NHS
Brighton and Hove
Clinical Commissioning Group

# Urgent Care Plan

July 2016

# Introduction and Context

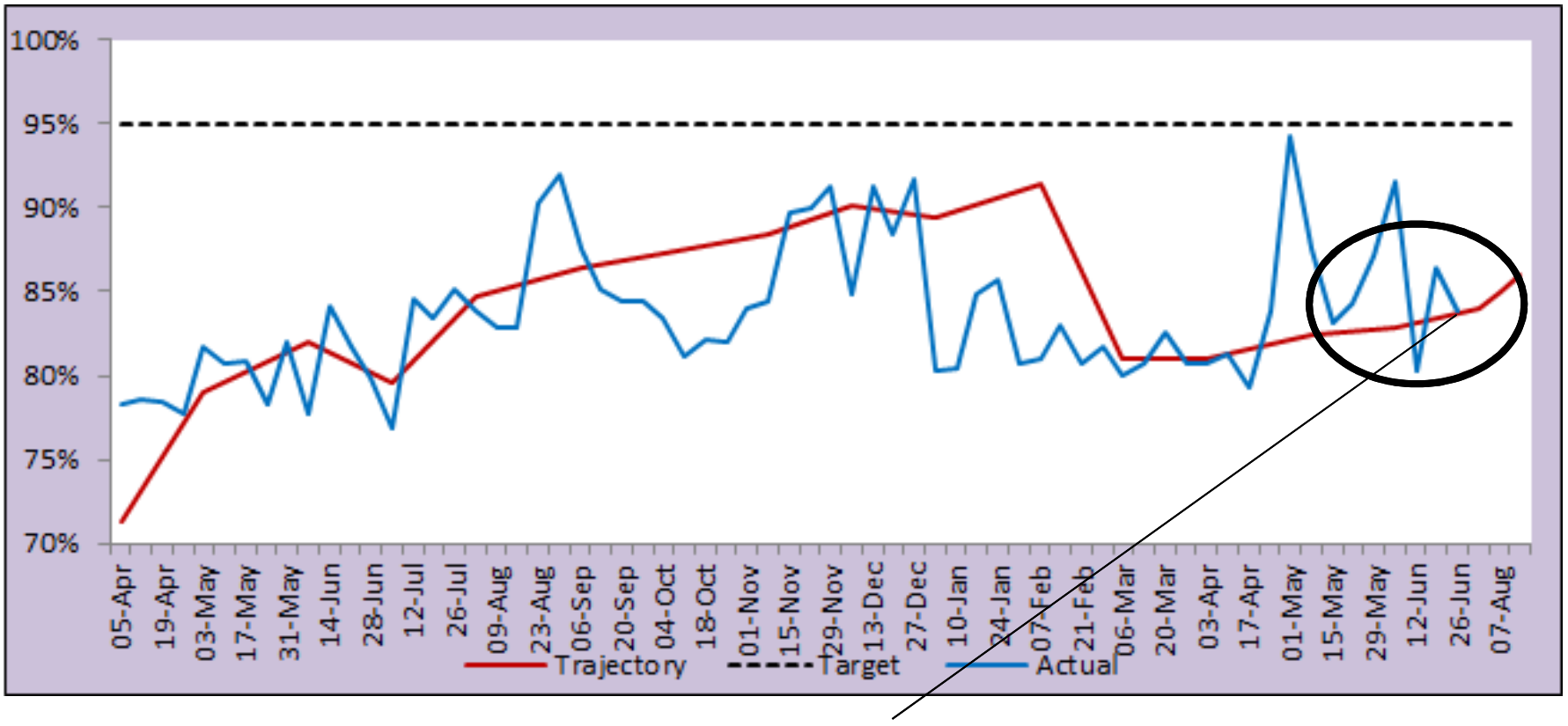
## 1. Overview of current performance:

- A&E 4 hour target
- A&E attendances
- Emergency admissions
- 12 Hour breaches
- Delayed transfers of care

