Buckinghamshire Health and Social Care Operational Resilience and Capacity Plan 2014-15
27.08.14

System performance

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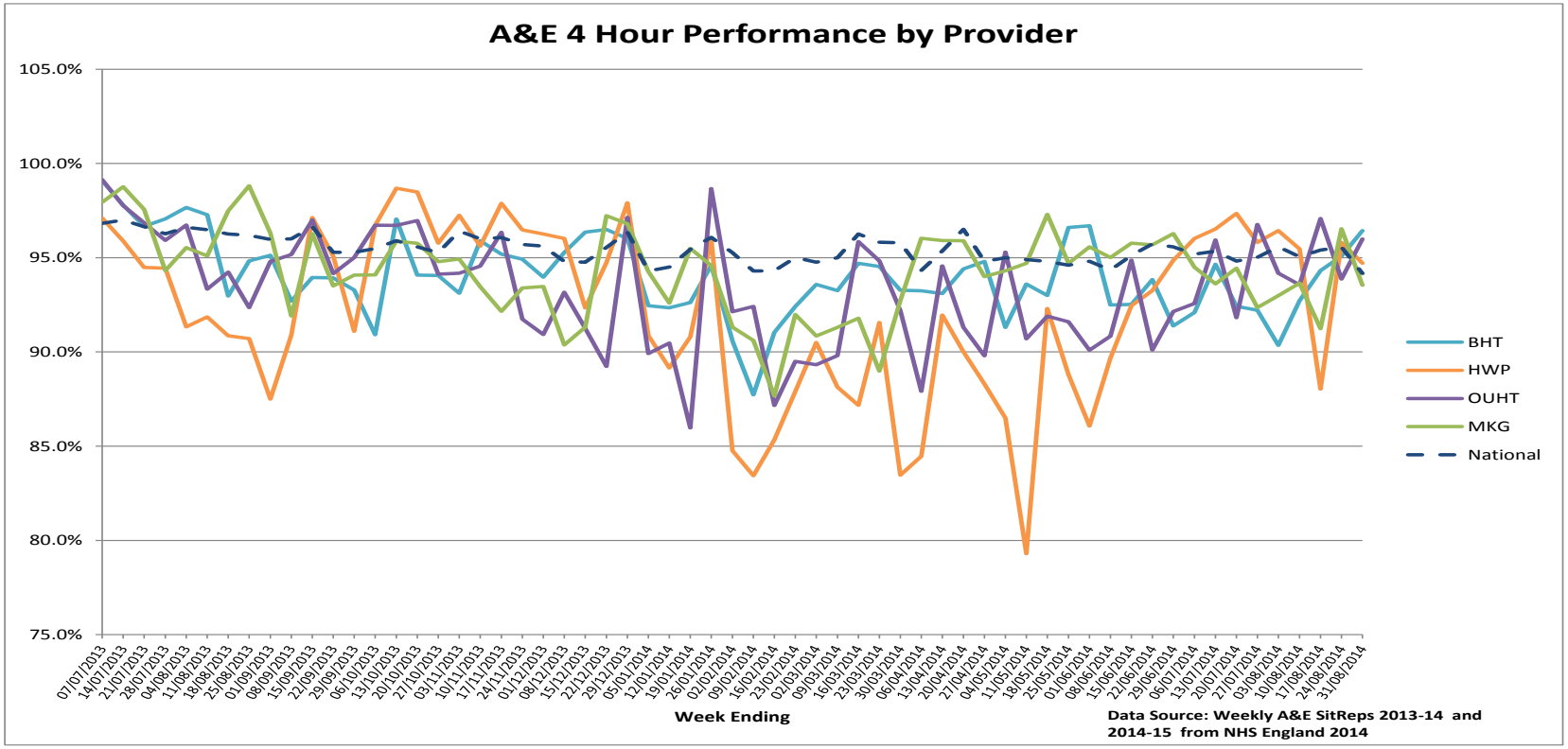
In 2013-14 BHT achieved 94.9% narrowly missing the A&E 4 hour standard, but in 2014-15 they have only achieved the standard on five weeks so far. While recent improvements at HWWP are not being sustained.



