NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group
Governing Body
Paper Summary Sheet

For: PUBLIC session ☒ PRIVATE session ☐

Date of Meeting: 24 November 2015

For: Decision ☒ Discussion ☐ Noting ☐

Agenda Item and title:	**GOV/15/11/12 Emergency Surgical Ambulatory Care (ESAC) at RUH**
Author:	A Jennings – Senior Commissioning Manager
Lead Director/GP from CCG:	M Harris – Director of Acute Commissioning
Executive summary:	The ESAC service at RUH ensures that patients who typically would otherwise have a non-elective admission, or in some cases an elective admission, are seen and treated on an ambulatory care basis. This provides a better patient experience; a reduced length of stay; a lower cost per patient to the CCG; and follows the CCG's preferred direction of travel (greater provision of ambulatory care-based services, and reduction in avoidable bed-based activity). The ESAC service at the RUH is currently agreed by CCGs, and funded at a local tariff rate, non-recurrently. It has been in operation since 2013. The RUH has requested that the commissioning of the ESAC service be agreed on a long term ongoing basis. Following a clinical, financial, and information-based review of the service, and subsequent clarification by RUH of a number of previously unresolved recording and reporting issues, the paper supports this request. On 10 Nov 2015 the Clinical Executive supported the proposal. The Governing Body is requested to formalise the commissioning of the ESAC service on an ongoing basis.
Evidence in support of arguments:	The service review at Appendix A comprising clinical, recording, reporting and finance elements; the RUH Finance & Information Group (FIG) led by CCG representatives, have agreed the resolution of the outstanding areas requiring clarification.

Who has been involved/contributed:	Acute Commissioning Team including Finance Lead Lindsay Kinlin (GP; WWYKD Exec)
Cross Reference to Strategic Objectives:	B. Commission appropriate services to meet the needs of the local population and national priorities, delivered in the right place (ideally in a primary care setting but acute where necessary) and accessible at the right times identifying and addressing health inequalities. D. Achieve a sustainable health economy optimising appropriate use of resources for the delivery of efficient and effective healthcare.
Engagement and Involvement:	Patient feedback is positive (see clinical review) Other CCGs whose patients use the service are supportive
Communications Issues:	None identified
Financial Implications:	The service delivers a saving to Wilts CCG of £67K p.a. at current level of activity with scope for this to increase as activity increases
Review arrangements:	Through normal contracting round arrangements
Risk Management:	Current Risks and mitigations: - Impact of future local tariff arrangements for ambulatory care – the ESAC work and tariff will help inform the process and outputs of work to agree local ambulatory care tariffs at RUH and elsewhere - Alignment with 16/17 commissioning arrangements – any mitigation required, will be managed in the same way as with all other local and national tariffs - Failure to continue to deliver the cost benefits already identified – reviewing data through existing monthly contract process and challenge as necessary - Request for tariff price change– to be negotiated if required
National Policy/ Legislation:	Not applicable
Equality & Diversity:	No issues identified
Other External Assessment:	No issues identified
What specific action re. the paper do you wish the Governing Body to take at the meeting?	That the Governing Body agree to the commissioning of the service on an ongoing basis, at the tariff price indicated.

NHS
Wiltshire
Clinical Commissioning Group
6 Nov 2015

Proposal to Agree the Long Term Continuation of the Emergency Surgical Ambulatory Care (ESAC) Model at Royal United Hospitals Bath NHS Foundation Trust (RUH)

INTRODUCTION

RUH is seeking approval from CCGs for the enduring commissioning of the Emergency Surgical Ambulatory Care (ESAC) pathway model. The purpose of this paper is to seek Governing Body agreement. Clinical Executive approval was given on 10 Nov 2015.

RECOMMENDATIONS

It is recommended that the Governing Body agree to the enduring commissioning of the RUH ESAC pathway model.

It is recommended that CCG approval is made contingent upon RUH seeking to further reduce the proportion of ESAC patients who also attend the ED.

It is recommended that, through the work of the CCG's Ambulatory Care Working Group, the opportunity is taken to explore the use the RUH ESAC costing model to help develop similar pricing for the broadly equivalent services currently being run at SFT and GWH, to promote a common Wiltshire-wide approach.

BACKGROUND[1]

At the Wilts CCG Governing Body July 2013 the ESAC model was approved to be piloted. It was and remains aimed at reducing the number of NEL admissions, by employing a dedicated Emergency Surgeon(s) to assess, diagnose and operate on patients who were previously being admitted to a bed on SAU, waiting for surgical review and then either being discharged or progressing to surgery. Often these patients are lower priority for theatre slots and have a high pre-operative length of stay. The service focussed initially on:

- Abdominal/groin pain
- Abscess
- Wound/post-op problem

And to a lesser degree:

- Rectal pain/prolapse
- PR bleeding

The benefits were expected to be: improved patient experience; faster treatment for patients; GP access to Consultant opinion using the GP direct admit pathway; reduced NEL activity; a tariff reflecting a reduced LOS; reduced demand for acute trust inputs (usually bed days); improved acute trust scheduling; improved acute trust ability to manage demand.

