Health Scrutiny Committee Report

Purpose of this report

The purpose of this report is to provide responses to five questions posed by the Surrey Wellbeing and Health Scrutiny Board (the "Board") in a letter dated 21 July 2015 as well as to provide an update on planning and risks around winter 2015/16.

The five questions are:

1. How did you work with partners in health and social care to manage the increased demand in A&E in December 2014 and January 2015?
2. What plans are in place in your area to manage such a spike in demand should it re-occur in 2015/16?
3. What, in your view, needs to be done to ensure that A&E is used appropriately in the future?
4. What are the risks to A&E performance in your area?
5. Do you have any suggestions as to what other partner agencies can/should be doing to alleviate the situation?

This is a joint response from all addressees of the request:

- Michael Wilson, Surrey and Sussex Healthcare
- Elaine Jackson, East Surrey CCG
- Philip Greenhill, First Community Health and Care
- Jo Poynter, Surrey County Council

The sections of this report set out background to the Emergency Department provision at East Surrey Hospital, look back at the health system working in 2014/15 before looking forward to 2015/16. The final sections allow each organisation that forms part of this response to put forward individual views in relation to questions three and five.

Q1 - How did you work with partners in health and social care to manage the increased demand in A&E in December 2014 and January 2015?

Surrey and Sussex Healthcare NHS Trust receive 50% of referrals and attendances from Surrey and 50% from Sussex and sit on 3 System Resilience Groups (SRGs)

- East Surrey SRG
- Surrey Downs SRG
- Crawley & Horsham SRG

- The total allocation of funding to support the delivery of ED and ambulance response time standards for East Surrey SRG was just over **£1m** in 2014/15 and this was allocated to the following organisations to fund 16 separate schemes that would enable delivery of the key national performance standards, some of these schemes include:

- £245,000 First Community Health
    - Discharge to Assess service to help reduce the number of patients who become Medically Ready for Discharge but are delayed leaving hospital

- £43,695 Surrey Social Services
    - Additional social care resource to support discharge process

- £29,000 South East Coast Ambulance NHS FT
    - Additional operational support to manage times of peak activity at East Surrey Hospital

- £20,346 British Red Cross
    - Additional resource to support more patients at home following discharge

- £50,045 Surrey and Borders Partnership
    - 7 day overnight psychiatry liaison service for ED

- £582,601 Surrey and Sussex Healthcare NHS Trust
    - 21 extra medical beds for Nov – March
    - Extra ED medical staff
    - 7 day cover for OT & phsyio staff
    - Extended weekend cover for pharmacy
    - Extended weekend medical cover for inpatient wards

Surrey and Sussex Healthcare NHS Trust are consistently in the Top 20% nationally for performance in delivering the 4 hour ED access standard and achieved 95.1% overall performance for 2014/15.

Performance against the 4 hour standard in November was 95.7% and there was every expectation that the standard would be delivered for Q3 & Q4 given the investments made and partnership working through the SRGs. However, there were a significant number of extreme or unpredictable events relating to the type of admissions into hospital though ED that began on Sunday 7 December 2014 and lasted for 5 weeks that put the hospital under extreme pressure.

The timeline and tables below evidence admissions throughout December and into January.

An amber event is 1 standard deviation from the mean and a red event is 2 standard deviations from the mean so the reds in particular detail significant and unprecedented variation from our expected activity.

Week 1 – w/c 1/12/14

	ED - Amb - Adult: 17-74	ED - Amb - Geriatric: 75+	ED - Walk - Adult: 17-74	ED - Walk - Geriatric: 75+	ED Performance	Admissions - Non Elective (1+LOS) - Adult: 17-74	Admissions - Non Elective (1+LOS) - Geriatric: 75+
Mon	45	32	109	12	96.2%	40	32
Tue	40	21	102	7	98.3%	48	22
Wed	48	34	87	6	99.2%	37	29
Thu	44	40	99	11	98.8%	45	36
Fri	41	38	73	14	97.8%	34	40
Sat	50	36	88	8	95.9%	33	32
Sun	48	34	95	7	93.3%	28	36

