Briefing to the Kent County Council HOSC Friday, 7 March 2014

Subject: Accident and Emergency – North Kent (Dartford, Gravesham and Swanley)

From: NHS Dartford, Gravesham and Swanley Clinical Commissioning Group, Dartford and Gravesham NHS Trust, Kent Community Health NHS Trust, Kent and Medway NHS and Social Care Partnership Trust and EllenorLions Hospices

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Introduction

The invitation to attend Kent County Council's Health Overview and Scrutiny Committee (HOSC) is warmly welcomed. The opportunity has been taken to engage key partners in the health economy of Dartford, Gravesham and Swanley (DG&S) to come together to prepare this briefing.

While the challenging winter period is not yet over, the health system has responded comparatively well to the demands placed upon all health services, albeit that this briefing concentrates upon the Accident and Emergency Department at Darent Valley Hospital (DVH) managed by Dartford and Gravesham NHS Trust. The main finance for these services comes from NHS Dartford, Gravesham and Swanley Clinical Commissioning Group - the lead commissioner. It was supplemented by an additional £4 million from NHS England in September 2013 to cover a five-month period. In return for the additional funds, the health economy must ensure 95 per cent of patients attending A&E receive treatment, be discharged or are admitted within four hours. Furthermore, 75 per cent of staff must have received a flu vaccination.

It is worth highlighting that all health bodies have benefited from the supplementary resources and worked together in partnership to assist in cushioning the effects of patients waiting for services in the A&E Department.

Governance

While Dartford and Gravesham NHS Trust has the day-to-day managerial responsibility for A&E services at Darent Valley Hospital, it is dependent upon efficient services throughout the health and social care system. To assist in delivering this objective an Urgent Care Delivery Group (UCDG) operates with a wide membership. It meets monthly and has the responsibility of holding to account each partner for the smooth operation of the operational management of the urgent care system.

The UCDG reports through to an Executive Programme Board, with representation of Chief and Accountable Officers. It covers all health matters and the interaction with social care.

The Executive Programme Board, which is wider than just A&E, is an opportunity for the whole system to come together to agree the medium to long-term approach for

sustainability. This includes a real focus on integration and the co-development of the Better Care Fund proposal which has been received well by KCC councillors.

Each health organisation regularly reports through to its statutory Board about the issues of A&E and the impact upon the rest of the service.

In addition to the above, GP Dr David Woodhead has established a Clinical Interface Group (CIG) which has, with a limited number of DVH clinicians, worked on the clinical systems, models and joint working between acute and primary care. This has resulted in the production of the Integrated Discharge Team (IDT) and a joint Service Level Agreement. This joint team consists of professionals from acute, mental health, community health and social care (medical, nursing and therapy).

To ensure that all partners are constantly aware of each other's pressure points and to assist in resolving operational challenges in recent weeks, daily (often more than once a day), Executive Team conference calls have been held to monitor service delivery. The local Area Team on behalf of NHS England and the Trust Development Authority each have a performance management role in the health system.

Performance Management

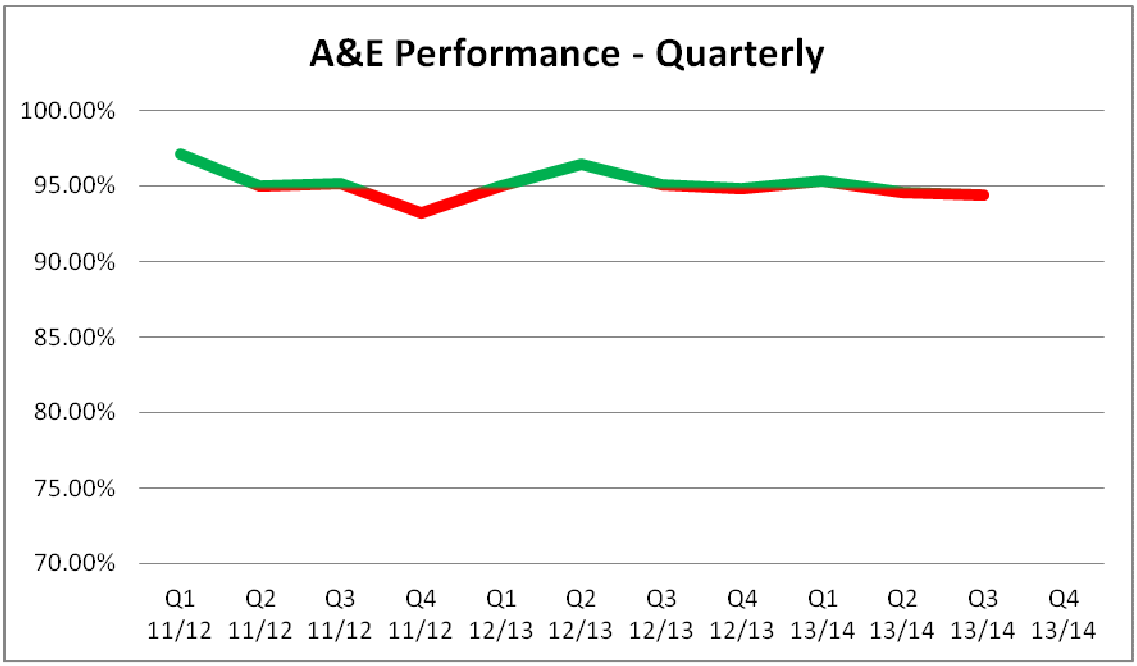
From the tables below, it can be seen that 94.6 per cent of patients are receiving their care within the prescribed four hours. To achieve 95 per cent by 31 March is going to be a challenge but all agencies remain committed to the target.

