South West System – System Resilience Group / ORCP Briefing – Urgent Care Whole System Action Plan

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Topic Area	Update on Urgent Care Whole System Action Plan (WSAP)
Purpose	The South West System Resilience Group (SRG) agreed that a common paper would be taken to all organisational boards to provide an agreed update on the key actions being taken to address poor performance in urgent care. This paper is prepared monthly by the Unscheduled Care Delivery Group (USDG)

Information	• The WSAP was developed by the system with support from ECIST to drive improvements in the urgent care system.
	• The WSAP provides an overview of the key workstreams that are being progressed. There are detailed plans for each project which underpin this overview.
	• It has been agreed that the report will be brought to organisational boards in order to increase the levels accountability.
	• Delivery of the plan is supplemented by the additional funding that has been received as part of the ORCP activity which commenced in September. The aim of the ORCP funding is to stabiles the system through winter and to accelerate delivery.
	• The ORCP plan focusses onto the key system, priorities areas which are:
	  o Primary care
	  o In-reach to acute hospital
	  o In hospital therapy
	  o Fraility pathway
	  o Reducing DTOCs
	  o Mental health
	  o ED flow
	• The key messages for November are:
	  o ED performance remains significantly off trajectory
	  o The bulk of the ORCP plans for tranche 1 are being implemented, with an average of 4-6 weeks slippage
	  o An additional plan for the use of Tranche 2 funds has been developed to address the key areas that are driving a high level of breaches within the UHS Emergency Department
	  o Changes to the System Resillience Group to ensure increased oversight by the Chief Officers have been agreed and are being implemented
	• This action plan is reviewed monthly at the SW Hants Unscheduled Care Delivery Group by system partners.

Key/Contentious issues to be considered	ED performance remains below operational standards.
Please indicate which meetings	SW Hampshire Unscheduled Care Delivery Group

this document has already been to	
Principal risk(s) relating to this paper	• Delivery of ED performance • Potential Delays to implementation of Better Care Plans
Report Author	Lucie Lleshi, Senior Commissioning Manager
Date of paper	14/11/14
Actions requested /Recommendation	To note the actions being taken in the Urgent Care Whole System Action Plan.

South West Hampshire System Urgent and Emergency Care Whole System Action Plan 2014/15this is from last month – it will need to be changed

The urgent and emergency care action plan is structured around three main programmes of work:

1. **Urgent and emergency response**
2. **Building and sustaining operational resilience**
3. **Patient discharge and flow**

These programmes report monthly into the Urgent Care Delivery Group, in turn reporting up to the Urgent Care Working Group.

The system has been working to an action plan that was derived from recommendations made by the Emergency Care Intensive Support Team (ECIST) in Quarter two 2012/13. The primary focus for work in 2013-14 was around improvements to discharge and patient flow; the focus for 2014-15 will shift to ED and associated front door pathways, while continuing to improve whole system discharge processes and sustain operational resilience.

