ABM University Health Board	
Subject	Unscheduled care performance and improvement
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1. Situation

Timely access to the appropriate urgent and unscheduled care services contributes to patient outcomes and is therefore a critical safety and quality issue. ABMU Health Board overall performance against the unscheduled care key performance measures saw incremental improvement for the first six months of the 2017/18 financial year, followed by a notable deterioration in performance during Quarter 3.

Unscheduled care is one of the areas of concern for the Health Board Targeted Intervention status. This paper describes the most recent performance, outlines some changes to unscheduled care demand, and provides an overview of key actions being undertaken within the unscheduled care and patient flow improvement programme to stabilise and improve performance.

2. Background

2.1 Performance

Welsh Government sets out the following unscheduled care delivery targets:

Category A ambulance performance (shared target with WAST)

- 65% of ambulance emergency responses to Red calls (immediately life threatening calls) should arrive within 8 minutes.

4 hour performance.

- 95% of patients should spend less than 4 hours in all major and minor emergency care facilities (A&E and minor injuries units) from arrival until admission, transfer or discharge.

12 hour performance

- No patient should wait over 12 hours from arrival at hospital major and minor care facilities until their admission, transfer or discharge.

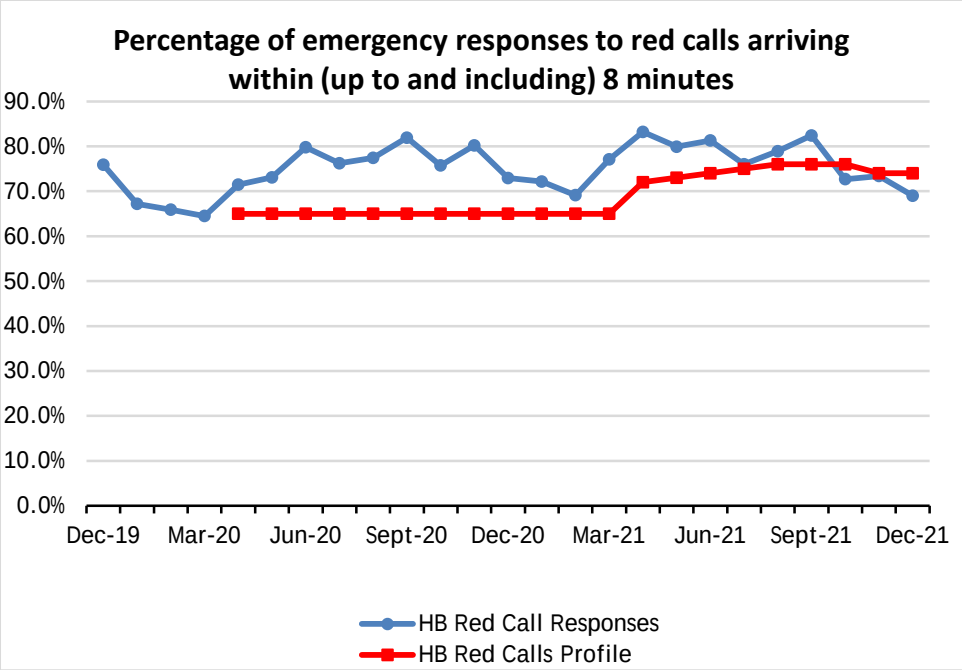
Ambulance/hospital handover performance

- All patients who arrive by ambulance should be handed over to hospital care within the hour.

Each of our service delivery units within ABMU Health Board has a role within the unscheduled care system as there are interdependencies between all service delivery units as patients move through the unscheduled care pathway. The spectrum of care spans self-care, primary and community care, the 111 service, acute and rehabilitation services, 3rd sector, local authority and private care provision and therefore each part of the system will ultimately impact upon unscheduled care performance.

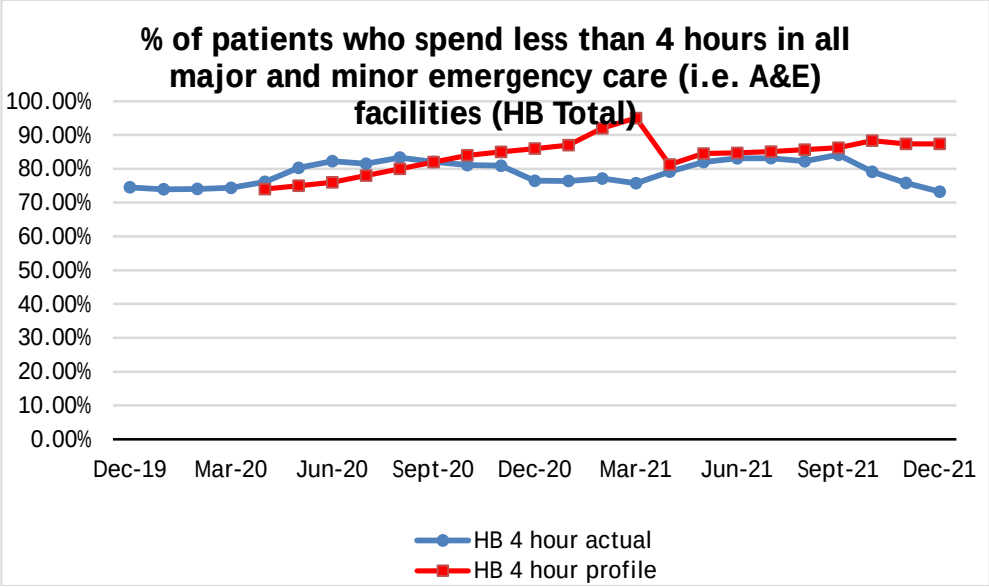
The chart below shows the Health Board wide compliance against the unscheduled care targets over the last 2 years.

2.1.1. Category A ambulance response times



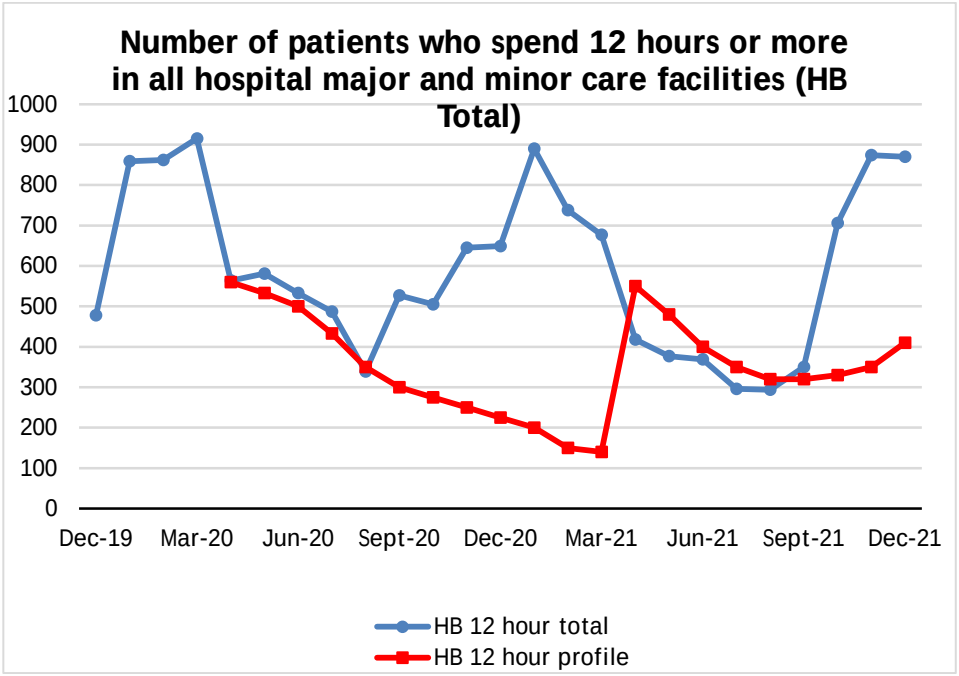
The Health Board has generally performed above the All Wales 65% target for response times to life threatening calls. However December 2017 Category A performance dipped below 70% for the first time since February 2017.