Analytical review – 1
Demand and capacity analysis

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We know from our monitoring that …

- NHS 111 has increased demand for ambulances. Alternatives needed re-profiling in the DoS.
- A&E attendances are increasing at both departments and including MIIU attendances are 10% higher than last year. This pressure is mainly driven by minor illness attendances.
- Emergency admissions in 2013-14 were 5% higher in Chiltern compared to 2012-13. 50% of the rise in Chiltern was driven by people over 75. Although these have stabilised since April at HWWP. The trend in AVCCG is more complex to interpret due to CDU tariff changes having a stronger effect.
- Ambulance call numbers are starting to stabilising this year but SCAS continue to fail response times in rural areas. SCAS forecast increasing see treat and convey activity.
- BHT length of stay already reduced from 5.2 to 4.7 days indicates limited potential for improvement as upper quartile performance for overall median LOS for all age medical emergency admissions is 4-5 nights (Source ECIST).
- CCG accessing Simul8 software via CSU to model capacity and flow to inform changes at BHT and later across the system.

Analytical review - 2

ECIST diagnostic at BHT identified…

- Workforce constraints are confounding new pathways
- Ambulatory care required further development
- Intermediate tier services in the community are not rapidly pulling medically fit patients out of hospital
- Managerial processes to manage patient flow are complex and reactive and could be streamlined and more proactive
- Alternatives to hospital are not being fully utilised

Analytical review - 3

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From last winter we know that ……

- There are reduced discharges at week-ends due to lack of ASC staff to organise care packages
- Spot purchasing is useful in transferring people out of hospital
- HALO in A&E reduces handover delays
- Patients requiring admission are arriving late in the day

Variation between demand for admission and discharges leading to acute capacity problems and 100% bed capacity, which exacerbates efforts to reduce LOS

Plan alignment and partnership working

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Robust plan developed through partnership working across SRG, with organisations making bids and SRG sign off 9/9/2014.

Alignment with:

- BCF (frail elderly focus)
- MRET reinvestment
- QIPP plans
- S256 for same day capacity and 7 day working
- Locality working including over 75s Funds

Best practice implementation - 1

ECIST said… Constraints in availability of NHS clinicians, ASC staff and carers are confounding new pathways

BHT have already …

- Enhanced medical and community cover
- Put in place an additional Physician of the Day over the weekend
- Implemented community in reach (REACT) to support discharge from A&E
- Recruited 1 additional A&E Consultant and 2.5 additional Physicians
- Invested in ED Workforce

Best practice implementation - 2

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To further mitigate lack of more senior clinicians we are….

- Funding extending Psychiatric In-Reach Liaison Service (PIRLS) to older people wards to reduce LOS and increase capacity in A&E to reduce 4hr breaches. KPI: Time of referral request to being seen
- Funding 7/7 support services; phlebotomy and a team of pharmacists to cover A&E CDU seven days a week 7am-8pm and at weekends.
- Funding increased radiology resource to increase the urgent care capacity.

Best practice implementation - 3

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ECIST said…

- Ambulatory care required further development

We have already….

- Appointed to Acute Physician post- 3.5 wte in place by November 2014
- Developing clinical pathways for EAC conditions
- Designated space co-located to ED

Best practice implementation - 4

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ECIST said…

- Ambulatory care required further development

We are going to….

- Fund appointment of Acute Care Co-ordinators to improve AEC at BHT.
- Fund an enhanced REACT therapy team at SMH to reduce admissions for frail elderly
- Fund opening up the day surgery over the weekends
- Developing the Ambulatory Hub to incorporate MUDAS service
- Fund nursing and clinical staff appointments

Best practice implementation - 5

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ECIST said… Intermediate tier services in the community are not rapidly pulling medically fit patients out of hospital

We have….

- Recruited for 7/7 social care staff at SMH and HWWP to increase weekend discharges using s256 funding
- Implemented ambulance referral to ACHT, MuDAS and Falls service
- Utilising Red Cross services following discharge to reduce readmissions

Best practice implementation - 6

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ECIST said… Intermediate tier services in the community are not rapidly pulling medically fit patients out of hospital

We are going to ….

- Invest in additional ACHT cover out of hours
- Fund additional spot purchase of beds
- Implement discharge to assess models of care
- Fund increased BHT Rehabilitation and Reablement Service
- Fund extra step down community rehab bed capacity for Bucks patients in Wexham Park A&E and PACE service
- Fund a vulnerable care home nurse facing WPH
- Fund a Carer's Hub from 11.00-18.00 Mon-Fri at SMH

Best practice implementation - 7

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ECIST said…

- Managerial processes to manage patient flow are complex and reactive and could be streamlined and more proactive

BHT have….

- Reviewed daily operational meetings. Ward sisters now attend to provide 80% of total daily discharges and highlight where support is required for discharges the flowing day.

