Wolverhampton City Council

Health and Wellbeing Board

31 July 2013

Time 2pm **Public meeting?** YES **Type of meeting** Oversight

Venue Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Room Committee Room 3 (3rd floor)

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No.	*Title*
MEETING BUSINESS ITEMS	
1.	**Apologies for Absence (if any)**
2.	**Notification of Substitute Members (if any)**
3.	**Declarations of interest (if any)**
4.	**Draft Urgent and Emergency Care Strategy**

Part 2 – exempt items, closed to the press and public

Item No.	*Title*	*Grounds for exemption*	*Applicable paragraph*
	NIL		

WOLVERHAMPTON CITY COUNCIL

HEALTH AND WELL BEING BOARD

Wolverhampton Clinical Commissioning Group **Royal Wolverhampton NHS Trust**	
Author:	Dr Morgans – Wolverhampton Clinical Commissioning Group (WCCG) Board Member and WCCG Urgent Care Lead Richard Young – Director of Strategy and Solutions WCCCG Dr Odum – Medical Director RWT and Chair of the Joint Urgent and Emergency Care Strategy Board
Contact Details:	r.modiri@nhs.net
Title of report:	The Draft Urgent and Emergency Care Strategy
Date of Meeting:	31st July 2013

1. Purpose of Report

The Urgent and Emergency Care Strategy has been developed to provide a cohesive response to the significant pressures seen within the Urgent and Emergency Care System. The existing system has not been designed to cope with the levels of current and predicted activity and access to the right urgent care facility is too complex and confusing. This has been evidenced through our discussions with patients so far, who have told us that they do not know where to go for their urgent care needs.

Further to the May Health and Well Being Board the joint Urgent and Emergency Care Board has considered the feedback from members and taken these views into account to develop the latest version of the strategy.

2. Recommendations

1. That the Health and Well Being Board acknowledges the challenges within the existing Urgent and Emergency Care System as set out within the draft Strategy document.
2. That the Health and Well Being Board identify any areas missing from the document;
3. That the Health and Well Being Board agree the way forward being proposed.

3. Detail

The Urgent and Emergency Care Strategy brings together views of patients and healthcare partners to help develop an improved and simplified urgent and emergency care system.

The short to medium term solutions are being developed alongside the strategy.

Other strategies are being developed for Intermediate Care, Long Term Conditions, Planned Care etc and Urgent Care will be considered within them, particularly Long Term Conditions.

The strategy outlines the vision for Urgent and Emergency Care. It is envisaged that once the 12 week public consultation is complete, an implementation plan will be developed for the detailed changes required. It must be noted that the usual 3 month consultation applies for any significant service change which may be proposed as a result of the implementation plan.

4. Key Risks

4.1 The existing system must change due to the pressures being experienced over a sustained period. If a change to the system is not delivered key quality measures will continue to be missed;

4.2 Our patients have told us that they are currently confused about how to access urgent and emergency care. Without the changes to simplify the system there will continue to be additional pressure on the current Emergency Department and the West Midlands Ambulance Service

4.3 There are significant financial implications for the health economy resulting from the increased in activity in the Emergency Department

4.4 Patient care will suffer if the system does not change;

4.5 The increased pressures and the onset of winter will result in a further decline in the quality of patient care.

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Joint Urgent and Emergency Care Strategy

The Future Vision for Urgent and Emergency Care for patients using services in Wolverhampton

"Improving and Simplifying Arrangements for Urgent and Emergency Care"

'We must do things differently'

July 2013

Document Control

Purpose of this document

The purpose of this document is to provide key information on the options for the future Urgent Care System in Wolverhampton. This will enable our stakeholders requirements to be more clearly understood and included in the final Urgent Care Strategy Document.

Version History

Version	*Issue Date*	*Brief Summary of Change*	*Author*
0.1	23/01/13	Initial draft	R Modiri

Document

Version	*Issue Date*	*Brief Summary of Change*	*Author*
0.1	21.02.13	Document Creation	RM
0.2	05.04.13	Include Patient engagement feedback	RM
0.3	17.04.13	Continuation of document content	RM
0.4	26.04.13	Circulation of initial draft	RM
0.5	29.04.13	Additions added to the strategy document	RM
Draft v3	29.04.13	Circulation of strategy document	RM
Draft v4	30.04.13	Circulated to Strategy group	RM
Draftv5.1	02.07.13	Circulated to Strategy Board	LL, DP, ML
Draft 6	10.07.13	Amendments to document	RM
Draft 7	15.07.13	Amendments	JO
Draft 8	16.07.13	Amendments from Strategy Board	RM
Draft 9	19.07.13	Amendments from core revision group	RM
Draft 10	23.07.13	Refinement by Core Revision Group	RM, LL

Sign Off

Name	*Position*	*Date*	*Signature*
Dr Julian Morgans	Wolverhampton Clinical Commissioning Group (WCCG) Urgent Care Lead		
Dr Jonathan Odum	The Royal Wolverhampton NHS Trust (RWT) Medical Director		

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1. Foreword

Wolverhampton Clinical Commissioning Group (WCCG) and the Royal Wolverhampton NHS Trust (RWT) are wholly committed to improving the health and wellbeing of our population. We have worked with our health and social care partners and commissioners from South Staffordshire to develop a joint urgent and emergency care strategy. We will place patients at the centre of our decision making and deliver this strategy through the newly established model of clinically led commissioning, and collaboration across the health and social care economy. This model will bring about real differences for the health of our population and their experience of services.

The pressure seen by the urgent and emergency care system across the country is unsustainable. Performance on a number of important indicators has worsened over the winter period in 2012 and has continued into 2013. Indicators including how quickly patients are seen, discharged or admitted at the Emergency Department are particularly affected. This deterioration is also reflected in the experience and quality care patients receive.

"We must do things differently."

The urgent and emergency care strategy has been developed by health and social care partners to provide a collaborative way forward to tackle some of the mounting problems with urgent and emergency care within the City.

Given the complex nature of patient flows across different services, urgent and emergency care services cannot be commissioned in isolation and the process requires a multidisciplinary, whole systems approach across acute, primary, community-based services, social care and mental health. Collaboration between partners, patients and services are vital. Patients and healthcare professionals have and will continue to be at the forefront of the developments and their views integral to the final strategy.

This strategy is centred on improving service provision by examining the whole urgent and emergency care system and describing the proposed arrangements for the future system in Wolverhampton until 2016. The strategy focuses on urgent and emergency care, however it is interlinked with other strategies being developed for the City such as Primary Care, Planned Care, Long Term Conditions, Mental Health, End of Life, Health Inequalities and Intermediate Care amongst others. Short to medium term solutions are being developed alongside the strategy.

The strategy intends to improve quality and translates local and national policy into action, outlines the local context, current activity and defines how the vision for urgent and emergency care will be delivered through a proactive, robust system that directs patients to the right service in the right place at the right time.

This is important work to ensure that we develop an affordable and sustainable urgent care system for all of our patients.

Dr Julian Morgans
WCCG Lead – Urgent Care

Dr Jonathan Odum
Medical Director – RWT

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2. Statements of Support

South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (SES&SP CCG)

South East Staffordshire and Seisdon Peninsula CCG have worked closely with Wolverhampton CCG and the Royal Wolverhampton NHS Trust and agree with the core principles and objectives outlined in this strategy. We will continue to work closely to support the joined up delivery of services across the local geographical boundaries to ensure our local population receives high quality urgent and emergency care.

Tim Dukes
For and on behalf of Seisdon Peninsular CCG

Wolverhampton City Council (WCC)

Wolverhampton City Council welcomes a strategy and is committed to one that works on partnership principles that support modernised ways of working. We share the need to focus on a better quality of outcome for citizens and look forward to taking this strategy forward.

Tony Ivko
For and on behalf of Wolverhampton City Council

West Midlands Ambulance Service NHS Trust (WMAS)

West Midlands Ambulance Service NHS Foundation Trust has worked closely with Wolverhampton CCG and the Royal Wolverhampton Trust and agrees with the core principles and objectives outlined in this strategy. We will continue to work closely to support the joined up delivery of services across the boundaries to ensure people get high quality urgent and emergency care.

Nick Henry
For and on behalf of West Midlands Ambulance Service NHS Foundation Trust

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3. Executive Summary

3.1 Urgent and Emergency Care has been a focus of attention in the press both locally and nationally due to the extreme pressures that the entire system is under. The focus of attention has been on the Emergency Department and the ambulance service. However the entire system has experienced increased activity with patients experiencing longer waits to be seen and treated and Wolverhampton is no exception and has experienced high levels of activity increase and pressure across the whole economy.

3.2 It is understood that there is no single cause to the increased pressure nor is there a single solution. The existing system, providing urgent care in Wolverhampton, is unsustainable and was not designed to cope with the significant and unpredicted increased levels of activity. Our patients are experiencing long waits and have told us that they are confused on how and where to access appropriate services.

3.3 This has prompted the development of a joint Urgent and Emergency Care Strategy Board with partners from WCCG, SES&SP CCG, RWT, WCC and WMAS coming together to undertake a review of urgent and emergency care in Wolverhampton in order to develop an urgent and emergency care strategy and a commitment to work with our patients to develop a cohesive and sustainable way forward. The joint Urgent and Emergency Care Board brings together clinicians and managers from the health and social care providers and commissioning organisations. More recently the Board has expanded its membership to include public health and patients representatives.

3.4 Urgent and emergency care is a priority in Wolverhampton and this clinically led strategy focuses on the vision of urgent and emergency care for people resident within the City and for those who use our services. The strategy will be subject to a consultation process further to which an implementation plan will be developed to set out the key deliverables for this work. The strategy outlines the vision and areas of focus however the 'how' and 'what' will be included in an implementation plan.

3.5 The government is committed to the idea of a 24/7 urgent care service. This is reiterated in its White Paper, 'Equity and Excellence: Liberating the NHS' that has led to the current health reforms. "The government will develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care. This will incorporate GP Out of Hours services and provide urgent medical care for people registered with a GP elsewhere. It is intended to make care more accessible by introducing, a single telephone number for every kind of urgent and social care and by using technology to help people communicate with their clinicians".

3.6 Given the high profile nature of the pressures, a national review of emergency care is underway led by the NHS England Medical Director, Professor Sir Bruce Keogh, and an inquiry by the Health Select Committee. NHS England has also announced that its local area teams are drawing up A&E recovery plans and Wolverhampton is no exception. An A&E Recovery Plan is currently in development, the delivery of which will be overseen by the Joint Urgent and Emergency Care Board.

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3.7 Emerging principles from the review for urgent and emergency care in England outline a system that:

- Provides consistently high quality and safe care across all seven days of the week;
- Is simple and guides appropriate choices by patients and clinicians;
- Provides the right care in the right place by those with the right skills, the first time;
- Is efficient in the delivery of care and services.

3.8 Financial sustainability is an important factor in the commissioning and provision of services across the country. However, the key principal and reason for developing this strategy is to improve the quality of urgent and emergency care service provision in the City whilst ensuring its affordability and sustainability.

3.9 There have been many changes to the Urgent and Emergency Care system over the past few years with the introduction of urgent care provision at the walk in centres at Showell Park and the Phoenix Centre; new out of hours provision by Primecare and new pathway developments for conditions which more recently have been managed in the community including DVT, COPD exacerbations and Cellulitis amongst others. In addition, ways of navigating the system for both patients and healthcare professionals have been streamlined with services such as the Wolverhampton Urgent Care Telephone Service (WUCTAS) and more recently NHS 111.

3.10 The ambulance service continues to deliver 999 ambulance responses for hear and treat, see and treat and see and convey for patients in Birmingham, the Black Country, Staffordshire, West Mercia and Coventry & Warwickshire (West Midlands region). Work is being undertaken to upgrade paramedic skills to enable further diagnostic skills to treat patients in the right setting first time with Community Paramedic schemes, (a hub model for efficiencies) and Hospital Ambulance Liaison Officers (HALOs) are being established to better support the acute and community services. WMAS is continuing to develop the Directory of Services (DoS) that supports the identification of alternative services for appropriate patients who call 999, the new 111 number and for utilisation by health care professionals with patients. Work is also underway to identify frequent service users with the intention of reducing the number of 999 calls to WMAS through a multi-disciplinary approach. It is the intention of the Urgent and Emergency Care Board that this work continues.

3.11 To ensure our patients views are integral to the strategy development, the board commissioned an engagement project in December 2012 with patients who were using the urgent and emergency services within Wolverhampton. Our public health, patient engagement and commissioning colleagues worked together with an external organisation to undertake a project where patients completed surveys and attended focus groups to explore their use & thoughts of urgent and emergency care service provision. In addition to the initial project, further engagement work has been undertaken during February-April 2013 with stakeholders and patients to understand their views on different ways the urgent & emergency care system could progress and what the key issues are. Further details can be found in Appendix 1.

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3.12 Our patients have expressed their concern at difficulties accessing primary care and the significant impact this has on increasing Emergency Department (ED) attendances. A recent review of Access to Primary Care and Visits to Emergency Departments in England (Thomas E. Cowling et al) has shown a direct correlation between General Practice providing more timely access to primary care and having fewer self-referred discharged Emergency Department visits per registered patients.

3.13 There is recognition that patients want to see their own GP but are often confused about which services are available for them to access for their urgent care needs, and how quickly they can be seen, particularly at different times of the day. GPs from across the city also believe that Primary Care could help to reduce Emergency Department activity if the system were to change both in and out of hours. It is the view of the Urgent and Emergency Care Board that access to primary care and the provision of services in the out of hours period must be improved to ensure patients can see a GP when their GP surgery is either open or closed. We must also improve communication across the system for both health and social care professionals and also for our patients.

3.14 Pathways of care across health and social care are fundamental to the delivery of urgent and emergency care. A patients journey from the start of their urgent care episode right through to their recovery must be considered. Work with our partners to ensure that the social care and mental health requirements for attendance, admission and discharge should be a focus to improve the quality of the journey for patients. Improving timely and appropriate discharge of patients from hospital beds is also a contributing factor to a lack of flow through the hospital with detrimental effect on other patients requiring urgent care.

3.15 The King’s Fund report “Managing Emergency Activity – Urgent Care” May 2011, summarised some of the key reasons why urgent and emergency care is important. The report describes how walk in centres do not appear to have led to shorter waits in general practice or lower admission rates at other health care providers. In addition to this work, Monitor is currently undertaking a national review of Walk in Centres and it is the intention of the Urgent and Emergency Care Board to take into account the outcome of this review in assessing the benefits of the service provision at walk in centres within the city.