## 2. Overview of improvement plans and actions

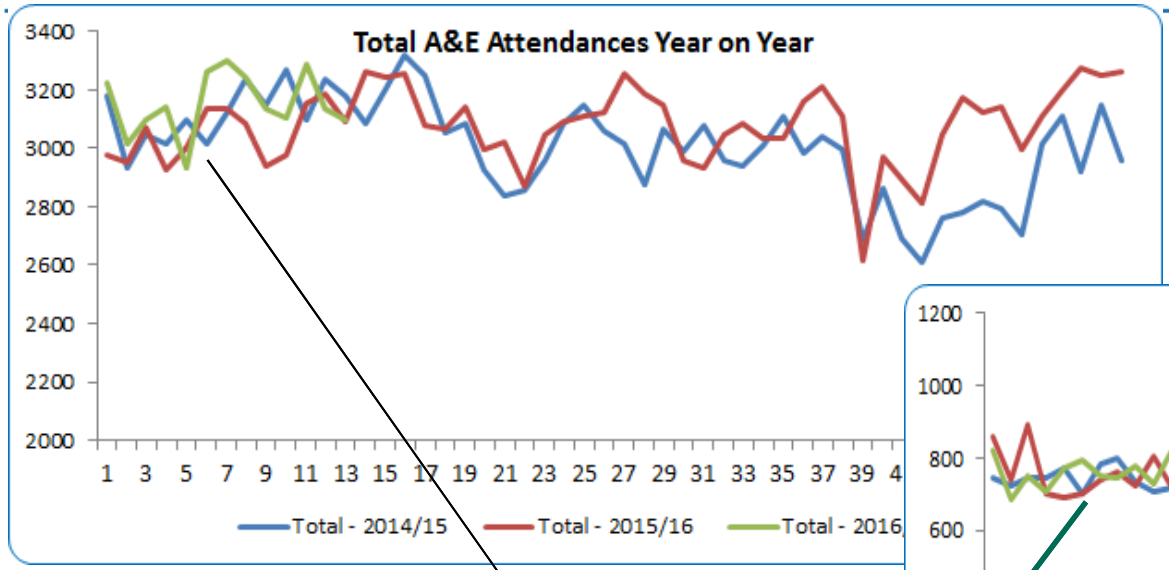
- Preventing admissions and A&E attendances
- Improving urgent and emergency flows
- Improving discharges and reducing delayed transfers of care

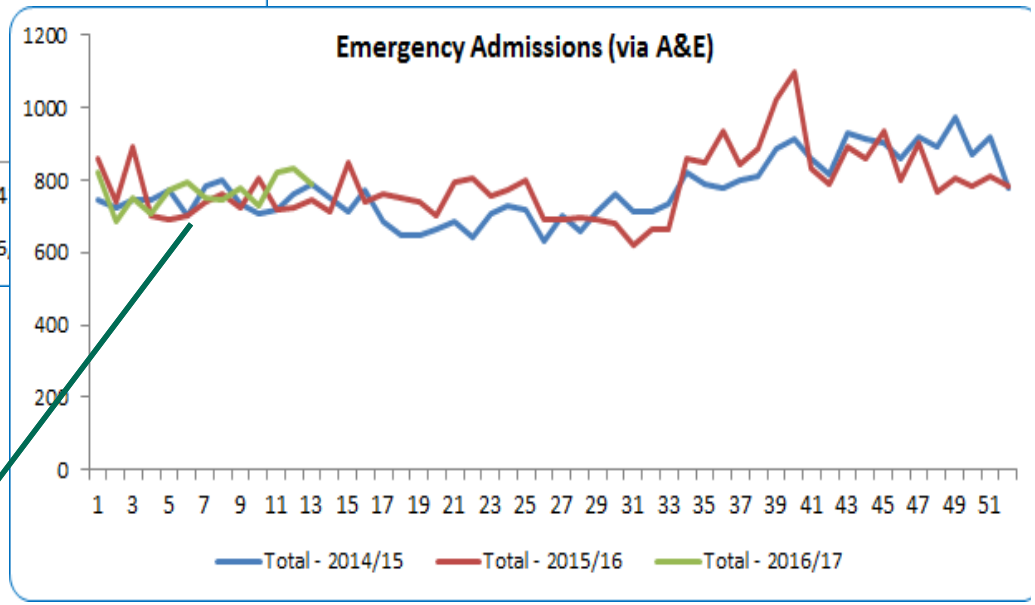
# A&E 4 Hour Target




Currently meeting the recovery trajectory of 84%
(national target 95%)

