Operational Resilience and Capacity Plan 2014-15 Herefordshire

Herefordshire System Resilience Group
September 2014

Contents

Appendices

1. Herefordshire SRG Terms of Reference
2. A&E / Urgent Care analysis June 2014
3. ECIST Review
4. Transformation Programme Overview
5. SRG Action Plan
6. WVT Action Plan
7. RTT Information – SRG investment in elective Activity
8. Escalation Management Plan
9. Herefordshire Flu Plan
10. PM Challenge Fund Overview
11. Risk Register
12. Integrated Urgent Care Slides
13. Templates – Non-elective and Elective Care
14. Care Pathways Progress

1. Introduction

"We want to create a high quality, sustainable and integrated Herefordshire health and social care economy with the public and patients at the heart of everything we do."

[1] *Herefordshire System Resilience Group (HSRG) Terms of Reference August 2014*

The creation of the Herefordshire Urgent Care Working Group (UCWG) in 2013 presented a unique and valuable opportunity for all parts of the local health and social care system to continue to work collectively to co-develop strategies and collaboratively plan safe, efficient services for patients around urgent care (non-elective care).

The next evolution has been to expand the role of the UCWG to cover planned care (elective care), as well as non-elective care. This shift is reflected in the change in name to the Herefordshire System Resilience Group (SRG).

The SRG is the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. The group works to plan for the capacity required to ensure delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for the whole of Herefordshire.

Herefordshire Transformation Programme

System leaders in Herefordshire have established a transformation programme across health and Social Care targeted at delivering high quality sustainable and integrated services from a residents perspective aimed at improving the Health and Social Wellbeing of the population of Herefordshire.

The project involves Herefordshire County Council and Herefordshire Clinical Commissioning Group as the principle commissioners of health and social care services for patients and residents, with full involvement of the providers of services such as Wye Valley NHS Trust, 2Gether NHS Foundation Trust, Taurus Healthcare, West Midlands Ambulance NHS Trust, Prime care, Social Care providers, as well as Voluntary organisations and patient representatives.

It is focused on delivering system wide transformation to enable sustainable, joined-up, delivery of health and care services using all sectors of our community by:

- Supporting personal choices and enabling personal goal setting
- Improving clinical outcomes
- Improving preventative and predictive pathways
- Increasing quality and efficiency
- Reducing demand on urgent care pathways

Within it there are four Transformational Programmes, each with a SRO, terms of reference and joint agency board:

- **Supportive Communities**

  Integrated support and empowerment of people to live independently to manage their own health and care through: Health education & promotion; and illness prevention, Patient involvement in care planning, Patient access to their own care record, Use of social capital, e.g. healthy neighbourhoods, volunteering and 3rd sector partnerships.

- **Community Collaboration**

Care integrated around the individual person's needs, enabling them to access seamless care at the right level, enabling them to return to independent living , Elderly care, Community hospitals, MH crisis care (prevention), Wider primary care, Primary Care at scale, Shropshire model (pull out & deflection), Parity of esteem, Care coordinator, Single point of access, PM Challenge Fund, Better Care Fund.

- **Planned Care**

  Determining the future role for elective acute services that are fully integrated and seamless from the patients' perspective across providers. Determining the role of generalist versus specialist, community / primary care based or hospital based services. Effective high quality and sustainable services across Elective Medical, Surgical, Patient Transport, Specialised services, Diagnostics, Paediatrics, Obstetrics and Gynaecology, Pathology, Stroke. With appropriate clinical and medical management to support seamless service delivery.

- **Urgent Care**

  Determining the future role for non-elective acute services that are fully integrated and seamless from the patients' perspective across providers. Effective high quality and sustainable services across Accident and Emergency (A&E), Minor Injuries Units (MIUs), GP out of Hours (OOH), NHS111, Role of Primary Care and GPs, Psychiatric Liaison, Ambulances, access to Diagnostics, non elective Medical and Non-elective surgical care.

These transformation programmes are themselves supported by four system transformation support and enablement workgroups:

- **Finance**

  Joint Finance Sub-Committee of Transformation Programme to review: Estate, Overheads, Assets, Contracts, duplication of roles, organisational finances (operating losses / surpluses, reserves and contingencies).

- **Workforce**

  Workforce strategy group, looking to support and develop the future workforce to influence and respond to changes in service delivery including integrated workforce planning, employment terms and conditions, educational support and training, skills mapping.

- **Technology**

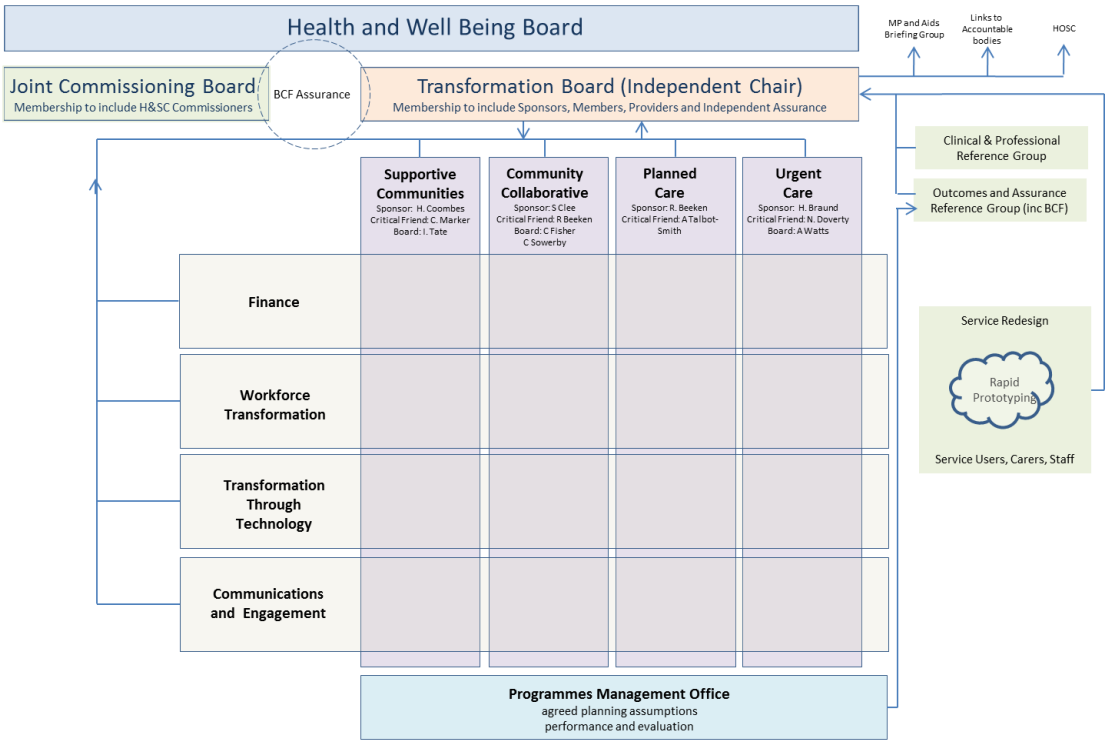
  Technology steering group, working to understand and deploying digital technology to enhance service delivery through effective and appropriate information sharing including single patient held record, assistive technologies and telecare.

- **Engagement**

  Engagement sub-group an all agency strategy group enabling the adoption of best practice with regard to co-production, engagement and consultation.

The Transformation Programme sits under the auspices of the Herefordshire Health and Wellbeing Board, and alongside the Joint Commissioning Group and a key aspect of the programme is to ensure alignment in terms of concurrent policy implementation and transformation such as implementation of the **Care Act 2014**, compliance with the CCGs **five year strategic plan**, and the joint Health and Social Care plans around the **Better Care Fund (BCF)**.

Herefordshire Transformation Programme



The Systems Resilience Group helps to contribute to short and medium term ***operational delivery and support*** of **Planned Care** and **Unplanned Care.**

The Operational Capacity and Resilience Plan deals with planning of the capacity around non-elective and elective care over the next 12 months, to meet expected and jointly agreed views of the demand for these services.

Operational Resilience and Capacity Plan 2014-15 is sub-divided into sections dealing with:

- How the plans ensure and deliver locally good and best practice across unplanned care (**Urgent care**), planned care (**Planned care**),
- The wider considerations that ought to be taken into account such as: patient experience, management of chronic conditions, engagement with independent and voluntary sectors, the Social Action Fund, The Care Act 2014, and the Better Care Fund,
- Governance of the SRG itself, reporting arrangements, assurance and support, and
- Building on existing work.

2. <u>Un-planned Care – Operational Delivery of Urgent Care in 2014 -15</u>

2.1 Vision for Urgent Care

The Herefordshire Systems Resilience Group is working to design a model of urgent care services to ensure that those who require urgent advice, care, support, treatment or diagnosis can access the right care in the right place, by those with the right skills; that

- Are simple to understand, to access and to navigate
- Provide as much care as possible, locally, for the majority of people
- Support people's options for self-care of their health need or long term condition
- Ensure specialist care with high quality outcomes is easily accessible for the smaller number of patients needing these services.

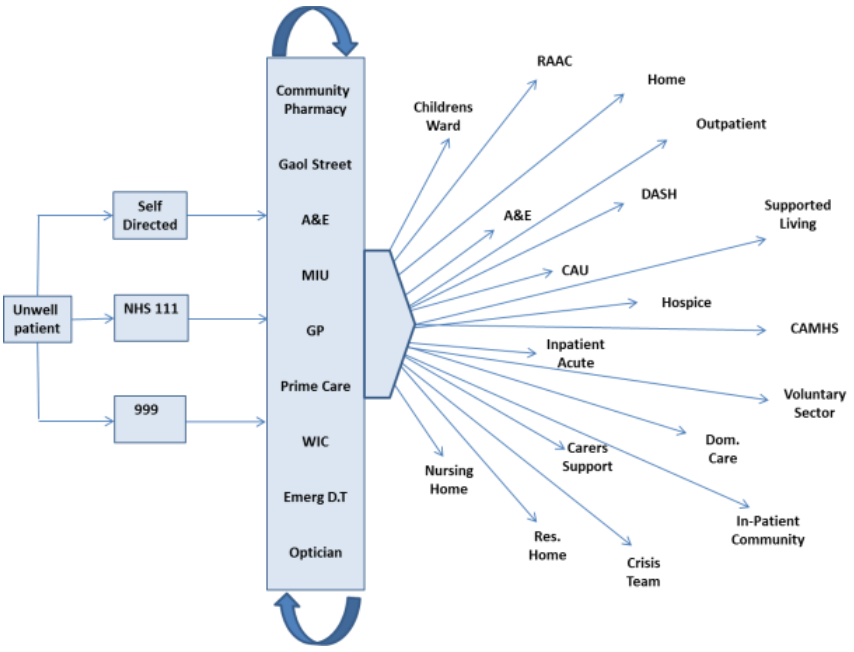
NHS urgent and emergency care services provide life-saving and life-changing care for patients who need medical help quickly and unexpectedly. It is clear that accident and emergency services are under increasing pressure and the SRG wants to improve the urgent and emergency care system so that patients get safe and effective care when they need it.

Listening to the views of patients, carers and individuals across Herefordshire a clinically proposed model of care is being developed to reflect the outcomes of discussion and consultation with Herefordshire residents. The Herefordshire vision for urgent care reflects the following key areas:

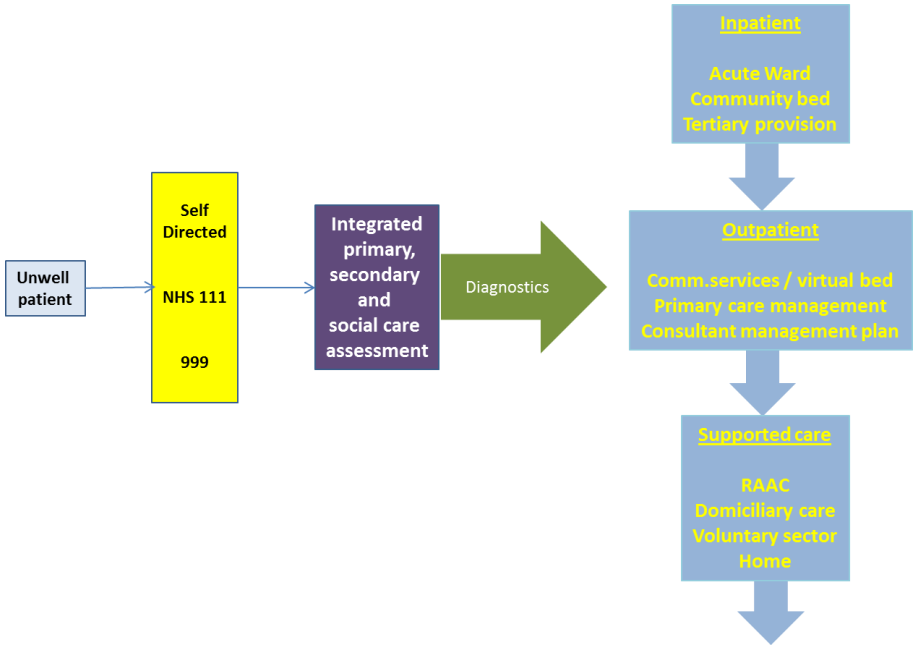
- Patient safety is the priority.
- Services have clear objectives, and must be evidenced based with measurable outcomes based on quality.
- Services are clinically led and involve expert clinicians in each of the key component areas of an urgent care service.
- The service is as efficient as possible and must provide an excellent patient experience.
- Clinical and operational governance must apply consistently to all patients and pathways.
- Capacity is matched to real demand and services are not duplicated.
- The service offers value for money.
- Activity, outcome data and performance monitoring should be produced in as close to real time as possible.

Current services across Herefordshire are complicated for patients to navigate, with too many entry points that often direct the patient to receiving a more acute focused service than their needs actually require. Patients are often being returned into a more acute environment within the community rather than enabling them to return to their home with the necessary help and support to enable them to continue to live an independent life.

Current State



Future Desired State



System Transformation

The proposed system transformation makes use of the priorities for change and sustainability, to integrate and order services to guide the unwell patient into an integrated service model, that focuses on the needs of the patient, and is aimed towards rehabilitation, making use of community based services and only taking those patients requiring urgent acute care quickly into and through the acute service.

The system transformation is underpinned by the local joint strategy for an Integrated Urgent Care System (IUCS) that identifies the vision for community services as:

- Acute discharge is supported in a timely way: immediately
- Includes acute admission prevention
- Community based comprehensive assessment
- Integrated pathways across health and social care
- Maximises independence of Service Users.

The system transformation will be considered successful when there is:

- An Urgent Care integrated pathway for acute discharge AND prevention
- A Single point of access
- Discharge to Assess as the default position
- Any member of the ICUS/MDT can refer to certain elements of the pathway as a Trusted Assessor / Referrer
- A shared, unified generic referral process
- A system that supports maximised independence
- Increased informal support by families and carers

Key Community Services elements that have to be a part of the IUCS include:

- Hospital at Home / Virtual Ward
- Community / Neighbourhood MDTs
- Links to GP's Community Matrons. Sisters, Nurses and OTs
- Effective in-reach services to pull patients out into the community

The current design of urgent care services has led to an increase in demand for the more acute focused services in secondary care, a demand that has outstripped the ability of the service to deliver against key performance targets such as managing to the 4 hour wait in Accident and Emergency.