3.16 It is well documented that the existing Emergency Department at the Royal Wolverhampton Trust is not adequate for current service requirements. Concerns about the sustained rise in activity and the resultant pressures, together with the safety issues, particularly where patients are waiting in corridors due to the lack of space, has focussed the need for a new facility. It is the intention of the strategy to support the case for the development of a new Emergency Department at RWT that is designed to provide improved quality and quality measures that directly affect our patients.

3.17 Taking the views of our patients and stakeholders, and the extreme pressure the system is under, a cohesive vision for urgent and emergency care has been developed. **“Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population. Our patients will receive high quality and seamless care from easily accessible, appropriate, integrated and responsive services. Self-care will be promoted at all access points across the local health economies and**

patients will be guided to the right place for their care and their views will *be integral to the culture of continuous improvement."*

3.18 All Urgent and Emergency Care services will ensure that services are appropriate and do not discriminate on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex or orientation. The Urgent and Emergency Care Board is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity. Where services are required based on age, the reason will be on the grounds of service provision such as children's services or services aimed specifically at older adults due to the nature of their conditions. Further details can be found in Appendix 2.

3.19 The aim of the strategy is to improve and simplify arrangements for urgent & emergency care, to ensure that strong patient centred clinical leadership is available in all access points of the system, to provide better value for money and sustainability, and to provide greater consistency, transparency and openness. It is intended that the strategy will improve quality, safety and standards, provide better patient experience, service integration and be supported by the sharing of information and regular reporting of outcomes. A no blame culture will be adopted with clinicians, managers and patients working together to improve the services offered to patients.

3.20 The strategic objectives include improved assessment and discharge, managing patient expectation, improving quality and timely access to services. Self-care will be encouraged, communication will be improved and patients will be actively identified through the use of risk stratification. The system will be seamless and consistent with the regular exploration and development of alternative solutions to improve quality.

3.21 It is the intention of the Urgent and Emergency Care Board to deliver the strategy in phases. A consultation process will be undertaken in phase 1 to understand areas of concern our patients and stakeholders identify with the draft Urgent and Emergency Care Strategy and how they want us to continue to involve them. The exercise will inform the implementation plan to deliver real and sustainable change across the system. It is important to note that any significant service change resulting from the implementation plan will be subject to an independent 3 month consultation process.

3.22 Partnership working and involving our patients will be a theme that runs throughout. We will work together to develop pathways of care, to undertake focused work (particularly for 0-5's and over 65's), to work with social care and mental health partners to strengthen responses for urgent and emergency care needs.

3.23 There is evidence from the literature, and a view from our patients that changes in primary care will help the urgent and emergency care system therefore the board will focus in phase 2 on delivering real change in Primary Care including access to general practice and improvements in the quality and integration of out of hours service provision.

3.24 Phase 3 will include work with secondary care to implement the proposed new Emergency Department at RWT with a view to it opening its doors in late 2015

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3.25 Phase 4 will include a continuous cycle of improvement with a commitment to on-going system capacity reviews to ensure that surges in activity can be managed. We will continue our work with partners and providers to deliver improvements in the quality of services.

3.26 The strategy intends to improve quality whilst ensuring a sustainable and affordable system. The system should be designed to allow for surges in activity to enable the system to flex during times of pressure. Primary Care should be accessible for our patients, it should be clear where patients should attend for their urgent or emergency needs, Ambulances should wait no longer than 15 minutes to be turned around at ED and our patients should wait no longer than 4 hours to be seen, discharged or admitted from the Emergency Department. To support the strategy, work must be undertaken jointly with our partners to ensure the patient journey is as seamless as possible. The proposed outcomes of the strategy can be found later in this document.

3.27 This is important work and it is imperative that we start the process to incrementally change the system so that urgent and emergency care provision can respond more effectively to patient's needs, improve the quality of care and manage the challenges of the projected increase in activity.

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The Urgent and Emergency Care Strategy

4. Introduction

4.1 The Health and Social Care Act 2012 initiated one of the most radical reforms to the NHS since its creation in 1948. The Act has major implications for the local health system and the relationship between that system and local government. (Integrated Commissioning Plan 2013). The Coalition Government has enshrined the definition of quality into the Health and Social Care Act 2012. The Act now places new duties on the Secretary of State for Health, the NHS Commissioning Board, and Clinical Commissioning groups to act with a view to ensuring continuous improvement in the quality of NHS services.

4.2 Over the years there have been many criticisms and frustrations from local people and healthcare professionals when it comes to having a more responsive urgent care service. In particular it seems clear that if presented with a responsive, reliable and accessible primary and community services then our patients would rather use these for many of their needs instead of going to the Emergency Department.

4.3 There is often confusion about the terminology used by providers, commissioners and users of urgent and emergency care. Terms such as unscheduled care, unplanned care, emergency care and urgent care are used interchangeably. The Department of Health's guidance on telephone access to out of hours sought to clarify commonly used terms **Emergency Care** = immediate response to time critical healthcare need and **Urgent Care** = a response before the next in-hours or routine (primary care) service is available. We need to ensure that the local system is clear for patients.

4.4 The significant pressures on urgent and emergency care services locally, has highlighted real concern about the sustainability of services and has resulted in collaborative and cooperative support to facilitate change. The delivery of urgent and emergency care within the context of the model of care described in this strategy has been devolved to the joint Urgent and Emergency Care Board by the respective organisations.

5. Who Are We?

5.1 Wolverhampton Clinical Commissioning Group (WCCG) - is a relatively new organisation formed in March 2012 from the amalgamation of two discrete clinical commissioning groups and formerly the Wolverhampton City Primary Care Trust. The CCG is responsible for managing approximately £485 million and is committed to developing an organisation that will deliver for the people of Wolverhampton modern, high quality, integrated and value for money services.

Every practice in the City is aligned with the clinical commissioning group and this provides the optimal environment to work with our patients to improve outcomes by commissioning high quality, evidence based services. This will be achieved by focussing on health needs, outcomes, sustainability and building effective care pathways. Wolverhampton ranks amongst the 25 most deprived areas in England.

- 51 GP practices

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- One hospital provider (The Royal Wolverhampton NHS Trust - RWT)
- Two walk in centre providers across the city:
- Phoenix Walk in Centre, provider RWT
- Showell Park, provider Docs on Call;
- One out of hours provider (Primecare);
- One Local Authority (Wolverhampton City Council)
- One Mental Health Provider (Black Country Partnership)
- There are also a number of other services including West Park Hospital, Penn Hospital, Social Care Provision, Mental Health teams.

Demographic information for Wolverhampton is available at Appendix 3

5.2 The Royal Wolverhampton NHS Trust (RWT) - is an NHS Trust providing secondary, tertiary and community services;

- Providing a range of services for the people of Wolverhampton, the Black Country, South Staffordshire, and the wider West Midlands;
- Largest teaching hospital in the Black Country providing teaching and training to around 130 medical students on rotation from the University of Birmingham Medical School;
- It also provides training for nurses, midwives and allied health professionals though well-established links with the University of Wolverhampton. One of the largest NHS providers in the West Midlands the Trust has an operating budget of £374 million, more than 800 beds on 2 sites, and employs more than 6,700 staff.

5.3 South East Staffordshire & Seisdon Peninsula Clinical Commissioning Group (SES & SP CCG) South East Staffordshire and Seisdon Peninsula CCG was formed in 2012 by the merger of two former clinical commissioning groups in South Staffordshire. It is unusual in having two geographically separate localities. Associated with the Urgent & Emergency Care Strategy is the Seisdon Peninsula Locality which consists of 9 GP Practices looking after a population of approximately 55,000. The practices cover Codsall, Bilbrook, Perton, Wombourne, Claverley, Kinver and Featherstone and their surrounding areas.

Health & Social Care Partners

5.4 Black Country Partnership (BCP) - The Black Country Partnership is a major provider of mental health, learning disabilities and community healthcare services for people of all ages in the Black Country. It provides mental health and specialist health learning disabilities services to people of all ages in Sandwell and Wolverhampton, and specialist learning disability services in Walsall, Wolverhampton and Dudley community healthcare services for children, young people and families.

5.5 Wolverhampton City Council - Wolverhampton City Council exercises responsibility for meeting the Social Care needs of its citizens within the City through a range of universal and specific services. For vulnerable adults across all client groups, these are both Commissioned externally, some through joint Commissioning with the CCG and others provided by services directly controlled

by the Council. Preventative services are also available e.g. that support Carers, to maintain an individual in their home.

5.6 **Health & Well Being Board -** Wolverhampton has a Health and Well Being Board made up of senior decision makers from across the city including health, social care and police amongst others. This board will help give communities a greater say in understanding and addressing their local health and social care needs. Urgent care is one of their key priorities and the board is fundamental in agreeing the way forward for urgent and emergency care service provision.

5.7 **Healthwatch** England was established in October 2012 and took over full responsibility of the patient voice from 1st April 2013 in place of LINk. Healthwatch England leads and supports the Healthwatch network, made up of 152 community-focused local Healthwatch. It is the intention of the Urgent and Emergency Care Board to work closely with Healthwatch to ensure that high quality care is delivered across the City.

5.8 **West Midlands Ambulance Service NHS Foundation Trust** (WMAS) - The Trust is commissioned to deliver an emergency and urgent ambulance service to the West Midlands region. It was authorised as a Foundation Trust in January 2013 and continues to be a significant provider of urgent and emergency care services.

6. Strategic Context

6.1 The Government has set out a clear vision for a modernised NHS driven by a new commissioning system focused relentlessly on improving outcomes for patients. The cornerstone of the proposed system will be local clinical commissioning groups, which will put GPs – using their knowledge and understanding of patients' needs – at the heart of the commissioning process (www.gov.uk).

6.2 The NHS Outcomes Framework 2013/14 – Everyone Counts has a number of principles supporting the new approach to clinically led commissioning from 1st April 2013 including: **empowered local clinicians delivering better outcomes; increased information for patients to make choices; greater accountability to the communities the NHS serves.** The key measures covered within the Outcome Framework include: **listening to patients; focusing on outcomes; rewarding excellence; improving knowledge and data.** All these domains will impact upon the work of the urgent & emergency care services across the city and will be underpinned by the use of NICE guidance. The key measures highlighted above are also included within this strategy.

6.3 The Department of Health (DoH) vision for urgent and emergency care is of universal, continuous access to high quality urgent and emergency care services. In practice, this will mean that whatever our urgent or emergency care need, whatever our location, we get the best care from the best person, in the best place and at the best time (DoH, 2012). The 24/7 vision of a coherent Urgent Care Service should aim to provide **Greater consistency, Improved quality and safety, Improved patient experience, Greater integration** and **Better value.**

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6.4 The RCGP (Royal College of General Practitioners) suggests that 'good urgent and emergency care is patient-focussed, based on good clinical outcomes (survival, recovery, lack of adverse events and complications, a good patient experience, ease of access and convenience, timely, right the first time) and available 24/7 to the same high standards. They have also developed a Commissioners Guide to Urgent and Emergency Care (Urgent and Emergency Care – A Whole System Approach). The document suggests that 'the urgent and emergency care system still appears fragmented and needs to be more joined-up to make the care provided seamless, more efficient and effective, and offering greater value to commissioners'. See Appendix 4 for further details.

6.5 The national agenda for urgent and emergency care services highlights the need to ensure services are more responsive to people, use resources more efficiently and use developments in medical and technological advances to deliver better care and support to people.

7. Local Drivers

7.1 The WCCCG has considered a range of evidence and indicators over the past 12 months including: the Joint Strategic Needs Assessment (JSNA) information supplied by NHS England, data from Public Health England, information provided by our GP's and our key providers. In addition, engagement has taken place with patients and the wider public. The results of the engagement and the analysis of the data has enabled the WCCCG to identify three key priorities and Urgent Care is one of these. The WCCCG has set out a plan to **"Improve and simplify arrangements for Urgent Care".**

7.2 RWT has also set out Urgent and Emergency Care as one of its strategic priorities. This reflects the importance of ensuring its patients access the correct urgent and emergency care facility and only attend the Emergency Department when necessary. As the front door of the hospital, the Trust recognises the interdependence of urgent care on other services and the impact that the growth in urgent care has on the hospital as a whole.

7.3 In establishing the drivers impacting on the model of urgent and emergency care delivery, the following are of particular relevance.

- Francis Report
- NHS England – National Commissioning Board
- Emergency Department Development
- NHS 111
- Achievement of Hyper Acute Stroke Unit Status (HASU) at The Royal Wolverhampton Trust
- The Future of Mid Staffordshire NHS.

The Board recognise that these drivers will have varying levels of influence on the strategy, however it is difficult to predict to what extent and timescales. Further details are outlined at Appendix 5.

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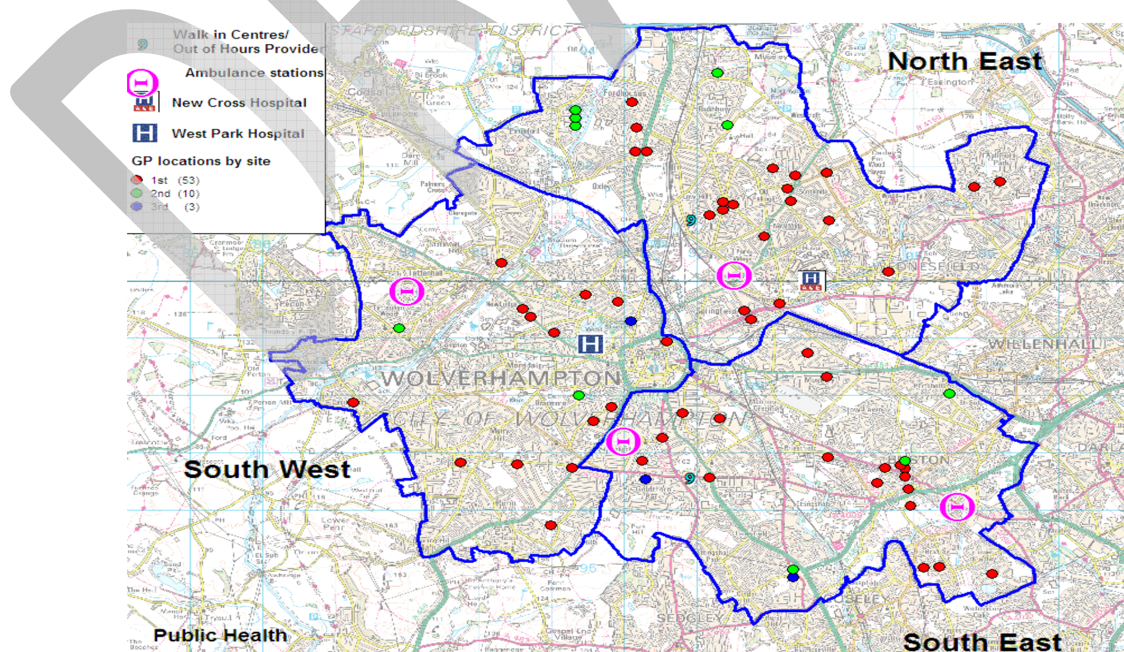
7.4 The local drivers for urgent & emergency care are closely linked with the challenges that are faced within the city. See section 9 in the document for further details.