Week 2 w/c 8/12/14

	ED - Amb - Adult: 17-74	ED - Amb - Geriatric: 75+	ED - Walk - Adult: 17-74	ED - Walk - Geriatric: 75+	ED Performance	Admissions - Non Elective (1+LOS) - Adult: 17-74	Admissions - Non Elective (1+LOS) - Geriatric: 75+
Mon	48	28	108	7	83.8%	51	32
Tue	47	40	88	5	80.4%	43	37
Wed	46	41	91	12	90.2%	50	26
Thu	57	36	73	5	86.7%	41	38
Fri	47	47	95	8	86.1%	41	35
Sat	60	42	73	7	92.7%	41	38
Sun	40	32	95	9	94.3%	34	33

Week 3 – w/c 15/12/14

	ED - Amb - Adult: 17-74	ED - Amb - Geriatric: 75+	ED - Walk - Adult: 17-74	ED - Walk - Geriatric: 75+	ED Performance	Admissions - Non Elective (1+LOS) - Adult: 17-74	Admissions - Non Elective (1+LOS) - Geriatric: 75+
Mon	50	48	100	12	82.2%	34	41
Tue	47	31	86	13	86.0%	41	34
Wed	45	38	82	8	85.0%	38	34
Thu	34	41	84	11	87.4%	38	33
Fri	53	35	67	6	91.4%	34	41
Sat	51	30	103	5	98.0%	36	22
Sun	52	38	100	9	93.8%	21	32

Week 4 – w/c 22/12/14

	ED - Amb - Adult: 17-74	ED - Amb - Geriatric: 75+	ED - Walk - Adult: 17-74	ED - Walk - Geriatric: 75+	ED Performance	Admissions - Non Elective (1+LOS) - Adult: 17-74	Admissions - Non Elective (1+LOS) - Geriatric: 75+
Mon	47	40	88	7	76.7%	41	36
Tue	44	31	87	5	96.2%	36	29
Wed	27	38	72	10	92.3%	29	32
Thu	27	25	65	3	93.8%	19	21
Fri	38	39	113	14	94.1%	33	37
Sat	51	44	127	22	87.4%	46	40
Sun	55	39	91	10	79.2%	34	32

Week 5 – w/c 29/12

	ED - Amb - Adult: 17-74	ED - Amb - Geriatric: 75+	ED - Walk - Adult: 17-74	ED - Walk - Geriatric: 75+	ED Performance	Admissions - Non Elective (1+LOS) - Adult: 17-74	Admissions - Non Elective (1+LOS) - Geriatric: 75+
Mon	45	53	84	11	73.5%	43	40
Tue	43	38	70	8	77.6%	40	37
Wed	37	33	73	12	94.0%	39	32
Thu	53	42	99	7	81.6%	33	38
Fri	51	46	96	12	84.0%	47	46
Sat	41	37	115	7	81.0%	40	35
Sun	50	42	105	10	69.8%	28	34

