

Bolton Urgent Care Report of Strategic Review October 2007

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1. Our Vision and Strategy for Urgent care in Bolton

The purpose of this document is to describe a model for urgent care in Bolton and to recommend changes that need to take place to deliver this. This has been informed by national and local evidence, supplemented by the experience of people using and working within local urgent care services. This will ensure that people in Bolton receive urgent care to meet their needs which is both safe and convenient.

1.1. Current Scenario

“On a Sunday afternoon my 81 year old aunt became confused and her speech was slurred. I called the number which was given on our GP’s surgery’s answer phone but the call handler said that they could not deal with it because it was a social problem. I told them that she had had mini strokes before and eventually they agreed to get someone to ring me back, which they did after a couple of hours. It was agreed that a doctor would visit, but I was told that it would probably be in 5-6 hours time. Soon afterwards she became more agitated and so I called NHS Direct. An automated message said that there was a 20 minute wait and when I finally got through to an advisor I was told to call an ambulance. This arrived quite quickly and took my aunt to the A&E department. After an assessment in A&E we were told that she would be able to go home if we could manage, but as she lives alone it was decided that she would need to be admitted to hospital. It then took 7 hours to find her a bed and she remained in hospital for 3 weeks whilst awaiting a community care package to be arranged.”

1.2. Future Scenario

*“At midnight my disabled son had a fit. I telephoned the **Bolton Urgent Care Centre**. After a brief but reassuring discussion, the urgent care advisor arranged for an ambulance to come immediately. We were taken to the children’s assessment area and seen by specialist staff within a few minutes. My son was discharged home after a few hours with some new medication and a follow up appointment was made for a specialist nurse to visit us the next morning”.*

2. Background

2.1 The size of the problem

Bolton is the largest town in the UK with a population of 265,000. In addition up to 50,000 people from areas adjacent to Bolton receive their care from services based in Bolton. Bolton as a whole falls in the top 15% of deprived districts in England, although there is great variation in the levels of deprivation. Much of the central parts of Bolton fall into the 10% most deprived areas in England. People living in areas of high deprivation are much more likely to have poor health, and be much higher users of urgent care. (See Appendix, 1 illustrating Bolton demographics.)

2.2 Frequent Attendances

In 2006, 203,850 people requested urgent medical care. This comprised 102,358 people attending the A&E department (A&E) at Royal Bolton Hospital, 30,726 people attending the town centre walk in centre, and 64,043 people ringing the out of hours GP service with 28,594 (45%) of these attending Landmark house. 29,168 ambulances arrived at the Royal Bolton Hospital in 2006, and 32,826 people were admitted for continued hospital care. 6,723 patients attended for urgent dental care. Many people needing urgent care have one or more long term medical condition that has worsened and most of these people live in deprived areas of Bolton and surrounding districts. (See appendix 2, Urgent Care data)

2.3 What do we mean by urgent care

Within this document we define urgent care from the perspective of the patient and their family. This includes health and social care. Therefore **if a patient perceives the need for an urgent assessment this is urgent care.**

In addition we also refer to emergency care. This is a subgroup of urgent care, but means that the patient's condition needs to be treated immediately and they will commonly access care for this via a 999 ambulance.

Emergency care will require initial treatment within a maximum of 4 hours. Urgent care requires immediate assessment but treatment may not be necessary for between 12 and 72 hours.

Unscheduled care is a term often used to describe health and social care that has not been planned or prearranged.

Out of hours GP care refers to contact with primary care services when the local GP surgery is closed.

A 24/7 service is one that is always open – 24 hours a day, seven days a week including bank holidays. 16/7 is a similar service which closes at night for eight hours.

2.4 Why do we need to change the way that care is currently delivered.

Patients are dissatisfied with the current system and their experience of care (*Which Policy Report, 2006*)

Staff are frustrated that they cannot provide the quality of care they would expect for themselves and their family

The governments NHS plan 2000 introduced a target that 98% of patients presenting to A and E or similar services should complete their treatment or be admitted to hospital within 4 hours (*ref NHS Plan, DH 2000*), and despite numerous changes in practice by different departments and organisations this is consistently not being achieved in Bolton.

The number of people presenting for urgent or emergency care has increased by 24.8% over the last 7 years and continues to increase at a rapid rate. (See figure 1, page 4)

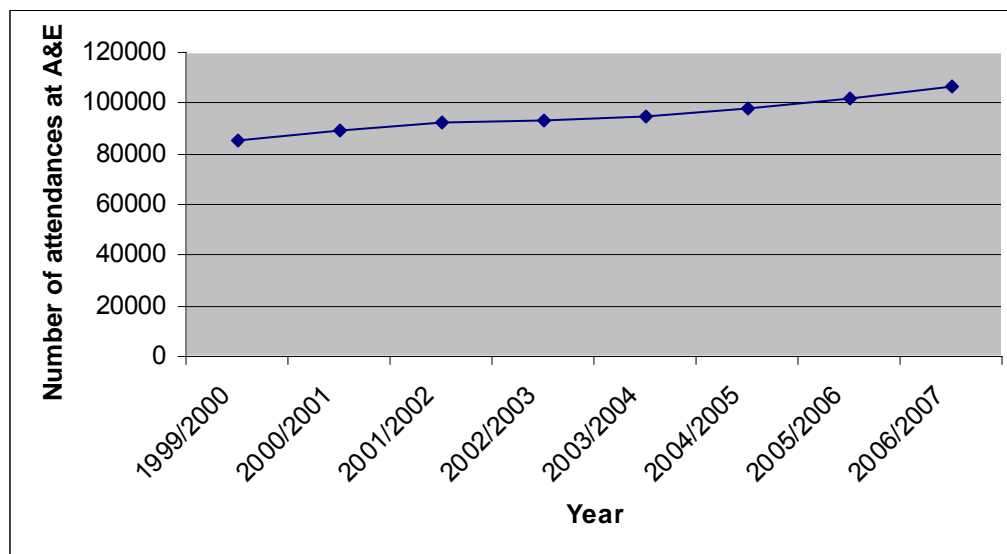


Figure 1 Number of increasing A&E Attendances

The new contract of employment for GPs means that when GP surgeries are closed care is provided by a separate “out of hours service” now managed by Bolton PCT.

The way that doctors nurses and other health professionals are trained, work and are employed has changed significantly in the last few years. In addition the composition of this workforce is very different from the past.

There will be new healthcare facilities built in Bolton that mean that care can be provided in locations other than the hospital in line with government policy. (*Our health, our care, our say, DH 2005*)

Therefore there is both a need and an opportunity to deliver care better to meet the needs of people requiring urgent care.

3. Commissioning of the review of urgent care

The chief executives of Bolton PCT and Bolton Hospitals NHS Trust commissioned a review of urgent care services in Bolton. They asked that this review recommends how urgent care could be improved for the future, taking the above issues into account. (*See Appendix ,3 Bolton Urgent Care Review, Terms of Reference*)

3.1 Core Principles

The six core principles identified by the Department of Health, *Direction of Travel for Urgent care: a discussion document 2006*, are built into this review.

1. My **voice** as a service user or carer is clearly heard
2. I **know** how to access services if I have an urgent care need
3. If I have an urgent care need I can access care **quickly and simply**
4. My **safety** is paramount to everyone who cares for me
5. I can **rely** on getting the right care (including support for self care), **whenever** I need it and **whoever** I am
6. The care I receive meets my needs **appropriately, taking account of the urgency and value for money**

3.2 What has been done during the review?

Terms of Reference for the review were agreed by chief executives of Bolton PCT and Bolton Hospitals NHS Trust in May 2007 (see *Appendix 3*)

An external expert review team examined care at Royal Bolton Hospital in June 2007 and an action plan from this external review was agreed in August 2007. (See *appendix 4, Review of Emergency Care Pathways across the Bolton Health Community*)

Many changes to care and processes are already being made as a result (*appendix 5, External review action plan*)

Over 100 people including patients, practitioners and managers from across the Bolton Health economy took part in workshops during August 2007 that examined current care, and desired future care. (See *appendix 6, Workshop attendance list*)

A public workshop was also held in September exploring concerns and desires for improved urgent care for Bolton people. (See *appendix 7, Workshop attendance list*)

30 people from across Bolton health and social care spent 6 days doing a detailed examination of current care processes at times of urgent care need. This included community and hospital based health and social care in order to identify duplication and waste. They explored a joint vision of high quality, waste free, urgent care for the future and agreed what can be achieved in practice by 2010. The early steps that can be taken to improve care immediately and make a significant impact by winter 2007/8, were also identified and agreed. (*Appendix 8, VSA Attendance list and appendix 9, Issues arising from the Value stream current state analysis*)

3.3 This report

This document sets out the evidence obtained during the review of urgent care services and makes recommendations for a model of urgent care that will meet the core principles set out above, and the changes that need to take place to implement it.

4. Current Urgent Care for Bolton

Care and access to urgent care is confusing and complex for patients and professionals consequently A&E is the default. Urgent care is often a result of failure of planned care to deliver. (See appendix 2, appendix 9 and figure 1, page 9)

If a patient perceives a need for urgent care, they may take a number of routes. Many will contact their general practitioner and receive an assessment there. Often an appointment to meet patients' expectation of need cannot be given, as a result the patient chooses to access care via another route. Most commonly this is via A&E at Royal Bolton Hospital. They could also choose to go to the walk in centre at Lever Chambers, but many people are not aware of its existence or function.

If the GP or practice team recognise the need for other urgent care services then they have to contact the appropriate service. There is not a widespread knowledge of all of the services available to general practice teams. A number of phone calls may need to be made. It is often easiest to arrange admission to hospital, call an ambulance or ask patients to attend A&E.

If the patient requires assessment by a specialist team, but not necessarily admission, there are few services that are designed to respond quickly to meet this need and no easy method of access to them. Hospital admission is therefore the safe option for general practitioners.

If the patient requires hospital admission the GP will telephone "GP direct", but will then be passed to another speciality, this may be medical or nursing staff, but serves little function as patients are admitted anyway.

If the patient attends A&E, some will be taken by the paramedics directly into the resuscitation room where they receive immediate medical care e.g. a patient who is unconscious or fitting. A much larger number of patients arriving by ambulance are called "major cases" of which over 30,000 a year are assessed and wait on a trolley for medical assessment. Some of these patients have considerable delays as they wait for doctors to see them for tests such as x-rays. Each year around 21,000 patients need specialist assessment or admission to hospital. There is a significant delay until specialist opinion is achieved. Sometimes, when demand exceeds capacity these patients can wait a long time for a hospital bed to become available.

For some patients who require social or community medical care they are transferred to the Bolton Community Services Unit (BCU) where they are treated and a package of community care is formulated.

Around 70,000 patients a year have so-called "minor" conditions. These people often have quite serious injuries or illnesses but these are not life-threatening. The treatment for these conditions is usually completed in the A&E department within four hours. This is still too long but delays occur whilst the doctors and nurses attend to "major cases". (See appendix 2)

In A&E and also in specialist departments patients are often seen by trainee staff for a detailed assessment before a final plan of care is agreed with senior staff.

If the GP surgery is closed, patients are advised by answer phone messages to ring the "out of hours" service. There were 64,043 such calls last year in Bolton. After

discussion with an advisor, 28,594 (45%) of these patients are seen by a GP or a specialist nurse. Some are subsequently referred to hospital.

Dental services out-of-hours are less accessible resulting in many people with toothache presenting at the A&E department. However, there is an emergency dental service at Lever Chambers each evening and on Saturday and Sunday mornings. Last year, this service saw 6,723 patients.

Mental health services have regular contacts with patients in the community, many of which are unscheduled. However, most patients with mental health problems out-of-hours present to the A&E department. Again, they can experience long waits for both A&E assessment and for a specialist opinion.

Children are given priority in all of the above services but can encounter the same potential delays as adults. They account for 25% of all A&E patients and an even larger proportion of urgent appointments in primary care. Teenagers can fall between the two systems. There is a new children's unit in the A&E department at the Royal Bolton Hospital which has an integral specialist assessment area.

The Royal Bolton Hospital has 692 beds. Availability of beds in some units can be very limited at peak times. Sometimes this can be because patients have to wait to leave hospital. When this happens patients being admitted cannot be moved to the best area for their care, and those referred by GPs are diverted to the A&E department. This causes further difficulties resulting in more delays in care.

If the patient is very worried they may choose to telephone 999. The ambulance service has to respond to this very quickly. Patients are assessed by ambulance staff both over the phone and in the patients home, but only a limited number of conditions can be treated at home by ambulance staff according to protocol. All other patients have to be taken to A&E.

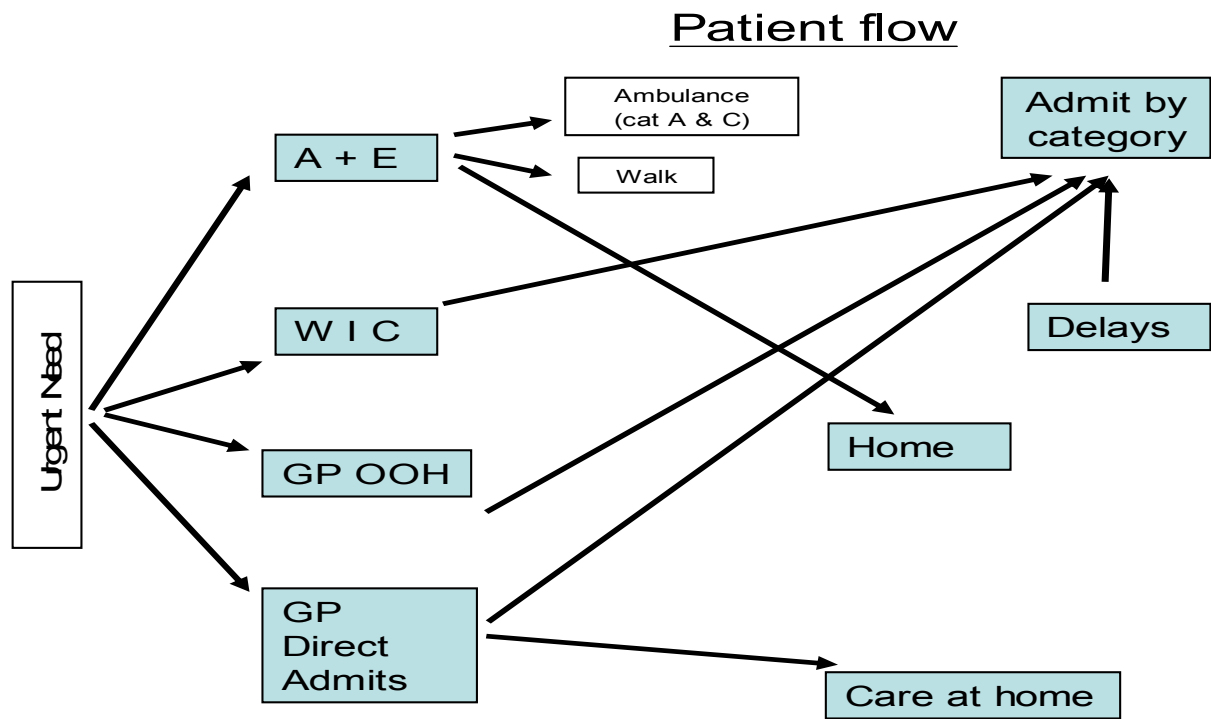
At the walk in centre at Lever Chambers, the procedure is very similar to those patients in A&E treated as "minors", except that facilities are poor and there are no medical staff present and no x-ray facilities available.

Intermediate Care Services for patients who need complex care in the community are accessed by the GP, social services or the hospital (including Bolton Community Services Unit). These services can also become overloaded. Some community services (such as crisis response and "out of hours" district nursing) see patients without an appointment but cannot always meet the needs of patients quickly enough. Some of these patients are therefore admitted to hospital or attend A&E.

Assessment of patients is limited by the availability of relevant medical records in community and hospital settings. Diagnostic facilities are only available on the hospital site; around 60% of patients in A&E need an x ray including around 50% of "minors". Demographic details and clinical baseline assessments are done on multiple occasions repeating work already done, and adding nothing to care.

Availability of transport is a key issue. Patients without their own transport who have been assessed at hospital have considerable delays in being transported home by Patient Transfer Services. Perversely for patients in A&E because of the 4 hour target, some of these may end up being admitted if transport is not available in that time.

Figure 1 Current Flow for Urgent care



In summary, it is clear that currently care is delivered in isolated components. This results in multiple duplications of care and assessment and unnecessary interactions that complicate and delay care. Furthermore it is unclear who is responsible for the overall care delivery.

We do not provide care in a consistent way across the whole healthcare system; different components may not be available at the same time to meet patient need. We do not respond to demand flexibly, even when the pattern is predictable. The complicated way in which care is currently organised makes this more difficult and means that we are not using our resources efficiently.

As a result of the above, the right skills to meet the patients' needs may not be immediately available at the point of access.

Patient information is held in multiple formats and therefore duplicated and repeated, wasting professional time, further delaying care and causing frustration to patients.

Overall:

- Only 20% of the time patients are in a care environment is beneficial to their treatment. Much of the rest of this time is waiting for care or assessment. This clearly affects patient experience, bed availability, and staff morale.
- Complicated care processes mean that the chance of complete care being delivered at the right time, in the right way, first time is typically 1:100.
- Many care processes require up to 100 exchanges of information between carers and could involve up to 30 different people. This delays and complicates the care.

These inefficiencies result in increased length of hospital and community stay, and a poor use of staff and critical resources including beds.

The issues that we have identified in this review are common in the NHS particularly in areas that have a high level of need. (See appendix 9) We have an opportunity in Bolton to greatly improve the care for people with urgent care needs.

We recommend that a radically different model of care is developed to meet current and future patient need.

We also recommend that early actions are taken to address current care processes as outlines in appendix 5 and 11, with robust monitoring of their implementation.

5. Potential models of urgent and emergency care.

The potential models are influenced by NHS policy and the level of funding available. These policies include the need to deliver care close to home whenever safe and possible, and the need for the right staff and equipment to be available in local hospitals or specialist centres to meet patients' needs.

- We could decide to expand the current A&E department at Royal Bolton Hospital to ensure that there is adequate staff to meet all urgent and

emergency needs, and continue with a separate out of hours GP service. Other speciality services would remain as currently configured.

- We could decide to open some “satellite” A&E departments in other locations across the town, and link these to the main A&E department. Some basic facilities such as xray would need to be available in the satellite sites. Again the out of hours GP service would remain separate, and other speciality services would remain as they are.
- We could decide to have the first part of A&E as a GP and walk in service, and incorporate the out of hours GP service into this. Some other areas in the country are planning to do this. Patients requiring hospital assessment or admission would be passed on from this primary care “front end”.
- We could decide to re design the whole of urgent care services into an integrated system that can provide care on and off the hospital site. So that it is simple for patients and clinicians to access care via a single route, whether this is primary, community or any speciality care, and so that specialist staff see the patients straight away whenever possible.

6. Recommended model for urgent care in Bolton

(See appendix 10, Future Care)

We recognise that the majority of urgent care should continue to be provided by GP surgeries. There are other plans and strategies in development that aim to increase the availability of GPs and other members of primary care teams both within current working hours and at other times. These fall outside the scope of this review.