A critical role of the System Resilience Group is to attempt to match services to the demands being made on them, and to help direct the flow of patients into the right services at the right time. This is to ensure that more clinically appropriate alternatives to acute hospital care are fully utilised benefiting both the patient themselves, and the more acutely ill patients whose experience of care is currently being compromised by the pressures of patients not going to the right service at the right time.

2.2 Understanding Lessons From Last Year and Independent Reviews

Critical to getting services right is to understand both the pressures and demands on services, and the types of initiatives that have worked in previous years.

Lessons from 2013 - 14

What went well	**What could be improved**
Hospital at home OPAT – Antibiotics in the Community Clinical Assessment Unit Rapid Access to Assess (RAAC) Virtual Ward Discharge to Assess Placements Hospital at Home Psychiatric liaison Ambulatory care in the acute trust GPs in A&E Operational Conference calls Flexibility in freeing up capacity in a crisis Urgent Care Working Group Clinician / GP support to 111	Additional Acute Capacity Increased capacity for 24/7 working Virtual Ward / Hospital at Home Rapid Access to Assess (RAAC) Increased community capacity – to enable patients to stay and return home Increased Mental Health / Social care especially at Weekends Improved discharge planning Primary care access OOHs WMAS / Patient Transport Services GPs /clinical support in cars/ambulances Single Point of Access for Urgent Care Referral Sharing of Data & Communication
What was found to be ineffective	**Priorities for action**
Too frequent conference calls on the same day Nursing home beds – gaining quick access at points of high levels of acute care pressures and block purchasing was too inflexible Inappropriate expectations of Powys community beds only available for step up not for step down Acute bed base – too little scope for escalation Communication – public messages, and need for multiple calls to organisations to get patients services in place, or to discharge	Intelligence – sharing information in real time Teleconferences – Ensure escalation is matched by seniority of people on calls Rapid response – off the shelf packages of care Increased Reablement Service Shared systems between organisations Single Point of Access for Urgent Care Referral Ongoing communications with Powys organisations Third sector support to community Reset patient expectations regarding systems Early discharge within the day Hospital based social care team

Recommendations from ECIST Review – October 2013

Acute Medical Assessment

- Implement an AMU based physician of many days model
- Implement twice daily review of every patient on the AMU, not just post take.
- Consider direct admissions of GP expected patients to the AMU.
- Create a short stay stream, with twice daily consultant reviews.

- Consider creating a separate surgical assessment unit
- Model bed requirements and reconfigure wards as necessary (but do not increase total bed numbers).

Improving patient flow and expediting discharge

- Ensure that the care plan and progress of every patient in every bed is reviewed every day by a senior clinician.
- Increase the frequency of consultant ward rounds.
- All patients to have a care plan with a discharge date and criteria for discharge no later than 12 hours following admission to a ward.
- The discharge date to be signed off and 'owned' by the consultant in charge. It should only be changed with the consultant's permission.
- Ward round check lists should be considered for all wards.
- One stop ward rounds should be piloted, written up and then embedded as routine practice.
- The process of completing the nursing documentation should be reviewed and rationalised
- Stroke care model should be reviewed with the aim of introducing a seven day TIA service within the context of a stroke network.

The Emergency Department

- Consider introducing See and Treat
- Work with commissioners to enable a redeployment of ENPs from MIUs
- Establish safe staffing to manage ambulance arrivals and reduce queuing
- The observation ward must not be used for inpatients as it does not comply with the definition of a ward.
- Consider using the Observation ward for ambulatory emergency care.

Ambulatory Emergency Care (AEC)

- Develop an ambulatory emergency care service.
- Consider a consultant staffing model for ACE that integrates with a reformed process for managing acute medical admissions and short stay patients.
- Maximise AEC by avoiding a pathway approach and making it the default choice for emergency admissions who are ambulant and with a low MEWS score.

<u>Analysis of Pressures Experienced in Early 2014-15</u> (**appendix 2**)

The following are the key findings from the SRG diagnostic review

- A&E Attendances – There has been a year on year growth of 1,640 (3.6%) from 2012/13 to 2013/14. The majority of the increase since 2012/13 1,368 (83.4%) are over 65's.
- MIU - Data shows that activity has reduced by more than the increased attendances at A&E. Activity at MIUs has been reducing significantly since October 2012. Overall attendances were down by 2,056 attendances, a 38% reduction year on year. The closure of MIUs in January 2014 did have an impact although the trend is a significant reduction. It is likely that the over 65s would be lower users of MIU.
- Referral sources of A&E Attendances – There has been an increase in both GP referrals and 'other provider' referrals, but a big decrease in 'other non-specified'. This is inconclusive as there is a need to understand the reduction and the impact of reclassifications.
- Ambulance – The number of conveyances is up by 6% from 2012/13 to2013/14.
- Delayed Discharges – There is a 5% growth in the number of discharge delays.

- Trends - A number of significant trend changes have been identified since January 2013, which may be due to a change in A&E system/coding.
- Analysis of attendances by over 65s per GP practice has provided a list of top ten practices where work is to be undertaken to understand possible changes in patient presentation and referral patterns. This work will dovetail with other frail elderly pathway initiatives.
- Analysis has shown a significant decrease in Prime care Out of Hours activity year on year due to the introduction of the NHS111 service, which came on line in April/May 2013.
- The GP Led Walk in Centre saw a drop in activity in 13/14. However in the first part of 14/15 there has been a significant increase in the activity and Prime care is also reporting a greater acuity in the patients attending.
- In terms of flow of Prime care patients to A&E, the Walk in Centre has reported an increase of 32% year on year with an average of 30 patients per month in 13/14. March 2014 recorded a significant increase to 49 patients referred into A&E from the Walk in Centre.
- During the last 4 months the NHS111 data has shown an increasing trend in ambulance, A&E and other services signposted. This confirms other data showing an increased in emergency activity and acuity.
- In the early part of 13/14, admissions via A&E at WVT were significantly lower than 12/13. However in August and from November onwards there was a marked increase. This in part is attributable to the increased A&E attendances activity, but also the reported increase in the acuity of presenting patients' conditions.
- This increase in admissions via A&E is more pronounced for the over 65s. There was a 2% increase in the 13/14 conversion rate for over 65s, whilst under 65s increased by 1%. The over 65s attending A&E have a 49% chance of being admitted, whilst for under 65s the chance falls to 18%.
- Virtual wards were implemented as a pilot across the 8 city practices in October 2013, with two components, a risk stratification component and a hospital at home component. To date the hospital at home has supported early discharge for 174 patients, and admission avoidance for 135 patients mainly avoiding what would have been short stay admissions.
- Implementation of the RAAC scheme (Rapid Access to Assessment and Care), which commenced in January 2014 with the "discharge to assess" component. By June this had taken 51 patients out of Wye Valley Trust. An additional 32 patients were supported through earlier discharge by spot purchase of additional capacity within the scheme during periods of increased emergency pressures. Increasing capacity in this scheme requires consideration of dedicated community nursing staff capacity to support the community matron who manages these patients through the scheme.

Next Steps

Reduce in-flow, including the following factors;

- Work with high access rate GP practices to understand referral patterns and issues impacting referral rates
- Ongoing work with WMAS to understand changes in activity/case mix profiles, to provide assurance that there is no change in practice outside of contract
- Support reduction to acute activity through NHS111 development
- Target care home practice linked to presenting diagnosis (falls / dehydration)
- Target access and referral patterns and link to Taurus Prime Minister's Challenge Fund project performance
- Identify further opportunities to increase see & treat including community paramedic development
- Work continues around the frail elderly pathway which will include a focus on the impact on A&E
- A focussed patient education campaign which ensures the right care at the right place at the right time

Increase outflow:

- Increase capability to manage hospital admissions
- Community teams and social care colleagues to improve discharge pathways
- Increase capacity for Hospital at Home
- Increase levels of Primary Care supported discharge

2.3 Demand for Acute Urgent Care

Expected Demand versus Available Capacity

The experience to-date of demand is that it is above joint plans and has outstripped the planned capacity across the system, with all sectors reporting demand above forecast and contracted levels. As such the system has been unable to cope effectively and performance measures such as ensuring 95% of patients are seen, discharged or admitted within 4 hours have been unable to be met.

The ability of the system to manage demand against its capacity to treat is complex. It is not simply that the capacity is not there, that demand is too high, but it also involves managing the flow of patients towards the most appropriate capacity, and that the processes to support flow through that capacity are also working as effectively and efficiently as they can do at all times of the day and week.

The earlier lessons learnt from 2013-14, the recommendations from ECIST, and the analysis of demand pressures demonstrate all of these complexities. The system is not yet truly a functioning 24/7 service, so there are issues with accessing the correct services both out of hours, and at weekends and bank holidays, where also the absence of services impacts flow.

As a result A&E attendances at a weekend are higher than they might be, discharges from both acute and community beds are less than necessary, admissions increase because alternatives are not being accessed effectively, leading to severe operational issues for the system at the start of the week. Pressures on acute beds, leading to delays in admission, breaches of the 4 hour target, and escalation processes having to be taken across the system, that in some cases are less than the best practice the whole system aspires towards.

Capacity that is in place to meet demand can have physical constraints to its flexibility of response, in that there may be fixed assets that can only deal with a set demand, after which the service is swamped. There are only a certain number of cubicles in A&E, a fixed number of ITU / HDU / CAU beds. The capacity in the community is likewise constrained, it is difficult to flex upwards at short notice as extra staff have to be put in place. The ideal system would have access to a level of flexible capacity that could be brought into service very quickly, as escalation and demands are shown to be rising. The reality is that for much of 2014-15 this flex capacity is being used as routine, leaving the system exposed at peak times of demand.

The priorities therefore for the System Resilience Group in planning the capacity over the winter period have been:

- Ensuring that best practice recommendations are in place
- Managing the flow of demand to the right place at the right time
- Increasing the level of non-acute clinically appropriate alternative capacity in the Community
- Creation of the right acute capacity to manage both presentations and admissions
- Optimising the management and flow of patients through the urgent care system
- Ensuring that the correct level of end of urgent care pathway capacity is in place within the Community

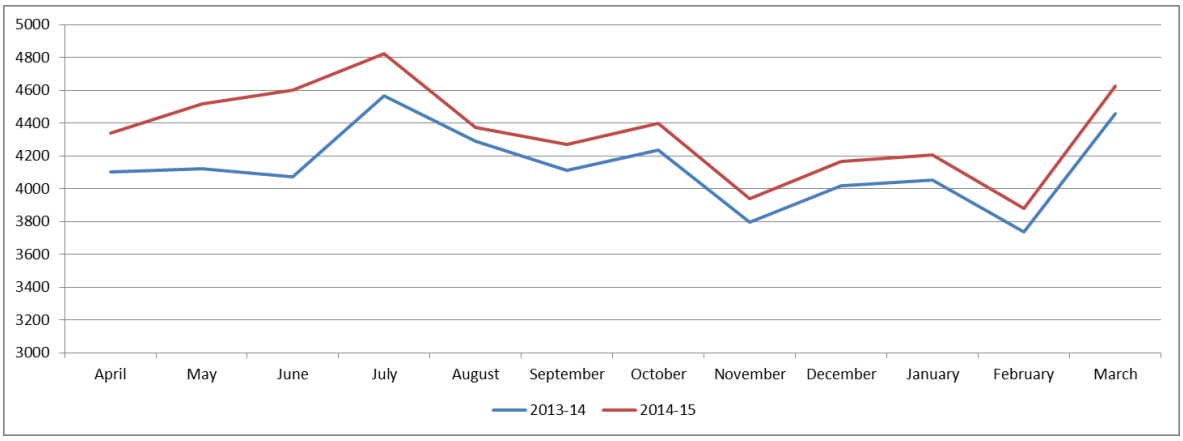
- Avoiding duplication of assessments and removal of unnecessary organisational / systems barriers to enable the right thing to be done at the correct time
- Increasing the capacity and capability for the system to operate more effectively 24/7
- Sizing capacity to meet demand, and understanding how initiatives being put in place across organisations, either funded from core resources, or from the extra nationally available urgent care resilience fund (£1.1m for Herefordshire), impact on demand or the capacity to deal with that demand.

Given that the system is often under severe pressure across all sectors, the measures being taken are under constant re-evaluation to ensure that they are appropriate, and delivering what is expected. Some are directed a short-term increase in capacity to ease pressures, whilst other longer-term strategic initiatives are put into place that will help to reshape the service and mitigate current demand pressures. There are lead in times for some of the proposed measures, eg building work to take place, or staff to be employed, and trained.

The Urgent Care part of the Operational Resilience and Capacity Plan 2014-15 is charged with achieving sustainable delivery through systems redesign and transformation, it is about managing effectively over the short-term whilst the more substantial service transformation is put into place.

Overall demand profiles based on current activity projecting until the end of year before any impact of additional schemes over the winter period.

Accident and Emergency Attendances



For Wye Valley NHS Trust A&E (including MIU) attendances are significantly above last year by 7% year to date, although the average over the last 3 months into September is averaging 3.8% above last year. The demand assumptions overall are that using the last 3 month average growth for the remainder of the year will arrive at an overall growth over last year of 5.2%.

For Herefordshire CCG as at month 4 attendances via SUS were recorded as 16,572 against a plan of 16,313 so 1.6% above contract, although the cost of activity was 6% above plan signifying that the case mix being richer than was contracted for.

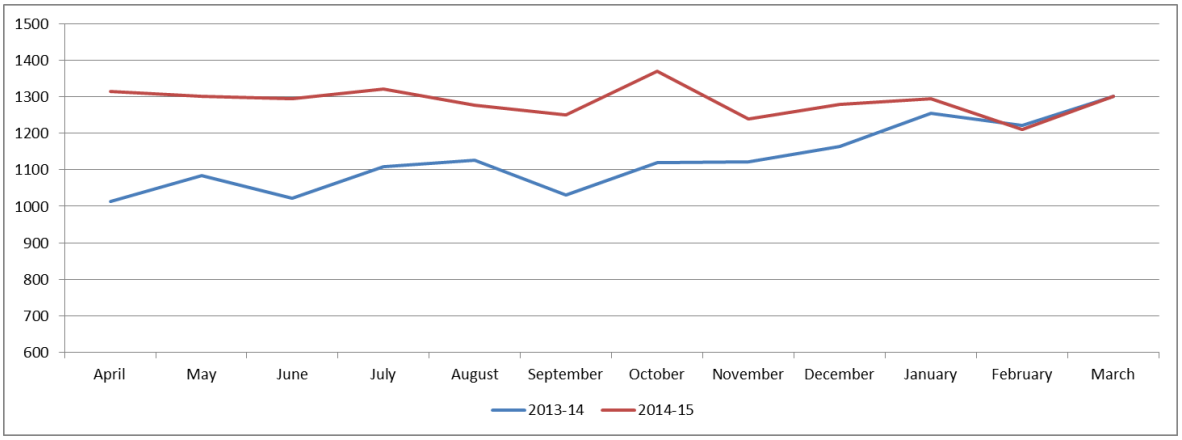
This activity averages at 143 attendances per day, with peaks above 170 on some days the peaks often arising on Sundays and Mondays.

The Wye Valley A&E was designed to operate with an average of 125 attendances, so for most of the week it is operating above its original design parameters. Part of the problem is that too many referrals are being directed to go through A&E rather than going direct to existing speciality beds or directly into the Medical Assessment Unit (MAU).