2.1.2. 4 hour performance



The Health Board has not met the 95% target for the number of patients seen within 4 hours in the last 2 years. The best Health Board performance against this measure was in September 2017, when 84.13% was achieved. During the period January to September 2017, 4 hour performance was however consistently above 2016 performance for this same 9 month period. However between October 2017 and December 2017, there has been a decline in performance to below the 4 hour performance levels achieved in the same period in 2016.

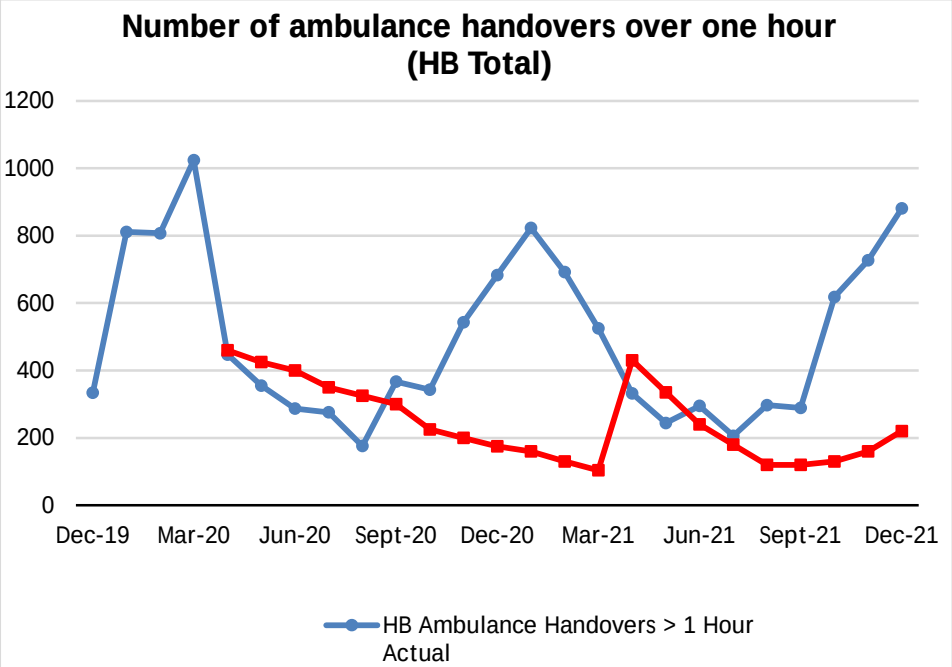
2.1.3. 12 Hour Performance



The Health Board has not achieved a zero 12 hour performance position during this period – the best performance was achieved in August 2017, when 294 patients

waited longer than 12 hours for admission /discharge or transfer. Between February 2017 and September 2017, 12 hour performance exceeded performance for the same period in 2016. However 12 hour performance between October 2017 and December 2017 deteriorated to below the performance achieved during the same comparative period in 2016.

2.1.4 >1 hour ambulance handover performance



The >1 hour ambulance handover position generally mirrors the 12 hour performance profile, as exit block from the emergency department has a direct impact on patient handover performance. August 2016 saw the best performance against this metric in this reporting period, with 176 patients experiencing an >1 hour ambulance handover delay, followed by 206 patients waiting over 1 hour in July 2017.

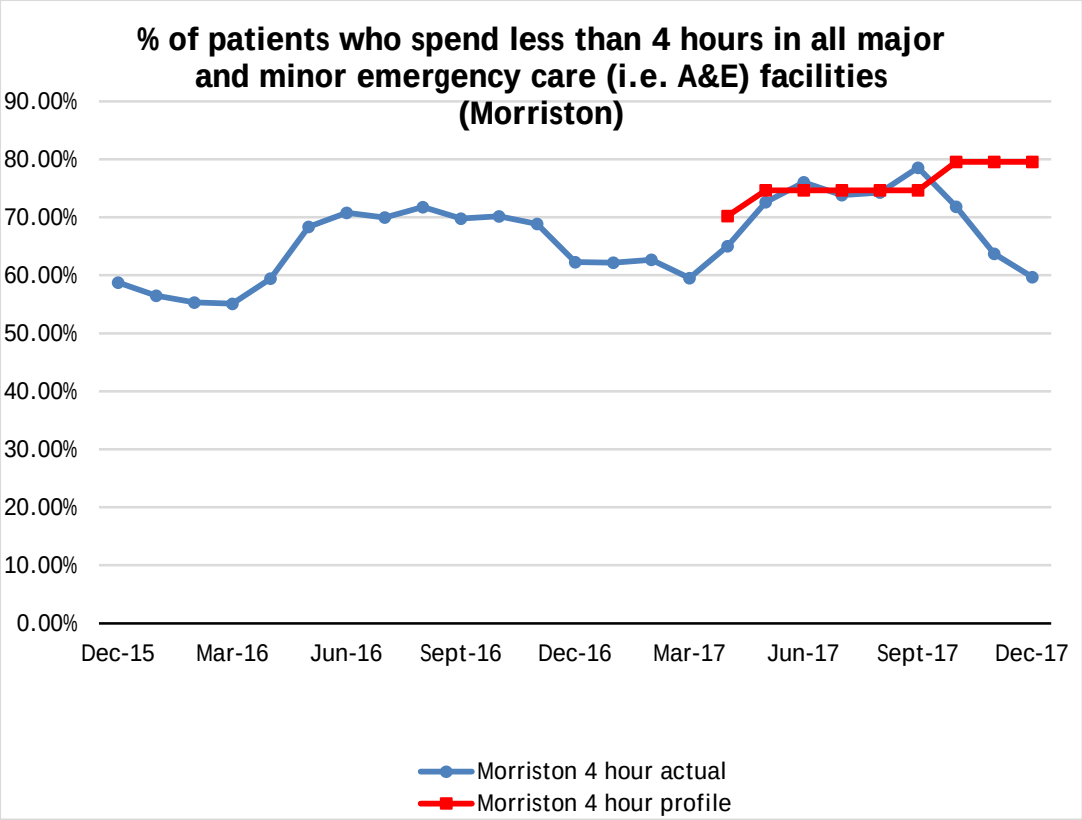
When viewed against the rest of Wales, ABMU HB along with Betsi Cadwaladr HB has generally reported the greatest number of 4 hour breaches, although performance within ABMU HB moved much closer to the all-Wales average position during the summer months. 12 hour performance across Wales has been variable, with ABMU performance being more consistent with the all-Wales position over the summer months.

The pattern of unscheduled care performance within the Health Board has generally been one of improving performance during the summer period, with deteriorating performance during the winter months – as seasonality presents different challenges in terms of patient demand and flow through the unscheduled care system. Whilst there have been improvements in overall HB performance during the summer it has not been possible to achieve sustainable all-year round improvement to bring unscheduled care performance consistently closer to the all-Wales average position.