Major changes to urgent care services are required to deliver care when general practice is not available or cannot meet patients needs. We recommend a system of urgent care that will work under a tightly coordinated management structure, have a single care record and provide the right care in the best possible setting in a timely fashion. This would include services currently provided in the community and in hospitals, by Bolton PCT, Bolton Hospitals NHS Trust, Bolton Metropolitan Council and Bolton Salford and Trafford Mental Health Trust.

6.1 Recommended urgent care services

We outline below the key components of the services that we recommend in a future integrated service for urgent care in Bolton.

6.2 Bolton urgent care – The Control Centre

This would be the point of contact by

- all referring clinicians requiring access for urgent care services,
- for patients when their general practitioner is not immediately available.

The control centre would be staffed by urgent care advisors, who will have a level of clinical skills for assessment and a detailed knowledge of local urgent care services.

It would have real time information on hospital and intermediate care bed state, including individual wards and units, on community services and state of activity, and

what is happening at accident, emergency and urgent care centres as described below.

The centre would arrange appropriate urgent care in an appropriate location. It is complimentary to NHS Direct and 999.

The centre would also be able to make appointments for patients in planned care when appropriate, and in rapid access clinics. Specialities must provide access to outpatient clinics for patients with urgent care needs.

The control centre would have agreed trigger points to contact operational managers in all clinical areas of urgent and emergency care, in order to flexibly use staff and facilities to meet the current and predictable needs.

6.3 Ambulance

Paramedics would treat more patients in the community. This would be a move from a transport only service to one of 'care or transit'. (DH 2005)

This means that they would be able to commence initial investigations, make a detailed assessment and arrange the care required. If there is an emergency need for hospital inpatient care, the patient would be moved to the emergency ambulance receiving area at Royal Bolton Hospital. If they can be treated at home that would occur via community services arranged by the urgent care advisors in the control centre, or the patient would be transferred to an Accident, Emergency and Urgent Care Centres.

6.4 Accident, Emergency and Urgent Care Centres

Patients with urgent illness and minor injury would access care at one of two Accident, Emergency and Urgent care centres, one on Royal Bolton Hospital Site and one in Bolton town centre linked to the planned PCT Diagnostic and treatment centre. These centres will have the appropriate facilities including xray and other equipment to help make rapid diagnoses, and skilled staff to make timely assessments. Patient environment should be designed to promote health and self care opportunities.

Patients would be able to walk directly into these centres or would be directed there by the control centre, ambulance services or their GP. The town centre facility would be open for 16 hours per day and the hospital site centre would be open 24 hours per day.

These centres would be staffed by a mixture of nurses, advanced practitioners, GPs and specialists. They would have the skills or access to specialists so that the best care can be given to all patients including children and people with mental health needs. Skill development would therefore be a key element in the implementation of these recommendations. Clinics with rapid access i.e. same day or next day appointments for a number of conditions should also be held here by appropriate specialist staff. Care would be designed to flow through the system to avoid duplication and rework and give a positive patient experience. These would be important considerations in the facilities design.

Patients with eye problems, currently 5% of A&E attendance, and those with mental health needs could be directly transferred to emergency areas of those departments.

There would be direct access from these centres to

- outpatient speciality assessment
- inpatient speciality assessment or admission.
- an observation and extended assessment area which would fulfil the functions of the current BCU and allow observation of patients for short periods of time i.e. up to 24 hours.
- community urgent care services
- emergency receiving unit at Royal Bolton Hospital.

They should have their own transport system to enable timely access, transfer and discharge.

6.5 Emergency Hospital Care

There would be an emergency receiving unit at Royal Bolton Hospital.

Patients would only be received by emergency ambulance (999), from referral from the Accident, Emergency and Urgent care centres, or via the control centre.

The function of the emergency receiving unit would be to stabilise the patient and have immediate access to appropriate specialities and diagnostic facilities. It would not be a holding area. Patients would be seen by senior staff who would have more junior colleagues working along side them.

For some patients with obvious diagnoses, an assessment by urgent care staff does not contribute any useful additional value. These patients should be seen immediately by a specialist in that location.

6.6 Speciality inpatient care

Wherever possible patients requiring hospital admission should be admitted direct to the speciality area that they require as arranged by the control centre or the Accident, Emergency and Urgent care centres.

Those specialties that receive large numbers of patients e.g medicine and surgery should have a receiving area which is integrated with the emergency receiving unit. Patients will be seen initially by senior staff who can make decisions to implement the care needed.

The emergency receiving unit and speciality units will have direct access to the observation and extended assessment beds. Access to community urgent care services would be via the control centre.

Inpatient capacity (beds and staff) should be planned to allow flexibility to meet needs. This would require an 85% average occupancy rate to cope with expected variation in requirements. This occupancy rate has also been shown to facilitate flows in almost all systems and also to reduce infection rates in hospitals.

6.7 Flow through the hospital system

Detailed planning of the capacity required for inpatient care in different specialities and sub-specialities should inform the design, use of inpatient facilities and staff availability. Flexibility between speciality areas and staff which can be coordinated by the control centre would also be vital.

All urgent inpatient care services will need to operate 7 days per week including bank holidays, and many will need to introduce 24/7 practices.

Capacity planning will also need to incorporate plans for elective inpatient care.

6.8 On the way home from hospital

Enabling patients to return home, when it is safe and appropriate to do so, in a planned timely fashion is crucial to enable the best use of staff and other facilities. There is considerable room for improvement in ensuring that care occurs without delay, and that patients return home at the appropriate time. Non medical staff should have authority to discharge patients as per care plans.

Implementation of the proposed model must include a detailed review of discharge processes and a number of additional changes in practice will be needed.

Immediate electronic communication to the patients' general practitioner at the time of discharge from all urgent care services must also occur, to ensure continued care and prevent unnecessary readmission.

6.9 Community Care

Current community based urgent health and social care teams should be integrated into single teams. These combined community teams could work from a small number of locations across the borough and would deliver responsive and immediate care packages for patients at home and in community settings as appropriate. They would be accessed via the control centre. They would have direct access to urgent and emergency care facilities, observation and extended assessment beds, intermediate care, and inpatient speciality beds. A night service will cover these needs for the whole borough and ensure patients are safe until further assessment.

6.10 Patients with long term conditions.

People with long term medical conditions should have a personalised care plan which includes what to do when their condition worsens. They would also have a named contact who coordinates their care. Depending on the complexity of their condition this would be a member of the primary care team, or specialist team. Patients with multiple complex conditions would have an active case manager, who should work as part of the primary care team. When their condition worsens patients would alert their named contact.

Specialist services should provide telephone cover outside normal working hours, to advise patients and staff in urgent care services.

Rapid access for patients into specialist outpatient services should also be planned in all specialities.

6.11 Management of urgent care services.

Whilst services will continue to be provided by multiple agencies it is essential that there is a coordinating management function of urgent care services in Bolton. All providers of urgent care should have shared values and shared responsibility for the effective delivery of quality care that meets and exceeds national targets. This coordinated management should have delegated authority from the key providing organisations to develop, deliver and continuously improve urgent care.

It is key that there is a designated clinical lead for urgent care, and an overarching operational management leader within the coordinating management team. Members of all key providing groups would be in a coordinating management team that should include nursing lead, GP lead, diagnostic lead, administrative lead, and a member of ambulance services, mental health services and social care services.

7. Recommendations

7.1 An implementation team should be appointed as a matter of urgency to ensure delivery of the immediate changes in care that can take place, including the winter plan for 2007/8 and continued implementation of the recommendations of the external review (*appendix 5 external review findings and appendix 11, Implementation Plan*)

7.2 A clinical lead for urgent care across the health economy should be appointed as soon as possible with designated managerial support.

7.3 An Urgent Care Partnership Board should be established to include senior accountable officers of all partner organisations

7.4 A project board should be established to oversee the delivery of a new model of urgent, with a full time project manager.

7.5 The new model of urgent care in Bolton should include:

- A control centre staffed by urgent care advisors for telephone access to urgent care services for patients and practitioners, and with a coordinating function to manage capacity.
- Ambulance staff providing as much care within the community as needed, and transferring patients requiring additional care to the appropriate facility.
- Two Accident, Emergency and Urgent Care Centres for patients with urgent illness and minor injury, with integrated urgent care and specialist staff and with diagnostic facilities. One would be in the new PCT Diagnostic and Treatment Centre and one on Royal Bolton Hospital site.
- Rapid access speciality clinics.
- Direct transfer of patients to speciality departments for urgent care.
- An emergency receiving unit at Royal Bolton Hospital to stabilise patients before speciality care, and immediate assessment by senior specialists.
- Speciality receiving areas integrated with the emergency receiving unit.
- Observation and extended assessment beds.
- 85% average occupancy of urgent care beds.
- Planned flexibility of staff and facilities to meet changes in demand.
- 7 day per week inpatient urgent care services, with extended 24/7 working.

- Improved discharge planning including non medical discharge, and immediate electronic communication with GPs
- Combined community health and social care teams working from a small number of locations 24/7
- Personalised care plans including for exacerbations for patients with long term conditions, with named care coordinators and access to specialist advice outside normal working hours.
- Integration of active case managers into primary care teams

7.6 The project board should ensure

- A clear communication plan to ensure full consultation and engagement on the new model of care.
- A review of current and future workforce requirements, including skills and competencies.
- Development of training of current staff to meet the anticipated needs.
- Examination of internal and external capacity to develop and deliver the training.
- Detailed costing of the proposed model of care.
- Detailed modelling of inpatient capacity at Royal Bolton Hospital, and in intermediate care to meet urgent care needs and flows.
- Further work on coordinated discharge planning.
- Agreed funding to implement the changes.
- Agreed financial flows to support the organisations involved in care delivery.
- Coordination of the estates review of Bolton PCT and Bolton Hospitals NHS Trust to design care facilities and agree timelines for service changes
- Performance standards are developed and agreed to monitor the changes in care and their effect. These should include

National performance measures such as percentage of patients seen and treated within 4 hours

Patient experience of urgent and emergency care

Staff satisfaction

Emergency bed days

Emergency attendances to hospital and non hospital sites

and should be put in place as soon as possible to continuously monitor improvements in care as these recommendations including the early actions are implemented.

Appendices

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Demographics of Bolton population

Appendix 1

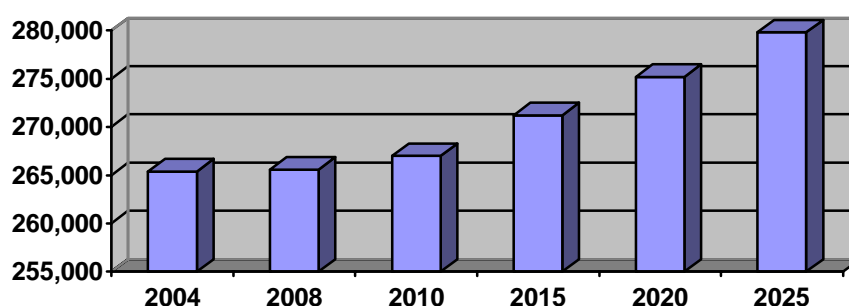
1. Number of residents

Mid 2004 population estimates

Total:	265,400
0-15 years	55,400
15-64 years	163,500
65+	46,500

The graph below illustrates the expected growth of population is set to over the next 20 years. The largest increase will be in the over 60s, in particular the over 85s, whereas there will be fewer people under the age of 20.

Population estimates

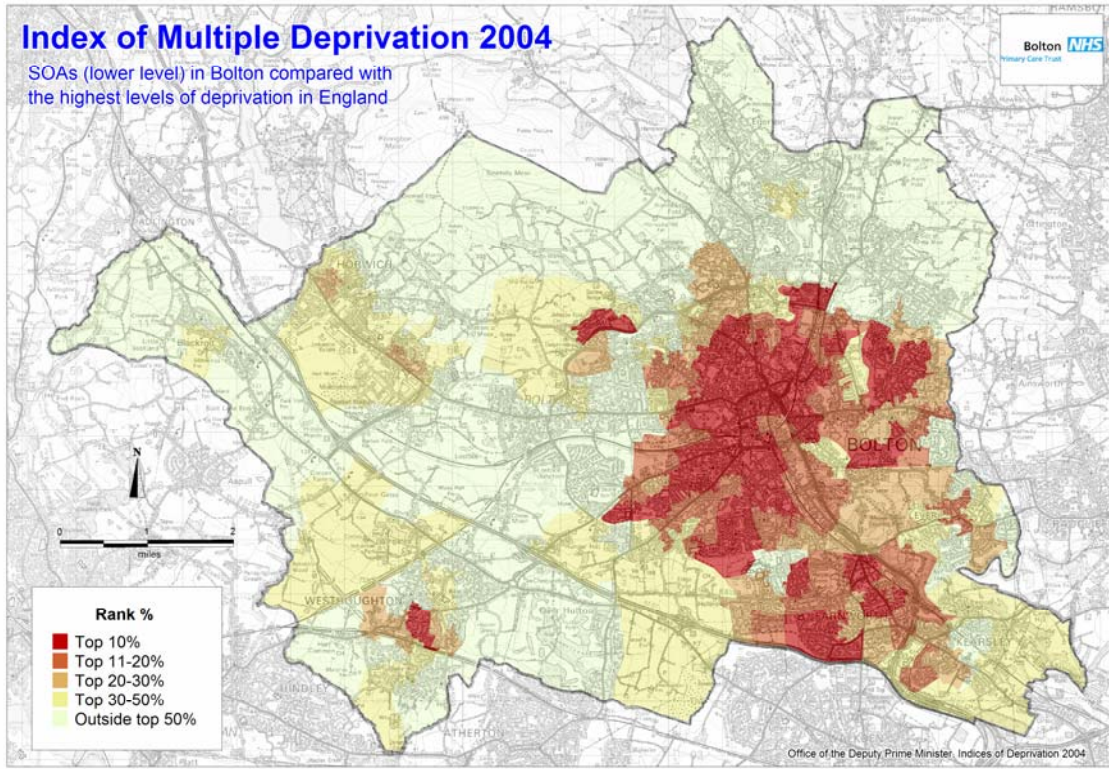


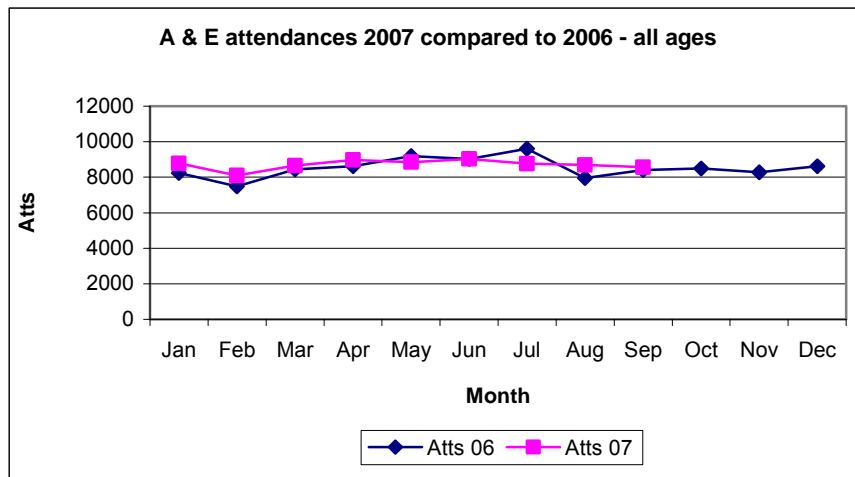
2. Ethnicity

Just over 1 in 10 people in Bolton (11%) state that they are from a minority community, which is slightly more than England (9%). The largest minority community in Bolton is the Indian which accounts for 6.1% of the population. The main concentration of black and minority ethnic communities (BME) are around the town centre. The BME population in Bolton has a young age profile, with almost a third being aged under 16, compared to 16% of the whole Bolton population.

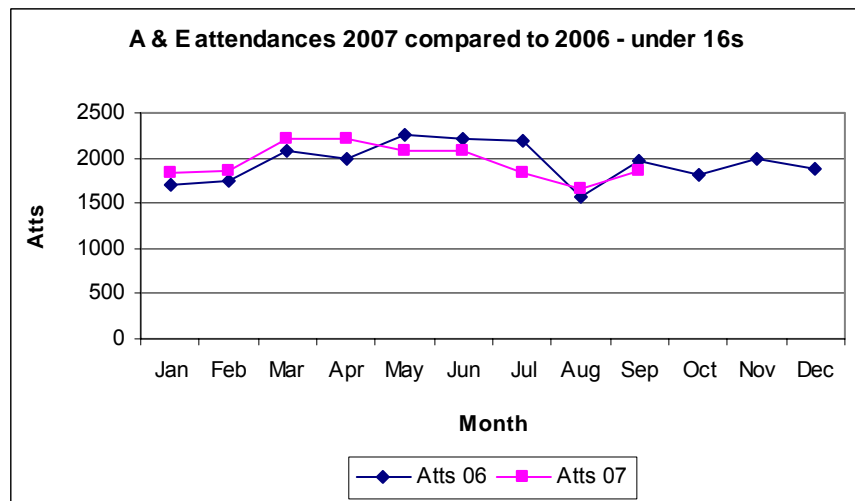
3. Deprivation

The map below illustrates the variation in Bolton between areas of relative affluence and high deprivation. It can be seen that areas around the town centre have levels of high deprivation when compared to the rest of England, as do several pockets outside of the town centre. The majority of Bolton falls within the top 50% most deprived areas of England. The indices of Deprivation draws upon data from 7 domains of deprivation (income, employment, health, education, barriers to housing, crime and living environment).

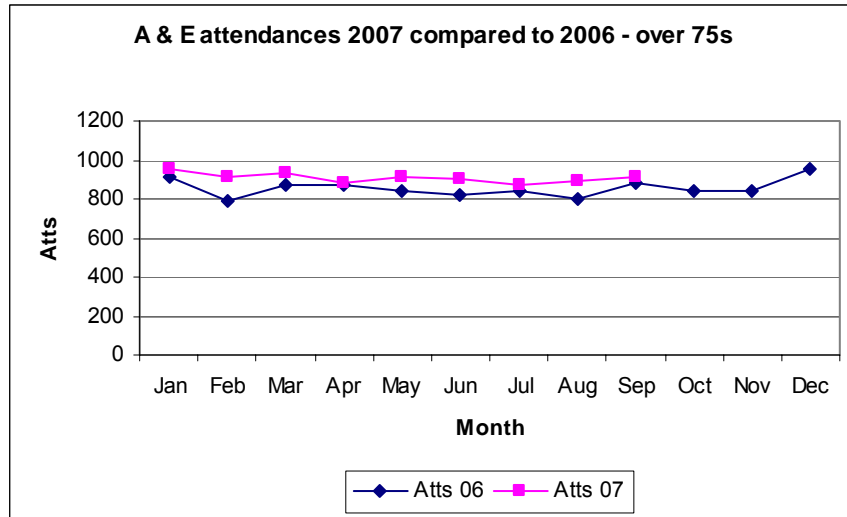




A & E activity for all ages have been generally higher in the first four months of 2007 compared to 2006 with the exception of July, as illustrated by the above graph.



The above graph looks at admissions to A & E for patients under the age of 16. During the first four months of the year, attendances followed the pattern for all ages above although activity appears to have dropped a little as the summer progressed.