[1] Majority of text in this section is taken directly from, and summarised from, RUH proposal dated 05.02.2014

CCG REVIEW

RUH is seeking the enduring commissioning of the service by CCGs at an agreed local tariff. In order to establish whether CCGs wished to routinely commission this service, a review was carried out in Dec 2014/Jan 2015 by Wilts CCG on behalf of all CCGs. This identified that the clinical case was proven: from a clinical perspective this is a safe, well led, and clinically robust service which is straightforward for GPs to access and has improved the quality of the patient experience when they present with an ambulatory surgical condition. The full review report including detailed clinical report is at Appendix 1.

However the review identified unresolved issues regarding reporting, recording and therefore cost effectiveness. A paper was presented to the Clinical Executive in Feb 2015 detailing the findings of the review and recommending the continuation of support to the ESAC model pending the resolution of the unresolved issues. This was agreed.

RESOLUTION OF UNRESOLVED ISSUES

Reporting & recording issues that were identified have now been addressed and resolved, to the satisfaction of the RUH Finance & Information Group (FIG). The FIG meets monthly and comprises Information and Finance representatives of RUH, Wilts CCG and B&NES CCG. Their agreement, that the reporting and recording issues have now been resolved, is minuted in the Minutes of both the FIG and the RUH Commissioning College to which the FIG reports. The activity information being reported is now accepted as being accurate.

Financial effectiveness and performance against the ESAC business case assumptions were also challenged by commissioners. The work to address the reporting and recording issues has resulted in further iterations of the financial effectiveness calculation provided by the RUH. The service, on its current throughput, generates a net saving across all CCGs of £167K per annum (£67K for Wilts). The revised financial effectiveness model is at Appendix 2.

The previously unresolved issues and the resolution are summarised below:

- Recording and reporting errors: duplicates have been identified and removed, errors have been corrected
- The value of overall saving: revised, and detailed in latest financial model dated 9 Oct 2015 (attached)
- Impact on average length of stay for patient cohort: Month 1-Month 4 saving of 150 bed days per month for c.90 patients/month = c.1.6 bed days reduction in LOS per patient
- Charging, for some patients, of both ESAC tariff and NEL tariff: where patient also has a NEL admission, the ESAC charge is now at the rate of a General Surgery OP appointment – this is c.80% lower than the standard ESAC rate
- Reduced admissions due to GP phone consultation: the ESAC Consultant receives up to 4 calls from GPs per day for patients who would otherwise attend and be admitted to the RUH. Conservative estimate of one reduced admission per day = 220-250 reduced admissions p.a.

- Basis of tariff: this is based on costs incurred, primarily it relates to staff costs; details of all costs incurred have been shared with commissioners; ED attendance element for that part of the cohort accessing ESAC via ED also reflects the lowest level of ED charge.

As a result, all of the concerns that existed prior to, and identified during, the review, have now been addressed.

NEXT STEPS

Following CCG approval, there is further scope to expand the service, which in turn will result in increased net financial benefit to the CCG. There is also scope to carry out further refinement of the model in order to further increase the reduction in ED activity and again improve both the patient experience and the net financial impact for the CCG.

A Jennings
Senior Commissioning Manager
Wiltshire CCG

Appendix 1 –

4 Feb 2015

Review of Emergency Surgical Ambulatory Care (ESAC) Model at Royal United Hospitals Bath NHS Foundation Trust (RUH)

INTRODUCTION

The purpose of this report is to provide a review of the effectiveness of the RUH Emergency Surgical Ambulatory Care (ESAC) model. The review considers the delivery and impact of the model from a number of perspectives. It has been carried out by Wiltshire CCG on behalf of all CCGs whose patients use the service.

BACKGROUND[2]

The ESAC model was first piloted in 2013/14, aiming to reduce the number of NEL admissions by employing a dedicated Emergency Surgeon to assess, diagnose and operate on patients who were previously being admitted to a bed on SAU, waiting for surgical review and either being discharged or progressing to surgery. Often these category C/D patients were lower priority for theatre slots and had a high pre-operative length of stay. The service focussed on:

- Abdo/groin pain
- Abscess
- Wound/post-op problem

And to a lesser degree:

- Rectal pain/prolapse
- PR bleeding

The benefits were expected to be: improved patient experience; faster treatment for patients; GP access to Consultant opinion using the GP direct admit pathway; reduced NEL activity; a tariff reflecting a reduced LOS; reduced demand for acute trust inputs (usually bed days); improved acute trust scheduling; improved acute trust ability to manage demand.