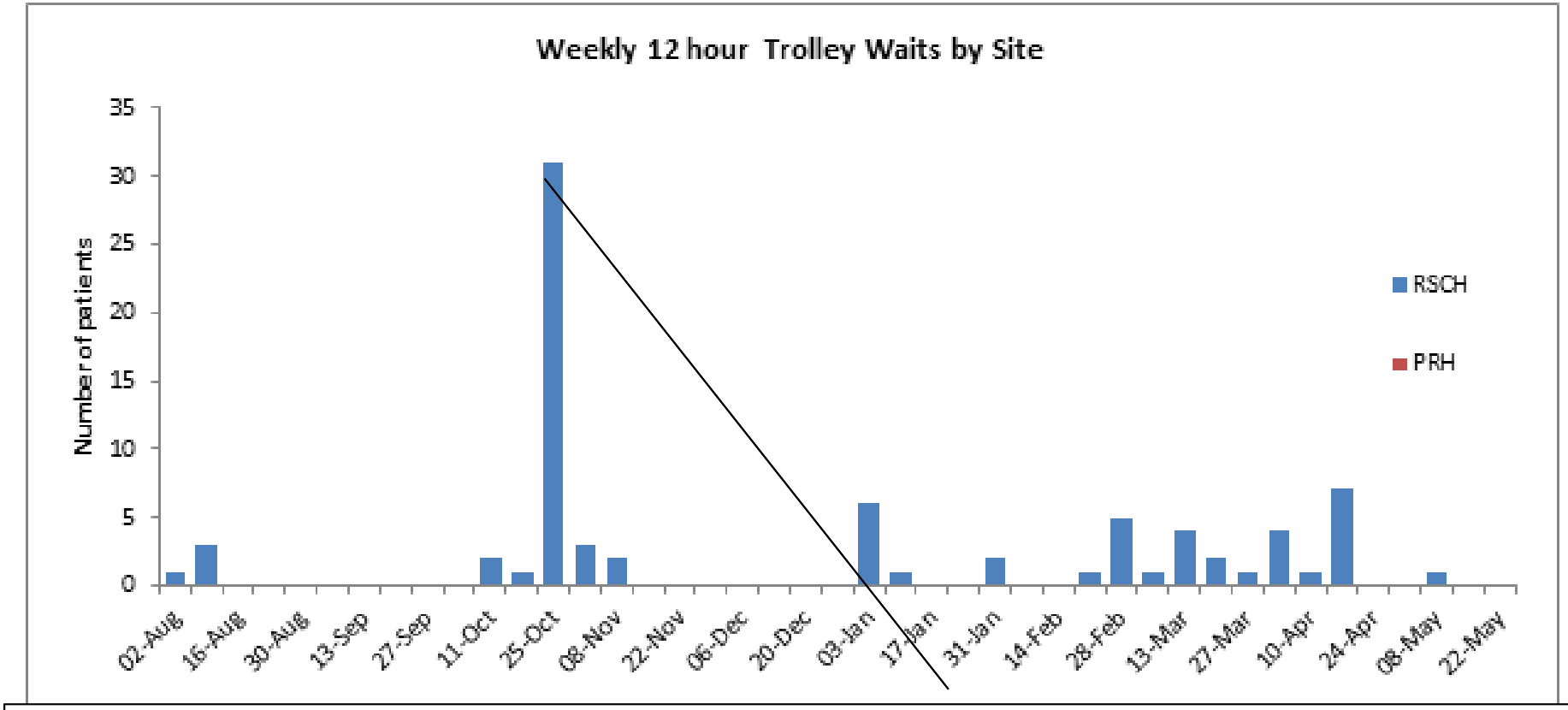
# A&E Attendances and Emergency hospital admissions