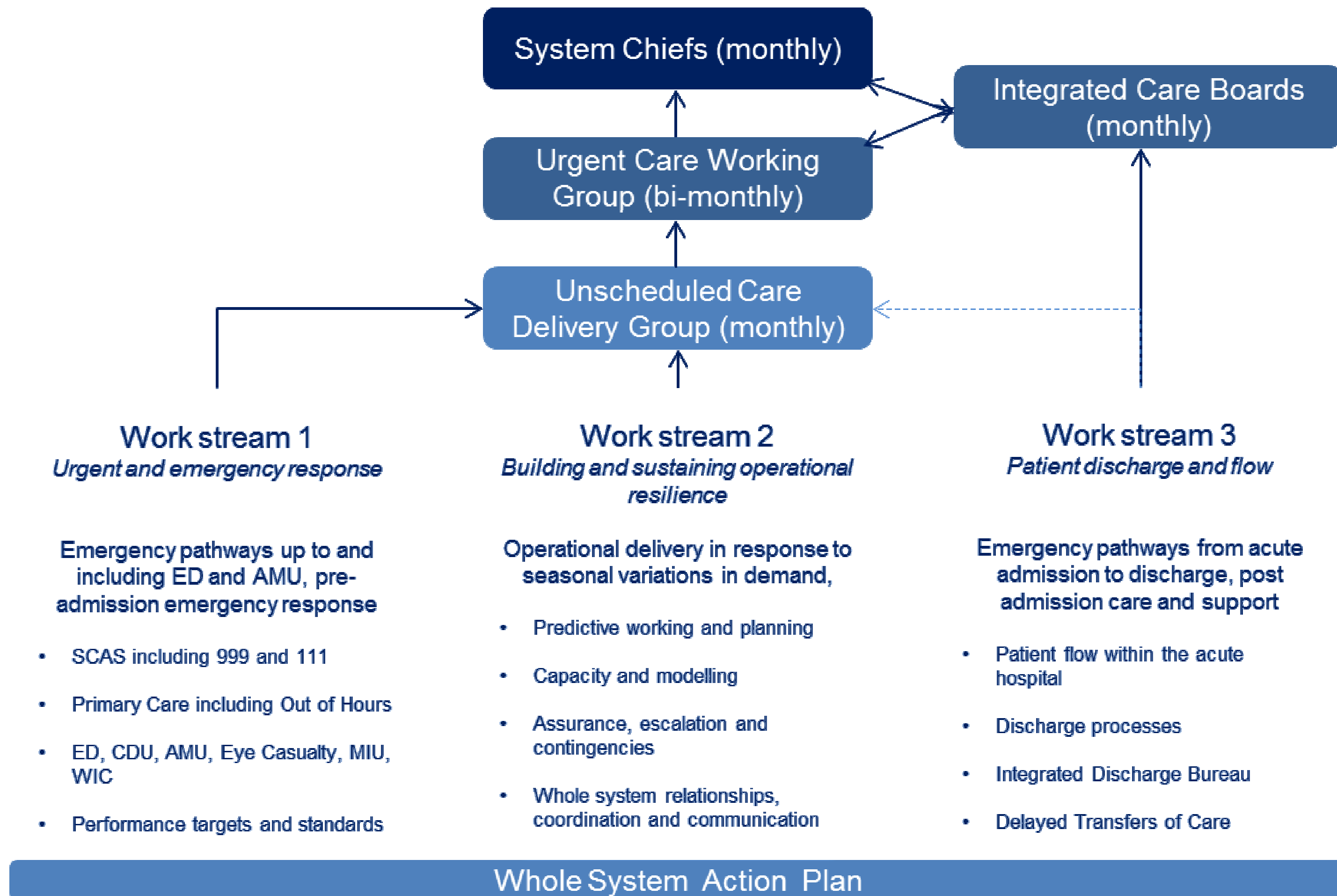
This plan has been refreshed following an ECIST review of 2013/14 winter and a system-wide evaluation of the joint resilience fund and winter monies funded initiatives.

This plan reflects system resilience learning from 2013/14, continued implementation of the UHS ED remedial action plan to achieve the 4-hour standard, CCG QIPP and CQUIN proposals and links to the Better Care Fund and Integrated Care work stream.

This plan is intended to provide a summary of more detailed project tasks being delivered within the governance structure on page 2. It is supported by a set of system-wide metrics which are reviewed monthly.

Please note that this plan DOES NOT INCLUDE admissions avoidance actions being led through the Integrated Commissioning Units, but does still include complex discharge which has transferred to Integrated Commissioning Units and is overseen by the Integrated Care Boards.

South West System – Urgent Care Programme Governance



Work stream 1: urgent and emergency response

This work stream incorporates 4 projects:

1.1 GP tools and information: to manage patients' use of urgent and emergency service

1.2 Minor Injuries Unit (Care UK) and Walk in Centre (Solent): appropriate alternative services to ED for minor injury and minor illness