Recording and coding of activity proved to be difficult, resulting in commissioner concerns about the real benefit opportunity that the service offered. As a result Commissioners agreed to continue to support the service for the first 6 months of 2014/15 under a local tariff, pending a review, which would consider:

- Total numbers going through the clinic v forecast/plan (119/month)
- Whether the % of those going on to have surgery was per the current assumptions
- The number that are prevented from being admitted through phone consultation with a GP
- Sample case note review with local GP(s) to ensure the inputs set out in the Trust local tariff is justified
- A comparison of non-elective surgical admissions during Q1 & Q2 with Q2 and Q3 in 2013/14

[2] All text in this section is taken directly from, and summarised from, RUH proposal dated 05.02.2014

Approach / Scope

A number of concerns existed prior to the review:

- Activity levels were thought to be below the planned levels, therefore the service was unlikely to be delivering in full the anticipated benefits.

- Activity reporting anomalies were identified, resulting in erroneous excess charging. These have been fed back to the RUH and manual adjustments made. Reassurance is required to ensure that this is corrected routinely before charging to CCGs, in order to reduce the need to validate and check. Anomalies included:

    - Additional unbundled diagnostic charges – duplicating the diagnostic cost element already built into the ESAC price.
    - Multiple ESAC charges on same day / consecutive days – all attendances in the clinic were originally being recorded as NEW attendances rather than as a mix of NEW and Follow Up.
    - Same-day / consecutive day ESAC and with subsequent NEL admission charge – ESAC model is based on no ESAC charge if a NEL admission results.
    - ESAC NEW attendances being charged at £756 (per the original business case) rather than the £746 indicated in the final proposal put to CCGs

The review was to be based on information provided by the RUH, in the form of interviews and data sharing. It has not been possible to achieve all of the aims of the review as originally envisaged, due primarily to time constraints.

The nature of the review was revised in light of further discussion. The timing of the review was delayed due to challenges in ensuring availability of relevant clinical and managerial colleagues.

The approach taken was to remain aligned to the original intent so far as reasonable, and to consider the effectiveness of the service from four perspectives:

- Clinical effectiveness/quality

- Reporting & recording

- Financial effectiveness - performance against the ESAC business case assumptions

- Impact on ED / NEL activity levels

Findings

1. Clinical Effectiveness and Quality

This aspect of the review was carried out by Dr Lindsay Kinlin, a GP member of the WWYKD Group Exec within Wiltshire CCG. The focus was on:

- Patient experience examples

- Transition from primary care into secondary care and back out again – particularly looking at handovers (between clinicians, and also information given to the patient).

- Alignment to ensure that the service is safe, and good decisions are made at the right time for the patient.

- The speed of the pathway.

The full clinical review report is at Appendix 1. It concluded:

> From a clinical perspective this is a safe, well led, and clinically robust service which is straightforward for GPs to access and has improved the quality of the patient experience when they present with an ambulatory surgical condition.

Additionally, the ESAC clinical lead fed back the following perspective on the strengths of the model:

- Patients like it - good patient feedback and experience data

- Those patients who need urgent surgery get operations quicker

- LOS has fallen

- GP/ED doctors like it

- Nationally RUH is now very well regarded by ECIST and AEC, and regularly has other Trusts approaching to model the opportunities presented.

2. Reporting & Recording

RUH had acknowledged that there have been some challenges in the reporting and recording of the episodes of care during the current year for those patients who as part of their pathway have used the ESAC service. These errors have not necessarily originated from the reporting and recording of the ESAC element of the episode/pathway, although in some cases, this may have also been the case.

This has continued to influence the degree to which we can rely on the reported financial and operational effectiveness of the ESAC service, and these issues will need to be fully resolved on a sustainable basis, in order that the effectiveness of the ESAC service within the wider RUH systems, can be fully demonstrated.

3 & 4. Financial effectiveness - performance against the ESAC business case; Impact on ED / NEL activity levels

These two perspectives are considered together. The planned operational and financial impacts of the ESAC service were described in the ESAC business case, and are detailed in the table below. This indicated, for the expected volume of activity, a cost reduction to all CCGs of £477K annually based on an activity level of 1,428 patients seen/treated/admitted as NEL, annually, compared to previous arrangements. This activity level was identified as the expected volume by RUH. A risk share

agreement was put in place should activity levels increase above 15% of planned activity levels in order to mitigate against any possibility that the service might ultimately prove to be more expensive overall than the previous arrangements:

	Monthly	Annual
Number of patients who meet the criteria for ESAC (a)	112	1344
Number of Patients seen but admitted Non Electively (b)	7	84
Total (c)	119	1428