Priorities for action are to:

- Enable direct GP referral to the Clinical Assessment Unit (CAU)
- Ensure the appropriate direct referrals are going to Specialty Beds/Clinics or directly into MAU.
- Ensure that inappropriate referrals, or referrals that could be dealt with more appropriately in the Community, are done so, either through directing them to the Walk in Centre (WIC), within Primary Care, or direct referral access to alternative clinical pathways and diagnostics.
- Sizing the department appropriately to deal with the remaining referrals that ought to be going through the A&E department.

Acute Emergency Admissions (non-elective admissions)



What can be seen is that there was a significant increase in emergency admissions recorded by the Wye Valley NHS Trust that started in November, but that since February and up to September seems to have remained relatively steady month on month. The demand profile above reflects this going forward.

Wye Valley NHS Trust is therefore recording a 20% growth in emergency admissions year on year up to the middle of September, with the expectation that by the end of the year this will average out at around 13.2% year on year.

Herefordshire CCG is over-performing against contract with Wye Valley NHS Trust in terms of Non-electives via the SUS data at the end of month 4, having 4,601 spells against a plan of 3,732 or 23% above activity plan. In terms of the financial value of this activity it is almost exactly in line with the financial costs to within £500 against a projected £6.75m to the end of July. (This is before any adjustment for marginal tariff as part of Payment by Results (PbR).)

This reflects an increase in short-stay admissions, and is led in part by changes in the management of patients as a result of actions taken by the Trust in response to both the ECIST independent review, and the Rapid Response Review (mini Keogh quality review) that also took place in October. This is therefore an improvement in the management of patients rather than gaming.

As a general rule of thumb taken from the detailed analysis of information already shared across the system each day, the Trust in weekdays admits between 7 to 11 elective inpatients overnight, with a further 40-60 daycase elective patients each day; in addition there are a further 35-55 emergency admissions each day into the Trust with roughly 23% of these being discharged the same day, leaving between 30-45 overnight non-elective admissions.

This means that from its total bed base of 208, Wye Valley NHS Trust has during week days to discharge between 40-50 patients who have been in hospital overnight or longer in total (7-11

electives, 33-40 non-electives). At weekends as admissions are less there is a need to discharge between 25-35 non-elective patients who have been admitted for at least one night.

Using the current metric of patients who stay overnight non-electively having an average length of stay in hospital of 6.1 days, and elective patients who stay overnight having an average stay in hospital of 2.5 days, with the bed occupancy being targeted at 95% this gives an over-night bed requirement of between 220 to 240 beds dependent on the month of year. This is well above the actual operating bedded state of the hospital and in part explains the operational difficulties in managing to the 95% 4 hour target in A&E.

This doesn't currently include additional overnight elective patients transferred to the Independent Sector as the Trust does not have the physical capacity to deal with them without further compromising urgent care capacity. This is circa 50 patients a month, or roughly a further need for elective beds of between 6-8 beds each weekday.

It should also be noted that operating bed occupancy at 95% is well above the national performance metric which is expected to be circa 85%.

Herefordshire as a population due to the high quality management of patients within primary care already benchmarks very low in terms of overall access rates for non-elective admissions per head of population, although this overall position does mask that there is considerable variation in terms of access rates by practice. Understanding and taking action to manage variation across practices through peer support, practice reviews, and internal practice referral/access reviews are all ways in which Herefordshire is looking to equalise towards best referral and patient management practice.

However, as can be seen from the recent report, ECIST believed that extra beds were not the answer in the medium- term. ECIST cited a significant number of operational changes to the management of flow of patients that they believed would reduce the average length of stay, and therefore reduce the need for over-night beds. This was however prior to the increase in A&E attendances which in part has increased admissions as a result.

Operationally the Trust is only managing to deal with the required bed numbers presently by having to use capacity set aside for Day Case surgical patients, and the Clinical Assessment Unit (CAU) which should not really be used for patients requiring overnight admission. This increases the costs for the Trust in having to staff areas in addition to normal capacity overnight, and potentially compromises the quality care of patients in these facilities.

ECIST, the Trust itself, the CCG and partner organisations believe more can be done to deliver alternatives to admission, through greater development of capacity for ambulatory care patients both inside the hospital and within the community. This could both reduce the number of attendances at A&E, as well as reduce short-stay admissions especially overnight, as well as improving the quality and experience of care for the patients themselves.

In addition it is clear that the operational issues are leading to less than optimal systems and processes across the whole health and social care system. With continual fire-fighting the pressure is to move patients on through the system as quickly as possible, and occasionally requiring more intensive support in care settings outside hospital as a result. Fire-fighting has in some part become the norm, rather than ensuring that the systems are working effectively, sharing data and operating to best practice guidance in terms of Expected to Discharge Dates (EDDs) for patients on admission, effective discharge planning across organisations to reduce delayed discharges (transfer of care DTOCs), ensuring that patients are identified for discharge earlier in the day, that assessments are carried out in a planned way by partner organisations.

There is a cohort of patients who with better planning ahead of a personal health crisis could be supported to remain in the community, patients who are referred or who self-refer to hospital where existing care packages are in place, but this is not effectively communicated so the hospital staff try to address problems for which existing support service already exist, i.e. patients with long term illness, chronic care conditions, those in receipt of existing home care support from either health or Social Care. In addition data would suggest that a number of patients are being admitted to hospital simply to die, whereas with better end of life care (EOL) planning, they could be supported to die with greater dignity in their own usual place of residence in the company of their family and friends.

2.4 Priorities for 2014-15

Priority for action has been to:

- Identify and source additional bedded capacity to be in place at WVT by the autumn (this gives extra capacity above baseline of 7 extra beds).
- Extend access to more clinically appropriate ambulatory care pathways across the LHE, as an alternative for referral to and admission to hospital, including increased capacity for Hospital at Home, Virtual Wards, Community Nursing Support, Domiciliary Care packages.
- Direct referral to specialty clinics / beds, MAU without having to go through A&E, this will reduce the number of patients having to be dealt with in A&E.
- Extended access to diagnostics from Primary Care outside 9-5 and at weekends, to reduce the need to refer into A&E or admit patients for diagnostics out of hours.
- Improved communication in relation to Patients EDDs across and within organisations, to endure an integrated approach to discharge planning on admission, which will reduce the ALOS for patients on average.
- Improved anticipatory care planning for patients at risk, i.e. Frail Elderly, patients with long term and Chronic Conditions, EOL plans and services for patients near to death. This will reduce conveyances to hospital from the community, nursing and residential homes, and reduce unnecessary admissions to hospital as a result.
- Support to care homes to enable them to be confident to manage patients in their usual place of residence, thus reducing referrals to A&E, admissions and often delays in returning patients back to the care home.
- Earlier identification of patients able to be discharged in the day. Too many ward rounds / board rounds occur too late in the day to be effective in releasing bedded capacity ahead of when it is required for newly presenting patients.
- Greater capacity to support earlier discharge, using the Discharge to Assess model of working to discharge patients home wherever possible with home support, and then assessing longer term health and social care needs, or to Discharge to assess beds where rehabilitation takes place to re-able people to return home. The SRG plans to purchase 13 Discharge to Assess Beds which will reduce by equal measure the pressure on Wye Valley Beds in the Community and Acute settings. We are failing patients if we 'medicalise' their problems too early which results in them being discharged to places other than their home unnecessarily.
- Increased flexibility in the options and use of community capacity to enable discharge, at times of stress there is often capacity but of the wrong sort, whereas with proper planning greater flexibility of use could be made.

2.5 Supporting Urgent Care

2.5.1 Primary Care supporting Urgent Care

Herefordshire benefits from having a history of excellent primary care services, which has helped the urgent care system in that hospitalisation rates for urgent care are generally low and benchmark well in comparison both to national and other rural areas. However, the pressures on Primary Care have increased in line with pressures on all providers of health care, so there are challenges to continuing

with high quality services compounded by having a resident base that is sparsely populated, and with significant numbers of GPs approaching retirement.

Whilst it is difficult to identify any local trends, national stories abound in relation to patients having difficulty in accessing GP services, which anecdotally is leading to an increase in self-referral to other services such as Walk In Centres (WIC), or direct to A&E. the 'I can't get an appointment with my GP, so I'll go to A&E instead'.

Herefordshire in this context does benefit from having both a Walk In Centre in the centre of Hereford a service which is extremely popular with patients and extensively used. In addition it has recently been awarded extra resources this year as part of the 'Prime Minsters Challenge Fund', where the remit was about increasing access to primary care through the use of innovation, and extending GP practice hour, and creation of primary care hubs, including direct bookable appointments in Primary Care for patients presenting at A&E who could be dealt with in Primary Care.

One of the realities of Herefordshire is that it has a significant migration of people into Herefordshire each year, the population has grown faster in proportion that the national average as a result of migration, as well as being a net exporter of young people who leave Herefordshire after schooling has finished in order to gain employment. This growth in population brings with it issues in how these people make use of Primary Care.

The current (mid-2012) resident population is 184,900, having grown entirely due to migration by six per cent (10,000 people) since 2001 (compared to eight per cent in England & Wales overall). This doesn't include 3,000 students living away from home during term-time who may well use local services when home. It also does not include approximately 3,000 temporary seasonal workers from Eastern Europe each year. Latest demographic trend-led projections suggest that, if recent trends were to continue, the population would reach 205,400 by 2031.

Net migration increased from both elsewhere in the UK (net in-flow of 300 people) and overseas (1,000 people) in 2011-12, although remained lower than prior to the recession. As every year, this included net in-flows of most age-groups – the only notable exception being 800 18 to 20 year-olds moving to other parts of the UK (a net 'loss' of 14 per cent of the population of this age-group each year).

Studies elsewhere have suggested that both the young and migrants do not fully utilise Primary Care services in the same way as the older population, they are less likely to register with and seek help and assistance from Primary Care services, and more likely to go direct to other providers such as WICs and to A&E.

However, the principle users of health services in general do tend to be the very elderly, and the proportion of very elderly in Herefordshire is due to increase significantly. Currently 22 per cent of the population is aged 65 years or above (40,800 people), compared to 17 per cent nationally. This includes 5,500 residents aged 85 and over.

There are 25 GP practices in Herefordshire, including the GP led Walk in Centre, offering a wide range of services, including advice on health problems, physical examinations, diagnosis of symptoms and prescribing medication and other treatments. The core hours for surgeries are 8.00am – 6.00pm with a number providing extended hours to their patients. The extended hours appointments are booked in advance. Each practice offers 'on the day' appointments and one practice offers a 'walk in' service, home visits are available for those too ill to attend the surgery. Therefore as part of the service offered by these practices patients with an urgent need for healthcare advice or treatment should be able to access their own GP practice.

Primary Medical Services as part of their contract fulfils the following range of functions to support the urgent care agenda for the Herefordshire Health Economy

- Prevention and screening
- Assessment of undifferentiated symptoms and diagnosis
- Triage and onward referrals
- Care coordination for patients with long term conditions
- Treatment of episodic illness
- Provision of palliative care

The new Directed Enhanced Service for proactive care which aims to reduced unplanned admissions has had a very high take up by practices in Herefordshire and will mean that those greatest at risk will have focused care specific for their needs. This sits alongside the development and roll out of Virtual Wards, currently piloted with City practices.

There is a Local Enhanced Scheme (LES) as part of the £5 per head monies targeted at supporting the over 65s, that has been introduced to bring community link nurses into the system to further support the capacity in primary care to reduce admissions and support earlier discharge. This work is being implemented during September 2014.

GPs in Herefordshire have signed up to and are playing a major role in the comprehensive planning of flu preparedness, and are well prepared in terms of delivering flu vaccinations to at risk groups and primary care practitioners. Details of the Flu plan can be found in the attached appendices.

Herefordshire CCG has expressed an interest in entering into a 'co-commissioning' relationship with the NHS England Arden, Herefordshire and Worcestershire area team in relation to the commissioning of primary medical services.

The CCG has done this in order to better:

- support the integration of health and social care services locally; through working with patients and the public and with the Health and Wellbeing Board to assess needs and decide strategic priorities, designing and negotiating local contracts (e.g. PMS, APMS, any enhanced services commissioned by NHS England) to align service transformation programmes, and deciding in what circumstances how to bring in new providers for integrated health and social care services and managing the associated procurement, plus making decisions on practice mergers where in the best interests locally.
- support member practices to drive quality improvement within primary care, and reduce health inequalities;
- increase the level of public involvement in the development of primary care services;
- support the development of sustainable local services;
- ensure, as a membership organisation, the CCG has a greater positive influence on decisions affecting primary care locally.

All of these aims, in particular supporting the integration of health and social care align with and are congruent with the aims and objectives locally that form the basis of the Better Care Fund proposals for the Herefordshire Health and Social Care Economy.

Pharmacies

There are 26 community pharmacies which in total provide access to a primary healthcare professional without the need for appointment 1390 hours per week across Herefordshire on up to 7 days per week. One community pharmacy based in HR2 opens 100 hours per week across 7 days. Community pharmacists provide advice and supply of medicines prescribed on prescription as well as responding to requests for advice on self-care for example; minor self- limiting conditions for which the minor ailment scheme covers ten common conditions.

In addition, community pharmacists provide advice and supply of emergency contraception, advice and supply in hours and out of hours of medicines commonly used in palliative care. Eleven community pharmacists respond to call outs working closely with the GP Out of Hours when advice and supply of medicines is required to prevent the need to be admitted to hospital for example so that palliative care patients can remain at home if they so wish. Community pharmacists routinely provide a number of services to patients daily which if not provided would impact on other service providers e.g. supervised consumption of methadone, syringe and needle exchange services, emergency supplies of NHS medicines as well as responding to general requests for advice on health matters and signposting. Regular medicines reviews with patients on repeat medicines, newly prescribed medicines and additional pharmacist support into care homes help individual patients manage their medications.

Walk In Centre

There is one walk-in-centre and it is located in the centre of Hereford. The vast majority of the attendees are from the area local to the centre. Access is walk in only. The service is managed by Prime care. The service is open 8am – 8pm 7 days per week. The walk-in-centre is run by nurse practitioners and medical staff and offers treatment for minor injuries and illnesses including wounds, cuts, bruises, sprains, strains and minor burns. There are no diagnostics and investigations available on site. The conditions being managed are of a low need similar to that primary care would normally manage.

The service sees on average about 100 patients per day. Information collected from patients attending for advice or treatment demonstrates that over 95% of patients that attend the Walk in Centre are already registered patients from the City GP practices.

A key are of work pursued by the CCG over the past 12 months has been the development of an outcome based approach to the commissioning of Urgent Care Walk Ins, MIUs and A&E. This approach is well advanced and will be implemented through a prime contractor model. Discussions are underway with provider on how they could deliver the services in a more integrated and innovative way, to ease pressures especially for minor patients in A&E, and to improve the quality and experience for patients as a result.

GP Out of Hours

The GP Out of Hours service is delivered by Prime care and is physically based on the Wye Valley Trust hospital site. The service runs evenings, nights and 24hrs on weekends and bank holidays. GPs are also located across bases in Herefordshire to see patients. Some of these bases include the Minor Injury Unit (MIU) buildings where the public can access the GPOOH doctors at the weekends.

