when alternatives to A&E are most

often available. There has been little change in out of hour's activity performance. One key workstream for the Urgent Care Board to consider is whether improved out of hours provision could reduce the number of arrivals by ambulance further and ease pressure on the system.

Category A & C calls from NHS 111 since its launch have also been included. As expected, there are more arrivals of this type during out of hours. However, the total numbers are small and therefore unlikely to have put significant pressure on the A&E/Urgent Care System.

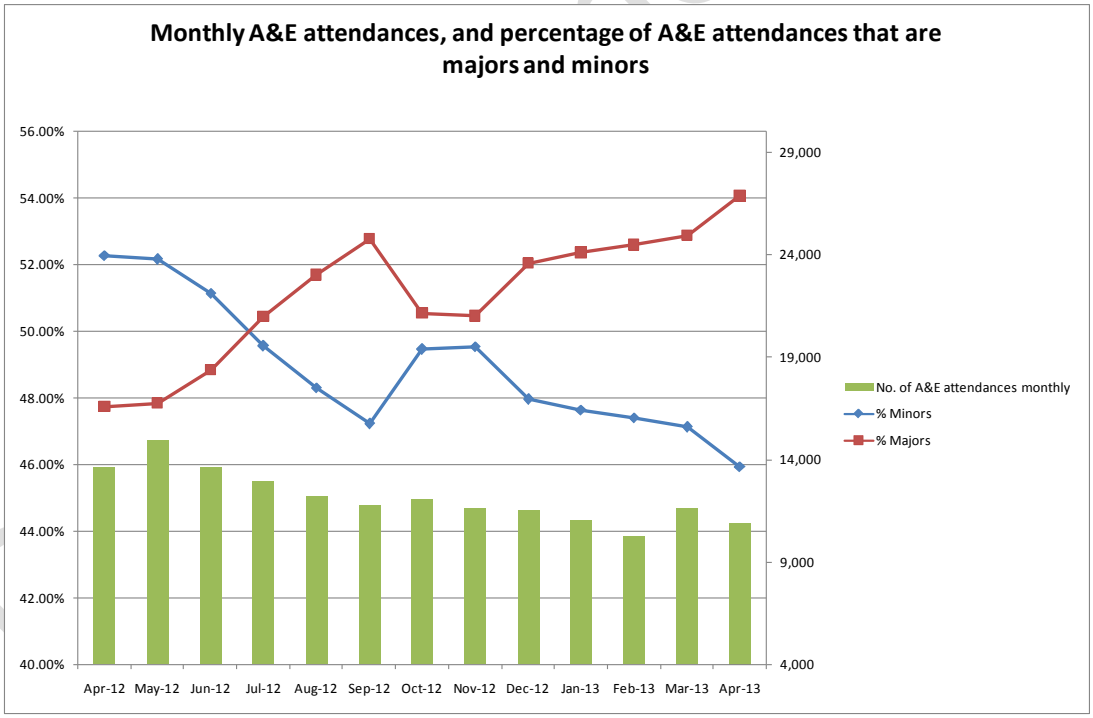
Acuity of Patients in A&E

The graph on the following page shows number of A&E attendances for Wandsworth residents and the percentage of these that are Minors and Majors between April 2012 and April 2013

Summary

There has been a reduction in A&E attendances from July 2012, at which point the Urgent Care Centre opened and appropriate patients were diverted from the UCC to their local GP or other services.

July 2012 also saw a switch in proportions of minor and major patients. St George's is experiencing a lower proportion of minors and a higher proportion of attendances from patients with a higher acuity, who still require emergency admission.

