Basildon, Brentwood and Thurrock Health System

Urgent Care Recovery and Improvement Plan

2013/14

V9.0 29/07/13

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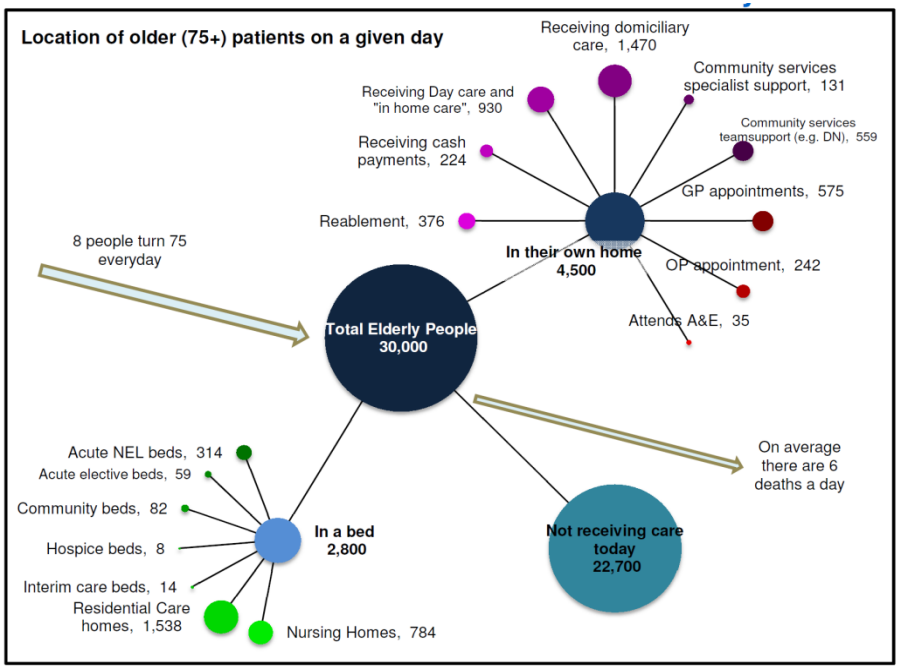
Executive Summary (1)

This plan sets out the approach of the Basildon, Brentwood and Thurrock health system will take to deliver our core objectives of ensuring that everyone who needs urgent care in our area receives a safe service and meets the standards set out in the NHS Constitution.

Context

Since quarter 3 2012/13, Basildon Hospital has failed to achieve the A&E 4 hour standard resulting from increased demand for unplanned care, weak QIPP delivery and inadequate system wide management. This impacted on a variety of standards, including increased cancellations and failure against the RTT standard.

In response to this work the health system commissioned a review of unplanned care which identified **providing effective unplanned care for older people is the key challenge facing our local health economy.**



This plan which we believe is a good plan sets out our response to this challenge and the lessons learned from last year (slide 25), alongside the core operational improvements which are being made by individual organisations to provide safe, effective unplanned care. We are now more than ever before working collaboratively with our partners to find a common solution and are confident and assured that through this process we will achieve our goal.

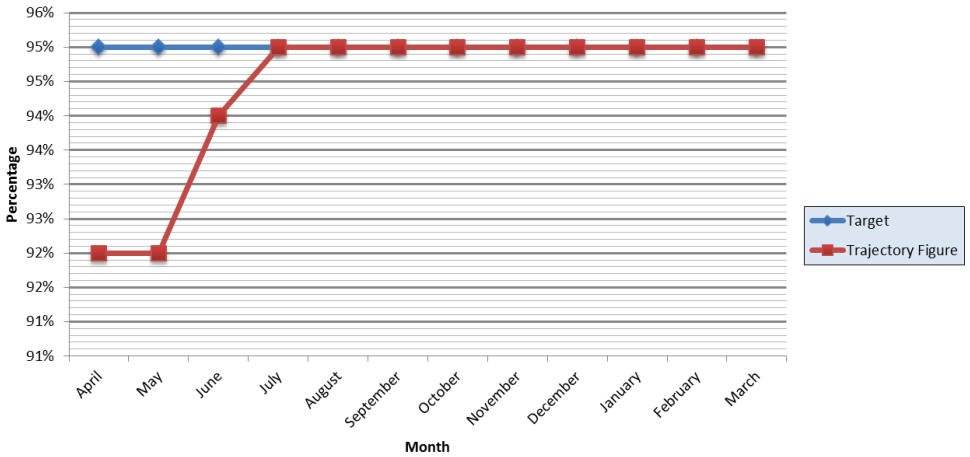
Trajectory and challenges

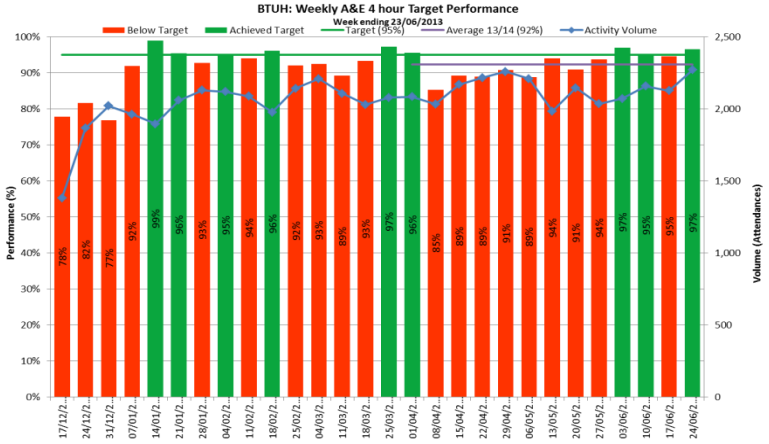
This plan sets out the trajectory for improved A&E performance (slide 19) and the Trust achieved the 4 hour standard in June. The work outlined within this plan sets out how the system will seek to establish sustainable compliance with this standard.

Executive Summary (2)

The Urgent Care Plan submitted to Monitor on the 1st May outlined an intention to recover 95% compliance on the 4hour A&E target by September 2013. This urgent care recovery and improvement programme revised this trajectory to compliance by June 2013.

Based on the actions already taken through QIPP and the Trust's Right Place Right Time programme the Trust achieved the 4 hour A&E standard in June 2013 meeting the revised trajectory in advance of the requirement placed by Monitor under its' licence conditions. The Trust is now on track to sustain that achievement in July.





There are a number of risks associated with this revised trajectory, these are being mitigated as follows:

Risk	Mitigation
A&E overall activity remains above a level that is sustainable without the longer term actions being delivered	The GP in A&E and Community Geriatrician initiatives are already realising benefits, ensure this is replicated across all initiatives.
The Right Time Right Place and QIPP initiatives require a number of medium and longer term actions to be undertaken	The GP in A&E and Community Geriatrician initiatives are already realising benefits,, ensure this is replicated across all initiatives.
Whilst there is agreement on capacity requirements for the system, the additional bed base is yet to be implemented	Additional capacity in the form of 60 beds will come on line in November.

Executive Summary (3)

Governance and system management

The local system sets out the revised governance and system management arrangements that are being implemented to secure a sustainable unplanned care system. This includes delivery of: QIPP delivery, in-hospital processes, delivering integrated health and social care, day to day operational delivery, oversight of this plan. All of these areas will be overseen by a CEO forum of all key stakeholders.

Escalation and surge

This plan sets out that we will develop system wide escalation and surge plans by August, with a stress test being undertaken at the end of August.

Our approach to improvement

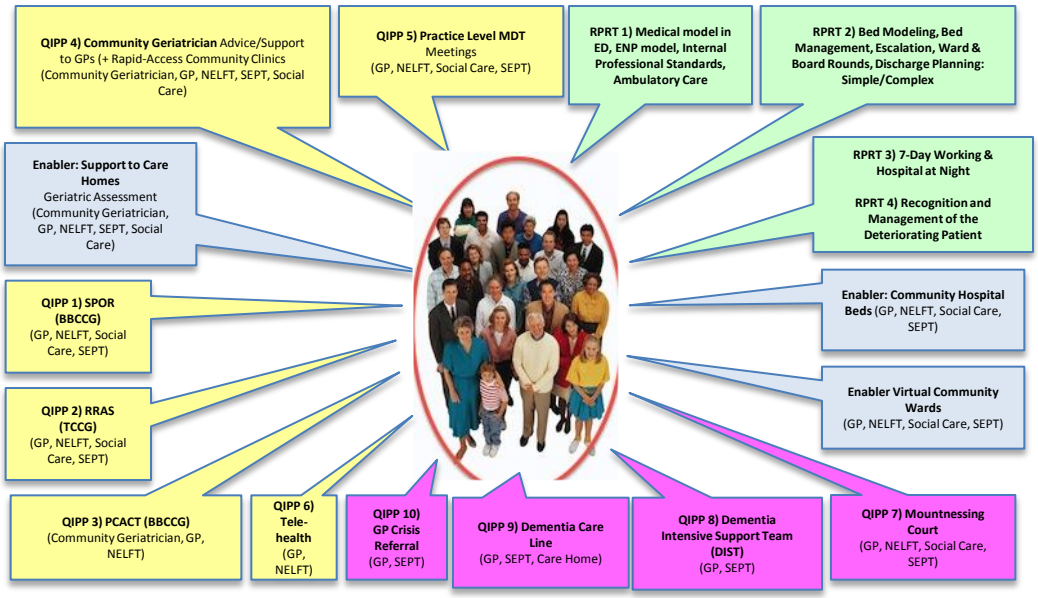
Our areas of focus within this plan are on: (1) ensuring the delivery of QIPP (2) improving in-hospital processes. Key QIPP **and hospital based schemes in the Right Place Right Time programme (reflecting the Emergency Intensive Support Team recommendations)**, are illustrated on the following slide. Key projects outlined within this plan include:

- Strengthening primary and community care for frail and elderly patients.
- Use of Community Diversion Schemes.
- Use of virtual wards in the community, including supporting care homes.
- Increasing hospital bed capacity.
- Reducing length of stay in hospital.
- Improving discharge processes and out of hospital support.