Week 6 w/c 5/1/15

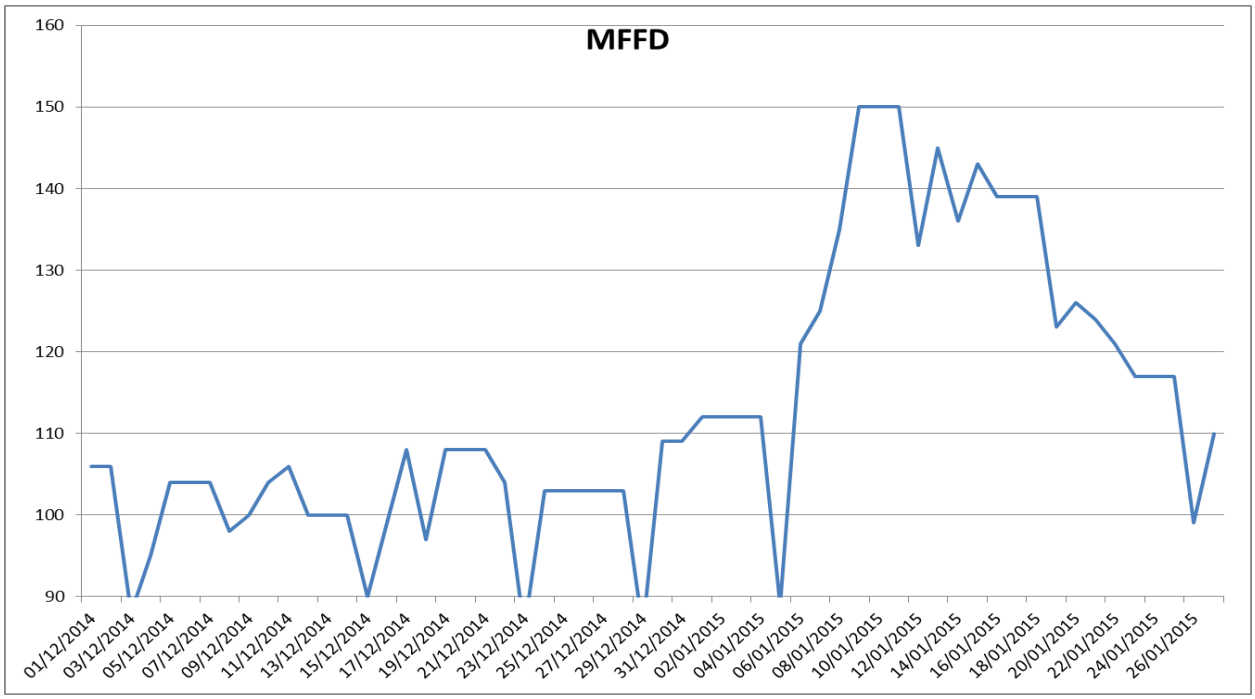
	ED - Amb - Adult: 17-74	ED - Amb - Geriatric: 75+	ED - Walk - Adult: 17-74	ED - Walk - Geriatric: 75+	ED Performance	Admissions - Non Elective (1+LOS) - Adult: 17-74	Admissions - Non Elective (1+LOS) - Geriatric: 75+
Mon	53	42	104	16	75.0%	39	33
Tue	31	34	95	11	88.6%	32	44
Wed	38	25	74	6	96.5%	35	24
Thu	51	37	72	7	97.1%	34	32
Fri	45	24	75	4	99.4%	34	21
Sat	43	35	83	6	95.7%	42	28
Sun	30	36	69	3	94.8%	30	26

As the above charts show, for 5 consecutive weeks there were much higher levels of admissions of elderly patients (75+) into acute hospital beds. Frail elderly patients with complex needs, specifically complex social care needs have a much longer length of hospital stay then the average person and so this continued pattern of higher than expected admissions of this specific cohort of patients meant that the hospital quickly filled up.

Moreover, although the pattern of admissions became more normalised in January the consequences of the previous 5 weeks meant that the number of patients medically ready for discharge but unable to leave the hospital spiked severely hampering patient flow through the hospital.

Throughout this period we were in regular contact with our partners via a number of forums from daily operational meetings such as daily Integrated Discharge Team Meetings, Consultant led Multi-Disciplinary Team meetings in all Elderly Care Wards, Daily Conference Calls confirming available capacity in the community, weekly Top 20 delays meetings to higher level meetings such as the System Resilience Group and the Chief Officers Group.

First Community Health and Care (FCHC) co-located the health and social care teams at East Surrey hospital in order to deliver joint assessments for patients presenting to A&E. When patients could be discharged they would be assessed in a community setting (their own home, nursing home, residential home, or an interim bed) to address on-going health and social care needs. On a daily basis, Surrey adult social services and FCHC reviewed and discussed those patients that could leave the hospital, this included A&E and together ensured that patients were discharged in a safe and timely manner and has set the tone for an integrated health and social care approach to caring for patients.