The third graph for A & E attendances looks at elderly patients aged 75 and over. Attendances started to increase at the end of last year and the trend has remained relatively high in 2007.

A & E attendances by arrival mode

Arrival mode	Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Private Transport	2006	5841	5346	5985	5979	6584	6512	7156	5771	6139	6053	5910	6013	73289
	2007	6139	5634	6303	6493	6480	6527	6429	6352	6168				56525
Ambulance	2006	2326	2076	2322	2365	2276	2168	2290	2101	2114	2281	2236	2532	27087
	2007	2506	2304	2200	2347	2232	2418	2213	2213	2223				20656
Walk In	2006	8	10	8	10	16	6	13	6	8	26	20	12	143
	2007	10	11	9	4	8	14	7	9	8				80
Not Specified	2006	42	36	83	242	287	326	118	58	118	94	69	23	1496
	2007	92	128	120	92	112	45	83	76	149				897
Others	2006	30	18	33	24	26	28	30	25	27	35	35	32	343
	2007	39	16	24	38	18	21	22	33	18				229

Others include patients brought in by police, public transport or helicopter - these are small numbers

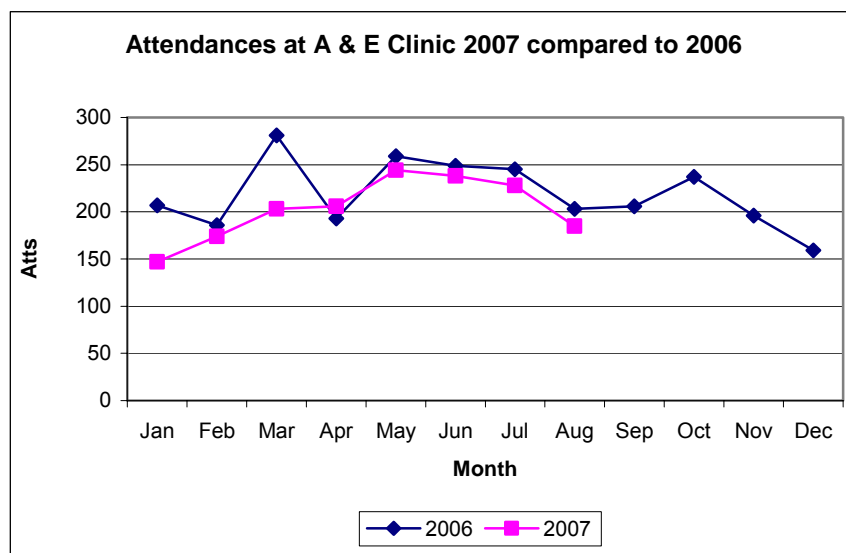
The above table shows attendances at A & E by arrival mode by month for 2006 and 2007. Most people arrive at A & E by private transport, followed by ambulance. The number of people walking into A & E is relatively small. The figures for admissions by private transport and ambulance are higher this year than at the same stage in 2006, while other admission sources are similar.

A & E attendances by arrival mode - under 16s

Arr mode		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Private Transport	2006	1511	1522	1790	1690	1914	1896	1928	1356	1704	1543	1720	1629	20203
	2007	1581	1622	1931	1905	1827	1816	1616	1457	1599				15354
Ambulance	2006	186	211	256	229	245	215	232	193	218	237	249	236	2707
	2007	227	207	247	273	218	247	205	176	224				2024
Walk In	2006				1	1					4	3		9
	2007	1		2	1		1		1					6
Not Specified	2006	8	9	24	65	98	93	23	13	40	23	24	6	426
	2007	26	30	29	26	34	11	22	13	38				229
Others	2006	1	1	1	1	0	2	3	0	0	1	2	1	13
	2007	1	2	4	6	1	0	2	2	0				18

Others include patients brought in by police, public transport or helicopter - these are small numbers

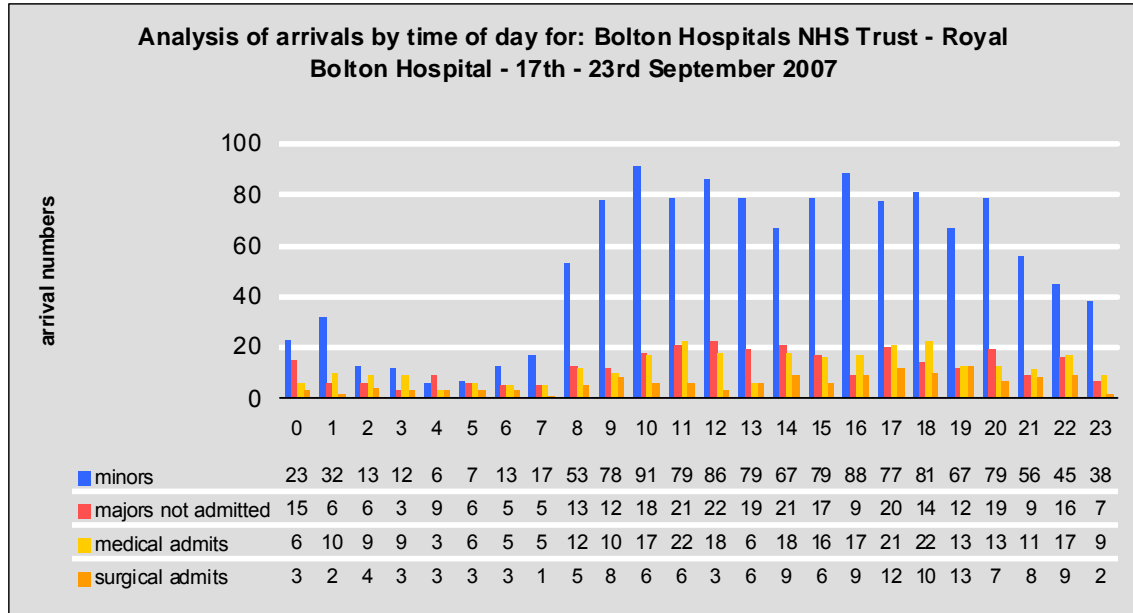
The table above shows paediatric attendances at the department by arrival mode. The proportions of children arriving privately, by ambulance, etc. reflects a similar overall pattern to all ages.



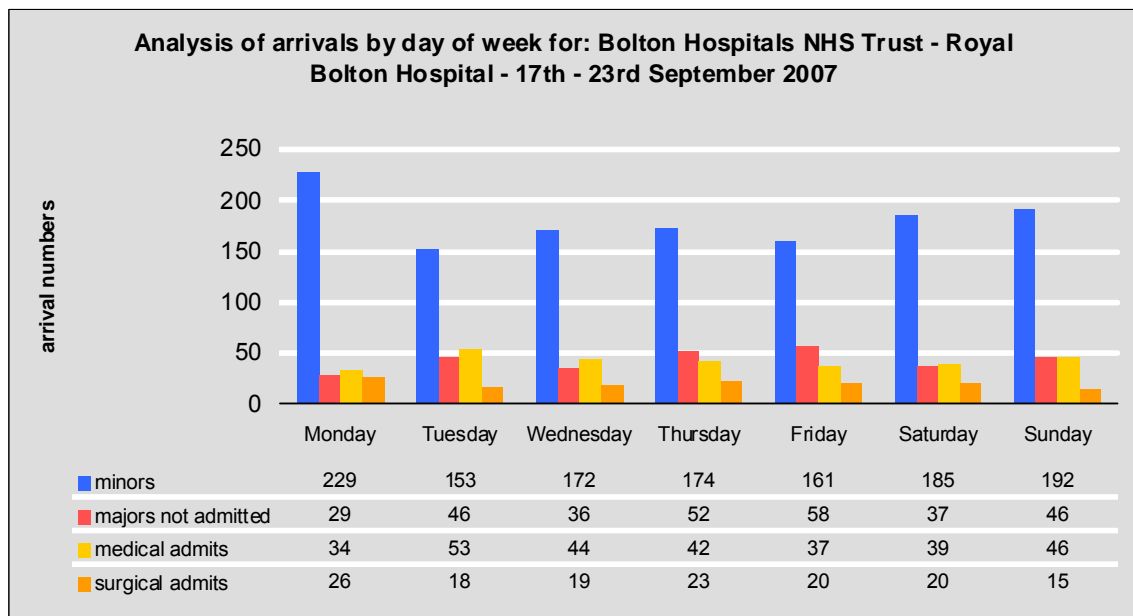
Monthly attendances at the A & E Clinic are shown in the above illustration. Generally the trend in 2007 to date is downwards compared to 2006.

A & E Analysis Charts – 17th-23rd September 2007

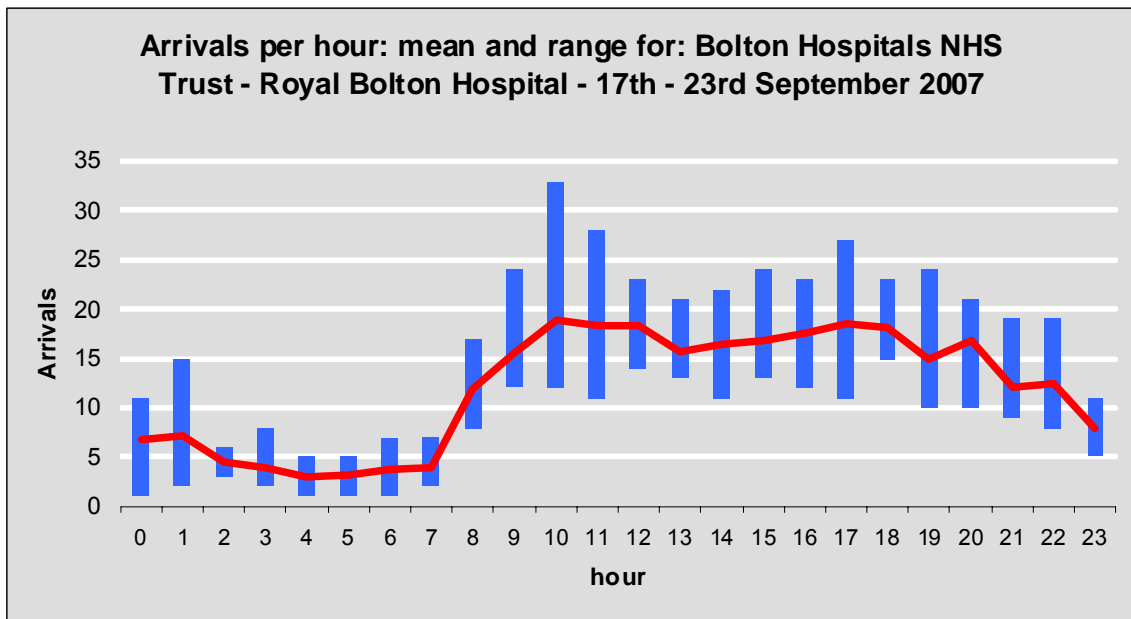
The following charts show information from 1 week activity at A&E, and although it illustrates some trends it should be noted that it is a snap shot only, and does not necessarily reflect an accurate trend analysis.



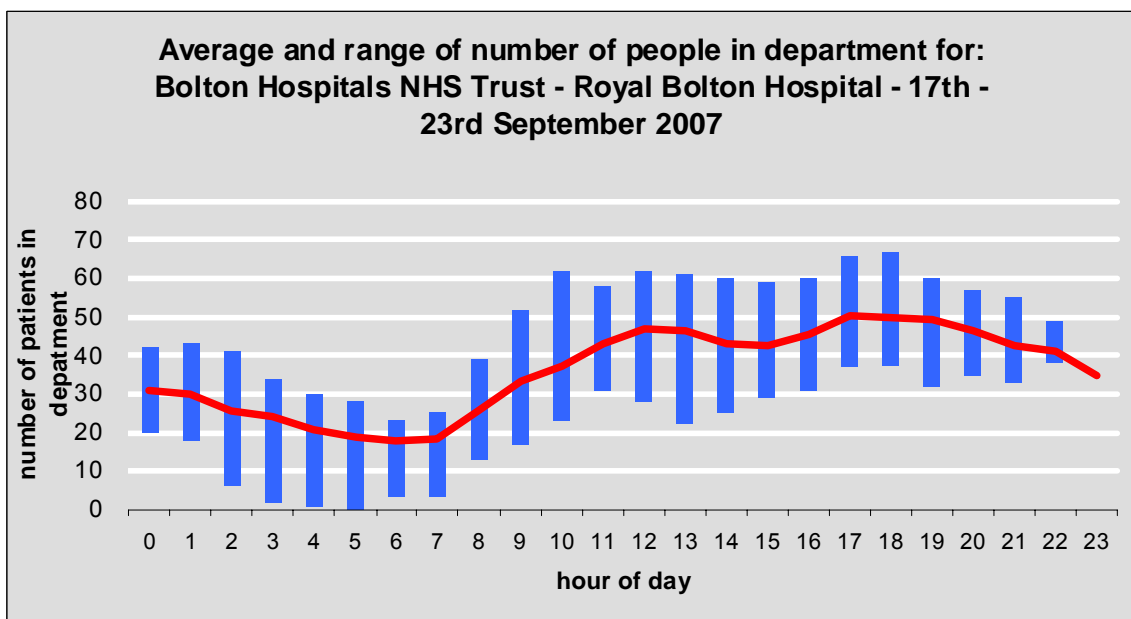
The above chart shows the variance in arrivals throughout a 24 hour period. The busiest time period is between 8am and 9pm, with the quietest time between 2am and 7am. During quieter periods there is a higher percentage of majors than minors.



The above chart shows the variation on attendance during the week, with the greatest attendance on Monday. There are variations within the week in the type of attendance, with minors tending to peak Friday through to Monday and admissions remaining relatively stable, with the exception of a rise on Tuesday.



The above chart shows the average number of arrivals over a 24 hour period by hour. It highlights the range in number of patients who arrive in the department. At peak, there were over 30 patients arriving in 1 hour.



The above chart shows the total number of people in the A&E department by hour over a 24 hour period. It highlights the length of time some patients experience as part of their care in A&E, and pressure points over the day. At its peak over 60 patients can be in the department and this level of occupancy can persist for over 10 hours with attendant carers and relatives also in situ.

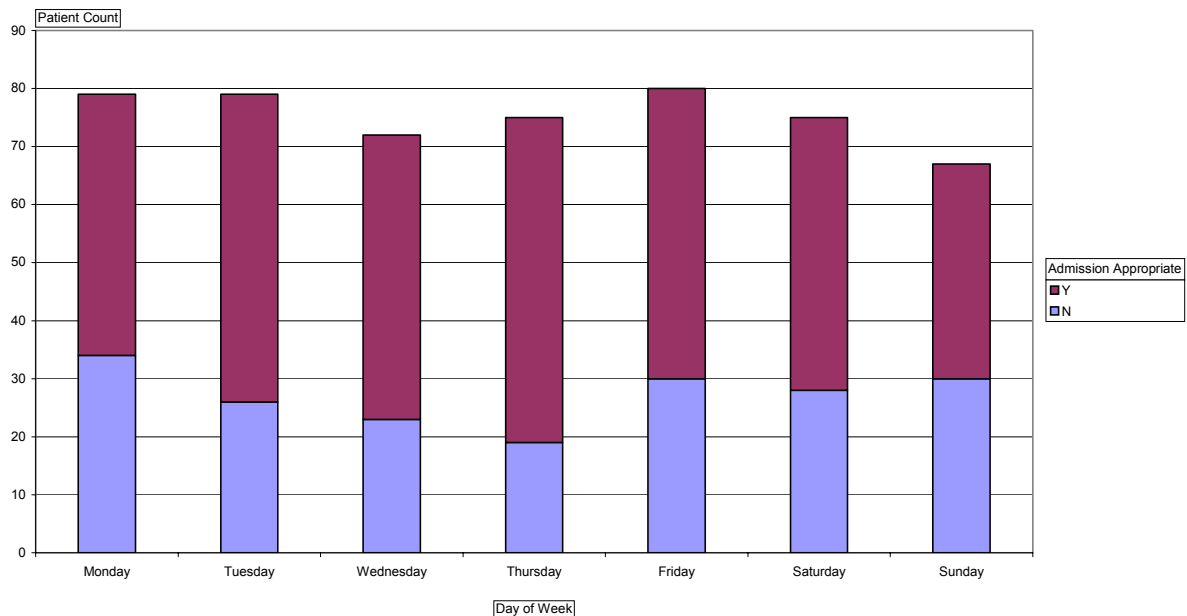
Appropriateness of admissions

During the 2 week review period in 2006, there were a total of 525 emergency admissions. 64% of these were considered appropriate. Appropriateness is defined by an agreed level of both intervention and care received by the patient during their inpatient stay, and is calculated by and standardised across the NW by the utilisation management service.

In terms of timescale, the highest number admissions occurred on Fridays, closely followed by Mondays and Tuesdays. The hours between 9 am and 9pm also saw the greatest number of admissions, although overall there was no difference between the appropriateness of admissions.

Trust Site | ROYAL BOLTON

Number of Patients By Admission Appropriateness By Day of Week



Looking at age and sex, more admissions occurred in the over 70s and women. In terms of appropriateness, as age increases the admission is more likely to be appropriate, with the exception of under 16s. Although women are admitted more frequently, there are more appropriate admissions for men.

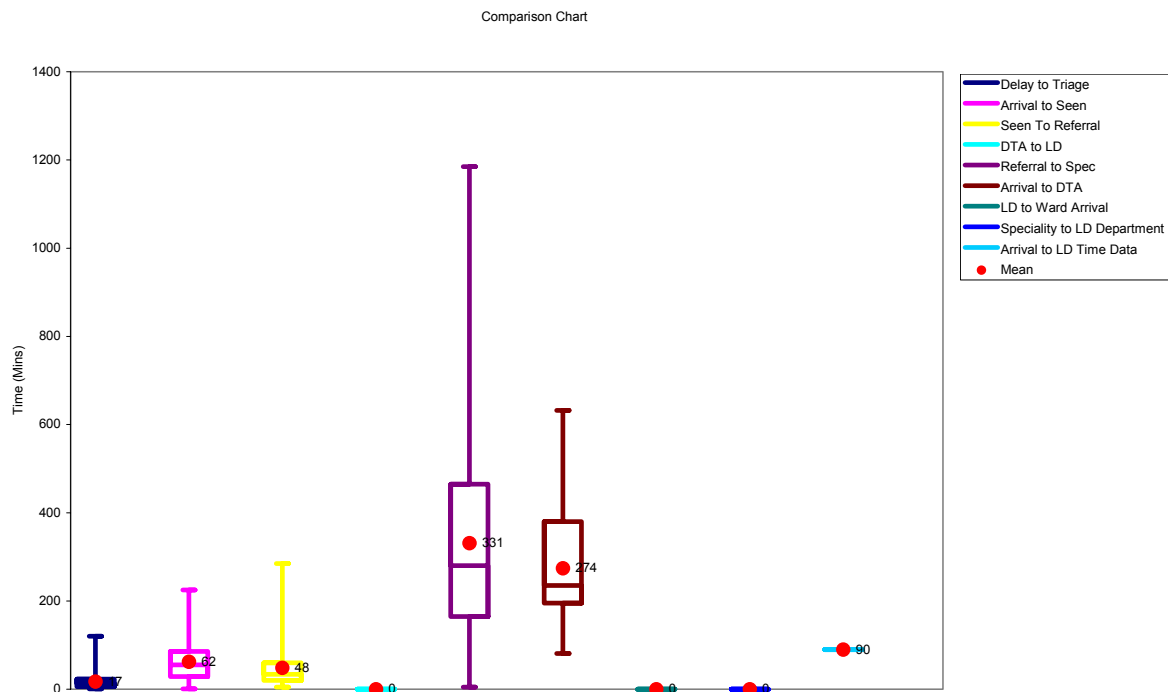
There is a wide variation between both GP practices and Consultants in both the number and appropriateness of admissions, with the highest number of inappropriate referrals at 60%.