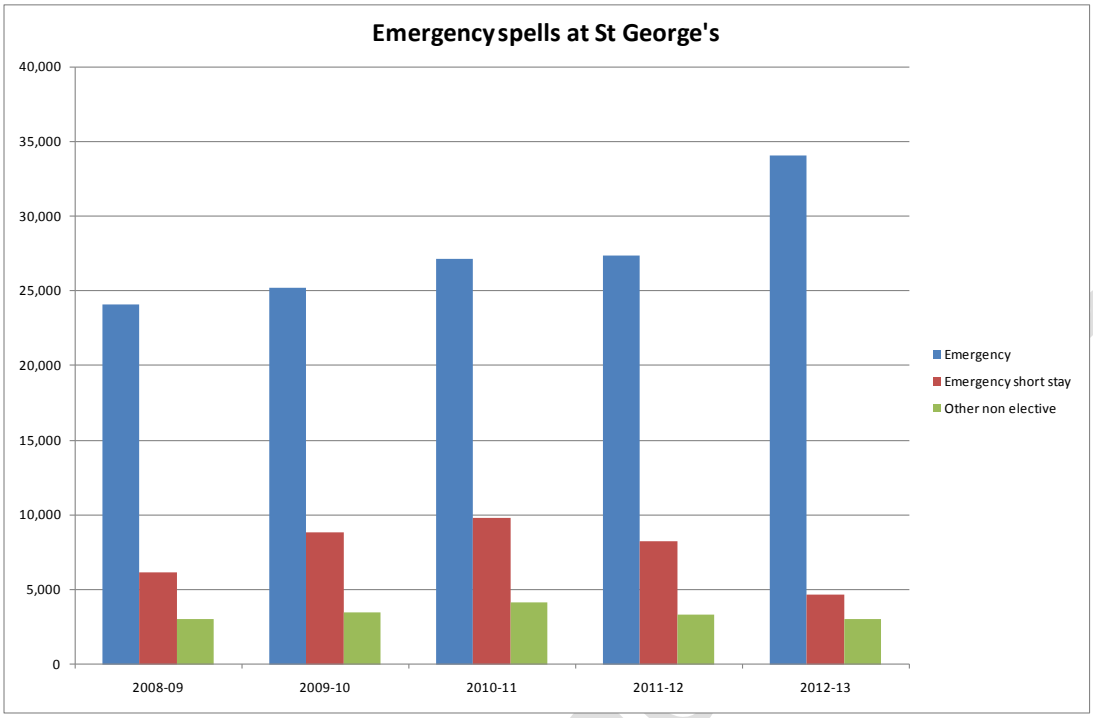


Emergency Spells at St. George's

The graph on the following page shows the increase in emergency spells at St. George's. This represents Wandsworth resident patients admitted via the Emergency Department.

Summary

This demonstrates an increase in patients attending the Emergency Department requiring admission and also a decrease in emergency short stay activity, a proxy for increased complexity of patients admitted.



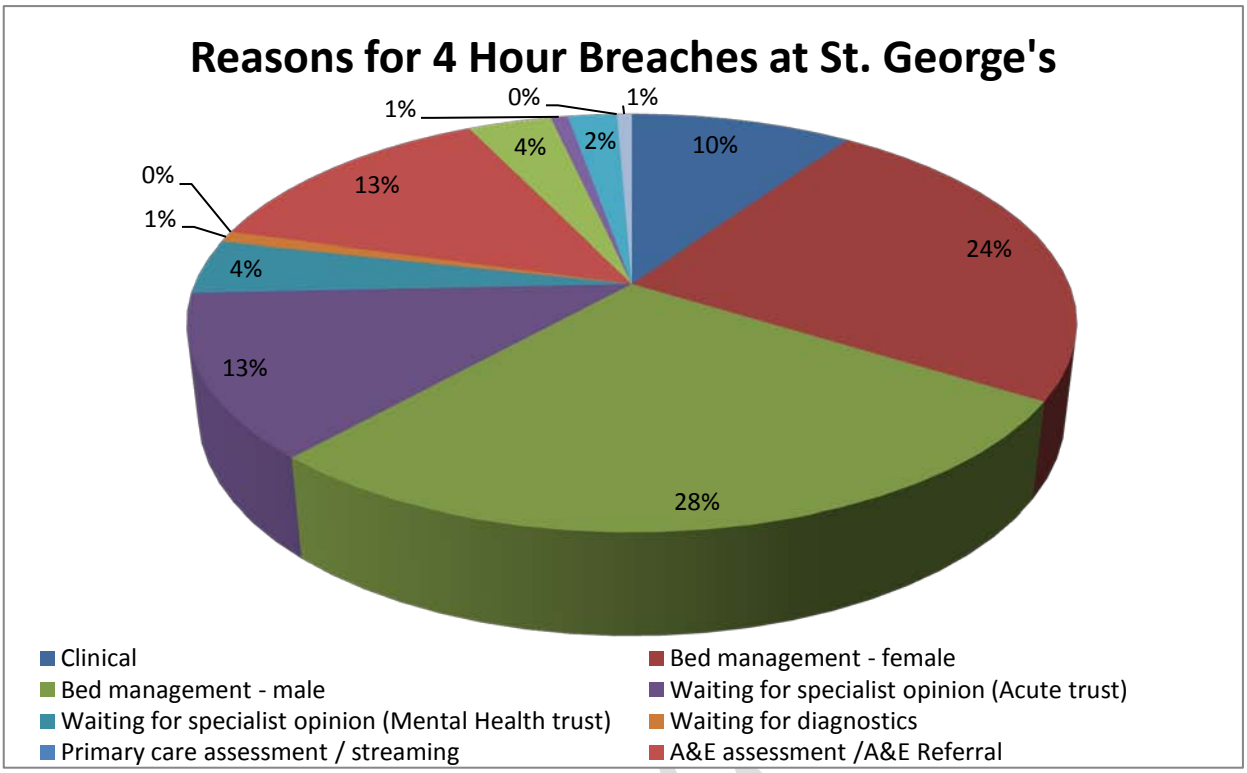
There are complex factors driving these changes but key drivers are considered to be demographic changes, the fact people are living with chronic long term conditions, and life style choices which have an adverse impact on health. The fact that St Georges is a Major Trauma Centre and is one of the eight Hyper Acute Stroke Units in London means that they are more likely to receive higher number of patients requiring emergency treatment.