		Monthly		Annual		1.080476
Old Model of Care:	Tariff	Activity	Income	Activity	Income	With MFF
33% (c) attend A&E first, remainder are direct referrals	£105	39	£11,760	468	£49,140	£53,095
All result in NEL activity at average tariff:						
"More serious"	£2,362	39	£92,099	468	£1,105,184	£1,194,125
"Less serious"	£1,032	80	£82,530	960	£990,360	£1,070,060
Total income under Old Model			£186,389		£2,144,684	£2,317,280

		Monthly		Annual		1.080476
New model of Care:	Tariff	Activity	Income	Activity	Income	With MFF
5% (c) Attend A&E first, remainder are direct referrals	£58	6	£348	72	£4,176	£4,512
94% (c) attend ESAC clinic as a First Appointment	£746	112	£83,538	1,344	£1,002,461	£1,002,461
11% (a) attend ESAC clinic as a Follow Up Appointment	£82	12	£984	144	£11,808	£12,758
28.8% (a) Referred from clinic for Elective procedures	£1,459	32	£46,683	384	£560,199	£605,281
NEL Admissions (no ESAC clinic charge)	£2,362	7	£16,531	84	£198,366	£214,330
Total income under New Model			£148,084		£1,777,010	£1,839,343
INDICATIVE INCOME IMPACT			-£38,304		-£367,674	-£477,937

The actual activity reported by RUH shows a reduced total volume, and different % presenting through ED first; then leading to NEL admission; and also a number leading to EL admission:

	Apr-Aug	Monthly		Forcast Outcome	
Number of patients who meet the criteria for ESAC (a)	269	54		750	
Number of Patients seen but admitted Non Electively (b)	36	7		100	
No of people with multiple attendances	47	9		131	
Total (c)	352	70		982	

		Monthly		Forcast Outcome		1.080476
Old Model of Care ESTIMATE:	Tariff	Activity	Income	Activity	Income	With MFF
33% (c) attend A&E first, remainder are direct referrals	£105	23	£5,649	324	£34,020	£36,758
All result in NEL activity at average tariff:						
"More serious"	£2,362	23	£54,315	326	£769,850	£831,805
"Less serious"	£1,032	47	£48,899	656	£676,746	£731,208
Total income under Old Model			£108,863		£1,480,616	£1,599,770

		Monthly		Forcast Outcome		1.080476
New model of Care:	Tariff	Activity	Income	Activity	Income	With MFF
10.2% (c) Attend A&E first, remainder are direct referrals	£58	6	£348	87	£5,046	£5,452
86.6% (c) attend ESAC clinic as a First Appointment	£746	61	£45,497	850	£633,981	£633,981
13.4% (a) attend ESAC clinic as a Follow Up Appointment	£82	9	£738	132	£10,824	£11,695
19.7% (a) Referred from clinic for Elective procedures	£1,459	12	£17,506	168	£245,087	£264,811
NEL Admissions (no ESAC clinic charge)	£2,362	7	£17,003	100	£237,170	£256,257
Total income under New Model			£81,093		£1,132,108	£1,172,195
INDICATIVE INCOME IMPACT			-£27,770		-£348,508	-£427,575

Although diagnostics costs are currently included in the bundled ESAC charge, there is a proposal from RUH to unbundle diagnostics across the Trust. At this point, it will be necessary to conduct a review to agree the value at which the “basic” (no diagnostic element included) ESAC tariff should be set. This in turn will provide greater clarity of the relationship between ESAC tariff and ESAC inputs.

Impact Analysis:

A&E. There has been a reduction in A&E attendance first for this patient cohort; although not be as much as was anticipated. Before ESAC began, 33% of this group would have attended A&E first. The expectation was that under the ESAC model, 5% would come via A&E. The reality is that 10% have come via A&E. Hence the level of benefit achieved has been slightly lower than expected.

NEL episodes. Before ESAC began, all patients in the now ESAC cohort would have had a NEL episode. The expectation was that under the ESAC model, 84 of 1,344 (6.25%) patients annually would still have a NEL admission - and none of these would also generate an ESAC charge. The reality (forecast outcome, based on 6 months' data) is that 100 of 982 (10.2%) will still have had a NEL episode but no ESAC charge. This is a bigger proportion than expected. Since the average NEL cost is considerably higher than the ESAC attendance cost (£2,362 vs £746), the level of benefit achieved has been lower than expected.

EL episodes. Before ESAC began, there was no calculation of a proportion of patients going to EL episode. The expectation under the ESAC model, was that 28.8% would be referred on from ESAC clinic to EL procedure, average cost £1,459 plus the ESAC charge £746. The reality is that 19.7% have been referred from clinic for EL procedure. This is a smaller proportion than expected. This expectation has over delivered in terms of benefit to CCGs in terms of the original model assumptions. Note, however, the related area detailed below as requiring clarification.

