Meeting Date	**28 January 2020**	**Agenda Item**	**2.1**
Report Title	A deep dive on unscheduled care relating to ambulance waits and hospital to home		
Report Author	Craige Wilson, Deputy Chief Operating Officer Hilary Dover, Service Director, Primary and Community		
Report Sponsor	Chris White, Chief Operating Officer		
Presented by	Chris White, Chief Operating Officer		
Freedom of Information	Open		
Purpose of the Report	The Health Board is experiencing unprecedented pressures in unscheduled care and 2019/20 so far has been a challenging year in terms of service delivery across the entire unscheduled care system. The Health Board has responded to these challenges through its consolidated unscheduled care action plan and more recently its winter plan. The purpose of this report is to provide the Board with detailed information on progress to improve ambulance handover performance and to provide a progress report on the implementation of the Hospital to Home Project; formally launched across the region on 10th December 2019.		
Key Issues	This report brings together two key activities to update the Board on the work underway to improve our unscheduled care system. The issues are: • the Health Board is under targeted intervention for its Unscheduled Care and a key element of this is ambulance handover performance. • the implementation of the Hospital 2 Home which provides provision that encompasses the physical and mental well-being of individuals and facilitates earlier discharge of patient on an agreed pathway		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☒	☐	☐

Recommendations	The Board is asked to: • Note the actions being taken to improved ambulance • Note the initial impact and early reflections on the introduction of the Hospital to Home

A deep dive on unscheduled care relating to ambulance waits and hospital to home

1. Purpose

The Health Board is experiencing unprecedented pressures in unscheduled care and 2019/20 so far has been a challenging year in terms of service delivery across the entire unscheduled care system. The Health Board has responded to these challenges through its consolidated unscheduled care action plan and more recently its winter plan. The purpose of this report is to provide the Board with detailed information on progress to improve ambulance handover performance and to provide a progress report on the implementation of the Hospital to Home Project; formally launched across the region on 10th December 2019.

2. Ambulance Handover

As the Board will be aware, the Health Board is under targeted intervention for its Unscheduled Care and ambulance handover performance. This is an issue that is continually raised in discussion with Welsh Government through the Quality and Delivery meeting and on the weekly Chief Executive calls with the Director General.

The table below demonstrates a significant increase in both the 1 hour and 2 hour handover delays over the last 12 months at Morriston Hospital; this correlates with a deterioration in both 4 and 12 hr unscheduled care performance.

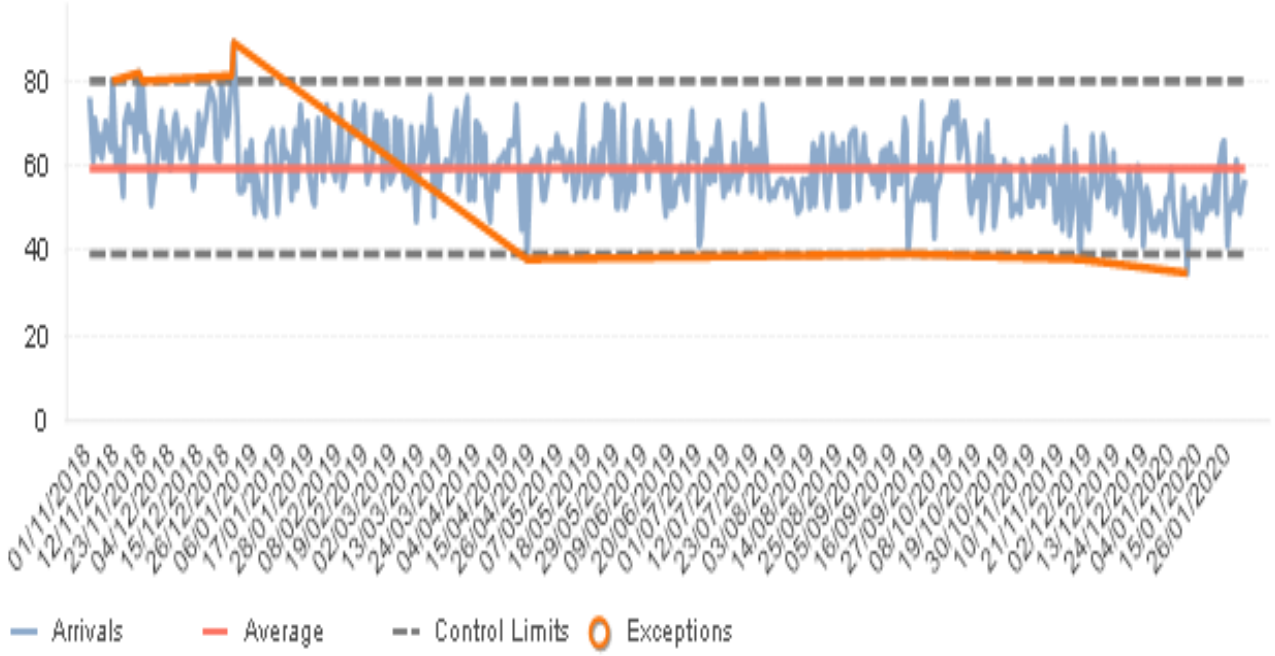
Current Trend:

Measure	Site	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	January 2020 Profiles
A&E 4 hours	Morriston	67.21%	67.01%	67.99%	64.21%	65.24%	63.42%	63.97%	63.70%	60.49%	60.92%	62.21%	60.17%	60.73%	68.7%
	NPTH	98.82%	98.42%	97.84%	95.23%	97.43%	97.44%	95.70%	96.41%	94.61%	95.34%	99.01%	97.39%	95.08%	100.0%
	POWH	76.30%	77.68%	71.95%											
	HB Total	76.89%	77.18%	75.70%	74.52%	75.91%	74.98%	74.51%	74.26%	71.45%	70.99%	73.22%	70.94%	71.59%	**78.4%**
A&E 12 hours	Morriston	621	448	534	653	602	644	642	740	941	889	926	1017	1038	612
	NPTH	0	1	0	0	0	0	0	0	0	1	1	1	0	0
	POWH	365	236	327	0.00%										
	HB Total	**986**	**685**	**861**	**653**	**602**	**644**	**642**	**740**	**941**	**890**	**927**	**1,018**	**1,038**	**612**
% Red Calls (prev Cat A) responded to within 8 minutes		72.7%	78.2%	72.8%	66.0%	73.5%	74.5%	70.9%	70.7%	66.7%	66.4%	58.8%	61.8%	66.6%	
Number of handovers > 1 hour	Morriston	684	387	544	669	629	681	550	599	746	802	799	830	819	451
	Singleton	68	41	44	63	18	40	44	33	32	25	22	38	28	0
	POWH	412	191	340											
	HB Total	**1164**	**619**	**928**	**732**	**647**	**721**	**594**	**632**	**778**	**827**	**821**	**868**	**847**	**451**
Number of handovers > 2 hour	Morriston	391	206	310	421	362	459	304	335	474	542	569	587	573	0 breaches
	Singleton	40	9	12	28	4	9	14	15	16	7	9	11	6	
	POWH	255	95	187											
	HB Total	**686**	**310**	**509**	**449**	**366**	**468**	**318**	**350**	**490**	**549**	**578**	**598**	**579**	