Reasons for 4 Hour Breaches at St. George's

The pie chart on the following page highlights the main reasons given for patients breaching the 4 hour wait target at St. George's during Winter 2012/13

Summary

This data is taken from 4 exception reports submitted by St. George's when the 95% target was not met. 52% of breaches were due to bed management within the Trust, with a further 26% of patients delayed waiting for assessment in the Emergency Department or by Specialty teams.



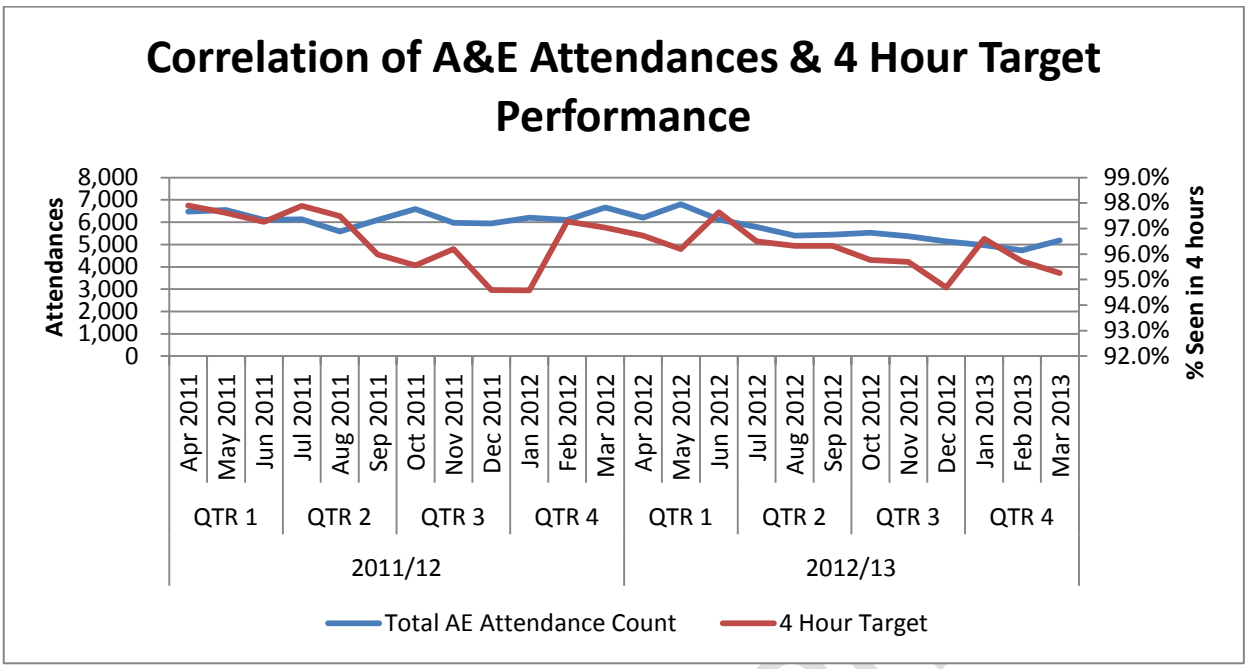
Correlation of A&E Attendances and the 4 Hour Target Performance

The graph below shows attendance numbers and performance against the four hour target in 2011/12 and 2012/13.