- Reviewed escalation processes and developed training programme for an all new Silver/gold to support OOH. Work also being undertaken to develop ED overcrowding tool , aligned to a full capacity plan.

- Reviewed the daily breach meeting and significant changes introduced to enable better cross divisional working . Daily attendance by division at meetings to produce focused action plans. These are monitored with associated actions to mitigate risk.

HWWP implemented a “Spring to green” (Perfect Week) which improved performance markedly. BHT also plan to implement this approach and can be expected to benefit.

Best practice implementation - 8

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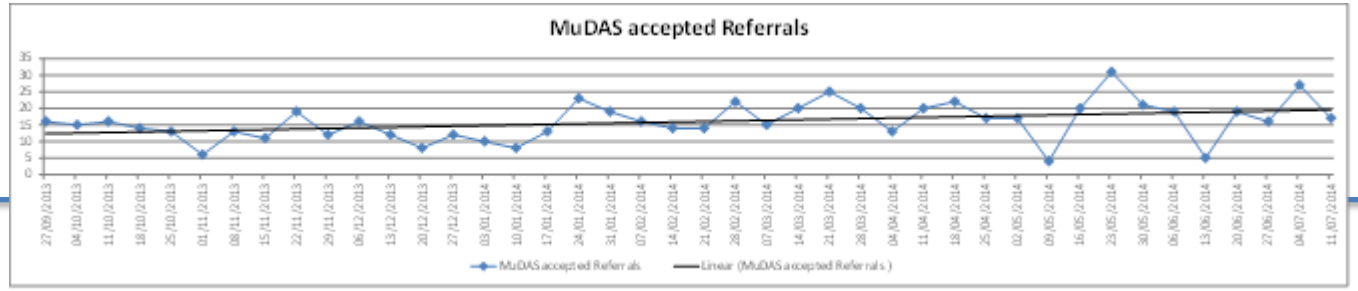
ECIST said… Alternatives to hospital are not being fully utilised

We have improved MuDAS by …

- Funding CPN and PTS transport to improve effectiveness
- Additional referral pathways for A&E, SCAS and ACHT
- Working with BHT to get practice level data so localities can work to increase GP referrals
- SRG monitoring shows referrals are now slowly increasing



Best practice implementation - 9

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ECIST said… Alternatives to hospital are not being fully utilised

We have supported Primary Care by …

- Piloted and evaluated “Doctor first” approach to GP triage to reduce A&E attendance
- Implemented an acute visiting service in Chiltern and are exploring extending this.

Best practice implementation - 10

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ECIST said… Alternatives to hospital are not being fully utilised

We plan to supported Primary Care by …

- Extending “Doctor first” approach to 5 further GP Practices
- Monitor via SRG to identify whether reducing demand for minor illness at MIIU and A&E
- Exploring a trial of “Web GP” in 2 AVCCG practices
- Develop a Primary Care co-commissioning strategy to ensure sustainability and utilise GP expertise to best effect.

Best practice implementation - 11

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ECIST said…

- Alternatives to hospital e.g. Community crisis response

We are….

- Rolling out 2 hours crisis response to provide carers at home to prevent admissions. This is jointly supported by ACHT and BCC commissioned Buckinghamshire Care staff.

- Funding a communication and engagement campaign “Talk before you walk” to reduce A&E attendances

- Working with NHS 111 to ensure the DoS dispositions effectively direct patients away from A&E to alternatives. MIIU already signed off and implemented

Best practice implementation - 12

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ECIST said…

•Alternatives to hospital e.g. Frail elderly

•

We have…

- Implemented a Milton Keynes discharge co-ordinator who has reduced long stay patients from 13 to 2 per month.

We are….

- Over 75s funding and Admissions avoidance DES (£1m AVCCG + £1.6m Chiltern) e.g. Care Home Matron; Vulnerable Older Persons Peripatetic Nursing; Primary Care Early Intervention team.
- Using over 75s, ORCP and localities to establish “proof of concept” before extending and incorporating into normal practice.
- NHS Area team will commission flu jabs for clinical at-risk patients, children in special schools and pregnant women.

Best practice implementation - 13

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We know…

- Variation between demand for admission and discharges leading to acute capacity problems and 100% bed capacity, which exacerbates efforts to reduce LOS

We are….

- Reducing variation in demand for hospital admission, variation in hospital discharge and so improving patient flow through the system to minimise delays.
- Funding additional bed capacity to consolidate escalation beds to retain surge capacity supported by capital funding bid.