For detail of the QIPP and RPRT plans see 'Our approach to improvement" later in the document

The risk assessed impact of these measures have been reflected within our contractual agreements with providers (slide 59).

Executive Summary (4): whole system impact



Admissions	Q1	Q2	Q3	Q4	Total
Impact of QIPP* (agreed with BTUH)	**-179**	**-231**	-282	-333	-1,025
CCG QIPP Plan	**-349**	**-449**	-548	-648	-1,994
Actual April/May (data due in Sept)					

Bed Shortfall		Right Time Right Place*		
		Fully delivered	Partial delivered	No change
BTUH Assessment QIPP Delivery	Maximum	**-40**	-60	-79
	Most Likely	-46	**-66**	-85
	None	-68	-88	**-107**

Impact Timeline: QIPP/RPRT Schemes 2013/14	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Top 6 QIPP Schemes: 1) SPOR, **2)** RRAS, **3)** PCACT, **4)** Practice Based MDTs, **5)** Community Geriatrician and **6)** Telehealth)										
Review Urgent Care activity and throughput for the top 6 QIPP Schemes										
Next 4 QIPP Schemes: 7) Mountnessing Court, **8)** DIST, **9)** Dementia Care Line, **10)** Crisis Response										
Review Urgent Care activity and throughput for the next 4 schemes										
RPRT Schemes I): Medical model in ED, ENP model, Internal Professional Standards, Ambulatory Care										
RPRT Schemes 2): Bed modelling, Bed Management, Escalation, Ward and Board Rounds, Discharge Planning – Simple / Complex										
RPRT Schemes 3): 7-Day Services & Hospital at Night										
RPRT Schemes 4): Recognition and Management of the Deteriorating Patient										

Primary Care MDT Reviews

Costs	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD (Apr - Jun)
12/13 Outturn													
12/13 Cost Outturn													
13/14 Activity Plan	120	160	160	160	160	160	160	160	160	160	160	160	280
13/14 Activity Actual	76	68	82										144
13/14 Cost Plan													
13/14 Cost Actual													
13/14 Savings Plan (-)	(£134,549)	(£163,089)	(£146,780)	(£130,471)	(£114,162)	(£97,854)	(£81,545)	(£65,236)	(£48,927)	(£32,618)	(£16,309)	£0	(£444,418)
Savings Delivered (-) / Overspend (+)	(£85,214)	(£69,313)	(£75,225)										(£229,752)
% Delivery (%)	(63%)	(43%)	(51%)										(52%)

The table above shows a snapshot of delivery against plan for Thurrock CCG's element of QIPP 5) Practice level MDTs in Q1. This snapshot has been developed to offer a proxy means of assuring QIPP performance in the absence of SUS data and is being extended to include a suite of summary tables showing progress for all SW Essex urgent care QIPP schemes.

** For detail of the QIPP and RPRT plans see 'Our approach to improvement" later in the document*

Executive Summary (5)

Winter pressure monies

The plan sets out a long list of priority areas on the utilisation of winter pressure monies which will be refined during August:

Basildon & Brentwood CCG (total c£2m, including AT improving GP access).
- The AT would like to target GP extended hours/improved access. Costs are estimated around £500 – 750k.

In addition **schemes put forward by the CCGs** are as follows:

Acute Services	Community Services	Social Services
• Additional capacity for GP in A+E Scheme (£180k) • Additional Patient Transport provision (£35k) • Outsourcing elective work support (£500k) • Additional CHC Assessor Capacity (£25k)	• Additional intermediate care bed capacity / spot purchase of step-up or step-down beds (£390k) • Community MDTs (£85k) • Community Equipment (£50k)	• Improving Social Work and Interim Placement Capacity and Responsive (£50k) -

Plan assurance

This plan and the timescales set out within it have been reviewed and approved by each of the stakeholder organisations to this plan.

Context

Basildon, Brentwood and Thurrock Health System
Urgent Care Recovery and Improvement Plan
2013/14

Context (1)

The problem

Since quarter 3 2012/13 Basildon & Thurrock University Hospitals NHSFT has failed to achieve the A&E 4 hour standard. We have identified a number of contributing factors to this failure, including:

- 3% increase in emergency admissions between 2012/13 and 2011/12.
- 8% increase in A&E attendances between 2012/13 and 2011/12, this increase included a 30% increase in resuscitation attendances
- 4% increase in length of stay for all inpatients at Basildon Hospital.
- Weak QIPP demand management delivery within Commissioners.
- Inadequate escalation and surge planning across the south west Essex health and social care system.
- Ineffective system wide management of older people presenting to the service (slides 14-15)

Contributing factors

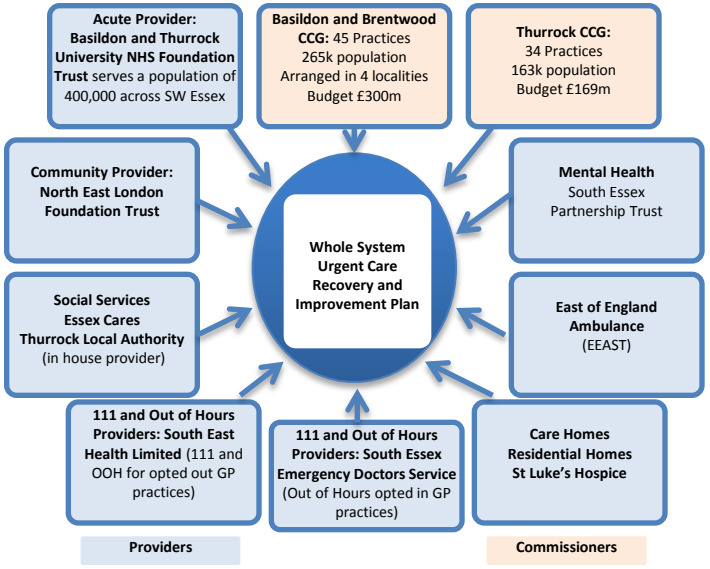
These factors all contributed to poor performance against the A&E standard, but also resulted in:

- Patients having to wait longer than 8 hours for a bed after a decision being made to admit them.
- Four escalation areas being opened and in continuous use between October and April.
- Failure to achieve ambulance turnaround targets.
- Elective cancellations, resulting in a failure to achieve the 18 week referral to treatment standard.

The Basildon, Brentwood and Thurrock health and social care system

The key organisations in the local system are set out below and in the diagram):

- NHS Basildon & Brentwood CCG and NHS Thurrock CCG: **Clinical Commissioning Groups**
- Thurrock Council & Essex County Council:: **Social Care Commissioners / Providers**
- Basildon & Thurrock University Hospitals NHSFT: **A&E & Acute Services**
- Barking, Havering & Redbridge Hospitals NHST: **A&E & Acute Services (Brentwood area)**
- North East London NHSFT: **Community Health Services**
- South Essex Partnership University NHSFT: **Mental Health Services**
- East of England Ambulance Service NHST: **Ambulance Services**



Context (2)

Developing a system wide solution (see slide 22)

All partners have undertaken to develop a system wide solution to respond to increased demand and to deliver the NHS Constitution. This was initiated through the commissioning of a review of services for our frail elderly population from 2020 Strategy (embedded at **Appendix 1**). The key findings of this report were:

- Care for frail elderly individuals is important as it accounts for approximately £170 million, which is a quarter of spending (across health and social care).
- There are 30,000 individuals aged 75 and over in South West Essex, approximately 8% of the population, and this group is likely to grow by approximately 1,000 per year for the next ten years.
- Analysis indicates that of the 30,000 people aged 75 plus in Basildon, Brentwood and Thurrock approximately 7,000 will require on-going, proactive management.
- The integrated care and proactive pilots are not currently at scale and not implemented in all areas, for example; Thurrock integrated care are providing the majority of services, and with larger teams than for Essex equivalents (standardised for population). Nursing home support and primary care MDTs are not held regularly and do not provide a structured environment for management of individuals with complex needs who may be dependent on support.

All local providers have plans in place to develop and improve their operational performance across the unplanned care system, including the implementation of practice based MDTs at NELFT to the 'Right Place, Right Time' operational improvement programme at Basildon Hospital. The detail of these plans are set out on slides 29 to 50.

In addition to this work the CCGs and Councils have submitted a pioneer bid and have already commenced the process of developing plans for developing integrated care. NHS Basildon and Brentwood CCG and Essex County Council have agreed that the initial focus of this work, supported through the use of s.256 monies will focus on:

- Implementing a single point of referral for the south of Essex (in collaboration with NHS Castlepoint & Rochford CCG).
- Ensuring we have an effective re-ablement service.
- Social work and interim placement capacity.
- Intermediate care bed capacity.

NHS Basildon & Brentwood CCG also recognises the vital role that high quality, responsive General Practice has in ensuring appropriate use of the unplanned care system. As such, we are committed to developing a support and intervention process with NHS England and Primary Care Commissioning to tackle poor performing General Practices in our area.

Context (3)

NHS England

Developing a robust understanding of demand and the capacity required to meet it (slide 17)

The current work undertaken across the health system into service demand is outlined within the contract between commissioners and hospital as well as within the Urgent Care Plan which was submitted to Monitor on the 1st May. The key assumptions within these documents are set out below:

- A net growth of 1.8% in emergency admissions and A&E attendances across the system (this is following the Trusts' own assessment of the deliverability of commissioner QIPP plans).
- Partial delivery of the 'Right Time, Right Place' operational improvement programme at the Hospital resulting in reduced length of stay.
- Reducing in bed occupancy levels from c.99% to 92%.
- These assumptions have identified a total additional bed requirement within the Trust of 66 beds which plans have been signed of to secure.
- Commissioners have agreed to additional investment to support the Trust to implement this additional capacity.

The detail of the delivery timescales for these plans are set out on slides 28 to 49 which are aligned to contractual requirements of the hospitals' contract.