Summary

Comparing the two winter periods, total attendances were down in 2012/12 compared to 2011/12. However, performance against the 4 hour target was also down.

This supports the suggestion that the acuity of patients is greater, when read alongside the graph showing attendances and percentages of patients seen in minors and majors.



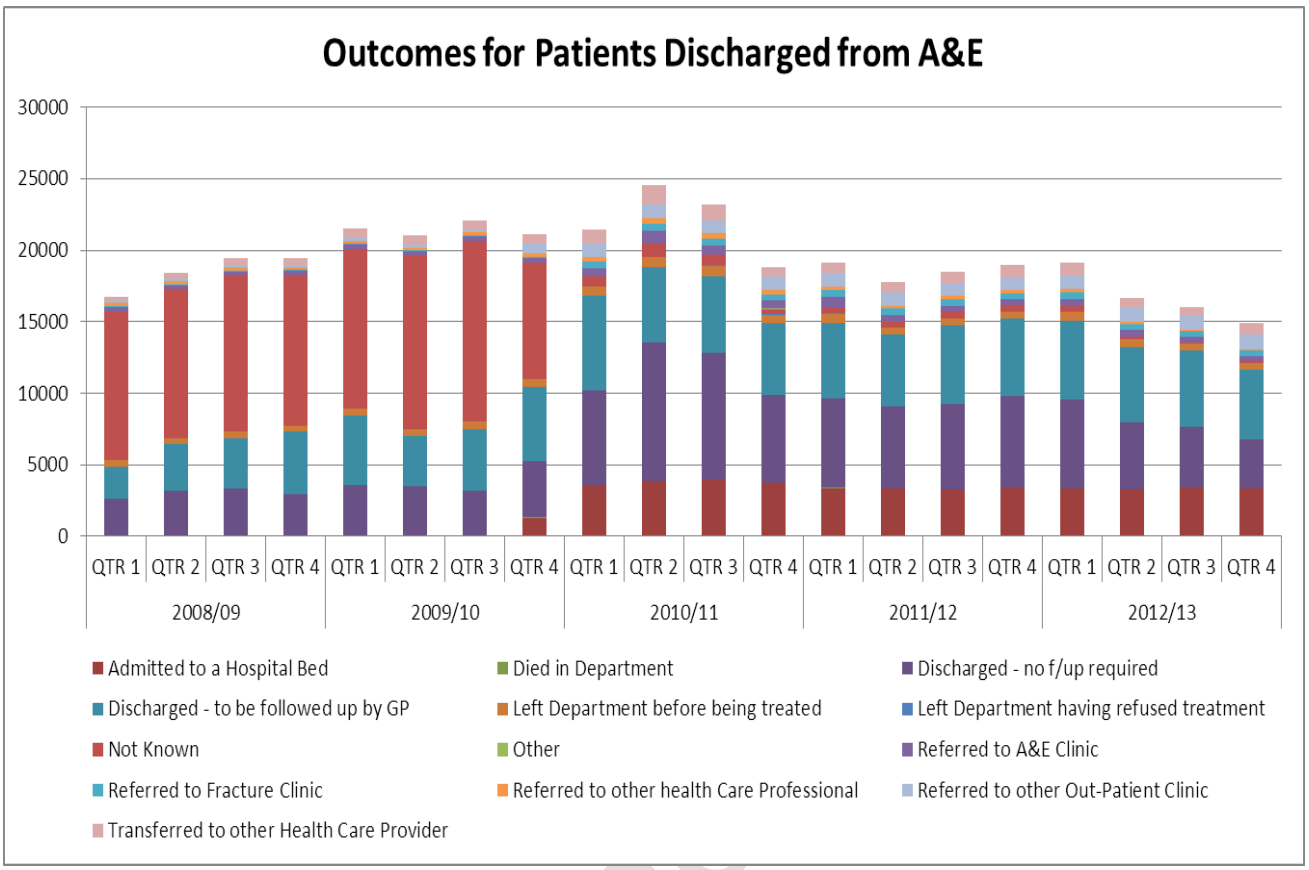
Outcomes for Patients Discharged from A&E

The graph on the following page outlines the outcomes / destinations of patients upon discharge from A&E over the past 5 years.