The service is contacted approximately 2,500 times per month. 95% of patients are managed by the clinical staff by telephone, in a primary care centre site or at home. 5% will be advised to attend A&E or will be called an ambulance.

Prime Ministers Challenge Fund

Herefordshire was successful in its bid for investment from the Prime Ministers' Challenge Fund to improve access to primary care. Taurus, a primary care owned and run organisation, is in the process of implementing a series of projects, including 3 hubs, that will extend access to primary care and it will therefore help to support the pressures in our system. This project provides a significant opportunity both to help with the immediate challenges, but also to test our wider assumptions of how services should be configured for the future.

Taurus is in the process of implementing three Hubs within existing GP practices (Hereford City, Ross-on-Wye and Leominster). These hubs will be open 8am -8pm Sat and Sun. 6.30pm-8pm Monday to Friday having a range of professionals available to meet patient needs.

Although these Hubs will not see urgent patients, the opportunity to see a GP out of normal hours will prevent minor issues from becoming concerns which result in unnecessary A&E attendance.

From 1st October there are plans to have an emergency doctor at each of the hubs.

The aim is to provide both urgent and non-urgent primary care over weekends, bank holidays and evenings, especially for those (usually working) who find it hard to get appointments during working hours. In addition other agencies including Wye Valley NHS Trust, will be able to make urgent appointments directly for patients who present to them.

The level of access is based on having 40 slots available each weekday, with 480 slots available at weekends, practices will be sent a copy of the consultation with proposed action plan. Routine and urgent blood tests can be booked by Taurus. Whilst the principles of the Challenge Fund is to improve access for Primary Care, it does this by offering more opportunities for patients to be seen by their local practice, have an impact on the numbers of patients presenting at A&E or at the Walk In Centre.

2.5.2 Seven Day Working

Dr Bruce Keogh's report on seven day services identified the various levels of service provision in regard to seven day services, against which to judge current provision.

- **Level 0** -Five days a week e.g. Monday to Friday, 9am - 5pm, 8am – 4.pm (routine eight hours service)
- **Level 1** – Monday to Friday at departmental level, extended hours e.g. 8am – 8pm Services limited to one department or a service that is beginning to deliver some services beyond 8am - 6pm Monday to Friday services. This could be extended working days and some weekend services however, does not deliver equitable services irrespective of the day of the week.
- **Level 2** – Services are delivered seven days a week, but limited range of services on a Saturday and Sunday. Services that are delivered seven days per week, but not always offering the full range of services that are delivered on week days. This limited range of services goes beyond "on call" and emergencies only and facilitates some clinical decision making and discharge, though is likely to be one service and not integrated with other service delivery, (e.g. pharmacy services offering a limited range of services with several staff available, radiology offering weekend lists for inpatients).
- **Level 3** – Services offered seven days a week with several departments working together to provide services across the organisation. A whole service approach to seven day service delivery that requires several elements to work together in order to facilitate clinical decision making or treatment, often covering more than one workforce group (e.g. stroke services integrating acute stroke clinicians, imaging, specialist nurses, TIA clinics, and thrombolysis).
- **Level 4** – An integrated seven day service across the organisation. A whole system approach to seven day service delivery by integrating the requirements for elements of seven day services across more than one speciality area (e.g. across several departments and services within an acute trust, integration of several services across health and social care to reduce admission to the acute sector).

An important tenant to having an operational resilience and capacity plan is the ability to extend services where possible to address 24/7 working and build resilience in the system across the whole week, primarily the focus is on developing as soon as practicable services that are level 4 compliant.

Priorities agreed for action as part of the SRG resilience plan are:

- Integrated approach across health and social care, providing care closer to home for frail and older patients.
- Access to imaging and reporting seven days a week.
- Access to consultant outpatient clinic and diagnostic services seven days a week.
- Clinical decision making and treatment of acute stroke.
- Nurse led triage, assessment and treatment of GP referrals to avoid unnecessary acute admissions.
- Social care presence on acute medical unit, seven days a week, improves discharges from hospital.
- Patients being able to die in the place of their planned choice when services are not available seven days a week.
- Single point of access for referral of patients in crisis, 24/7, 365 days.

Within this context some specific actions to increase 24/7 day access have been set as a priority for 2014-15:

- Taurus Challenge Fund schemes, weekend and extended hours access to primary care across Herefordshire. **Level 2.**
- Extension of Rapid Access to Assess (RAAC) to include weekend access. **Level 2.**
- Local Authority Brokerage – to include weekend cover. **Level 2.**
- Falls response – includes extended hours and weekend cover. **Level 2.**
- Wye Valley Trust has implemented a range of initiatives that support 24/7 access including access to imaging, and diagnostics. **Level 3.**
- Single point of access for referral of patients in crisis, 24/7, 365 days. **Level 3.**

2.5.3 Patient Experience

The CCG has been working closely around designing services to meet the expectations of the public and patients, and in particular to improve the patient experience. During 2013-14 an Urgent Care Public Engagement was undertaken to gain the views of the public on how services should be developed going forward. This was undertaken to support the outcome based commissioning approach to urgent care, outlined above.

What has taken place already:

- 7 event roadshow (September & October 2013): Hereford (2), Bromyard, Kington, Leominster, Ledbury and Ross (125 participants made up of public/patients, family/carers, frontline teams).
- Workshops and surveys (September to November 2013), Hereford College, Wye Valley Trust Survey, Children's Centres, Newton Farm Community Association, Primary Schools.

In total more than 540 patient experiences were captured that involved 372.5 hours of co-design work with local community, with the full engagement of Healthwatch who were facilitators at the public engagement events and involved Patient Participation Groups.

Key lessons to be fed into the development of an Outcomes Based Approach to Commissioning included:

- An outcomes based urgent care service should be designed to educate about conditions and help prepare people for the next time they are approaching crisis.
- An outcomes based urgent care service should make people feel at home and offer effective reassurance and support at the point of first contact (especially out of hours).
- An outcomes based urgent care is one that can instil confidence and will innovate and redesign the experience so people feel as if they are 'known' to the service and care professionals they meet. IT systems should support the care, so that they could integrate care planning for people with Long term Conditions and 'Frequent Flyers'.

- An Outcomes based urgent care service will measure relationship based care, and not just focus on transactional outcomes.
- An outcomes based urgent care service will support design so front line teams feel more positive and should focus on education.
- An outcomes based urgent care service must measure 'ease of access to my own GP when I have urgent care issues' as an outcome.

Hereford College – 40 experiences
Access to services, lack of knowledge and clear signposting to what is needed were the core concerns for these health and social care students. Easier and more flexible access to GP appointments – preferably around the clock - being able to access prescriptions more easily and better mental health services were also highlighted as being important to these students.

Wye Valley Trust – 64 experiences
A brief, hand held survey was carried out over two days at County Hospital's main reception and A&E reception. Generally, people were pleased with the services received (at hospital and practice level) and they valued the walk-in centre. Waiting times were a consistent theme when it came to people's wish list (again, at hospital and GP level so appointments in general). Essentially, those surveyed identified their most important priorities as; having their doctor looking after most of their health needs and having a sustainable hospital in Herefordshire with an A & E department.

Children's Centres – 60 experiences
Broadlands and Widemarsh Children's Centres, Hereford.
Taking responsibility for their own personal health and keeping well was the overwhelming theme from those surveyed at Children's Centres. This included young parents, older parents and Grandparents. Many stated that diet, exercise and having a strong support network around them was most important.

Newton Farm Community Association
An intensive workshop was held involving 12 people. Mental health, community support networks and being able to get access around the clock to urgent care services were most important to this group of people.

Bromyard GP Practice, Nunwell Surgery
A morning was spent at Bromyard Surgery as this was the roadshow event that saw the least attendance. More than 20 experiences were captured from patients or relatives in the practice waiting area. Many spoke highly of the surgery and had no issues of great concern when it came to urgent care. Waiting times was their only suggestion for improvement and the priorities they identified also fell in line with those of the other groups surveyed.

Primary Schools – 20 experiences
Two schools were visited in October and November 2013 to capture young people's views between the ages of six and ten years.

Children said that their parents should take them when they need to come into contact with health services and that it was important that parents/carers knew where to go and why. They spoke of the need to go quickly to see experts and that these should be the same services day or night. They also felt that, whoever they see, should talk to the child and give them information that is suitable for that child. Having a friendly and caring nurse or doctor was also important to them. The practitioner should be able to explain about needles and surgery involved (things that the children had concerns about).

The group discussed how they wanted to be treated – they wanted to be listened to and feel safe; know what would happen next and have the opportunity to get better at home. If they were in urgent

or emergency care, then they wanted visitors or carers in hospital to make they feel better as well as child-friendly toys and activities while they were being treated.

2.5.4 Social Care

Adult Social Care

Herefordshire Council, and as part of that Adult Social Care, is going through an unprecedented level of change due to national policy changes, the challenging financial environment and the need to reduce demand and reset public expectation of entitlement to adult social care and housing services. As a result, the Council is in the process of reshaping and reducing significant elements of its current offer. By 2016, the Council will have a different role in the delivery of services, responding to the requirements from central government for things to be done differently.

Alongside national policy changes, there is less money available and the public and community will expect us to play a new role. The Council will provide services to residents that offer longer term health and wellbeing benefits for Herefordshire residents in the most affordable way. Adult Social Care is a key contributor to delivering the Council's key priority of: Enabling, within the resource available to us, residents to live safe, healthy and independent lives.

As part of meeting this strategic priority the Adult Social Care offer is being significantly reshaped, however, high demand coupled with more complex need and changing legislation and practice is resulting in pressure within the system. During the past year, despite increases in prevention interventions, the Adult Social Care service waiting times to assessment, responses to safeguarding and deprivation of liberty assessments and ability to respond rapidly to crisis situations has become more difficult.

The Council has to meet its statutory obligations and responsibilities and balance this with meeting the requirements of the acute and urgent care system for people who do not have adult social care eligibility. Whilst performance on delayed discharges for care has remained good during the past few months, achieving this has compromised work for people within the community. This will need to be addressed and the system resilience plans and investment will contribute to allowing capacity for the Adult Social Care service to meet its statutory responsibilities and supporting the urgent care system whilst it undergoes transformational change alongside its community partners.

The council during 2014 has introduced Reablement, rapid response and extended its telecare offer. In addition, it is introducing through redesign of existing functions during September 2014 a 'Discharge to Assess' pathway, which will be delivered by the Integrated Urgent Care Team (IUCT). Initially comprising of LA resources in the first phase of implementation, in the second phase will be a fully integrated pathway with WVT community services. Slides included at Appendix 18.

Children's Services

Challenges in Children's Services

Drivers in the Herefordshire system which impact on resilience and capacity in Children's Services include emergency pressures created by high levels of child protection activity, adolescent health issues, growth in the birth rate and an increase in young families from Eastern Europe.
Child Protection – Although the numbers of children on Child Protection Plans have reduced by 18% since May, there is a spike on pre-birth assessments and numbers are still higher than statistical neighbours.

This non-elective activity is particularly marked in the numbers of domestic abuse cases, non-accidental injury, child sexual exploitation and a growth in emotional abuse cases. The number of

children in care has stablised but is still well above the proportions for statistical neighbours. Particular pressures are also being placed on the system by the number of children and young people placed in residential care homes from other local authority areas which puts pressure with little funding on all parts of the system.

Adolescents and Young Adults – activity is being driven by a rise in sexual health issues and teenage pregnancies in some wards, access to a comprehensive emotional health pathway to address in patient/specialist service issues in drugs and alcohol, self-harm and children who are currently being placed in units outside Herefordshire due to lack of community-based alternatives within Herefordshire. The inclusion of adolescent health projects in the Challenge Fund combined with stronger emphasis on the Troubled Families programme (Families First), the implementation of the Children and Families Act and co-ordinated safeguarding activity provides opportunities to address this.

The growth in the birth rate is increasing activity in the system. There is also a doubling of children from Eastern European families over the past three years, which brings challenges and opportunities to the system.

Educational and health outcomes are poor for vulnerable groups of children and young people at every educational key stage. The system in Herefordshire is clear that addressing this is one of the best long term system improvements we can achieve as this will create resilient adults who will put less pressure on the health and care system.

Children's Social Care capacity and demand

The main pressures are set out in the preceding section. The Social Care system has seen significant growth in capacity over the past 18 months which is leading to improved quality of child protection work, which in turn will reduce demand on the multi–agency system. However, the decade long underperformance of the multi-agency child protection system means it is highly likely that numbers will remain high for the next three year.

The services for children with disabilities are under particular pressure, with an under developed market which is not yet in a position to enable the system to move as swiftly as it wants from a long standing medical model of support. The growth in numbers of children with disabilities is also causing pressures for and access to therapies, education provision as well as social care. The pressures are particularly acute for under 5s and adolescents.

There has been a gap in community based multi-disciplinary therapeutic mental health approaches for children on the edge of or in care. A new service commences in the autumn to address this with ambitious aims to reduce activity and cost to the system by this small number of challenging and challenged young people

The Herefordshire system is showing promising progress in improving quality and managing demand effectively through its multi-agency safeguarding hub. As well as exhibiting externally validated practice improvement, the amount of child protection activity is much better controlled and is more appropriate, ensuring that children and families are supported in the right place by the right people in the system.

The capacity challenges in Children's Wellbeing Services driven by increasing demand and poor quality practice require system wide change, with the emphasis being placed on building the capability of children and families to take responsibility for their own health and wellbeing.

Clear plans exist to commission alternatives within the development of a new strategy to improve outcomes for children and young people with disabilities, whilst ensuring the current model offers value for money.

2.6 Agreed Use of the Winter Resilience Monies

Herefordshire as a system has been given £1.1m non recurrent resource to help the system to gain extra resilience over the winter period. As a system that is under considerable operational pressure it is recognised that the resource whilst gratefully received, may be insufficient to address the totality of these system pressures, and that more has to be done to ensure a sustainable high quality urgent care service that can be resilient over the winter. (See **appendix 5**).

Schemes	Implementation Date	Cost	Avoided A&E Attendances	Avoided A&E Breaches	Avoided Admissions	Avoided Admissions Bed Days	Early Discharges	Reduced DTOCs	Early Discharges avoided bed Days
GP in the A&E department – review model in response to evidence from pilot. Alternatives effective elsewhere	2014-08-30	£100,000		1904	244	366			
Enhanced social care response: Rapid assessment by Residential and Nursing Homes	2014-10-01	£8,000						2 per week	58
Implementation of additional RAAC bed capacity in community settings to support system flow: commissioning of additional nursing home bed capacity supported by case managers.	2014-09-01	£300,000					364	1 per week	2220
Enhanced Social Care Response: Additional Brokerage capacity - take assessments, support plans and work to obtain providers for clients. Extended hours	2014-09-01	£72,000	280		196	235	140		70
CPN support to Community Hospitals in effective management of people with mental health needs.	2014-11-01	£60,000	28		28	171	440		440
System capacity to Health and Social Care providers (WVT/ASC), single point of access	2014-08-01	£60,000					58		174
Work with self funders and non-eligible: additional social work capacity to undertake work with people who are self funding and/or not eligible for a social care service. Assists rapid discharge	2014-09-01	£82,000					168		336
Use of Vanguard unit to provide short-term day case capacity, as an enabler to utilise current day case unit as escalation capacity for overnight patients.	2014-11-15	£358,000		1680					
PM Challenge Fund - Improved Access to GP Services	2014-08-01	Other Funding	952		95	190			
			1260	3584	563	962	1170		3298

It has been a balancing act within the SRG to determine the priority for investment, the resource itself being non-recurrent ideally should be targeted at pump-priming system transformation, on initiatives that over the funding period could be self-financing, however, the growth in demand in 2014 to date may mean that simply to stabalise services has required that some of the resource is committed on some recurrent service provision that will need to be picked in contract discussions for 2015-16.