The top 3 reasons for admission are ischaemic heart disease, digestive disorders and respiratory diseases. In the 2 week period these accounted for 149 admissions, with approximately 20% being inappropriate.

There is a difference in the appropriateness of admission depending on the initiation of the referral. The main two groups are GP and self initiation, with the former initiating fewer admissions, but with greater appropriateness.

Delays in care

The major delays in care are from the time of referral to speciality until seen, and in decision to admit.



(Appendix 3)

Bolton Urgent Care Review:

Terms of Reference

1.Task

1.1 To review the provision of Urgent Care services in Bolton focussing on the Urgent Care services to be provided on Royal Bolton Hospital site and in a new Bolton Diagnostic and Treatment Centre in the context of services across the Bolton Health Community, taking account of:

- Existing demand and acute, community, primary care and Local Authority service provision;
- Planned improvement in Paediatric A&E services;
- Planned increases in Primary Care Resource Centre capacity (in particular changes in the use of District Nurse treatment rooms and increased local Walk In capacity);
- Planned provision of Diagnostic and Treatment Centre capacity (in particular the increased potential for minor injuries within an expanded Walk in Centre in Bolton Town Centre);

1.2 To recommend key change requirements, specifically:

- Process improvement within existing services on the Royal Bolton Hospitals site and between acute, community, primary care, and Ambulance services on and off site.
- Additional service or capacity requirements including in intermediate care.
- Estate improvements which could enable improved service

1.3 To use LEAN techniques in order to structure process review, and to take expert clinical, estates and other advice as appropriate in order to develop a clear model of care for people with urgent care needs.

(The review will assume but not examine an underlying level of self-care and urgent care that is undertaken in General Practice.)

1.4 To consider and prepare an immediate action plan for performance improvement arising from the recommendations of an Initial Review Team established by Bolton PCT Director of Commissioning that is to report by end of June 2007.

2. Membership

2.1 Project Leader.

John Dean, Medical Director Bolton PCT

2.2 Project Director.

Ian Lurcock, Divisional Manager Bolton Hospitals NHS Trust

2.3 Clinical Advisor.

Chris Moulton.

2.4 Project Manager.

Martin Reddy.

Other members, as determined by the Project Leader.

3. Resources

3.1 Bolton Primary Care Trust will dedicate at least 20% of John Dean's time during the review.

3.2 Bolton Hospital NHS Trust will dedicate at least 20% of Ian Lurcock's time during the review.

3.3 Bolton Primary Care Trust will dedicate at least 50% of Martin Reddy's time during the review.

3.4 Bolton Primary Care Trust will fund extensive LEAN support from an appropriate external consultancy to be agreed between Project Director and both Chief Executives. (Budget to be endorsed by Bolton PCT Following firm proposals and costs)

3.5 Finance and Secretarial support to be provided by Bolton PCT, Personnel and Procurement support by Bolton Hospitals NHS Trust.

4. Key partners

4.1 The review will work with the following key partners to achieve a wide consensus on the way forward:

Bolton Primary Care Trust
Bolton Hospitals NHS Trust
North West Ambulance Services NHS Trust
Bolton Metropolitan Council
General Medical Practices in Bolton
Out of hours medical services (CMEDs)
Voluntary Services related to acute care needs
Representatives of patients and public

5. Output

5.1 Two written reports will be presented to the Chief Executives of Bolton Primary Care Trust and Bolton Hospitals NHS Trust.

5.2 An initial interim report based on the findings and recommendations for the Initial Review Team (*see 1.4 above*) will set out an action plan to implement those recommendations that are accepted and respond to any recommendation not accepted.

5.3 A final report will:

- describe the current position,
- describe an appropriate model of urgent care for Bolton,
- make firm recommendations for improvements in Urgent Care service with a view to maintaining a maximum 4 Hour A&E wait for at least 98% of A&E attenders and attaining an appropriate model of urgent care.

recommendations will cover:


- medium term (eg subject to staff recruitment) and;
- longer term (eg subject to estate development) actions.

(see also 1.2 above)

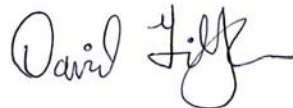
6. Timescale

6.1 The initial interim report will be presented to both Chief Executives by 31 July 2007.

6.2 A Final Report to be presented to both Chief Executives by 1 October 2007.



Tim Evans
Interim Chief Executive
Bolton PCT



David Fillingham
Chief Executive
Bolton Hospitals NHS Trust

Emergency Care Project Team

The review team comprised of the following individuals:

Ms Lis Nixon

Mrs Catherine McLaughlin

Dr Simon Walford

Mr Richard Bowen

The team members have worked in emergency care at an operational and executive level. The team formerly worked with the National Emergency Care Support Team at the Department of Health and have extensive experience in reviewing emergency care pathways.

INTRODUCTION

Bolton PCT commissioned the review of emergency pathways. This report reflects our findings following diagnostic visits carried out on 13th and 14th June 2007 at the Bolton Hospital site.

The report is presented in the following format:

- Introduction
- Scope of report
- Data and patient flow
- Emergency department
 - Minors
 - Majors
 - Paediatrics
- Surgical Assessment Unit
- Acute Medicine
- Bed Management and discharge
- Clinical engagement
- Primary and Community Services
- Conclusions

The visit comprised interviews with key people, data and information gathering and formal and informal visits to departments. Key personnel from across the emergency care pathway were identified for us to meet. We would like to acknowledge the welcome we received and thank all that we met for their input into helping the team understand how emergency care is delivered.

SCOPE OF REPORT

Our commission was to determine what the issues and blockages are to 98% of patients who attend the Emergency Department being seen and either admitted, discharged or transferred within four hours across the Bolton Hospital Trust.

We reviewed the whole emergency care pathway in as much detail as was possible within the tight time framework and tried to capture all the key factors and influences across the system.

DATA & PATIENT FLOW

Data about the flow of patients into medicine is poor and efforts should be made not only to use historical data for more effective capacity planning but also to systematise the real time tracking of patients and capacity in the system across the whole community. This may require some investment but a safe and reliable pathway is unlikely to be sustained without better operational data. Some of the “wisdom” driving the culture, for example, about avoidable admissions is appears to be based on very limited data and we could not find any significant evidence of the links to Utilisation Management Reviews.

The models being used to determine the capacity of BCU, Acute Medical receiving and acute medical short stay have little quantitative justification. The capacity of the short stay (48-hour) acute inpatient unit proposed in the current reconfiguration is, correctly, recognised to be small. If it cannot meet its proposed contribution to the pathway, there is a risk that receiving functions will become congested and degraded. The risk should be recognised and a plan should exist to enlarge the short stay unit because the principles on which the current acute service reconfiguration has been based are very sound and work very effectively elsewhere. As a rule of thumb, the number of short stay (48-hour) beds should be roughly equal to the number of assessments performed each day. The risks could be significantly mitigated by avoiding the use of the short stay beds for programmed investigation (which most hospitals would manage in the endoscopy/day-case unit) and by avoiding boarding of surgical patients.

The clinical leadership and team working we saw in the acute medical service is most encouraging. The organisation of medical staffing around the many pressures is prudent and plans to invest in acute medicine as a specialty have been well developed. Nursing roles are developing and the operational relationships with other specialist teams are generally good. Waiting for specialist opinion is not a significant cause of delays. However, there are signs of tension between the acute medicine service and the rather slower modernisation of clinical process in the Emergency Department. We are concerned that the separate culture of development by clinical teams now based in the PCT clearly has some very exciting potential but at the price of some deterioration in clinical collaboration across boundaries which in many communities are becoming more blurred rather than harder edged as seems the case in Bolton.

Infrastructure support from portering, secretarial services, diagnostics and even the generally excellent social work provision needs to be more effectively incorporated into the effort to achieve prompt and high quality clinical assessment of all patients presenting at the hospital.

The clinical leaders in the hospital trust have done a really effective job of making length of stay data available to wards and clinical teams, of encouraging the vital daily review of all inpatients by senior clinicians and by encouraging more effective discharge planning. The level of commitment shown by the local authority to the social aspects of patients' needs on discharge is also considerable and should not be undervalued. Whilst there is still room for improvement, this health economy has benefited enormously from the concerted effort to reduce the length of inpatient stays and by the promotion of novel and effective health and social community care programmes. There is a danger that clinical relationships and the potential for even greater hospital and community teamwork may be compromised by the lack of shared values and goals in the organisations managing the use of resources.

EMERGENCY DEPARTMENT

Having spoken to a range of clinical and operational staff during our visit, it was very apparent that overall patient experience and clinical care within the Emergency Department had deteriorated markedly over the last 2-3 years despite a number of initiatives being instigated by the Trust and PCT to address the emergency care standard.

Over the last 12 months in particular, the ED has seen a marked decline in performance which has largely been attributed to accessing timely bed capacity or delays in clinical assessment. Whilst the former has undoubtedly been compromised by bed reductions and a corporate emphasis prioritising delivery of the 18 week standard, the organisation and leadership within the ED is limited and both are ultimately compromising clinical care.

Continuity of experienced clinical staff within ED had also been identified as a contributing factor during this period, with a number of nursing posts becoming vacant or secondees placed into senior roles for short periods of time (a recurrent theme across the Trust). There was little if any strategy or vision being articulated by the ED team and limited (if any) clinical or nurse leadership in evidence. It was not unexpected therefore to witness a lack of clarity in roles and functions within the ED and a duplication of effort and clinical assessments taking place on a regular basis.

Of more concern however was the general malaise and low morale within the team and a reluctant acceptance that during periods of peak demand, 30+ patients could be assessed and treated within the majors 'quadrangle' clinical area, be two abreast with no patient privacy or dignity or that there could be 8+ patients waiting in the A&E corridor waiting to be assessed. Notwithstanding the 4hour operational standard, there are clearly more

fundamental issues associated with clinical risk and patient care that needs to be urgently addressed;

Recommendations:

- Substantively appoint a senior nurse /clinical manager at the earliest opportunity in order to address the lack of clinical and nurse leadership within the ED.
- Instigate early senior assessment and clinical decision making throughout the patient pathway; initial assessment and diagnostics should be triggered within 15 mins of patient arrival. At this point patients should be immediately streamed into the correct area.
- Develop means by which ED staff can capture and utilise 'real time' patient tracking to assist in clinical management and performance monitoring.
- Set and monitor standard of handover of ambulance patients to ensure it happens within 10 mins of arrival and so allows NWS to meet their turnaround target.
- Remove ambulance patients from majors corridor.

Minors

Having reviewed the limited clinical data available to us, it was evident that despite 99% of minor's patient being 'seen, assessed and treated' within 4 hours, only about 23% of patients are being treated within the first hour. Our experience would suggest that units of similar size would be treating 50-60% of patients within this timescale by having a dedicated group of nursing /clinical staff focused on managing this workload. Most minor episodes should be completed well within two hours.

The implications are self evident as fewer patients within the department equates to greater control across the clinical floor. It would also prevent consultants being pulled to majors to 'queue busting' within minors when the wait becomes excessive.

Recommendations:

- Reintroduce the see & treat process where possible and ring fence ENP capacity for this purpose;
- ED consultants should not run the minors stream but remain focused on the clinical leadership and treatment within majors /resuscitation.
- A named senior nurse must be identified to run each shift and proactively manage the shop floor (both minors and majors). This nurse leadership role will be critical in avoiding duplication of effort between teams and would be supported by the ED champion.
- Reintroduce the necessary support and training for ongoing ENP and nurse development across all grades as the clinical competencies and confidence of nurses within the team which is currently being questioned by the staff themselves.

- The 6% follow-up rate of A&E attendees is high; with so much primary care input it should be far lower....

Majors not admitted

BCU provides the ED clinicians with the capacity for 4-8 observation beds which are sufficient to meet the demands of the local population. In addition the unit offers assessment and treatment for targeted patients.

The Emergency Department does not stream patients directly to BCU; rather patients are assessed and then chosen by the BCU staff for admission to the unit. The rationale stated was that they must have an exit strategy; surely this philosophy applies to all patients admitted to hospital.

Majors

We recognised that the physical environment of the department places significant limitations on what can be achieved to improve patient experience. However, there is a Trust and departmental acceptance of continued utilisation of the major's area way beyond its physical capacity. This is unacceptable practice, both clinically and operationally. This reinforces the need for greater emphasis on rapid assessment on arrival, prompt referral when the need for specialist help is clear and improved organisation, leadership and senior decision support to clinicians caring for these patients.

We were also concerned to witness the use of the major's corridor being utilised by ambulance crews waiting to offload and understood that during periods of peak demand, this could have up to 8 patients at any one time. The pattern of ambulance arrivals is predictable and well understood. It is disappointing that a more effective management strategy has not been developed.

The lack of shop floor co-ordination within majors and the delays in assessment by senior decision-makers is resulting in medical and surgical admissions taking at least 90 minutes to be appropriately identified and streamed. Evidence suggests that most departments are able to reach this point within 15 minutes. Despite this bottleneck, ED staff are often faced with significant difficulties in accessing speciality beds (inc MAU and SAU) which further restricts patient flow and patients are often 'bedded down' overnight or wait for up to 12 hours for admission.

The Trust 7 day analysis also indicated a high proportion of medical and surgical admissions that were transferred from the ED just prior to the 4-hour breach time. This indicates that your current levels of performance are far from sustainable and with the lack of real time clinical information we would question the validity of the performance data.

Recommendations:

- Instigate unified processes for clerking, assessing and recording clinical observations both to minimise duplication but also to encourage some linked working between medical and nursing teams.
- Ensure appropriate patients are streamed into BCU.
- Commence named nurse policy.
- Ensure ED clinicians remain focused on the clinical and multi-professional leadership within majors and resuscitation to enable early senior decision making.
- Improve information management.
- Review Trust escalation policies which are not currently understood.
- Although not quantified by the department (due to lack of poor data), there were implications of x-rays and other diagnostic tests (urgent bloods, D-dimer) having a turnaround time of 2hrs+.
- ED and pathology must come up with a more effective way of notifying staff of test results.

Paediatrics

The existing infrastructure does not allow for the separate streaming of paediatric cases however Bay 4 (resuscitation) and cubicle 15 (majors) are allocated for this purpose. The new build will facilitate the complete audio-visual separation of all paediatric cases however we would question whether the clinical model of care has been appropriately consulted on and agreed by all parties concerned.

SURGICAL ASSESSMENT UNIT

Staff clearly articulated the significant contribution that the SAU can make to improving patient flow within the Emergency Department but with an average surgical take of 15+ patients, managing this demand within 7 beds represents a daily challenge. There was clear nurse leadership in evidence and the advanced nurse practitioner has an expanded scope of practice which assists in both assessing and treating patients.

Clinical input on SAU is restricted to the post-take ward round at 8am and the registrar review at 5pm. Team handover is at 8pm. The on-call registrar (or consultant) should be available daily to meet the demands of SAU or ED however the reality is that both will either be in theatres or occupied with elective commitments. This delays clinical decision making and the early discharging of patients.

Patients should remain on SAU for no longer than 12 hours however at the time of our visit, over 50% of patients had been on the unit for 24hrs plus which makes the turnover of beds to manage the daily demand almost impossible. Reasons for delayed transfers were primarily attributed to no bed capacity within specialty areas, diagnostic delays (up to 18 hrs for an ultrasound particularly out-of hours) or senior clinical decision making.

We would question the modelling assumption of placing elective urology, HDU patients and SAU activity within a 25 bedded ward as the latter is compromised on a daily basis. There was clear evidence of elective patients taking priority over surgically assessed patients waiting for admission within the emergency department and a number of SAU defined patients being actively managed on MAU at the time of our visit.

Recommendations:

- The on-call registrar /consultant should be set a one-hour standard to respond to surgical opinions within SAU or ED. If this cannot be achieved, ED should be able to transfer directly into the unit without the need to obtain the agreement of the on-call team.
- Elective urology activity should be planned around predictable emergency surgical demand. Previously, it has been the norm to routinely admit a high numbers of urology elective cases on a Monday!
- Establish the standard that no post-operative surgical patients are returned to the unit.
- Following the successful ultrasound pilot, timely scanning by the SAU team has demonstrated that hospital admissions can be avoided. These lessons need to be applied both during the day and out-of-hours and weekends when the pressures are more acute.
- There is an opportunity to dovetail the clinical expertise of the nurse practitioners and night co-ordinators to ensure that the right patients are streamed into the right clinical areas.

ACUTE MEDICINE

Entry to the assessment pathway:

The acute medical team in the Royal Bolton Hospital sees approximately 45-50 patients each day whilst another 10-15 have a similar assessment in the Bolton Community Unit in the same hospital. Formal integration between these two services is lacking although informally there is a real desire to improve this situation. Urgent steps should be taken to integrate a pathway for all the patients needing specialist medical assessment to ensure that the benefits of the multi-disciplinary teams of community and hospital based practitioners is available to all and that decisions about where and with what resources treatment of each patient should continue are made after assessment, rather than before.

Transfer from BCU to in-patient care should be seamless, just as an acute medical assessment should be able to offer transfer for care in the community under the expert guidance of the BCU team. The current distinction of one pathway from another is discriminatory and has clearly compromised the care of some patients and led to tension between clinical teams.

A review of entry to the pathway should also seek to minimise the delay in referral from the Emergency Department and to avoid duplication of work through adoption of joint assessment documentation such as is now used in many communities. Evidence suggests that approximately three-quarters of Emergency Department attendees who need specialist medical assessment

can be identified within a few minutes of arrival in the Emergency Department – a process which at present seems to take at least 90 minutes.

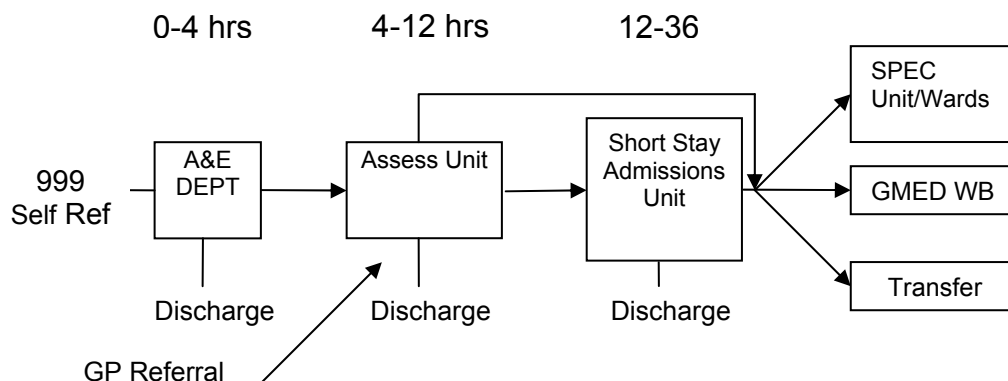
Patients referred by GPs are generally accepted efficiently but processes to manage surges in demand should not rely on patients being diverted to the Emergency Department. That department is already congested and such an “escalation” mechanism serves to slow down and compromise the quality of care for everyone.