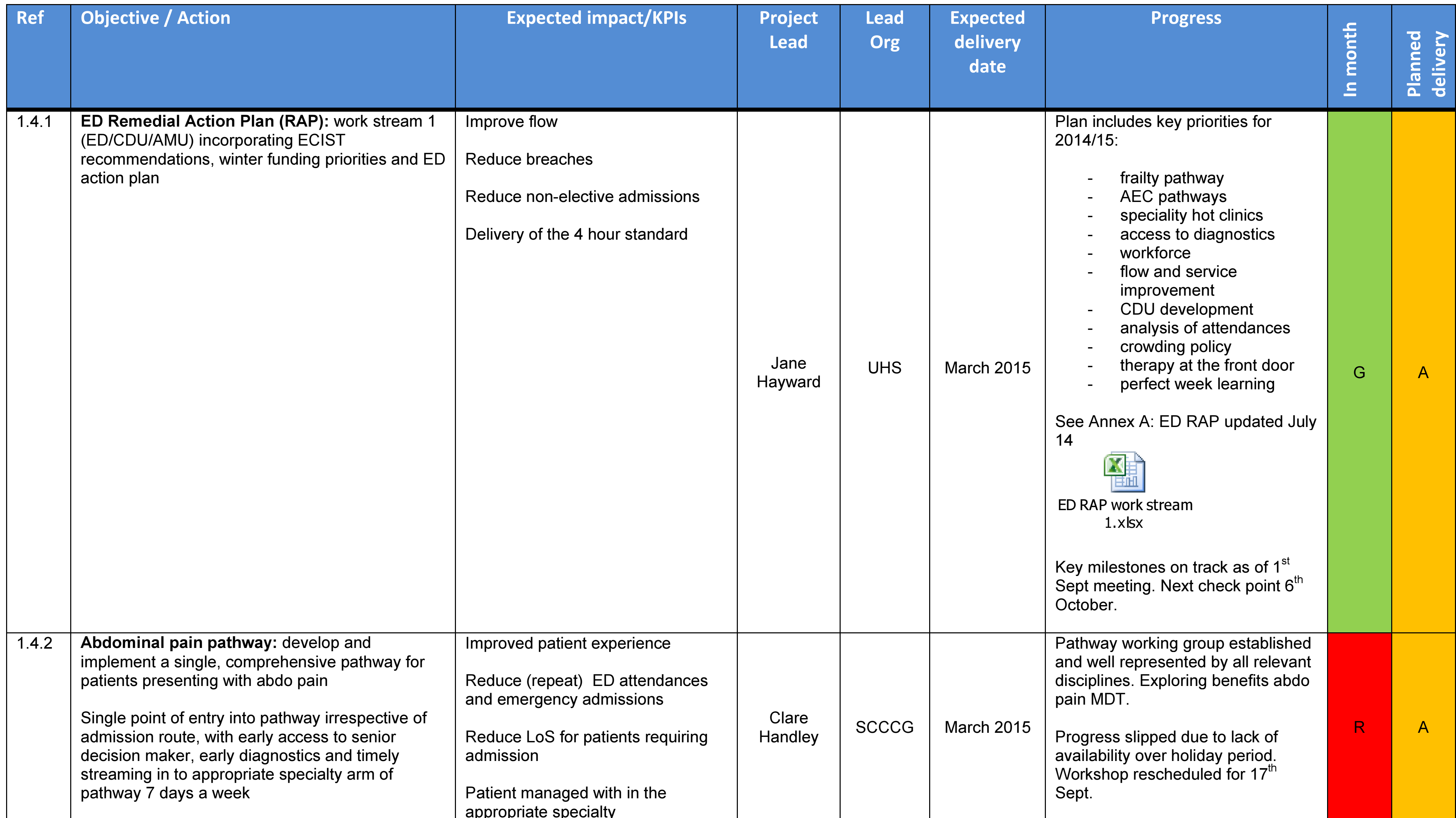
1.3 Public access : SCAS 111 and 999, GP out of hours (OOH, Care UK) and GP extended hours: 24/7 access to out of hours primary care, advice and onward referral including emergency response and managing patients outside of hospital

1.4 UHS Emergency Department (ED, including Clinical Decisions Unit (CDU)) and Acute Medical Assessment Unit (AMU): managing demand at the hospital front door, incorporating the ED RAP

Ref	Objective / Action	Expected impact/KPIs	Project Lead	Lead Org	Expected delivery date	Progress	In month	Planned delivery
1.1.1	**GP urgent care dashboard**: pro-active use of information to understand, monitor and actively manager patients' use of emergency services	Reduction in avoidable/repeat ED attendances, non-elective admissions and 999 calls	Ali Howett	SCCCG	Review quarterly Next update due September 2014	Roll out of tool to all Southampton practices completed Sept 13. Initial review of 2013/14 identified commissioning and QIPP opportunities and early indications of success in managing targeted cohorts of patients	G	G
1.1.2	**Clarity platform:** implantation of a tool that uses business intelligence from data supplied by primary and secondary care to provide useful reports to support risk stratification, predict activity and identify commission gaps and opportunities for patient and provider education	Intelligence can be used to manage our population and the provision of their healthcare by commissioning services differently Reduce ED attendances, 999 calls and non-elective admissions	Tina Woodcock	SCCCG	October 2014	Tool development and learning session held end of July 2014.	A	A
1.2.1	**Minor Injury Unit:** change of provider. New service to commence in August, offering imaging and extended to children over the age of 2	Further shift of minor injury activity to reduce ED attendances	Katy Collins	SCCCG	1st August 2014 Review monthly	Service commenced 1st Aug – review performance monthly. First CRM due 17th Sept, awaiting type III activity report	G	G