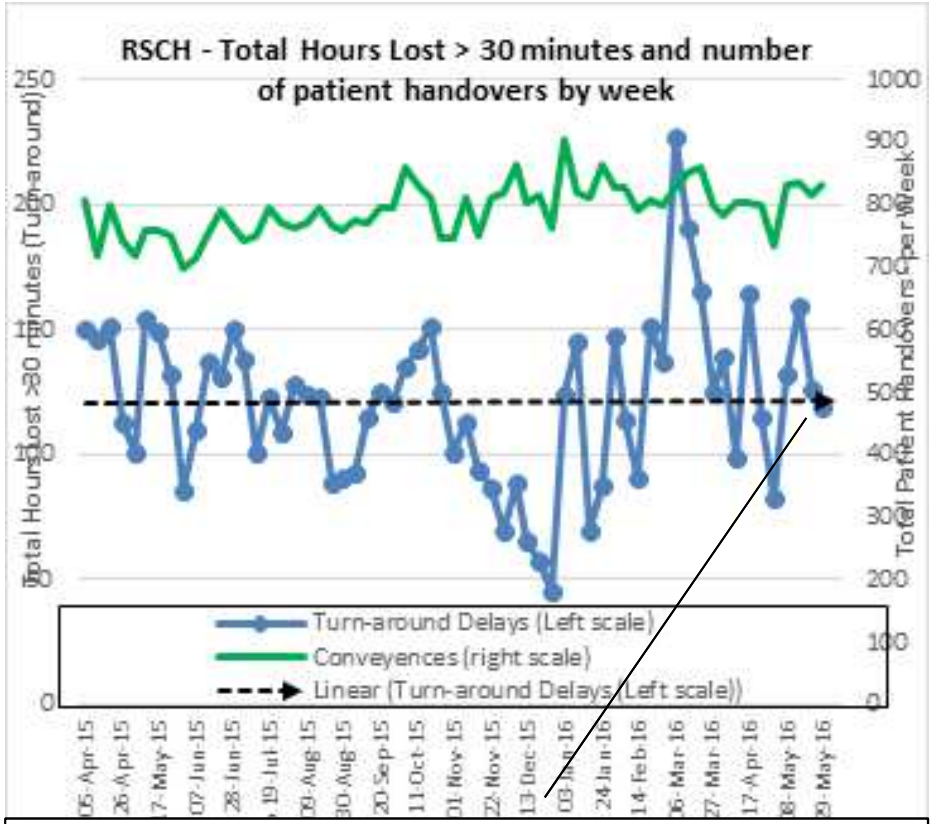

Number of A&E attendances and emergency admissions in 2016/17 are consistent with previous years

# 12 Hour breaches

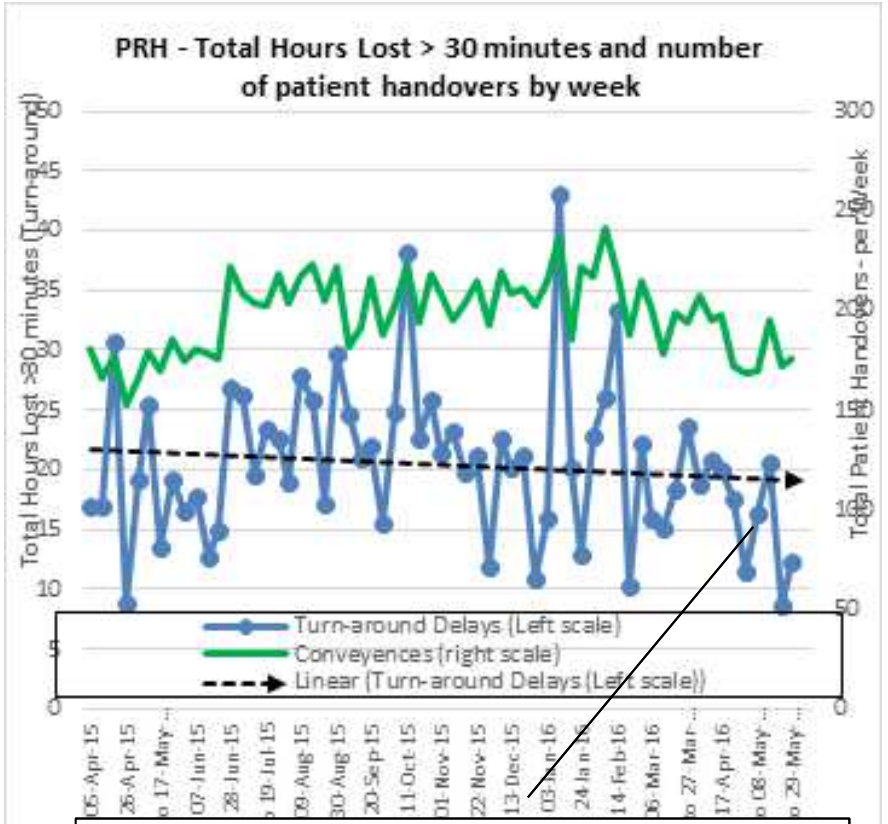



The number of 12 hour breaches peaked in October 2015
There have been no 12 hour breaches at Princes Royal Hospital