Elective Care: Capacity and demand

Buckinghamshire System Resilience Group

We know…

There are gaps in orthopaedics and plastics

We are….

- Increasing capacity from three independent providers to meet demand and reduce waiting times.
- Working with Practices to reduce unwarranted variation in demand.
- Extending weekend surgery capacity to support trauma at BHT
- The Trust has a fully revised patient access policy supported by a set of standard operating procedures.
- Funding virtual orthopaedics clinics
- Fund an annual programme for further capacity and demand planning work for increasing the breadth of sub-specialities

- CCGs and Providers are working together to redesign the pathway to support the delivery of sustainable orthopaedic services (including pain services and imaging)

Training
The Trust is currently planning to offer refresh training to over 150 administrative staff. This will be followed by a competency assessment and a training programme for new starters. A specific RTT training program will be developed for appropriate staff to ensure awareness of rules around RTT.

Performance Management
Weekly waiting time information and backlog trajectories are published on a weekly basis. The Trust meets internally weekly with CCG representation through an 'access and performance management group' to review information. The Commissioner meets informally with the Trust on a two weekly basis and formally with clinical leaders once a month to review performance.

Leadership
There is a GP Clinical Lead from each CCG that regularly meet with clinical colleagues at the Provider Trust.

Elective:
Best practice implementation

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A range of innovations are being progressed across the system to support changes to the current treatment pathways with the aim of improving quality and increasing efficiency. Some examples would be:

- Introduction of an advice and guidance email service by the provider Trust to support GPs and offer a choice in not necessarily moving straight to making a referral

- The establishment of a virtual clinic model through the use of technology to screen and remotely manage both elective and acute orthopaedic referrals

Monitoring: Urgent Care KPIs by SRG – see spreadsheet

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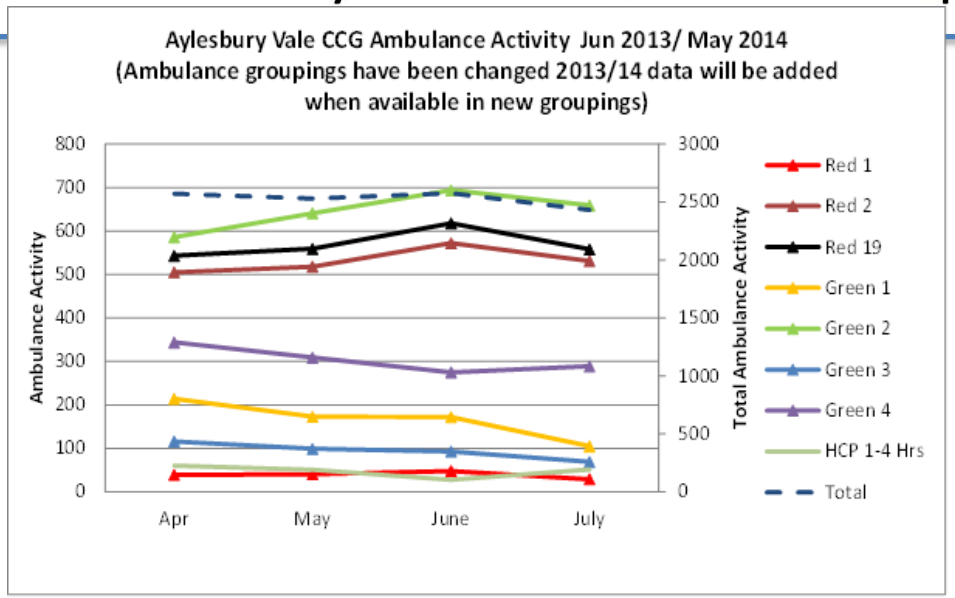
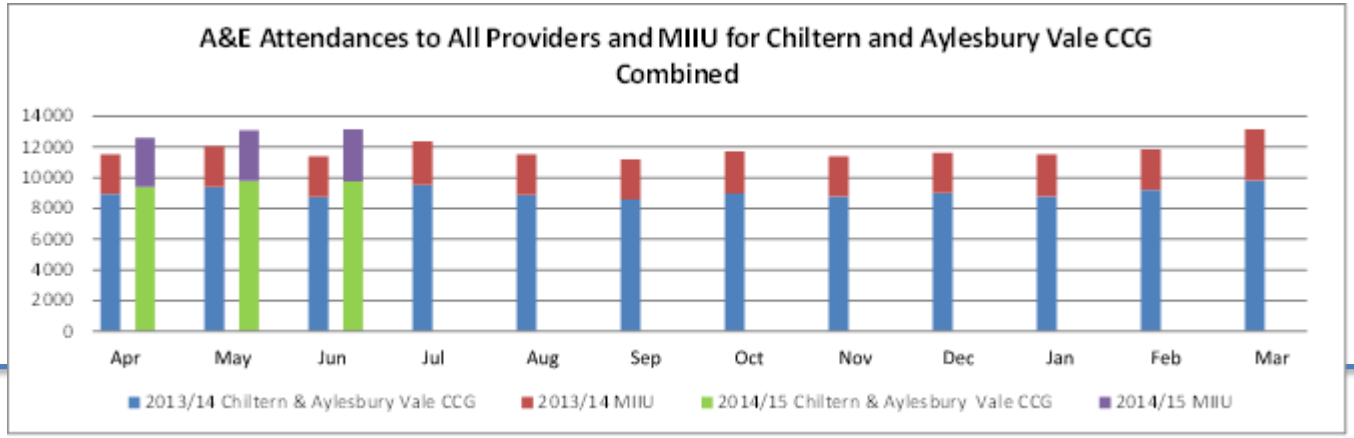
Examples include……..