Delivering RTT (slide 62)

The partners are aware of the requirement to ensure sustainable RTT delivery as part of our collective commitment to upholding the NHS Constitution with an action plan currently in place to deliver Trust level performance in August.

The CCG and Hospital have identified the need for further work to be undertaken on elective capacity and demand to deliver a sustainable RTT position across all specialities and have agreed to seek IST support to achieve this.

Trajectory and challenges

Basildon, Brentwood and Thurrock Health System

Urgent Care Recovery and Improvement Plan

2013/14

Urgent Care Challenges

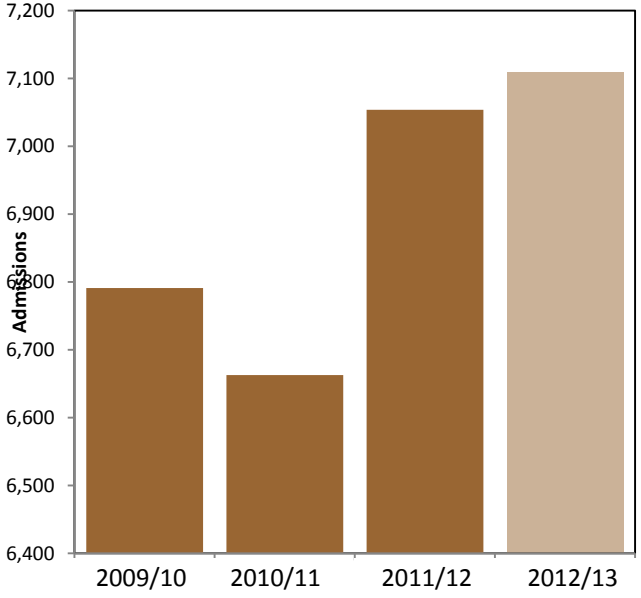
Providing effective unplanned care for older people has been identified as the key challenge for our local health economy

The sub economy jointly commissioned a Frail/Elderly review undertaken by 2020 Strategy. This review analysed trends in activity, current service provision and forecast demand to support stakeholders prioritisation of initiatives for 2013/14. The full review is available in the Appendix section.

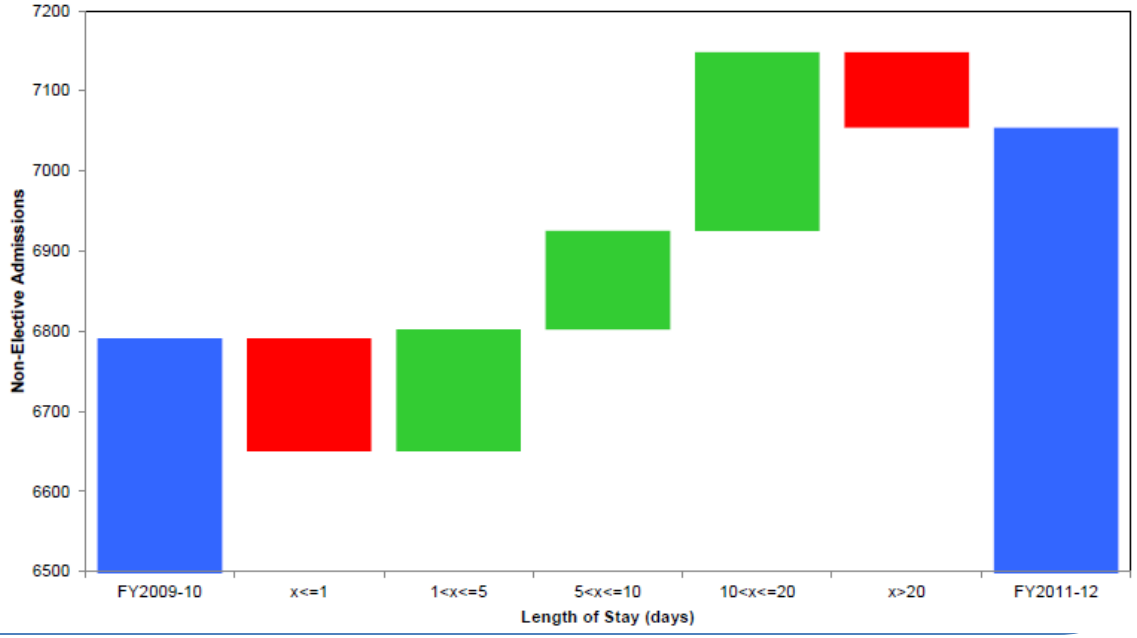
This report showed an increasing trend of older people requiring hospital admission alongside an increase in the number of patients with a length of stay in hospital between 2 and 20 days, as show in the graphs below.

Between FY2010 and FY2012 the growth in admissions was for stay lengths of 2 to 20 days. Shorter and longer stays have been reducing

Total older people admissions (75+) per year (FY2010-13)



Length of Stay and Growth in NE Admissions between 2010-2012



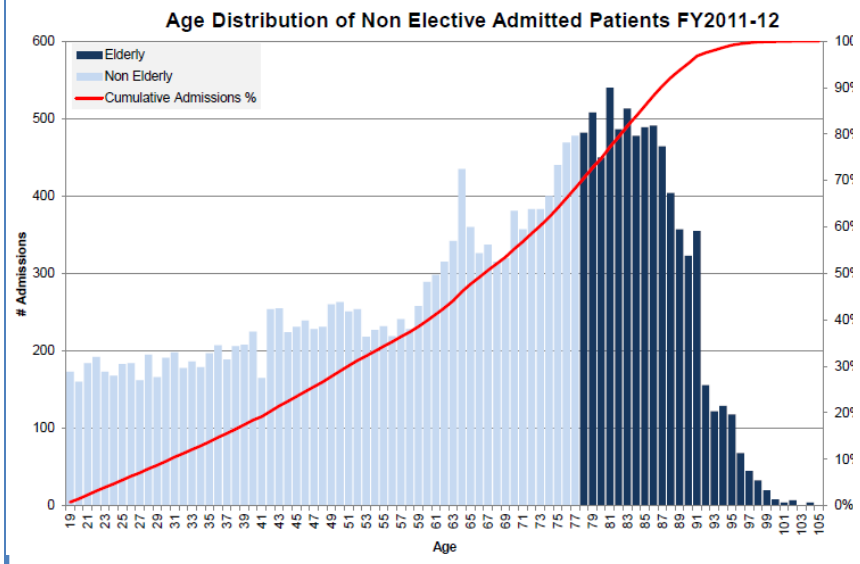
Urgent Care Challenges

The report by 2020 also identified that:

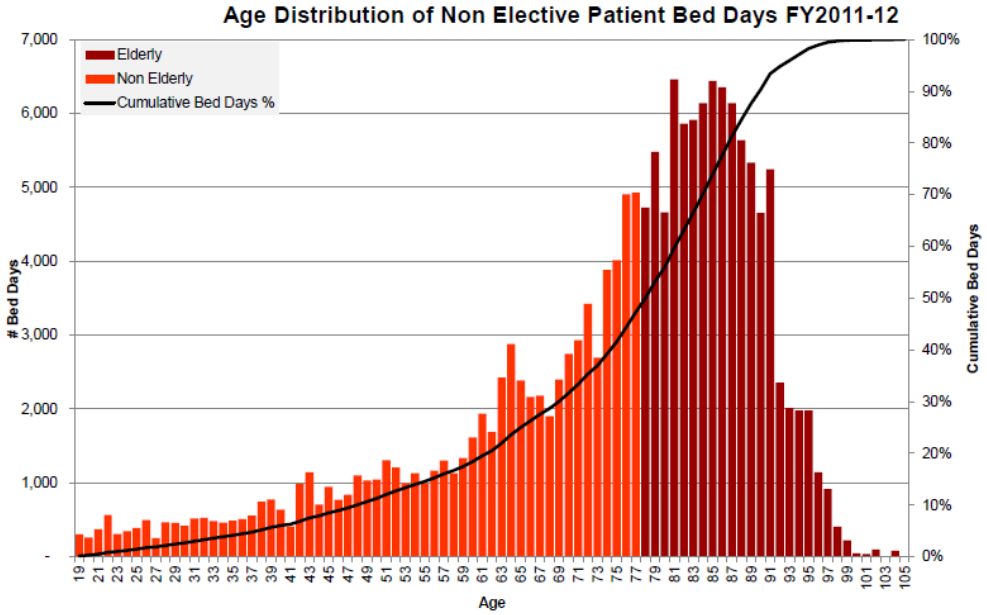
- A significant proportion of (30%) of all non-elective admissions are accounted for by people over the age of 78.
- 50% of non-elective bed days are for people over the age of 78.

Based on these findings, improving the management of older people has been identified as a priority area for the local health system to more effectively manage demand, safety and performance in 2014/15.

30% of Non Elective Admissions are for elderly aged over 78



50% of non elective bed days are for elderly aged over 78



Urgent Care Challenges

Impact on Finance and Contracting

Emergency Threshold Resources (70% Non Elective Threshold):

- Basildon & Brentwood and Thurrock CCGs have agreed £2.5m additional funding to reflect the Emergency Threshold gap across the sub economy,
- The CCGs are agreeing with the acute Trust how this resource is best invested as part of the overall Unplanned Care programme.