# Ambulance Handovers

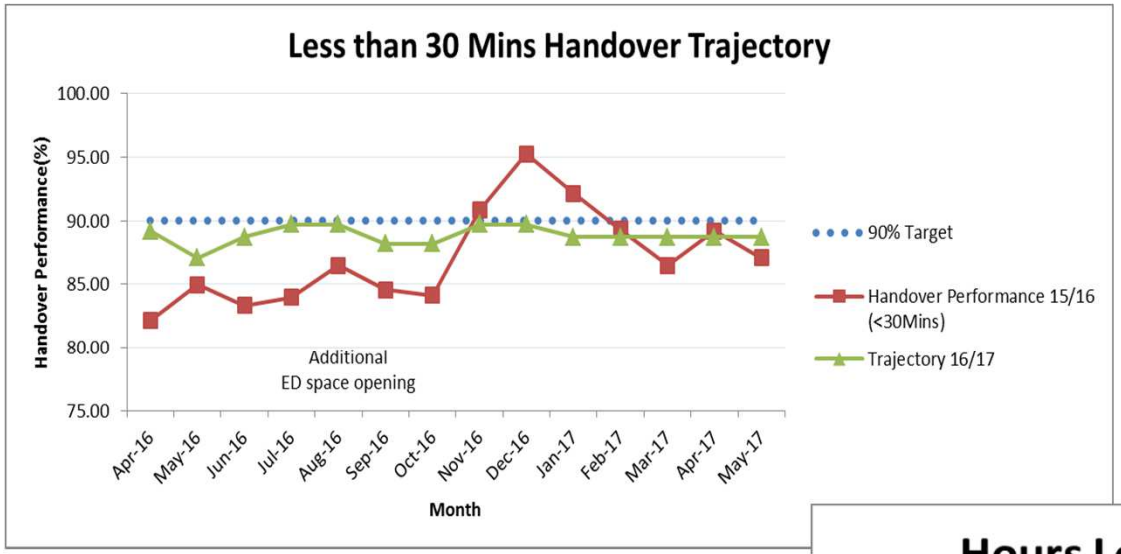


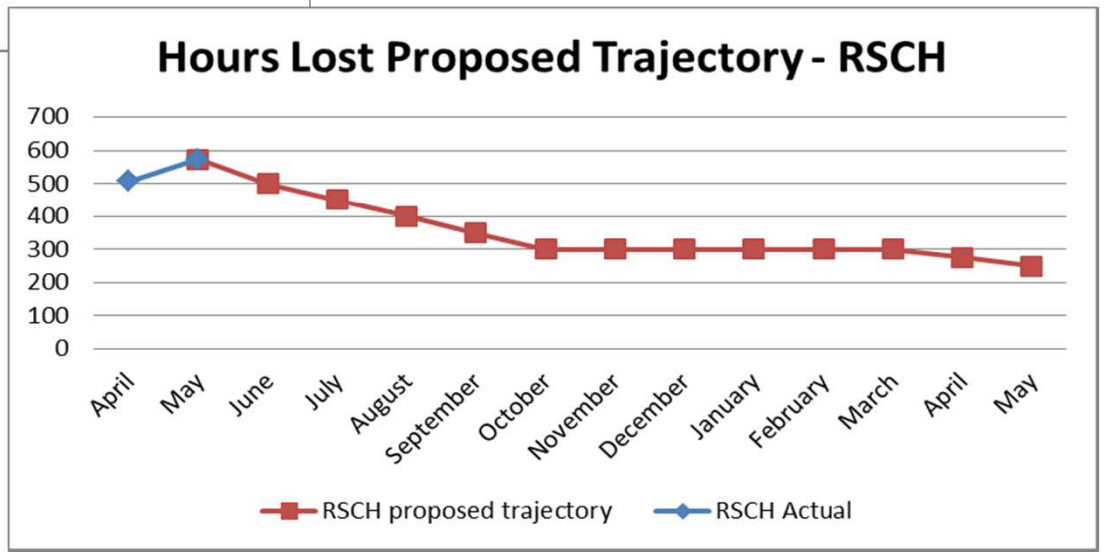

The number of ambulance handover delays at the Royal Sussex County Hospital has not improved this year so far