8. Urgent and Emergency Care in Wolverhampton

The scope of Urgent and Emergency care is broad and services vary nationally. In Wolverhampton the existing urgent & emergency care system includes:

- Self-care & NHS Choices
- Community Nursing Teams including Hospital at Home, Community Matrons, Tele Healthcare, CICT
- Pharmacists
- Single Point of Access including Wolverhampton Urgent Care Telephone Access Service (WUCTAS)
- General Practice (GP) practices
- West Midlands Ambulance Service NHS Foundation Trust (WMAS)
- Walk in Centres (WiC)
- NHS 111
- Urgent Social Care
- Out of Hours Primary Care Service
- Urgent Mental Health
- Care Homes (Residential and Nursing Homes
- Emergency Department (ED)
- Emergency Hospital Admissions including Paediatrics, Acute Medical Unit and Surgical Assessment Unit.

Further information on the service descriptions can be found in Appendix 6.



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9. Challenges / Case for Change

9.1 Pressure within urgent & emergency care has grown year on year. More recently however, the Wolverhampton local health economy has seen unprecedented surges in activity. Significant numbers of patients have attended the Emergency Department in 2013 with the ED seeing its highest number of patients in one day (n. 392) compared to an average of 300 per day between 1/5/13 to 15/7/13.

9.2 Performance against national targets is becoming increasingly difficult to achieve. Historically, RWT have never failed the annual 95% quality indicator for patients being seen, discharged or admitted at ED. The overall target for 2012/13 was achieved however the measure was not achieved during Q4 of 2012/13.

9.3 Ambulances are waiting for more than 15 minutes to turnaround at the Emergency Department, hospital bed capacity is seriously challenged and 'winter' wards remain open throughout the summer of 2013/14. Primary Care has also seen significant increases in demand with many of the primary care and community based urgent and emergency care services seeing equivalent pressure across the City.

9.4 There were 106,838 attendances at Emergency Department in Wolverhampton in the year 2012/13 compared to 101,298 in 2011/12, an increase of 5.19%. There were also 44518 non electives admissions, an estimated 2,188,866 GP consultations, over 60,000 attendances at both Walk in Centres and approximately 23,923 contacts with the out of hours service. There were 44,936 patients in contact with the ambulance service and ambulance conveyance to RWT increased by 5.4% compared to the previous year's data. An average increase of 56 ambulances per week attending RWT compared to 2011/12 based on Q4 average (A&E Recovery Plan).

9.5 Finance and activity modelling has been used to support the redesign of the urgent and emergency care system. A reference group has been developed and the Commissioning Support Unit (CSU) invited to undertake the exercise to understand the potential increases in activity and finance. To highlight the current pressures, the modelling predicted an increase in activity from 2012/13 to 2016/17 of 4.3% if no changes were made to the system. However existing pressures have already shown a 5.19% increase at the ED. Further detail can be found in Appendix 7.

9.6 Wolverhampton has one of the highest ED attendance rates in the country however one of the lowest attendance to admission ratios. This means that there is a high number of people attending ED, however there is a low number of attendances that turn into an admission. This would suggest that the needs of the patients could be met by other services, such as in primary care, should those services be available.

9.7 There has been regular focus on the existing Emergency Department and the limitations of the current service provision due to the building's current geographic layout and design. The current A&E department opened in the mid 1990's and is not designed for service provision in 2013. Safety concerns due to the lack of space have been documented in the local press. RWT is

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currently making a number of interim improvements to increase capacity but these do not provide suitable long term solutions.

9.8 The emergency attendance and admission departments including the ED, Acute Medical Unit (AMU), Surgical Assessment Unit (SAU) and Paediatric Assessment Unit (PAU) are separated across the hospital site making the physical transfer of patients and economies of scale/ shared staffing resources impractical. Work is underway to develop the case for a new building that will house the urgent and emergency care services together withan out of hours primary care resource on the New Cross site. It is imperative that the wider system improves in addition to the proposed new build to ensure that patients are seen in the right place at the right time.

9.9 Through our research it is clear that there is duplication across the system with a small percentage of patients using two or more services for one episode (1591 attendances in 2011 and 1847 in 2012 at the Phoenix Centre and Showell Park which also had an A&E attendance within 24 hours). In addition, there is duplication between the users of the ED and Showell Park given the close proximity of the services. Further detail can be found in Appendix 8.

9.10 To understand the patient perspective a research project was undertaken with patients during 2012/13 to understand their use of urgent care services. Approximately 180 patients were involved at urgent and emergency care portals across the city including GP Practices, A&E and walk in centres. Patients were also invited to focus groups where they were able to discuss their thoughts in more detail.

- Participants displayed uncertainty as to when they should be accessing the different parts of the urgent care system;
- The majority of respondents reported that the following factors would influence their decision on which service to access when they had an urgent need:
  1. The ability to book a GP appointment
  2. The severity of their condition
  3. Time of day (if the surgery closed/Out of Hours)
  4. Consideration of busy periods/time of year
  5. Waiting times
  6. Limited availability of appointments/access (GPs).
  7. Panic and anxiety influence the use of ED

Patients report that they are familiar with their GP and the service that their practice provides. They were confident that they would get the answers and treatment that they need quickly. The summary of the findings are available in the Appendix 9 however the overall findings of the report include:

- Urgent Care is confusing for patients and professionals (our patients say that they are unsure where to go for an urgent care need quickly and services are hard to navigate);
- Too many access points (our patients say that they are not always sure which service to go to for different needs – there are additional layers in the system);

- GP appointments are not always available when patients have an urgent need (our patients say that they are using the walk in centres and ED because they cannot get an appointment at their own GP);
- There is significant variability in patient experience;
- Patients want to see their own GP but cannot always get an appointment when it is urgent;
- Patients want to know where to go and what for when they have an urgent need (we need to communicate with patients better);
- There is a recognition that services have to be sustainable;
- There is a strong appetite for patients to be involved in the commissioning of services;
- Access to urgent care should be fast especially for vulnerable e.g. elderly, young people;
- Accessible services such as Walk in Centres receive differing views/criticism e.g. Positives: easy access, superb, positive treatment vs. Negatives: just end up in ED anyway, poor response times.

10. The Urgent and Emergency Care Vision

10.1 Our Strategic Vision

"Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population. Our patients will receive high quality and seamless care from easily accessible, appropriate, integrated and responsive services.

Self-care will be promoted at all access points across the local health economies and patients will be guided to the right place for their care and their views will be integral to the culture of continuous improvement."

10.2 The Urgent and Emergency Care Strategy for 2013-2016 aims to:

a) **Ensure improved and simplified arrangements for urgent and emergency care** – by developing a simply designed and rationalised system supported by easy telephone and web access - by reducing the confusion in the system and reducing and by making the entry points more efficient to reflect a new and sustainable 24/7 system.

b) **Ensure strong patient-centred clinical leadership in all access points of the urgent and emergency care system** - Senior clinical decision makers will be a fundamental part of the system and their decisions will be made early and regularly in a patients care pathway.

c) **Provide better value for money and sustainability – Improving appropriate use of urgent care facilities and services.** Reducing inappropriate use of NHS services, to deliver better value for the taxpayer, for local organisations and to provide a financially sustainable

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system for the future. A reduction in unnecessary ED, ambulance and emergency admissions are a focus of the strategy.

d) **Provide greater consistency and openness, transparency and candour –** by providing consistently high quality, integrated care led by our Clinical Commissioning Group delivering the best outcomes and experience 24/7, with no noticeable differences out of normal office hours. A culture of openness and insight will be developed and action taken where honest concerns about the standards or safety of services are made.

e) **Ensure improved quality, safety and standards -** Deliver up-to-date, high quality services which are clearly focused on meeting the clinical needs of the patient and putting the patient's needs first, with less variation across the city and ingrained in a culture of continuous improvement. NHS standards will be applied.

f) **Ensure improved patient experience** - Ensuring a greater focus on the patient journey. Compassionate, caring and continuous improvement in response to patient and carer feedback;

g) **Provide greater integration & information -** Services working together to provide a seamless service, irrespective of the provider organisations which operate them. Sharing of information and regular reporting of the outcomes of the patient pathway will be ingrained in the system using the latest IT facilities where possible;

h) **No blame culture** - The strategy will support a 'No Blame Culture' with clinicians, managers and services working together to improve the services offered to patients.

10.3 The Urgent and Emergency Care Strategic Objectives include:

a) Improved Assessment and Discharge;
b) Managing Patient Expectation by clinicians working together;
c) Standardising and Improving Quality in Urgent Care by ensuring services are high quality and clinically robust;
d) Improve Timely Access to Services by improving access and operating hours;
e) Encourage Self-Care (where ever possible) by communicating with our patients;
f) Use of Risk Stratification by managing patients who are at high risk of admission into hospital;
g) Improved Communication by using technology and promotional campaigns;
h) Seamless and Consistent Urgent Care Services by ensuring all providers are managed through a system approach;
i) Explore and Develop Alternative Solutions by ensuring new solutions to improve quality within the system are identified, considered and delivered.

11. Delivery of Urgent and Emergency Care

11.1 The **Joint Urgent and Emergency Care Board** will provide the leadership and governance to oversee the development of the strategy and the delivery of the

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urgent and emergency care implementation plan, and the Board is also responsible for overseeing the delivery of the short-,medium term A&E Recovery Plan. The Board will develop a strategy implementation plan acknowledging the outcomes of the consultation process. Workstreams will be developed to deliver the implementation plan. The following groups will feed into the Board:

a) **Black Country Urgent Care Group** - This group manages urgent and emergency care across the Black Country and regularly considers models of care that have been tested elsewhere and which have been seen to work. It also reviews the existing system and the impact of current pressures, the impact of schemes such as NHS111, WMAS, discussion of fines and targets, out of hours contracts and cluster opinion of implementing guidance. It is imperative that the work of this group is considered as there are clear links to developments that can support the growing surges in activity. Collaborative commissioning can be undertaken where economies of scale will provide benefit to the wider urgent and emergency care system, and which can then be realised. The groups chair is a member of the Urgent and Emergency Care Board.

b) **Wolverhampton Surge Planning Group -** The Surge Planning Group provides resilience support to the current urgent & emergency care system by advising on tactical changes to manage surges in activity across Wolverhampton. The primary focus is on the urgent care system, the impact of pressure on those services and the decisions that need to be taken to alleviate the immediate pressures. This group will work to deliver the A&E Recovery Plan but the work will be overseen by the Urgent and Emergency Care Board.

c) **Emergency Portal Board -** The Emergency Portal Board has been created to develop the business case for the new Emergency Department at the New Cross site. This development links directly to the strategy.

12. Delivery - A Phased Approach

12.1 The Urgent and Emergency Care Board will undertake a phased approach for delivery of the strategy. A formal consultation will be undertaken to understand patient and stakeholder views. Through our research, we are clear that there is a number of areas of focus that must be taken forward:

a. Our patients have already told us that they want access to primary care to improve and there is a recognition across the system that work can begin to improve timely access to primary care both in and out of hours;
b. Work is already underway to develop the proposals for the new ED build at RWT. It is the intention of this strategy that this work will continue and the outline business case and full business case will go through the required sign off processes;
c. It is the intention of the Urgent and Emergency Care Board that work is undertaken in partnership with the Mental Health Trust to improve the pathway of care for patients who require urgent & emergency mental health care services;
d. It is the intention of the Urgent and Emergency Care Board to undertake work in partnership with the local authority to develop rapid access to social care support for patients who attend ED.

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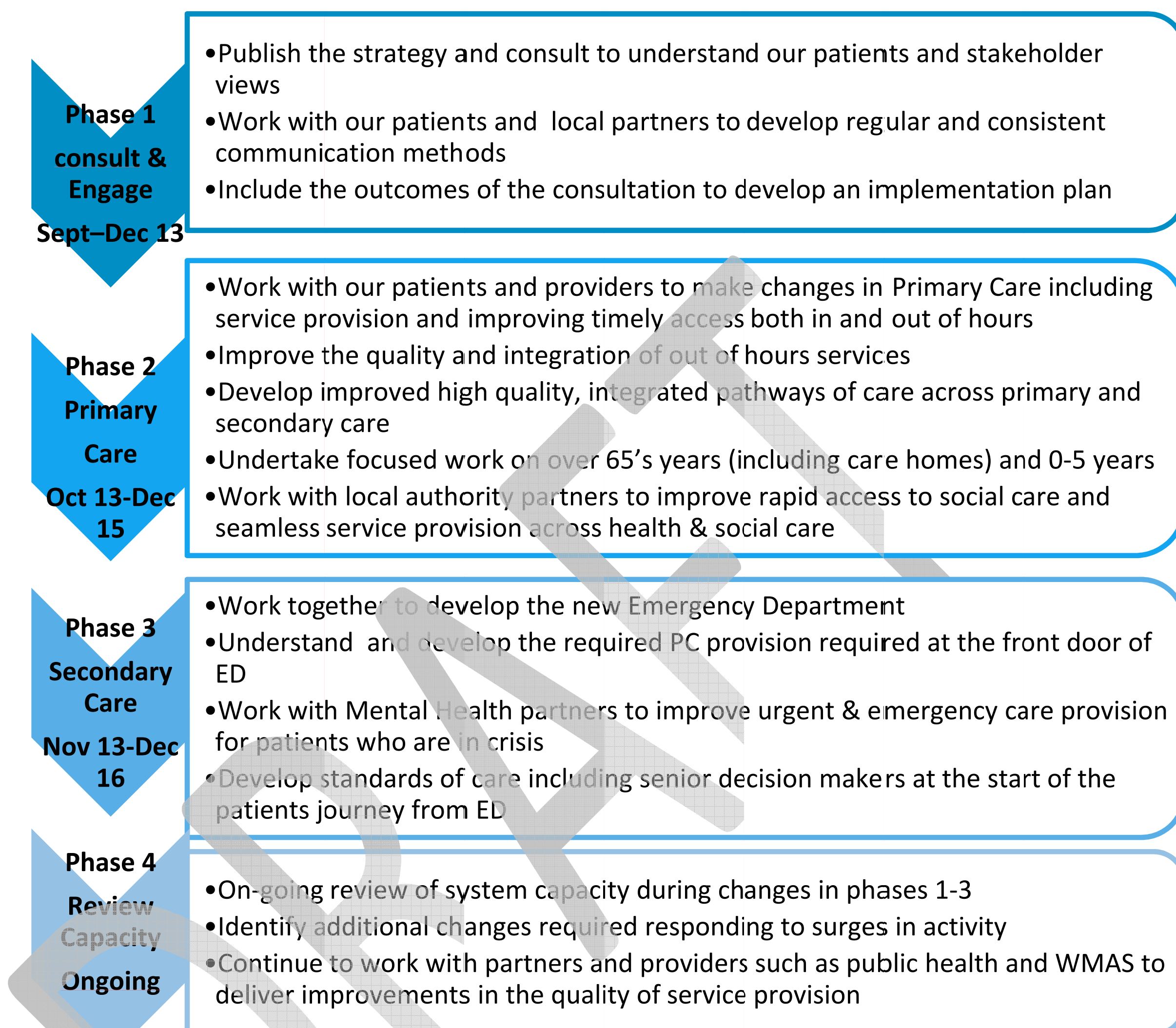
12.2 The chart below shows the process that the Urgent and Emergency Care Board would like to take forward. The process will begin with the consultation.