Ref	Objective / Action	Expected impact/KPIs	Project Lead	Lead Org	Expected delivery date	Progress	In month	Planned delivery
1.2.2	**WIC:** review WIC functions and activity as part of wider stakeholder engagement on 24/7 urgent access to primary care. Ensure value for money and appropriate use of commissioned services	Patients have access to appropriate care for minor illness Reduce avoidable ED attendances Reduce duplication of services available	Lucie Lleshi	SCCCG	May 2015	Full service review completed April 14. Recommendations presented to SCCCG Clinical Executive Group May 14 for consideration. Options currently being appraised	G	A
1.3.1	**SCAS 111 Directory of Services:** improvement to directory of services so that callers are able to signpost patients to the most appropriate services	Reduction in ED attendances	Judith Collyer	SCAS 111	Ongoing through 2014/15	Full time Programme Manager in post. DoS is up to date and now includes eye casualty, MIUs and WICs	G	A
1.3.2	**SCAS 111 performance and capacity:** improve clinical cover to ensure call staff are able to check with a clinician regarding a disposition to dispatch an ambulance or attend ED. Improve staff fill rates to sustain performance against KPIs	Patients are managed in the most appropriate service (or through education and self-care) to avoid ED attendances and 999 calls - conversion to 999 ≤7% (threshold 10%) - conversion to ED below threshold of ≤5% - calls answered within 60 seconds above threshold of ≥95% - calls abandoned rate below threshold of ≤5%	Mark Rowell	SCAS 111	Ongoing through 2014/15 Review performance monthly	- conversion to 999 7% (SHIP) - conversion to ED 7% (SHIP) - locally referrals to ED have been declining over past 16 months) - calls answered in 60s 94% - calls abandoned 1% Over summer staffing issues resulted in a dip in performance around call answer in 60 seconds. This is being closely monitored and managed and has significantly improved	A	A
1.3.3	**Emergency response and pre-hospital care action group (replacing SCAS ambulance group):** multi-agency group established to share experience and identify potential areas for system reform within the context of pre-hospital urgent care	Reduce ED attendances and emergency admissions Reduce hand-offs between urgent care providers	Sarah Knight	WHCCG	March 2015	Terms of Reference and overarching priority areas agreed. Senior representatives from key providers have shared information about service provision, challenges/gaps and suggestions for improvements to appropriately manage patients outside EDs	A	A
1.3.4	**SCAS direct link to GP practices:** manage in-hours calls *Winter funding priority*	*Winter funding priority*				*Dependent on successful funding bid*		

Ref	Objective / Action	Expected impact/KPIs	Project Lead	Lead Org	Expected delivery date	Progress	In month	Planned delivery
1.3.5	**SCAS 999 pathways:** transition to NHS pathways, aligned with 111. Provide the right care, first time. Optimise the benefits of closer working between 999 and 111 services and explore the potential for a fully integrated clinical assessment and signposting service.	- reduce number of vehicles dispatched - single, consistent triage tool - increase in amount of call auditing - enables 999 emergency call takers to directly refer patients safely to alternative care pathways, via the local DoS - right outcome for patients based on commissioned services available - reduce re-contact rates - increase hear and treat capability - integration: 999 and 111 operations centres to become fully integrated, with improved resilience	Deb Ingram	SCAS 999	Transition complete June 2014 Review performance monthly of hear and treat and conveyance	Rollout of NHS pathways is complete for the South Hear and treat performance dropped significantly from plan for May, the opposite of what was expected. Assurance received from SCAS that performance is looking much improved Continue to monitor closely through contract performance route	A	A
1.3.6	**GP OOH direct booking:** implement direct booking directly into Primary Care Centres for patients requiring a face to face appointment with a GP	Improve response and waiting times for patients. Out of hours access to primary care to avoid attendances to ED	Justin Cankalis	Care UK	October 2014	Progress delayed due to other pressures (contract dispute, performance issues, RAP). Slip to Q4. Best model yet to be defined	R	R
1.3.7	**GP OOH performance and capacity:** improve staff fill rates to improve performance and ensure all NQR12 targets are met across the system	Out of hours access to primary care to avoid attendances to ED All response times for emergency, urgent and routine home visits and primary care centre appointments above the threshold of ≥95%	Justin Cankalis	Care UK	Ongoing through 2014/15 Review performance monthly	NQR12 performance is improving, but not all standards met. This is being managed through the contract review process Staff fill rate being monitored closely.	R	A
1.3.8	**Access to primary care outside of core hours for urgent patients:** funding targeted at extended hours/OOH services specifically for urgent patients. To be delivered by local practices and/or OOH services *Winter funding priority – link to 1.3.7*	*Winter funding priority*		CCGs		*Dependent on successful funding bid*		