Summary

Data quality has improved significantly since 2009/10 with far fewer outcomes recorded as 'not known'. Over the past 5 years, numbers of patients admitted have remained stable. Fewer patients are discharged with ""no follow up required"", indicating an increase in acuity.

Referrals to other outpatient clinics have become increasingly common since the beginning of 2010/11.



7.5 Capacity Planning – St George's Bed Capacity

Summary

St. George's has carried out an analysis of capacity with operational managers and clinical leads using an operational bed modelling tool called PROMPT. This was developed by a Professor of Operational Research and uses recent trust activity patterns and length of stay distributions to simulate future bed configurations to optimise efficiency, and plan capacity. Based upon activity levels as outlined within their 2013/14 Service Level Agreement activity proposals, areas where capacity was considered to be pressurised are as follows:

- Haematology& Oncology (8 extra beds required)
- Medicine, including Specialist Medicine and Senior Health (33 extra beds required during winter period)
- Urology and General Surgery (15 extra beds required)
- Neurosurgery (12 extra beds required)

High Level Capacity Plans for 2013/14

Plan	Milestone	Deadline
Beds	Open 23 acute medicine beds on Caesar Hawkins Ward for winter 2013	Oct 13

	Focus on LoS in acute medicine (RCP4), senior health, surgery & neurosurgery (RCP3)	Mar 14
	Relocate and expand surgical admissions lounge to release 6 surgical beds	Dec 13
	Plan for medium to long term capacity expansion in neuroscience	Sep 13
	Redevelopment of the existing SAL /(Gray/Vernon) into new bed capacity - 15 beds with en suite facilities; Medicine in winter, surgery in summer	Nov 13
Critical Care	Plan for 5 additional beds for winter 2013	Dec 13
	Complete business case for definitive expansion of GICU in 14/15	Jun13

Theatre Capacity

A target of 85% utilisation of theatres has been set by St George's, based upon what seems to be achievable in terms of peer performance. Most specialties currently achieve between 75-85% in Main Theatres, and between 65% to 80% in Day Surgery Theatres. The main elements of the plans to improve theatre utilisation are as follows;

- Any growth in activity from 2012/13 to 2013/14 is to be absorbed by improved utilisation, this principle was also agreed by divisions at the capacity planning meeting held in January 2013.
- Individual services are creating individual action plans to increase theatre utilisation as well as targeting the main areas of lost time.
- In the Day Surgery Unit (DSU), utilisation is being targeted to drive more work through as day cases and as a result to ease pressure on beds and inpatient theatres. The whole DSU pathway has been mapped and there are several projects ongoing which should see an improvement in theatre utilisation.
- St George's will continue to use off site elective theatre provision during 2013/14 as required – with Bariatrics, Gynaecology and Cardiac Surgery activity continuing to be off site with Neurosurgery and ENT cases planned to go off site in 2013/14 as per the plan agreed for theatres by EMT in February2013. The estimated bed impact of off-site theatre provision is 10 beds.
- Agreed to review the cost effectiveness of outsourcing different types of activity and/or moving to 3 session days as well as weekend working.
- Continue planning for theatre expansion in 2014 including the new hybrid theatre as well as use of the 5th floor.

Critical Care Capacity

Critical care bed capacity is also a significant pressure point. Currently there are 49 adult critical care beds split as follows:

- 18 General ICU
- 17 Cardiothoracic ICU
- 14 Neuro ICU

Occupancy is currently high at 85%-90% (excluding booked beds and cleaning time). Certain beds were opened during 2012/13 to alleviate some of the pressure as follows;

- One extra bed on General Intensive Care opened Oct 2012
- 2 beds plus recovery on Ben Weir opened Nov 2012
- 4 beds on Holdsworth ward opened Feb 2013

As a result an extra five beds will also be required by winter 2013/14, the estimate includes the helipad impact and assumes that the beds opened on Holdsworth ward remain critical care. Decanting options to facilitate build in the shortest possible time are currently being clarified.