Avoided admissions: the number that are prevented from being admitted through phone consultation with a GP is not known.

Areas Requiring Clarification:

The data currently available leaves a number of areas requiring clarification in order to ensure the correct conclusions are drawn. These include the following:

The pre-ESAC model, and the ESAC business case, did not specify any patients attending ESAC (whether via A&E or not) then an EL admission. It is assumed that a patient, who has a first ESAC appointment then an EL procedure, incurs an ESAC charge and also an EL referral charge (£746 plus £1,459). If so, it is unclear whether, in these cases, paying ESAC plus EL represents overall improved value for commissioners, compared to the alternative (which would presumably be either: A&E plus NEL plus EL; or OP, diagnostics, and EL tariff).

Details of the impact of the ESAC model on average LOS for the cohort of patients seen and treated by ESAC (one of the originally stated measures for the success of the scheme) are not currently known.

Confirmation is required that the recording arrangements now ensure there is no ESAC charge where there is then a NEL admission; and that no additional diagnostic charges are being applied to the current tariff arrangement.

There is no information currently available regarding the number of patients who are prevented from being admitted through phone consultation with a GP.

Clarification is required as to whether the originally proposed tariff of £746 is now a realistic value to cover the costs of delivering this service, given the reduction in activity as compared the original plan.

Should diagnostic unbundling be applied to the ESAC tariff, the full financial impact of this change is not currently known.

The number of patients who are prevented from being admitted through phone consultation with a GP is not known.

Conclusion

From a clinical perspective this is a safe, well led, and clinically robust service which is straightforward for GPs to access and has improved the quality of the patient experience when they present with an ambulatory surgical condition. It appears to have been less than completely successful when considered against the other perspectives. Greater robustness and accuracy of the reporting and recording of activity across the whole patient pathway will help to provide the additional reassurance not currently available. This will also enable improved evidencing of the impact on LOS; NEL activity; EL activity.

Recommendations

Overall the review recommends the continuation of ESAC model with a view to make it business as usual, caveated by the requirement for it to be supported by reliable, accurate and transparent recording, coding and charging. In particular, all elements of the full pathway, for those patients whose pathway includes ESAC input, needs to be monitored, to remove any potential reporting errors.

It is recommended that the RUH provide further details, for commissioner review before the end of Q1 15/16 in response to the areas requiring clarification (except diagnostic unbundling impact on ESAC tariff, which will need to follow in due course).

A Jennings
Commissioning Manager
Wiltshire CCG

Appendix 1 - Clinical Report on RUH Emergency Surgical Ambulatory Clinic (ESAC)

Introduction

I interviewed the consultant in charge of the clinic Miss Sarah Richards on 16/12/14. The purpose of this interview was to look at clinical aspects of the service as part of a review of the contract between Wiltshire CCG and the RUH.

The conversation was wide ranging but covered the following themes:

Accessing the clinic

Patients are referred into the clinic in a variety of ways:

- from the community via GP
- from A+E via ESAC clinicians 'pulling out' patients they think will be suitable for ESAC
- from OOH centre next to RUH A+E via OOH GP
- from consultant colleagues for patients who are suitable for 'accelerated discharge' – this now accounts for about 25% of the clinical workload.

When referred by the GP a clinical discussion is had between ESAC and the GP prior to referral to ensure that the patient is considered fit to wait until following morning to be seen. This question 'is the patient able to wait until morning and then come into the clinic?' is a good method of clarifying the appropriateness of the patient for the ESAC approach. If it is felt that the patient is not safe to wait until then, then another referral pathway needs to be used. If the patient can wait, then they present at the clinic having had a light breakfast. The patient is assessed and any investigations are completed in the morning. If the patient needs surgery they are then operated on that afternoon with the expectation that they will go home that evening.

Education across the GP population about how the clinic works is still needed, to reinforce messages about which conditions can be treated, how to frame expectations for the patient so they understand it is an ambulatory service (some patients still turn up to the clinic with overnight bags), and updates on the management of common surgical conditions such as appendicitis, where it is considered safe to assess the patient the following morning, (and in fact this approach may actually result in faster access to theatre than the conventional admission route).

Some patients simply access a surgical assessment, urgent investigations and are discharged home with advice to the GP. This letter is typed within 24 hours so that the information reaches the GP in a timely manner. Miss Richards says she tries to add contingency advice in this letter, so that the GP has a plan of care to help with ongoing follow up of the patient.