Unplanned Care Additional Consequence Costs

	Annual Costs £000s	
ERT Funded		
Additional 28 Bed Ward Costs	1,250	from 1st April
Temporary Ward Hire	300	from 1st April
CDU 5 Additional Beds Escalation	220	from 1st April
Medihome 10 beds	547	from 1st April
Discharge lounge additional support	190	from 1st April
AMU lounge additional support	220	from 1st April
Additional Medical Staff cover	610	from 1st April
Agency Premium	300	from 1st April
Total	**3,637**	
Other Costs not Funded		
Agency Premium	850	from 1st April
Short Stay Ward Staffing	700	from 1st April
Waiting List Costs/loss of elective surplus	1,250	from 1st April
Capital		
New ward Block	4,750	from end of November
Total Costs of unplanned care	**11,187**	

National Assessment of Local Issues

The National assessment of the Urgent Care position at BTUH relates to the Emergency Care Intensive Support Team (ECIST) who are currently working with the Trust, sharing and advising on implementation of good practice. This work has identified a number of themes:

- Demand
- The clinical decision making capacity
- Flow from admission to discharge, and
- Physical bed capacity

An initial response to these findings has been reflected within the 2013/14 activity plan between commissioners and the Trust, which is based on the principle that it should reflect the true level of demand for emergency and elective admissions and be a realistic reflection of the impact of QIPP schemes. The methodology which has been adopted is as follows:

- Forecast outturn for 2012/13
- 3.2% growth in unplanned care for patients over the age of 65, in line with historical and population growth.
- Risk assessed impact of QIPP schemes, despite which overall demand is expected to increase by 1.8% than 2011/12.

Issues regarding capacity identified by the ECIST are outlined over the subsequent two slides. The other issues identified by the ECIST are reflected within the 'Our Approach to Improvement' section of this plan.

Understanding Capacity (1)

Bed Requirement

Then a better understanding the actual bed capacity in the system.

The unmitigated capacity plan suggests that 107 beds will be required in order to meet the forecast levels of demand for 2013/14. This assumption is based on 92% occupancy, 4% growth on non elective outturn and no change in average length of stay.

This will be mitigated through a combination of improved management of patients within the acute setting (delivering a LoS reduction of up to 10%) through the Right Place, Right Time programme, in addition to the delivery of the CCGs QIPP programme (community services providing more care at home/closer to home).

However, even if both programmes are delivered, there will be a shortfall of beds as indicated in the table below.

Workforce

The assumptions regarding capacity at BTUH:

- A corporate nursing recruitment strategy has been launched for permanent staffing.
- The expanded 66 additional adult medical bed base will require recruitment of
  - 2 consultants, 9 middle/ junior grade doctors, 32 qualified and 22 unqualified nurses, and a range of clinical support staff.

Community Service provision via NELFT:

- Implementing integration of unplanned car community teams to work particular hours.
- Identifying the cost of expanding this to a 24hr day.

Bed Shortfall		Right Time Right Place		
		Fully delivered	**Partial delivered**	**No change**
BTUH Assess-ment QIPP Delivery	Maximum	**-40**	-60	-79
	Most Likely	-46	**-66**	-85
	None	-68	-88	**-107**

Understanding Capacity (2)

Bed Requirement

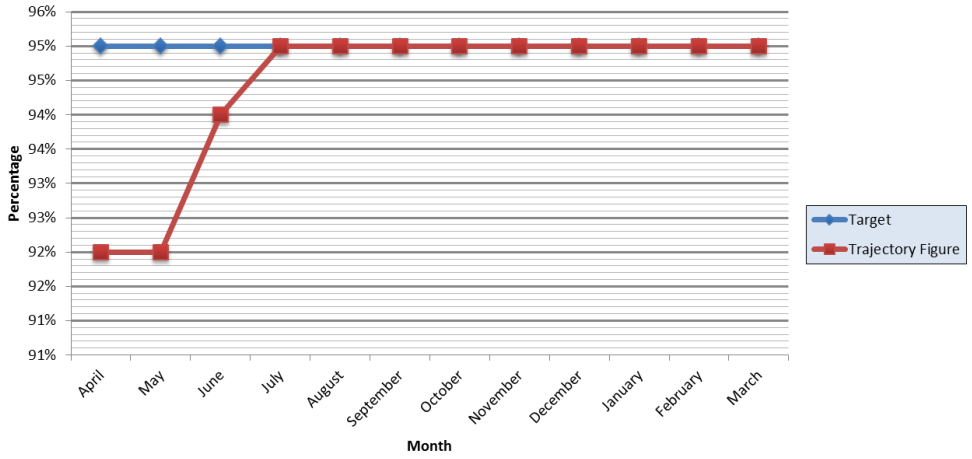
The assumptions the bed model is based upon are:

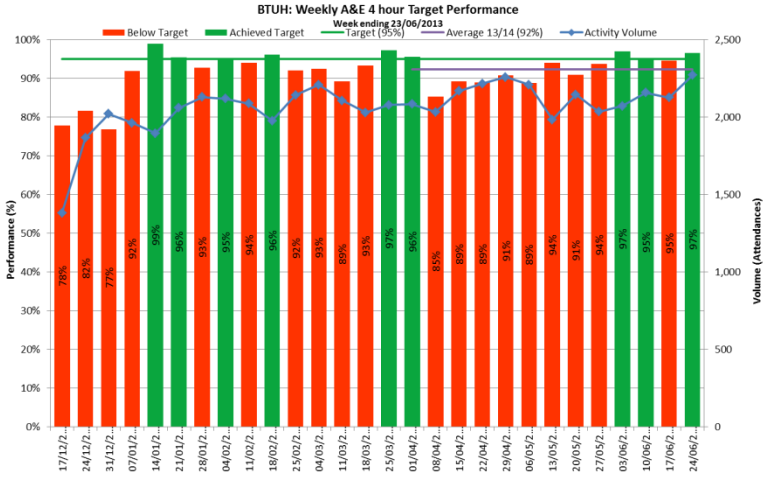
- It covers acute beds and excludes paediatrics, maternity, critical care beds and daycase activity
- It assumes that there will be no escalation beds in use.
- Growth levels as agreed with the CCG of 3% for emergency admissions and 1.5% population growth for the rest (other non elective and elective)
- Movement from current occupancy levels of near 99% to 92% as a step towards best practice of 85%. With the exception of CTC which is based on current rate and T&O at 85%
- It ring fences James Mackenzie (Cardiac ward), CTC beds & Horndon ward for elective T&O
- Zero day LOS bed requirement based on throughput of 2 per day
- Planned outsourcing, as agreed as additional contracted activity, from April to July 13 is excluded from the bed requirement
- FCE LOS is adjusted to deduct days in relation to paediatrics and critical care
- The sensitivity analysis was based on LOS reductions delivered in full or part (50%) as quantified by the NHS Comparators benchmarking
- The sensitivity analysis also factored in QIPP schemes deliver in full or part.

Trajectory: A&E 4 hour standard

Based on the actions already taken, a trajectory to achieve the 4 hour standard has been agreed and achieved

The Trust has achieved the revised trajectory to achieve the 4 hour A&E standard in June 2013, this is in advance of the requirement which has been placed on the Trust by Monitor under its' licence conditions.





Sustainability and risks to on-going delivery

The principle risk underpinning sustainability is that overall activity levels remain high and above sustainable levels without further structural and delivery change between providers and commissioners. The mitigations to these risks are set out below:

Mitigation	Lead	Timescale
Improved operational governance / escalation arrangements Secure 60 additional beds Implement MDTs in Primary Care Other things from QIPP / RTRP	CCG BTUH CCG / NELFT	August-13 Dec-13

Governance and system management

Basildon, Brentwood and Thurrock Health System

Urgent Care Recovery and Improvement Plan

2013/14

Governance & System Management (1)

Refocus on Governance Process

Changes to our governance and system management arrangements are currently being implemented in order to deliver our objectives at set out on slide 29. Key changes as a result of this programme are outlined below:

- QIPP delivery: **CCG QIPP Boards (CCGs)**
- Improving in-hospital processes: **Right Place, Right Time Board (BTUH)**
- Delivering integrated health & social care: **Essex Wide Integration Programme (CCGs / ECC / TC)**
- Oversight and assurance of this plan: **Urgent Care Programme Board (all stakeholders)**
- System oversight: **South west Essex CEO System Board**

Operational Delivery

Under the new proposed governance arrangements, a Planned and Unplanned Care Access Board will be setup between BTUH and the CCG to oversee the detailed delivery of the recovery plans for A&E and RTT performance. This group will report any cross-cutting issues into the Urgent Care Programme Board.

QIPP

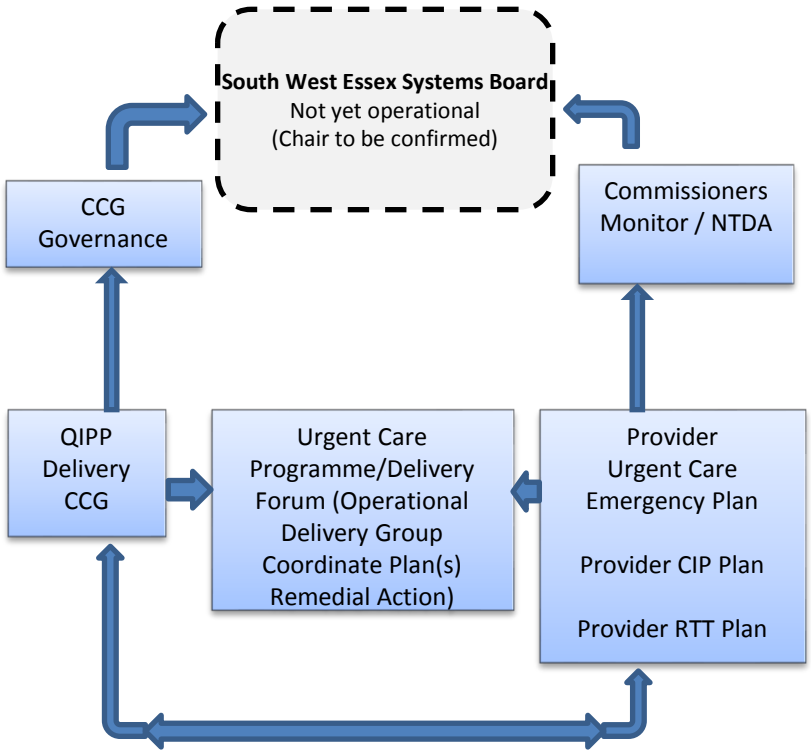
There is a fortnightly QIPP meeting across Basildon & Brentwood and Thurrock CCGs. This is chaired by a CCG CFO and is primarily an officer meeting to ensure delivery of key projects. Among other related changes there is also a revision of the QIPP delivery mechanism to ensure stronger PMO focus and a genuinely whole system/all organisational remit.