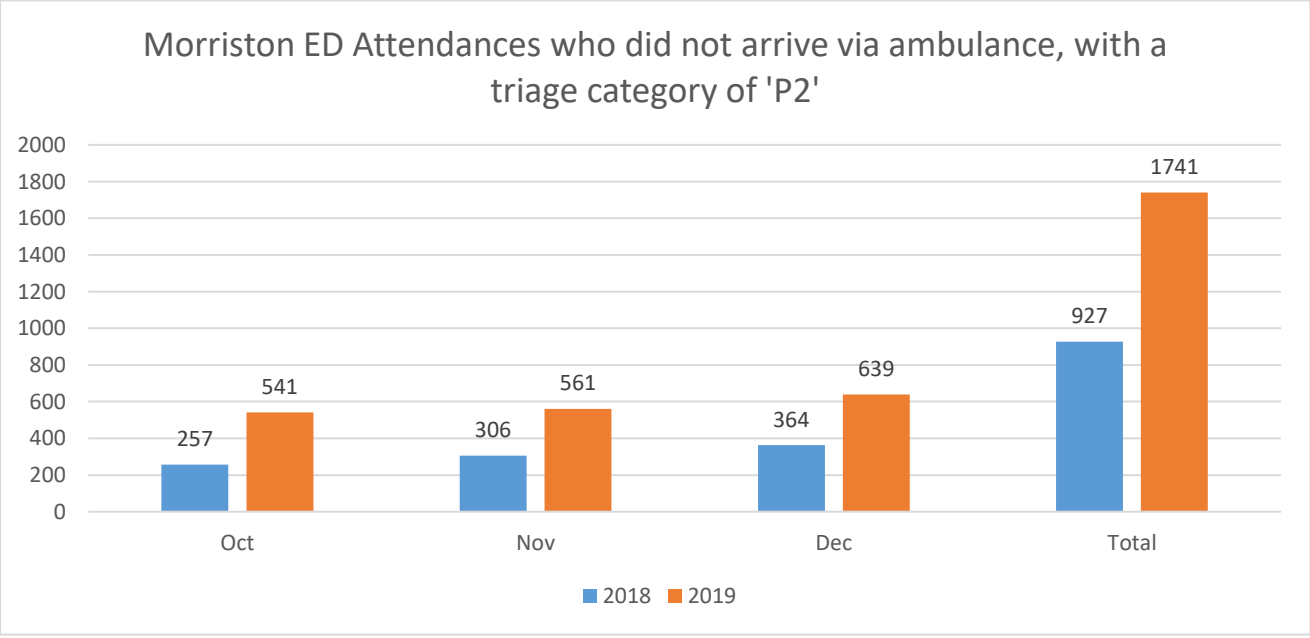
This deterioration in performance is not activity related. The chart below demonstrates a steady reduction in ambulance activity arriving at the Morriston site (the Health Board view for this period is skewed by Princess of Wales activity); which represents the majority of the WAST activity received within Swansea Bay UHB. The reduction in the

activity could, in part, be attributed to the various improvement initiatives targeted at ambulance handover described later in this paper.

Ambulance arrivals at Morriston Hospital November 2018 – January 2020.



The number of Emergency Department (ED) attendances for October to December 2018 and 2019 remained stable. However, there has been an 88% increase in the number of self-presenting patients with a triage priority 2. These are sick patients who have self-conveyed to the Department, previously this patient group would have invariably arrived via ambulance.



2.1 Actions to Date

There are a number of contributory factors to the ambulance delays and in response a handover action plan has been developed in partnership with WAST, as detailed Appendix 1. There are a number of elements to the action plan and they include:

- Escalation procedures – both internal and external to facilitate additional support for ambulance handover
- Additional capacity – within the emergency department to enable release of ambulance and across the wider health system to support hospital flow
- Alternative Pathways – to avoid conveyance; respiratory, mental health and falls being the key focus
- Review of the ambulance stack – undertaken by GP's in AGPU to direct patients to alternative services or seek alternative conveyance solutions
- Enhanced co-ordination – WAST Patient Flow Manager in place and a Health Board Patient Flow Manager has been appointed to monitor flow across the entire unscheduled care pathway.

The majority of these actions are now in place or being further developed. The one area that is currently outstanding is a facility to cohort patients to allow the release of ambulances. A facility has recently been commissioned at the Royal Gwent Hospital and early indications that this "portakabin" with capacity for 6 patients, staffed by paramedics is proving successful.