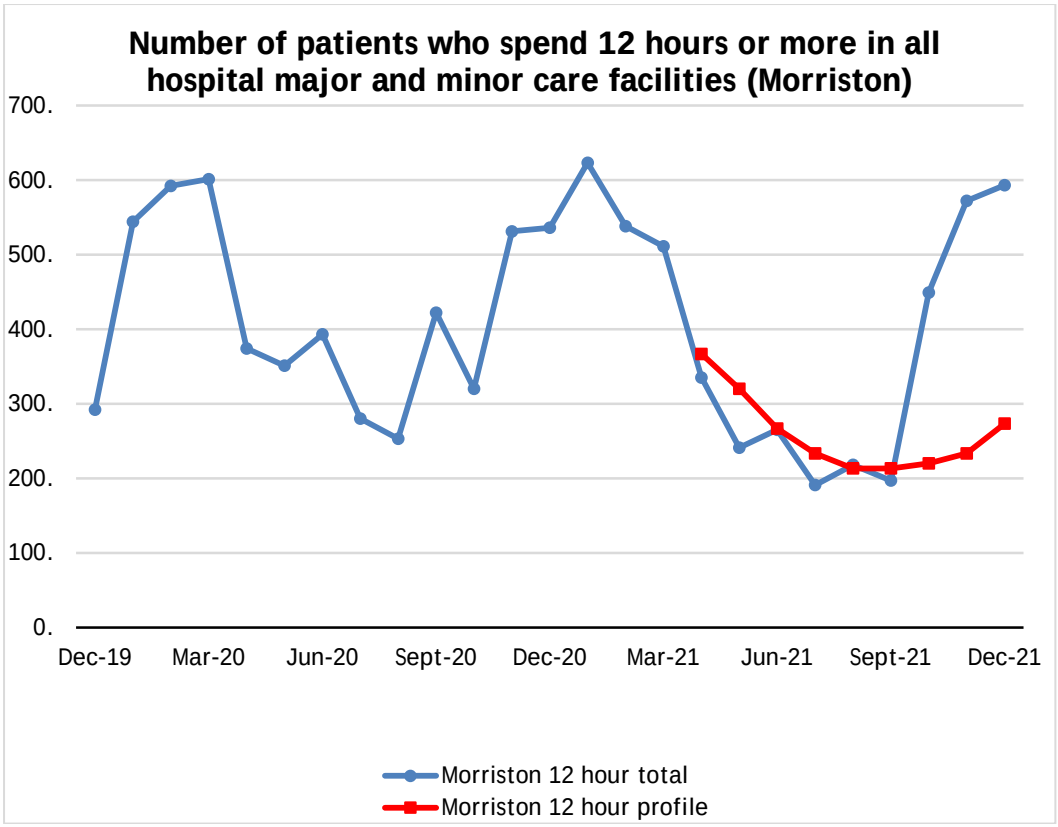
2.1.5 Morriston and Princess of Wales hospitals 4 and 12 hour performance

During the summer months, Morriston Hospital's 4 and 12 hour performance improved, and exceeded the internal improvement trajectories for September. However 4 and 12 hour performance subsequently deteriorated in Q3.

Morriston 4 hour performance

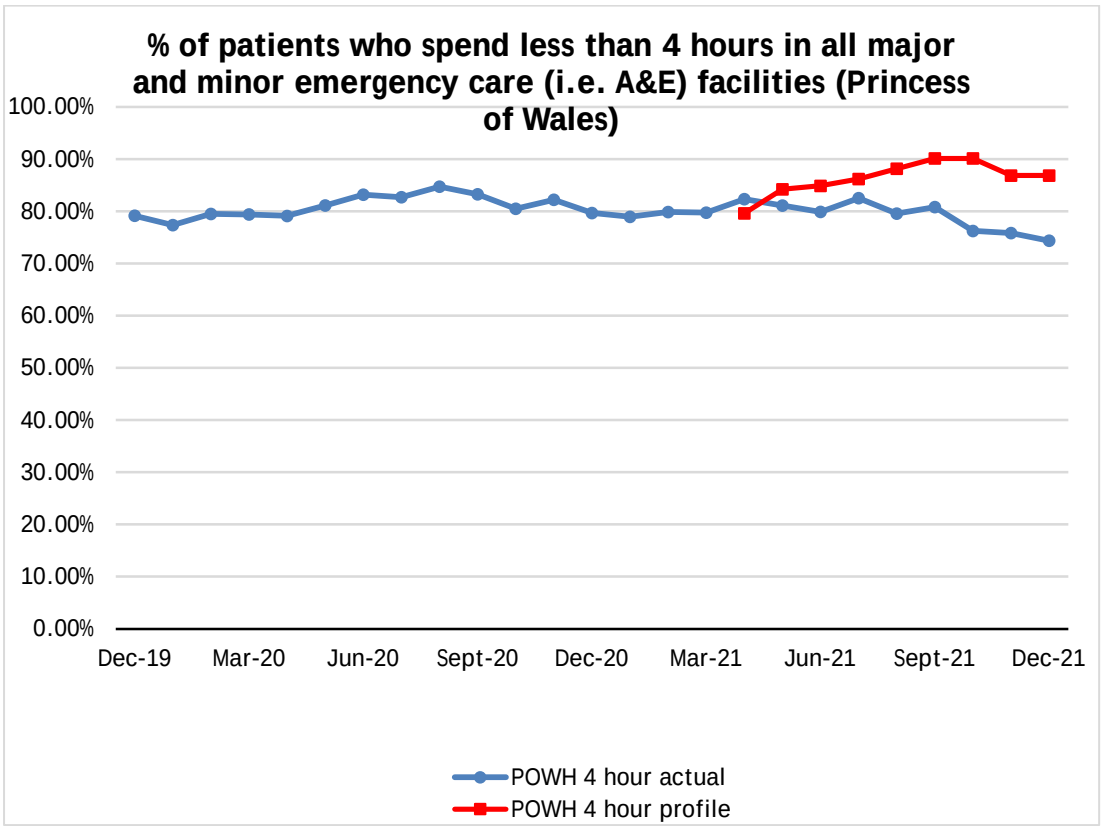


Morriston 12 hour performance



Princess of Wales hospital 4 hour performance

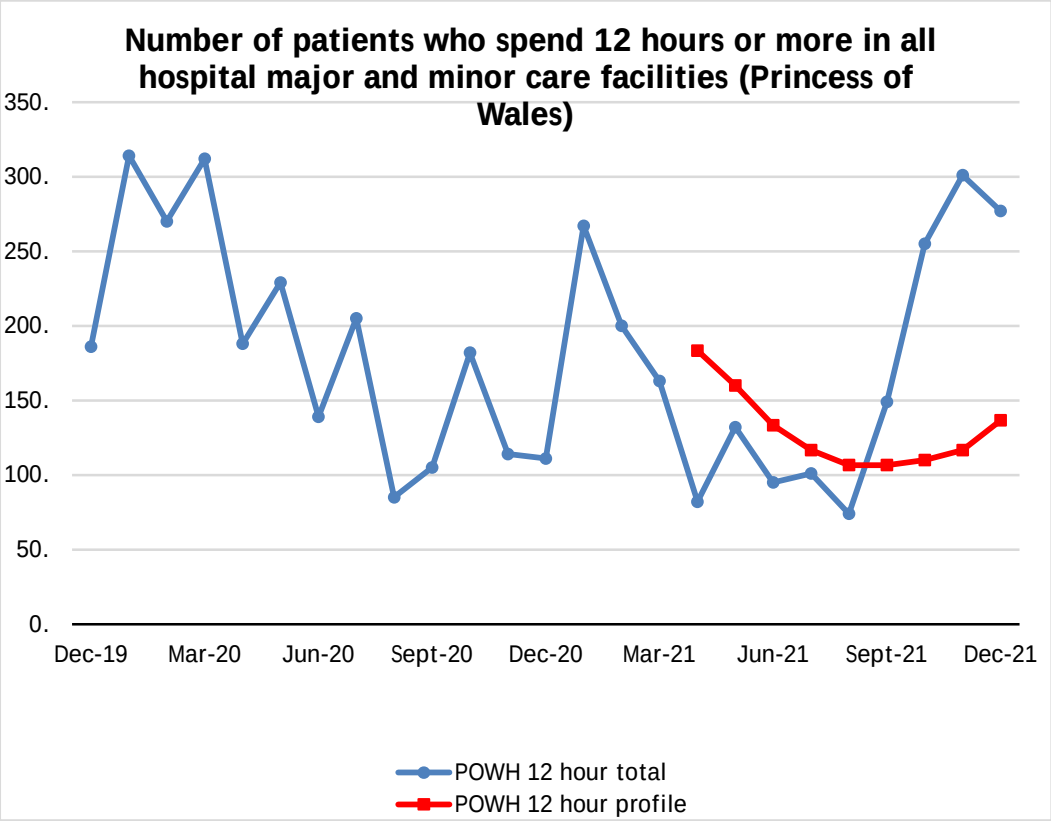
4 hour performance at the Princess of Wales Hospital has struggled to achieve 2016 performance levels, and has generally seen a deteriorating position throughout 2017.



As a consequence, the Health Board commissioned NHS Elect to review potential opportunities at this hospital to recover and improve performance against both measures. The initial review took place on 8th and 9th January and the formal findings from the review will be used to shape the unscheduled work programme for this unit for 2018/19.

Princess of Wales 12 Hour Performance

Following a positive reduction on 12 hour waits in the early part of 2017, 12 hour performance since August has subsequently deteriorated, with particular challenges in November and December.