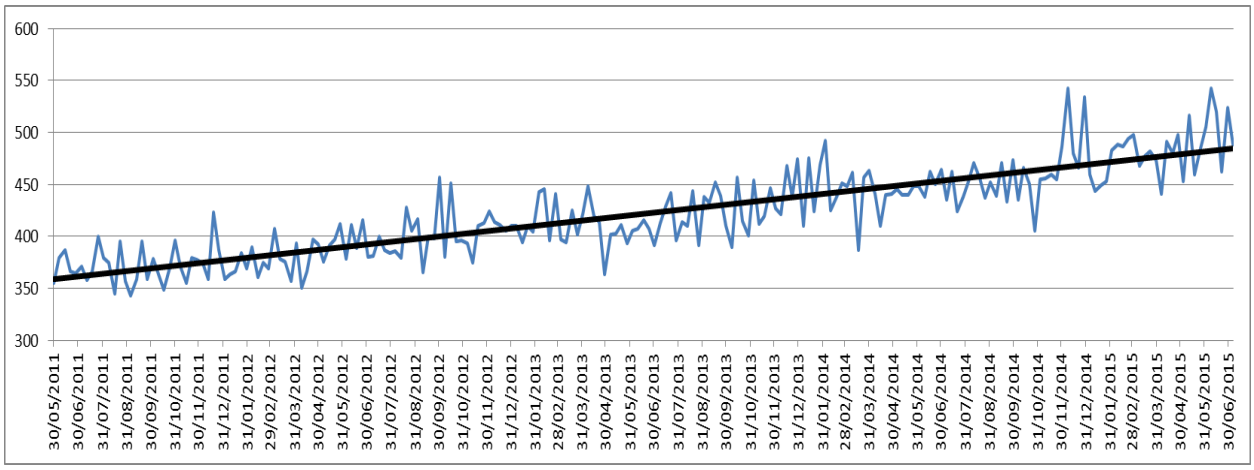


Q2 - What plans are in place in your area to manage such a spike in demand should it re-occur in 2015/16?

One of the key lessons that were learnt from the December 14/January 15 experience was the need to be able to respond more quickly as a system when spikes in demand occur. It took longer for the hospital to recover because once the spike of patients who had been admitted were treated and fit for discharge; there was insufficient capacity available to move them into, partly because the spikes had not been recognized until after they had occurred. The lack of flow was not simply between the acute and the community provider but between the community provider and nursing homes, continuing healthcare, residential homes and social care.

There is much more focus now on the MRD list and a dashboard is sent out every day to all internal and external stakeholders.

However, it is clear that more health and social care capacity will be required to manage winter for 15/16 as emergency admissions to SaSH patients staying 1day+) continue to grow at an annual rate of c8%



Similar levels of funding are available for 15/16 and many of the schemes put in place last year will continue on a recurrent basis. The East Surrey SRG has agreed to invest more money in to community schemes this year and less into the acute hospital with the expectation that this will allow some patients to be discharged much more quickly through the expansion of the Discharge to Assess (D2A) scheme in recognition of the fact that this is a much better solution for patients and helps with capacity

There are also current discussions about creating some additional and different capacity on the East Surrey Hospital site that would be funded by Social Care in the East Surrey and staffed by Health and Social Care This would be for patients who are medically fit for discharge and who do not need an acute hospital bed, however remain in progress through the social care process. This could potentially create 21 more sub-acute beds.

We have also recognised that we can improve the ways we work together so we are more responsive to such spikes and as providers and commissioners we recognise that working together in partnership helps to create momentum around change. We have collectively agreed and developed an Improving Discharge Action Plan which we are currently actioning.

In addition we are jointly running a Breaking the Cycle Week from 1st to 4th September when we will pilot a number of initiatives and actions with the specific aim of improving flow and reducing the number of medically fit patients in the acute hospital beds.