Real time monitoring:

Capacity via CMS via TVEA
- possibly expand to Primary Care

Daily resilience teleconference calls – predicted demand and capacity





Monitoring:
RTT by Right Care Group

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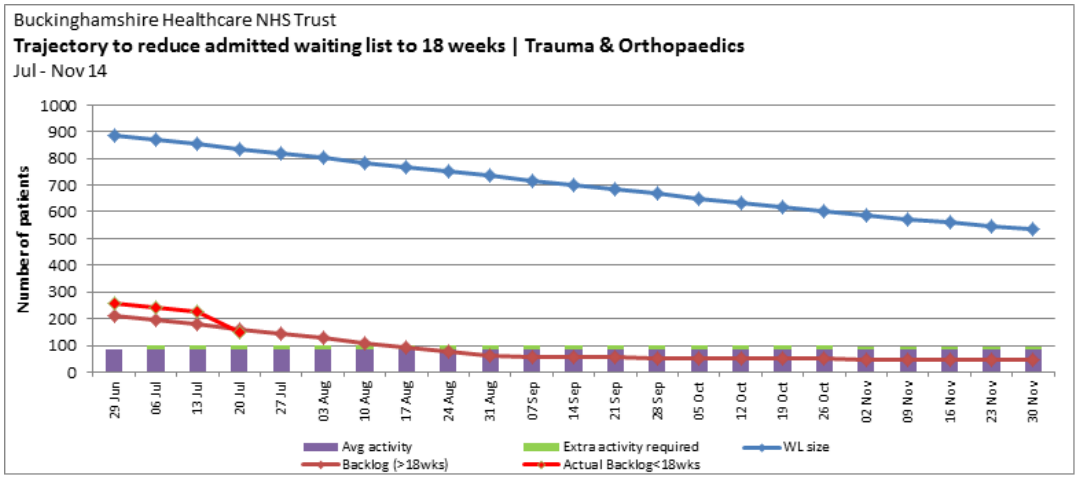
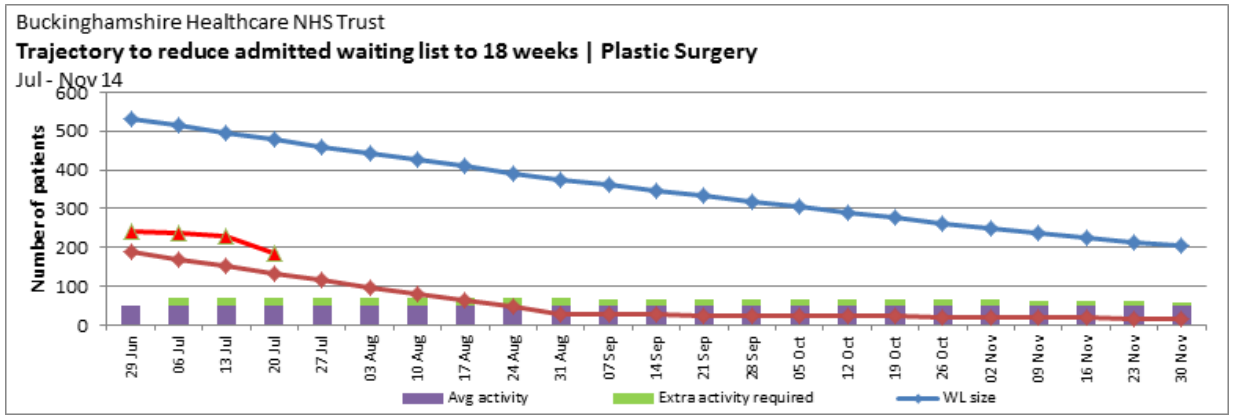


