JOINT STRATEGIC COMMISSIONING BOARD
Urgent Care Update

Risk Please indicate	**High N**	***Medium Y***	***Low N***
Detail of Risk Description	Delivery of performance trajectories in-year.		

Engagement taken place	**N/A**
Public involvement taken place	**N/A**
Equality Analysis/Impact Assessment completed	**N/A**
Quality Impact Assessment	**N/A**
Strategic Themes	
Working as One, Acting as One – we will work together with all partners for the benefit of the people of Wirral.	**Y**
Listening to the views of local people – we are committed to working with local people to shape the health and care in Wirral.	**Y**
Improving the health of local communities and people – Wirral has many diverse communities and needs. We recognise this diversity and will help people live healthier lives, wherever they live.	**Y**
Caring for local people in the longer term – we will focus on having high quality and safe services, with the best staff to support the future as well as the present.	**Y**
Getting the most out of what we have to spend – we will always seek to get the best value out of the money we receive.	**Y**

JOINT STRATEGIC COMMISSIONING BOARD

(Committee in Common)

Meeting Date:	**12 November 2019**
Report Title:	**Urgent Care Update**
Lead Officers:	**Nesta Hawker, Director of Commissioning** **Jacqui Evans, Assistant Director of Unplanned Care and Community Care Market** **Martyn Kent, Assistant Director of Primary Care Transformation and Unplanned Care**

INTRODUCTION / REPORT SUMMARY

This report provides an update and overview of the key challenges and priorities faced by the Urgent Care system. The report focuses on the following system wide priority issues:

- Reduction of long length of stay patients
- Increase patients streamed out of Emergency Department (ED) - internally and externally
- Achievement of ambulance handover and turnaround times

An update summary on the Urgent Treatment Centre (UTC) is provided as Appendix 1.

RECOMMENDATIONS

The Joint Strategic Commissioning Board (JSCB) is asked to note the contents of this report.

Wirral Health & Care Commissioning

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

1.1 The report provides an update position for JSCB.

2.0 OTHER OPTIONS CONSIDERED

N/A

3.0 BACKGROUND INFORMATION

3.1 **Operational Update**

The following priority areas have been agreed for urgent care across all providers:

- Reduce long length of stay patients (defined as patients with an acute Length of Stay (LOS) of 21 days or more) by 40%
- Increase patients streamed out of ED both internally and externally. 20% of ED attendees are to be streamed to primary care
- Ensure Ambulance handover and turnaround standards are met and corridor waits are eliminated

The Emergency Care Intensive Support Team (ECIST) are supporting the system to deliver the above objectives. The approach and actions being taken are described below.

3.2 **Length of Stay (LOS)**

Twice weekly long length of stay (LLOS) reviews are being conducted across 5 wards at Arrowe Park Hospital and two wards at Clatterbridge Hospital. These wards have been selected as the wards with the highest number of LLOS patients. The reviews provide the opportunity to ask questions and coach ward staff on managing and planning for discharge as well as escalating any issues external to the ward. From the reviews, three key messages of the week are agreed and shared across all ward staff.

3.3 In addition to the above, an intensive two-week period has been agreed from 10-25 October. As part of this process, each ward has been allocated a designated lead matron to micro-manage LLOS patients, starting with 21 day + then reducing down to 14-20 cohort. The lead matron will work closely with the ward manager and ward consultants to expedite discharge. They will also liaise with the Multidisciplinary Team (MDT), patient and family to progress discharge and unblock delays. The process will ensure that all patients have an estimated discharge date, clear plan and clear criteria for discharge.

3.4 A trajectory is in place to achieve 40% reduction by end March, this equates to a position of 107 patients (current position 185 as of 11/10/19).

3.5 A Senior Manager has been allocated to 'hold the reigns' on the LLOS actions at ward level, supporting the lead matrons.

3.6 The Integrated Discharge Team (IDT) will move to single leadership, under WCFT, and focus on reducing LLOS. The wider system will be ensuring traction and taking responsibility for flow into the community, including reablement and domiciliary support, End of Life Care (EoLC) pathways and Intermediate services.

3.7 **Streaming**

NHS England have mandated that 20% of ED attendances must be streamed to primary care by end of December, a trajectory has been agreed to achieve this. It equates to an average 50 patients per day. The following actions have been agreed to achieve this:

- Collaborative workforce approach at the front door that delivers an ED/Primary Care model of simple and complex streaming
- A pull model using Primary Care GPs going into ED including the ambulance corridors to identify patients that could be managed in Primary Care
- Point of Care Testing (POCT) to eliminate the need for patients to go into ED including those patients that are sent there due to late laboratory results
- Mobile POCT for housebound patients that would otherwise be conveyed to ED but could now be managed by GP Out of Hours
- GPs having access to diagnostics such as x-ray
- Collaborative working which includes WUTH Emergency Nurse Practitioners (ENPS) so that minor injuries can be seen within the walk-in centre footprint
- Enhanced frailty model with the unplanned care team to support a turnaround plan at the front door were appropriate
- Enhanced pathways between tele triage and North West Ambulance Service (NWAS) to support care plans
- Enhanced pathways with NWAS to allow direct access into Primary Care

3.8 In addition to this, the ECIST have been supporting the introduction of internal streaming whereby patients in need of specialist input or a period of assessment can bypass ED. This includes access to Urgent Medical Assessment Centre (UMAC), Surgical Assessment Unit (SAU), Older People Assessment Unit (OPAU) Gynae Assessment Unit (GAU), hot clinics for Ear, Nose and Throat (ENT), Ophthalmology and Orthopaedics.

3.9 **Ambulance Handover and Turnaround Performance**
If the system can achieve trajectories for streaming and LLOS, ambulance handover and turnaround times will be met and there will not be any corridor delays. Through the above streaming processes being implemented, a clear criteria for diversion to Primary Care will be established to ensure paramedics are only conveying those care cannot be managed elsewhere to ED.

3.10 Alongside the above key priorities, the following associated workstreams are progressing well:

- New Target Operating Model in development for Single Point of Access with refreshed directory of service agreed
- NWAS end to end audit complete, workstreams addressing falls and respiratory being prioritised to reduce avoidable conveyances and enhance collaborative working
- Tele triage and Primary Care GP (previously Acute Visiting Scheme (AVS) continuing to reduce avoidable admissions
- High Intensity Users project going well with care plans developed and reviewed for this cohort of patients across primary and community care
- Implementation of Same Day Emergency Care pathways ensuring effective use of assessment units
- Restructure and redesign of Integrated Discharge Team
- New Target Operating Model for Rapid Community Response/ Home First to be implemented 1 November 2019
- New commission in development for Transfer to Assess (T2A) beds, work ongoing in current model to reduce LOS to a maximum average of 5.2 weeks. Specification and clinical support to be improved for winter, prior to new commission.

4.0 FINANCIAL IMPLICATIONS

N/A

5.0 LEGAL IMPLICATIONS

N/A

6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

N/A

7.0 RELEVANT RISKS

N/A

8.0 ENGAGEMENT/CONSULTATION

N/A

9.0 EQUALITY IMPLICATIONS

No implications have been identified because it is not anticipated that the Urgent Care development and priorities will have an impact on equality. Rather, potential impacts on equality will come from commissioning decisions for which EIA's will need to be produced.

10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 The content and/or recommendations contained within this report are expected to have no impact on emissions of CO2

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APPENDICES

Appendix 1 - UTC Update Summary

BACKGROUND PAPERS

N/A

HISTORY

Meeting	Date