Ref	Objective / Action	Expected impact/KPIs	Project Lead	Lead Org	Expected delivery date	Progress	In month	Planned delivery
1.4.1	**ED Remedial Action Plan (RAP):** work stream 1 (ED/CDU/AMU) incorporating ECIST recommendations, winter funding priorities and ED action plan	Improve flow Reduce breaches Reduce non-elective admissions Delivery of the 4 hour standard	Jane Hayward	UHS	March 2015	Plan includes key priorities for 2014/15: - frailty pathway - AEC pathways - speciality hot clinics - access to diagnostics - workforce - flow and service improvement - CDU development - analysis of attendances - crowding policy - therapy at the front door - perfect week learning See Annex A: ED RAP updated July 14 ED RAP work stream 1.xlsx Key milestones on track as of 1st Sept meeting. Next check point 6th October.	G	A
1.4.2	**Abdominal pain pathway:** develop and implement a single, comprehensive pathway for patients presenting with abdo pain Single point of entry into pathway irrespective of admission route, with early access to senior decision maker, early diagnostics and timely streaming in to appropriate specialty arm of pathway 7 days a week	Improved patient experience Reduce (repeat) ED attendances and emergency admissions Reduce LoS for patients requiring admission Patient managed with in the appropriate specialty	Clare Handley	SCCCG	March 2015	Pathway working group established and well represented by all relevant disciplines. Exploring benefits abdo pain MDT. Progress slipped due to lack of availability over holiday period. Workshop rescheduled for 17th Sept.	R	A

Ref	Objective / Action	Expected impact/KPIs	Project Lead	Lead Org	Expected delivery date	Progress	In month	Planned delivery
1.4.3	**Mental health pathway:** develop mental health pathways to ensure patients' needs are met in a timely manner Ensure that patients are appropriately defined and managed according to their physical and mental health care needs Include out of hospital urgent and emergency services (GPs, MIU, WIC, IIH, SCAS 999 and 111)	Improved quality of care and patient experience Reduce ED attendances and non-elective admissions	Katy Bartolo-meo	SCCCG	March 2015	Four priority patient groups identified for pathway and service improvements, commencing with repeat attenders with self-harm. Progress slipped due to lack of availability over holiday period. Next check point end of Sept 2014	R	A
1.4.4	**Mental health in ED:** improve psychiatric service responding to support patients in ED	Mental health impact on ED defined and quantified	Katy Bartolo-meo	UHS CCGs Southern Health	March 2015	Project team established to clarify the programme of work around psychiatry liaison, resolution for Section 136 patient care, access to other services, admissions avoidance. Service review underway. Next checkpoint October 2014. Currently a significant issue for ED	R	A
1.4.5	**Support patients to make good choices:** promoting choose well principles through patient and public engagement, communication and education	Increase use of 111 Reduce minor illness and injury attendances to ED	Chris Bailey Lisa Sheron	WHCCH SCCCG	December 2014	Communication and education programme for 14/15 developed and linked to Seasonal Plans 111 awareness, bus advertising and 'phone first' campaign MIU awareness and promotion Continue with choose well campaign Self-care and use of community pharmacies awareness Regular tweets and media messages	G	A