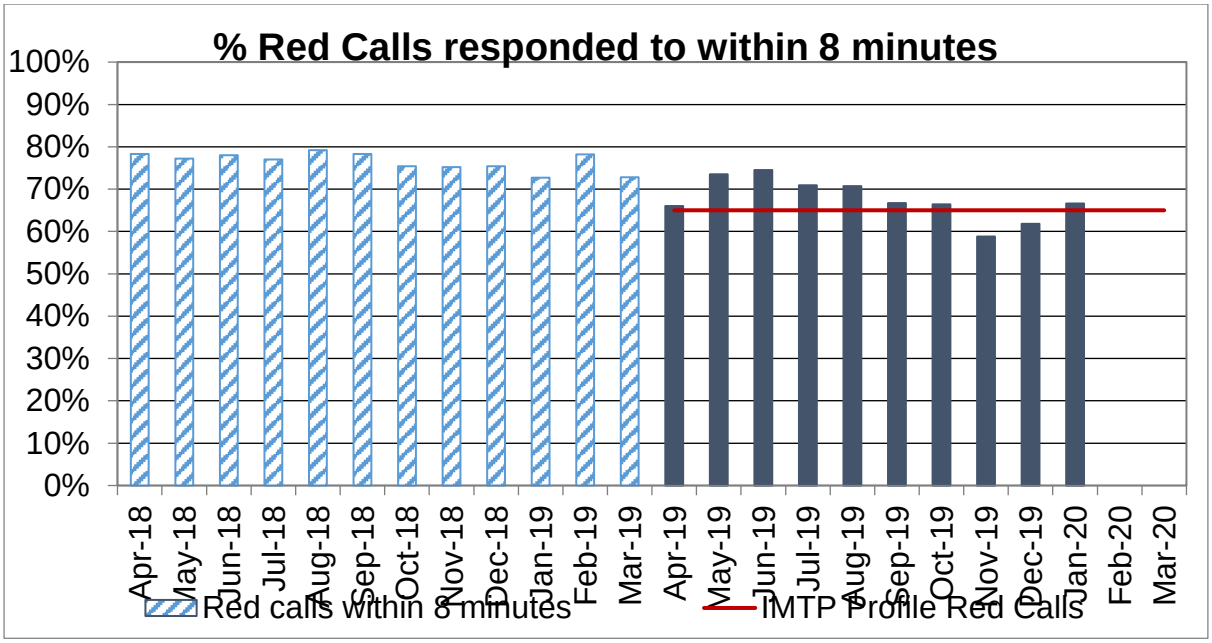
The Health Board are in the process of going to tender for a mobile unit similar to the above that could be located outside of the Emergency Department at Morriston Hospital.

2.2 Monitoring Improvement

Red call performance

One of the key measures for assessing performance for WAST is the number of red calls responded to within 8 minutes. There is a direct correlation with ambulance availability i.e. not sitting outside of hospital Emergency Department and response times. As per the table below the Health Board performed well through April 18 to March 19 but there have been two months (November and December 2019) during 2019/20 where the 65% target has been missed and overall performance has been lower than the previous year.

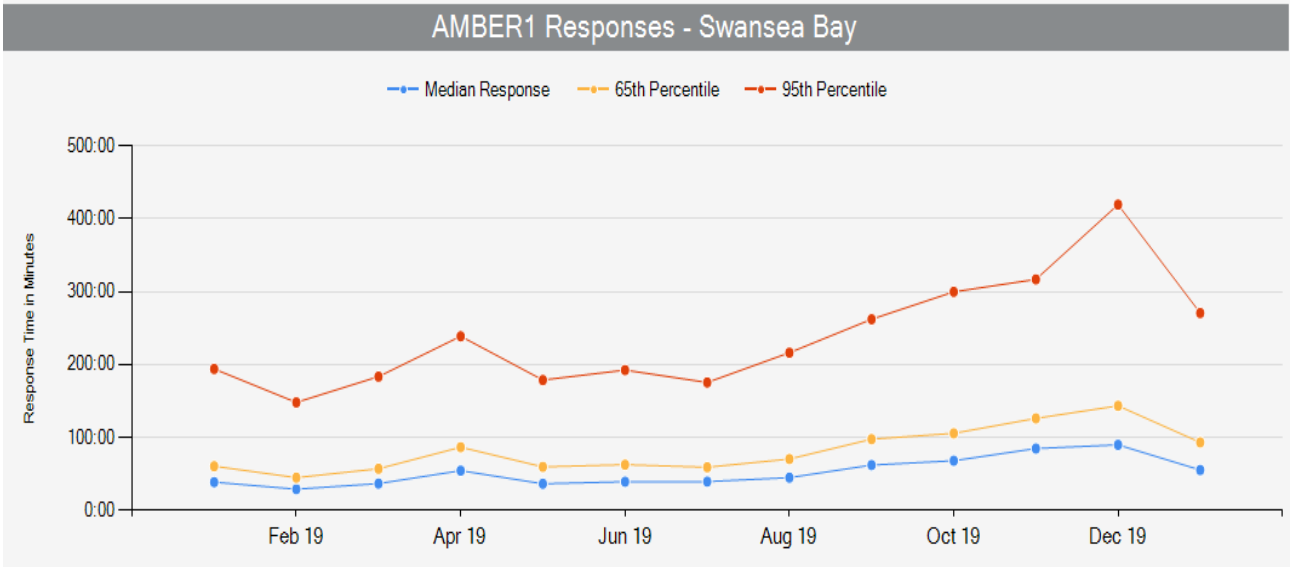
However in January 20, arguably one of the busiest months, the target was once again met and the signs for February (1st-17th) where performance is 71%, is that the target will be met again.