2.1.6 Delayed Transfers of Care

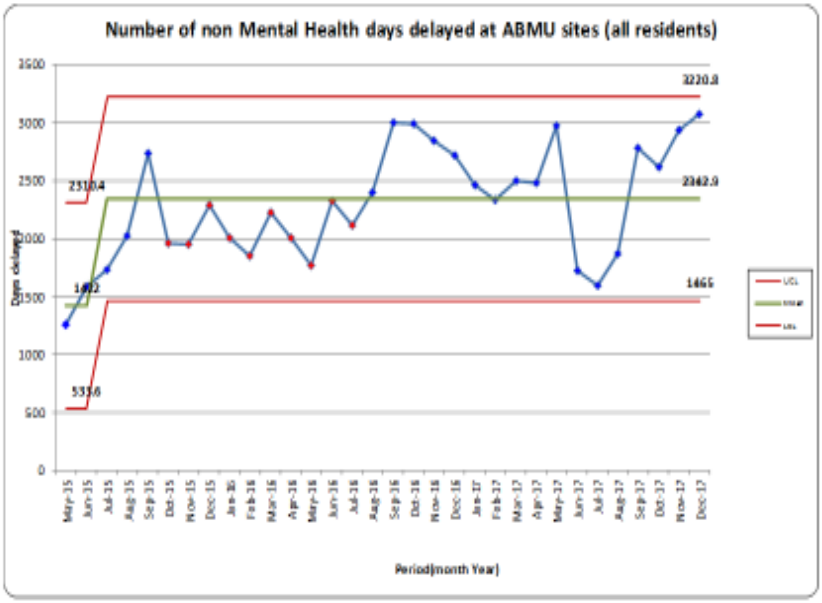
The Health Board is monitored on a monthly basis on the number of patients in the system who are reported as a delayed transfer of care.

A delayed transfer of care is experienced by a hospital inpatient when they are ready to transfer to their next stage of care, but this is prevented for a variety of reasons. Delayed transfer of care can have an adverse impact on an individual's recovery and future wellbeing, with a significant and growing evidence base indicating a reduction in independence and mobility (de-conditioning), and the increased risk for patients who have greater exposure to hospital acquired infections and falls. The Health Board audits the number of patients who are categorised as a delayed transfer of care on a monthly basis, and this information is validated by Local Authority colleagues.

It can be seen from the graph below that the number of bed days lost associated with a delayed transfer of care has increased in the last quarter of 2017.

The reasons for this are multi-factoral but the key factors within ABMU Health Board relate to capacity in domiciliary care services (particularly in Neath/ Port Talbot and Swansea), care home capacity (particularly in Bridgend), limited EMI care home provision across ABMU Health Board, and healthcare delays in processing patient discharge.

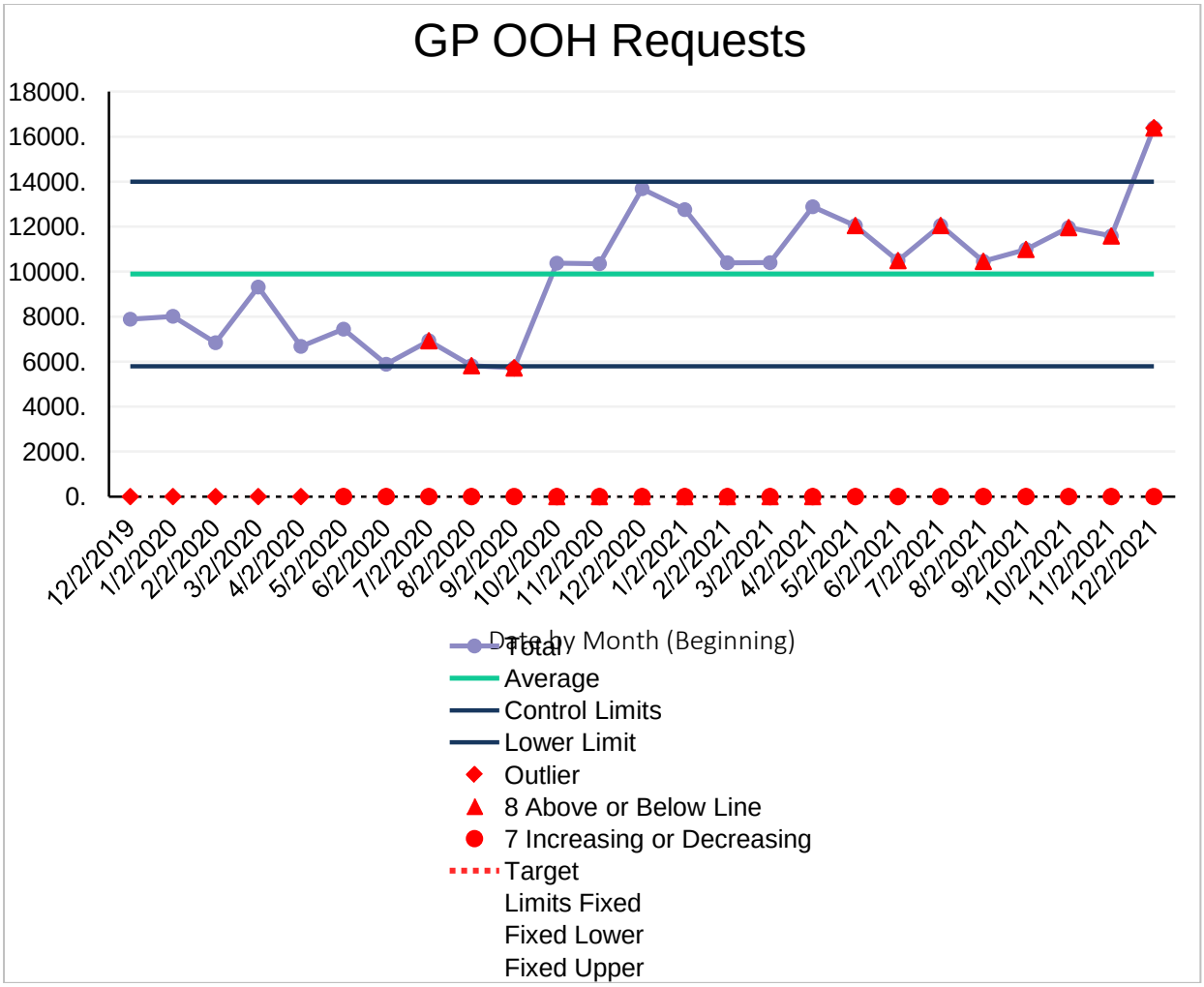
Delayed transfers of care – bed days lost



2.2 Demand

2.2.1 GP out-of-hours services

There has been an overall and continuing increase in demand for our GP out-of-hours services during the 2 year period. The out-of-hours service has responded to the increase through service redesign and the development of the 111 service, although the ability to retain an ageing GP workforce and to recruit new GPs to work out of hours is a continual challenge.



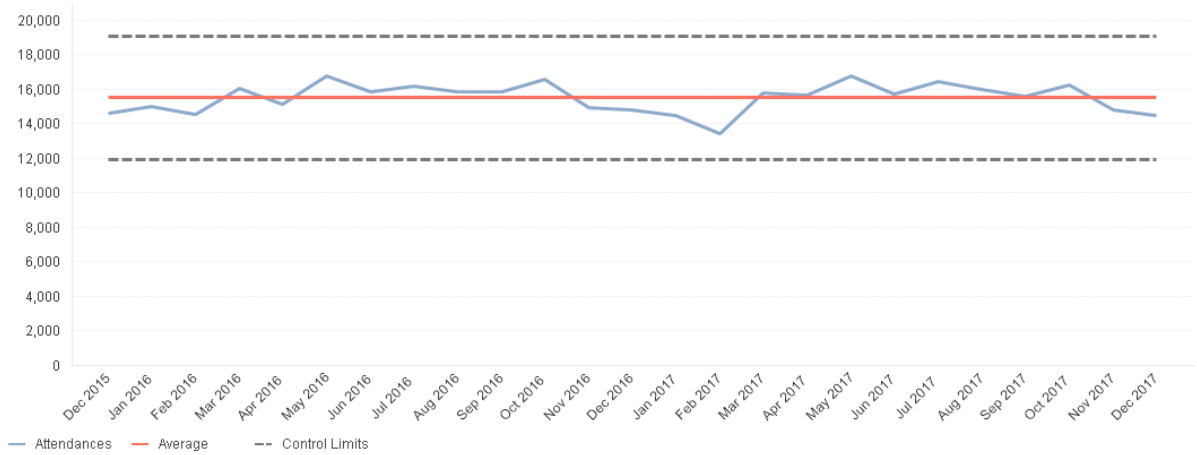
N.B. Quarter 3 activity increases are currently being validated and therefore remain draft.

