Fit for the Future
Working together to keep people well

Report to STP Board: 20 May 2019

Agenda item:	2.3
Title:	A & E
Lead:	Caroline Walker, Chief Executive, North West Anglia Foundation Trust (NWAFT) and Sam Higginson, Chief Operating Officer, Cambridge University Hospital (CUH)
Author:	Clare Hensman,

Report purpose *(Please mark one in bold)*

APPROVAL	DECISION	**ASSURE**	INFORM

Link to STP Priorities *(Please mark all applicable in bold)*

AT HOME IS BEST	SAFE & EFFECTIVE HOSPITAL CARE, WHEN NEEDED	**WE'RE ONLY SUSTAINABLE TOGETHER**	SUPPORTED DELIVERY

Committees/groups where this has been presented to before *(including date)*

N/A - paper circulated to Matthew Smith (Clinical Commissioning Group (CCG) Senior Responsible Officer (SRO), Urgent & Emergency Care (UEC) and Vaz Ahmed (UEC Sustainability and Transformation Partnership (STP) Clinical Lead)

Purpose of the paper

This paper provides an update to the STP Board on the current Accident and Emergency (A&E) Performance and wider context in the STP and efforts to address increasing attendances.

The STP Board is invited to:

The STP Board is asked to note the contents of this report.

1. INTRODUCTION / BACKGROUND

The national standard is for at least 95% of patients attending A&E to be either admitted to hospital, transferred to another provider or discharged within four hours. As a system we are failing the A&E four hour wait standard; the provisional 2018/19 A&E performance was at 86.2% for Cambridge University Hospital (CUH), North West Anglia Foundation Trust (NWAFT) and Minor Injury Unit's (MIU).

2. BODY OF REPORT

A&E Performance

Trusts are measured by their daily performance on the four hour standard. The latest performance metrics as per the following table:

Table 1: A&E performance at Month 12

	A&E performance to end of March (YTD)	Recent A&E performance (week ending 31 March)	A&E attendances (week ending 31 March)
England Average (type 1 and 3)	87.76%		
England Average (type 1 only)	81.53%		
Total CUH (type 1 and 3)	**85.97%**	**85.35%**	**3,275**
CUH type 1 only	81.32%	81.99%	2,428
NWAFT incl. MIU	**86.40%**	**89.21%**	**4,095**
Peterborough City Hospital (incl. Stamford)	78.74%	87.14%	2,201
Hinchingbrooke	92.51%	97.47%	1,046

A&E Performance: CUH year to date (YTD) performance was below the England YTD average and performance was flat towards the end of March. Performance at Peterborough and Stamford declined at the start of November which meant NWAFT performance finished slightly below the England average in March.

Appendix 1 is a letter from the NHS England and NHS Improvement Regional Team, summarising the regional context. Ann Radmore, Regional Director, notes that "When I look across the region it is clear to me that the largest single issue remains the provision and sustainability of the appropriate staff." The region is due to meet on the 10 May to discuss this in more detail.

Activity growth – including A&E attendance, 111, Out of hours and MIUs/MIIU

A&E departments have had a busier 2018/19 compared to 2017/18. The number of A&E attendances by the Cambridgeshire and Peterborough population has increased by 5.8% 12,700 attendances (4.3% CUH, 7.1% Hinchingbrooke, 7.0% PCH). The last quarter had much higher increases of 12.1% (12.3% CUH, 18.3% Hinchingbrooke, 7.7% PCH).

Recent activity growth is not just a local issue as NHS England and NHS Improvement data shows that ED attendances across the region have grown significantly.

This growth is from patients who have received triage from another part of the system - the largest volume growth being ambulant majors and paediatric patients referred by GPs.

Cambridgeshire and Peterborough have alternatives to A&E, and we can look at how patients are using all services in the round. The table below sets out three alternatives to A&E, along with A&E attendances, the relative level of activity and how activity has changed compared to last year. There are other alternatives, such as use of Pharmacy and self-care, where we do not have information.