The funding regarding additional capacity has yet to be fully finalised but the £358k is confirmed as being made available for this by the SRG, it is likely extra resources will be required above this.

In addition the use of the resource should ideally be about the creation of head room above core provision, to deal with peaks in demand. Given the current situation simply getting back to a consistent level of performance across the system, that keeps services safe and delivers high quality care for patients, whilst meeting the ley performance metrics of the 95% 4 hour target, avoiding long trolley waits in A&E, reducing ambulance delays, and allowing elective activity to be undertaken as planned, would be an achievement in itself.

The priorities for investment have been drawn up to address lessons learnt from 2013-14, the recommendations of the ECIST report, best practice guidance, the views of patients, clinicians and

health and social care workers, the independent and voluntary sector, the Health and Wellbeing Board outcome priorities, and work ongoing to redesign urgent care for the future as part of the overall 5 year strategies of the CCG, of Wye Valley NHS Trust and the joint objectives of the local community around implementation of the Better Care Fund.

There is general agreement across all commissioners and providers that this represents the best use of the resource available, albeit that it cannot address underlying issues and concerns relating to system deficits, and the sustainability of services wholesale that fall under the Transformation Programme.

The use of the resource plus other investments being made are detailed below using the target service areas defined in the guidance around Winter Resilience Monies. The actual detail of the schemes and key performance metrics are to be found in the associated excel templates, attached in the appendix.

2.6.2 Best Practice Implementation

Section 1 – Minimum Plan Requirements (£1m from Winter Funds, £2.7m PM Challenge Fund, plus existing contracted Investments made in 2014-15 – see templates for detailed breakdown)

Enabling better and more accurate capacity modelling and scenario planning across the system.

- Information sub-group established to support both the SRG in its planning, monitoring and evaluation of the impact of investments and overall oversight of the delivery of urgent care, and to support the SRG operational group in having a real-time dashboard of system performance and pressures. Critical to this is an agreed view of the demand and capacity in place to meet demand.
- Appointment of a System Resilience Lead to oversee modelling, evaluation of impact of planned interventions.

Working with 111 providers to identify the service that is best able to meet patients' urgent care needs.

- Real time Directory of Service (DOS) in place and used by 111 Provider
- COBIC project to support development of new models of provision.

Additional Capacity for Primary Care

- £2.7m from PM Challenge Fund – Taurus implementing primary care hubs, extending GP opening hours, extra 680 slots for primary care appointments per week out of hours, with direct booking into slots by other agencies. Improved access for some diagnostics out of hours.
- £5 per head LES to support over 65s in primary care – Link nurses to work between primary and secondary care.

Improve services to provide more responsive and patient centred delivery seven days a week.

- Taurus Challenge Fund schemes, weekend and extended hours access to primary care across Herefordshire.
- Extension of Rapid Access to Assess (RAAC) to include weekend access
- Local Authority Brokerage – to includes weekend cover
- Falls response – includes extended hours and weekend cover
- Wye Valley Trust has implemented a range of initiatives that support 24/7 access including access to imaging, and diagnostics
- Single point of access for referral of patients in crisis, 24/7, 365 days.

SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda.

- Governance around SRG / H&WB Boards / BCF and Transformation programme all fully aligned, shared objectives agreed, and roles agreed within ToR.
- Transformation Director to support delivery of BCF, and report into SRG.

Seven Day Working Arrangements

- Taurus Challenge Fund schemes, weekend and extended hours access to primary care across Herefordshire.
- Extension of Rapid Access to Assess (RAAC) to include weekend access
- Local Authority Brokerage – to includes weekend cover
- Falls response – includes extended hours and weekend cover
- Wye Valley Trust has implemented a range of initiatives that support 24/7 access including access to imaging, and diagnostics, EPOD delivering 12hrs per day over the whole week, Daily ward round / Board rounds / Improved Discharge.
- Single point of access for referral of patients in crisis, 24/7, 365 days.

Expand, adapt and improve established pathways for highest intensity users within emergency departments.

- Stroke pathway – 7 day TIA services
- Mental Health Liaison (RAID)
- Community hospitals in-reach
- COBIC project to redesign pathways based on outcomes and lead provider model

Have consultant led rapid assessment and treatment systems within emergency departments during hours of peak demand.

- Part of Wye Valley Trust action plan, EPOD arrangements, acute physicians, 2 hourly 'Huddle'.

All parts of the system should work towards ensuring patients medicines are optimised prior to discharge.

- Pharmacy discharge project (WVT Action Plan).

Process to minimise delayed discharge and good practice on discharge.

- Wye Valley NHS Trust Action Plan – Daily Ward rounds / Board Rounds, Implementation of discharge bundle, extension of discharge lounge.
- Additional Social Care Investment
- Brokerage at weekends
- Care home incentive scheme
- Mental Health Liaison Service
- Community Hospital Liaison
- Increased NH capacity for supported discharge
- Additional Acute Hospital Beds through redesign of Day Case Unit and use of Vanguard Unit to expand current bed base by 20, whilst demand mitigation and systems improvements lower requirements for beds

Plans to deliver a considerable reduction in permanent admissions of older people to residential and nursing homes.

- Reablement, rapid response and extension of telecare.

- Social Care redesign to extend concept of Discharge to Assess with Integrated Urgent Care Team
- Integrated pathway with Wye Valley NHS Trust Community Team

Cross System risk Stratification systems in place

- RIsk stratification system agreed and being rolled out in primary care
- Virtual wards in place in Hereford
- Redesign of Social Care Service to support risk stratification identification of patients at risk

Real Use of real-time system wide data

- Daily Sitreps covering Community and Acute Care Activity and KPIs
- Regional Escalation Management Reports covering Community and Acute Hospitals several times each day, shows pressures across Worcestershire as well
- RMCT escalation process to respond to levels of escalation across the system
- Template of systems pressures used in Operational and Strategic teleconferences and meetings
- Daily Executive Call across partners in place to support predictive response
- Demand predictions covering the future two weeks
- Data Intelligence Group in place to ensure operational dashboard includes LA pressures as well as health, and to increase use of information for demand and capacity modelling in real time.
- Systems Resilience Lead to coordinate whole systems approach at an operational level

Section 2 – Local Plans for Innovation (£123k from Winter Funds, plus existing contracted Investments made in 2014-15, and planned investments in 2015-16 – see templates for detailed breakdown).

- COBIC project – Outcomes based approach to commissioning, use of lead provider framework and outcome based incentives.
- Transformation of health and social care community services, to be wrapped around primary care, linking with Better Care Fund system transformation work. Community collaborative project.
- Fallers Response scheme to address gaps in falls pathway, linking to telemedicine and reablement.

Local Stakeholder Engagement

- Use of Nursing /Residential Care capacity in development of Discharge to Assess, and Rapid Access to Assess (RAAC) using an extended framework through LA procurement. Development of skills and capacity programme in Nursing and Residential homes.
- Hereford Housing engagement on reablement and fallers response scheme.
- Active membership and partnership of Voluntary Sector on the SRG.
- Flu Plan developed in in place to ensure appropriate vaccination of health and social care workers.
- SRG investment in the development of 7 day a week care packages, such as extended brokerage support, and incentives to Nursing / Residential Care Homes to have 7 day a week assessment and placement including extended hours.
- Improvement in access to psychiatric liaison through additional SRG investment.
- Ensuring that Children's services are not forgotten in the development of robust Urgent Care direct engagement with stakeholders, parents, children and carers in framing priorities for development. Joint Commissioning Group established to improve collaborative commissioning across adult and children's services.
- Herefordshire Carers Support and Healthwatch full and active members of the SRG. Herefordshire transformation programme supported by system wide engagement and communication programme.

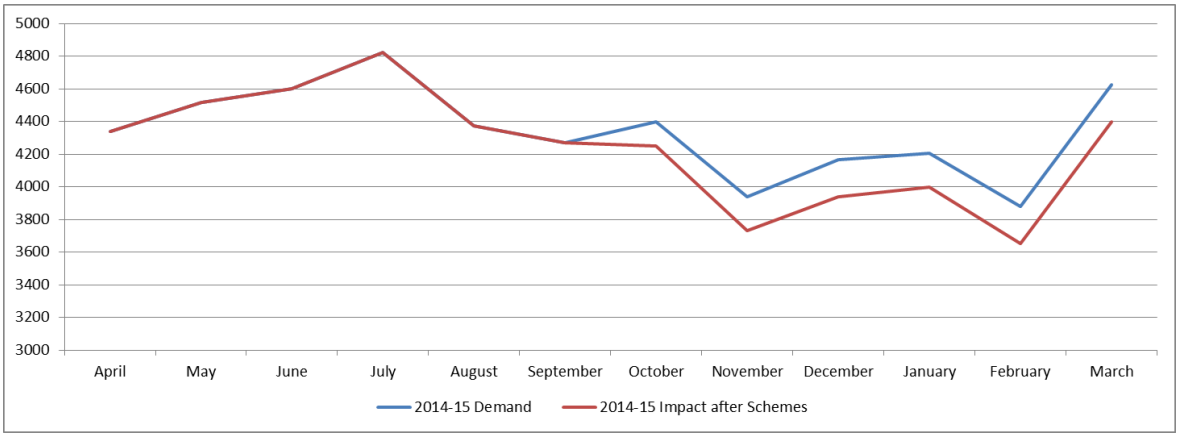
2.6.3 Impact of Investments on Mitigating Demands and Increasing Capacity

The projected impact of targeted investment and its impact on demand and response to demand is detailed in the attached excel templates as appendices. The monitoring of impact is a key responsibility of the SRG, and of the data intelligence sub-committee feeding in actual impact on services of each scheme, and its impact on demand to both the operational group, and SRG itself.

Use will be made of the national templates released recently on monitoring of the spend and achievement of the KPIs associated with each investment, as this is in line with local monitoring already in or being put in place.

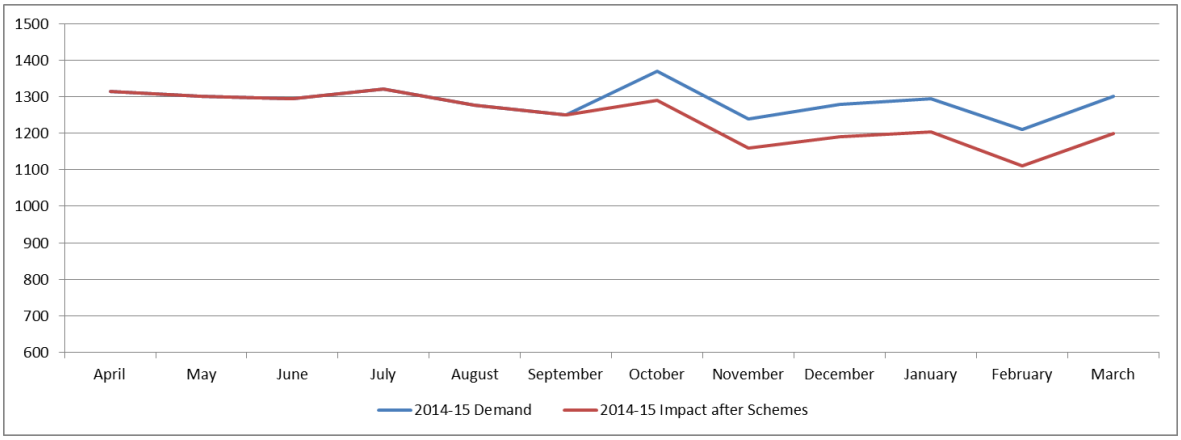
The following graphs shows the cumulative effect on demand as faced by the Acute Hospital in terms of the expected reduction in A&E attendances, and urgent care admissions against the earlier predicted demand without schemes being in place.

Accident and Emergency Attendances



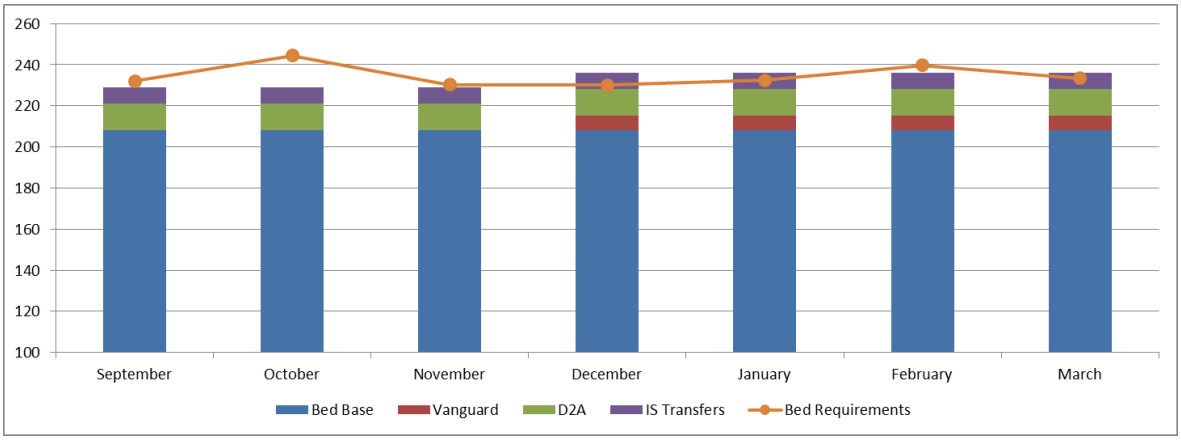
Demand is expected to fall by between 4-6% month on month from October onwards, affecting a 2.4% reduction overall on the whole years level of attendances.

Non-Elective (Urgent) Admissions



Demand is expected to fall by between 1-5% month on month from October onwards, affecting a 3% reduction overall on the whole years level of attendances.

This impacts on the bed requirements within the Acute Trust to deal with demand over the winter months, the capacity being met through additional Discharge to Assess Beds (13), additional IP capacity via the Vanguard Unit (7), transfers to the Independent Sector (50 patients a month – equivalent to 8 beds a day weekdays).