2.2.2 Attendances at ED and Minor Injuries Units

Overall attendances at our ED and minor injuries units appears to be fairly stable over the 2 year period December 2015 – December 2017, with a recognised pattern of increased demand in the summer months.

However, the chart below masks a trend of reducing attendances at our minor injuries units, and increasing attendances at our major ED units. For Quarter 3 of 2017, both Morriston and Princess of Wales Hospitals' ED's experienced a 5% increase in attendances when compared with the same quarter in 2016, whilst combined attendances through NPT and Singleton minor injuries units have experienced a 10% reduction when comparing 2016 and 2017 activity.

Attendances at ABMU ED and minor injuries units.



2.2.3 Ambulance Attendances

When comparing 2016 and 2017 the number of patient arriving at the front doors of our hospitals by ambulance has increased by 2.5%.

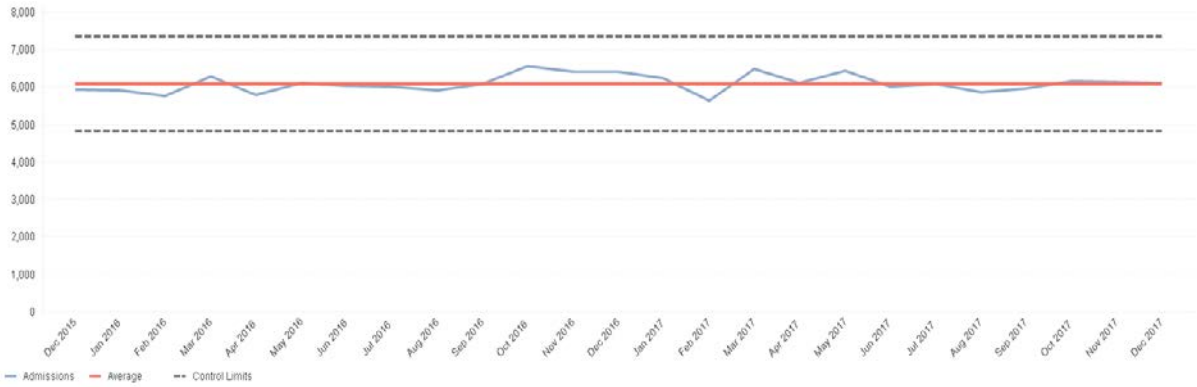
Within this overall increase however our lower acuity (green) conveyances have reduced by 18.7%, whilst amber calls have increased by 5.7%, Red calls (life threatening calls), whilst representing the lowest proportion of overall ambulance conveyances, have increased by 20% during this 2-year comparative period. The increase in amber and red calls suggests an increase in patient acuity.

The reduction in green call ambulance conveyances is attributable to joint working between the Health Board and WAST on implementing new models and prehospital pathways of care that avoid the need to convey patients to a hospital setting. Examples of these include the 111 service, new mental health pathways, the development of the community clinical response teams, and multi-agency working to reduce the conveyance of frequent attenders to an emergency department.

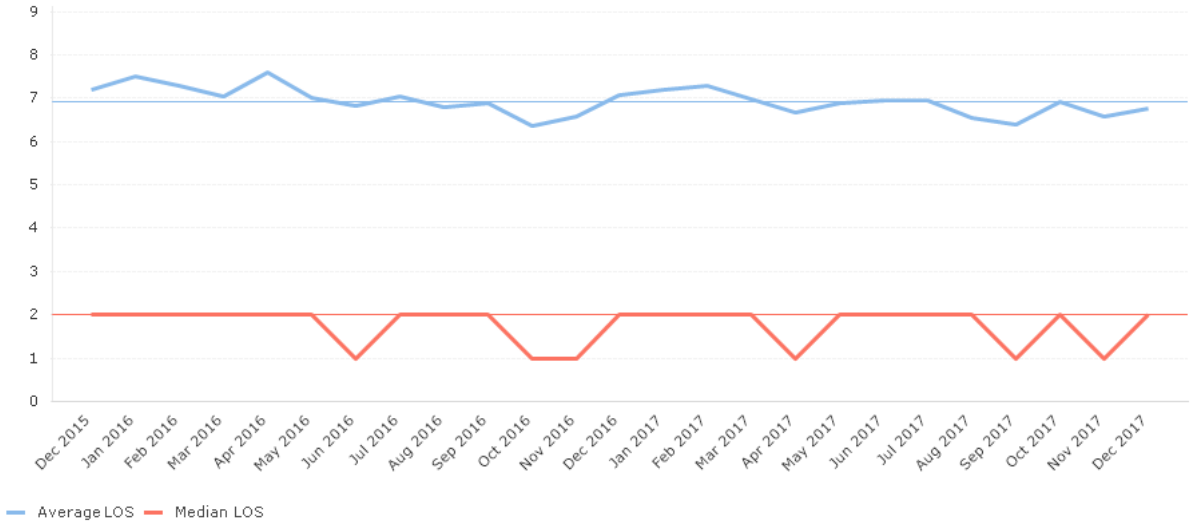
2.2.4 Emergency Admissions

The overall pattern of emergency admissions within the Health Board has been one of reducing demand in 2017 when compared with 2016. Increased pathways of care that do not require admission such as hot clinics, acute response services in the community, ambulatory care models, increased day of surgery activity will have had a positive impact on reducing overall emergency admissions and also length of stay.

Emergency admissions (all specialities)



Emergency length of stay (all specialities)



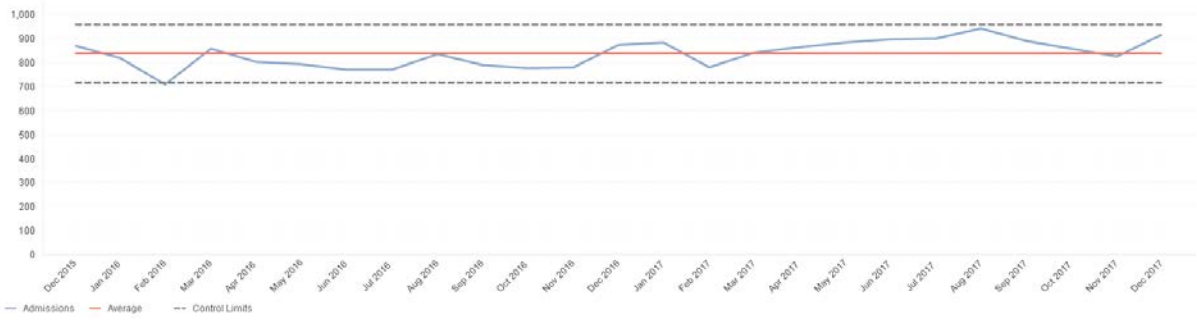
Within this overall profile of emergency admissions however, there are variances between Delivery Units and within specialities. For example, there has been a 12.5% increase in regional services emergency admissions when comparing 2016 and 2017, which impacts upon Morriston Hospital in particular, and also Singleton Hospital.

Medical Admissions

Morriston Hospital

Medical admissions into Morriston Hospital have increased during 2017 when compared with 2016. Whilst there have been improvements in the Morriston Hospital medical length of stay over the summer months through the implementation of the 'Everybody Counts' programme, this has not been matched by a consistent reduction in the number of patients who are medically fit for discharge. Length of stay has consequently started to increase towards the end of Q3, impacting on patient flow and unscheduled care performance, although still remained lower than length of stay in Q3 of 2016.