Patient Access Point	Activity		Growth	
	2017/18	2018/19	#s	%
111 Calls	239,282	251,272	11,990	5%
Out of Hours Calls	92,577	92,753	176	0.2%
MIU/MIIU Attendances	95,406	95,605	199	0.2%
Type 1 A&E attendances	256,683	271,352	14,669	6%

Source: SDU analysis of CCG weekly report, week ending 31/03/2019 and Winter Pressures Predictor

Most patient contacts are through a type 1 A&E attendance, then 111 calls, with out of hours calls and Minor Injury Unit (MIU) attendances. Currently, we cannot say what overlap there is with individual patients.

More calls are being made to NHS 111 although the number of 111 ED and ambulance dispositions has been reduced through increased clinical validation over the past 5 months. Attendances at MIUs has remained the same overall, but Peterborough Urgent Treatment Centre (MIU) saw a 5% decrease in the total number of patients, offset by increases at North Cambs Hospital MIU (Wisbech) and Doddington MIU.

CUH Field Testing new A&E performance standards

It is worthwhile noting that CUH is one of 14 sites selected by NHS England to test new accident and emergency standards which could replace the four-hour target. The field test is currently scheduled to start at the end of May, and will look at measuring:

- Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments);
- Time to emergency treatment for critically ill and injured patients. Complete a package of treatment in the first hour after arrival for life-threatening conditions;
- Time in A&E (all A&E departments and mental health equivalents). Measure the mean waiting time for all patients; and
- Utilisation of Same Day Emergency Care.

Arrangements for reporting the existing 4-hour standard during the trial period are still being finalised.

Projects on Admission Avoidance and Out of Hospital Urgent Care 'Roundtable'

The Cambridgeshire and Peterborough system are working on a range of schemes designed to reduce unplanned activity and cost in 2019/20, which will be a transitional year as we move towards the following major changes:

- Re-structured investment in primary care for 2019/20 to reduce unwarranted variation from Q2 including unplanned acute activity;

- Transformation of out of hospital urgent care ('Roundtable' programme) which will move to pilot phase from October 2019;
- Development of Integrated Neighbourhoods and Primary Care Networks.

The 2019/20 transition year model and schemes are summarised in Annex 2. It should be noted that these are subject to further development and change in order to deliver the system control total. In broad terms, there are two groups of schemes:

- Incremental schemes which build on existing delivery in 2018/19 and will deliver from Q1: for example,
    - increasing use of consultant liaison lines;
    - clinical validation to reduce 111 dispositions to ED and ambulance; and
    - increasing Same Day Emergency Care.

- New schemes linked to national and local priorities: these will be subject to case for change processes, and where appropriate will need to align with the roundtable specification. For example:

    - Acute Visiting Service pilot;
    - 111 direct on the day referral into primary care and extended primary care slots;
    - Development of community ambulatory care hubs; and
    - Enhanced services for High Intensity Users.

3. RECOMMENDATIONS

The STP Board is asked to: note the contents of the report

13 May 2019

Appendices: ***Appendix 1: System Regional letter on A&E Performance from 30 April 2019***
Appendix 2: UEC Model 2019/20: 'Roundtable'

Appendix 1 - System Regional letter on A&E Performance from 30 April 2019

Sent via e-mail

To: Acute Trust CEOs

Dear colleagues

You will be aware of the position of the urgent and emergency care pathway across the country and within your own organisation. I have noted below the regional position in relation to both last year and the recent period and you can see our position in relation to the rest of the country and the position for each of our individual Trusts.

We have already asked two systems – Hertfordshire and West Essex (and all three acutes) and Norfolk (with NNUH) to work on a plan to address the significant and ongoing poor performance in those organisations. We will be reviewing those this week. I will want to review the position with regard to a number of other organisations where performance has struggled recently.