Currently, primary care, secondary care and community providers are writing a joint proposal for consideration by the CCG to secure funding for a multi-disciplinary, multi-agency team working at the front door of A&E to see, treat, prioritise diagnostics and send patients home should they not need acute admission. Research has shown that admitting someone over the age of 65, they can become deconditioned and develop a secondary infection in acute care, so we intend to target this group of patients, working in partnership with the GP Federation to ensure there will be primary care presence at the point of triage and we are looking to implement this by the 1st October.

In the interim until we have secured funding, FCHC are providing two community nurses in A&E to work with an East Surrey hospital physiotherapist and occupational therapist to work together, the aim being admission avoidance by signposting to multi-disciplinary and multiagency services including primary care, red cross etc. This will also help to build relationships with IC24, the out-of-hours provider.

FCHC are currently changing their IT system from Rio to EMIS. This is the same system that the GPs use in East Surrey. Once this is compatible, we are looking at the interoperability between CERNER and EMIS to inform primary care of the presentation, diagnosis and treatment of their patient attending East Surrey A&E department. This will enable the GP to track their patient whilst in the A&E department and monitor their outcome.

Q3 - What, in your view, needs to be done to ensure that A&E is used appropriately in the future?

- Ensure that patients are involved in everything we develop and that we clearly communicate potential changes to them
- Ensuring an integrated community and social care infrastructure for our practice population.
- All agencies collaborate and work together for the good of the patient.
- Using one single point of entry into the health and social care system.
- Interoperability between IT systems so the patient only tells their story once.
- To stop hand-offs and duplication within the system.
- Ensure that we are training the nurses and social workers we need for the future.
- Follow the five year forward view as it appears to guide us through transformation and develop integrated care models.
- Increased access to GPs/primary care out of hours & weekend ends
- Increased access to urgent care for appropriate patients
- More admission avoidance (long term conditions)
- EOL care in nursing homes
- 24/7 mental health access and CAHMs
- Help patients to better self-manage

Q4 - What are the risks to A&E performance in your area?

The biggest risk to delivery of A&E performance remains the ability to discharge patients when they are deemed ready for discharge by the clinical teams. Rarely is the failure to achieve the 95% standard due to ED, instead it is the ability for patients to move through the hospital into the right bed at the right time and to be discharged as soon as well enough to leave the hospital. Length of stay is often increased when patients are not placed onto the right specialty ward or are moved to other wards medicine to surgery, to create a bed for a more acute patient or patients are placed into escalation areas to create additional bed capacity. On average 100 patients are deemed medically ready for discharge at any one time. This can be split as:

- 51% Social services (either awaiting assessment or awaiting placement)
- 15% awaiting nursing home placement
- 13% awaiting CHC outcomes
- 10% awaiting a community bed
- 11% other (self-funders, hospital delays)

If this number were to be reduced by 30 – 40% this would make a considerable difference to hospital flow and the ability to keeps A&E functioning.

Another significant risk is the continued increased in emergency admissions that present through A&E and the infrastructure and capacity that is required to meet this demand.

- Shortage of qualified nurses and doctors to staff additional capacity
- National caps on the use of agency staff
- Funding

Q5 - Do you have any suggestions as to what other partner agencies can/should be doing to alleviate the situation?

- Increased social care funding
- Increased capacity in CHC, Social Care rehab and community
- Improve and streamline processes
- MDT Assessment for discharge as close to the point of admission as possible
- Undertake assessment in interim placement beds
- Pull from hospital into community (more in reach services)
- Support to nursing homes
- Integrated Rapid Response/Reablement approach between community health and social care
- All parts of the system must act with pace around change

Conclusion

Despite the enormous pressure the surge of emergency admissions created in December 14/Jan 15 the East Surrey Health economy worked really hard and really well together to ensure recovery and delivery of the 4 hour ED access standard by March 2015. The schemes that have been funded recurrently together with the additional schemes identified for this year should result in an even more resilient heath economy to meet the challenges of Winter 15/16.

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