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13. Expected Benefits

13.1 The strategy has been developed to; set out the challenges to the system, the improvements that have been identified, and a phased approach to delivery of these. The implementation plan will describe the service changes in detail.

13.2 The strategy intends to make the system easier for patients to navigate to the right place for assessment and treatment and for services to respond in a timely way.

13.3 The true benefits of this work will emerge over time however the intention of this strategy is to facilitate:

1. 5-10% Reduction of ED attendances by 2016.
2. 5-10% Reduction in Emergency Admissions by 2016.
3. Patients who arrive at ED by ambulance will be assessed by a nurse within 15 minutes.
4. The sustainable delivery of the 95% ED target will be achieved 98% of the time.
5. An increase in Primary Care appointments for urgent requests of 5-10% by April 2015.
6. An increase in Mental Health Practitioners within the ED to improve urgent care provision for patients in crisis by April 2014.

13.4 Success will result in a reconfigured urgent and emergency care system that is organised, effective and efficient and where our patients can find the right care, at the right time, first time. Communication will be improved and our patients will be empowered to know the right service available for their needs.

14. Conclusion and Next Steps

14.1 This strategy describes the importance of the delivery of urgent and emergency care within Wolverhampton to improve the quality and affordability of services for our population. The importance of delivering a streamlined and efficient system must not be taken lightly. The current system is not sustainable given the levels of pressure that it is experiencing and we must do things differently.

14.2 The Urgent and Emergency Care Strategy has been developed to improve quality across the system and to respond to the changing landscape of the local health economy. The system has seen extreme pressure during winter and continues into 2013. It is imperative that the urgent and emergency care system sees improvement prior to winter 2013 when further pressure is expected.

14.3 Our patients have suggested that the system is confusing and they are not sure where to go for their urgent and emergency care need particularly at different times of the day. Healthcare professionals confirm that the ED is "not fit for purpose", service provision can be confusing and timeliness is a factor causing delays across the system.

14.4 Our patient's voice is vital in ensuring that services provide high quality and appropriate pathways across organisational boundaries. Our links with Healthwatch will become increasingly important to deliver such an ambitious strategy.

14.5 It is the intention of the Joint Urgent and Emergency Care Board to consult on the strategy to ensure that our patients, partners and stakeholders are able to help us to shape the future. It is also our intention to understand how our patients and stakeholders want to continue to be involved to ensure the future developments are inclusive. The timescales for the consultation are not yet available and will be dependent upon agreement by the Health and Well Being Board. The Joint Urgent and Emergency Care Board will provide the

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governance structure required to oversee the consultation and the delivery of the strategy through the implementation plan and workstreams.

14.6 The draft strategy will be amended in late 2013 further to comments from the consultation and the final strategy will be available early in 2014.

14.7 It is our intention that our patients receive the right care, right place, first time. To achieve this, the existing urgent and emergency care system must change.

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Appendices

1. Appendix 1 - Our Stakeholders Views

To understand patient and stakeholder views, the Strategy Board has engaged with the local health economy to understand initial views of the proposals. This process took place during March – April 2013.

In order of presentation:

1. Provider face to face meetings including Primecare, Showell Park & Phoenix
2. Senior Management Engagement
3. LMC Leads
4. WCCG Governing Body
5. WCCG Commissioning Committee
6. Seisdon Locality Board
7. Surge Planning Event (winter wash up)
8. RWT Directors Meeting
9. Practice Managers and GP Partners
10. Circulated to GP's via Survey Monkey
11. Health Scrutiny
12. RWT Trust Board
13. LINks/Healthwatch
14. Health Scrutiny
15. Seisdon Patient Participation Group (via Patient event invitation)
16. Patient Engagement Event
17. Health and Well Being Board (via the Chairman)

Engaging Further with Patients

To ensure that our patients views are integral to the development of the Urgent & Emergency Care Strategy, some engagement work was undertaken with patients. The feedback from the initial Patient & Public Engagement undertaken in Dec 2012 was used to support the event that was arranged in April 2013.

The event was about identifying the preferred ways forward and capturing patient's views. Patients were invited from the LINk Board and from patients who have identified Urgent Care as an interest in previous Patient Engagement work including the previous research project with patients in December 2012. The patients views of the pros and cons for the ways forward are noted in the appendices.

There were also some additional suggestions for ways forward including:

1. Extending primary care to include 24/7 access at walk in centres by redesigning OOH provision;
2. The development of 'good' GP practices that have multi doctor and multi skills within them. The practices should have an urgent care facility that incentivises general practice.

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There were a number of significant themes identified by our patients including:

- The system is too complicated;
- Too many names;
- Too many ‘steps’;
- Availability of GP appointments and access to GP practices including appointments available, capacity, opening hours;
- Out of hours care;
- Mental Health support at A&E particularly for those in crisis and who have self-harmed;
- Communication, self-care and education on where to go are key;
- An acknowledgement that patients want clarification of figures; the number of patients attending walk in centres;
- It was highlighted by some that it was difficult to make a decision without discussing it further with ‘groups’;
- There is a need to consider Mental Health, Dental, Pharmacy, etc for Urgent Care;
- Training/knowledge gaps in levels of primary care/enhancing streaming roles in A&E/Primary Care Centres;
- The need for Behavioural change.

Patients are keen for improvements to be undertaken in primary care with total system change a close second. Patients want to access their GPs and view that significant improvements in primary care are a must.

Engaging with the GP community

In addition to patient engagement, a survey was circulated to all GP’s in Wolverhampton. In addition, Seisdon Locality also responded to the proposals.

Wolverhampton GPs agreed with patients suggesting that improvements could be made in primary care together with their second most popular way forward total system change.

Seisdon GPs suggested that total system change was their most preferred way forward although improvements in primary care were also a high priority.

Outcomes from the Engagement Process

Total System Change was the most popular with Improving Primary Care and the potential to move the walk in centre provision at Showell Park the third most favourable way forward.

The Urgent & Emergency Care Strategy will agree the principles of the way forward – any significant service changes will be subject to a 3 month consultation period and sits outside the remit of the strategy.

2. Appendix 2 - Equality & Diversity

All Urgent and Emergency Care services will ensure that services are appropriate and do not discriminate on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex or orientation.

NHS Wolverhampton Clinical Commissioning Group (WCCG) is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity. As a result the Urgent & Emergency Care Strategy will ensure:

- Urgent care services that will be accessible, high quality health services on the basis of clinical need, tailored appropriately to the different healthcare needs of the various groups in the community we serve;
- That barriers to accessing services are identified and removed. No person will be treated less favourably on the grounds of their protected characteristics or any other factor that it would be inequitable to take in to account;
- Ensure that our premises do not create barriers, physical or social for service users or employees;
- Communicate effectively and ensure that the information we provide is accessible easy to understand, relevant and appropriate.

The protected characteristics covered by the equality duty are:

a. Age: This refers to a person having a particular age (eg 32 years old) or being within an age band (21-25, 46-50 years old)
b. Disability: A person has a disability if they have a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities
c. Gender reassignment: This is the process of transitioning from one sex to another
d. Marriage and civil partnership: A union between a man and a woman or the legal recognition of a same-sex couple's relationship
e. Pregnancy and maternity: The condition of being pregnant or the period after giving birth. It is linked to maternity leave in the employment context
f. Race: This refers to a group of people defined by their skin colour, nationality
i. (including citizenship), ethnic or national origins
ii. Religion or belief: Religion means the religion a person belongs to and a belief is one that affects how an individual chooses to live their life (political views are not included)
iii. Sex: Being either a man or a woman and also referred to as Gender
iv. Sexual orientation: Whether a person's sexual attraction is towards their own sex, the opposite sex or to both.

Where services are required based on age, the reason will be on the grounds of service provision such as children's services or services aimed specifically at older adults due to the nature of their conditions.

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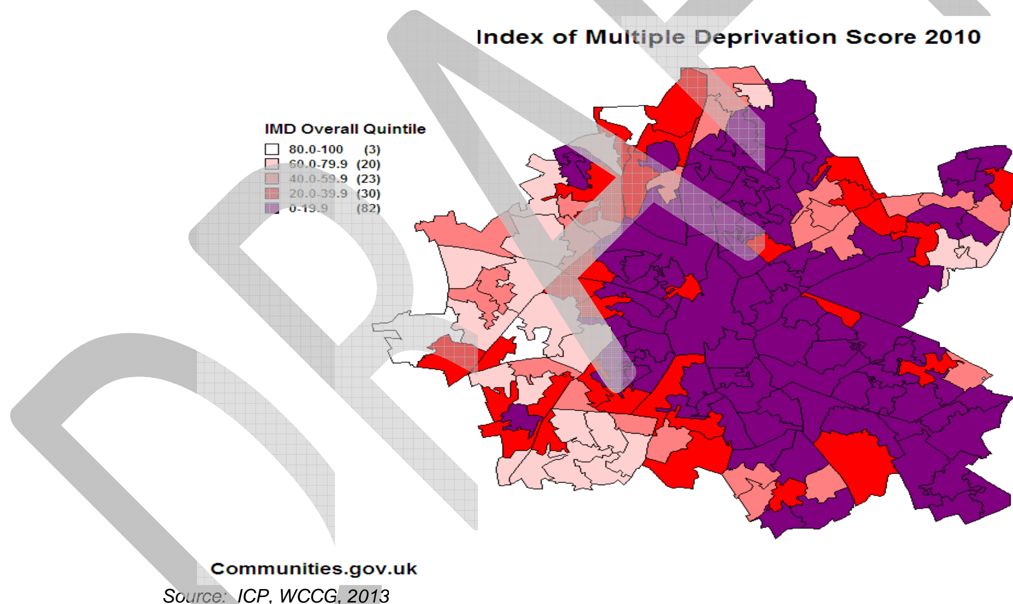
3. Appendix 3 - Demographics

Wolverhampton's resident population is approximately 249,500, although the registered population is reported as 236,000. It is one of the most densely populated places in the country, with nearly 9,000 residents per square mile.

About a quarter of the population is of black and minority ethnic (BME) origin. The biggest growth in the population is likely to be in this group with BME communities constituting around one third of the city's population by 2026.
Births have increased in the last 8 years leading to an increase in the 0-19 age group. 75% of these births are in the most deprived areas. This contributes to increased child poverty and intergenerational cycles of ill-health.

- Wolverhampton is ranked 21st most deprived out of 354 local authorities. Deprivation is not concentrated in a few areas – almost half of the city's neighbourhoods are amongst the 20% most deprived in the country. Deprivation is focussed in the North East and South East.
- Social marketing tools demonstrate distinct groups that will respond to services and health promotion in different ways.
- Deprivation is correlated with poor lifestyles, high morbidity and high mortality.



Source: ICP, WCCG, 2013

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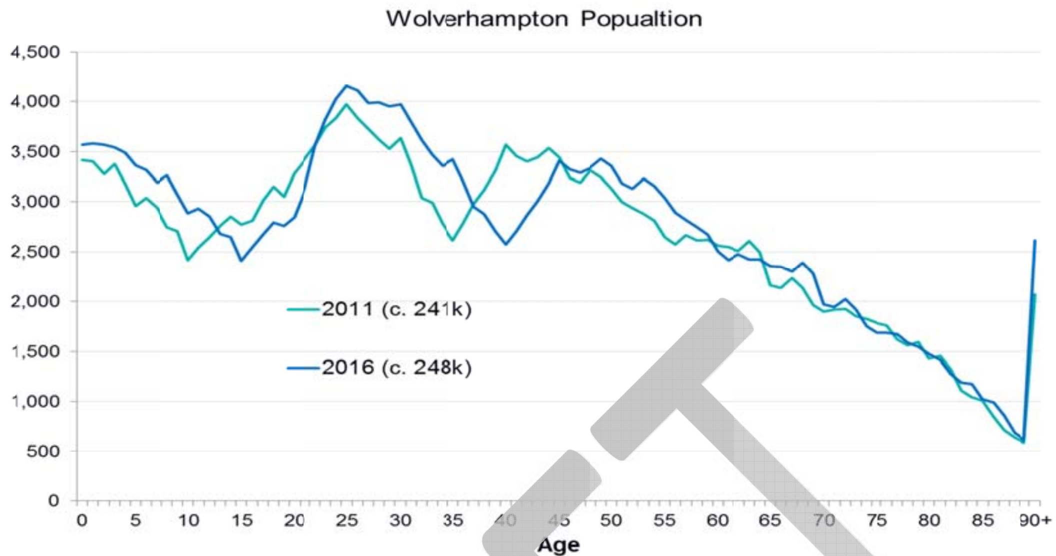
Population Size and Age Profile in Urgent & Emergency Care

The chart below shows the changes in population size and age profile from 2012 to 2016.