Contract Management

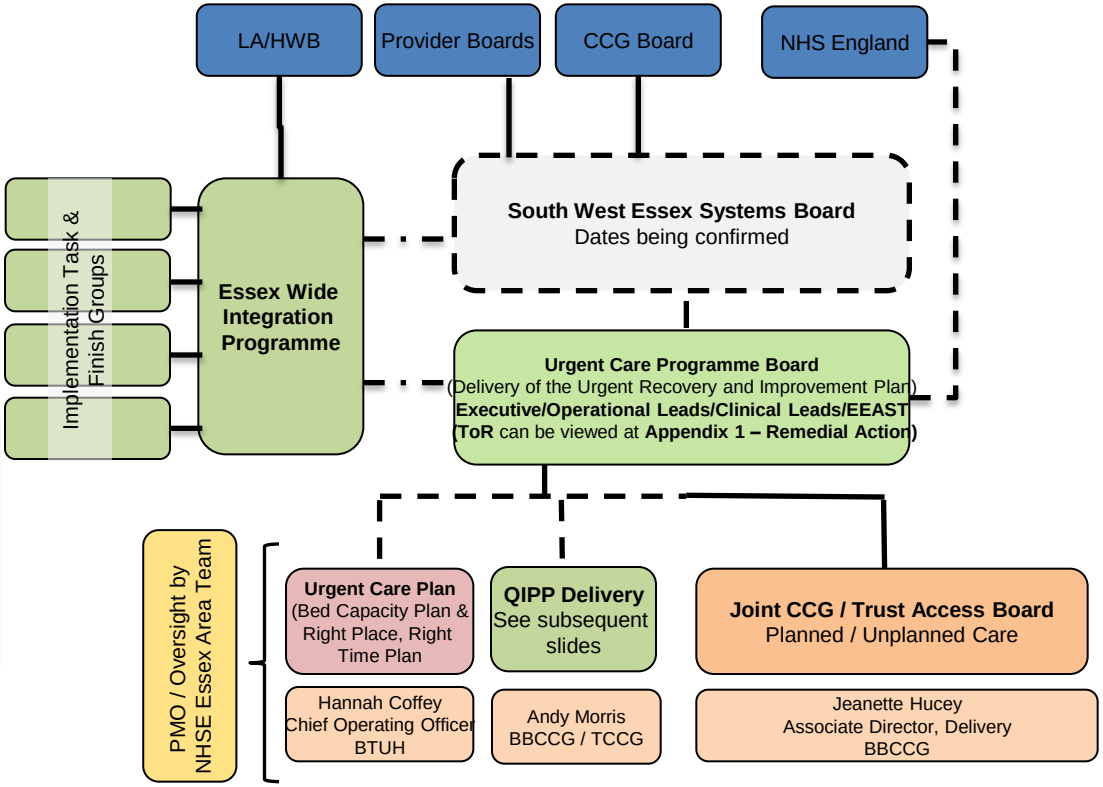
The delivery of the unplanned care agenda will in part be delivered through strong contract management process for acute, community and mental health contracts. Within each contract are clear requirements for delivery of services, performance metrics and activity levels. Failure to comply with these agreed outcomes will result in the instigation of the formal contract management processes.

Governance & System Management (2)

Governance Structure For Urgent Care Delivery



Urgent Care Management System



QIPP Governance

- QIPP reports internally through to the CCGs Board meetings
- QIPP will informally report to the Urgent Care Programme Board
- The CCGs have commissioning Programme Management Office services from the CSU.
- The PMO will monitor delivery across commissioners and the wider health/social economy.

QIPP Governance

Programme Management through established PMO

- Programme Management Office – April-13
- Fortnightly 1:1 Review meetings with BB&T (combined) CCGs Commissioning Leads
- Fortnightly reporting of RAG milestone updates from Commissioning leads
- Fortnightly Basildon and Brentwood, and Thurrock (combined) CCGs QIPP Programme Meeting (chaired by CFO) reviews key programme deliverables, issues and mitigation action plans, disseminate key messages
- Key issues escalated via CFO to CEG and CCG Board as appropriate
- Baseline of 13/14 QIPP delivery plans/FYE and monthly savings
- Baseline QIPP Tracker in preparation for monitoring delivery of QIPP schemes
- Redefined QIPP working group meetings across all workstreams
- Basildon and Brentwood, and Thurrock CCGs to develop new opportunities
- Monthly QIPP Delivery Assurance Template returns

Escalation and surge

Basildon, Brentwood and Thurrock Health System

Urgent Care Recovery and Improvement Plan

2013/14

Surge Planning: Lessons from 2012/13

Surge Planning (including winter planning)

Lessons Learned

Whilst mitigating some pressure during winter 12/13, the implementation of the sub economy Escalation Plan did not enable the health system to return to a sustainable position. The following observations can be made:

- The system remained in "black" for a sustained period and therefore the escalation plan became business as usual rather than short term actions to return to a green/amber position.

- There were several issues that were not covered by the escalation plan e.g. CHC patients, out of area patients.

- The raising of the escalation status was largely reactive/related to on the day pressures rather than pre-emptive.

- It was unclear whether partners were fully compliant with all actions within the escalation plan.

- When crisis point arose and diverts were requested, there was an operational delay of several hours between trust to trust agreement for a divert and the divert occurring. This limited the effectiveness of a divert.

Surge Planning: Actions for 2013/14

NHS England

Surge Planning (including winter planning)

- System wide surge plans will be developed during July and August, stress tested at the end of August and revised where required by September 13.
- Plans will be understood by all providers (surge plans linked to business continuity process).
- Predictive modelling tools/systems will be utilised to proactively manage the predicted activity.
- New protocols to be put in place for areas not covered by current winter plan
  - CHC Additional Capacity
  - Triggers for outsourcing elective activity and the protocol for doing so
  - Spot Purchasing Nursing Home Beds
  - Out of Area Patients
  - Improved divert request process/resus capacity policy
- Based on the learning from 2012/13, the CCGs will work with stakeholders to agree priorities for the use of winter pressures/surge monies for winter 2013/14. This will enable a quick implementation of schemes when resources are released.

Surge System Planning Timeline 2013/14	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Review lessons learned from winter 2012/13											
Develop 2013/13 Surge Plan											
Communicate Surge Plan											
Modelling and Stress Testing of the Plan											
Amend plan to reflect lessons learned from Stress Test											
Develop training, education and comms Potocols											

Information and Situational Awareness

Prospective Planning and use of system triggers

Systems do not have sufficient data & information to support decision making and provide intelligence for proactive situation management and future commissioning.

Urgent Care Plan goal is to develop and implement a new model/system.

Planned actions

- System receives daily information from all providers to understand capacity issues within the local health economy.
- System reviews daily data to understand previous day's activity to predict future trends.
- System uses predictive modelling to proactively manage coming days (linked to escalation/surge planning).
- Development of key metrics to monitor performance within all areas linked to urgent care.
- Intelligence/Information used to design future commissioning of services.

Our approach to improvement

Basildon, Brentwood and Thurrock Health System

Urgent Care Recovery and Improvement Plan

2013/14

Whole system objectives

Our improvement plans have been developed to achieve the following objectives:

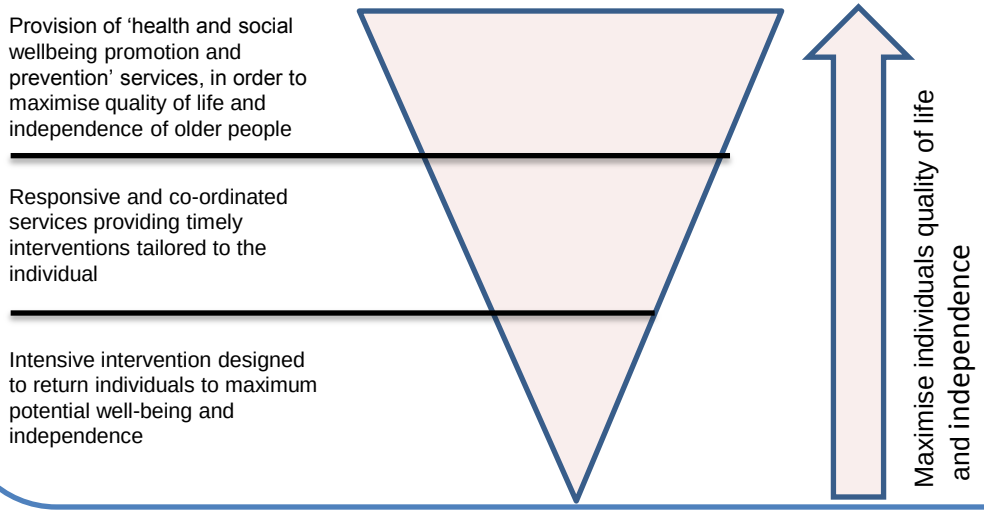
Core objectives:

- To ensure that everyone who needs urgent care in south west Essex receives a safe service.
- To deliver the standards set out in the NHS Constitution relating to urgent care.

Supporting objectives

- To establish effective governance arrangements to support the delivery of our core objectives.
- To proactively manage the local health system through improved information and situational awareness.
- To deliver a supporting change and transformation programme covering all aspects of individual patients' pathways including pre-A&E, within hospital, discharge and community care.
- To have clear and well understood escalation and surge arrangements in place.