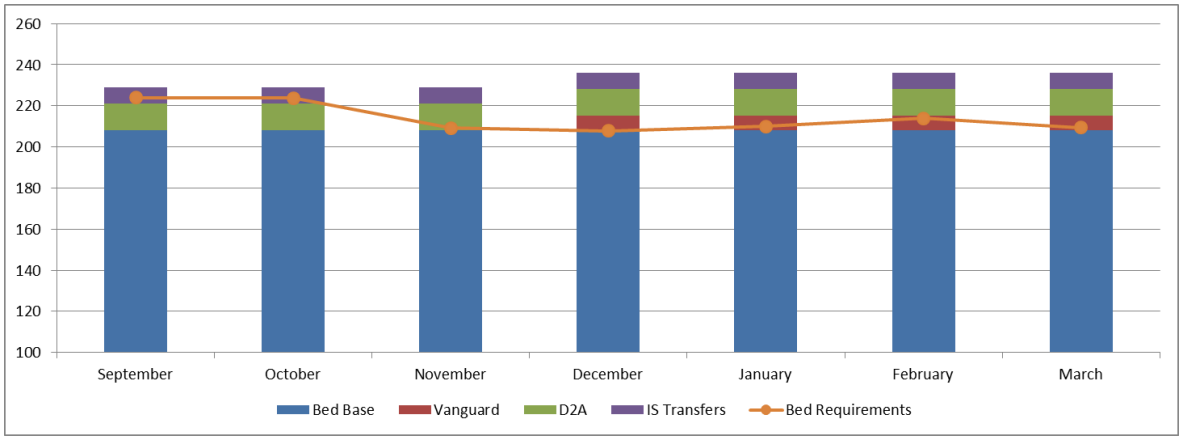


Worst Case Bed Modelling

The graph above shows the calculated bed requirements before any impact of SRG winter resilience schemes, month on month over the winter period, against which the base beds, additional beds made available via the Vanguard Unit, Discharge to Assess Beds, IS transfers is compared. This still shows a deficiency in September and October where extra measures have to be taken by the Trust to open up extra areas to deal with the gap, but from November onwards this extra capacity should not be required to be opened in addition. This creates a limited amount of surge capacity for the Trust over these months to deal with unexpected demand pressures. The above is a worst case scenario.

Best Case Bed Modelling

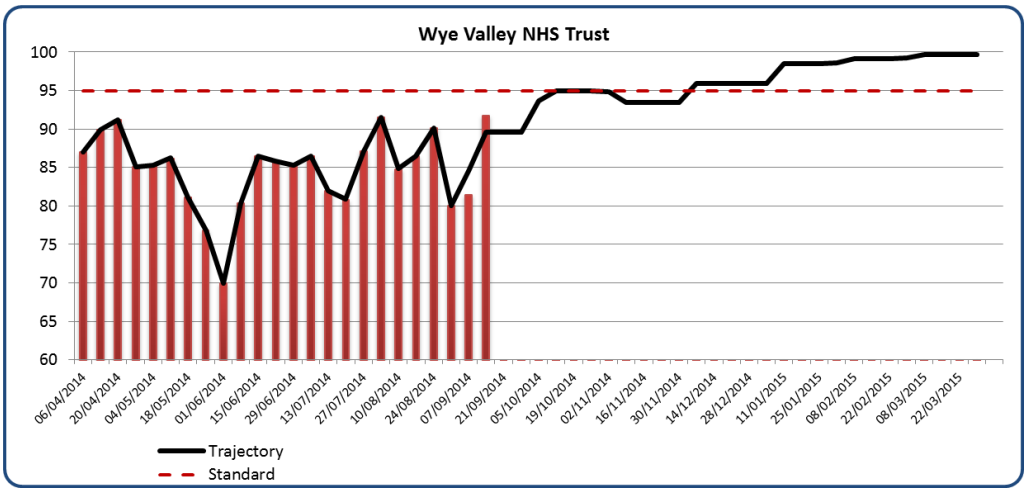
The graph overleaf shows the bed requirements after implementation of the SRG winter reliance schemes, and demonstrated the positive impact of these schemes on both impacting demand over the winter period and the extra resilience achieved as a result. This is the best case scenario.



The best case graph doesn't suggest that there won't be a need for the private sector or vanguard unit, as the system will still be working hard to be recovering RTT. It indicates a level of confidence that the system should be able to cope with peaks on a daily basis. Modelling also assumes that all SGR schemes have the impact proposed in the timescales outlines, and that there is a constant flow of patients into the Discharge to Assess scheme beds.

2.6.4 A&E Recovery Trajectory

The impact on key performance measures such as the 95% 4 hour target needs to be consolidated with the existing recovery action plan to bring A&E performance back into line, but the revised trajectory is shown below, with 95% being delivered sustainably from the end of December.



This is the combined effect of the SRG initiatives, together with the additional Trust wide operational recovery plan actions as a result of the ECIST recommendations. The RAP trajectory is the one that both the TDA and CCG will hold the Trust to account for.

The Wye Valley Trust recovery plan actions are summarised below and detailed updates are provided at **Appendix 6**:

WVT scheme in place or in development to facilitate improved management of the urgent care pathway	Action	Output
Ensure Daily MDT Board & Ward Rounds in all clinical areas (currently 5 days, moving to 7 days)	standardised checklist established for both ward and board rounds	Reduce LOS improve patient journey and outcomes
Ensure EDDs in place for all patients	This forms part of the discharge bundle	Improved communication with patients/relatives/carers Reduce LOS
Increased use of Discharge lounge	currently 9am - 8pm (some recruitment outstanding; current reliance on bank) to extend to 7 day service	Improved flow from ED to Wards. Commence discharge 10 before 10am; Reduce LOS
Implement Discharge Care Bundle based on best practice	Improve staff understanding and confidence in achieving safe sustainable, timely and effective discharge. Currently working with ECIST to establish launch and roll out	Reduce LOS improve patient journey and outcomes
New ways of working within Complex Discharge Co-ordination team- uplift in staffing compliment	Early identification and MDT focus on most complex patients.	Reduce LOS improve patient journey and outcomes
Weekly MDT with ASC, DMHOP and RAAC community matron	Improved MDT focus, delayed patients, complex discharge requirements and those known to DMHOP at point of admission	Reduce LOS improve patient journey and outcomes

WVT scheme in place or in development to facilitate improved management of the urgent care pathway	Action	Output
Daily list of delayed patients circulated internally and externally (encrypted)	Improved MDT focus, delayed patients, complex discharge requirements and those known to DMHOP at point of admission	Reduce LOS improve patient journey and outcomes
In-reach to County Acute beds from Virtual Wards on a daily basis	Early and rapid discharge support from acute beds; improved communication and planning between secondary and primary care; signposting new referrals to Neighbourhood teams	Reduce LOS improve patient journey and outcomes
Community Nurses in-reach daily to Community Hospital beds to identify patients fit for discharge and to support good practice re discharge planning	Earlier Community Hospital discharge, improved communication and planning	Reduce LOS improve patient journey and outcomes
Clinical review/accountability of long stay patients	This forms part of the discharge bundle	Reduce LOS improve patient journey and outcomes
Eliminating Powys delayed transfers of care. Exec to Exec meeting held to identify key issues; weekly conference calls in place; spot purchasing of nursing home beds by the Health Board (WVT EMS = Level 4)	Reduction in extent of Welsh inpatient DTOCs; improved patient outcomes for non-local inpatients; Improved communication and planning	Reduce LOS improve patient journey and outcomes
EPOD reforms: standardised service delivery established	SOP now in place.	Earlier senior decision making. Reduce LOS improve patient journey and outcomes
Improved patient flow from A&E to appropriate Ward environments (non-Ambulatory Emergency Care conditions) and establish FOPAL dedicated beds	task and finish group established; high level business case to be presented to Trust Executive Management meeting	Reduce LOS improve patient journey and outcomes
Recruitment of Acute Physicians		Reduce LOS improve patient journey and outcomes
Pharmacy discharge project	recruiting 2x band 5	to reduce the length of time from decision to discharge to physically leaving the hospital
Information generate daily list of inpatients per GP surgery which is available to GP's	This not regularly or universally accessed by the GP surgeries	Improved communication and planning between secondary and primary care. Reduce LOS improve patient journey and outcomes
A&E 2hrly 'Huddle' (Nurse in charge – senior Dr.) review activity; agree plan to avoid 4 Hour breach, disseminate and review actions required/taken.	AE and CST have established this as part of daily business	Improve the management and flow of patients through the department
Additional SHO A&E 6pm – 2am; it is recognized that attendances have significantly increased during this timeframe.	Currently this is reliant on agency	Improve the management and flow of patients through the department
Transfer team 1x band 5 1x band 2 12.30pm - 9pm	Currently reliant on bank and agency	to reduce the risk of delay in patient journey from AE to wards
24 hour Site team ward clerk/support worker	to support completion of PAS ; transfer of patients deep cleans. Working with medics to facilitate up to date PAS data and Dr tracker list	Reduce LOS improve patient journey and outcomes
AE improvement plan	investment in medical and nursing staff ; internal review and development of improvement plan	Improve the management and flow of patients through the department

WVT scheme in place or in development to facilitate improved management of the urgent care pathway	Action	Output
Enhanced Phlebotomy service	investment in additional phlebotomists	release medical staff; reduce LOS improve patient journey and outcomes
weekend and Bank holiday; discharge consultant and registra	Internal Consultants; usually regular agency registras	Reduce LOS improve patient journey and outcomes
extending Pharmacy coverage OOH's	extended coverage at weekends	to reduce the length of time from decision to discharge to physically leaving the hospital
Ward sisters now supernumery	investment to facilitate supernumery status	Improve the management and flow of patients to and from wards. through the department
CAU	Establishment of the unit to stream off patients with ambulatory emergency conditions	Release pressure on A&E and improve the patient journey
Theatre huddle	Twice daily meeting between Site and Recovery	Create effective patient transition through theatres and supporting Elective Flow
Site team call taker	Evaluation of GP calls for CAU appropriate patients. Direct access to CAU clinician to advise.	Reduce GP admitted footfall and release pressure on A&E
Emergency Planning	Training for all on-call colleagues	Ensuring consistent and confident management of on-call issues
A&E site works	Environmental changes in A&E	To support delivery of A&E transformation
7 day diagnostics	Plain film, MR and Ultrasound including protocol for CAU and 'bring back' next day diagnostics	To support Urgent Flow

2.7 Operational Management of Urgent Care Pressures

The system has a robust plan in place agreed across all agencies for dealing with Surge and Escalation, based on the daily regional Management Capacity Team EMS alerts, with de-escalation actions agreed across various levels of escalation, as well as the attendance frequency, and seniority of staff on calls or in face to face meetings.

A revised strategic call template has been included within this response to manage effectively the system at the highest level of escalation, together with a clear requirement of information to be used to inform decision making.

In addition there is an agreed system wide Flu Plan, to ensure residents at high risk from the effects of Flu and all operational staff are given the opportunity to be vaccinated, also there is an all agency Flood response plan that forms part of the emergency preparedness resilience and response planning for the locality.

<u>Real Time Data</u>

Each organisation has its own set of key operational data that is used to monitor and respond to levels of surge and demand in real time. Much of this is aligned with the strategic call template which expects all agencies to have shared and come prepared with key performance indicators of pressure at both operational and strategic calls and meetings.

Wye Valley Trust for example has a live data system feed that shows the position in A&E, patients in the department, attendances against prediction, admissions against prediction, current bed state in

the acute and across the community, pressures on specialist beds. This is available to access by all operational managers and clinical managers and allows drill down to individual patients in A&E, or onto individual patients on wards and to specific beds.

The above is the overall screen that shows the live as is position for the Trust. Drill downs against each measure are available to assist in assessing issues to be addressed.

In addition the Trust also issues 4-5 hourly status reports both internally and to external partners that show how the pressure is progressing through the day. These are timed at 06:00 11:00 14:00 16:00 and 22:00.

These are used at the operational call discussions with partners.

PATIENT FLOW REPORT

Wye Valley NHS Trust

Date:	16 / Sep / 14	E-POD:	DR. BURDSALL
Executive On-Call:	VANESSA LEWIS	Duty Manager On-Call:	JO CLATERBACK

YESTERDAYS PERFORMANCE

Admissions: (Predicted / Actual)	39 / 56	Discharges: (Predicted / Actual)	46 / 39	CAU: (Total / Discharged)	18 / 9

SITREP LEVEL

	0600 hrs	1100 hrs	1400 hrs	1600 hrs	1800 hrs	2200 hrs
Escalation Level (1,2,3,4)	Level 3	Level 2	Level 2	Level 2		
CSM Indicator (Senior Support Required)						

A&E

Predicted Attendance	166		142		142		142					
Attendance to date	12		42		77		93					
Actual Patients in A&E / Awaiting Beds	8	0	11	4	22	2	16	4				
Cumulative Unvalidated 4hr Breach Position	0		4		2		0					
Ambulance Off-Load	Clear		Clear		Clear		Clear					
CAU Currently / Since Midnight	3	0	7	7	6	8	5	9				

ADMISSIONS

Predicted Admissions	49		49		49		49					
Admissions to date	6		12		19		26					
Confirmed Discharges & Empty Beds	2		4		12		13					
Potential Discharges	9		19		16		1					
Worst Case			-42		-24		-21					
Best Case			-19		-8		-20					
DCU - 23hr Patients	3		3		1		1					
Paeds & Maternity	NO PROBLEMS		None Reported		None Reported		None Reported					
Outliers	Medical: 6	Surgical: 5	Medical: 4	Surgical: 4	Medical: 4	Surgical: 3	Medical: 4	Surgical: 4	Medical:	Surgical:	Medical:	Surgical:

ADDITIONAL CAPACITY

Day-Case Unit	7IP	7	4IP	4IP		
Fred Bulmer Medical Unit	DL	Discharge Lounge	Discharge Lounge	Discharge Lounge		
Other		0	0	0		

STAFFING - NURSING

Red Areas		NONE TO REPORT	NONE TO REPORT	NONE TO REPORT		
Ambers Areas		A&E ADMISSIONS ARROW WYE	ARROW REDBROOK	NONE TO REPORT		

STAFFING - MEDICAL

Issues	None Reported	None Reported

SPECIALIST BEDS AVAILABLE

CCU	0	0	2	1		
HDU	0	0	0	0		
ITU	2	2	2	2		
NOF	NO	NO	PLAN	YES		
Stroke	YES	NO	YES	YES		

COMMUNITY HOSPITALS BEDS

	Beds Available			Total
	Male	Female	Either	
Ross		1		1
Leominster				0
Bromyard				0
Ledbury				0
Hillside				1
Kington			4	4

OTHER INFORMATION

	In	Out
Tertiary Transfers	4	6
Where	1 x Neville Hall 3 x QE Birmingham	4 x QE Birmingham 1 x James Paget 1 x Worcester
	Capacity	Workload
Virtual Ward	3	12

The RCMT EMS alerts are issued by providers into a central system operated by

West Midlands Ambulance Service, and issued as email alerts to key people across the locality to inform people of emerging pressures and current escalation status. An example is shown below.

Hereford County Hospital is now at EMS LEVEL **2**

Expected time to de-escalation reported as : Less than 2 hours

Comments: **A&E steady flow**

Trigger Number	Selected Trigger	Trigger Level
1	No current risk of patients waiting more than 4 hours in ED	1
2	Transfer of Ambulance patient care is between 15 and 30 minutes.	2
3	There is an expected admission capacity deficit of less than 10% of expected demand for the next 24 hours	2
4	Elective work proceeding as planned.	1
5	Patients subject to a decision to admit not at risk of 8 hour trolley waits.	1
6	Medical outliers form between 1% and 3% of total inpatient population.	3
7	Cubicles in A&E are less than 80% occupied.	1
8	More than 1 resuscitation bay available for immediate use.	1
9	Beds in Assessment areas are less than 90% occupied.	1
10	All planned additional bed capacity open and full; unplanned capacity in use.	4
11	No loss of admission bed capacity due to infection control measures.	1
12	Critical care capacity is 80%-100% occupied.	2
13	Gender specific beds available as planned.	1
14	DTOC cases form between 1% and 3% of the inpatient total.	2

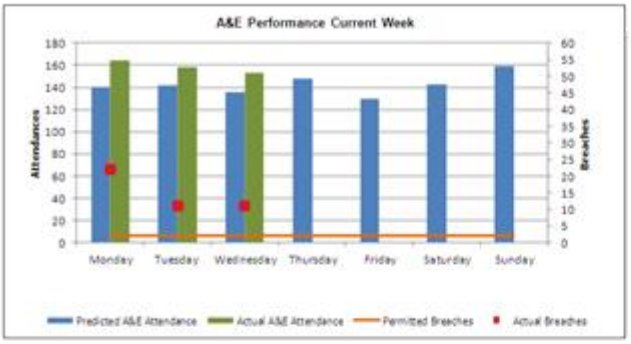
The triggers for both Acute and Community Trusts have been chosen as being the key indicators of pressures for Trusts through a West Midlands Wide series of workshops, the early triggers indicate pressure at the front door, the middle ones, issues with internal flow, and the later ones pressures at the back door.