CCGs and BHT jointly monitor performance through the Right Care Steering Group and decide appropriate action



Governance - Urgent Care

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- UCJET and UCWG/ SRG
- Revised Terms of Reference
- Refreshed membership
- BHT Reforming Urgent Care Programme Board
- Metrics tracker and ORCP Co-ordinator

Governance - Elective care

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- The implementation of revised operating procedures is clearly visible to the commissioner in the weekly information set. For example the information set shows by speciality the admitted 'clock stop' patient numbers including total activity, breaches and previous week comparison.

- BHT are also leading a 'reforming elective care group' under the chairmanship of the Chief Operating Officer and Medical Director, to track other pathway capacity gaps that have been identified and implement improvements.

- The governance of system wide elective delivery is managed through the well established joint commissioner and provider "Right Care Steering Group"

Key risks

1. Ability to recruit additional staff - mitigation: Using a range of existing staff more flexibly

2. BHT additional bed capacity not until Jan 2015 - mitigation: BHT reconfiguring existing bed use to reduce safari ward rounds and so improve EDD and reduce LOS

3. Bucks CC timely support to release s256 and implement rapid discharge processes - mitigation: Utilise BCF mechanisms to implement changes

4. Ability to flex capacity to respond to variation in demand and across 7/7 - mitigation: Using predictive data and use of modelling tools – We are very interested in working with NHSE on this.

5. Slow patient flow in SMH and handover delays - mitigation: HALO

Risk Management

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Close monitoring of KPIs by linking with BHT internal Reforming Urgent Care (RUC) programme and metrics, will lead to early escalation. There are twice daily resilience teleconferences which are part of the system escalation framework and organisations have business continuity plans in place. The System Resilience Programme Manager will also be able to review ORCP KPIs weekly with BHT and other partners. This will create the ability to utilise funding from slippage to effectively respond to events as they unfold on the ground. e.g. by implementing bids which have been kept in reserve.

This is within the context of a very efficient system with one of the lowest uses of urgent care and emergency admission in England, where driving further improvements is particularly difficult.

Confidence

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Confidence levels in terms of meeting the 95% A&E standard throughout Q3 and Q4?

- 2013-14 BHT A&E 4 hour achievement 94.9%

- 2013-14 achievement to week 23 was 96.3%
- 2014-15 achievement to week 23 = 93.7%
- 2014-15 Q1 93.6%; Q2 likely to fail.

- Q3 & Q4 we are implementing virtually everything ECIST recommend to sustain higher levels of performance.

Finance - 1

Pathway Flow: Flow & Throughout

Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
6	A1:Enhancement of Psychiatric In-Reach Liaison Service (PIRLS)	PIRLS Rapid Specialist Mental Health Assessment for BHT Older Ward Based patients (not currently covered by PIRLS)	1. Time of referral Request to being seen = 1 hr 2. Assessed patients will have documented psychiatric needs care plan and risk assessment. 3. Professional level assessment [qualifications] per practitioner.	£59,000	OH
7	A3: Enhancement of Psychiatric In-Reach Liaison Service (PIRLS) based at Stoke Mandeville Hospital	Increased PIRLS Band 6 [per shift] A&E located.	1. Time of referral Request to being seen = 1 hr 2. Assessed patients will have documented psychiatric needs care plan and risk assessment. 3. Professional level assessment [qualifications] per practitioner.	£96,000	OH
8	E5: Modelling bed capacity	Revenue support to additional bed capacity This bid was internally prioritised by BHT, post the SRG (29 July 2014) and therefore needs confirming by SRG. The use of resilience funding is supported by a separate bid by BHT for £2m strategic capital from the Trust Development Authority	Support additional capacity, consolidates escalation beds.	£400,000	BHT