Ref	Objective / Action	Expected impact/KPIs	Project Lead	Lead Org	Expected delivery date	Progress	In month	Planned delivery
1.4.6	**Front door model:** review, reconfirm and specify the front door model within the emerging strategic context and adjust joint plans and priorities accordingly. Agree and articulate a coherent front door model that incorporates best practice, strategic direction (Keogh/ Willets), local changes (e.g. 111, Children's Hospital, MIU, primary care, mental health, eye casualty) etc.	Preferred front door model defined within an updated strategy Service specification for UHS front door	Lisa Sheron Chris Bailey	SCCCG WHCCG	September 2014	CCGs have agreed to review, confirm and articulate the urgent care strategy, linking in with current work, ED RAP, ED service improvement and learning. Identify any gaps and ensure what is already in place works. Next check point October 2014.	R	R
1.4.7	**30 Day Readmissions:** complete re-admissions audit and build on existing action plans	Reduction in 30 day re-admissions	Sarah Knight	WHCCG SCCG	October 2014	Output from previous audit reviewed to inform next steps Audit planned for 24th Sept 2014	G	A
1.4.8	**ED re-attendances:** review 7 day un-planned re-attendances	Reduction in ED re-attendances to below the threshold <5%	Sarah Knight	WHCCG SCCCG	October 2014	Current re-attendance rate remains at ~9% Further review initiated now that data issues have been resolved. Slip to Q4 for resolution	R	A

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Work stream 2: building and sustaining operational resilience

This Work stream incorporates 3 projects:

2.1 Operational daily system resilience: escalation, alerts, daily dashboards and system communications

2.2 Operational resilience planning: system-wide seasonal plans, incorporating provider plans and contingencies and lessons learned

2.3 Capacity and demand modelling for system management and planning: predictive working using system intelligence, data trends and IT tools for forward planning and pro-active system working

Ref	Objective / Action	Expected impact	Project Lead	Lead Org	Due Date	Progress this month	In month	Planned delivery
2.1.1	**Triggers for escalation:** build upon existing daily dashboard and escalation framework to develop an interactive whole system escalation matrix. Matrix to include agreed measures, thresholds and actions to trigger appropriate responses across the system to manage points of pressure in a pro-active rather than reactive manner	Reduction in red and black alerts Consistent, pro-active responses to organisational and system pressure	Sarah Knight Rob Chambers	WHCCG SCCCG	September 2014	Most providers have identified a number of relevant measures and applied a threshold to trigger escalation. The new dashboard is produced and circulated daily. Outstanding actions to be resolved at meeting end of September 2014.	A	A
2.1.2	**System communications:** develop improved methods of system communication to ensure the right people receive the right information at the right time. Further strengthen provider-to- provider communications Ensure relevant information is obtained and ahead in a timely manner to support pro-active response to pressure Maintain contact list to ensure all relevant contacts are listed against correct organisation, with right job title and contact details	Improved system-wide relationships Reduction on red and black alerts All organisations feel informed and supported	Sarah Knight Rob Chambers	WHCCG SCCCG	October 2014	Pilot use of NHS.net text messaging to identified individuals Contact list reviewed and updated Next check point mid-Sept 2014	G	A

Ref	Objective / Action	Expected impact	Project Lead	Lead Org	Due Date	Progress this month	In month	Planned delivery
2.2.1	**Seasonal Planning for 2014/15:** review seasonal plan, implement 13/14 learning into practice and produce a revised plan for 14/15 Obtain assurance from NHSE	Updated seasonal plan and processes	James Lawrence Parr Clare Handley	WHCCG SCCCG	August 2014	Submitted on time at end of July as part of ORCP submission. Awaiting final assurance from NHSE (expected end of September)	G	R
2.2.2	**Activity and capacity planning**: produce annual profiled activity plans for expected seasonality across planned and unscheduled pathways, with matched capacity (staff and facilities), for normal business continuity Resource gaps highlighted to inform Seasonal Plans and flex requirements	Annual plans reflect usual seasonal variation and plans to maintain delivery, including performance standards	Named provider planning leads CCGs	WHCCG	July 2014	Wessex Demand Modelling Tool under development for all CCGs and providers; limited progress at August 2014. Next check point October 2014.	R	R
2.2.3	**Winter 2014 review:** post winter review, including review of dashboard, plan, escalation and communication processes, predictors identified and lessons learned for next winter	Further improve processes for proactive management of system pressures to prepare for winter 2015	TBC Rob Chambers	WHCCG SCCCG	April 2015	To be carried out April 2015		
2.3.1	**Predictive working:** introduce more predictive information within system resilience co-ordination and the identification of future/predicted pressures across the system	Forecast pressure to enable a proactive system response	Sarah Knight Rob Chambers	WHCCG SCCCG	Sept 2014	Predictive information now available, the sub group now need to refine how this is used. Next check point end of September 2014.	A	A
2.3.2	**Capacity management system:** explore the implementation of a system wide electronic capacity management system to support the sharing of system resilience alerts/information across all organisations on a daily basis.	Forecast pressure to enable a proactive system response	James Lawrence Parr Rob Chambers	WHCCG SCCCG	March 2015	This has now been superseded by the in-house tool developed by the predictive working group – see 2.3.1		