3a&b – Population Size and Age Profile (2)

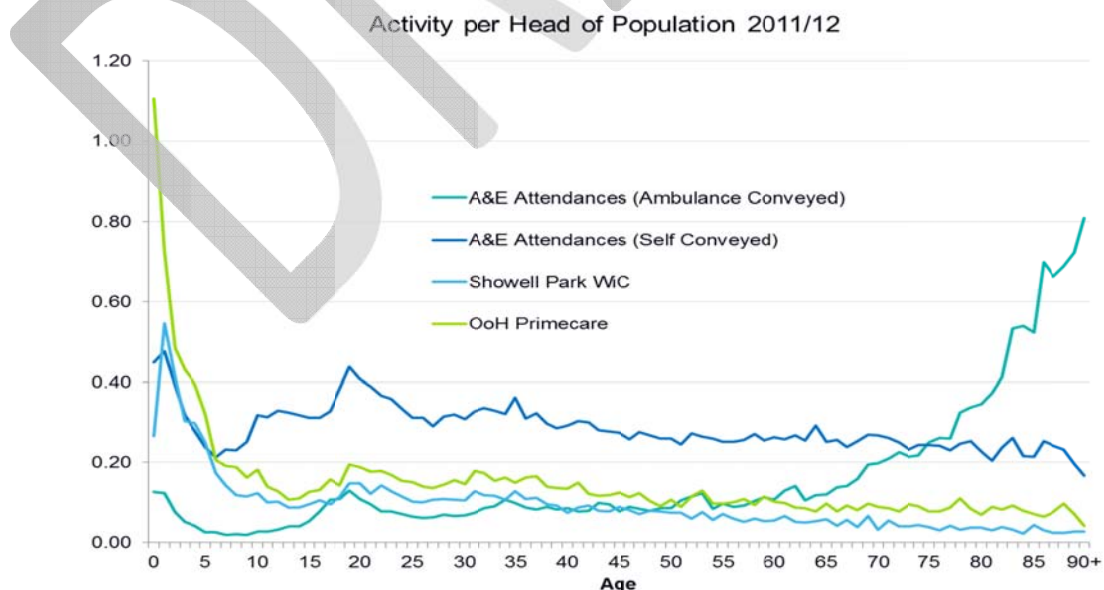


Source : ONS 2010 based sub-national population projections

The chart below shows the activity levels at the ED, the Out of Hours service and one of the walk in centres in Wolverhampton (Showell Park) during the year 2011/12.

There is a significant peak in activity for children 0-5 years in the out of hours period but also for ED attendances (both ambulance and self conveyed) together with a peak in older adults that are conveyed via an ambulance.

3a&b – Population Size and Age Profile (1)



Source : SUS A&E, Showell Park MDS, Primecare MDS 2011/12

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Risk Factors

There are a number of significant risk factors for the population of Wolverhampton including:

- Obesity, smoking, physical inactivity and high alcohol consumption are all risk factors for circulatory disease mortality
- Obesity, smoking, physical inactivity and high alcohol consumption are all risk factors for cancer mortality
- High alcohol consumption is a precursor to alcohol related mortality
- Smoking in pregnancy and high rates of teenage conceptions increases the risk of infant mortality
- Smoking in pregnancy and high rates of teenage conceptions increases the risk of infant mortality.
- A bout of flu will reduce quality of life for people with long term conditions and increase unplanned hospitalisation for chronic ambulatory care sensitive conditions.
- Parental smoking are risk factors for emergency admissions for children (particularly around asthma and lower respiratory tract infections)
- Obesity and smoking impacts on effective recovery following any health event. Obesity can particularly effect recovery following hip or knee replacement

Source: ICP, WCCG, 2013

The Big Six

- The gap between life expectancy in Wolverhampton and England and Wales is driven by six causes of death – infant mortality, coronary heart disease, alcohol related mortality, suicide, lung cancer and stroke.

Further to the review of our demographics, the following areas require addressing:

- High attendance rates at ED
- Prevalence of epilepsy – hospital admissions as a result of epilepsy for children
- Stroke admissions
- Asthma for adults and children
- Emergency admissions for lower respiratory tract infections for children
- Need to transfer care from emergency care to primary care. This should be focused on high need groups.
- Close work with social care to support recovery following discharge from hospital.
- More detailed data on emergency hospital admissions.

NHS Atlas of Variation in Healthcare 2011

The NHS Atlas of Variation in Healthcare shows the prevalence rates for a number of different areas, mostly planned or Long Term Conditions.

However there are a number of areas that relate to Urgent and Emergency Care.

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Rate of Accident & Emergency Attendances per 100,000 population by PCT (2010)

Wolverhampton has one of the highest rates

Rate per 100,000 of conversion from Accident and Emergency to admission by PCT (2010)

Wolverhampton has one of the lowest A&E attendances to admission rates

Rate of admission with emergency ambulatory care conditions (EACC's) per 100,000 population by PCT (2010)

Wolverhampton has one of the lowest rates

Emergency admission rate (DSR) for children with Epilepsy per 100,000 population aged 0-17 years by PCT (207/08-2009/10)

Wolverhampton has one of the highest rates

Source: NHS Atlas of Variation in Healthcare 2011 (http://www.sepho.org.uk/extras/maps/NHSatlas2011/atlas.html)

Wolverhampton has one of the highest A&E attendance rates in the country however one of the lowest attendance to admission ratios. This means that there are a high number of people attending ED however there are a low number of attendances that turn into an admission.

4. Appendix 4 - Strategic Context – Supporting Information

Urgent and Emergency care has particular significance to commissioners due to:

- Clinical safety issues
- The changing expectations and experience of patients as a result of a 24/7 culture
- The unacceptable variation in quality and availability in some services
- The volume of the work and high visibility to all
- The increasing demand for some services
- The duplication in the system
- The complexity of service provision, including primary care, acute hospitals, ambulance services, mental health services, pharmacies, social services and third sector
- Escalating costs
- The challenge to make efficiency savings in the NHS
- High profile and press and media interest
- The changing political context.

It is important to ensure that the urgent & emergency care system is 'integrated'. One service affects the other therefore it is imperative that they are commissioned as part of a system.

The King's Fund report "Managing Emergency Activity – Urgent Care" May 2011, summarised some of the key reasons why urgent and emergency care is important:

- Urgent care services are currently often highly fragmented and generate confusion among patients about how and where to access care
- Poor sharing of information as patients move between different providers of care in an emergency is a cause of many significant failures of care
- The quality of out-of-hours care is highly variable, particularly in terms of continuity of care, leading to variable patient experiences
- The growth of new forms of urgent care has failed to reduce A and E attendances. For example, emergency attendances in England rose by 46% between 2003/04 and 2009/10 (however, from 2004 the data also included Walk In Centres & Minor Injury Centres with ED (A&E) attendances increasing around 6% per annum and Emergency 999 calls over 8 million in 2010/11 with demand rising at 4% per annum)
- Walk-in centres do not appear to have led to shorter waits in general practice or lower admission rates at other health care providers
- Emergency admissions have also grown rapidly. The number of emergency admissions in England rose by 11.8% between 2004/05 to 2008/09 – resulting in around 1.35 million extra admissions.

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5. Appendix 5 - Local & National Drivers

- Francis Report
- NHS England – National Commissioning Board
- Emergency Department Development
- NHS 111
- Achievement of Hyper Acute Stroke Unit Status (HASU) at The Royal Wolverhampton NHS Trust
- The Future of Mid Staffordshire NHS

Francis Report

The final report into the care provided by Mid Staffordshire NHS Foundation Trust was recently published. ‘The Inquiry Chairman, Robert Francis QC, concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care.

Robert Francis QC has made 18 recommendations for both the Trust and Government. His final report is based on evidence from over 900 patients and families who contacted the Inquiry with their views.'

The presentation of his report was concluded with a message for all concerned with the management of NHS hospital services that:

"People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences. This is what must be remembered by all those who design and implement policy for the NHS."

Under the new reforms, local Healthwatch is intended to be the local consumer voice with a key role in influencing local commissioning decisions through representation on the local Health and Well-being Board. They will be expected to build on existing LINks functions.

“The extent of the failure of the system shown in this Inquiry’s report suggests that a fundamental culture change is needed. That does not require a root and branch reorganisation – the system has had many of those – but it requires changes which can largely be implemented within the system that has now been created by the new reforms.” Francis enquiry

Five steps are needed now (Communications lead, Birmingham, Black Country and Solihull Commissioning Support Unit, Feb 13):

1. **Clearly understood fundamental standards.**
2. **Openness, transparency and candour throughout the system.**
3. **Improved support for compassionate caring.**
4. **Strong patient-centred leadership.**
5. **Accurate, useful and relevant information.**

In response to the Francis Report, the Urgent & Emergency Care Strategy Board has included the areas of improvement within this strategy.

NHS England (National Commissioning Board)

NHS England supports NHS services nationally and ensures that money spent on NHS services provides the best possible care for patients. It funds local clinical commissioning groups to commission services for their communities and ensures that they do this effectively.

Some specialist services will continue to be commissioned by NHS England centrally where this is most efficient. Working with leading health specialists, NHS England brings together expertise to ensure national standards are consistently in place across the country. Throughout its work it promotes the NHS Constitution and the Constitution's values and commitments. Formally established as the NHS Commissioning Board on 1 October 2012, NHS England an independent body, at arm's length to the Government.

The area team will ensure the development and delivery of A&E Recovery plans regionally.

The Emergency Department Development

The Emergency Portal Board is developing an outline business case for the new Emergency Department which is scheduled to open its doors in late 2015.

A Planning Application for the redevelopment of the New Cross site was submitted to Wolverhampton City Council and received approval in 2010. This included outline planning approval for a new Emergency Centre.

The Outline Business Case will focus on the provision of redesigned services within a new facility which will support operational benefits for Emergency Services with the Trust. It will also afford the opportunity for the development of the required system changes within the existing urgent & emergency care system.

It is proposed that the new facility will be provided on a phased basis. Phase 1 is proposed to include a new Emergency Department and supporting ambulatory and diagnostic facilities. Subsequent phases of the development are proposed and include a second and third floor housing Emergency Admissions Units for Children (PAU), Medical Patients (AMU), Surgical Patients (SAU) and a proposed Clinical decisions Unit (CDU).

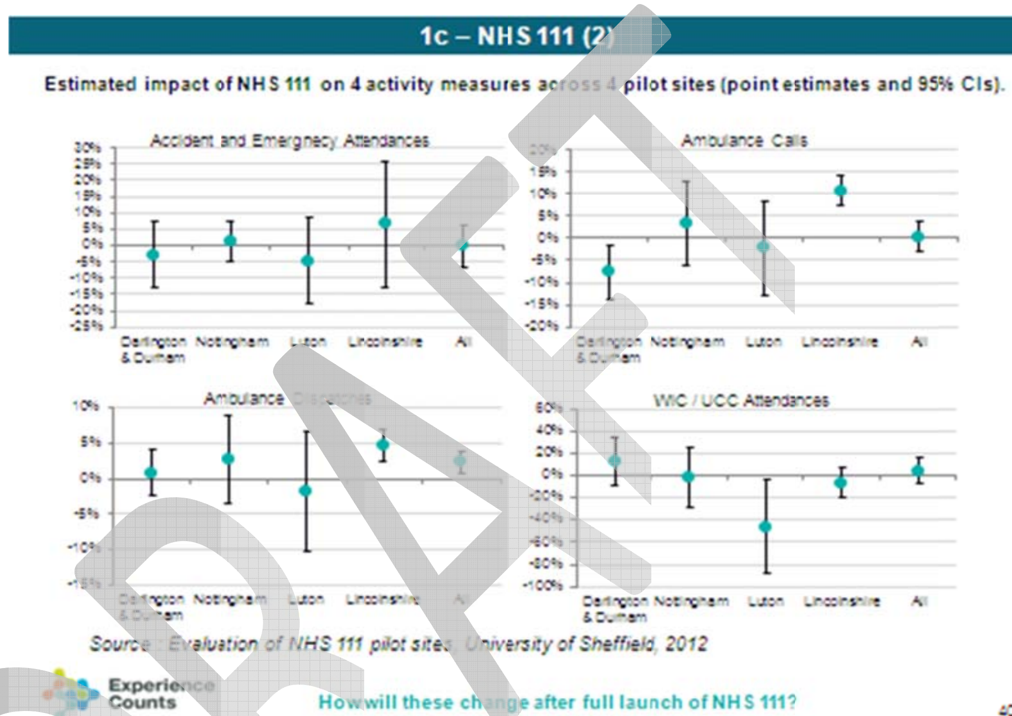
The new ED Business case is tightly linked to the emerging Urgent & Emergency Care Strategy and work has been undertaken to provide assurance to the CCG's that the new ED will improve quality.

NHS 111

NHS111 has been introduced to Wolverhampton in 2013 and is a new service to make it easier for patients to access local NHS healthcare services. Patients can call 111 when they need medical help fast but when it is not a 999 emergency.

The intention is that through access to a directory of services, NHS111 will be able to direct patients to the most appropriate service such as pharmacies, GP practices and walk in centres as an alternative to ED when they are unsure where to go.

As this is a new service, it is unclear of the impact of NHS111 on activity and costs. Pilot sites have shown varying results but as the chart below shows, the overall impact was limited with the exception of Ambulance dispatches. It should be noted that the impact of NHS111 may be very different to the pilots once the national advertising campaign is launched.