Finance – 2

Pathway Flow: Admission Avoidance

Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
1	A2: Enhancement of Multi-Disciplinary Assessment (MuDAS)	MuDAS Co-morbid Mental Health patient, mental health assessment and sign posting, reducing avoidable admissions, home support and dementia assessment. CPN based in MuDAS during opening hours.	1. Immediate mental health assessment & sign posting. 2. Assessed patients will have documented psychiatric needs care plan and risk assessment. 3. Professional level assessment [qualifications] per practitioner.	£45,000	OH
3	E15: Ambulatory Emergency Care Service	To set up an ambulatory emergency care service (Monday to Friday 09:00 – 17:00). To provide co-ordination of the medical take and triage into ambulatory emergency care through the appointment of Acute Care Co-ordinators. (ACC).	Manage 10% of medical take through AEC. Through the appointment of the ACC's: Improved co-ordination of the medical take. Early senior review of patients by registrar as they are freed to do so.	£361,000	BHT
4	E13: Admission Avoidance MuDAS SMH	To strengthen the frailty pathway by providing an on-site MuDAS at Stoke dedicated to supporting the 'front door' (A&E, CDU and AMU) supported by an enhanced REACT therapy team.	1. Ratio of frail elderly patients attending A&E to those admitted 2. An increase in the proportion of frail elderly zero to one day length of stay patients	£151,000	BHT
5	H1:	Communication and Engagement Campaign to promote appropriate use of health services in Buckinghamshire	Talk Before You Walk Health Help Now.	£66,600	CSU/AVCCG & CCCG

Finance – 3

Pathway Flow: Flow & Throughout Continued…

Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
9	7 Day working support services	Development of 7 day working and support services E8: Phlebotomy Support: Progress through the patient pathway for urgent admissions. Urgent blood samples require adequate staffing levels 7 days a week. E12: Pharmacy Support: A team of pharmacists to cover A&E CDU seven days a week 7am-8pm and 7-8 at weekends. Key role is to prevent primary admissions within the ED MDT, intervene on medicines related patient care issues, prevent deterioration due to omission of medicines. E16: Radiology – resource to increase the urgent care capacity: Enable ongoing efficient response to radiology requests from A&E and urgent care pathway to ensure a timely and efficient Radiology service.	1. Pathology reporting turnaround time. 1. Medicines Reconciliation Targets. 2. Admission Rates 3. Omitted doses in A&E 1. Waiting times in MRI 2. Reported backlog to manageable levels, and have all reports reported by the agreed departmental standards.	£200,000	BHT

Finance – 4

Pathway Flow: Supported Discharge

Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
10	E9: Rehabilitation and Reablement Service	Early discharge from Acute and Community beds. Increased rehabilitation, nutrition and mental health support in community settings.	1. No of referrals to community from ED + Out of Hours. 2. Length of hospital stay. 3. MUST score for diabetic patients. 4. Mental health assessments and support.	£116,000	BHT
11	G2: Extra step down rehab packages supporting transfer of Care Wexham Park Hospital A/E	To support extra demand for step down community rehab beds for Bucks patients from A/E transfer of care Wexham Park	1.Number of patients assessed 2.Reduce conversion rate from A/E to admission Increase in patient number discharged from A/E to community services	£143,000	CCCG
12	G3:	Vulnerable Care home Nurse Facing WPH	1.No of care home admissions 2.Number of referrals to community services with reasons for referral. 3. No change in the number of discharges back to care homes based on 2013.14 baseline.	£50,000	CCCG

Finance – 5

Pathway Flows: Admission Avoidance/ Flow & Throughout

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Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
13	B2: System & Capacity Vehicle	Increased capacity.	1. Conveyance time % within 1 hour improves	£114,760	SCAS
14	B5: HALO	ED/SCAS Interface Performance & Handover Support	1. Handover times 2. Clear up times	£90,600	SCAS

*Triangulation with national ambulance funding and SCAS contract to be finalised.

Finance – 6

Pathway Flows: Admission Avoidance/ Supported Discharge

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Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
15	B3: System Community Demand Practitioner	Support for Very High Intensity Users (VHIU)	1. Number of VHIUs calling SCAS each month 2. Number of hours at scene with VHIUs pm 3. Number of conveyances to A&E from VHIUs pm	£42,428	SCAS
16	E6: Patient Transport	Focussed on responding to and managing the urgent care assessment and treatment needs of the frail elderly people. The aim is to be able to transport people to MuDAS and home providing multidisciplinary assessment that prevents attendance to and admission via A&E.	1. Number of patient attending MuDAS 2. Referral to transfer time. 3. Number of potential admissions avoided.	£120,000	BHT
17	E7: ACHT Extension	Managing the urgent care needs of house-bound and frail patients. Provide support to patients in their place of residence to prevent out-of-hours attendance and admission via A&E.	1. Number of patient contacts. 2. Referral of response waiting time. 3. Percentage of urgent admission avoidance referrals visited. 4. Reduced travel time and cost.	£84,000	BHT