Some patients are sent home but held on a waiting list - 'the red board', where they are provisionally booked an operation slot, on the understanding that they may be called in at short notice to have their operation. Typically these patients are waiting for cholecystectomy. We discussed a particular patient who has 3 small children at home, where an inpatient stay while waiting for her operation slot would be very disruptive for her family. She is currently at home, waiting for her call up for surgery. A typical inpatient stay for urgent cholecystectomy would be 6 days while waiting for

theatre time to become available. National guidance for patients with gallstone pancreatitis suggests that laparoscopic cholecystectomy should be done within two weeks to prevent further attacks. The ESAC pathway allows this surgery to happen on an expedient basis and therefore reduces morbidity. An obvious clinical benefit for patients who remain at home instead of in hospital is that they are far less likely to develop infectious disease such as norovirus while waiting for their operation. The more intangible benefits from staying at home - such as maintaining social networks and independence will be increasingly important as the population becomes older and frailer and the often fragile networks of support risk being disrupted by even short hospital stays.

Patients on the accelerated discharge programme typically have issues such as wound infections or post-op collections where they do not need to stay in hospital, but still need regular surveillance - e.g. face to face reviews, scans and blood tests eg. CRP checks to ensure that they are recovering steadily.

-Miss Richards believes this part of the service could be nurse-led with clinical supervision from her. Perhaps selected patients could be transferred into community led care with remote / virtual support from Miss Richards and her team?

Complaints

The clinic has now been running for 17 months and to date Miss Richards has had only one complaint. This patient was referred in with a possible inguinal hernia, but on examination and investigation was shown to have an inflamed lymph node which was eventually excised. There was a delay in ultrasound diagnosis, as there are variations in the skills of the ultrasonographers for performing certain scans, and on the day this patient had his scan, the radiographer was not trained to scan for hernias. There was further delay before he had his excision of lymph node due to factors which were beyond the control of the ESAC team. The patient was phoned regularly by Miss Richards to ensure he was not deteriorating while waiting for his surgery. It would appear from the account of this complaint that the quality of care that this patient received was of a good standard and the ESAC approach did not lead to a poorer quality of care than he would have received with usual care.

The skill mix of the radiology team is outside the remit of this clinical review, but it may be worth reviewing the radiology support being offered to the ESAC, particularly as a defining feature of this service is rapid access to diagnostics which result in the patient being able to go home safely.

Future development

Miss Richards is keen to develop a PR bleed pathway with rapid access to sigmoidoscopy. This may help relieve some of the anticipated pressures on rapid access to bowel investigations.

She is also keen to develop an email advice service for GPs as a further way of managing demand and access to urgent diagnostics.

Within the RUH there has been some discussion about developing an ESAC team with a rolling rota of 4 consultants who spend 2 weeks ‘on take’ with alternate days covering A+E and ESAC, with one week to do elective operations in a surgical speciality and one week for training/clinical

admin/service development/holiday cover. One possible benefit of this system is that it would release speciality surgeons to continue doing elective work more consistently, as they will not be forced to cancel elective lists due to emergencies resulting from their on-call commitments – this would result in more efficient use of theatre resources, and backing up of elective waiting list times.

Summary

This initiative has been well-received by the primary care community and patient feedback via primary care has been generally positive. There are some areas where the service can be improved such as improving the GP / secondary care interface, and ensuring that patient expectations are framed clearly about the service.

There is potential for the ESAC approach to be extended into other ambulatory surgical conditions, which will lift pressure off other services and release capacity for them to deal with the more complex surgical problems.

A general shift in approach towards managing more of the clinical pathway in the community using remote/virtual support from the ESAC team is feasible and could be developed with minimal investment needed.

Recommendation

From a clinical perspective this is a safe, well led, and clinically robust service which is straightforward for GPs to access and has improved the quality of the patient experience when they present with an ambulatory surgical condition.

Dr Lindsay Kinlin
GP - The Avenue Surgery Warminster
GP Commissioner - Wiltshire CCG