General Capacity Planning Principles and Assumptions

- St George's will continue to ring fence beds on a divisional basis in 2013/14
- The divisional ring fence will only be overridden on the grounds of patient safety
- Outlier charging will remain in place.
- The bed allocations to each division will remain as they currently stand.
- All directorates need to put in place service improvement plans for reducing length of stay (LoS).
- No extra on site theatre capacity will be available to any specialty until it has achieved the 85% utilisation of current theatre capacity.
- It has been agreed that both Medicine and Critical Care need to plan for recruitment to cater for additional beds, commencing immediately
- It is also acknowledged that Critical Care and inpatient bed expansion planned in 2013/14 will impact on the 2013/14 capital programme and the programme has therefore been revised accordingly.

8. Committed Resources for Urgent Care – The 70% Non-Elective Threshold Adjustment (NETA)

Guidance states that the Urgent Care and System Improvement Board will be directing resources to support initiatives that further improve the performance and sustainability of urgent care services. The Board will consider the specifics at the first meeting but the finance remit is likely to include the following:

- A commitment from all Board members (health and social care) to review all current spend on urgent care pathways, to consider if there is optimal integration and value for money from current spend
- A process for collation of current and proposed new spend across commissioners and providers, split into common resource 'buckets' for benchmarking purposes
- Consideration of potential new money for priority areas as identified by the Board, through application of the NETA monies
- A process for management of spend (re-allocation of current, distribution of new) once the Board has agreed priorities.

8.1 Provider Plans to Meet Funding Resource Requirements

This is currently in development and the section will be added once finalised.

9. QiPP Plans and Associated Reductions in NE Admissions and Attendances

The QIPP schemes below are aimed at improving services within the community, shifting non-clinically appropriate activity away from A&E to reduce non-appropriate attendances and admissions to ensure the continued achievement of the A&E 4 hour target and the effective management of the urgent care systems.

Wandsworth CCG QIPP Plans

WCCG CATEGORY	PROJECT	PROJECT DESCRIPTION
Out of Hospital	**Community Ward**	Via the application of a risk stratification tool, both high risk and high need patients are identified and supported to manage their Long Term Conditions. In doing this both emergency attendance and admissions are reduced. **Impact - Emergency attendance and admissions are reduced. Patients are treated closer to home and are enabled to stay at home for longer. Earlier discharge is made possible via the supported discharge mechanism.**
Out of Hospital	**GP Referrals**	This programme seeks to increase the quality of GP referrals into secondary care and promote the full use of community based services. It is supported through education and the training of clinicians, peer review and practice based software which presents, national and local guidance, care pathways, referral templates and formalised peer reviews with trained practice leads. **Impact – Reduced inappropriate GP referrals and the increased quality of referrals.**
Out of Hospital	**Falls and Bone Health Programme**	This programme seeks to identify patients at risk of poor bone health as well as promoting good bone health in those patients at risk, by using tools such as education, exercise and prescription of medicines for bone health. Further support is provided for patients at risk of falling and those who have already experienced falls though exercise, balance classes and medication reviews. **Impact – A greater number of patients receiving bone health medication as well as an increase in those patients identified as being at risk. As a result emergency attendance and admissions avoided and a better quality of life for those who have previously**