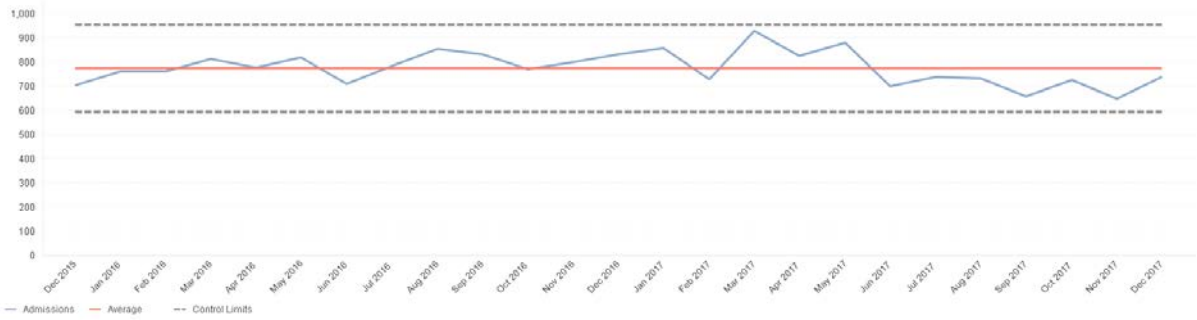
Morriston medical admissions



Princess of Wales Hospital Medical Admissions

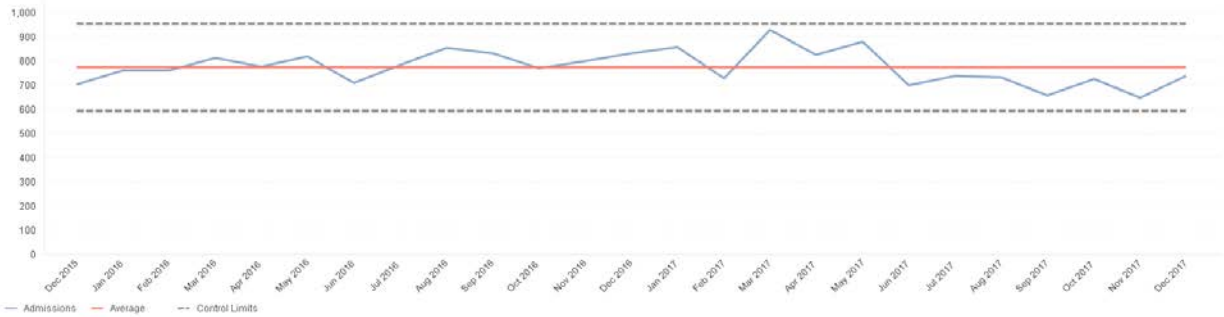
There has been a reduction in medical admissions at the Princess of Wales Hospital during 2017 – this has been as a result of recent changes to the medical unit admissions model and the increased focus on the development of ambulatory emergency care services within this unit.

Princess of Wales Medical Admissions



Singleton Hospital Medical Admissions

Singleton Hospital has seen an overall reduction in medical admissions during 2017.

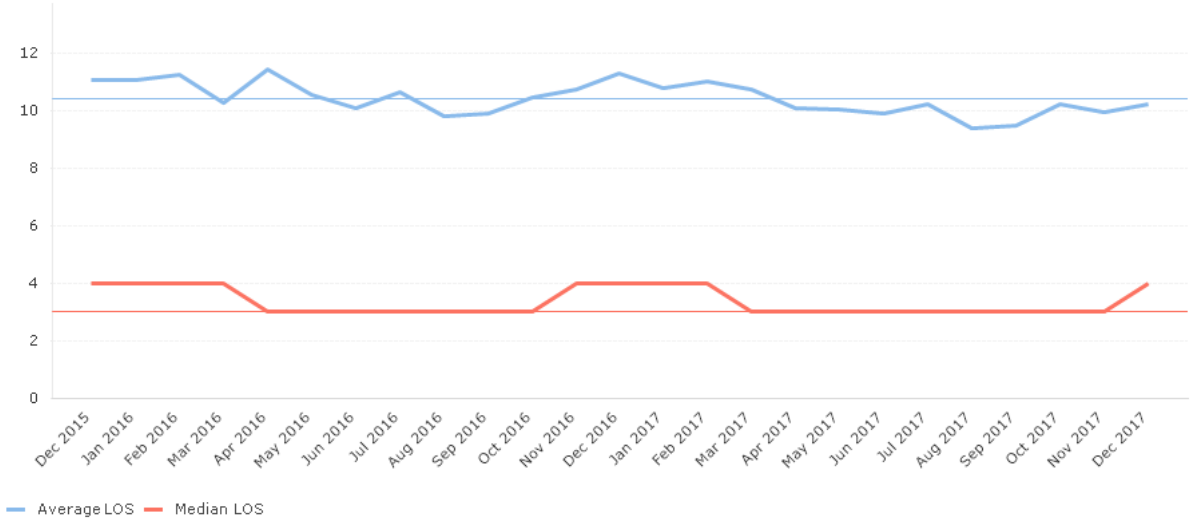


Changes to the frailty model at the front door of this hospital have had a positive impact on reducing medical admissions, and the patient length of stay for this speciality group. Alongside this service change, plans to increase the range of medical procedures and interventions being undertaken on a day case basis are being progressed through the expanding role of the medical day unit at this hospital.

Medical Length of Stay

There has been a particular focus during 2017 on improving pathways of care and length of stay in medicine, as benchmarking reports have indicated that the Health Board's length of stay in acute medicine and non acute medical pathways presented opportunities to deliver improved efficiency. This focus has resulted in on overall reduction in length of stay for this speciality group as outlined in the graph below.

Medical Length of Stay – ABMU wide



The improvements in reduced length of stay achieved through planned activities within the unscheduled care improvement programme during Quarters 1 and 2, enabled 86 medical beds to be removed from the baseline bed capacity. However following increased challenges in patient flow and performance, **winter** '**surge**' **capacity** was opened earlier than planned in quarter 3. This surge capacity currently remains open with the aim of decommissioning this capacity by the end of Quarter 4.

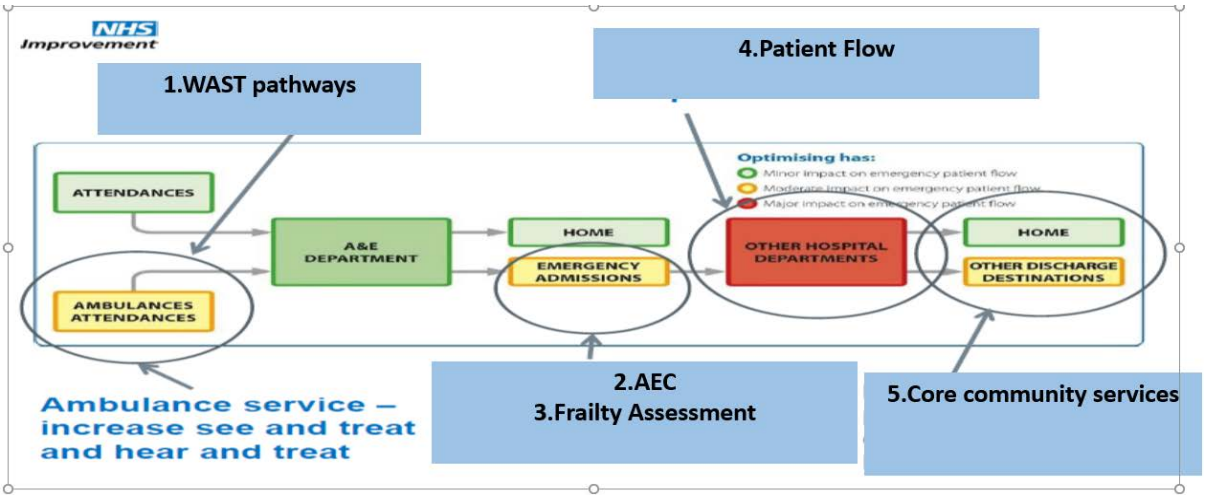
3. Unscheduled Care Improvement Programme

The Health Board's unscheduled care improvement programme largely reflects the NHS improvement priorities that have been widely recognised as key to supporting sustainable improvement in patient flow namely:

- Pre-hospital/WAST pathways - signposting increased number of patients to alternative pathways that avoid conveyance by ambulance to an emergency department.
- Increasing the number of patients following Ambulatory Emergency Care pathways
- Increasing the number of patients benefiting from a frailty assessment process(in light of the predicted increase in the older population).
- Improving compliance with SAFER flow bundles to reduce variation in the management and discharge planning of patients on unscheduled care pathways.