Physical environment for assessment

Current plans to modify the way facilities are used for assessment and short stay are very constructive. The value of using consulting rooms, rather like an outpatient facility is appropriate, the benefit of facilities for ambulatory patients is very sensible and a mixture of trolleys and beds will be provided. Both the medical receiving area and the BCU contain essential working space which is likely to be needed even in a more collaborative and synergistic partnership. If capital investment is considered to improve the Emergency Department environment, the resources for specialist assessment can very usefully be better integrated. The Royal Liverpool provides an interesting example of better integration of both facilities and clinical teams at the front door of such a busy hospital. Neither the current configuration of Emergency Department facilities, nor the BCU building nor the acute medical facility can be considered to provide satisfactory long term accommodation.

Recommendations

- A vision for the medical model of care needs to be agreed and implemented with commitment to the philosophy that senior decision makers need to be available in a timely fashion to assess patients presenting as emergencies.
- Establish time bands for each area of work, then decide where patients will be seen and by whom:



NB: Times = **Maximum**

- Develop clear pathways to describe how medical and surgical patients receive prompt and effective acute care.
- Consideration could be given as to whether both these processes would function most effectively in an integrated unit.
- A clear, qualitative description of the medical pathway should be accompanied by agreed quantification of resources required, including beds and clinical staff.
- Facilitate a discussion with the physicians so an understanding of the competing priorities between speciality medicine and emergency medicine is understood by all in the context of the corporate 'must deliver'.

We would be happy to discuss quantification of resources with your clinical teams.

BED MANAGEMENT AND DISCHARGE

Bed Management does not exist across the Trust as a corporate function. There are separate bed managers for disparate groups of patients, whether emergency or elective and there are different roles during the day and throughout the night.

The bed managers appear to work on a reactive rather than proactive basis and it was difficult to ascertain where the final decisions with regards to placing patients were made. The lack of corporate ownership of the bed management function is making the job of the bed manager almost impossible to develop; it is purely a 'placing' service.

Discharge co-ordination is also divided; there are a number of discharge co-ordinators who are dealing with the complex case discharges and simple discharges are the responsibility of the ward managers and matrons. This division does not facilitate a smoothing of discharges either earlier in the day or over the weekend.

The discharge lounge has been newly expanded with the intention of being more fully utilised and developing a proactive approach to collecting patients.

Recommendations:

- Introduce a corporate clinical site management team with executive support and input who have the seniority and support to make the final decisions about bed allocation
- Ensure the bed managers and discharge co-ordinators are fully supported and have access to the same level of education and training as the rest of the nursing workforce
- Implement a real time bed management system
- Ensure *all* admissions and discharges wherever they originate are routed through the clinical site management team in order to allow for a true picture of the status of the hospital to be held and understood in one place.

- Development of an operations centre to manage capacity in a proactive and predictive way over the full week.

CLINICAL ENGAGEMENT

The Trust lacks a cohesive approach to delivering emergency care in a timely fashion across all specialties including the Emergency department. Individuals are working hard but the benefits of working together in seeking solutions are not present.

There is a state of paralysis with individuals not knowing how to address the issues they face, linked to a perception that the bed reconfiguration has led to the deterioration in performance. Some elements of the medical and nursing staff in certain specialities are felt to block any innovation or suggested change that could improve the emergency care delivered to patients as speciality takes precedence over emergency work.

Recommendations

- There needs to be a forum for communication and discussion between the executive body and the wider medical and senior nursing body in a constructive, facilitated way.
- The 7-day analysis should be used to commence the debate and add evidence to the discussions around the changes required in clinical behaviours and practice (appendix 1).
- Specialities need to review how their emergency take is supported and senior surgeons and physicians must be available to see patients.

PRIMARY AND COMMUNITY SERVICES

We had the opportunity to speak with members from the local PCT, who described how services are commissioned. The clinicians and managers we met are committed to a whole-system approach to managing the urgent care pathways. There is certainly a comprehensive understanding of the issues and a palpable disappointment at the failure to deliver the operational standard for emergency care. There is a commitment to seek solutions in a whole system way evidenced by;

- A cross economy review of urgent care services led by the PCT
- An impressive range of community and social services in place, to support patients in their normal place of residence.
- Bolton Community Services unit – Implemented July 2006. Extended to 24/7 opening Winter 2006/7
- A weekly A& E recovery meeting chaired by the PCT Chief Executive for the whole health system
- High level of clinician seniority for credibility
- Enhanced quality of care for frail elderly patients

From our observations and discussions, the PCT has adopted a model of trying to solve the problem by joint clinical appointments and or establishing services to ease pressure (BCU). While it could be argued this is commendable and a sensible approach, what is lacking is clarity from the commissioners regarding the model of care they wish to commission and see delivered for their population. The picture for unscheduled presentations is very confused and lacks a performance framework. This in turn leads to a poor understanding of the issues leading to decisions making that could be perceived as more of a hindrance than a help.

Recommendations

- Clarify the model of care for unscheduled presentations at Bolton Hospital with time lines as described as a basis for the performance management framework.
- Assessment and triage at the front of the Emergency Department is unsatisfactory, with delays for all presentations. The Health System as a whole needs to decide how the front of the Emergency Department is managed to support optimum delivery of care. There are models being developed and in place where primary care conducts a see and triage service with more robust links to primary and community services at the front door (Blackpool, Maidstone).
- Linked to the front-end triage, the PCT should review access to 'out of acute care' services so that patients are assessed and streamed into appropriate services either before an admission or once the acute episode has subsided.
- PCTs need to clarify their model of care for IV Therapy, COPD, and DVT management so the pathways of care are clear.

SUMMARY OF RECOMMENDATIONS:

The following is a summary of our recommendations which we would be happy to discuss further to explain our rationale:

- Bolton PCT to clarify the model of care for unscheduled presentations
- Bolton PCT to develop a performance framework that all sections of the community and those involved with delivering unscheduled care understand and there is clarity about key deliverables
- Bolton Hospital Trust needs to review its current management structure so there is clarity of purpose, leadership and a higher profile being placed on delivering effective and quality care to patients presenting as emergencies.
- Bolton Hospital Trust must substantively appoint a senior nurse /clinical manager at the earliest opportunity in order to address the lack of clinical and nurse leadership within the ED
- The Health community needs to consider the case for creating a true a primary care stream at the front of the Emergency Department in order to stream patients into the most appropriate clinical area and/or service.
- Trigger initial assessment and diagnostics <15 mins of arrival
- Remove ambulance patients from majors corridor
- Need to set standard of handover of ambulance patients within 10 mins

- of arrival and allow NWAS to meet their own handover target
- Bolton Hospital Trust needs to ensure a more rigorous approach to floor management and a reduction in duplication of clerking /observation /record keeping
- Organisational focus on accurate data capture and real time information within A&E
- Clinical site management team needs to be developed and must have corporate role with high profile
- Develop clear pathways to describe how medical and surgical patients receive prompt and effective acute care.
- Consideration could be given as to whether both these processes would function most effectively in an integrated unit
- A clear, qualitative description of the medical pathway should be accompanied by agreed quantification of resources required, including beds and clinical staff.
- Facilitate a discussion with the physicians so an understanding of the competing priorities between speciality medicine and emergency medicine is understood by all in the context of the corporate 'must deliver'
- Development of an operations centre to manage capacity in a proactive and predictive way.

CONCLUSIONS

Bolton Hospitals NHS Trust and its partner organisations have the potential to deliver truly integrated emergency care, utilising the many resources available much more effectively. The community has very willing clinicians and managers who need to be enabled to work in a collaborative way to provide better services to the emergency patients presenting.

Currently there are many real and virtual barriers which are being reinforced and so preventing good partnership working, whether internally across the Trust or externally with PCT and other partners.

There is a lack of clinical leadership across the Emergency Care pathway and this is compounded by a lack of role clarity and a reluctance of ownership. At times this is leading to a very poor experience for the population of Bolton and surrounding areas that access the Acute Trust as an emergency.

Executive leadership, ownership and focus are required in order to ensure that the provision of emergency care across Bolton is driven forward and had the resulting improvement in patient care and experience.

June 2007

Bolton Report

APPENDIX ONE DATA ANALYSIS

This appendix will describe the main findings using the breach reports and the 7-day analysis provided to us.

Breach Reports

We had a number of breach reports covering over 10 weeks; whilst these are fairly detailed in performance measurement terms they do not include any specific reasons for the breaches. *We would suggest that reasons for the breaches be included with information on resolution of any issues and trends identified.* The Urgent Care team will need more robust information in order to performance manage and improve the flow of patients.

7-day analysis

We were given a 7-day analysis report for the week ending 13th May 2007. The overall Trust performance against the 4-hour standard was 95.2%.

Analysis 1 and its supplements describe a picture of an Emergency department, which is busiest during the early part of the week, Monday, Tuesday and Wednesday and less so at the weekends.

The busiest hours are from 10am – 7pm with a peak around lunchtime.

Arrivals per hour peaks at 18 but the average is nearer to 14.

Does the department know at what number of arrivals it begins to become unmanageable?

Do they map the arrival numbers with the departure numbers across the department to ascertain their maximum manageable capacity?

Analysis 2 presents a bleak picture of breaches, with particularly high percentages in the medical and surgical admits groups of patients.

Does the Trust have internal standards for referral to specialities and for their response times?

The minors stream should never breach.

Analysis 3 identifies some of the causes of breaches – the main two are ‘waiting for a bed’ and ‘waiting for assessment’.

(There are recommendations in the main report related to both these issues)

Analysis 4 gives more detail on the breaches and when they occur. Tuesdays, Wednesdays and Thursdays seem to be particularly high numbers with the late evening and early hours of the morning being the worst times.

Almost all the minor breaches are in the overnight period.

Are the staff available for the minors patients overnight?

The majors not admitted patients rarely breach at the weekends – *does the Trust understand how this performance is achieved in order to try to replicate during the week. (The demand is slightly reduced but is not significant)*

Medical admits are very poor with a high number of breaches, rising to 70% on a Thursday! It is also equally poor across the 24 hours with a worsening after 8pm into the night.

Are these patients referred to the medical teams in a timely manner and do they respond quickly?

Is a senior medical opinion available in the first instance to prevent duplication of effort and poor initial assessment?

Surgical admits waits are at their worst on Tuesdays and Wednesdays and between 4pm and 3am.

The same questions will apply here as for medical admits.

It is worth noting from Analyses 5 and 8:

Only 18.8% of all patients arriving at the Emergency Department are seen in the first hour

Another 37% are seen by the end of the second hour; 25.7% by the end of the third hour and a further 13.6% by the end of the fourth hour.

This demonstrates a slow start with a push to catch up between 2.5 and 4 hours. Within these figures are some very long average waits – 5.6 hours for medical admits – with the longest waits reaching 11 hours.

Minors had a number of 10-hour waits; majors not admitted 8.5 hours and surgical admits up to 11 hours

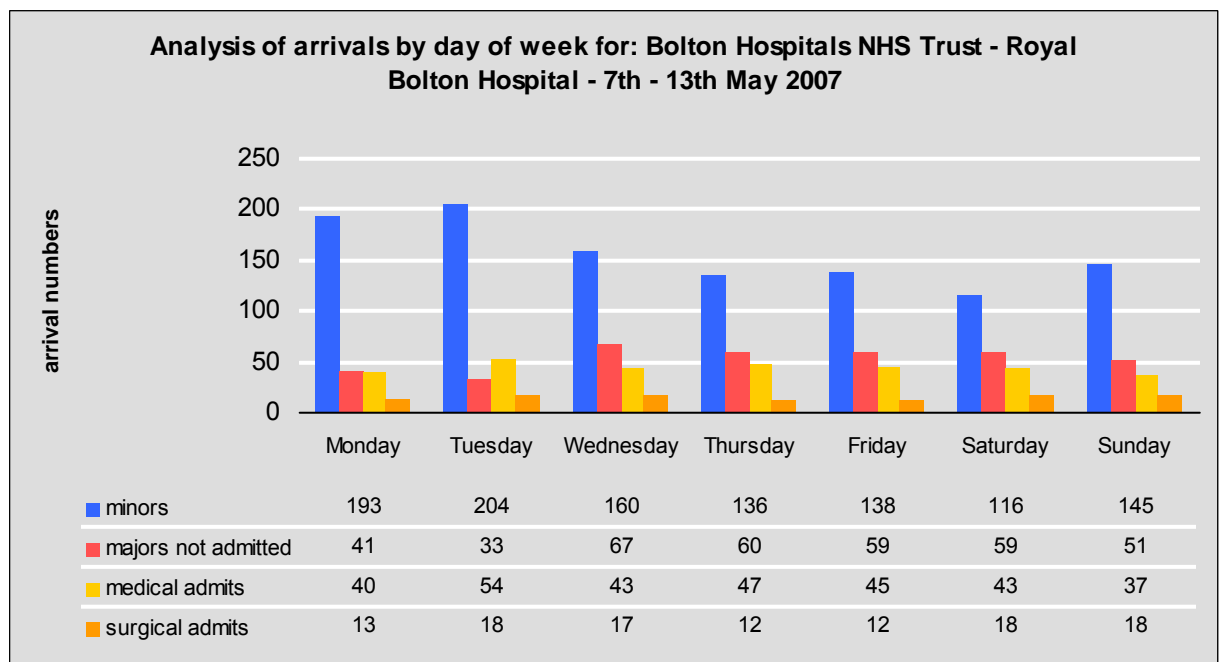
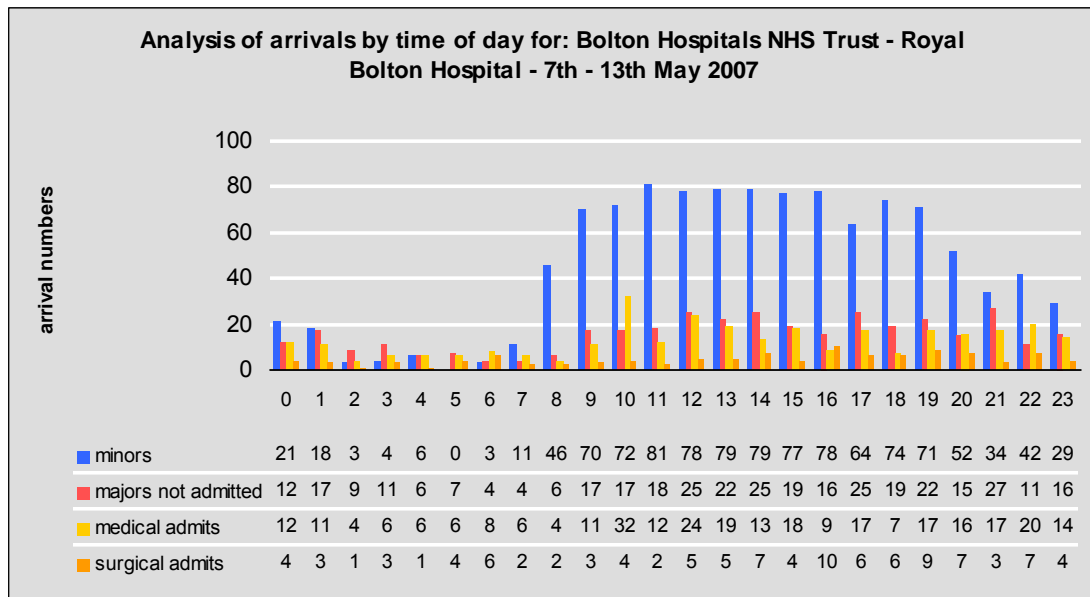
This suggests a need for more effective management of the whole flow; a few but significant few of the patients are waiting well over the 4 hours and there is a significant during the last 30 minutes of the 4 hours. Both of these factors suggest crisis rather than proactive flow management.

Analysis 6 demonstrates that the older you are the longer you are likely to wait.

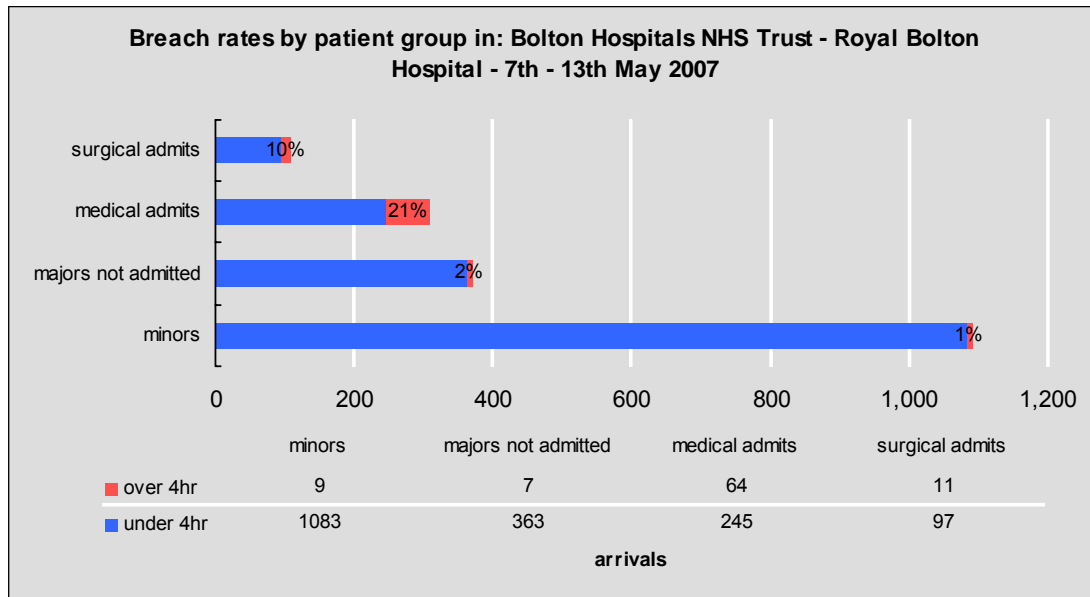
Analysis 7 demonstrates some lengthy waits for a decision to admit compounded by some very long waits for a bed.

The standard for the time waiting for a bed should be 15 – 30 minutes.