West Hampshire Clinical Commissioning Group

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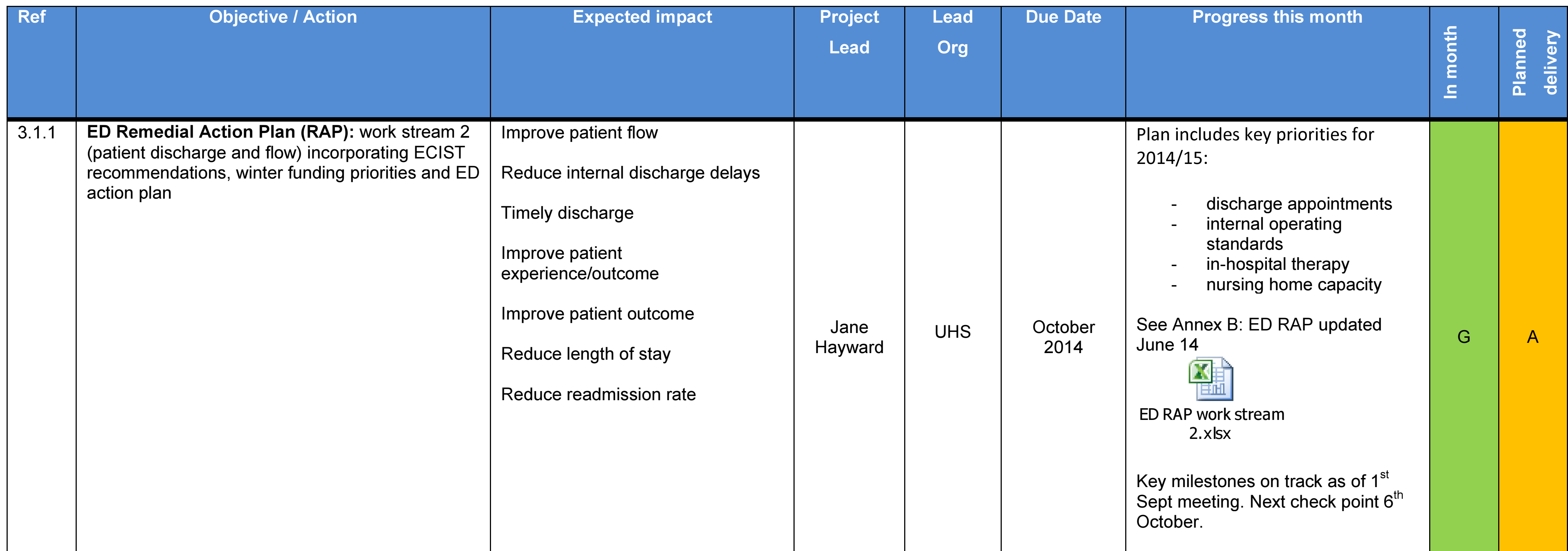
Work stream 3: patient discharge and flow