- Improving access to health and social care community support for admission prevention and timely discharge.

This programme is represented schematically below:



3.1 WAST Pathways - pre-hospital

This programme of work has predominantly focussed on developing pathways of care and implementing changes to service models in conjunction with WAST that support and care for patients closer to home, and that avoid the need to convey a patient to hospital by ambulance. Examples of this work programme are outlined in section 2.2.3

A particular focus for 2018/19 will be to reduce the number of patients who are conveyed to hospital by ambulance following a fall, but who have not sustained a bony injury, and do not require secondary care input, as this group of patients represents a high proportion of patients arriving at hospital by ambulance within the Health Board.

3.2 Ambulatory Emergency Care

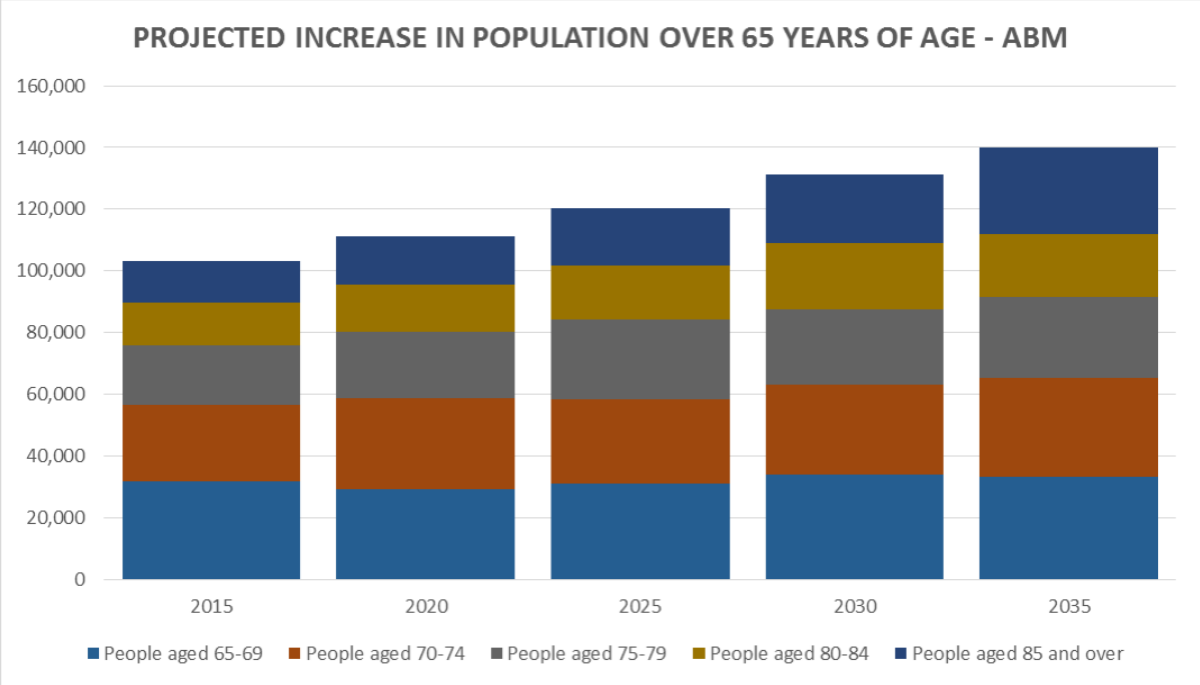
The underlying principle of Ambulatory Emergency Care (AEC) is that a significant proportion of adult patients requiring emergency care can be managed safely and appropriately on the same day, either without admission to a hospital bed at all, or admission for only a number of hours. This is achieved by streamlining access to diagnostic services and reorganising the working patterns of emergency care clinicians to be able to provide early decision making and treatment. There is also a need for immediate access to support services in the community to provide robust safety net systems and optimise integrated care. This is particularly important for managing frail elderly patients on an AEC Pathway.

Within ABMU Health Board, ambulatory care services are being progressively developed within each of our hospital sites and within primary and community services. These services have largely been developed through service redesign supported with some investment, and include surgical, medical and frailty services. Owing to the different nature of the services provided within each service delivery unit, the models of ambulatory emergency care services vary, although the underlying principles remain the same.

Current challenges include data capture of this activity to evidence the number of patients who are being managed on an ambulatory care basis, and the sustainability of models in some areas owing to workforce capacity/ lack of a critical mass. The national ambulatory emergency care programme is working with the service and NWIS to confirm ambulatory emergency care data definitions within Wales which will assist with data capture and recording.

3.3 Frailty Services

There has been a particular focus during 2017 on the development of our frailty services. The over-65 age group is predicted to experience a 35% increase by 2035. Within this, increases are particularly expected in the 85 and over age group, which is projected to more than double in this period, with over 5% growth every year. This will clearly have a significant impact on unscheduled care services.



In recognition of this predicted change in demand, different models of care have been developed during 2017 that have focussed on the frailty pathway within the Health Board. This has included the development of the Transfer of Care and Liaison service (ToCALs) and the enabling ethos ward at Neath Port Talbot Hospital, and the development of the frailty/ambulatory care service at the front door of Singleton Hospital, following the appointment of a new consultant in the Autumn of 2017.

Developments in the frailty service at Princess of Wales Hospital are being implemented during Q4, with increased Care of the Elderly consultant presence at the front door to enhance earlier patient assessment and decisions on patient management plans, along with increased access to elderly care medical day unit services.

Morriston Hospital has developed the elderly care nurse practitioner role, although capacity within the frailty service at this hospital has been affected with the recent resignation of one of the 3 care of the elderly consultants, and a replacement appointment has not yet been secured.

Primary care services are now providing a 7 day acute clinical response team service model across the whole Health Board, with the ACT service in Bridgend commencing a 7 day service from late Autumn 2017.

3.4 Patient Flow

The unscheduled care improvement programme is also supported by the **patient flow programme.** Systematic compliance with the **SAFER patient flow** bundle is key to achieving better outcomes for patients entering the unscheduled care system.

The agreed scope of the patient flow workstream is to complement and support the development and implementation of unit-driven plans to reduce length of stay, as quantified in the benchmarking reports and the PWC report, through achieving improvements in patient flow.

The main elements of the patient flow workstream as outlined in the original project outline are:

- The provision of Health Board wide policies on patient flow
- Health Board wide standard operating procedures
- Workforce models and plans
- Service models and standards
- The provision of patient flow metrics, and support to work towards improving the capture of patient flow information electronically.

The Executive lead for the patient flow group is the Director of Therapies.

An early focus of the workstream has been on the development of a small suite of metrics that provide an indication of changes to patient flow in the unscheduled care system.

The patient flow workstream identified that there was lack of clarity of definitions and inconsistency of reporting of information in relation to medically fit and discharge fit patients, and has therefore focussed initially on agreeing a standardised approach.

It has been agreed that the patient flow system should primarily capture information on when a patient is medically fit. The definition of medically fit is when a patient reaches the point in their clinical plan when assessments, treatment and ongoing recovery can continue outside of an acute inpatient ward. This may include various types of rehabilitation/reablement ongoing clinical care, e.g. IV antibiotics, various functional assessments, including the provision of equipment, and ongoing social care needs.

Increasing the number of patients who follow a '**Discharge to Assess**' pathway will support a reduction in the Medically Fit for Discharge patients within the acute sector, by carrying out the other decisions / interactions in a non-acute setting. This discharge to assess approach has been recommended by WG Delivery Unit reports on discharge models, and is also referenced in the recent draft WAO report on discharge planning within the Health Board. The Health Board's uptake of the discharge to assess pathways has been limited to date, and presents a key opportunity to improve patient flow and outcomes. Developing the Trusted Assessor model is also key to avoiding patient hand-offs, and reducing duplication of patient assessment processes between services and systems.