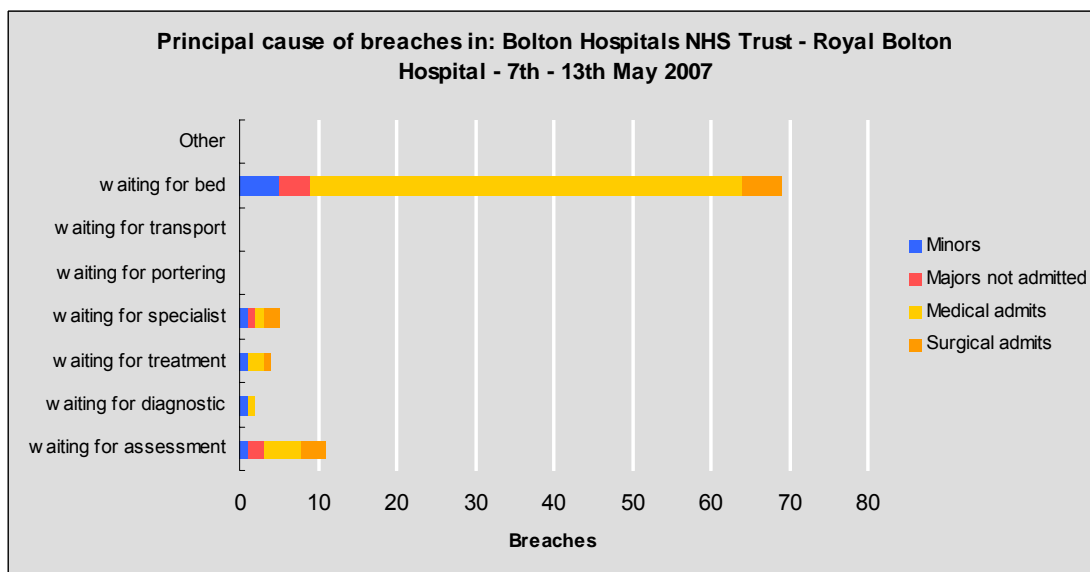
Analysis 1



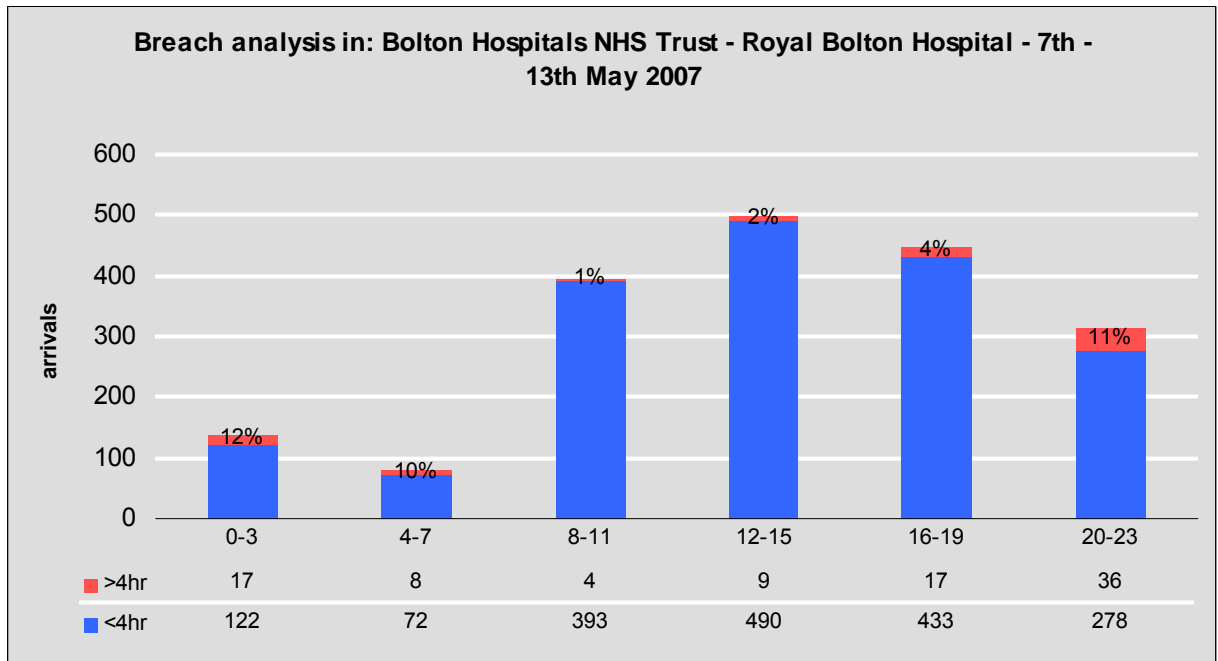
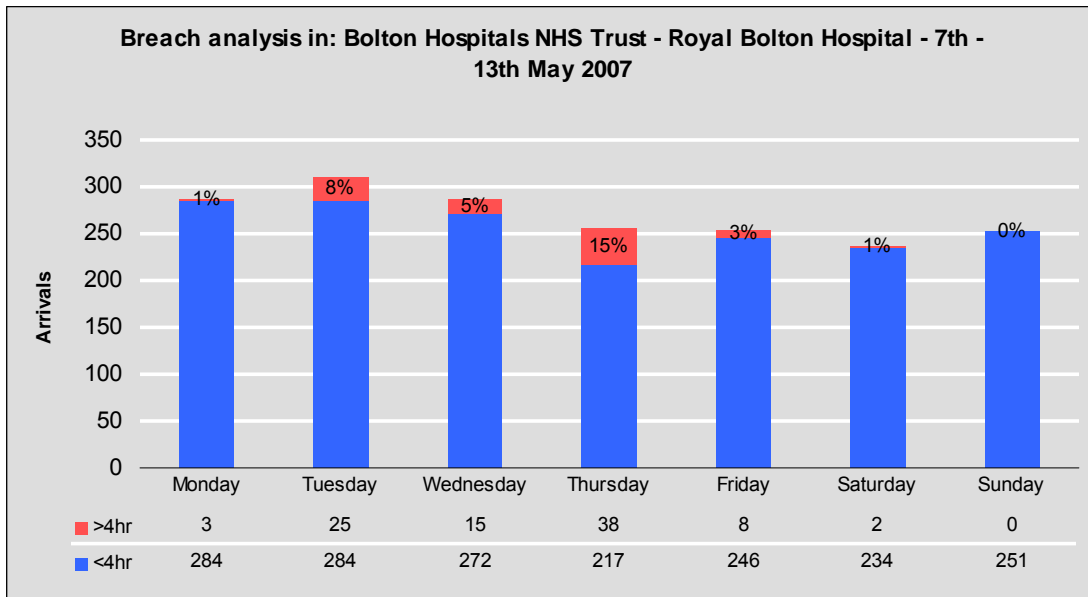
Analysis 2



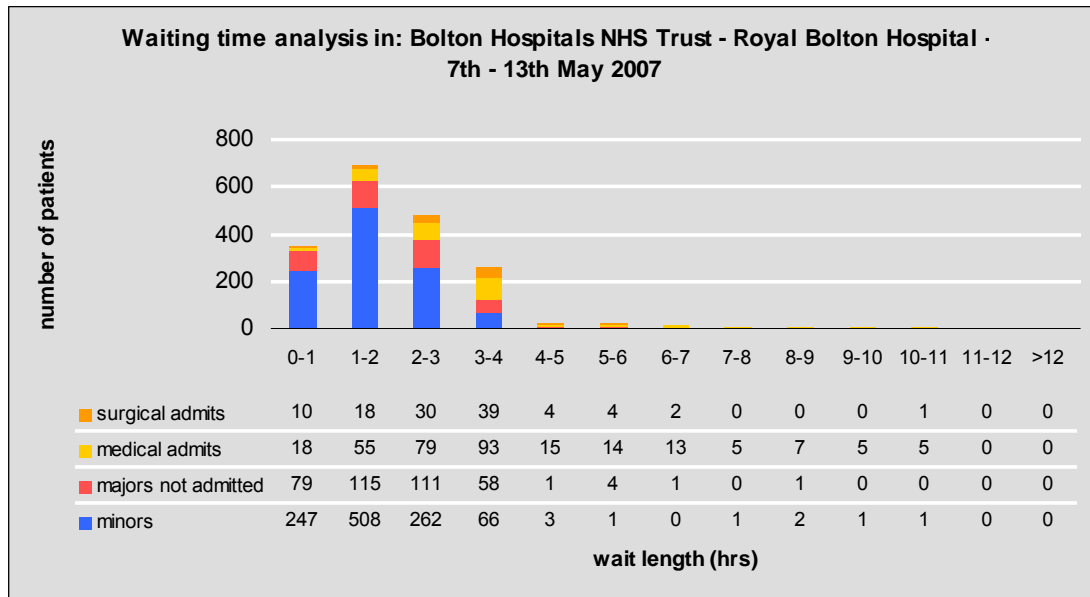
Analysis 3



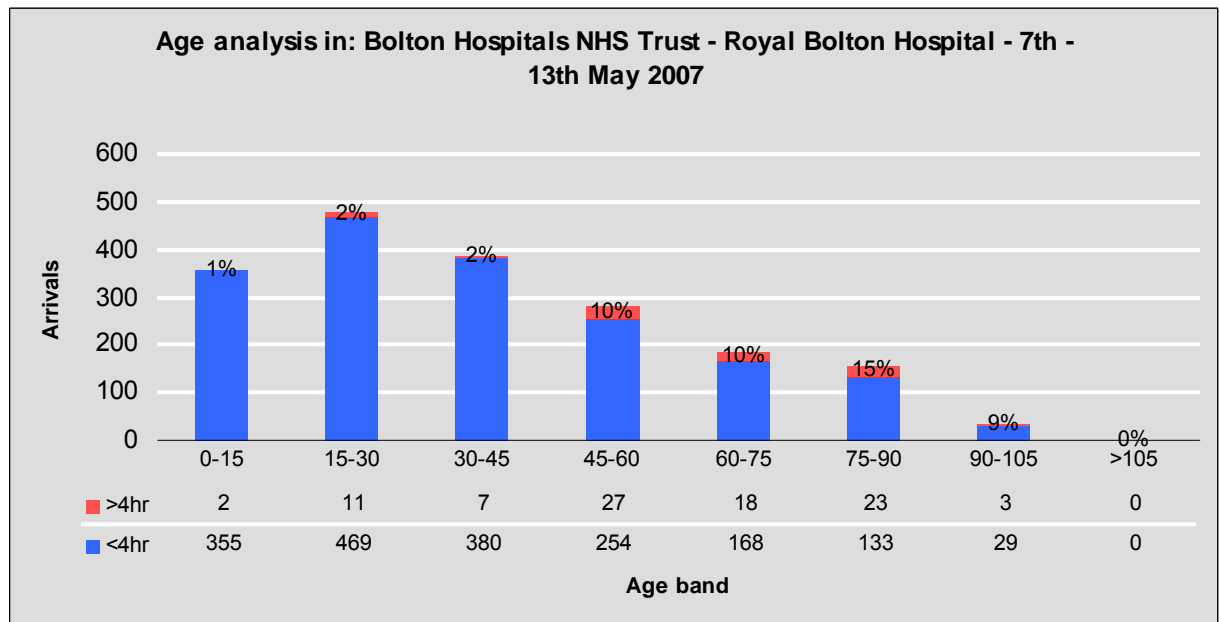
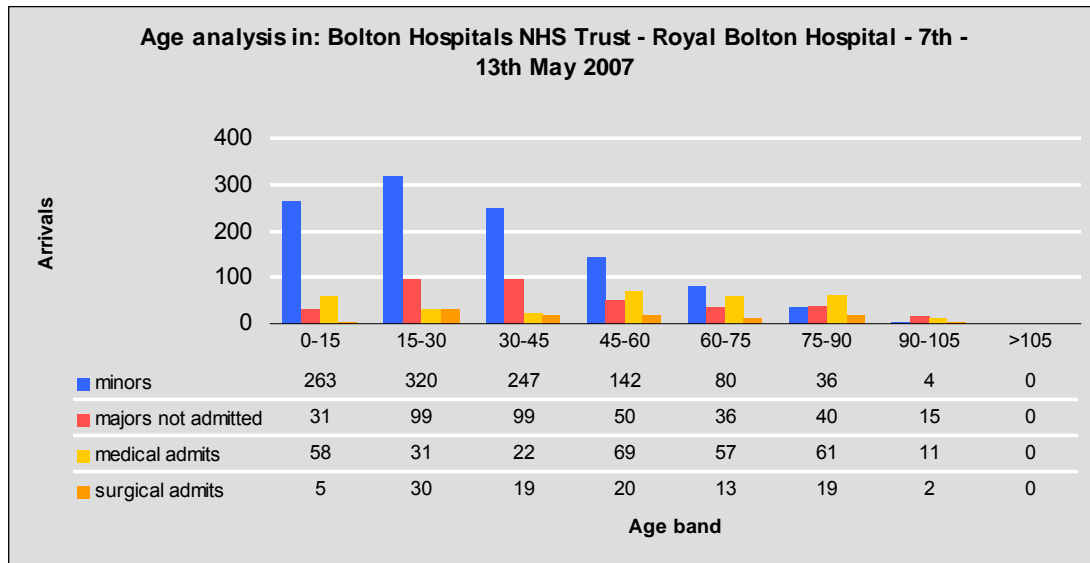
Analysis 4



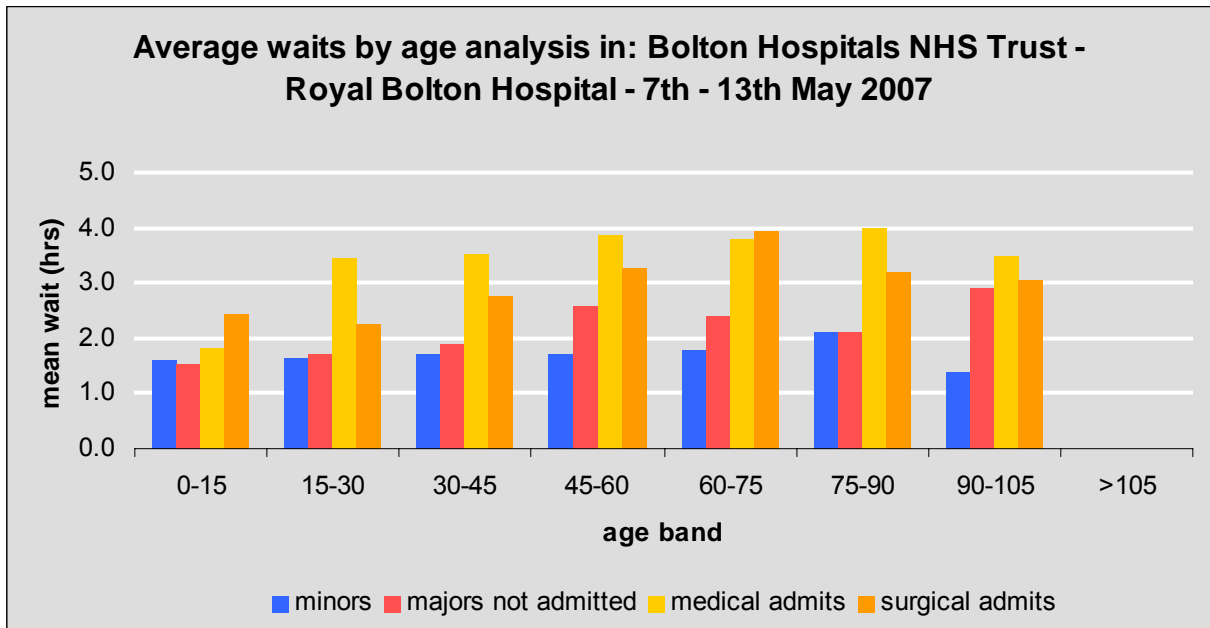
Analysis 5



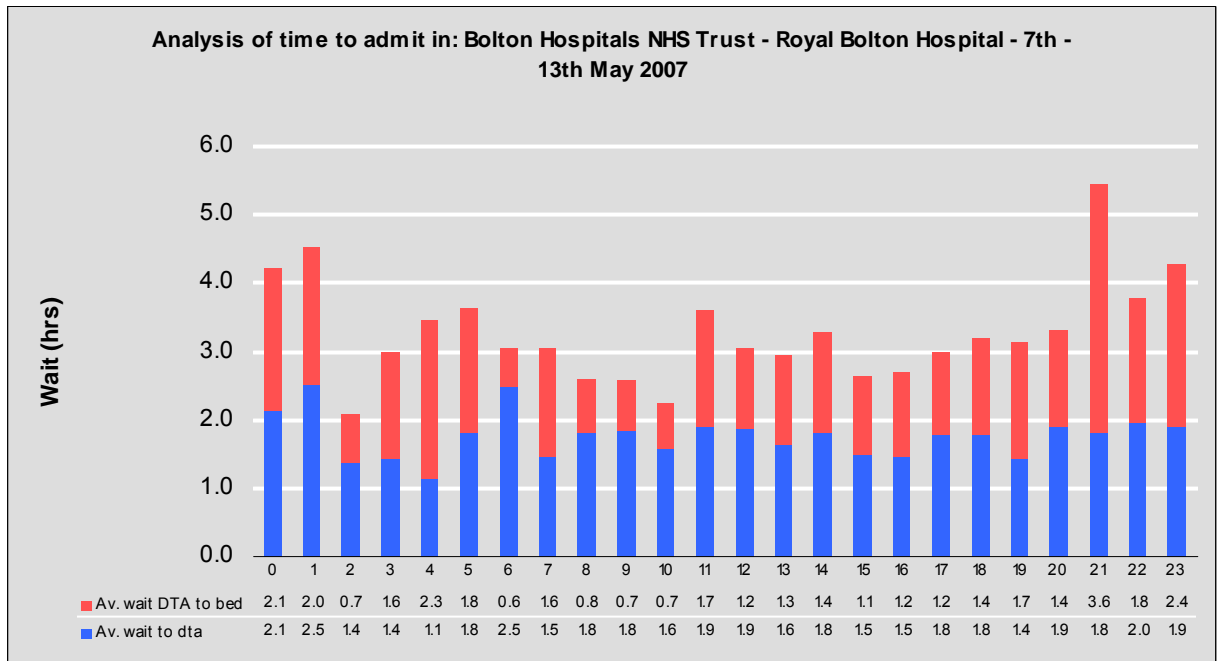
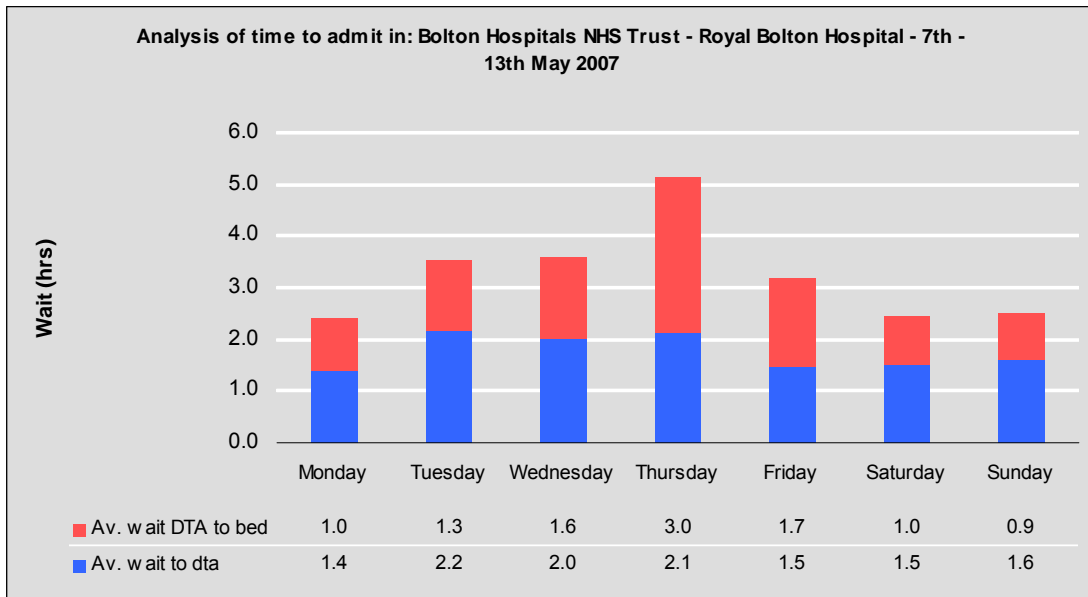
Analysis 6