While the average number of patients attending A&E appears stable over the past two years at around 264 per day, the number admitted has risen significantly, from 63 to 77 per day, and demonstrates the pressure on beds and may indicate the increased complexity of health requirements of patients. This has had a significant impact on the number of beds needed at DVH.

Table 1 – A&E activity data

	Annual				Average - Daily		
	April 11 - March 12	April 12 - March 13	April 13 - January 14	Est. April 13 - Mar 14	April 11 - March 12	April 12 - March 13	April 13 - January 14
A&E Attendance	97,616	97,975	81,551	96,536	267	268	264
Emergency Admissions *(via A&E)*	22,965	26,130	23,749	28,118	63	72	77
Ambulance conveyances	25,145	25,763	22,008	26,275	69	71	72
A&E Performance against 4 hr target *(Average)*	95.1%	95.3%	94.6%	95.0%	95.1%	95.3%	94.6%
	Average - Monthly				Average - Winter Months (Dec-Feb)		
	April 11 - March 12	April 12 - March 13	April 13 - January 14	Est. April 13 - Mar 14	Winter 11/12	Winter 12/13	Est. Winter 13/14
A&E Attendance	8,135	8,165	8,155	8,045	25,521	25,615	25,570
Emergency Admissions *(via A&E)*	1,914	2,178	2,375	2,343	6,706	7,399	7,855
Ambulance conveyances	2,095	2,147	2,201	2,190			
A&E Performance against 4 hr target *(Average)*	95.1%	95.3%	94.6%	95.0%	92.7%	95.2%	93.7%

Table 2 – measuring performance against the four-hour target



Compliance with the flu vaccination rate, at DVH, is at the target level.

Financial Support and Winter Programme

As mentioned above, the health economy received £4 million on a non-recurrent basis against specific programmes with the objective of delivering a maximum waiting time of four hours in A&E. Key schemes are as follows:

Integrated Discharge Team (IDT) (£1,518k) *– the most significant of the winter schemes, involves all health and social care bodies in a collaborative partnership to focus on individual patients and their needs, wherever possible avoiding hospital admission and minimising hospital length of stay by providing appropriate services in the community . A Service Level Agreement has been signed by all parties including Kent County Council. One of the first objectives is to halve the number of medically stable patients who are inappropriately occupying a hospital bed from the current level which varies between 60 – 80 patients at any one time and reduce conversation to admission where care can be provided more appropriately in other settings including the patients own home. Although this team is embryonic, the CQC have noted in the recent Inspection of Hospitals, that it was an area of good practice across the whole system.*

Telehealth Project (£300k) *– ensuring that technology is in place to make contact with offsite carers to give safe and appropriate clinical guidance to avoid hospital admission. The technology is being targeted to care homes where referrals to hospital are highest*

Additional acute and community capacity (£1,268k) *– beds have been opened at Elm Court, Dartford. Currently 31 are open, with a further eight planned to open shortly. From December, additional escalation beds at DVH have been opened to meet demand although it is recognised that these are inappropriate.*

A&E Redesign (£560k) *- Additional senior medical and nursing staff are being recruited to ensure that there are sufficient senior staff with the skills to make early clinical decisions, particularly in paediatrics.*

Palliative and End of Life care resources (£225k) and Electronic Palliative Care Co-ordination System (£28k) *– the aim has been to keep people out of hospital where appropriate, especially at the end of life. Additional staff have been recruited to provide a more responsive service in patients' own homes and at the Hospice Inpatient Unit, to admit patients more rapidly as required, the majority on the same day as referred.*

Urgent care app (£50k) *- The Health Help Now app, developed with funding for Medway and Swale, has been marketed in Dartford, Gravesham and Swanley at a cost of some £20k. Further monies will be spent on a survey later this year to evaluate its effectiveness, particularly with the groups with the highest number of attendances at Darent Valley Hospital; young adults (18 to 34) and young children (0 to 4). Printed materials have been produced for other patients who prefer not to use online methods.*

Out-of-hours primary care (£33k) *– this is an investment by IC24 to provide GP primary care services within the A&E department to work alongside A&E staff.*

GP in the Emergency Operational Centre (£50k) – *this is an investment by South East Coast Ambulance Service NHS Trust (SECAmb) for a GP to be located in the call centre to help give advice. Two additional GPs are providing cover for eight hour shifts.*

Hospital Ambulance Liaison Office (HALO) at DVH (£48.1k) - *A HALO rota has been in place since 1 December 2013 providing 16 hours of cover every day and to provide a link between the ambulance crews and the A&E operational staff at DVH.*

Progress reports and key performance indicators (KPIs) are reviewed through the governance structures and, while it is too early to conclude the effectiveness of each scheme, there is evidence that collaborative working is developing, for the benefit of patients.