In support of the patient flow improvement work, the service improvement team within the information department has developed the provision of the following **high level suite of metrics** that are specifically captured to measure the impact of the patient flow activities:

- All patients with a length of stay > 7 days (stranded patients)– Every patient should be reviewed by the Multi disciplinary team to determine the reason for delays and to ensure that an appropriate discharge plan has developed.
- Discharges by hour of day (this links with discharges before midday to demonstrate if discharges are being pulled forward to earlier in the day)
- Estimated date of discharge – aim is 100% compliance for all inpatients within 14 hours of admission by 31st March 2018.
- Discharges before midday – target is 35% by 31st March 2018. Where this is already being achieved the target is for 5 % improvement.
- Length of stay – NB increased uptake of the discharge to assess pathways may result in longer inpatient ALOS, but better patient outcomes.

These measures are now available on the patient flow dashboard and will be used to monitor progress towards delivering improvements in patient flow.

3.5 Community Services

During 2017, the Health Board commissioned Capita to undertake a review of community services capacity and demand within Western Bay Regional Partnership.

The review highlighted the need to realign community resources with work flow – to maximise efficiency and productivity. The Primary and Community services unit also continues to work towards delivering the agreed optimal model for intermediate tier services across the Western Bay .

The development of performance data in this area has been a key priority to ensure that the use of the increased community capacity provided through additional investment in Intermediate Care Fund (ICF) monies is fully understood by partners across Health and Social Care, and to inform future capacity requirements that will support increased admissions avoidance and timely patient discharge.

The Primary and Community services unit is piloting the provision of a Primary and Community Services performance dashboard, which will go live during Quarter 4. This will support the provision of daily information on admission avoidance and discharge activity across the Health Board.

3.6 Winter plan

The unscheduled care programme is also underpinned by the Health Board's winter plan.

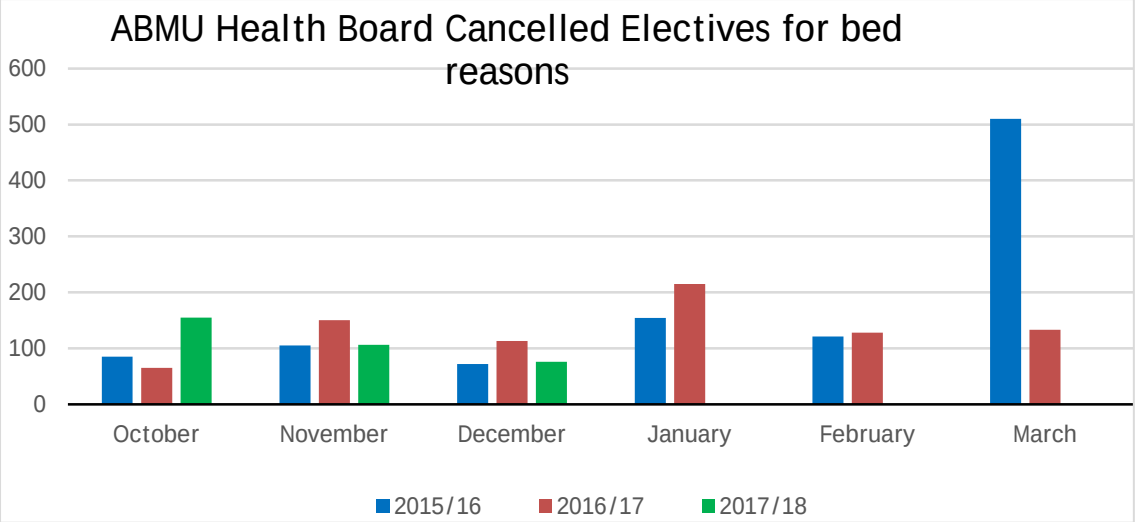
In addition to agreed plans to manage predicted changes in patient demand and flow over the winter months with the opening of additional 'surge' capacity, the winter plan includes a number of other key elements.

Learning from the National evaluation of winter planning for 2016/17, the Health Board has implemented '**Breaking the Cycle**' approach from the 8th – 21st January 2017. Early January is a period where winter pressures have historically been most challenging. Breaking the cycle approach has been implemented as an opportunity to 'reboot the system' by staff working in different ways to provide increased capacity to focus on patient flow, and to resolve issues that impact on timely patient care and discharge within and between services. During this period there has been increased senior leadership, **SAFER** flow principles have been supported and encouraged, and there has been increased operational focus on bringing forward planned patient discharges to earlier in the day. Whilst the period has continued to present challenges, there is early evidence of improved recovery following periods of intensive unscheduled care pressures, along with lower escalation levels. The lessons learnt from this approach will be collated and evaluated following the Breaking the Cycle period. Executive team support in resolving some of the wider system issues impacting on patient flow will be key.

The Health Boards's winter plan also recognised the need to continue to deliver elective surgery over the winter months to support our **Cancer and RTT** delivery programmes. As part of the winter plan, specific proposals have been developed and

implemented on all of our hospital sites, to enable elective operating to continue during the height of the winter pressures.

The early indications suggest that with the exception of October, the number of patients who have had an operation cancelled as a result of bed pressures, is lower than in 2016. The increase in patient cancellations in October was experienced at Singleton hospital, but subsequent adjustments to the day of surgery model at this unit, have resulted in a recovery in this position during November and December.



4.0 Quarter 4 Performance and Delivery Actions

The unscheduled care performance trajectories for the end of March 2018 are as follows:

4 hour	90%
12 hours	300 patients
>1 hour ambulance handover	100 patients
Category A ambulance response time	75%

Based on current performance and delivery through 2017/18, achievement of these trajectories will be extremely challenging.

The following actions are however being implemented during Quarter 4 to recover and improve upon the deterioration in unscheduled performance experienced during Quarter 3.

Actions	**Measurable Impact**	**Times cale**
Implement suite of	Reductions in the number of	End of Q4

proposals agreed from the additional WG non recurrent investment of £1.7million in Q4 – proposals are largely focussed upon improving discharge processes/ discharge to assess pathways , enhanced community capacity and piloting 'green to go' models of care.	patients medically fit for discharge Improvement in key unscheduled care performance against key metrics. Reduction in days lost due to delayed transfers of care. Increase the number of patients who are being managed on a discharge to assess pathway.	
Evaluate and implement the learning from the Breaking the Cycle period in early January.	Improvements in key unscheduled care performance and patient flow metrics.	During Quarter 4.
Princess of Wales hospital to develop the work stream programme to oversee the implementation of the recommendations from the NHS Elect review undertaken on 8th and 9th January.	Improved 4 and 12 hour performance.	Commence in Q4 and continue into 2018/19.
Fully implement and evaluate the agreed actions from the Health Board's winter plan	Reduction in elective cancelled operations and medical outliers compared with 2016. Improved performance against USC metrics	March 2018
Implement the full range of Quarter 4 unscheduled care and patient flow improvement plans.	Improved unscheduled care performance	Quarter 4
Reconstitute the ABMU Health Board Unscheduled care delivery board	Increased system wide engagement, support and governance for the unscheduled care improvement programme.	By March 2018

Fully implement and widen access to the primary and community services dashboard.	Improved information to inform daily demand and capacity, and to support the development of community service models to manage the predicted growth in demand across Western Bay.	By March 2018.

5. Risks

- Workforce capacity – challenges continue to be experienced in key service areas including acute care physicians, ED consultants/middle grades/GP workforce/social work capacity.
- Insufficient data on key areas of activity and constraints to inform investment/disinvestment decisions, as the patient information and community services systems do not currently capture and measure patient flow.
- Ability to fully implement and realise the benefit of the additional non recurrent investment announced by WG on 10th January.
- Community capacity/ sustainability of care providers

6. Recommendations

Despite the improvement work in the early part of 2017, Quarter 3 unscheduled care performance experienced a marked deterioration against the key unscheduled care performance measures.

The Finance and Performance Committee is requested to note recent unscheduled care performance, to recognise changes in the pattern of demand for our unscheduled services, and to support the ongoing implementation of plans to deliver improved and more sustainable unscheduled care performance during Quarter 4 and beyond.