**Average waits by age analysis in: Bolton Hospitals NHS Trust -
Royal Bolton Hospital - 7th - 13th May 2007**



Analysis 7



Agreed Action Plan following External Review

Appendix 5

DEMAND AND CAPACITY

1	Appoint Executive lead to support organisational capacity and demand management	LD	August 2007
2	Clarify the role and function of the programmed investigation unit ensuring clear communication of its role across health community	IL	July 2007
3	Deliver integrated MAU/CDU/BCU model with capacity equivalent to daily medical urgent assessments	IL	August 2007
4	Review size of surgical assessment unit to meet current demands and length of stay, ensuring separation of elective and non-electives	SN	August 2007
5	Develop and delivery model of ambulatory assessment of patients across specialities	AR	Sept. 2007
6	Review escalation policy to ensure clear procedures within medicine ensuring flexing capacity and managing GP referrals	IL/MR	August 2007
7	Implement performance measures for LOS and discharge activity including predictive date of discharge and compliance rates	IL	Sept 2007

PATHWAY DEVELOPMENT AND STREAMING

1	Agree to timeframes for streaming patients in and through A and E including: <ul style="list-style-type: none"> ▪ Minors (see and treat) ▪ Ambulance handover ▪ Initial senior management and clinical decision ▪ Develop across all areas agreed standards with the ability to track performance 	GS/SW	July 2007
2	Agree with clinical specialties, standards for timely attendance and applicable monitoring and performance framework	JB	Sept. 2007
3	Develop location and protocols for safe handover of ambulance patients	GS	August 2007
4	Agree maximum number of patients that can remain in A and E safety ensuring escalation outside the department	GS/IL/MR	August 2007
5	Agree criteria for immediate streaming from A&E to BCU and CDU/MAU/AMIU, in addition to the current "pull" arrangements	AR/JB	July 2007
6	Establish escalation mechanisms for increasing exit capacity from BCU at times of increased need and cease limitation to admission when intermediate care capacity "full"	CH/JB	Sept. 2007
7	Agree priorities between speciality medicine and emergency medicine	JB	August 2007
8	Agree pathway and location of care for post operative emergency patients	SN	August 2007
9	Establish 24 hour emergency ultrasound service, with	IL	August

	agreed response times in line with evaluation of pilot scheme		2007
10	Integrate health economy wide multi-agency working to pull patients into the most appropriate care services	IL	August 2007
11	Establish 7 day review with named physician/surgeon	JB/GS	Sept 2007

ORGANISATIONAL CONTROL

1	Review and develop the bed management and site co-ordination across the Trust, ensuring clarity of roles and functions to support capacity /demand and patient safety management, especially Out of Hours	SW/CB	August 2007
2	Review role of nurse practitioners and night co-ordinators and their role in streaming patients to appropriate clinical areas	LD	August 2007
3	Review discharge co-ordination and streamline roles and responsibilities, with particular emphasis on increasing weekend discharges	LD	August 2007
4	Review current data capture and dissemination	IL/MR	August 2007

LEADERSHIP, RESPONSIBILITY AND ACCOUNTABILITY

1	Review leadership arrangements within Accident and Emergency	DF	July 2007
2	Review roles of all staff within Accident and Emergency, including identification of senior nurse for each shift, and named nurse for each patient with responsibility to ensure timeframes achieved	SW	July 2007
3	Review skill mix within A and E to meet current demands, and identify immediate changes that can be made	SW	Sept. 2007
4	Agree timeframes for appointing substantive Clinical Nurse Leadership within A and E	SW/LD	August 2007
5	Ensure full integration and clinical collaboration between PCT based care and initiatives with Bolton Hospitals	JD	Sept. 2007
6	Implement daily health economy capacity and demand reviews ensuring links to escalation triggers	IL	Sept 2007
7	Provide suitable environment for capacity and demand control centre including effective IT/visual management	IL	Oct 2007

DEMAND AND CAPACITY

ACTION AS PART OF URGENT CARE REVIEW

1	Review all previous UM team data to inform Urgent Care Review	JD	Sept. 2007
2	Undertake a detailed review of demand and capacity for urgent care across the health economy, including intermediate care, emergency care, speciality care and its relationship to demand and capacity elective care	JD	Sept. 2007
3	Review estates requirements for urgent care, including use of consulting room type facilities, waiting areas, etc.	JD	Sept. 2007
4	Consider urgent care workforce capacity and relationship to elective and speciality workforce	JD	Sept. 2007

STRATEGIC ACTION AS PART OF URGENT CARE REVIEW

1	Suggest changes required to match capacity to demand for urgent care, including flexibility of capacity for clinical areas and workforce	JD	Sept 2007
2	Suggest changes to estates to meet urgent care needs in all locations	JD	Sept. 2007

PATHWAY DEVELOPMENT AND STREAMING

ACTION AS PART OF URGENT CARE REVIEW

1	Review infrastructure support, including portering, secretarial, diagnostics and social work	JD	Sept. 2007
2	Identify areas of practice where duplication of tasks occurs and shared assessment and documentation can be used	JD	Sept. 2007
3	Review how CDU/MAU and BCU functions can be more integrated	JD	Sept. 2007
4	Review further measures that could be taken to improve hospital and intermediate care length of stay	JD	Sept. 2007
5	Review current level of pathway development and implementation	JD	Sept. 2007
6	Review alternative models of urgent care delivery, for example, Blackpool	JD	Sept. 2007

STRATEGIC ACTION AS PART OF URGENT CARE REVIEW

1	Make recommendations about consistent pathway development and implementation and monitoring	JD	Sept. 2007
2	Make recommendations about future role of each component service for urgent care, for example, Primary Care, A and E, Specialist Services, BCU, Intermediate Care, DTC	JD	Sept. 2007

ORGANISATIONAL CONTROL

ACTION AS PART OF URGENT CARE REVIEW

1	Review examples of good practice in day-to-day, (and within day), real time data management to use capacity to meet daily demands	JD	Sept. 2007
2	Review training and support requirements of bed management and discharge co-ordinating team	JD	Sept. 2007
3	Agree data needs for operational management	JD	Sept. 2007
4	Consider benefits and remit of an "Operations Centre"	JD	Sept. 2007

STRATEGIC ACTION AS PART OF URGENT CARE REVIEW

1	Recommend mechanisms and systems for whole system and on site real time bed management	JD	Sept. 2007
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LEADERSHIP, RESPONSIBILITY AND ACCOUNTABILITY

ACTION AS PART OF URGENT CARE REVIEW

1	Review current and future workforce requirements to meet urgent care needs	JD	Sept. 2007
2	Review leadership structures and functions across health community for urgent care and explore new models to give strong leadership and accountability	JD	Sept. 2007
3	Explore performance measures for urgent care	JD	Sept. 2007

STRATEGIC ACTION AS PART OF URGENT CARE REVIEW

1	Ensure shared values and priorities across the healthcare community for people with urgent care needs	JD	Sept. 2007
2	Develop clear workforce development plans for all areas of emergency care	JD	Sept. 2007
3	Recommend leadership and accountability structures for urgent care	JD	Sept. 2007
4	Recommend performance management framework for urgent care	JD	Sept. 2007

Full Attendee List
Urgent Care Review - Workshops – August 2007
Facilitating Team – John Dean, Martin Reddy, Ian Lurcock and Chris Moulton

Area	Name	Title
PPI RBH	Armston Norma	RBH PPI Forum
Blackrod Health Centre	Armstrong Gillian	Advanced Practitioner for Nursing Homes
A and E RBH	Ariff Usman	Clinical Specialist A and E
PPI PCT	Bain Anne	PCT PPI Forum
Bed Management RBH	Barlow Andrew	RBH Bed Manager
A and E RBH	Bates Damian	E D Consultant
Anaesthetics & Surgery RBH	Bernstein Carol	Asst Divisional Manager
A and E RBH	Beswick Sue	Senior Sister
GP Bolton	Bhatiani Wirrin	Bolton GP
NHS Direct	Birkett Lorraine	Head of Operations
Walk In Centre	Bliss Jacqui	Urgent Care Manager
North West Ambulance Service	Bleazard Ged	Sector Manager
Emerg Med and Therapy RBH	Bownas Emma	Team Leader
Clinical Director	Brownlee Mike	Bolton, Salford & Trafford Mental Health
Bolton GP	Caldwell Ian	GP
PPI RBH	Chadwick Frank	PPI RBH
Elderly Medicine RBH	Cleary Ann	Acting Divisional Nurse
Pharmacy RBH	Cook Susan	Manager
Diagnostics and Therapy RBH	Cogan Andrew	Divisional Manager
Local Authority	Compston Evan	Head of Care Partnerships
NHS Direct	Crowe Janet	Service Delivery Manager
North West Ambulance Service	Daniels Carl	NWAS Sector Manager
Crisis Response Team	Dooner Jen	Team Leader
Anaes & Surgery RBH	Ellis Sue	Matron
Bed Management	Gerrard Vicky	Bed Manager RBH
Local Authority	Gannon Angela	Director of Health/Care Integration
PPI RBH	Gibson Janet	RBH PPI Forum
Older Adults PCT	Gillespie Ann	Head of Clin Ser Adults
Laboratory Medicine Haematology	Grey Mark Dr	Lead Consultant
PPI PCT	Halliwell Julie	PCT PPI Forum
Pathology RBH	Hamer David	Senior Chief BMS
Intermediate Care	Higgins Cathy	Assistant Director Older People
Clinical Lead Children's Services	Hindley Dan	Clinical Lead Children's Services
Local Authority	Hollando Larry	Head of Commissioning
Radiology RBH	Hopkins Christine	Radiology Manager RBH
North West Ambulance Service	Howcroft Phil	Operational Manager
GP Bolton	Hunt Bob Dr	Bolton GP
Pathology RBH	Hutcheson Andrew	Consultant Chemical Pathology
A and E - RBH	Kemp Rita	Sister
GP Bolton	Korlipara Dr	Bolton GP
District Nurse	Jones Maureen	District Nursing
Walk In Centre	Little Lynne	Sister
Older People	Lloyd Ann	Consultant Nurse OP
Pharmacy RBH	Lowe Christine	Pharmacy Serv Man RBH
Walk in Centre	McGaughey Freda	Sister
Radiology RBH	Martin Amanda	Clinical Manager
Local Authority	Moore Lisa	Domi Care Team Leader
Therapy RBH	Martin Penny	Therapy Manager
Radiology RBH	Martyniuk Sue	Team Leader RBH
Anaesthetics & Surgery RBH	Mason Brenda	Matron
Rapid Response Team	Matthews Ruth	Team Leader Rapid Response PCT
North West Ambulance Service	Mayor Robin	Operational Manager NWAS
Social Services	Morris Teresa	Local Authority Soc Services
Rapid Response Team	Mikolayewski Sue	Acting Team Leader
Radiology	Nicol Mike	Team Leader
Anaesthetics/Surgery	Nicolls Silas	Divisional Manager
A and E RBH	Nolan Janet	Sister A and E RBH
Intermediate Care	Nutter Lynn	Manager
Nursing Homes	O'Donnell Paula	Advanced Practitioner
NHS Direct	Owen Sue	Service Delivery Manager
A and E RBH	Parris Richard	E D Consultant – A and E RBH
Med., Surg., Therapy	Parkinson Janet	Acting Team Leader
Medicines, Surgery. Therapies RBH	Partington Dympna	Acting Clinical Manager

PPI RBH	Phillips Mike	PPI Forum RBH
Walk In Centre	Robinson Janet	Sister
Blackrod Health Centre	Robinson Karen	Advanced Nursing Practitioner
Egerton & Dunscair Health Centre	Rushton Janine	Head of District Nursing
GP Bolton	Saul Dr	GP Bolton
A and E	Saynor Gary	ED Consultant A and E
Mental Health RBH	Seabourne Alice	Consultant – Old Age Psychiatry
Walk In Centre	Seddon Carol	GP Out of Hours
Diagnostics and Therapy RBH	Senior Brian	Assistant Medical Director – Diag & Therapy
Pharmacy RBH	Shaw Sally	Deputy Chief Pharmacist
PPI RBH	Sherrington Jim	PPI RBH
Bolton GP	Silvert Barry Dr	Bolton GP
Pharmacy RBH	Smith Brian	Chief Pharmacist
PPI RBH	Taylor John	PPI RBH
Occupational Therapy Darley Crt	Troughton Anna	Occupational Therapist
A and E	Tunn James	Charge Nurse
Minerva Day Hospital RBH	Varman Dr S	Consultant Older People & Intermediate Care
PPI RBH	Waters Dorothy	PPI RBH
A and E RBH	Whittam Sue	Emergency Care Departmental Manager
District Nursing	Wilson Steven	Senior Nurse
BST Mental Health (RBH)	Wright Jayne	Assistant Director Business & Planning
Nurse Development Manager PCT	Young Joyce	Nurse Development Manager PCT

Appendix 7 Public Workshop “Our Health, Our Say” Sep 13th

Urgent Care Workshop

Rita Liddell,
Mavis Yates,
Sandra Clarkson,
David Wolstenholme,
Yvonne Laidlaw.,
Vic Wilde,
Marie Oxtoby,
Edna Liptrot,
Frank Chadwick,
Lillian Chadwick,
Wendy Pye,
Tom Lyth,
Farhat Shaheen
Mathew Anderson,

BAND
Bolton Aphasia
MhIST
MhIST
Breast Cancer S.G
Diabetes UK
GM Neurological Allnce
Osteoporosis
PPI Forum
PPI Forum
Compassionate Friends
Myeloma Support Group

Volunteer

Urgent Care Review in Bolton
Value Stream Analysis Event – 17 to 21 September 2007
L4 Day Room – L Block – Royal Bolton Hospital

ATTENDEES

Name	Title	Area
Armstrong Gillian O'Donnell Paula Robinson Karen	Advanced Practitioners Blackrod HC Going to share the week between them	PCT
Ayyar Anita	Consultant Elderly Medicine	RBH
Bernstein Carol	Asst. Div. Manager Anaesthetics & Surg	RBH
Bliss Jacqui	Or Rep Walk In/OOH Manager	PCT
Bownas Emma	Therapy Team Leader Medicine	RBH
Caldwell Ian	GP PBC Lead Bolton South East	GP
Morris Teresa Evan Compston	Social Services attend Mon Tues Wed am Social Services attend Wed pm, Thurs, Fri	Soc Serv Soc Serv
Daniels Carl	NWAS Sector Manager	GMAS
Doherty Lesley	Director of Nursing	RBH
English Matthew	Information Department	RBH
Fox Beatrice	Sister from AMRU	RBH
Greenhalgh Sarah	Paediatrics	RBH
General Sur Consult Middle Grade Clinician	Name to be given for feedback session (Mike Pantelides)	RBH RBH
Hackin Janet	Unit Manager Bolton Community Unit	RBH
Henderson Jon	Chief Pharmacy Technician PM ONLY	RBH
Hodgson Steve	To be confirmed (Silas)	RBH
Hunt Bob	GP	GP
Isherwood Dot	Site Co-ordinator	RBH
Larkin Christine	Act Tm Ldr Crisis Resolution Tm Mental HI	RBH
Longworth Christine	Ref & Assess Crisis Resp PCT	PCT
Lloyd Ann	Consultant Nurse	PCT
Moulton Chris	Consultant A and E	RBH
Nicolls Silas	Div Manager	RBH
Nutter Lynn	Intermediate Care Manager	PCT
Moore Billie	Public Health	PCT
Parkinson Andrea	Paramedic Supervisor for Bolton area	NWAS
Phillipz Mike	Bolton PCT and RBH Forum Rep.	PCT/RBH
Robinson Peter	IT	RBH
Shaw Sally	Deputy Chief Pharmacist AM ONLY	RBH
Singh Dr Yad	Consultant Crisis Resolution Mental Hlth	RBH
Troughton Anna	Team Ldr Occ Ther Int Care/Domi	PCT
Tunn James	Charge Nurse A and E	RBH

Whittam Sue	Dept Manager Emergency Care	RBH
Plus John Dean Martin Reddy Ian Lurcock Moira Roberts Cindy Walton Elizabeth Brad John Rutter		

Urgent Care Value Stream Analysis

DVT Clinic

- Relocation of anti coagulation service to community may create more work for DVT service
- Ambulance bringing people in cannot guarantee meeting appointment time, so patient then directed back to AMRU
- Not Nurse Led
- Dependent upon medical staff to prescribe Clexane and Warfarin
- Increase in workload for District Nurses
- Stress of hospital visits/parking for patients
- Turnaround time for INR results
- Ongoing visits to the hospital for the patient until within therapeutic range
- If diagnostics available same day – huge reduction in duplication possible

Emergency A&E Referrals to Mental Health

- Delay to register patient when busy – clock starts ticking as soon as the pt enters A&E (Ambulance and walk in's), not at referral time
- Police training re Section 136 & 135
- Delays for patients with transport (especially after 6pm and night time)
- OOH patients
- Reconfiguration of services within CRT
- Gate keeping all activities to MH beds
- Bed managing
- Increased workload and re-introduction of CRT access pt's in AMRU
- PCT targets within the CRT inclusive – homebased treatment team
- 9 other referral pathways to CRT – inclusive of emergency home assessment
- Recruitment issues
- HBT pts – priority
- “? place of safety status”
- A&E currently only OOH facility
- No 24 hour provision of services

Ambulance

- Dual crew to most incidents
- Paramedic training geared towards trauma/acute critical illness
- Provision of incorrect information at the time of call
- Most patient pick ups result in A&E attendance
- Numbers in A&E result in long ambulance waits
- Crews spending long times in A&E

IC @ home

- Qualified staff involved in significant amounts of clerical duties
- Access to computers
- Difficulties in communicating with other teams/individuals
- Limited office space
- Providing information which is not used
- Waiting for other providers information
- Duplication in assessments

Admits to Darley Court

- Trained staff required to perform inappropriate clerical functions
- Referral process over complicated
- Clarity in team names and functions
- Directory of services needed
- Referrals batched in afternoons or by day (Fridays)
- Transport access via fax prior to 12 noon or 999 only option
- Multiple assessments
- Process duplication when admitting into care units

Discharge Lounge

- Poor/ inconsistent documentation
- Waiting for results
- Waiting for TTO's
- Waiting for transport
- Waiting for Social worker
- Waiting for Consultants
- Multiple patient moves A&E – AMRU – C2 – Scan
- Duplications in assessment
- Referral documentation

GP Referrals & Rapid Access

- GP Direct staff have no scope to direct pt's
- GP letters to A&E – does the letter reach the intended recipient?
- Time spent on telephone calls to GP Direct, on call staff, Social Services, families/carers, GP
- Repetition of assessment process

BCU

- Waiting for porters, doctors, Nurse, diagnostics
- OOH pts
- Failed discharges

Crisis Response

- Not a 24/7 service
- Links with Social Services which actually set up care pathway. SS not a 24/7 service
- Time spent chasing information and communicating with several agencies
- Arranging and waiting for transport