In addition there is a daily sitrep report circulated around all key partners showing performance for the previous day, including net flows i.e. admissions versus discharges, and a heat map of key performance measures.

Breach reports are also routinely reviewed in terms of the reasons for breaches and actions required.

Wye Valley NHS Trust Daily Operational SitRep - Predictions — Thursday 18/09/14

A&E	Yesterday (Predicted)	Yesterday (Actual)	Today's Prediction	Friday	Saturday	Sunday
A&E Attendances County Hospital	136	153	148	130	143	159
MIU attendances Leominster and Ross	13	14	19	23	0	0
All A&E and MIU attendances	149	167	167	153	143	159

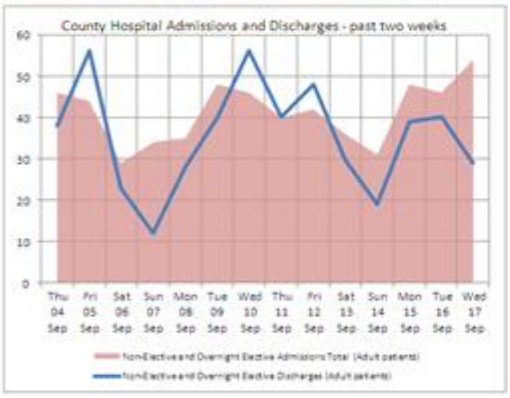


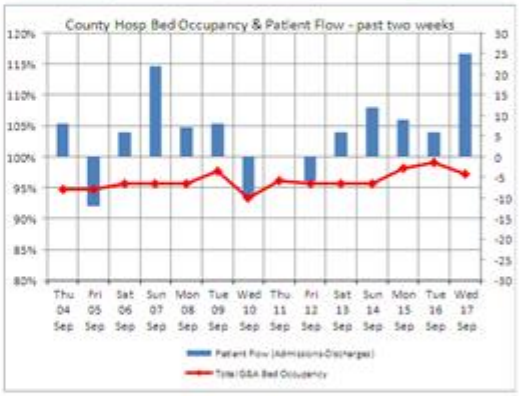
Weekly Performance

Actual Attendances in Week	475
Breaches in Week	44
Current Percentage County Hospital Only (Standard 95%)	90.7%
Breaches Remaining in week to achieve 95% based on predicted attendances (County Hospital performance)	9
Current Percentage WVT Combined (Standard 95%)	91.7%

Occupancy - Acute Adult G&A	Yesterday (Predicted)	Yesterday (Actual)	Today's Prediction	Friday	Saturday	Sunday
Funded Bed Occupancy County Hospital (208 beds Adult G&A)	92%	97%	94%	96%	96%	96%
Unfunded beds occupied County Hospital (Excludes 10 Daycase Ward Funded Beds Monday - Friday)	0	0	0	3	3	3
Total Bed Occupancy County Hospital (inc Unfunded) compared with 208 Adult G&A bedbase)	92%	97%	94%	96%	96%	96%

Patient Flow	Yesterday (Predicted)	Yesterday (Actual)	Today's Prediction	Friday	Saturday	Sunday
Patient Flow County Hospital (Admissions - Discharges)	-10	25	5	-9	6	17





Admissions	Yesterday (Predicted)	Yesterday (Actual)	Today's Prediction	Friday	Saturday	Sunday
Total Non-Elective Admissions County Hospital	51	42	46	50	38	38
Total Non-Elective Admissions County Hospital and Community Hospitals	60	46	53	64	42	40
Overnight Elective admissions County Hospital	5	16	7	9	4	0
Total Non-Elective and Overnight Elective Admissions County Hospital	56	58	53	59	42	38

Discharges	Yesterday (Predicted)	Yesterday (Actual)	Today's Prediction	Friday	Saturday	Sunday
Total Non-Elective Discharges (County Hospital and Community Hospitals)	66	32	53	72	35	21
Total Discharges County Hospital only	66	33	48	68	36	21

Average Length Of Stay County	12/09/2014	13/09/2014	14/09/2014	15/09/2014	16/09/2014	17/09/2014
Elective Ave. Length of Stay (overnight patients) County Hospital	4.6	1.0	2.0	3.0	5.0	5.9
Non Elective Ave. Length of Stay County Hospital	5.0	3.5	2.4	5.7	3.8	3.7

Average Length Of Stay Community						
Average length of stay Community	7.2	31.5	3.5	26.8	11.0	31.3
Delayed Transfers of Care - Acute	4	5	4	4	8	8
Delayed Transfers of Care - Non-Acute	7	12	7	12	12	12

3. Planned Care – Operational Delivery of Elective Care in 2014 -15

3.1 Strategic Aim

The strategic aim of the SRG is to ensure that planned care is being delivered effectively across the local health economy, meeting the NHS Constitution commitments that patients should be being seen and treatment started within 18 weeks from the point of referral by their GP for treatment measured by the Referral to Treatment Time (RTT), and that choice is being offered to patients both at the point of referral for treatment, and within a pathway should it become apparent that treatment cannot be started within 18 weeks.

At the same time there is a clear responsibility to ensure that the capacity of the local system to cope with demand has been assessed, and that there is a demand and capacity review each year undertaken as part of the contracting discussions between Commissioners and Health Care Providers.

Principle performance measures taken by the SRG as indicators that the system is responding well to the needs of patients for planned care are:

- 90% of patients requiring an operation do so within 18 weeks of referral.
- 95% of patients referred by their GP would do not need and operation are seen, treatment has started, or they are discharged back to the GP within 18 weeks of referral.
- 92% of patients referred who are still awaiting treatment to start have been waiting less that 18 weeks .
- That 99% of patients waiting for a diagnostic test, receive this test within 6 weeks.
- That all cancer target waiting times are being met.

Planning For Elective Care

Principal to the sound management of elective care for patients is having a robust and current jointly agreed local patients' access policy, which details the operational procedures to be followed and expectations of the management of patients between primary, community and acute care.

The Wye Valley NHS Trust Access policy was last updated in November 2012 in liaison with the PCT, the next review was planned for November 2015, but in light of the new role of the SRG in relation to oversight of planned care, this review has been agreed to be brought forward to November 2014, and will be taken through the SRG.

A desktop assessment of the policy against best practice from the IMAS website, indicates the policy is in line with national policy but could do with reviewing to ensure all best practice is fully embedded, and to ensure that the SRGs new role for assurance has been properly grasped.

There is a rolling training programme in place for staff involved in the management of RTT. As part of the review of the Access Policy any training requirement needs will be reviewed, and an action plan included as part of the November review.

Herefordshire starts with a good record of RTT delivery in terms of 18 weeks, having met the main planned care targets consistently over many months at an aggregate level, and with very few patients currently waiting over 18 week, albeit that this number has grown during 2014/15. Primarily as a result of cancellation of electives resulting from the operational pressures around urgent care.

Like many economies there are specialty specific issues in regard of managing to 18 weeks, with a reliance in part on having to utilise the independent sector where capacity constraints in a specific specialty arise.

All GPs are fully aware of the NHS Constitution rights, and do discuss with patients the possibility of being referred to alternative providers outside Herefordshire, and to the Independent Sector. Few patients choose to do so, but that right remains.

The CCG working with Wye Valley NHS Trust, and external providers with whom they have contracts for planned care do follow up waiters approaching their 18 week target wait, to ensure that a choice of alternative provider where clinically appropriate is made.

A full demand and capacity planning exercise was undertaken prior to agreement of the contract between Wye Valley NHS trust and Herefordshire CCG, this was targeted at ensuring all RTT targets would continue to be met, and specialty specific failures would be addressed during the year.

The pressures on the Urgent Care System have created operational constraints that have prevented the system from being able to deliver this, through the cancellation of elective work as a result of bed pressures, and from referral rates for some specialties being higher than anticipated within the contracting model. The contract also assumed that some activity would have to be undertaken externally to the Trust through sub-contracts with the Independent Sector.

3.1 Use of the RTT Resilience Monies

The announcement of additional resilience monies to support RTT earlier in the year was very much welcomed, and an agreed implementation plan put into place. This plan had timescales outside the national requirements of all RTT targets being back on track by the end of September, as the capacity constraints from ongoing urgent care pressures, and planned maintenance of theatre capacity locally prevented this, although more work was directed to the Independent Sector.

The plan for additional work is summarised below:

Wye Valley NHS Trust – Unify2 Submission

Planned additional activity (from June return)

	Admitted				Non-admitted				Total			
	<=18 wk pathways	>18 wk pathways	Total pathways	% <=18 wk	<=18 wk pathways	>18 wk pathways	Total pathways	% <=18 wk	<=18 wk pathways	>18 wk pathways	Total pathways	% <=18 wk
Jul-14	0	0	0		0	0	0		0	0	0	
Aug-14	0	0	0		0	0	0		0	0	0	
Sep-14	25	24	49	51.0%	1	2	3	33.3%	26	26	52	50.0%
Oct-14	69	67	136	50.7%	3	8	11	27.3%	72	75	147	49.0%
Nov-14	69	67	136	50.7%	3	8	11	27.3%	72	75	147	49.0%
Dec-14	0	0	0		0	0	0		0	0	0	
Jan-15	0	0	0		0	0	0		0	0	0	
Feb-15	0	0	0		0	0	0		0	0	0	
Mar-15	0	0	0		0	0	0		0	0	0	
Total for Jul-14 to Mar-15	163	158	321	50.8%	7	18	25	28.0%	170	176	346	49.1%

Herefordshire CCG – Unify2 Submission

Planned additional activity (from June return)

		Admitted				Non-admitted				Total			
		<=18 wk pathways	>18 wk pathways	Total pathways	% <=18 wk	<=18 wk pathways	>18 wk pathways	Total pathways	% <=18 wk	<=18 wk pathways	>18 wk pathways	Total pathways	% <=18 wk
Jul-14	05F_NHS HE\July	10	0	10	100.0%	8	0	8	100.0%	18	0	18	100.0%
Aug-14	05F_NHS HE\August	8	0	8	100.0%	7	0	7	100.0%	15	0	15	100.0%
Sep-14	05F_NHS HE\September	26	24	50	52.0%	1	2	3	33.3%	27	26	53	50.9%
Oct-14	05F_NHS HE\October	70	67	137	51.1%	3	8	11	27.3%	73	75	148	49.3%
Nov-14	05F_NHS HE\November	70	67	137	51.1%	3	8	11	27.3%	73	75	148	49.3%
Dec-14	05F_NHS HE\December	1	0	1	100.0%	0	0	0		1	0	1	100.0%
Jan-15	05F_NHS HE\January	1	0	1	100.0%	0	0	0		1	0	1	100.0%
Feb-15	05F_NHS HE\February	1	0	1	100.0%	0	0	0		1	0	1	100.0%
Mar-15	05F_NHS HE\March	1	0	1	100.0%	0	0	0		1	0	1	100.0%
Total for Jul-14 to Mar-15		188	158	346	54.3%	22	18	40	55.0%	210	176	386	54.4%

The two submissions represent that not all Herefordshire waiters are seen and treated at Wye Valley NHS Trust, although the majority of them are. There is a dual responsibility for Herefordshire CCG, both to oversee the planned care of their own residents across all hospital providers, but also as the

coordinating commissioner overseeing delivery of planned care within Wye Valley NHS Trust for themselves and any associate commissioners.

Given the capacity constraints locally, the CCG agreed with the Area Team to this delivery profile and that from the 1st November RTT targets would be delivered at an aggregate specialty level from that time. It would take longer for the overall level of backlog numbers to fall, as some individual specialties will not deliver before January 2015.

The resources allocated to the CCG were £453k which included a 15% premium for activity as part of the resilience monies for an indicative activity set nationally, as the locally calculated activity is greater than this the actual cost of activity is however above £650k, the CCG recognises that in order to deliver RTT sustainably that this will have to be a pressure on its reserves in 2014-15.

3.3 Demand and RTT Sustainability

Turnover target 13 weeks

Code	Treatment Function	Waiting List Feb 2013	Waiting list Feb 2014	Change in Waiting List in Year	Backlog Feb 2014	Average weekly Closure	Average Weekly Additior	Closures Greater than Additions Check 1 (Capacity meets Demand	Turnover Rate Incompletes as No. Weeks Closures Check 2 (Need for Non Recurrent activity to reduce incompletes	Backlog Greater than 0.5 weeks work Check 3 (Need for non recurrent activity to reduce backlog could be part of activity in Check 2)	Recurrent Capacity Gap % over last years Activity (Should have been addressed as part of contract baseline)	Size of Non Recurrent Closures Required to meet 13 weeks Turnover target	Size Backlog needs to reduce by to be within 0.5 weeks	Total non - recurrent activity Required (backlog reduction can be part of incomplete overall reduction)
100	General Surgery	273	313	40	16	20.2	21.0	No	15	0.8	3.8%	50	5	50
101	Urology	266	320	54	12	33.2	34.3	No	10	0.4	3.1%	0	0	0
110	Trauma & Orthopaedics	559	682	123	33	60.4	62.7	No	11	0.5	3.9%	0	2	2
120	ENT	370	477	107	8	38.5	40.6	No	12	0.2	5.3%	0	0	0
130	Ophthalmology	679	815	136	20	75.3	77.9	No	11	0.3	3.5%	0	0	0
140	Oral Surgery	0	0	0	0	0.0	0.0	Yes	0	0.0		0	0	0
150	Neurosurgery	0	0	0	0	0.0	0.0	Yes	0	0.0		0	0	0
160	Plastic Surgery	71	67	-4	2	7.1	7.0	Yes	9	0.3		0	0	0
170	Cardiothoracic Surgery	0	0	0	0	0.0	0.0	Yes	0	0.0		0	0	0
320	Cardiology	189	269	80	1	21.0	22.5	No	13	0.0	7.3%	0	0	0
330	Dermatology	125	308	183	4	37.0	40.5	No	8	0.1	9.5%	0	0	0
340	Thoracic Medicine	94	145	51	3	16.7	17.7	No	9	0.2	5.9%	0	0	0
400	Neurology	65	122	57	1	8.5	9.6	No	14	0.1	12.9%	11	0	11
410	Rheumatology	50	117	67	3	10.4	11.7	No	11	0.3	12.4%	0	0	0
502	Gynaecology	281	365	84	11	60.3	61.9	No	6	0.2	2.7%	0	0	0
X01	Other	778	1030	252	37	166.7	171.6	No	6	0.2	2.9%	0	0	0
GEN	Gen Med & Gastro & Geriatric Comb	258	292	34	0	41.3	42.0	No	7	0.0	1.6%	0	0	0
													7	63

The slide above shows the relative position of Wye Valley NHS Trust in relation to RTT delivery as at the start of the year, based on actual delivery in 2013-14. There is a delay in reporting RTT information nationally as activity has to be fully validated before it is published, so this was produced by the CGG in June 2014.