Finance – 7

Pathway Flows: Admission Avoidance/ Supported Discharge Continued…

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Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
18	G1: Transfer of Care Wexham Park Hospital A/E	This project is approached as an 'Invest to Save ' as it has the capacity to shift patients along the admission avoidance care pathway from A/E to community. Provisional data from PACE (East Berks commissioned services at Wexham Park A/E) for Bucks patients provides intelligence that is considered as a baseline in support of this proposal. The service aim is to provide all Bucks GP registered patients with a single point of access providing a comprehensive multi-disciplinary assessment for consideration of appropriate community health and social care teams including access to step down rehab beds 7 days a week.	1.Number of patients assessed 2.Reduce conversion rate from A/E to admission Increase in patient number discharged from A/E to community services	£102,000	CCCG

Finance – 8

Pathway Flows: Flow & Throughout/ Supported Discharge

Buckinghamshire System Resilience Group

Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
19	C1: Carers Hub	Operate a Carer's Hub from 11.00-18.00 Mon-Fri at SMH. Hub will support carers' health and wellbeing providing face-to-face support. Link the carers to Carers Bucks Adult Support Team. It will help health staff to facilitate timely discharge and improve re-ablement outcomes.	1. Readmission rates for individual/family they support.	£19,000	AVCCG
20	E11: Surgery-Ambulatory Care Model	Increased emergency surgical capacity and flow. Service aims to eliminate delays for surgical assessment. Open up the day surgery over the weekends, providing same day bed capacity.	1. Surgical breaches In the emergency department. 2. Time taken to theatre. 3. Discharges before 11am 4. Use of ambulatory capacity at weekends.	£200,000	BHT
21	G4:	Additional step down rehab beds supporting transfer of care Wexham park Hospital A&E	To support extra demand for step down community rehab beds for Bucks patients from A/E transfer of care Wexham Park Hospital	£103,000	CCCG

Finance – 9

Pathway Flows: Admission Avoidance/Flow & Throughout/Supported Discharge

Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
22	H3: Spot Purchase Beds	This is targeted at strengthening the frailty pathway and to support patient flow by providing a non hospital environment for reablement of patients requiring ongoing in-patient care but not within an acute setting.	1. Clinical KPIs 2. Care plan in place and delivery monitored and documented by the care home staff 3. Record the number of patients seen by GP within 24hrs of admission to the care home 4. Time of completion of assessments - MUST, Waterlow, moving & Handling Record of any adverse events. No. of pressure ulcers developed and category of same No. of falls including level of harm resulting from the fall Weekly activity report of use of the beds by bed (for BHT patients only) -.Daily bed occupancy -. by bed date of admission, EDD set, EDD achieved, -.LOS and outcome-discharge destination .-Total number of patients in beds	£150,000	AV & CCCG
23	H2	Programme Manager	1. A&E standard achievement	£60,000	AVCCG/BHT

Finance 10: Bids against RTT funding

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Number	Scheme Title	Scheme Description	Impact Forecast	Scheme Allocation	Organisation
1	E1: Op Res: Virtual Orthopaedics Clinics	To implement a virtual model of clinic management in orthopaedics, concentrating on remote management of clinic referrals and virtual management of electives to improve surgical capacity.	Number of face to face follow up appointments and capacity.	£64,500	BHT
3	E3: Vascular Diagnosis	Proposes system to condense multiple vascular clinics into fewer sessions and ultra-sonographer expertise to complete imaging at first appointment. remove significant numbers of follow up appointments and reduce RTT Pathways by 6-8 weeks. Require additional; sonographer and ultrasound machines for vascular dept. Supports resilience plan and reduces activity in secondary care services.	1. Number of patients imaged in 1 stop clinic 2. RTT Non-urgent vascular pathway reduction.	£52,340	BHT
4	E4: Elective Pathways Minimum Standards	To map further requirements needed to deliver the minimum standards of organisational resilience for elective care. Focuses on the RTT competency and training packages. An annual programme for further capacity and demand planning work for increasing the breadth of sub-specialities. Requires programme management support for a system wide transformational board in elective pathways. Provider specific support for a complete review of MSK service provision and internal efficiencies. Hope to increase the breadth of data quality monitoring and validation support.	1. RTT and data accuracy. 2. Completion of capacity and demand modelling. 3.KPI's of reforming Elective Care board. 4. Reduction in recommended configuration of MSK pathway.	£216,160	BHT