I would draw a few conclusions across the region. The capacity we have open currently is at least as much if not more than we had 12 months ago; we are struggling to secure additional or replacement staffing when staff are unavailable at short notice; we have high bed occupancy and lower discharges. In some places we have activity up compared to last year or the last 6 weeks but not all.

I would ask all CEOs to do a number of double checks to consider your planning for the next 4 weeks as we consider 2 Bank Holidays and the half term week:

- Your demand and capacity plans reflect your knowledge and understanding of what may flow to your organisation over this period
- You have tested your manpower plans for the high-risk days including your operations managers thinking through the response for very short-term absence or no show and non-availability of agency staff
- You have agreed with partners their role and contribution in helping you manage flow through the peak periods
- You are satisfied that you have the right leadership on site or able to respond on these difficult days and weekends
- You are reporting to your full board in sufficient detail for them to understand and assess the position and your recovery plans.

When I look across the region it is clear to me that the largest single issue remains the provision and sustainability of the appropriate staff. When we meet on the 10th May I am hoping we can spend some time beginning to scope how we might work on that problem and I believe that this context highlights why this is so important.

You will recognise that we need to work together in systems to improve the operation of key parts of the UEC pathway and reduce the stress in the system. We do need to commit time and focus to this over the next four weeks and going into the summer months.

I know that you will be putting in significant time and energy with your teams to focus on your service at the front door and patient safety. Thank you to you and your staff for all you are striving to achieve.

Do ring me if you want to discuss.
Ann

Yours sincerely
Ann Radmore
Regional Director (East of England)

Appendix 2: UEC Model 2019/20: 'Roundtable'

Out of Hospital Urgent Care ('Roundtable') procurement

Overall Objectives

To provide a local and simple integrated 24/7 urgent care service which delivers effective patient outcomes, that reduces duplication and maximizes the workforce.
There is a need to:

- *Decrease the inappropriate use of emergency departments*
- *Provide a timely access to appropriately qualified health & social care professionals*
- *Provide patients with a wider "at home" option*
- *Improve access to urgent appointment through scheduling non-scheduled care*
- *Improve the availability of information*

Benefits

- Reduced number of total attendances in ED
- Improved patient access to urgent care on the day
- Improved outcomes for patients requiring urgent care

Outcome Measures

- Decreasing Total urgent care spend
- Decreasing ED activity - Attendances and Admissions
- Decreasing the % of ED attendances where no action is taken
- Increasing 111 activity
- Increasing % of 999 calls not conveyed
- Increased access to primary care (through various modes)
- Increased number of on the day non-acute appointments
- Increase % patients receiving input from home

Deliverables

- System-wide acute GP visiting model
- Agreed specification for an Out of Hospital Urgent Care System
- Contract tender for an Out of Hospital Urgent Care System

Interdependencies

- Need to invest in community care diagnostics to reduce ED usage
- Dedicated programme resource requirement
- Dependent on GP incentivisation scheme

STP Governance	Clinical Lead	Management Lead	Programme Oversight
AEDBs	Clinical engagement with all providers	Louise Mitchell, COO	Roundtable Steering Group

Scope and Exclusions

The specific scope will be agreed with the providers and provisionally we have thought about the overlap with:-

- GP Extended Access
- 111
- Out of Hours GP provision
- Urgent Care Centres
- Minor Injuries and Illness
- GP Home visits
- Ambulance (non-cat 1)
- Clinical Assessment Service
- Step down (step up) community beds.

Milestones

Milestones	Start Date	End Date
Agree Out of Hospital urgent Care service specification	Jan 19	Mar 19
Provider led collaborative design of the new services	Apr 19	Jun 19
Agree commercial and contractual approach	Jun 19	Jun 19
Mobilise new Service (initially in pilot form)	Jun 19	Sept 19
Pilot new out of hospital urgent care services	Oct 19	Mar 20