Appendix 2 - ESAC Financial Modelling dated 9 Oct 2015

Based on April - July activity as at 27 August 2015 adjusted for actual activity							
Number of patients who meet the criteria for ESAC		**Monthly 89**		**Annual 1,068**			
		Monthly		**Annual**			1.08072
Old Model of Care:	**Tariff**	**Activity**	**Income**	**Activity**	**Income**		**With MFF**
33% attend A&E first, remainder are direct referrals	£105	29	£11,760	348	£36,540		£39,490
All result in NEL activity at average tariff:							
"More serious"	£2,362	25	£59,038	300	£708,451		£765,637
"Less serious"	£1,032	64	£66,024	768	£792,288		£856,241
Total income under Old Model			**£136,822**		**£1,537,279**		**£1,661,368**
		Monthly		**Annual**			1.08072
New model of Care:	**Tariff**	**Activity**	**Income**	**Activity**	**Income**		**With MFF**
38% Attend A&E first, remainder are direct referrals	£56	23	£1,302	279	£15,624		£16,885.17
62% attend ESAC clinic as a First Appointment	**£746**	62	£45,871	738	£550,456		£594,889
18% attend ESAC clinic as a Follow Up Appointment	£88	11	£968	132	£11,616		£12,554
22% Referred from clinic for Elective procedures	£1,506	14	£20,330	162	£243,954		£263,646
NEL Admissions (no ESAC clinic charge)		0	£0	0	£0		£0
Total income under New Model			**£68,471**		**£821,650**		**£887,974**
Agreement at SAU pathways meeting 10/7/14							
General Surgery OP attendance charge where patient attends ESAC clinic but ESAC tariff is not charged							
All result in NEL activity at average tariff	£1,574	27	£42,498	324	£509,976		551,141
General Surgery 1st Op attendance	£143	27	£3,861	324	£46,332		50,072
General Surgery Follow up attendance	£88	5	£440	60	£5,280		5,706
Total income under subsequent agreement			**£46,799**		**£561,588**		**£606,919**
INDICATIVE INCOME IMPACT			**-£21,552**		**-£154,041**		**-£166,476**
			Estimated Commisioner Split				
			Banes		40%		-66,590
			Wilts		40%		-66,590
			Somerset		20%		-33,295
					100%		**-166,476**

NHS Wiltshire Clinical Commissioning Group

Equality Impact Analysis – the EIA form

Title of the paper or Scheme: Emergency Surgical Ambulatory Care (ESAC) Model at Royal United Hospitals Bath NHS Foundation Trust (RUH)

For the record	
Name of person leading this EIA A Jennings	Date completed 13 Nov 2015
Names of people involved in consideration of impact A Jennings	
Name of director signing EIA M Harris	Date signed 13 Nov 2015

What is the proposal? What outcomes/benefits are you hoping to achieve?
To agree to the enduring commissioning of the RUH ESAC model, resulting in more timely care for patients, reduced length of stay, improved patient experience, reduction in non-elective admissions, and reduced cost for the CCG. The Governing Body approved the ESAC model in July 2013, on a pilot (non recurrent) basis, and it has been in use since that time.

Who's it for?
All patients presenting to, or referred to, the RUH, requiring urgent or emergency surgery for a range of conditions for which the patient does not need to be admitted to a hospital bed

How will this proposal meet the equality duties?
Referral to the emergency surgical ambulatory care service is based on medical need and is in line with our equality duties. Patients referred to the service undergo diagnostics, assessment and where appropriate same day treatment. If unable to undergo surgery the same day, patients are able to go home and await call-in, rather than occupy a bed whilst awaiting a theatre slot for typically up to 6 days. This reduces the disruption to normal daily life that is experienced by all patients using the service. Other patients, referred to the service following an in-patient non-elective stay, for post-operative wound management, are able to leave hospital sooner than would otherwise be the case, again reducing the disruption to their normal daily life. The service also helps avoid some patients being referred unnecessarily to hospital, by providing advice and guidance to GPs.

What are the barriers to meeting this potential?
No impact. The service is open and accessible to all. The RUH service has undergone a clinical review conducted by a Wiltshire CCG Exec GP, and the RUH model is well regarded nationally, by both ECIST and AEC, with other trusts regularly requesting visibility of the service delivery model being used. A copy of the RUH EIA is attached.

2 Who's using it?

Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?
The service is open and accessible to all. Appropriateness of any patient for the service is not influenced by whether the patient belongs to any of the equality groups, but purely by their need for urgent or emergency surgical ambulatory care assessment and/or treatment.
Patient feedback via primary care has been generally positive.

How can you involve your customers in developing the proposal?
The service has been running for over two years, funded non-recurrently. Patient feedback is

collected by the service and was reported during the service review in Jan 2015 as positive, the service has been further refined as a result of patient feedback received

Who is missing? Do you need to fill any gaps in your data? (pause EIA if necessary)
Nil. The Trust has a robust framework for clinical governance, regularly reviewing its clinical outcomes, complaints and compliments and the results of audits. No gaps identified.

3 Impact Refer to dimensions of equality and equality groups

Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation and if appropriate: financial economic status, homelessness, political view

Using the information in parts 1 & 2 does the proposal:

a) Create an adverse impact which may affect some groups or individuals. Is it clear what this is? How can this be mitigated or justified?
No adverse impact

What can be done to change this impact?
Not applicable, no adverse impact

b) Create benefit for a particular group. Is it clear what this is? Can you maximise the benefits for other groups?
Does not create benefit for any particular group

Does further consultation need to be done? How will assumptions made in this Analysis be tested?
No further consultation required

4 So what? Link to business planning process

What changes have you made in the course of this EIA?
GP review identified that there was scope to improve the patient expectations and understanding of the service. This has been incorporated into the information for patients provided by the RUH.