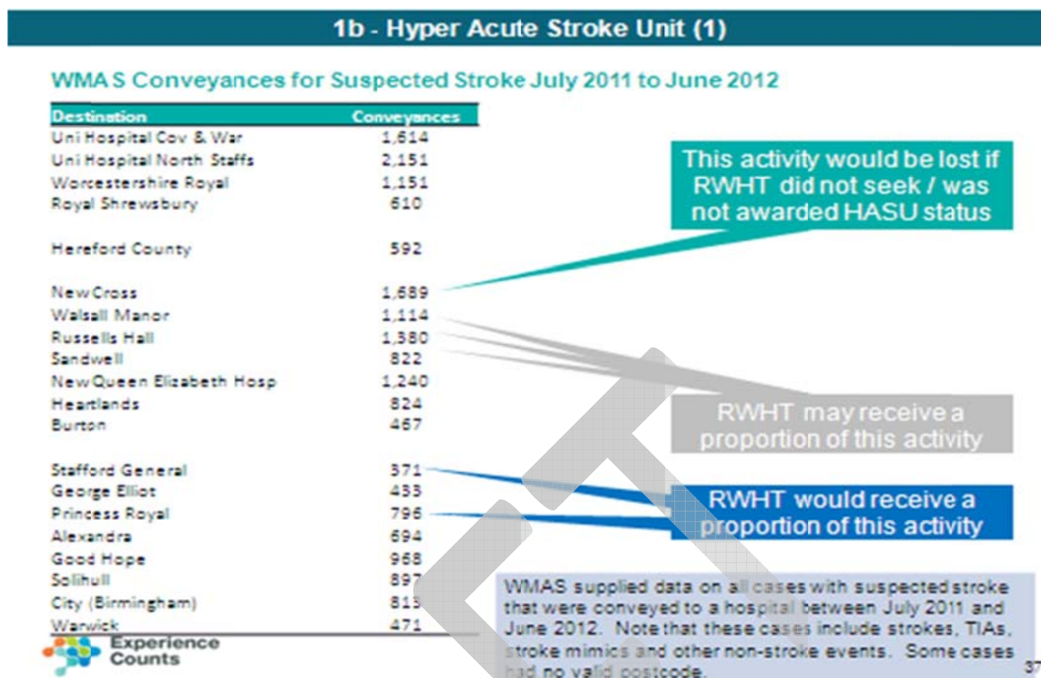
It is important that work is undertaken to focus on activity to ensure that 111 sends Wolverhampton patients to the right services at the right time and that gaps in services are identified

Regional Review of Stroke Services

In May 2012, it was announced that the NHS Midlands and East will be undertaking a review of stroke services, including the provision of Hyper Acute Stroke Services. The purpose of the review is to achieve a step change improvement in the quality of stroke services and stroke outcomes. The Royal Wolverhampton Trust is engaging in this review process to develop a proposal to deliver stroke services across the whole pathway including hyper acute services.

The Hyper Acute Service has been established in Wolverhampton for a number of years and provides a service to 600+ stroke patients. In 2009, the Trust doubled its stroke catchment area to provide hyper acute and acute stroke services to a wider catchment area, which increased the number of stroke patients attending the Trust.

Source: Emergency Portal Outline Business Case



Destination	Conveyances
Uni Hospital Cov & War	1,614
Uni Hospital North Staffs	2,151
Worcestershire Royal	1,151
Royal Shrewsbury	610
Hereford County	592
New Cross	1,689
Walsall Manor	1,114
Russells Hall	1,380
Sandwell	822
New Queen Elizabeth Hosp	1,240
Heartlands	824
Burton	467
Stafford General	371
George Elliot	433
Princess Royal	796
Alexandra	694
Good Hope	968
Solihull	897
City (Birmingham)	813
Warwick	471

The chart above shows the activity that is attributed for suspected Stroke between July 2011 and June 2012.

The decision on HASU status remains unclear and the outcome of RWT achieving Hyper Acute Stroke Unit Status will certainly impact the activity levels and service provision at RWT particularly within the Emergency Department.

If HASU is not awarded to RWT, almost 1700 patients annually will attend surrounding Hospital Trusts for suspected strokes. This will reduce the activity and service provision at RWT and will divert the ambulance activity away from the hospital site.

Closure of Mid Staffordshire Emergency Department overnight

In December 2011 Mid Staffordshire NHS Foundation Trust agreed to close its Emergency Department at Stafford General Hospital from 10.00pm to 8.00am, seven days per week and continues to close during these hours.

In response to this closure RWT assessed the impact that this might have on the Emergency Department and admissions at New Cross Hospital and put coping strategies in place. Over the 12 months January to December 2012 the Trust has seen an average increase of 135 South Staffordshire patients per month.

The future of Mid Staffordshire's Emergency Department still remains unclear but there are two options being considered:

1. Continued Closure of the ED over night
2. Stafford General A&E were permanently downgraded to an MIU
3. Closure of the department

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The following analysis considers activity from a set of postcode sectors located between Stafford General and RWHT that represent the vast majority of the population group that have (or are likely to) switched from Stafford general to RWHT under any reconfiguration of A&E services.

Annualised Net Impact of Overnight Closure*

	Self-Conveyed			Ambulance Conveyed		
	Stafford General	RWHT	Other Providers	Stafford General	RWH	Other Providers
8am to 10pm	1,317	206	188	218	97	490
10pm to 8am	-2,969	457	801	-3,988	742	2,441

* based on comparison of Jul-Sept 11 and Jul-Sept 12 & stripping out demand growth.

When Stafford General A&E closed overnight, of those attendances switching to another provider from the selected postcode sectors, 40% self-conveyed and 22% of ambulance conveyed attendances switched to RWHT.

To estimate the further potential impact of the downgrading of Stafford General A&E to an MIU, these same switching patterns were applied to recent A&E attendances at Stafford General of levels 3, 4 and 5 (i.e. excluding those that might attend the Stafford General MIU) from the selected postcode sectors.

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6. Appendix 6 - Existing Service Descriptions

In Wolverhampton the existing urgent & emergency care system includes the following, and these services should therefore be considered as within the scope of this strategy.

Service Name	Description
Self-Care & NHS Choices	Where appropriate, Patients are encouraged to look after themselves by self-caring. This may include resting or reviewing websites such as NHS Choices to review the symptom checker for the best course of action. This can now link into the new 111 service.
Pharmacists	Patients self-caring (or looking after themselves) by using over the counter medicines and/or advice and support from Pharmacists at Pharmacy shops based across the city. Pharmacists and chemists play a key role in providing quality healthcare to patients.
General Practice (GP) Practices	There are currently 51 General Practices within Wolverhampton and 9 within Seisdon Peninsula. Usually open from 8am-6.30 pm Mon-Fri with some practices undertaking Saturday morning opening.
Walk in Centres (WiC)	There are currently 2 walk in centres across the city including at the Phoenix Centre (nurse led) and Showell Park (GP led), both providing 'walk in' primary care services.
Urgent Social Care	The rapid response required by social services where patients are in crisis or require urgent support both in the community and within a hospital setting.
Urgent Mental Health	The rapid response required by mental health services where patients are in crisis or require urgent support both in the community and within a hospital setting. If a person's mental or emotional state quickly worsens, this can be treated as a mental health emergency or mental health crisis.
Urgent Community Nursing Teams	The rapid response required by community teams where patients are in crisis or require urgent support both in the community and within a hospital setting and includes:
➢ **CICT**	A rapid response service providing nursing and rehabilitation care in the community, patients own homes and a hospital setting to facilitate discharge.
➢ **Hospital at Home**	Community Hospital at Home focuses on specific conditions that are amenable to care in the community preventing a hospital admission from primary care or A&E or facilitating reduced LOS from AMU or the wards. Conditions such as IV antibacterials for Cellulitis, ESBL, IV steroids for MS patients, domiciallry management of patients with DVT, management of exacerbations of COPD.
➢ **Community Matrons**	The Community Matron Team delivers comprehensive, evidence-based holistic clinical assessments and interventions with the primary aim of reducing inappropriate/avoidable hospital admissions and where possible facilitating reduction in length of hospital stay for individuals with long term conditions.
➢ **Tele Healthcare**	Tele healthcare to support people with long term conditions, to enable them to understand their illness and manage it themselves, minimising the medical and social impact of the illness, avoiding unnecessary admissions to hospital, avoid unnecessary exacerbations and deteriorations, supporting patients who live at home, reducing the need for care in residential and nursing homes.
SPAR	SPAR accepts referrals from within the Trust, GPs and other health professionals to District Nursing Service, CICT, Hospital at Home,

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	Night Visiting Service, Tissue Viability and End of Life/Palliative Care. SPAR has a single contact number, with specific referral criteria for each service; it is a single access process for community services, run by a dedicated trained team that also provides WUCTAS.
West Midlands Ambulance Service NHS Foundation Trust (WMAS) - 999	Urgent and Emergency Ambulance services providing 'Hear & Treat', 'See & Treat' and 'See & Convey'. 999 should be used for life-threatening emergencies.
The New 111 Number (replacing NHS Direct)	Providing a telephone service to support less urgent responses required by patients. The service has access to a directory of services that allows 111 to navigate patients to the most appropriate place for their care.
Wolverhampton Urgent Care Telephone Access Service (WUCTAS)	A single point of access telephone service for Healthcare professionals only. Providing a range of alternatives to hospital attendance or admission including to a range of urgent diagnostic tests and clinical and community pathways/services. Open 10am to 7pm seven days a week. In addition to the SPAR element accepting referrals into community services
Out of Hours Primary Care Service	Providing an urgent general practice service for patients requiring a doctor in the out of hours period. A GP is always available from 6.30pm to 8am weekdays and all day weekends and bank holidays.
Care Homes (Residential & Nursing)	Since April 2002 all homes in England, Scotland and Wales are known as 'care homes', but are registered to provide different levels of care. A home registered simply as a care home providing personal care will provide personal care only - help with washing, dressing and giving medication. A home registered as a care home providing nursing care will provide the same personal care but also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.
Emergency Department (ED)	ED (formerly A&E) departments assess and treat patients with serious injuries or illnesses. The Emergency Department offer access 24 hours a day, 365 days a year. The Accident & Emergency Department at New Cross Hospital has many services. In the main, it provides services for minor injury and illnesses, acute medical/surgical/paediatric emergencies, out of hours stroke thrombolysis, in patient head injury management, emergency hand surgery, elective minor surgical operations, an emergency medicine follow up clinic, eye casualty and a physiotherapy service.
Emergency Admissions including:	Emergency admissions – that is, admissions that are not predicted and happen at short notice because of perceived clinical need (NHS Connecting for Health 2010)
➢ **PAU (Paediatric Assessment Unit)**	Emergency hospital admissions unit for children (under 18 years). Admissions methods are via the GP, ED or other parts of the hospital including consultant referrals.
➢ **AMU (Acute Medical Unit)**	Emergency admissions for patients who require an admission for general medical needs. The Emergency Assessment Unit is based at New Cross Hospital, it provides timely and accurate initial care for all emergency attendances with onsite senior decision making, 24 hours per day, 7 days per week. The service is open to all self-referrals, GP referrals and ambulance/paramedic delivered patients. Patients are seen, treated and discharged when appropriate, or resuscitated and referred on to the appropriate sub specialty medical/surgical

	team for further management.
➢ **SAU (Surgical Assessment Unit)**	Emergency admissions for patients requiring surgical assessment needs. The Unit receives patients who are over the age of 16 referred via Accident & Emergency, a General Practitioner or as a direct admission from a Consultant Clinic. The ward is for patients who present with acute general surgical or urological problems. On arrival patients undergo rapid assessment, diagnosis, stabilization and/or treatment of their condition, prior to transfer to an appropriate area or discharge. Patients who require <48 hours in hospital will remain on the unit whilst patients who require admission for a period of greater than 48 hours will be transferred to the appropriate ward. This service is provided 24 hours, 7 days per week.

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7. Appendix 7 – Finance and Activity

To understand the financial implications of any proposed way forward, activity and finance modelling has been undertaken for all descriptions.

A reference group was developed to ensure that the modelling was developed by primary and secondary care. The reference group identified two imminent service configuration decisions that are likely to impact on future urgent care activity levels in Wolverhampton.

- the award of HASU status to a subset of acute hospitals
- the potential downgrade of the A&E service at Stafford Hospital

As a result, 6 scenarios were developed including if RWT was/was not awarded HASU status (or Dudley/Sandwell are) and if the ED department at Mid Staffs was/was not downgraded to an MIU.

Scenario	HASU	Mid Staffs A&E
1	× RWHT	no change
2	× RWHT	↓MIU
3	✓ RWHT & Sandwell	no change
4	✓ RWHT & Sandwell	↓MIU
5	✓ RWHT & Dudley	no change
6	✓ RWHT & Dudley	↓MIU

For the purposes of the illustration below, scenario 4 has been used – RWT achieve HASU status and Mid Staffs is downgraded to an MIU. The chart below shows the baseline data for activity and cost for the key urgent & emergency care services in Wolverhampton.

Option 1 – Scenario 4
Changes in Activity and Cost at Service Level

	Activity ((000s)			Spend (£m)		
	Baseline	2016/17	Growth	Baseline	2016/17	Growth
A&E Attendances	105	110	4.3%	10.50	11.23	6.9%
GP Consultations	2,189	2,248	2.7%	83.18	83.18	0.0%
Phoenix Centre WiC Attendances	35	38	8.8%	0.86	0.93	8.8%
Showell Park WiC Attendances	31	34	7.6%	0.87	0.94	7.6%
OoH Contacts	24	25	3.1%	2.17	2.24	3.1%
Ambulance Journeys	45	47	5.5%	9.35	9.86	5.5%