WCCG CATEGORY	PROJECT	PROJECT DESCRIPTION
		experienced falls or are afraid of falling.
Out of Hospital	**Admissions avoidance for harmful & hazardous drinkers**	A range of secondary and primary care services to help harmful and hazardous drinkers manage their health better, this includes offering brief interventions, education for reducing the impact of alcohol on pre-existing Long Term Conditions and assisting hazardous drinkers engage with health care services. **Impact - Emergency attendance and admissions are avoided in those with alcohol issues. This reduces the numbers who present in A&E and who are then also admitted due to the observation time period required. In turn this has the impact of reduced bed stays for alcohol dependent patients.**
Out of Hospital	**Urgent Care Centre**	The establishment of an Urgent Care Centre (UCC) at the front of St George's A&E department will triage and divert those patients who do not clinically require to be treated within A&E. These patients will for example be referred back to their GP (if registered with a GP), or be triaged through to the UCC to be seen by the GPs within the UCC or referred onward to A&E for more specialist care. All patients not treated within A&E will be treated at lower tariff rates. A patient navigator will also redirect patients back into primary care by booking GP appointments and if necessary, registering patients with a GP. **Impact – emergency attendances avoided for non-clinically appropriate patients, an encouragement/increase in patients registered with a GPs practice.**
Out of Hospital	**Long Term Conditions**	As part of the Out of Hospital Strategy there are a range of rehabilitation and exercise schemes under the 'Expert Patient Programme – Self Management' being put in place which contribute to patients managing their Long Term Conditions better and to help them to remain mobile and healthier for longer. **Impact – emergency attendance and admissions are avoided due to better health and mobility.**
Secondary Care	**LAS Alternative Care Pathways**	Through the use of agreed pathways, patients are conveyed to more appropriate clinical pathways of care rather than immediately through A&E. **Impact – Emergency attendance & admissions are avoided through the redirection of**

WCCG CATEGORY	PROJECT	PROJECT DESCRIPTION
		patients to more clinically appropriate pathways.
Mental Health	**Dementia**	Through the development of a new Dementia pathway, patients will be diagnosed earlier and both they and their carers provided with support to ensure better management of their health as well as the learning of essential life skills to maintain independence and mobility. **Impact – Improved quality of care for patient and carers, reduced emergency admissions in the early stages of the disease and a delay in the need for care home placements.**

Merton CCG QIPP Plans

Merton CCG has developed QIPP schemes across a number of key areas, including; urgent care, planned care and long term conditions. The focus is to seek to impact on both A&E attendances and admission rates by providing alternative services and referral points within the community. A brief description of some of these schemes is provided within the table immediately below.

Other initiatives that will complement the QIPP schemes outlined below include the availability of a walk in centre and extended primary care access.

QIPP Scheme		Project Overview
Urgent Care Centres - St Georges+ St Helier	Urgent care	Reduction in A&E attendances through utilisation of urgent care centres
Acute Based Alcohol Teams St H & St G	Urgent care	A hospital based alcohol admission avoidance service at acute trusts, to reduce A+E attendances and alcohol related admissions
UCAH Nursing Home Service	Urgent Care	UCAH provides a call round service, advice over telephone and rapid response service to 10 Nursing & Care Home patients who are unwell to prevent attendance at A&E & admission
Prevention of Admissions	Urgent Care	Identification of patients at high risk of admission through use of a risk stratification tool and subsequent case management by an integrated team including social care. Commissioning of a new community rapid response team will provide rapid access to care for patients that would otherwise attend A&E
Managing D.V.T. in Primary Care	Urgent care	Assessment and testing in primary care of potential DVT patients that currently attend A&E

10. Balance Scorecard

The Urgent Care System Improvement Board (UCSIB) will develop this content based on the 'Whole System Urgent and Emergency Care Metrics' as detailed in Section 5.4 – Performance Management, as it is the UCSIB who will decide the performance metrics against which the plan will be measured.

11. Board and Partner Sign Off

This section will be added once the plan is fully complete post the second phase submission of 19th July 2013.

12. Summary Conclusion

Winter impacts on the full spectrum of health and social care services and each year there are extra demands on services during winter. Meeting the A&E standard during 2012/13 was challenging, but with the support of additional investment and the implementation of a range of initiatives, was achieved at St George's.

The year to date performance at St Georges is on track to meet the 95% standard. The Trust and local health and social care community will continue to focus all efforts on this throughout the year.

This draft plan has presented an overview of the initiatives and actions in progress to maintain and improve the performance and quality of the urgent care pathway for patients. The plan focuses on managing the three phases of a patient's journey through A&E / urgent care: prior to A&E, the hospital system and discharge and out-of-hospital care and involving all aspects of the health and social care system.

There is further work to be completed on the plan to reflect the full range of initiatives and workstreams across partner agencies. In particular, we need to draw further from the work of neighbouring CCGs and their local authority partners in Merton and Lambeth.

13. Appendices

1. Excel Checklist