VISION: Shared priority: to support older people to 'age well', remaining independent for as long as possible



Given our objectives and the findings from our diagnosis phase of work, our redesign initiatives across the system have focused on improving patient flows:

- **Primary/Community health & social care provision (pre-A&E)**
- **Within hospital, and**
- **Discharge and community care.**

The following slides outline how by working collaboratively each stakeholder's plans support delivery of the vision. Detailed actions are outlined in the individual stakeholder plans at **Appendix 1.**

Improving safety and quality (1)

Quality and safety improvement is at the core of our approach to improving unplanned care:

System commitments

All partners within our local health system are committed to improving the safety and quality of our services and we see the improvement initiatives set out within this plan to tackle a number of the quality concerns we know we face. These are articulated in a variety of reports such as Francis, and the Keogh Review which we absolutely support and for which the CCG and Trust are jointly developing an Action Plan. The CCG's response to the Keogh Review is on the CCG website: www.basildonandbrentwoodccg.nhs.uk. Actions have included:

- A&E Case Note Review.
- Increasing our overall bed base, which are established with permanent, well-trained staff reducing reliance on escalation beds.
- Internal operational improvements at Basildon Hospital to reduce patient movements following admission.
- Improved admission avoidance and supported discharge solutions to ensure that only people who need in-hospital care receive this.

Ensuring quality and safety is maintained during times of pressure

The CCGs intend to use their existing programme of announced and unannounced inspections of the hospital to ensure that service safety is maintained across all providers during the winter period. During periods of high demand, the CCGs will maintain sufficient flexibility to undertake rapid inspections of any areas of concern as identified through the CCGs quality surveillance mechanisms.

June unannounced visits (see table below) were identified through intelligence such as Friends and Family net promoter scores, Serious Incidents and Never events.

BBCCG	**BTUH**	**Lister Ward Pasteur Ward Renal Dialysis Unit**	**June**	**Wed 5th**	**14.00 hrs**		**Lynne Powell Nikki Livermore**	**Gerard Cronin John Delves**	
BBCCG	BTUH	Roding A&E Pasteur Marjorie Warren Kingswood	June	Thurs 13th	10.00 hrs	Chris Hooper	Nikki Livermore	Gerard Cronin Elisa Caddy	
BBCCG	BTUH	Elsdon Lister AMU East/West Paediatric A&E BDA	June	Thurs 20th	19:00 hrs		Nikki Livermore	John Delves Gerard Cronin	Tricia D'Orsi
BBCCG	BTUH	Paediatric Emergency Department, BDU Elsdon Ward, Lister Ward, AMU East, AMU West	June	Tue 25th	11.00 hrs	Lisa Allen Chris Hooper	Lynne Powell	John Delves Elissa Caddy	Jane Foster Taylor

Improving safety and quality (2)

Quality Impact Assessment (QIA):
Objective: QIAs are undertaken on all projects and programmes of work carried out by the CCG and CSU to ensure that the quality of the project and governance supporting it is robust.

BBCCG: Since handover of management of the QIA to the CCG, the proposal for monitoring the QIAs is as follows: Each QIA will be completed initially by the commissioner/clinical lead for the project and then ratified/reviewed by Karen Wesson (Senior Commissioning Manager). This will be shared with the Executive Nurse Lisa Allen to ensure the process is joint up and re-enforces the partnership between quality and commissioning within the CCG.

For those BB CCG specific QIAs this will be reported and monitored via the work stream group and all QIAs monitored via the QIPP PMO.

QIAs for those projects outside the remit of BBCCG but have direct impact on our population will be completed by the Quality Team and submitted to BB CCG for review and comment.

QIAs will be reported via the planned and unplanned care work groups and monitored and report monthly to the Quality Governance Group. A Snapshot from a summary of the QIA to date (as per handover from the quality team (30.4.2013) can be seen below.

QIPP Title	Monitoring Tool			
	QIA Baseline Assessment From		Final Assessment	
Planned Care	Date	RAG	Date	RAG
Musculo-Skeletal (MSK) Pathway	20/11/2012		21/02/2013	low risk
Referral Management (RMC)	20/11/2012		20/03/2013	Medium Risk
Prescribing	20/11/2012		29/01/2013	
Pulmonary Rehab & Home Oxygen Servcie	20/11/2012		17/01/2013	Low Risk
Diabetic Foot Pathway	20/11/2012		25/01/2013	
Ophthalmology	20/11/2012		23/01/2013	No Risk
Dermatology	20/11/2012		25/02/2013	High Risk

Decision Criteria for Quality Impact Assessments (C

Assessment by standard	RAG
No evidence of standard	
Partial evidence but incomplete	
Standard met	

Overall risk assessment	RAG
50% or more of the standards are red or amber	High Risk
≤ 49% but ≥ 25% standards are red or amber	Medium Risk
≤ 24% but ≥ 1% of standards are red or amber	Low Risk
100% of standards are green	No Risk

Improvement … the solutions

Improvement Redesign:

Set in the above context this plan outlines:

- The current 'system-wide' problems and activity planning assumptions for 2013/14
- The likely scenarios in relation to bed modeling and the required improvement actions that will allow the health economy to ensure it has the appropriate risk assessed core and surge capacity.
- The revised governance and system management arrangements which will be implemented to manage system escalation and surge.

This plan also outlines the actions set out within individual stakeholders' actions plans which, together, are expected to deliver the agreed objectives of this plan, as set out on the following slide. The plan sets out:

- The detail of actions which will be undertaken.
- The anticipated impact of these actions.
- Responsibilities and timescales for delivery of actions.

These individual plans can be found **at Appendix 1** of this plan.

Improvement Redesign: QIPP Initiatives

NHS England

Managing Demand through QIPP: Primary/Community health & social care provision (pre-A&E)

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	Timescale (Implementation RAG)	End Goal
GP Front End A&E ('Streaming' and 'Minors)	New scheme for FY 13/14.	• 'GP-in-front-A&E' service provision by 2 GPs (one 'streaming', one see-and-treat/see-and-deflect) between 8am to 12pm under review – by end-July 2013 CCG/BTUH to agree optimum streaming model, with a view to removing GP from streaming, whilst maintaining throughput of 'primary care' patients.	£0.4m	Phase 1 October 2013 Phase 2 April 2014	• Appropriate management of patients attending A&E with 'primary care' conditions. • Reduction in number of investigations carried out (inappropriately) for 'primary care patients. • Reduction in re-attendances as result of 'see-and-redirect' model.
GP Majors Triage and Admission Avoidance Team	New scheme for FY 13/14.	• 'GP-in-majors' pilot demonstrated that without I) a clearly defined categorisation process for identifying 'majors' patients that would most benefit from a 'primary care' approach, and ii) an effective clinical response infrastructure readily available within the A&E, this was an ineffective use of resource. Therefore, multiagency approach taken to development of both a mechanism for identifying the target patient population (i.e. frail/complex adults) rapidly on presentation in A&E; and a introduction of a co-ordinated primary/community health & social care response to take over the care of these patients immediately following identification, to facilitate safe discharge without recourse to inappropriate acute admission. Intermediate service to be introduced from October 2013, with to-scale approach from April 2014.	£0.8m (FYE £0.9m) (allocated savings estimate)	Phase 1 October 2013 Phase 2 April 2014	• Rapid identification of patients presenting at A&E due to 'frailty'/complex co-morbidity, that will not benefit from acute admission, • Implementation of effective, individualised management plan for each patient, allowing their return to community setting, with provision of appropriate health and social care support, and avoidance of inappropriate acute admission.

The activity data above has been taken from the BBCCG and TCCG UPC Workbooks embedded at **Appendix 1**

Improvement Redesign: QIPP Initiatives (2)

NHS England

Managing Demand through QIPP: Primary/Community health & social care provision (pre-A&E)

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	Timescale (Implementation RAG)	End Goal
PCAT* (BBCCG)	Between April 12-Nov 12 PCAT reported 672 contacts, of the people they saw only 56 were admitted within 30 days. Effective admission avoidance service. .	• PCAT service delivers community based assessment and is aimed at patients requiring a more intensive treatment, but do not require emergency admission to hospital. • PCAT hours extended to 19.00 in order to facilitate improved access and utilisation by more GP practices. • There has been a significant increase in PCAT activity since the extension of hours, the purpose of which was to ensure GPs could continue to access the service during their afternoon/early evening surgeries. • The data also shows that the PCAT has sustained a rate of admission avoidance of 80% on average, this is based on the number of emergency admissions to hospital within 30 days of those people seen by the PCAT	£0.4m (FYE £0.5m) (allocated savings estimate)	In place	• Admission avoidance to acute hospital. • Extending ease of access from all localities and increasing patient inflow. • Use of Primary Care and Treatment service in community. • GP Practice Engagement and Escalation to support delivery
Primary Care MDT (existing scheme)	Started with majority of practices but a small number have resisted engagement.	• MDT Co-ordinators recruited by both CCGs, to ensure a common approach to practice-level MDTs is adopted across the patch • Practices that are not engaging in the practice-level MDT process will be identified at a locality level, and will receive peer support to encourage appropriate engagement in future. • Development and implementation of a risk stratification tool to assist the identification of patients by GP practices, community health team or social care professional, who are a) deemed to be at risk of deterioration in their condition, and b) would benefit from an integrated response from primary health/community health/social care providers.	£0.4m (allocated savings estimate)	Ensure all practices have participated in a minimum of one MDT by August 2013	• Risk management of patients to avoid inappropriate admission to acute hospital. Refining and increasing integration of existing schemes • GP Practice Engagement and Escalation to support delivery

The activity data above has been taken from the BBCCG and TCCG UPC Workbooks embedded at **Appendix 1**

Improvement Redesign: QIPP Initiatives (3)

NHS England

Managing Demand through QIPP: Primary/Community health & social care provision (pre-A&E)