Experience Counts

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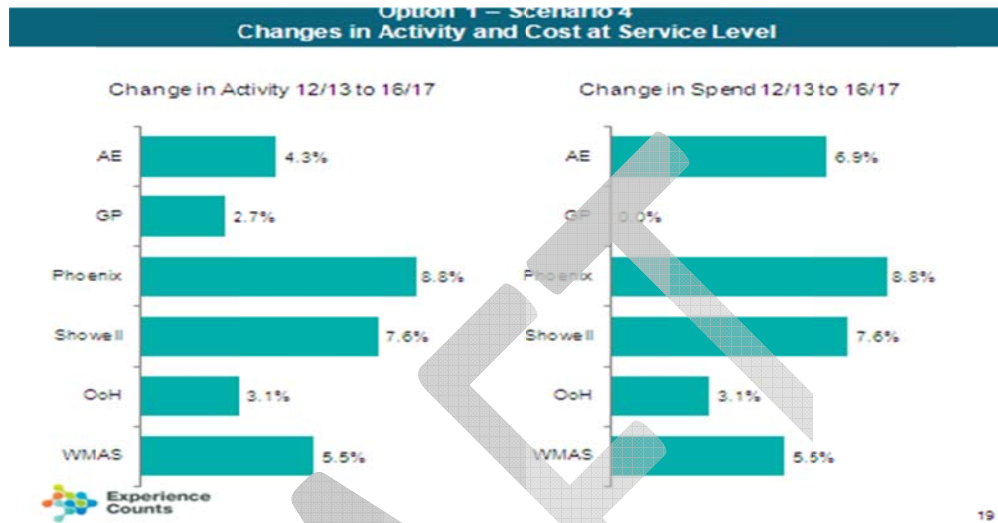
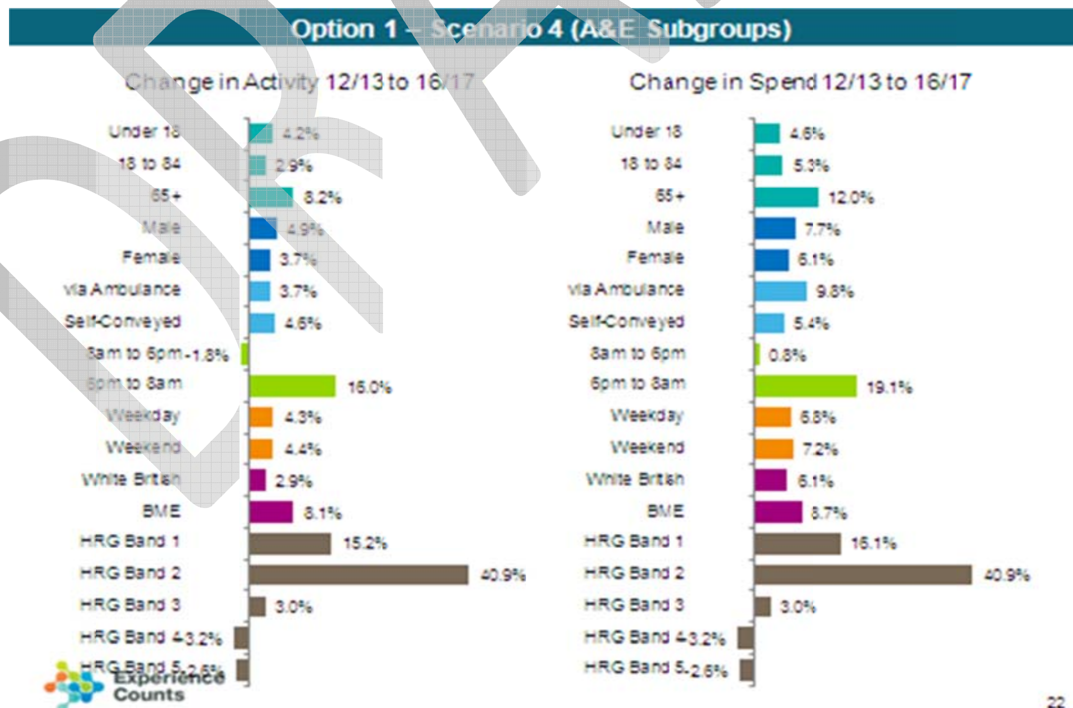
The unit costs are notional and are derived from contracts, activity and contract values. Some contracts are developed using cost and volume and others are on block contracts.

The system is complicated and modelling can never be exact however, the chart below shows the breakdown of the expected changes if 'no change' is made, RWT achieve HASU status and Mid Staffs is downgraded to an MIU.



The chart below details the breakdown of predicted activity from 2012/13 to 2016/17 if no changes are made.



There is a significant increase in activity for older people (65+) together with more patients being seen in the out of hours period.
Band's 1&2 are the more complex tariffs and see the most significant increase.

8. Appendix 8 - The Case for Change – Supporting Information

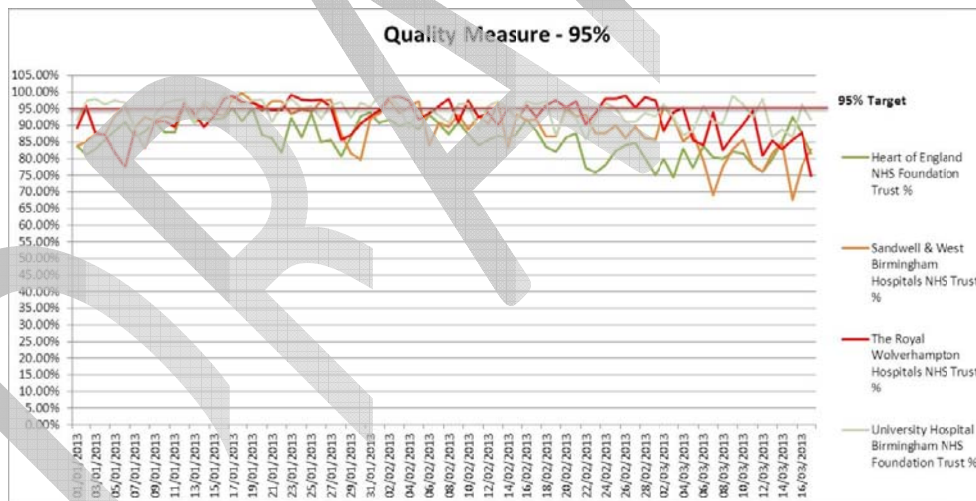
The existing system has improved and changed over recent years with investment in walk in centres, enhancements to general practice, a new out of hours GP service, changes to the Emergency Department amongst a whole host of other improvements.

There are a number of significant reasons why it is imperative that we develop a future urgent & emergency care system that is sustainable:

1. Quality measures are difficult to achieve (inc. waiting times, time in ED, ambulance turnaround).

The chart below shows the number of patients being seen and discharged within 4 hours at ED at the Royal Wolverhampton Trust, Sandwell and West Bromwich Hospitals NHS Trust, Heart of England NHS Trust and University Hospitals Birmingham from 1st January 2013 to 16th March 2013.

Although RWT does well to try and meet this target, it is becoming increasingly more difficult to ensure that patients are seen and discharged within a 4 hour period.



2. Confusion and duplication across the system (too many access points).

The chart below shows the Activity vs Proximity to services for the Emergency Portals across the city. The activity in the deepest 'purple' is where is the most concentrated activity is for that portal.

There is significant duplication in the following maps:

- Maps for ED and Showell Park – patients are using the walk in centre at Showell Park and also the ED department
- Maps for the walk in centre at the Phoenix Centre and Primecare – both services are based from the same building.

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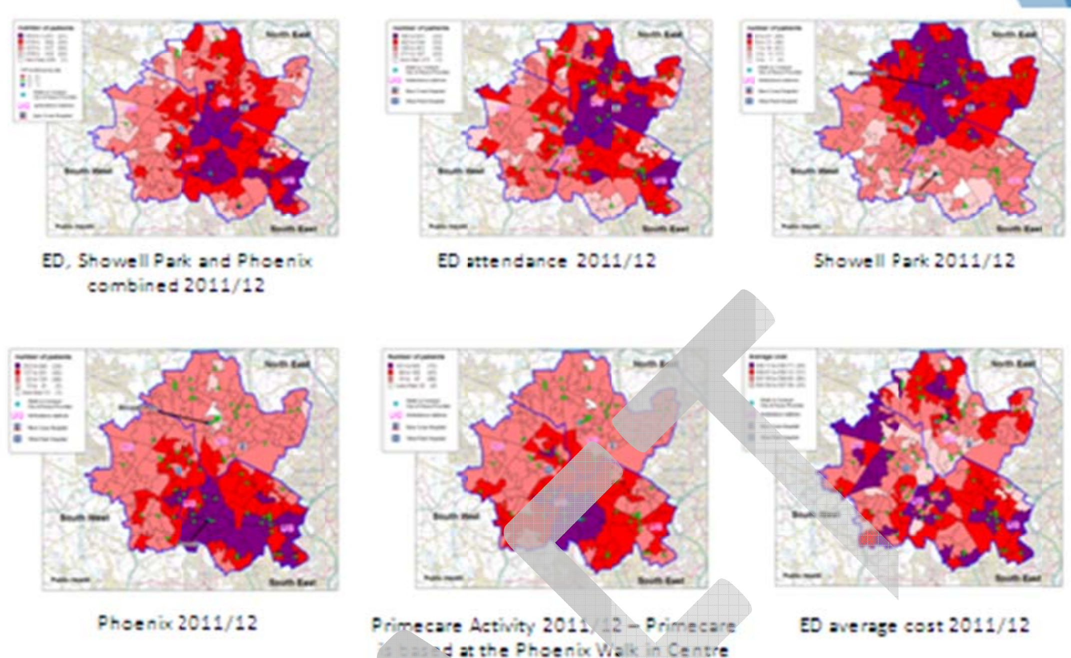
Activity vs Proximity to Services



In addition to the duplication of services from patients living in the same areas, the opening hours of the services are different:

- Pharmacies – variable but mostly 9am to 5.30/6pm (Mon to Sat);
- GP practices – variable but mostly 8am to 6.30pm with some afternoon closures Wed/Thurs;
- Walk in Centre - Showell Park - 8am to 8pm, 7 days per week
- Walk in Centre – Phoenix – Mon to Friday 10am to 7pm and 10am to 4pm on Saturdays, Sundays and bank holidays;
- Ambulance Service – 24/7
- Out of hours service – 6.30-pm to 8am Mon- Friday and all day at the weekend
- ED – 24/7.

3. Patient's health seeking between services (using several services in one episode).

Further to analysis of the walk in centre activity it appears that there are a number of patients who are using the walk in centres for their primary care requirements rather than using their own GP.

In total there were 1591 attendances in 2011 and 1847 in 2012 at the Phoenix Centre and Showell Park which also had an A&E attendance within 1 day. Some of this activity will be for conditions that have worsened however this does suggest that some patients are bouncing between services for the same condition.

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Very few patients attend all three services within a 24 hour period. There were only 19 attendances over an 18 month period who had attended all three centres in 1 day.

4. **Too many people getting the right care , but not necessarily in the right part of the system;**

The analysis also highlighted that activity is localised around the physical location of the Urgent Care Portal. When looking at the usage of the centres by patient based on their registered GP practice, it is clear that the proximity of the service to a patients home or GP practice has a significant impact on their use i.e. the closer they are based to the walk in centre, the more significant their usage. This might not always be appropriate as much of this activity could be resolved through self-care, through discussions with a Pharmacist or through visiting their own GP.

5. **GP access is variable (our patients are saying that they cannot get a GP appointment);**

GP access is difficult to measure and there are no routine ways of understanding our GP availability through data systems. However we have done much work with our patients to understand the barriers to our existing services and they say:

- GP appointments are not always available when patients have an urgent need (our patients say that they are using the walk in centres and A&E because they cannot get an appointment at their own GP);
- There is significant variability in patient experience;
- Patients want to see their own GP but cannot always get an appointment when it is urgent.

6. **Services are stretched due to increased activity and increased complexity;**

GP practices, both walk in centres, ED and the ambulance service have all seen increased activity or increases in the complexity of patients arriving at services. The out of hours service is the exception, having seen a reduction in activity.

7. **Increasing costs in the system - funding is a challenge, there is no new money;**

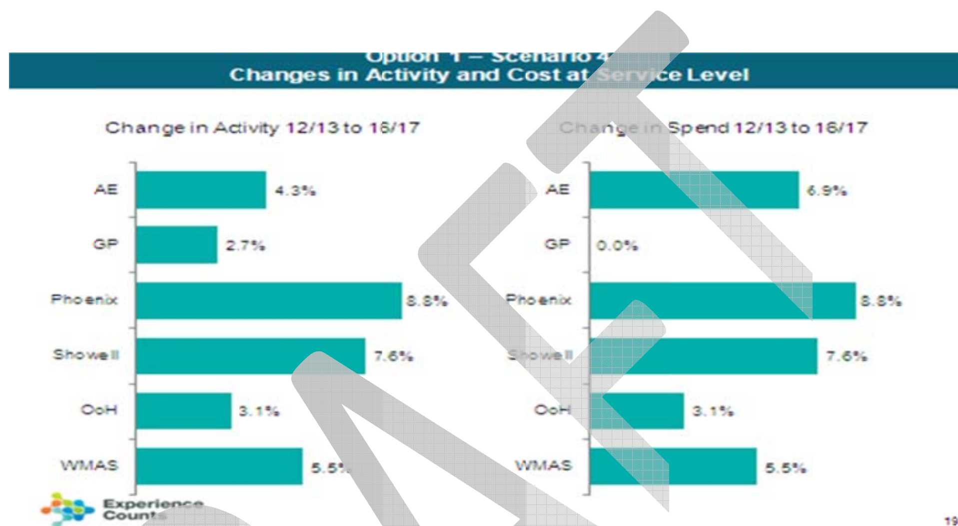
It is no secret that funding is a challenge in the public sector and will continue to be so over the next few years. To ensure that services are sustainable, Clinical Commissioning Groups must ensure that savings are made and that a continuous cycle of improvement is undertaken to improve quality for patients.

The chart below shows the activity and finance changes expected from 2012/13 to 2016/17 if ‘no change’ is made. Option 1 (No Change) is the first of 7 options that were developed by the Urgent & Emergency Care Strategy Board to allow a process of engagement across the city prior to developing the Urgent & Emergency Care Strategy.

The scenario relates to a number of potential changes that could impact activity levels over the next few years. Scenario 4 includes the potential for RWT to achieve Hyper Acute Stroke Unit status and the potential for Mid-Staffs to be

downgraded to an MIU, both of which would significantly change the activity levels across the system.

Activity and finance will move inline together for services that are on a block contract as the activity levels have a financial cap. Walk in Centre (primary care) activity appears to increase at the fastest rate however have only a 'like for like' increase in cost. The most significant change is the ED activity and finance changes. The ED was predicted to see an increase of 4.3% over the 4 year period however the associated cost of this activity increases at a far greater rate (6.9%). It must be noted that the activity for 2012/13 was already an increase of 5.19% more than 2011/12.



8. **An uncoordinated approach to Urgent Care (Urgent Care is a system);**

The existing services are commissioned individually and therefore one service might not compliment another. For example, the existing out of hours service has been commissioned in isolation of the wider urgent & emergency care services. As a result patients are confused about where the service is, if they can 'walk in' or the hours of opening.

Urgent & Emergency Care is a System

Understanding inter-dependencies of care settings and the impact of changes in one service affecting another.

Urgent Care begins in Primary Care with access to general practice key in supporting patient's urgent care needs.

System Gearing

95% of Urgent care is accessed in Primary care with 5% in Secondary care

As a result a 1% increase in Primary care causes a 20% decrease in Secondary care

Courtesy Dr Jay Banerjee
Consultant
University Hospitals of Leicester

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‘As a result of “system gearing” small changes in primary care, which includes general practice, can give rise to a much greater effect on the activity in hospitals (secondary care).

General practice provides the majority of urgent care and small changes to improve overall access and a consistent approach to urgent care requests, especially to older people, is likely to have a significant effect both on ED attendance and hospital admissions.

Improved access to timely integrated health and social care services in the community is also likely to have a significant impact on hospital admissions, length of stay, discharge and re-admission rates.’ (RCGP, 2011).