The performance of the Health Board in January 2020, on an All Wales basis, can be seen at Appendix 2:

Amber 1 performance

Whilst red call response performance in January 2020 is achieved the 65% target, amber 1 (next clinical priority) response times have deteriorated over the year. Patients in the Amber 1 category are patients with potentially serious clinical presentations such as stroke or heart attack, these patients are waiting an unacceptable length of time for ambulance response. Over the period January 2019 to January 2020, shown below, the mean amber 1 response time has been between 46 minutes and 2 hours 16 minutes, with December 2019 being the worst month in terms of Amber 1 performance. Validated information for January 20 is not yet available but from the data received on a weekly basis, it is anticipated that this will show and improvement.



3. Hospital to Home

A major cause of the ambulance delays is the flow (release of beds) through the hospital and despite the improvements at the front door, delays at the back door continue to be a key contributory factor. The number of medically fit patients occupying hospital beds across the Health Board continues to constrain both scheduled and unscheduled care flow. The Health Board have introduced the Hospital 2 Home pathways to support more timely flow of patients from hospital into the community. Whilst this model is still in its infancy and as it matures this should result in improved patient flow at the back door.

Hospital 2 Home provides provision that encompasses the physical and mental well-being of individuals including those living with dementia and cognitive impairment with conversations centered on “What matters to me”. It is felt that this service has the potential when fully implemented to help to maximize the use of the existing social care capacity to best effect and ensure there is flow across the system. It is based on a pathway model.

The following defines each pathway:

- Pathway 1 will focus on providing functional ability through reablement in a 2-3 week timescale;

- Pathway 2 will focus on providing functional ability through reablement in a 4-6 week timescale, including residential reablement;

- Pathway 3 will focus on reablement for those who have longer-term care needs ensuring any long-term care requirements are rightsized before out in place.

Regional implementation for pathway 1 commenced in November 2019, with full roll out completed in mid-January 2020 across all hospital sites in the region.

The overarching aims of the project are focused on improved outcomes for the individual older person, coupled with enabling recovery and recuperation that reduces overall need and demand for the system as the requirements for care packages is right sized following a period of reablement.

3.1 Key Objectives

- Earlier discharge facilitated through third sector and reablement services that support individuals to live in their communities and reducing deconditioning in a hospital;
- Care provided through an enabling ethos that recognises the importance of people managing their own health and wellbeing;
- Development of staff to provide services prudently and co-productively, based around individual and family needs, focusing on this rather than the traditional way services have been organised;
- Reduction in demand and long-term pressures on jointly managed care services;

- Ensuring care packages are right-sized before being put in place, preventing over the prescription of social care for long periods of time;
- Ensuring all appropriate provision of acute / managed care services to care for people within available capacity;
- Management of resources to deliver best outcomes for people within the resources available, enabling services within the West Glamorgan health and social care system to be financially viable.