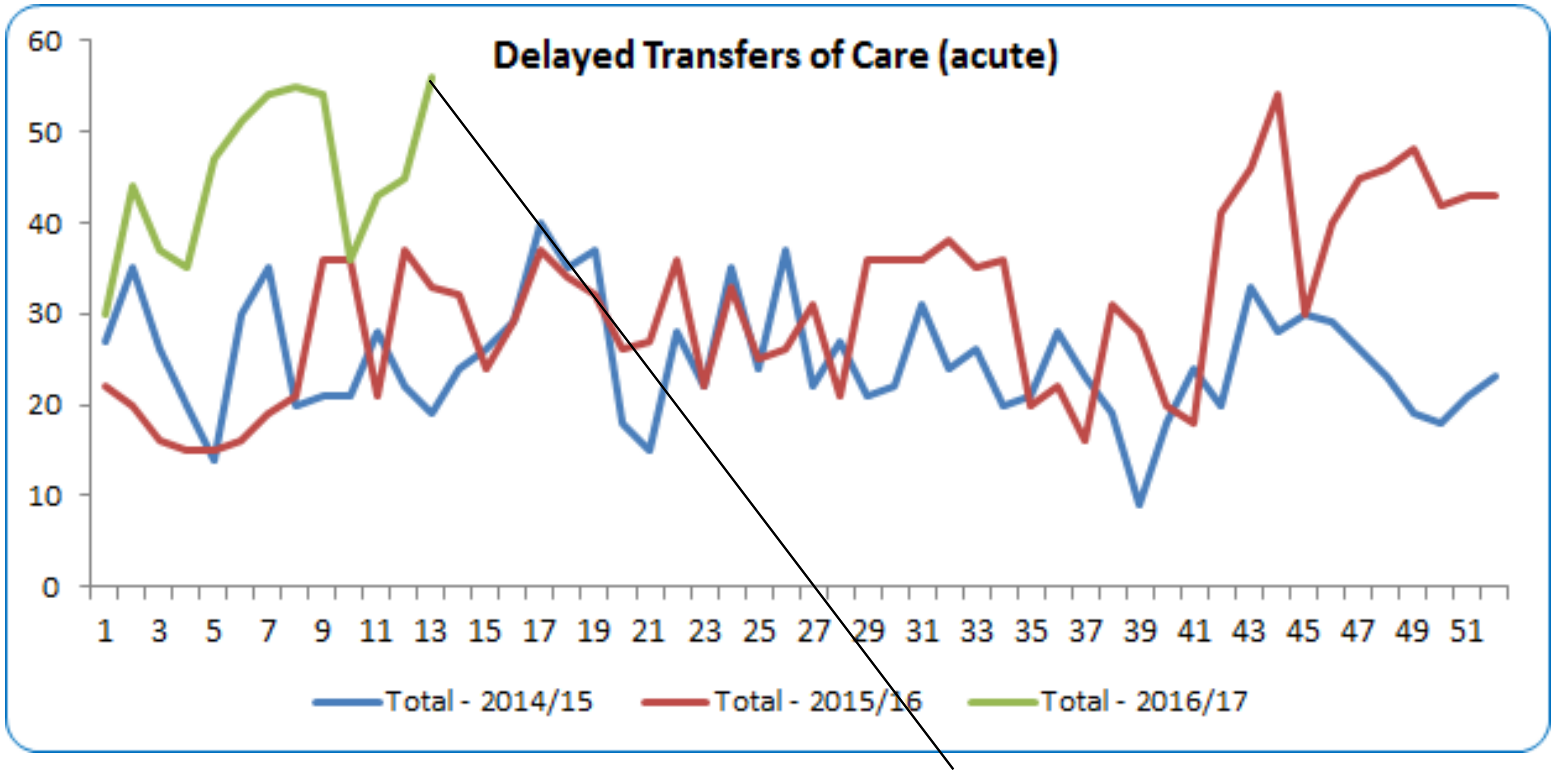

The number of ambulance handover delays at Princes Royal Hospital are reducing

# Ambulance Handover Trajectories



# Delayed Transfers of Care




The number of acute hospital beds which are occupied by a patient who is ready for discharge is 56 (7.1%). This includes Plumpton Ward (PRH) which is an error, hence the significantly higher numbers. BSUH will exclude Plumpton ward from subsequent data. Target is to reduce to 28 (3.5%)

# Urgent Care Improvement Plan

- Agreed system wide work plan for urgent care at System Resilience Group meeting underpinned by:
- Detailed individual project plans including milestones, metrics, risks AND quantification of the impact of each scheme that supports the trajectory
- Regular PMO process to monitor delivery:
  - Fortnightly highlight reports by project
  - Operational oversight at local /system wide urgent and planned care groups – UCORG and taskforce ( clinical and non-clinical)
  - Monthly system wide PMO sessions
  - Escalation of unresolved issues to SRG