9. **Walk in Centres offer an additional layer to the system**

‘Each year around 290 million consultations take place with GPs and practice nurses, many of which are of an urgent nature. Between 1995 and 2006, the number of consultations grew at the rate of 3% each year. Over this same period, there was also an increase in the proportion of telephone consultations (up from 3% to 10% of contacts) and a decrease in the proportion of home visits (from 10% to 4% of contacts, although this is largely linked to the reorganisation of out of hours GP services)’ (RCGP, 2011).

General Practitioners offer a service for minor health problems, illness, ailments and injuries. They look after the health of people in their local community and deal with a whole range of health problems including those requiring urgent treatment or advice. They also provide health education, offer advice on smoking and diet, run clinics, give vaccinations and carry out simple surgical operations.

In addition to routine medical care and the management of long term conditions, GP’s offer treatment for:

Minor cuts, bruises, burns, scalds insect bites, head injuries	Muscle and joint injuries such as strains and sprains, back pain
Coughs, colds, flu type symptoms and hay fever	High temperature
Skin complaints including rashes, minor allergic reactions, scabies, head lice, sun burn, nappy rash	Eye problems such as conjunctivitis
Ear, nose and throat problems including minor infections, sore throats, ear ache	Pregnancy testing/advice and appropriate referral
P Sexual health/lifestyle advice	

Primary Care commissioning is the responsibility of NHS England, However CCG’s will need to work closely with the local NHS England Birmingham, Solihull and the Black Country Area Team (the AT) to ensure that GP’s and their practices are providing an acceptable standard of care as a minimum.

GP practices provide the same services (and more) than walk in centres. In Wolverhampton there are two walk in centres offering slightly differing services:

- The Phoenix Centre is nurse led seeing patients excluding under 1 years;
- Showell Park Walk in Centre is GP led with no age exclusions.

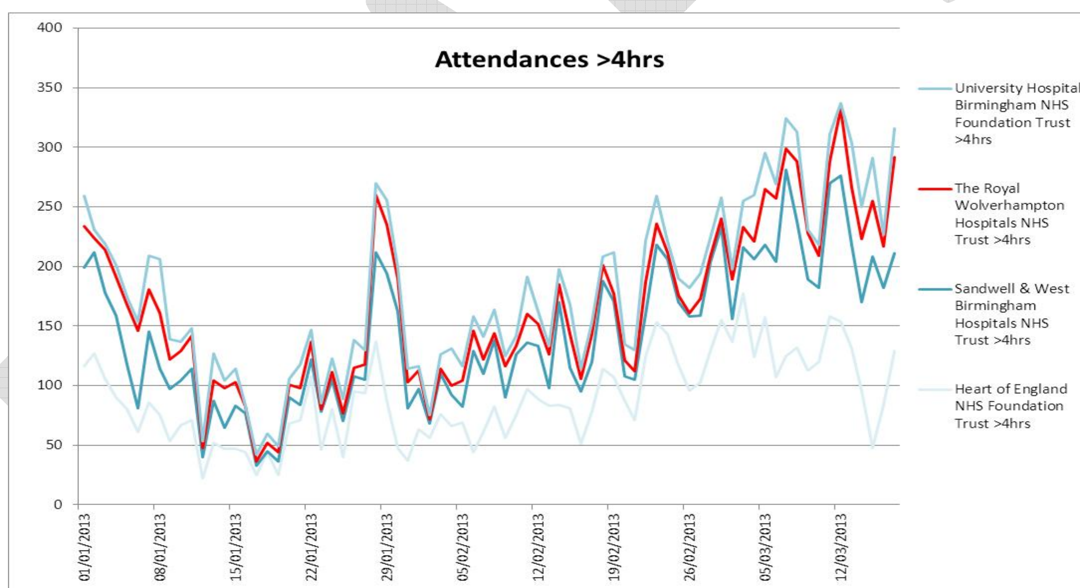
Both services were developed due to limitation in access to general practice and offer walk in facilities rather than the booked appointment systems that many GP services offer. If access to general practice is improved, there will be a correlating reduction in walk in centre and ED activity.

Monitor is currently undertaking a review of the effectiveness of Walk in Centre provision.

10. The current activity and finances cannot be sustained in the future – we must do things differently.

The existing system has seen significant pressure in recent months with patients attending the Emergency Department taking longer than 4 hours to be seen and treated. The chart below shows the number of patients who have had to wait for more than 4 hours to be seen and treated from 1st January 2013 to 16th March 2013 for four acute trusts including RWT.

Three of the four trusts have similar activity patterns showing the current pressures within the system.



In more recent weeks the Emergency Department has seen the highest number of attendances within one day ever experienced (n392).

9. Appendix 9 - Patient Research Project - Summary

Joint Urgent & Emergency Care Strategy 2012-2016

Patient Focus Group Findings

(Developed further to the ICE Creates Report January 2013)

February 2013
FINAL

* ICE Creates Ltd Commissioned to undertake the project (during Dec 12 and early 13);
* Commissioned to explore experiences, perceptions and attitudes as well as actual behaviours relating to the use of urgent care services;
* Weather conditions impacted attendance at the groups (snowfall);
* Interviews at urgent care portals including A&E, Showell Park, Phoenix Centre and GP Practices, a total of 125 face to face interviews & questionnaires;
* Seven insight groups with a total of 55 attendees.

Introduction & background

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Overall Influencing Factors on Where and Who are most likely to access Urgent Care

Influencing Factors:

- Severity of their condition
- Time of day
- Ability to book a GP appointment
- Consideration of busy periods/time of year
- Limited availability of appointments/access (GPs)
- Healthcare professional suggestion
- Panic and Anxiety influence use of A&E

Least likely factors

- Length of time waiting
- Travel/Parking facilities

Who are most likely:

- Parents with young children
- Student population
- Elderly Population
- Middle aged adults in full time employment

Patient quotes

- *"That's the problem - I think it is confusing where to go. At the time you don't know where to go. You go to a walk in and they say you should have gone to A&E"*
- *"People have differing ideas of what an emergency is. Some people think that a headache is an emergency. They don't always know where to go or what it is not"*
- *Your GP knows you family history and you trust your doctor, he knows your case"*
- *They are making a mistake of having larger surgeries, a family practice is what we want"*
- *NHS Direct "I just got passed around until I ended up putting the phone down. I didn't get any answers so I just did my own thing and went to the GP"*
- *"People think the facilities are there - why shouldn't they be treated"*
- *"People act differently when they are anxious"*
- *"People think it is their NHS"*

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* Findings - Urgent Care

* The most used UC services by respondents were GP practices, walk in centres and pharmacies with the least used were A&E, NHS Direct & Out of Hours GPs
* Patients think that Urgent Care is easy (or very easy) to understand (59.6%), only 14.2% did not know which service to access
* The inability to book a GP appointment is a consistent theme
  * Inappropriate use of services can be as a result of not getting a GP appointment
  * The most influencing factor of why patients use walk in centres is because they cannot get an appointment with their own GP
* Patients prefer to use their own GP - Participants trust the advice from their GP and feel it is a more personal service than other UC services
* Cost will not influence patients use of UC services (people see the NHS as free and/or that they have right to treatment because patients pay their taxes)

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* Findings - Urgent Care

* Two groups identified that are most likely to use A&E include parents with young children and people under the influence of drugs & alcohol (often seen quicker particularly if they are causing a disturbance)
* Walk in centres provide service out of hours & weekends
* Weekends are felt to be much more chaotic deterring people from attending A&E (especially the elderly)
* Patients are frustrated with people who use services inappropriately
* Patients think that the longer they are kept waiting=they must have attended inappropriately
* GP receptionists were cited as being a barrier however this was variable depending on Practice
* The majority of patients had not heard of NHS Direct but those who had thought it helpful to give advice and guidance (but that it took too long)

Portal	Reasons for frequent use	Reasons for less frequent use/barriers
A&E	• For some A&E perceived to be a central location	• Only used in an emergency
Walk in Centre	• Get seen quicker than at the GP practice • Referred by receptionist when they are unable to make an appointment • Able to access when the GP is closed (ie out of hours and weekends)	• Long waiting times
GP Practice	• LTC reviews • Many different services offered within the GP practice • Obtain prescriptions • GP has health history • Trust/relationship with health professional	• Difficulty making appointments • Not satisfied with the attention/service received in terms of appointment • Opening times • Receptionists
Pharmacy	• For minor ailments • Over the counter medicines • For advice • Confidence you can deal with your condition	• Bad experience in the past • Level of trust/confidence in pharmacy staff
NHS Direct	• Convenient to pick up the phone • Operates 24/7 when other services are closed • Very useful advice about what to do/where to seek help	• Lack of awareness of the service • Don't automatically think about using the service

Actual & Perceived Behaviours

* Joined up process for communicating with patients
* Patients think that more communication is needed on how and when to use UC services (majority of respondents pick up messages in a healthcare setting). Raising the profile of appropriate UC services
* Use of social media, local press, outdoor advertising, online information and direct mail. However receiving messages in healthcare settings was by far the best way to communicate with patients
* 'One size fits all' does not suit all patients
* Key messages need to be clear, direct and to the point
* Campaign messages need to reinforced through verbal communication via a health professional
* To continue to consult, patients suggest organising public meetings, working closely with community and users groups, gaining feedback through research methods such as focus groups and surveys
* The importance of giving feedback to participants was noted as important

Patient Interviews & Focus Groups - Findings - Communications

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* Inform people about the circumstances that they should attend different services AND when they have used services inappropriately. Tell them the most appropriate service that they should have used
* Issue charges or fines for inappropriate use/time wasting
* Educate people about what conditions can be self-managed and how
* Promote the role of Pharmacists and how they can support people in directing to services
* Engage with new parents in play centres/SURE start
* Educational programmes in schools
* Training of reception staff in GP practices to help sign post patients appropriately
* Promote the costs associated with inappropriate use: "people are not aware of the costs associated - particularly among those who get a lot of things for free (benefits)
* Communication needs to target those who end up in an ambulance or in A&E after a night out - informing them about 'abusing the system'

Patient Interviews & Focus Groups - Findings - Communications

Patient Interviews & Focus Groups - Findings - A&E

Significant Reason for Attending:

* Advised by a healthcare professional (25.6%)
* Could not get an appointment with their own GP (16.3%)
* Close to where they live (18.6%)
* Ambulance conveyance (14%), half of which were on patients own advice not HC professional
* Tried to use another HC service 53.5% (walk in centres 47.3% & GP practice 13.6%)
* Confidence that they will receive the treatment they need quickly
* Tests including x-ray/scans
* Panic and anxiety influence attendance at A&E (more than actual condition or urgency)
* Emergency Situation - severe conditions/broken bones/bleeding/breathlessness (supported by actual reason for attendance)
* Respondents had attended 0-3 times in 12 month period

Least cited reasons for attending:

* Second opinion
* Advice from friends & family

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Patient Interviews & Focus Groups - Findings - Walk in Centres

Significant Reason for Attending:

* Could not get an appointment with their own GP (higher at Phoenix) -42.3% & 19.6%
* Time of day/out of hours period (higher at Showell) -19.2% & 30.4%
* Taking a child or another person
* Minor ailments (eye infection, water infection, kidney infections - more at Phoenix)
* Considered/tried to use another UC service (mostly likely GP or NHS Direct) - more at Phoenix
* Conditions include minor cuts/burns, vomiting and diarrhoea, coughs and colds, rashes, earache, sore throats
* Tried to use another HC service 47.3% (A&E 53.5% & GP practice 13.6%) - more at Phoenix than Showell Park
* Respondents had attended 0-3 times in 12 month period

Least cited reasons for attending:

* Urgency of condition
* Distance from home

Patient Interviews & Focus Groups - Findings - GP Surgery

Significant Reason for Attending:

* Familiarity (used to attending) (26.5%)
* Confidence that they would get the answers and treatment they need quickly (16.9%)
* Advice from another healthcare professional (12.2%)
* Proximity (10.2%)
* Reason for attending: Pain from injuries, minor ailments, diarrhoea and vomiting, coughs and colds, minor cuts and burns, falls, collapse
* Routine appointments (midwife, check-ups, test results, general health issues, LTCs, repeat prescriptions)
* Tried to use another HC service 13.6% (A&E 53.5% and walk in centres 47.3%)
* Respondents had attended 6-10 times in 12 month period

Least cited reasons for attending:

* Time of day
* Urgency of their condition
* Advice from friends and family

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* Patient Interviews & Focus Groups – Findings – Pharmacy/ Self Care/NHS Direct

Significant Reason for Attending:

* Collecting medicines/repeat prescriptions
* Self care medications
* Conditions: Diarrhoea and vomiting, coughs and colds, minor cuts and burns
* Respondents did not have experience of using NHS Direct but would use this service to obtain health advice about symptoms or a condition
* Respondents had attended 2-5 times in 12 month period

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10. Appendix 10 – Glossary of Terms

Glossary of Terms	
A&E	Accident and Emergencies
AMU	Acute Medical Unit
BCP	Black Country Partnership
BME	Black Minority Ethnic
CDU	Clinical decisions Unit
CICT	Community Integrated Care Team
CIP	Cost Improvement Programme
COPD	Chronic Obstructive Pulmonary Disorder
DNAR	Do Not Attempt Resuscitation
DOH	Department of Health
EACC	Emergency Ambulatory Care Conditions
ED	Emergency Department
FSU	Frequent Service User
GP	General Practitioner
HASU	Hyper Acute Stroke Unit Status
HRG	Healthcare Resource Group
HWB	Health and Wellbeing Board
ICP	Integrated Commissioning Plan
IEP	Image Exchange Portal
LA	Local Authority
LINk	Local Improvement Network
LiNKS	Local Improvement Network
LMC	Local Medical Council
MIU	Minor Injuries Unit
ONS	Office of National Statistics
OOH	Out of Hours
PAU	Paediatric Assessment Unit
PC	Primary Care
QIPP	Quality, Innovation, Productivity, Prevention
RWT	The Royal Wolverhampton NHS Trust
SAU	Surgical Assessment Unit
SES & SPCCG	Staffordshire & Seisdon Peninsula Clinical Commissioning Group
SPAR	Single Point of Access and Referral
WCC	Wolverhampton City Council
WCCG	Wolverhampton Clinical Commissioning Group
WiC	Walk in Centre
WMAS	West Midlands Ambulance Service NHS Foundation Trust
WUCTAS	Wolverhampton Urgent Care Triage Access Service

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11. Appendix 11 – References

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