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	Timescale (Implementation RAG)	End Goal
SPOR* (BBCCG)	Since its launch in September 2012 and January 31st 2013 the SPOR has had made 102 contacts. Of these only 15% of patients had a subsequent emergency admission to hospital within 30 days and only 7% attended A&E.	Contact rates have increased slowly throughout the first quarter From July, the SPOR service has been redesigned to ensure improved effectiveness, based upon a revised specification using GP (users) input to make 'fit-for-purpose' service. Specification agreed with Essex CC who commissioned project manager to review service and work with CCG clinical workgroup. Utilisation of the SPOR, and effectiveness of 'sign-posting' function, under constant review.	Enabling gateway to achieve admission avoidance schemes	Review in July	• Admission avoidance. • Single telephone contact leading to rapid health and social care assessment of patients at risk of admission, and 'sign posting to appropriate services. • GP Practice Engagement and Escalation to support delivery
RRAS* (TCCG)	The service commenced in June 2012, Due to demand the service was able to expand the core operating hours in December to: 9am-9pm, Monday to Friday.	The CCG undertaken targeted promotion of the service with patients through a number of the unplanned care initiatives within 2013/14 e.g. Primary Care MDT, Ambulance service etc. In addition to these we have worked in partnership with Thurrock LA to fund the mail-drop of 2,106 RRAS leaflets to each social care client over the age of 65yrs	Enabling gateway to achieve admission avoidance schemes	In place	• Admission avoidance. • Single telephone contact leading to rapid health and social care assessment of patients at risk of admission, and 'sign posting to appropriate services. • GP Practice Engagement and Escalation to support delivery
Decommissioning of Admission Avoidance Car	This service has under-performed and can be provided using more effective alternatives.	• Notice served on contract. • CCG working with EEAST and NELFT to ensure the ambulance service is fully engaged in admission avoidance schemes available within the area, i.e. SPOR and PCATC.	£0.2m	Completed	• Decommission car and embed the principles across the entire blue light fleet

The activity data above has been taken from the BBCCG and TCCG UPC Workbooks embedded at **Appendix 1**

Improvement Redesign: QIPP Initiatives (4)

NHS England

Managing Demand through QIPP: Primary/Community health & social care provision (pre-A&E)

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	Timescale (Implementation RAG)	End Goal
Community Geriatrician * (existing scheme)	Model commenced 17th Sept 2012. Between Sep 12-Nov 12 community Geriatrician had 32 contacts, from which there were 10 hospital admissions within 30 days indicating potential 22 avoided admissions. Further clarification od 12/13 performance, (as an addition to the 2103/14 Q1 performance) will be carried out to inform the review/redesign of this service during 2013/14.	• Evaluation to improve effectiveness of service commenced from 25 Jan-13 and changes being actioned to ensure the most effective use of the geriatrician provided by NELFT, e.g. setting of care, frequency etc. • Continued engagement with practices and providers to embed schemes and changes. • Current round of practice visits completed by 31 Mar-13. • Operational dashboard completed - weekly information on engagement of community geriatrician with their registered patients will be made available once current IG issues have be resolved.	£0.3m (FYE £0.4m) (allocated saving estimate)	Phase 1 Completed Phase 2 Review in October	• Admission avoidance. Reduction in demand for secondary care capacity. • Consultant specialist input to management of frail elderly patients with complex co-morbidities, and development of a case management approach, based upon a Comprehensive Geriatric Assessment (CGA)
Step Up Beds	Use of step-up beds (29) to avoid admissions into hospital. Currently being utilised for step-down purposes to support BTUH capacity issues	• Resolve current blockage of step up beds due to over use for step down purposes as part of system wide support being provided to manage BTUH efficiency and capacity problems. • SPOR to hold accurate information on availability which will facilitate increase level and appropriateness of use of 'step-up' resource.	In progress	Phase 1 Completed Phase 2 August 2013	• Admission avoidance to acute hospital. • For patients requiring a high level of supervision and care for up to 7 days in order to stabilise their condition and allow for the appropriate packages of home care to be put in place. • GP Practice Engagement and Escalation to support delivery

The activity data above has been taken from the BBCCG and TCCG UPC Workbooks embedded at **Appendix 1**

Improvement Redesign: QIPP Initiatives (5)

NHS England

Managing Demand through QIPP: Primary/Community health & social care provision (pre-A&E)

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	Timescale (Implementation RAG)	End Goal
Use of virtual wards in the community*	N/A	The community health service provider (NELFT) have reconfigured their community based nursing and therapies services into locality focussed Integrated Community Teams, with the anticipatory and case management services ('virtual ward') provided by the Community Matrons in collaboration with these and other specialist conditions specific teams (e.g. COPD, heart failure, diabetes, neurological)	Enabling gateway to achieve admission avoidance schemes	In place	• Admission avoidance. Reduction in demand for secondary care capacity.
Support to care homes to avoid emergency referrals	N/A	Community geriatrician-led MDTs provide a proactive Comprehensive Geriatric Assessment and advanced care planning for vulnerable patients over-75 within care/nursing homes identified as having high admission rates, in order to reduce/manage deterioration which would otherwise lead to emergency admission.	Enabling gateway to achieve admission avoidance schemes	Ongoing	• Admission avoidance. Reduction in demand for secondary care capacity.
Peer review of GP emergency referrals	N/A	Local CCGs have introduced a system of 'buddying' GP practices with high emergency admission rates/1000 registered patients with practices that have managed to achieve lower than average admissions. Aim: to use peer-to-peer relationship to identify optimum primary care-level management/co-ordination with community health and social care services that contribute to reduced admissions.	Enabling gateway to achieve admission avoidance schemes	In place	• Admission avoidance. Reduction in demand for secondary care capacity.

The activity data above has been taken from the BBCCG and TCCG UPC Workbooks embedded at **Appendix 1**

Improvement Redesign: QIPP Initiatives (6)

NHS England

Managing Demand through QIPP: Primary/Community health & social care provision (pre-A&E)

Scheme	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	Timescale (Implementation RAG)	End Goal
Dementia Intensive Support Team (DIST)/Community Dementia Nurses	**N/A**	This scheme's aim is preventing inappropriate admissions, reducing the length of stay in hospital if admitted, promoting and facilitating the use of Intermediate Care for people with Dementia, and increasing the percentage of people with Dementia who return to their own homes instead of residential care.	Enabling gateway to achieve admission avoidance schemes	In place	• Admission avoidance. Reduction in demand for secondary care capacity.
Mountnessing Court	**N/A**	Mountnessing Court in Billericay is a 22 bed dementia friendly unit dedicated to step up and step down taking referrals respectively from community and hospitals. MC will provide flexible but time limited care and support for up to 8 weeks which will include specialist input and re-able people with dementia.	Enabler as above	In place Review October 2013	• Admission avoidance. Reduction in demand for secondary care capacity.
Dementia Care Line	**N/A**	Pilot project to see whether admissions from Care Homes could be avoided if they had telephone support from dementia experts. The telephone support will provide both physical and mental health advice.	Enabler as above	In place	• Admission avoidance. Reduction in demand for secondary care capacity.
Crisis Pathway - GP Crisis referral pathway	**N/A**	Feedback from GP's and patients said that many people were directed to A&E because GP's were unable to get timely access to crisis support. As part of the development of the Mental Health Gateway we will commission a single point of crisis access/advice/signposting for GPs via telephone between the hours of 8 am and 8 pm Monday – Sunday. The aim is that 95% of patients whom have are appropriate for the service have a booked appointment within 4 hours commensurate with their level of need.	Enabler as above	July 2013 Now in place	• Admission avoidance. Reduction in demand for secondary care capacity.

The activity data above has been taken from the BBCCG and TCCG UPC Workbooks embedded at **Appendix 1**

Improvement Redesign: QIPP Initiatives (7)

NHS England

Managing Demand through QIPP: Primary/Community health & social care provision (pre-A&E)

Scheme:	2012/13 Achievement	2013/14 Actions and Delivery Status	2013/14 Identified QIPP Savings	Timescale (Implementation RAG)	End Goal
Reducing ambulance conveyance rates		Both CCGs working with EEAST on development and implementation of: • integrated care pathways, access facilitated through SPOR/RRAS • 111 directory of service; • Direct access to community 'step-up' beds • Identification of care homes with high demand on service resulting in both conveyance and non-conveyance	Enabling gateway to achieve admission avoidance schemes	Ongoing	• Admission avoidance. Reduction in demand for secondary care capacity.
Patient education on appropriate use of emergency services		• 'GP in A&E' service: identification of patients presenting with 'primary care' conditions, and where appropriate, following assessment by GP, referral of patient back to their own GP practice (if appointment within 48 hours deemed necessary, availability of appointment confirmed by 'GP-in-A&E' administrator). Re-attendance rates monitored. • During winter 2013/14, adverts put in local newspapers to provide information on the availability of primary care services as a more appropriate alternative to attendance at A&E	Enabler as above	Ongoing	• Admission avoidance. Reduction in demand for secondary care capacity.
111 and the use of the DOS		• Phase 1 – the implementation of "111" is now coming to an end across South Essex. The service is working effectively and activity to date is demonstrating minimal growth impact on A+Es. • To date, a strong governance process has been established to oversee any changes to the use of the DOS. • The two South West CCGs will now work closely with providers to further refine and develop the Directory of Services (Phase 2 of the "111" plan).	Enabler as above	Ongoing	• Effective use of the DOS could reduce the dependence on acute services for the management of unplanned care.

The activity data above has been taken from the BBCCG and TCCG UPC Workbooks embedded at **Appendix 1**

Managing Demand through QIPP

NHS England

Further Opportunities

In addition to the QIPP plans outlined above, the CCGs have identified a number of quality improvement priorities. These align with the priorities of partners (Essex County Council, Thurrock Unitary Authority, Basildon and Thurrock University Hospital Foundation Trust, North East London Foundation Trust, South Essex Partnership Trust and East of England Ambulance Service Trust):

End of Life Services	The CCGS will lead providers to ensure that there are integrated end of life pathways across the health and social system (expected to support the improvement of BTUH's SHMI)
Nursing Homes Services	A disproportionate level of admissions into acute come from local nursing homes. These trends are being reviewed and if appropriate, a new model of care to reduce the level of admissions will be considered.
Falls Services	There has been significant growth in the level of falls related presentations (e.g. fractured neck of femur) into our local acute trusts. The CCGs will review best practice evidence and seek to work with partners to improve outcomes for patient that fall and reduce the level of recurrences.
Ambulance Conveyance Rates	In 2012/13, working with partners, the CCGs developed a number of alternatives to acute admissions which are now embedded. The CCGs will work with East of England Ambulance Service to reduce the level of conveyances to the acute care setting for patients that can be appropriately managed in an alternative setting.
Step Down CHC Beds	Suggested change of use of Collins House Care Home for Step Down CHC Beds
111	Details of roll out and impact follow on the next slide.