The foundation of the long-term changes will be the embedding of trusted assessments. Trusted assessment is a key element of best practice in reducing delays to transfers of care between hospital and home and is carried out by a trusted assessor who is authorised by the parties involved to carry out this assessment on behalf of others. The process is co-designed and agreed by all the involved parties, resulting in a streamlined and simple assessment process.

Using traditional model patients find it extremely confusing and frustrating telling their story multiple times to multiple care professionals. The trusted assessor model ensures that the patients tell their story only once. By not repeating their story, they will feel more trust in the system, reducing the boundaries that should be invisible to the individual and promoting seamless health and social care provision.

In line with the John Bolton model, reablement home-based support is the primary pathway for hospital discharge and no long-term care needs will be prescribed until the individual has experienced a period of reablement. The key aspect of this new model is that no patient will be assessed for long term care whilst in an acute hospital bed. This will ensure we have a sustainable integrated care system, which is person centered and maximises independence preventing over dependence on Health and Social Services.

3.2 Current Situation

The Hospital to Home Service was launched for Pathway 1 patient only (due to the limited funding available) using a “soft” approach in mid-November 2019, before formally going live with a gradual roll out to all wards commencing on 10th December 2019, the roll out was completed as planned by 25th January 2020.

3.3 Project Management

Since November 2019, it has not been possible to maintain full time Project Management capacity to support delivery of Hospital to Home, however the full rollout of phase 1 was completed within the deadline and budget.

Project management support for the Hospital to Home Project is currently being reviewed. A new Older People’s Strategic Planning Manager has been recruited by Swansea Bay University Health Board – start date yet to be confirmed. The new West Glamorgan Adults Transformation Manager is supporting an interim work programme to ensure that the pace of the project delivery is sustained and suitably supported. It is intended that a jointly agreed longer term work plan will be developed for the Strategic Planning Manager and Adults Transformation Manager to ensure effective

deployment of planning/project management resource across the remaining phases of the programme.

3.4 Training

To date, **thirty five** Care Navigators have completed the locally developed training with **33** of those Navigators having had the associated competencies signed off to undertake Trusted Assessments for Pathway 1.

Care Navigators complete a bespoke two day Care Navigator Training Course which is delivered by relevant senior lead staff. Feedback from those completing the training to date has indicated the package requires further modification before being further rolled out. Therefore an independently facilitated workshop will be completed on 25th February with all those who have undertaken the training invited to understand their experiences of the training itself and inform adaption of training package before further delivery is undertaken.

3.5 Performance Management

Initially it has been necessary to monitor Hospital to Home Project delivery manually using complex spreadsheets, which has led to local variation. These documents track the journey of each individual patient and gathers the necessary data to support and track progress against the delivery of Hospital to Home Model.

Simultaneously, a dedicated Swansea Bay University Health Board Project Team have been developing an effective digital mechanism through SIGNAL to ensure the required data can be electronically gathered as soon as possible to ensure consistency and provide a robust reporting mechanism.

The required development and build in SIGNAL is complete and now needs to be tested. It is planned that the necessary staff will be trained in March 2020 with SIGNAL itself going live for data collection late in March and the first reporting data available in April 2020. The agreement and inclusion of appropriate Patient Reported Outcome and Experience measures (PROM's and PREM's) will also be included as part of a wider Performance Management mechanism. SIGNAL will be able to report full H2H activity after 1st April 2020.

Prior to introduction of the H2H project, modelling indicated that the investment from ICF would provide the capacity to facilitate an additional 60 discharges a month.

Below is a summary of the additional capacity created through the introduction of Hospital to Home January 2020. A direct comparison cannot be made in December as Hospital to Home only ran from 10th December; the data excludes Enhanced Supported Discharge provision.

	Neath Port Talbot	Swansea	Regional	Additional Capacity
Number of Referrals to Hospital to Home January 2020	**57**	**98**	**155**	
Discharges Facilitated in January 2019	**11**	**49**	**60**	
Number started in Hospital to Home Service January 2020	**29**	**74**	**103**	**43**

A case study of one patient's experience of the service to date can be found as **Appendix 3.**

It is important to note that these changes represent significant change in culture and practice and it is envisaged that it will take time to truly embed the service and optimise the benefits of H2H on the whole system.