The financial resources are non-recurrent and, via the commissioning route, decisions about priorities are being developed. However, the Care Quality Commission (CQC) in its recent inspection commended the discharge arrangements for patients requiring multi-agency input, including the recently developed IDT.

Next Steps

The Better Care Fund (formerly Integration Transformation Fund) was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care. The BCF not only brings together NHS and local government resources but also provides a real opportunity to improve services and

value for money, protecting and improving social care services by shifting resources from acute services into community and preventative settings.

Locally, in DG&S, an approach to how the national policy is to be implemented was presented to the Kent Health and Wellbeing Board on 12 February 2014. The strategy looks to:

- Form integrated primary care teams (PCT)
- Establish local referral units (LRU) for crisis support services and Rapid Response
- Use technology to create a single record

In the short term there are three objectives:

1. IDT model expansion – with an objective of reducing hospital admissions by 10 per cent in 2014/15
2. Develop IPCT pilots from April 2014 and expansion across Swale and DGS throughout the year including Local Referral Unit (LRU) reconfiguration
3. Create a real focus on dementia support for patients and carers given the impact currently being seen, eg 32 patients out of 60 with a medically stable diagnosis in DVH have a diagnosis of dementia

It is also relevant to recognise the implications of the report produced in November 2013 by Sir Bruce Keogh, Medical Director of the NHS, which proposes a fundamental shift in the provision of urgent care with more extensive services outside hospital and patients with more serious or life threatening conditions receiving treatment in centres with the best clinical teams, expertise and equipment. Although these issues have already been considered for DVH as most trauma services are now handled by trauma centres, there is a need to audit compliance with the recommendations. All partners are engaging through the Urgent Care Delivery Group to ensure the recommendations are applied in the local health economy.

Nigel Edwards of the Kings Fund has been engaged to run a small number of workshops to help facilitate a joined up approach for the BCF and the provision of urgent care services. These workshops have allowed common goals and methods to be owned by all partners in the community. These workshops have also involved patient representatives.

Conclusion

In conclusion, it is clear that:

- The patient experience of the 2013/14 winter of accident and emergency services is likely to be one of relative satisfaction if the barometer of 95 per cent is used. There have, however, been significant numbers of hospital admissions that have placed huge pressure on Darent Valley Hospital's bed capacity.
- The opportunities presented by the Winter Fund have given a broad expansion of services and investments that have concentrated upon collaborative work across agencies.

- There is significant further work to be undertaken to deliver on the twin objectives outlined in the Better Care Fund and the Keogh Report into Urgent Care Services

Officers of the statutory bodies will be pleased to attend the meeting of the HOSC on 7 March to give clarification and further material in relation to the provision of Accident and Emergency services to the DG&S population.

END

Appendix

NHS England Response to HOSC question for 7 March

What role has NHS England taken with regards winter planning for A&E departments?

In preparation for winter 2013-14 NHS England ensured that each of the clinical commissioning group (CCG) led health economies (North, East and West) had effective winter plans in place.

These were **developed** through the CCG-chaired Urgent Care Working Groups (of which NHS England is a member, together with all providers) and signed off by all members of the group. The plans were aligned with the NHS England South Escalation Framework. These were reviewed locally by NHS England, feedback was provided and good practice identified and shared. The winter monies plans were also developed through these groups.

This ensured that the Kent and Medway Health economies had a shared command and control structure and a commonly understood escalation process and escalation criteria in place for winter pressures right through to major incidents which was understood by all in the economies.

NHS England ensured that the CCGs had completed the same action for the acute trusts (including all of those with A&E departments) that they commission.

NHS England also arranged for all of these winter plans to be tested via a series of three local and one regional exercise. Reports highlighting areas for improvement and good practice were prepared and circulated in time for all organisations plans to be updated before winter. All of these reports were taken to the Local Health Resilience Partnership and reviewed by the KCC Director of Public Health.

All of Kent and Medway's health organisations are represented on the Kent and Medway Local Health Resilience Partnership, which coordinates health planning for emergencies, including periods of significant pressure such as may occur in winter where, for example, this year normal business was disrupted by extreme weather. This group, which is co-chaired by NHS England Director of Operations and Delivery and KCC's Director of Public Health, coordinated a debrief of winter 2012-13. Each of the health economies reviewed their experience of last year to share lessons learned across the whole health economy prior to winter 2013-14.