What will you do now and what will be included in future planning?
Continue to review patient feedback on the effectiveness and patent experience of the service; identify the opportunity to extend the ESAC type of approach to other areas of surgical ambulatory care (a separate CCG working group is already pursuing the expansion of ambulatory care)

When will this be reviewed?
Through normal acute trust F&F reporting; during discussions for further enhancements to the ESAC model; through the CCG ambulatory care working group

How will success be measured?
By means of patient feedback

Appendix 2: Equality Analysis

Title of service or policy	ESAC Business Case
Name of directorate and service	General Surgery, Surgical Division
Name and role of officers completing the Equality Analysis	Stephen Roberts, Specialty Manager …
Date of assessment	7th April 2014

Equality Analysis is a process of systematically analysing a new or existing policy or service to identify what impact or likely impact it will have on different groups within the community. The primary concern is to identify any discriminatory or negative consequences for a particular group or sector of the community. Equality Analysis can be carried out in relation to service delivery as well as employment policies and strategies.

This template has been developed to use as a framework when carrying out an Equality Analysis on a policy, service or function. It is intended that this is used as a working document throughout the process, with a final version including the action plan section being published on the Royal United Hospital, Bath NHS Trust website.

1.	**Identify the aims of the policy or service and how it is implemented.**	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	The business case is to expand the current ESAC service to 5 and the 6 days per week. This will be delivered by 3 consultants providing cross cover for oneanother. This will mean a full Emergency Surgery [illegible]atory Care service throughout the week, providing support for the front door and surgical admission reduction.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there?	This is the expansion of an existing successful service.
1.3	Do the aims of this policy link to or conflict with any other policies of the Trust?	**No**

2. Consideration of available data, research and information

Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data** (including ethnicity, gender, disability, religion/belief, sexual orientation and age)
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information u can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	The profiles of the clinical staff are specific to national standards for General and Emergency Surgical staffing.
2.2	What equalities training have staff received?	Trust Equality and Diversity training.
2.3	What is the equalities profile of service users?	The service sees all appropriate patients coming through the surgical take and referred by GP practices, both male and female. No other barriers to access.
2.4	What other data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys, consultation findings). Are there any gaps?	The department has a robust framework for clinical governance, regularly reviewing its clinical outcomes, complaints and compliments and the results of audits. No gaps identified.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	No consultation required. Recruitment will be a competitive interview. Job description signed off by the Royal College of Physicians.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	Any future consultation on the requirement for medical and non-medical staff support/resource would include staff, service users and the public.

3. Assessment of impact: 'Equality analysis'			
	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups		
		Examples of what the service has done to promote equality	**Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this**
3.1	**Gender** – identify the impact/potential impact of the policy on women and men. (Are there any issues regarding pregnancy and maternity?)	No impact – the service is open to all.	None
3.2	**Transgender –** – identify the impact/potential impact of the policy on transgender people	No impact – the service is open to all.	…
3.3	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration of a range of impairments including both physical and mental impairments)	No impact – the service is open and accessible to all.	None
3.4	**Age** – identify the impact/potential impact of the policy on different age groups	No impact – the service is open to all appropriate users.	None

		Examples of what the service has done to promote equality	Examples of potential negative or adverse impact and what steps have been or could be taken to address this
3.5	**Race** – identify the impact/potential impact on different black and minority ethnic groups	No impact – the service is open to all.	None
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people	No impact – the service is open to all.	None
3.7	**Religion/belief** – identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion.	No impact – the service is open to all.	None
3.8	**Marriage/Civil Partnership -** identify the impact/potential impact of the policy	No impact – the service is open to all.	None
3.9	**Pregnancy/Maternity -** identify the impact/potential impact of the policy	No impact.	

4. Royal United Hospital, Bath
Equality Impact Assessment Improvement Plan

Please list actions that you plan to take as a result of this assessment. These actions should be based upon the analysis of data and engagement, any gaps in the data you have identified, and any steps you will be taking to address any negative impacts or remove barriers. The actions need to be built into your service planning framework. Actions/targets should be measurable, achievable, realistic and time framed.

Issues identified	Actions required	Progress milestones	Officer responsible	By when
None identified.				

5. Sign off and publishing
Once you have completed this form, it needs to be 'approved' by your Line Manager or their nominated officer. Please ensure that it is submitted to the body ratifying your policy or service change with your report/proposal. Keep a copy for your own records.

Signed off by: Suzanne Wills, Divisional Manager for Medicine
Date: 7th April 2014