However members of the West Glamorgan Partnership have reflected that the brokerage element of the social care system has been 'freed up' which in time will benefit the health system through patient flow.

3.6 Communications

The Hospital to Home Project has an agreed Communications Strategy and to date has shared limited messages and resources with the relevant target audiences. This is a deliberate approach because the project is new and evolving and therefore the required communications need to be developed in line with the ongoing growth and embedding of the service model itself. Initial feedback from those delivering the service indicates there is a specific need to create further targeted resources with a specific focus on changing behaviours and language internally to support delivery of Hospital to Home. A focus group with existing staff delivering the service will be facilitated in the near future. It is then the intention that the Hospital to Home Communications Strategy will be revised and reshaped to increase its reach and visibility across all partner organisations.

3.7 Reflections on project delivery to date

Benefits

- Ring fenced resources allows for easy and accurate prediction of capacity and positively impacts the quality of provision
- Daily board rounds
- Scheduled reviews of patients to ensure timely transition
- Communication between therapists, support workers and flow facilitators is excellent.

Challenges

- Significantly reduced finances available to deliver the model thereby only able to introduce a very limited model
- Ability to secure a robust manual data set consistently across the region in a timely manner
- Ensuring all stakeholders are kept appropriately informed in relation to the development and delivery of the service and supported to make changes to their behaviours and practice accordingly
- Difficulty in recruitment to posts and therefore provision of required capacity
- Increasing demand on community pathway due to number of recent hospital discharges being referred when patients have deteriorated

Next Steps

- Review the current manual data collection process
- Delivery of SIGNAL training for Hospital 2 Home Navigators
- Review, update and embed Navigator training
- Review of the communication documentation and development and implementation of a wider Communications Strategy
- Capture and formalise feedback from all Hospital 2 Home elements to create agile processes
- Review of the previous Hospital 2 Home Transformation Fund submission and development of a funding application to Welsh Government against the additional Transformation Funding. (it should be noted that if successful, the additional funding will only be an additional £485k on top of that currently being invested as a significant part of the current funding stream is short term winter pressures funding which will cease at the end of March 2020)
- Realignment of project management support to maintain effective implementation and delivery of the project
- Evaluation methodology to be agreed and undertaken regarding the models for pathway 1 in Swansea and NPT.

4. Recommendations

The Board is asked to note

- The actions being taken to improved ambulance
- The initial impact and early reflections on the progress of the Hospital to Home

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

Delivery of improved unscheduled care performance will decrease access times for patients, improve patient experience and promote increased flow through the unscheduled care system.

Financial Implications

There are no immediate financial implications of this report but consideration will be made through the IMTP process of the schemes which have delivered benefits in 2019/20 for continuation in 2020/21. As assessment of the financial implications will be made once these areas are agreed.

Legal Implications (including equality and diversity assessment)

There are no known legal or equality and diversity impacts. Patients are treated based on clinical need.

Staffing Implications

As with finance, there are no immediate staffing implications but longer term continuation of schemes currently in place may require a recruitment programme to make services sustainable.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The '5 Ways of Working' are demonstrated in the report as follows:

Long term – Actions within this report are for 2019/20 but will have a long term impact in terms of improved access and patient experience.

Prevention – some of the service modernisation within these services will help to prevent patient health deterioration and keep patients as independent as possible at home. Integration – clinical pathways are delivered across primary and secondary care. Collaboration – come clinical pathways within unscheduled care (stroke, vascular for example) cross Health Board boundaries and require collaboration within the NHS system. Involvement – Partner organisations, Corporate and Delivery Unit Leads are key in identifying performance issues and identifying opportunities to improve flow and develop services which are fit for purpose to meet the needs of our citizens.	
Report History	None
Appendices	**Appendix 1** – WAST Hospital Handover Improvement Plan **Appendix 2** – Red Call Performance January 2020 **Appendix 3** – Hospital to Home Case Study