What this showed at this time was that almost all specialties were operating within a clearance time of 13 weeks, i.e. the total numbers on the list were equal to an average of 13 week clock closures, this target is identified as good practice by the National Elective Care Intensive Support Team.

There were two specialties with clearance times above 13 weeks General Surgery and Neurology but only just. This is a relatively good starting position.

On the negative side most specialties saw a rise in waiting lists in the year, so more patients were being added than treated, this indicated a need for more recurrent capacity to be in place, and reflected the urgent care pressures impacting on planned care.

Backlog numbers in the main are extremely good, and only two specialties benchmarked against the Elective care Intensive Support Teams rule of thumb of not being more than 0.5 week clock closures.

Without the pressures from Urgent Care impacting on planned care delivery the system overall would have continued to be in an excellent place for RTT sustainability. Delivery of the unplanned care aspect

of the SRG is therefore crucial to RTT sustainability over the winter period, as is delivery of the profiled activity from the RTT sustainability resources.

Key points are:

- Excellent history of RTT delivery
- Management of Urgent Care pressures is critical to RTT sustainability
- Backlog numbers overall are still small and benchmark well in comparison to other areas.

3.4 Looking Forward

Moving forward into next year, a robust capacity and demand plan will be developed and taken through the SRG in its new role, using the principles if not the actual IMAS capacity and demand tools.

The RTT plan which is in the process of review includes plans for 300 patients to be seen in the Independent Sector by the Nuffield Hospital. The target is to bring all specialties within target by the end of November and maintain stability going forward.

Implementing e-consultation

A small pilot study to test the concept of electronic consultation was undertaken by HCCG and WVT and local 24 practices during 2013. The findings confirm local recognition and support for e-consultation with benefits to patients and clinicians demonstrated via the pilot. To implement e-consultation more widely and ensure realization of benefits across specialties a number of changes are necessary to ensure we establish a single efficient electronic referral pathway locally. In light of recent NHSE plans for a single NHS electronic referral service (e-RS) and vision for paperless referrals by 2015, it is proposed that the concept of e-consultation is taken forward as a clinical advisory service function within Choose and Book (CAB)/e-RS (Consultant undertakes triage of all referrals which ultimately determines the outcome).

Taking forward the learning from this pilot and keeping pace with national programme requires continued collaboration and collective responsibility to ensure we make smarter use of information and technology to achieve further benefits including ability to:

- Increase primary care CAB uptake with associated efficiency in referral processing for both primary and secondary care,
- Maximize cost-effectiveness of clinicians time (e.g. surgical specialists spending more time in theatre and less time seeing patients in OPD),
- Address volume of referrals in high demand specialties avoiding the need for waiting list initiatives.

Aims/ Objectives :

- To establish a single e-referral service for Herefordshire.
- To embed the concept of electronic consultation for local clinicians across all relevant specialties.
- Revise current choose and book arrangements locally to ensure provider is able to efficiently meet contractual requirements.
- Ensure GPs have access to all referral functions including Advice and Guidance/Clinical Advisory Service via choose and Book/e-RS.
- Ensure referrals consistently include the critical information needed in order for the consultant to complete clinical assessment to determine the most appropriate treatment and care for the patient.
- Provide alternatives to consultant outpatient appointments through the use of consultant written “community management plans”.
- Improve access and experience for patient and carers.

- Establish a robust clinical audit trail to support effective patient management at the interface of primary and secondary care.

An amount of £205k outpatient referral QIPP has been built into the contract with Wye Valley Trust targeting six specialties with effect from October.

The CCG has invested in an e-referral project manager (£50k. This post holder is working within WVT to ensure that system and processes are in place for October implementation

3.5 Operational Delivery

Key performance metrics relating to RTT do form part of the routine reporting of RTT delivery to the SRG Board, including delivery of additional planned activity as part of the RTT resilience funds.

This includes size of the waiting list, clearance times as indicated at specialty level, analysis of removals to ensure patients are seen in clinical order, use of a live PTL operationally to oversee delivery, use of a weekly PTL by the CSU to ensure issues are being addressed as expected.

We now have the national weekly PTL tracking system via Unify which shows un-validated data performance by Trusts each week, and weekly activity return in terms of activity delivered from the RTT resilience resources.

A routine report is received by the SRG detailing the nationally published information on RTT performance, together with more local un-validated tracker information.

All patients over 40 weeks are reviewed with providers to ensure that they have a TCI date to ensure no-one waits above 52 weeks, and this is monitored and reported to the Area Team and SRG on a monthly basis.

4. Wider Context

4.1 Governance of the SRG

Herefordshire System Resilience Group is established and meeting on a monthly basis. Terms of reference are to be found as **Appendix 1**. Further work is needed to extend the regular attendance at the SRG to voluntary sector, carers and patient representatives and the development of the ORCP has provided an opportunity to increase awareness and engagement.

Due to the challenges that Herefordshire is currently facing in delivering constitutional standards in Non-Elective Care, the SRG is currently chaired by the Area Team and weekly Executive Calls are in place including the Area Team and the Trust Development Authority to review performance and progression. Feeding into this, an Operational Group meets on a weekly basis to ensure progress with agreed actions relating to improvements in the Non-Elective Care system and includes membership from all key partners.

Herefordshire has had a long history of delivering against access targets and has not in the past been faced with the challenges that have become familiar to many other health and social care systems. The county's position has deteriorated over the past 2 years, with increasing demand in non-elective care impacting across the system and being echoed in building demands in social care at a time when budgetary constraints have tightened. Increasing demand from an ageing and geographically dispersed population have placed pressures on our system that require long term solutions that address the challenges of a rural and remote county, enabling us to sustain the provision of core health and social care services within Herefordshire.

Over the past 12 months, the increases in non-elective demand have had a significant impact on elective capacity, leading to building problems with Referral to Treatment Times. Plans have been developed to address the backlog that has built up in the system, but there is limited additional elective capacity available in Herefordshire and many people in our county live in rural areas that make accessing providers in bordering counties unattractive.

Position statement

This section aims to summarise the position across our system both for health and social care.

The System Resilience Group recognizes the importance of building shared understanding of the challenges across the whole of the health and social care system in Herefordshire, supporting both adults and children. Whilst our immediate and most apparent pressures relate to underachievement in the delivery of high profile NHS Constitutional rights, our system wide Transformation programme will only achieve sustained improvements for our population if we understand and address the full range of challenges in our system.

Areas for further development in understanding:

- Continued detailed analysis of the data sitting behind our current performance in every area
- Improvement in our understanding of capacity, capability, challenges and opportunities in the non-statutory sectors.

4.2 Integration of the Urgent Care Work and Better Care Fund

The Better Care Fund is being developed as an enabler to support the delivery of our aspirations for system wide Transformation. Specifically, the re-engineering of community health and social care services is being designed to reduce demand on acute services and support earlier and robust discharge for those who need an episode of in-patient care.

The minimum BCF budget for Herefordshire for 2015/16 is £11.7m of revenue and £1.4m of capital spend. Agreement on the components of the minimum commitment has been reached with partners in Wye Valley Trust and 2gether. Partners have supported the allocation and indicated their desire to move forward with service redesign and action to reduce the pressures within the Herefordshire system.
Financial and operational design principles have been agreed and include:

- Allocated budgets are not for supporting the status quo, but to ensure improvements and service redesign in line with BCF requirements and the Herefordshire System Transformation Programme
- The key tool for service redesign is based on the patient experience and their journey through the system with one person/professional accountability for the service user at the earliest opportunity and throughout the journey wherever possible
- Utilising the above tool to ensure that hand offs within the journey are minimised and unnecessary barriers removed
- That the default position for pathways should be all ages all conditions recognising that we may prioritise some ages and services within the programme for maximum whole system impact
- Proactive clinician input to redesign options and decisions must be maintained

The BCF is an enabler in terms of opportunities to pool budgets and jointly commission services to deliver collaborative integration that reduces demand on the acute services and improves the impact

of prevention and enablement within the wider Health and Social Care community. We are clear that discussions around BCF must move from BCF finance to more challenging and enabling conversations.

To deliver this, we are moving from a separate BCF programme-based approach into utilising the Better Care Fund opportunity, criteria and performance requirements within the newly developed Joint Commissioning Board and the System Lead Transformation Programme. This revised process will put service redesign for whole system benefit at the front end of commissioning activity, enable effective challenge and assurance but not supersede the CCG or Local Authority governance and decision making requirements.
Specific areas of work in place within the BCF pooled budget arrangement to deliver a reduction in avoidable admissions and increase the rapid discharge from hospital are:

- Rapid Access to Assessment & Care – a joint pilot between Wye Valley Trust, Adult Social Care and our Residential and Nursing Care providers that facilitates the early, safe discharge of patients from hospital to bed based care or to the usual place of residence with care through a rapid response team.
- Virtual Wards and Hospital at Home – Wye Valley Trust, the CCG and the Local Authority are continuing to evaluate, develop and extend the existing services, using learning from the current pilots to support our plans for the future.
- Integrated Community Services Model – Wye Valley Trust and Adults & Wellbeing (Adult social care and other care and support operational services) are building upon the learning from the pilots above (and other national best practice) to develop an integrated urgent care pathway that will reduce avoidable admissions at times of individual, family or carer crisis by ensuring a rapid response that can provide the relevant intervention on a short term basis until longer term needs can be assessed (as appropriate). The same pathway will also deliver an in reach service to the hospitals that enables safe discharge to the usual place of residence via therapeutic assessment and short term support interventions. This enables the default position of assessment in the usual place of residence as opposed to within the Hospital environment.

4.3 Planning For Winter / Flu

Public Health England will be leading the flu communications this year. NHS England will be offering a supporting role in the campaign. The main focus this year is on improving uptake in at-risk groups, pregnant women and carers.

Uptake figures across Herefordshire will be monitored by the SRG Groups.
The main targets and priorities for 2014/15 are:

- >75% uptake in the over 65s
- >75% uptake in frontline health care workers
- Expectation to improve on uptake from last year in other cohorts
- To prioritise improving vaccine uptake in people with chronic liver disease and neurological disease including people with learning disabilities
- Pregnant women

There will be an extension of the children's flu programme for 2014/15 to include 4 year olds and targeted work towards increasing uptake from last year. There will also be a national requirement for all acute trusts and organisations not achieving the 75% target among FHCW last year to demonstrate robust plans are in place for meeting it in 2014/15. A template flu plan has been issued to all local providers for completion and return.

We have agreed with the Area Team a scheme in community pharmacies to give the flu vaccine to certain groups of 'at-risk' patients to increase numbers vaccinated

Each agency holds its own emergency plans for winter or emergency occurrences. There is also a Herefordshire Flu Outline Plan and a Herefordshire Multi-Agency Flood Plan which form part of the Herefordshire wide planning.

Communication

A Communications sub-group has been established to support the SRG and will submit a plan to the September meeting of the SRG. This group links with the Transformation Programme which has a communications work stream bringing together system wide communications and engagement leads to support transformation across the system.

Media opportunities have been taken for key leaders within the system with the Clinical Chair of the CCG, the Director of Adult Social Services and the Chief Executive of Wye Valley Trust all securing regular slots in local media. This provides an opportunity for consistent and regular messages to be passed to the local population over a sustained period of time.

Partners in the SRG will be asked to review this final plan through their appropriate governance structures. The agreed final plan will then be shared with the Health and Wellbeing Board and will be published on the CCG's website.

4.4 Risks

The risks within this plan have been reviewed and a draft Risk Register is included at **Appendix 11**. This summarizes the top risks identified to date and will be developed and reviewed on monthly basis through the System Resilience Group

Nine high level risks have been identified and measures put in place to address them, although further and ongoing review and action is required to reduce these risks, some of which are long term and require significant changes.

The high level risks are:

- Delay in completing and agreeing detailed profiling of elective and non-elective capacity & predicted demand data for full system
- Delay in implementing agreed system transformation programmes to support long term delivery
- WVT ability to deliver and sustain 4 hour target within agreed trajectory given increased demand through A&E department
- WVT ability to complete RTT pathways of all patients waiting 18+ weeks given pressures in system
- WVT ability to sustain 18 weeks due to increasing referrals
- Lack of ability to sustain investment beyond 2014/15 in schemes that do not delivery identifiable savings but that do impact on delivery of required improvements in patient experience
- Inability to recruit to new temporary posts funded through the SRG plan
- Failure effectively to implement SRG plans and recover urgent care performance could result in reduced quality performance, poor patient care and experience.

The impact of local or national emergencies or other breakdowns in the system could result in the failure of these schemes. Locally, additional pressures or other service capacity restrictions could also impact on the success of these schemes.

Daily monitoring of key activities via sit-rep and other reporting will help to identify system pressures and progress against trajectories. Daily Health Executive Conference Calls to review the position of the Urgent Care system are being put in place from early September to support operational robustness

and to ensure predictive as well as reactive action is taken to support system delivery. A robust governance arrangement involving Operational Group (meeting on a weekly basis) and Executive Group (meeting on a weekly basis) will support the ability to respond and adapt.

Conclusions

The Herefordshire health and social care system recognises that it faces significant immediate and longer term challenges that require system wide engagement and change. Partners have responded to the immediate challenges and engagement in reaching agreement over priorities has been good with consensus achieved. . All partners are committed to working together to deliver improved care for local people and the system resilience plan is our roadmap to achieving this. There is however recognition that sustained improvement, in the face of growing demand, will require continuous focus and the direction of our attention and resources towards delivery.

A broad membership System Resilience Group has been established with appropriate governance to drive through improvements in the urgent care system. A number of schemes have been identified across health and social care and all parties are in agreement as to which schemes should be funded. A number of other schemes which do not require funding will also be undertaken.

Plans for achievement and maintenance of RTT targets from the end of October have been submitted and are in final review although there are significant concerns about the ability to deliver given the pressures on the system and increased levels of referrals. Other developments within the system such as the schemes within the Better Care Fund and the opportunity arising from the Prime Minister's Challenge Fund are supporting the work of the SRG. Sub-groups are in place to develop activity reporting around capacity and demand. There is also an established system wide communications group which will further support the ongoing work.

Whilst engagement is good and individual organisations are continuing to drive forward collective and individual improvement schemes, the system is struggling to deliver against key targets. The work of the Transformation Programme is recognised as vital to achieving sustainable long term system resilience for Herefordshire, however, in the meantime new ideas and innovative approaches are needed to support both short and longer term improvements in care for local people.

Appendices

1. Herefordshire SRG Terms of Reference
2. A&E / Urgent Care analysis June 2014
3. ECIST Review
4. Transformation Programme
5. SRG Action Plan
6. WVT Action Plan
7. RTT Information – SRG investment in elective Activity
8. Escalation Management Plan
9. Herefordshire Flu Plan
10. PM Challenge Fund
11. Risk Register
12. Integrated Urgent Care Slides
13. Templates – Non-elective and Elective Care
14. Care Pathways Progress