Active Case Management

- Uneven case mix causing stress
- Reduced ACM skills for exacerbation stage
- Poor information
- Letter in only one language
- OOH care
- Continuity of care
- Caseload dependency → waiting list
- Too much paperwork
- Poor communication

Out of Hours Service

- NHS Direct Decision making system (CAS) not as good as OOH decision making software (TA2) so ↑ referral

- Pt may have waited several hours in NHS direct system before getting decision e.g. Visit
- Nurse Triage works well and reduced GP face to face contacts, but only at weekends
- Dr's do not use triage software. Call handlers make priorities with use of the software
- Delays in speaking to Bed Bureau (up to 15 mins), GP held up on the phone causing surgery waits
- RBH system of speaking to Triage nurse in medicine and paediatrics works well
- O&G and surgical teams problematic – Dr in theatre or too junior
- Problems with Pts requesting visits – no transport, over alcohol limit, childcare issues, financial/economic constraints
- Call handlers unable to transfer calls to available clinicians
- Rigorous audit of calls required – volume, times, outcomes from all staff perspectives (Dr's nurses, clerical etc) Need for quality standards
- Flexible workforce (seasonal bank and substantive posts) – works well

Emergency Dental

- Waste of human talent – clinical staff in admin tasks
- Pts not completing forms correctly
- Defects - Pts can't get through first time
- Inventory - Record Card System
- Over production – Telephone log sheets
- Waiting times – Pts waiting to get through on phones
- Waiting in waiting rooms
- No parking facilities

AMRU GP Referral

- Increase nurse led assessment/intervention
- Waiting for medical/speciality review
- Time wasted in handovers
- Consistency in patient care/information
- ?elements of admission managed at home
- Setting up equipment
- Nurses looking for stuff
- Improve the pts journey

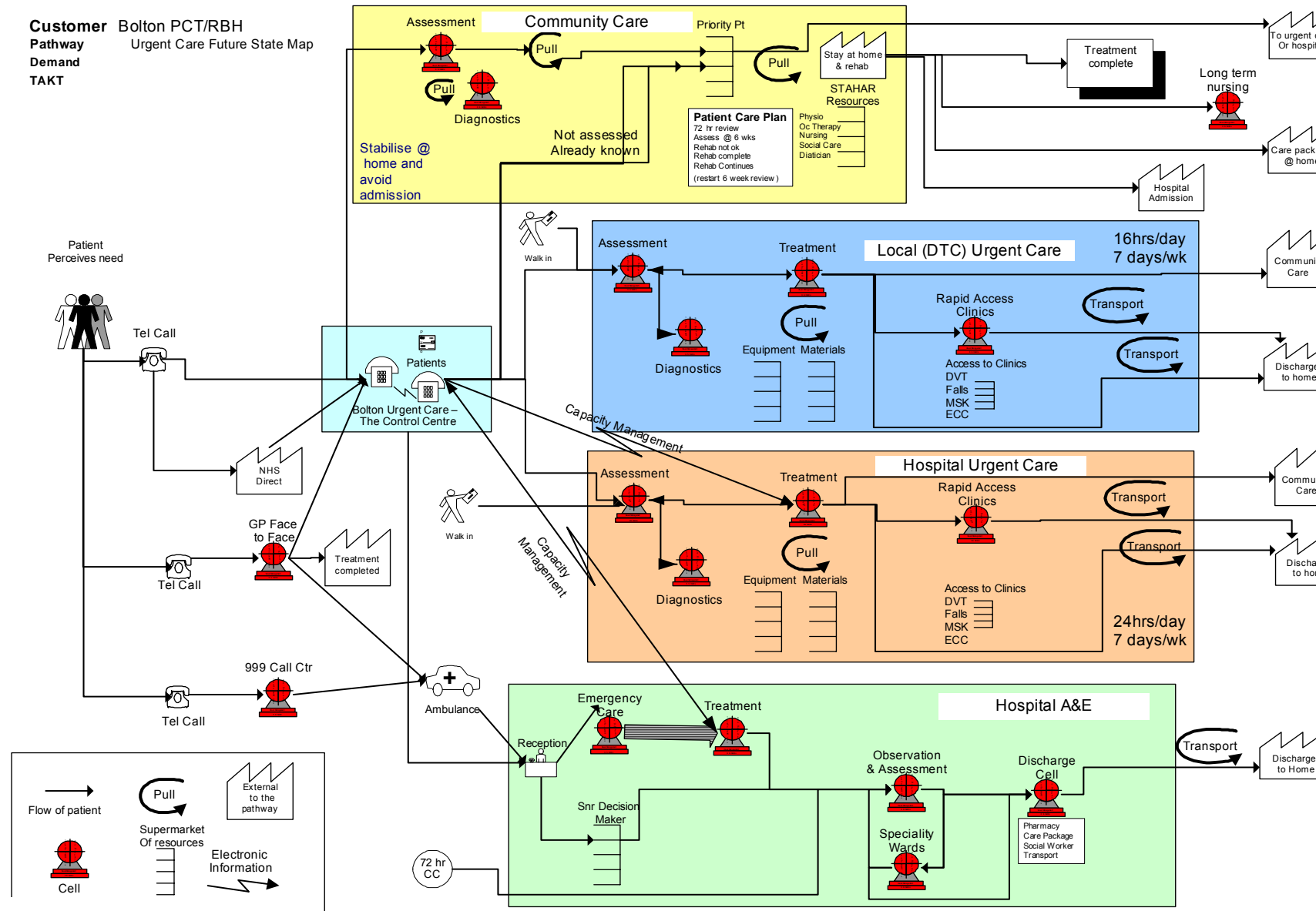
Walk – In Centre

- Poor access to other services therefore pts default to WIC
- Lack of consumable stock on the premises
- Lack of transport
- Referral out from WIC difficult via telephone
- Lack of available diagnostics
- Paper based systems and processes

A&E

- Waste of qualified staff time
- Waiting for xrays, results, beds, specialist opinion, treatment, looking for equipment
- Duplication of assessments

This is the Value Stream Map that demonstrates the vision for the delivery of urgent care by the winter of 2009 using the BICS principles.



The Future Patient journeys explained

Hospital Urgent Care Centre / A&E

I am a self-employed plumber and had cut my thumb. I needed it fixing quickly so that I could get back to work. I went straight to the urgent care centre / A&E on the hospital site and was seen by an emergency nurse practitioner within a few minutes. She decided that I needed an x-ray and I thought that I would then have a long wait. To my surprise, I was seen straight away as they had set up an x-ray in the urgent care centre! The x-ray pictures came back on the cubicle screen really quickly and the nurse was able to stitch my wound and dress it (using supplies already in the cubicle). Then she arranged an appointment for me at my local health centre to take the stitches out after 5 days. This was very different from the last time I came to A&E. The urgent care centre was in a nice big area where everything was clean and visible and in a logical order so that the staff didn't have to go far to get what they needed to treat me. Also, there were no major cases in the department. Last time, I had to wait for the A&E staff to treat people who were very sick before they saw me. This led to a long wait and made me feel guilty for attending with just a sprained ankle.

Town centre A&E with Urgent Care and urgent diagnostics

I am a retired lady and I tripped in town and broke my wrist. I had seen a poster at my doctors' surgery describing the new A&E service in the town centre. This was really convenient as I could walk straight there instead of waiting for an ambulance to take me to hospital and I was in a lot of pain. I was seen by a very nice emergency nurse practitioner who gave me some pain-killers straight away and then I had an x-ray without a wait as it was in the same building. The ENP was able to put a plaster cast on my wrist shortly after and, before I left, an appointment was arranged for me at the fracture clinic. This was so much faster than the last time I went to hospital!

Whilst at a café, I got severe abdominal pain. At the town centre A&E / urgent care centre, I saw a GP who sent me for an immediate ultrasound scan and then transferred me to a surgical ward at the hospital for the night.

My uncle drinks too much. He collapsed in the town and was found by a policeman who took him to the new local town centre A&E department. They transferred him to the Bolton Community Unit to wake up. The next day he was transferred to the detoxification centre and has now given up drinking.

Bolton Urgent Care (telephone and web advice) / urgent clinics / care at home

I am a teacher and I developed a painful, red eye. I was taking an A-level class in the morning so I telephoned Bolton Urgent Care after I had finished. They had the rapid access clinic numbers and were able to arrange for me to go straight to the nearest clinic for speciality assessment that same afternoon. I had expected to have to wait at my doctor's all afternoon for an emergency appointment and then wait a week for a clinic appointment.

I am getting more unsteady on my feet since I was widowed. When I became dizzy, a neighbour phoned Bolton Urgent Care and they arranged for a member of the community care team to see me at home. He assessed me and arranged for me to attend a rapid access clinic on the following day.

Direct to specialty and care at home

I was very frightened when I became short of breath and dialled 999. I was taken to the hospital ambulance reception area, assessed immediately and admitted to a specialist

respiratory care bed. When I was discharged, I was visited at home by the community care team so that I didn't have to wait for a doctor's appointment and travel to the surgery which is miles away. This was much better than my last visit as I did not have to wait for a bed and I went straight to a specialist ward. There were several empty beds around the ward. I am told that this makes the system more efficient and reduces the risk of hospital acquired infections.

Direct to specialty and urgent clinics

Whilst living alone again, I became very depressed and considered ending it all. I went to the hospital A&E / urgent care centre for help and was seen within an hour by a mental health specialist. She arranged for me to have some more support in the community and to see a consultant psychiatrist at the hospital within 24 hours.

Implementation Plan

Appendix 11

This is the Project Implementation plan that visually manages the key milestones, actions, stakeholders and control processes to execute the urgent care strategy.

An implementation team should be formed as soon as possible to ensure implementation of short and medium term actions, and implementation of Winter Plan 2007/8.

A strategic partnership board should be established with senior executive membership from key organisations to agree the strategic direction.

A project board should be established with delegated responsibility for overseeing the implementation of the model of care. This will require membership from Bolton PCT, Bolton Hospitals NHS Trust, Bolton Salford and Trafford Mental Health Trust, Local Authority, NWAS and PPI groups. Professional groups, staff side and unions must be involved in the implementation.

Milestones:

- **Strategy Approval.** High level approval of this recommendation by all key stakeholders. November 2007.
- **Implement short and medium term actions previously identified and include in Winter plan for 2007 – 08.**
- **Financial, estates and workforce implications and assessment.** To commence December 2007 for completion and approval by end of February 2008
- **Communication and Consultation.** To commence December 2007 for completion end of March 2007
- **Appoint Project leads and set up Partnership Board.** December 2007
- **Progress Review.** April 2008.
- **Planning and approval for Community Care Services.** To commence January 2008. Implementation programme to follow approval
- **Planning and approval for Call Centre.** To commence March 2008. Implementation programme to follow approval
- **Community Care Services and Call Centre to be operational by September 2008**
- **Planning and approval for Urgent Care and A&E Services.** To commence June 2008. Implementation programme to follow approval.
- **Urgent care and A&E services to be fully operational by September 2009.**

Timeline	Implementation Team Members																						
	Inputs	Strategic Health Authority	Local Authority	Bolton and Salford Mental Health Trust	PCT Commissioning	NWAS	PCT Estates Dept	PCT Workforce Dept	PCT Director of Finance	PCT Project Lead	PCT CEO & Trust Board	RBH CEO & Trust Board	RBH Project Lead	RBH Director of Finance	RBH Workforce Dept	RBH Estates Department	Social services	Patients	Carers	PPI	Professional Groups	Staff side / Unions	Output
05/10/2007																							
Oct-07										Complete Submission			Complete Submission										
Nov-07	Strategic Document & Implementation Plan	Freeze Point								Review JDs			Review JDs										Go No go Change
Dec-07										Estates/Financial and Workforce Estimates			Estates/Financial and Workforce Estimates										
										Create Partnership Board			Create Partnership Board										
										Appoint Project Leads			Appoint Project Leads										
										Communication/consultation			Communication/consultation										
Feb-08	Latest Strategy & review outcomes	Freeze Point								Estates/Financial and Workforce approval		Estates/Financial and Workforce approval											Go No go Change
Apr-08	Consultation Outcome & all updated plans	Freeze Point								Planned Review		Planned Review											Go No go Change
Jan-08	Future State & Implementation Plan	Freeze Point								Community Cell VSA/2P			Community Cell VSA/2P										Go No go Change
										Community Cell design approval		Community Cell design approval											Go No go Change
										Community Cell Workforce Planning			Community Cell Workforce Planning										
By Sept 08										Community Cell Implementation (7RIEs)			Community Cell Implementation (7RIEs)										
Mar-08	Future state & Implementation Plan	Freeze Point								Call Centre 2P/VSA			Call Centre 2P/VSA										Go No go Change
										Call Centre Approval		Call Centre Approval											Go No go Change
										Call Centre Workforce Planning			Call Centre Workforce Planning										
By Sept 08										Call Centre Implementation			Call Centre Implementation										
Jun-08	Future state & Implementation Plan	Freeze Point								A & EUrgent Care VSA/2P			A & EUrgent Care VSA/2P										Go No go Change
										A & EUrgent Care Approval		A & EUrgent Care Approval											Go No go Change
										A & EUrgent Care Workforce Plan			A & EUrgent Care Workforce Plan										
										A & EUrgent care Implementation			A & EUrgent care Implementation										

LEGEND	INPUT DATA FOR REVIEW	REVIEW SUBJECT & LEADER	BLANK (OTHER REVIEW ATTENDEES)	REVIEW EXIT CRITERIA (GO/NO GO)	TASK DESCRIPTION & OWNER	BLANK (OTHER TASK ENABLERS)	REVIEW DATE
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Implementation Plan from VSA Event

Appendix 11

URGENT CARE REVIEW

WINTER PRESSURES ACTION PLAN

JUST DO IT ✓	OWNER	TO BE COMPLETED	IMPACT
Equipment Access (in store room? Where)	Rachael/Dot	01/10/07	High – patient experience
Specialist RIV in A+E/AMRU (time scale)	Dot	Mid Oct	Moderate – staff morale
GP/A+E patients – WIR (not beds if appropriate)	Rachael	Implement 28/09/07	High – Patient, Targets
Increase RAC times and availability	Rachael	Implement 28/09/07	High – Targets Moderate – Emergency bed days
Dedicated porters from A+E – (taken from x-ray capacity)	Warren	31/10/07	High – patient experience, Targets, staff morale
Radiographic discharge from A+E (quick experiment)	Amanda/Warren	31/10/07	High – patient experience, Targets,
DVT diagnostics	Amanda	28/09/07	Moderate – patient experience Low - Targets
Wheelchair availability for A+E/ signage	Jimmy/Chris M	31/10/07	Moderate – patient experience, targets
Transfers to BUC for further assessment/social from AMRU	Jacqui Bliss	31/10/07	Moderate - targets
Psychiatry reviews on AMRU – in timely manner (136 issues)	Yad	Communicate with Consultants immediately	Moderate – targets (many breaches from small % of patients)
Raise awareness of services for GPs/Access	Ian	31/10/07	Low/Moderate – patient experience, targets
Single assessments (documentation) (may take time)	Evan (LD)	Communicate with Consultants immediately	Moderate/high – patient experience, targets
Patients to walk to x-ray	Amanda	24/09/07 - experiment	High – capacity issues
Hot reporting x-rays	Amanda	24/09/07 - experiment	High - capacity
Site Co/Bed Manager to take surgical/Orthopaedic/ENT referrals	Dot	28/09/07	High – capacity, remove waste, patient experience
Darley Court Diagnostics	Amanda	28/09/07	High – capacity, patient experience
Real time bed states (clarity of roles)	Dot	Mid Oct	High - capacity
Prevention of illness (i.e. flu vaccines) – publicity	Ian	Mid Oct	Moderate – long term effectiveness
Out of area admissions – delayed discharge (25%)	Jacqui Bliss/Evan	Long term	High – patient experience, capacity
Direct referrals to IMC from any Therapist (target – assessment within 24	Emma	By Nov	High – capacity, patient experience

hours)			
Availability to IMC / Social support	Emma	By Nov	High – capacity, patient experience
Pharmacy availability – out of hours	Sally	Nov	Moderate
RRT, Crisis RT = work together to keep patient at home, IC @ home and social care	Chris L/Jen	Winter 07 experiment	High – streamline, waste
Pre hospital bloods (i.e. via ambulance crews)	Carl	Experiment	Average/Moderate
Staff availability and skills (for pressured times)	Dot/Lynne H	? Oct/Nov	Average/Moderate
Booking in system in A+E	Warren	Experiment	Average/Moderate
Tel no for transport for urgent transfers i.e. Darley Court to hospital	Carl	Nov	High – residential Low in patient admission

References

Department of Health 2000, The NHS Plan, a plan for investment and plan for reform, DH, London

Department of Health 2005 Taking Healthcare to the patient. Transforming NHS Ambulance services, DH, London

Department of Health 2006 Direction of Travel for Urgent Care: a discussion document, DH, London

Department of Health 2006 Our Health, Our Care, Our Say: a new direction for community services, DH, London

Which 2006, Which Way? – Negotiating the Out of Hours Maze, Policy Report, Which, London

Glossary

A&E

The NHS brand name for emergency hospital based services. Red A&E logos appear on street signs in all towns with district general hospitals. It is colloquially known as “casualty” and provides a comprehensive range of emergency care including resuscitation, major illnesses and minor trauma. Increasingly patients with conditions traditionally seen in general practice present to A&E departments. Almost all A&E departments are open 24 hours a day every day of the year. In a typical UK department 20% of patients arrive by emergency ambulance and the other 80% by their own means.

Care plan

A professional programme of care which may involve several professions and agencies

Chief Executive

The managing director of an organisation

Condition

A disease, illness or injury

Continuing Care Teams

Teams of professionals who are responsible for a patient’s on-going treatment and support

Crisis Response Teams

Teams that provide intensive support for people with severe mental illness to help them through periods of crisis or breakdown

Diagnostic and treatment centre (DTC)

A new building in the town centre which will give patients much better access to x-rays and other investigations and some treatments

Emergency Care

Care which is immediately available day and night 365 days a year. It may be as simple as advice or reassurance

Emergency Care Department

An A&E department

GP

A general practitioner or family doctor

GP Contract

New working arrangements for GPs were introduced by the Government in 2006. Out of hours care was transferred from individual GPs to local PCTs.

GP Direct

Telephone contact point for GPs requesting Hospital admission

Long term condition

Conditions such as diabetes, asthma and arthritis that cannot at present be completely cured but whose progress can be managed and influenced by medication and other therapies.

NHS Direct

An NHS service that provides 24 hour access to health via telephone (0845 4645), a website (www.nhsdirect.nhs.uk), an interactive digital TV service and printed guides.

Observation and assessment Area

A short stay area (with beds) for keeping an eye on patients who are expected to improve quickly

Out of Hours

Outside of normal working hours

Specialist

Doctor (or nurse) with a knowledge of a particular area of care

Summary Care Record

A new system of electronic patient records which can (with a patient's permission) be viewed by urgent care staff in an emergency

Terms of Reference (TOR)

The conditions set for the review

The practice

Group of doctors and other staff who work together

Unscheduled care

Care which is required without an appointment or prior arrangements

Urgent care

Care which is available quickly (within 48 to 72 hours) but not day and night 365 days a year.

Urgent Care Centre

A walk-in centre which treats patients without the full facilities of an A&E department

Urgent Care Review

The work underpinning this document