# Preventing Admission and A&E Attendance

| Key Issue | Action | Expected Impact |
|---|---|---|
| Increase use of non conveyance pathways | ECIP workshop to review non conveyance pathways<br>SECAMB 16/17 contract prioritises use of see and treat pathways i.e. tariff is incentivised. | 0.5% reduction Sussex wide to conveyance rate of 40.7% |
| Reducing admissions and attendances for patients with complex needs | Implement Proactive Care model in B&H<br>Proactive Care (H&MS) | 849 NEL, 849 A&E (B&H)<br>380 NEL and 96 NEL |
| Enabling patients to make the right choices to access services | Develop 16/17 urgent care communication strategy | Enabling workstream – impact measured in terms of campaign exposure |
| Non SECAMB response pathway for Care link Fallers | Implement revised pathway – RFI issued to identify potential providers | Reduction in 999 calls from Carelink |
| Reducing admissions from care homes | Task and finish workshop to review current input to support admission to and prevent admissions from care homes ensuring joined up approach<br>Improving Quality in Care Homes Programme<br>Primary Care Ward Rounds in Care Homes | Reduction in NEL admissions and contribution to reduction in DtoC lost bed days<br><br>167 NEL |

# Urgent and Emergency Flows - Actions

| Key Issue | Action | Expected Impact |
|---|---|---|
| OOHs resilience | Implementation of RAP to address performance against LQRs, agree and implement approach re pharmacists and multi shift incentives.<br>Negotiation re contract extension | Improved shift fill and Local Quality Requirements |
| Ambulance handovers | ECIP to facilitate joint workshop to review current position and support implementation of good practice from elsewhere | Delivery of handover improvement trajectory |
| NHS 111 and clinical hub | Develop and commission new NHS 111 service<br>Develop and implement clinical hub | Develop clinical model and commence procurement process No impact in 16/17 |
| OOHs, WIC and UCC redesign | Integrated Front Door programme | Develop clinical model and commence procurement process<br>No impact in 16/17 |
| Acute Floor pathways at RSCH | Acute Floor programme at RSCH | Contribution of 3.5% to improved performance against trajectory |
| PRH Front Door | Implement new model of care for PRH front door | Reduction in 675 NEL admissions |

# Improving Discharge and Reducing DToC - Actions

| Key Issue | Action | Expected Impact |
|---|---|---|
| Homecare capacity | Independence at Home service redesign<br>Re-procurement of independent sector homecare service<br>System wide workshop to review demand and capacity and market for home care<br>Recruitment of East Sussex ASC homecare team | 50% reduction in lost bed days = 5 extra beds across BSUH, SCT , SPFT |
| Care home capacity | Workshop as above to include care homes | |
| Community Beds | Discharge Improvement Group established and meets weekly<br><br>Re-procurement of beds according to new service specification (B&H) | Reducing average referral to admission time by 50% = 3 beds at BSUH |
| Managing patient expectations | Implementation of new national choice policy across whole system<br><br>Patient discharge information on admission | 50% reduction in lost bed days = 3 beds at BSUH, 2 beds at SCT, 1 bed at SPFT |
| Complex Discharges | Revise daily threshold approach – operational managers do their job and escalate issues if required<br>Explore options to more closely align HRDT and SW Assessment team across beds at RSCH | Enabling workstream supporting reduction in lost beds days due to DToCs by 50% |

# Improving Discharge and Reducing DToC - Actions

| Key Issue | Action | Expected Impact |
|---|---|---|
| Good practice discharge planning | SAFER Flow Bundle implemented across all bedded and relevant community services | Contribution of 1% improvement to trajectory at BSUH |
| Hospital at Home | Implement Hospital at Home model | Opportunity to double capacity if moves to 4 day LOS community model |
| Discharge to Assess | Fully integrate D2A and CRRS to be intermediate service for all patients needing a service on discharge<br>Define longer term model linking integration of discharge functions | Contribution to 50% reduction in DtOC lost bed days. |
| Assisted Discharge | Continue current pilot and procure long term service, which will be designed to dovetail with East Sussex Service(in development) | To be quantified and set in new procurement model |
| Continuing Healthcare | Implement new national CHC requirements i.e. no assessment in acute bed | National requirement – plans need to ensure no negative impact on performance. |