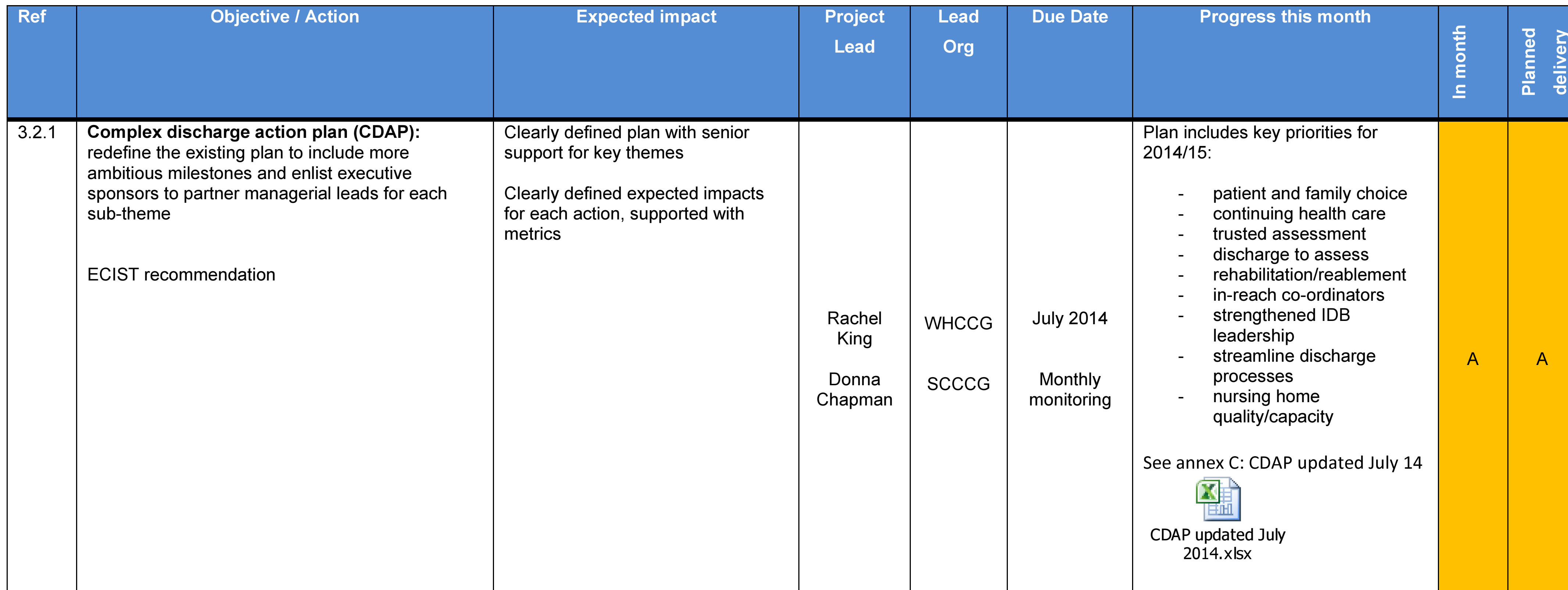
This work stream incorporates 2 projects:

3.1 Patient flow within the acute hospital: operating standards, post admission care and support and discharging planning

3.2 Complex discharge: Integrated Discharge Bureau, health and social care discharge processes, incorporating the whole system complex discharge action plan



Ref	Objective / Action	Expected impact	Project Lead	Lead Org	Due Date	Progress this month	In month	Planned delivery
3.1.1	**ED Remedial Action Plan (RAP):** work stream 2 (patient discharge and flow) incorporating ECIST recommendations, winter funding priorities and ED action plan	Improve patient flow Reduce internal discharge delays Timely discharge Improve patient experience/outcome Improve patient outcome Reduce length of stay Reduce readmission rate	Jane Hayward	UHS	October 2014	Plan includes key priorities for 2014/15: - discharge appointments - internal operating standards - in-hospital therapy - nursing home capacity See Annex B: ED RAP updated June 14 ED RAP work stream 2.xlsx Key milestones on track as of 1st Sept meeting. Next check point 6th October.	G	A



Ref	Objective / Action	Expected impact	Project Lead	Lead Org	Due Date	Progress this month	In month	Planned delivery
3.2.1	**Complex discharge action plan (CDAP):** redefine the existing plan to include more ambitious milestones and enlist executive sponsors to partner managerial leads for each sub-theme ECIST recommendation	Clearly defined plan with senior support for key themes Clearly defined expected impacts for each action, supported with metrics	Rachel King Donna Chapman	WHCCG SCCCG	July 2014 Monthly monitoring	Plan includes key priorities for 2014/15: - patient and family choice - continuing health care - trusted assessment - discharge to assess - rehabilitation/reablement - in-reach co-ordinators - strengthened IDB leadership - streamline discharge processes - nursing home quality/capacity See annex C: CDAP updated July 14 CDAP updated July 2014.xlsx	A	A