111 Service

NHS England

Roll out and Impact

111 across South Essex was rolled out in March 2013. Nationally, the NHS 111 service in South Essex is being held in high regard, particularly in relation to the integration of services and technical systems. The success of our launch compared to other areas is proving an area of interest of others and we have been asked to take part in a national task and finish group looking at NHS 111 in terms of current service delivery, areas yet to launch and future developments.

In the first month of the service over 18,000 calls were made to NHS 111 with c.11,600 callers triaged through NHS Pathways.

- 2687 calls have not required NHS 111.
- 11638 patients have been triaged through NHS Pathways (clinical assessment system).
- 790 ambulances have been dispatched (this includes out of area as well as EEAST). This equates to 6.7% of calls triaged and 5.5% of calls answered. Both below the national average and in the highest performing range for a 111 service.
- 4420 patients referred onto OOH services (38%).
- 589 patients referred onto A&E (5%) – this includes out of area A&E departments.
- 566 callers referred onto dental services or pharmacy.
- 914 callers recommended home care.
- 184 callers given health information.

Improvement Redesign: BTUH - within hospital

Right Place Right Time Delivery

Right Place Right Time (RPRT) Action Plan

As part of the system strategy for managing the unplanned care pressures, BTUH is implementing a programme called Right Place, Right Time. A key part of this programme is to deliver a year on year reduction in Length of Stay including a 10% reduction in the Length of Stay by the end of 2013/14. The full delivery of this programme will make available the equivalent of 39 beds.

The programme is extensive in scope, incorporating every clinical service involved in non-elective inpatient care. A Programme Director is working with senior medics and other clinical professionals to ensure agreed actions are taken up across the Hospital. External provider agencies (such as social services and intermediate care) are formally out of scope as the programme is focussed on internal systems and processes, but are engaged in interface aspects of the work streams.

Governance and Accountability

Each work stream has a project plan, and reports to the Programme Board monthly via exception reporting against milestones, with an overall Balanced Scorecard showing current implementation progress. The Programme Board is chaired by the BTUH Chief Operating Officer and reports directly through to BTUH Trust Board. As part of the system Urgent Care Plan, there will be informal reporting through to the Urgent Care Programme Board, and formal reporting to Monitor within the monthly Urgent Care Plan submission.

Improvement Redesign Dashboard

NHS England

Right Place Right Time Delivery

Right Place Right Time Dashboard - Year to w/c 01 Jul

			Baseline Start Point Jan 2013	Current Week w/c 01 Jul	Trajectory Plan w/c 01 Jul	Current Month B/(W) than Trajectory	Workstream
Process Metrics							
	A&E	% of Patients in A&E no longer than 4 Hours	90%	97%	95%	2%	1
		Median Time to See a Clinical Decision Maker	70	55	60	5	1
	Assessment Units	% of Patients in AMU no longer than 4 Hours	10%	14%	40%	(26)%	1
		% of Patients in AMU no longer than 2 Days	90%	95%	95%	(0)%	1
		% of Patients in SRU no longer than 2 Days	77%	83%	86%	(3)%	1
	Bed Management	Total Unnecessary Ward Moves	76	58	40	(18)	2
		% of Bed Days as Specialty Outlier	10%	6%	7%	1%	2
		Total Unplanned Escalation Bed Days	84	23	23	(0)	2
	Discharge Process	% of Patients Discharged With a Recorded EDD (Excl. 0LoS, AMU/SRU, incl. Paeds)	92%	95%	98%	(3)%	2
		% of Discharges Made by 11am	16%	12%	21%	(9)%	2
		% of Discharges Using Discharge Lounge	17%	17%	30%	(13)%	2
Outcome Metrics							
	Mortality	Total Deaths in Hospital	37	19	27	8	3
		Deaths as % of Discharges	2.7%	1.3%	2.0%	0.7%	3
	ALoS	Average LoS - Emergency Patients	8.2	7.3	6.0	(1.3)	2
		Average LoS - Elective Patients	3.1	4.0	3.0	(1.0)	2

Snapshot from BTUH RPRT Performance Dashboard for week commencing 1 July 2013

Improvement Redesign – within Hospital (1)

Right Place Right Time Delivery

1) Unplanned Care (Supported by ECIST)

1) Primary Care support in ED	Model for initial assessment and streaming agreed and under implementation. Close working with CCG and wider stakeholders on integration into ED.
2) ENP model in ED	Roles and responsibilities reviewed, Gap analysis completed between current and future model, realigning with the GP model
3) Medical support in ED	Medical rotas reviewed; middle grades adjusted to match demand, consultant team job planning being finalised to increase consultant shop floor presence
4) Escalation SOP	Escalation Policy reviewed against best practice, and being incorporated into Trust-wide Escalation Policy
5) Ambulatory Care	Pilot implemented July 2013 of four pathways: Deep Vein Thrombosis, Urinary Tract Infection, Pulmonary Embolism and Pleural Effusion. Six further pathways being developed for implementation August: Falls, Cellulitis, First Seizure, Headache, Transient Ischemic Attack and Low risk Chest Pain.

Improvement Redesign – within Hospital (2)

Right Place Right Time Delivery

2) Inpatient Pathways

1) Bed Model	Additional 66 beds signed off at Trust Board. Implementation being operationally managed by Division of Medicine .
2) Bed Management	Alert triggers established and implemented for each division. Escalation policy under review and being incorporated into Trust Escalation Policy.
3) Ward and Board Rounds	Sub group formed and development of project plan is underway to achieve standardised approach
4) Speciality Referral	Liaised with Clinical Leads to compile specialty groups on Electronic Medical Record (EMR). EMR pilot to commence with Gastroenterology and Renal medicine for a two week period.

Improvement Redesign – within Hospital (3)

Right Place Right Time Delivery

2) Inpatient Pathways - continued

5) Discharge Planning Project split by Simple and Complex discharge	***Simple Discharge*** 'Blaylock tool' pilot commenced July for a two week period across four wards Discharge checklist audit commenced 8th July for a two week period across 10 wards Discharge documents being reviewed Clinical Pathway Facilitator role to be piloted on two wards Nurse Facilitated Discharge to be implemented Education and training programme to be developed
	Complex Discharge Pilot commenced on five DMOP wards Twice daily board rounds implemented with Social Care and CCMT attendance Joint work with Health and Social Care partners to commence when Simple Discharge Pilots complete Education and training programme developed

Improvement Redesign – within Hospital (4)

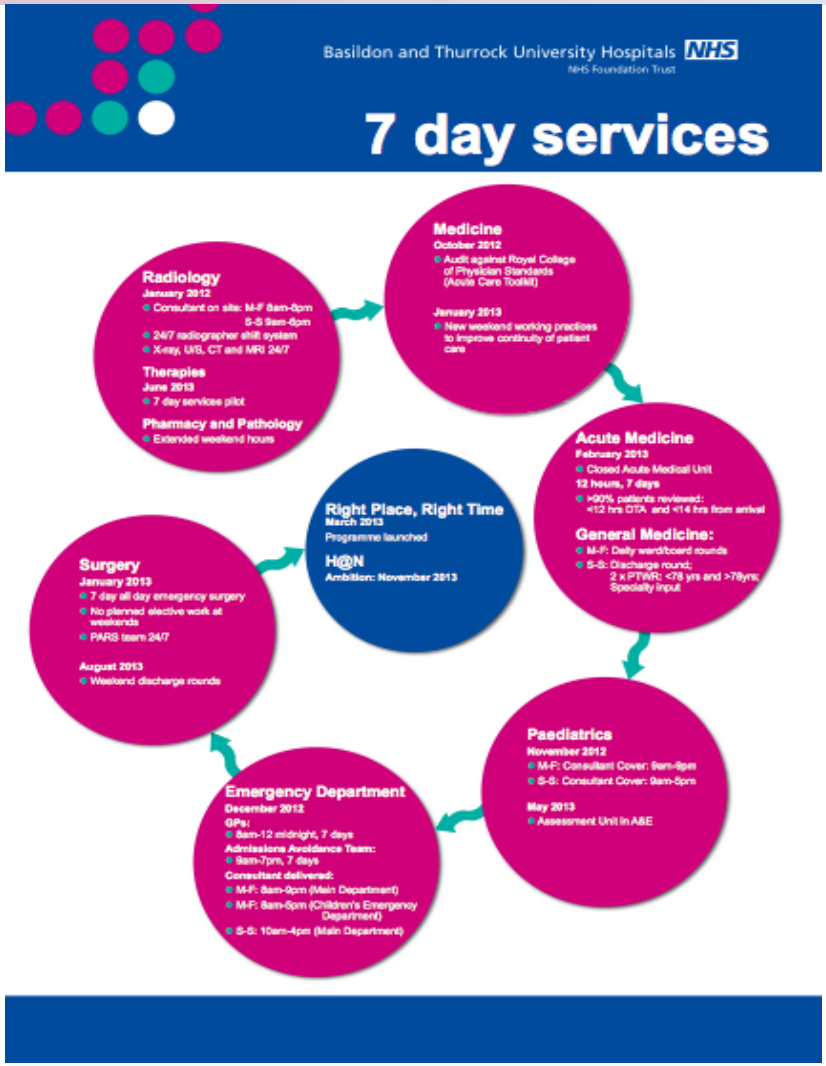
Right Place Right Time Delivery

3) 7-Day Services

This work stream has been refocused on the delivery of improved seven day consultant delivered care, supported by consistent clinical support services.

Current baseline analysis is underway to scope current services delivered with attention being on the development of robust 'Hospital at Night' services.

Service level agreements are monitored monthly on clinical support services turnaround times for inpatients.



Improvement Redesign – within Hospital (5)

NHS England

Right Place Right Time Delivery

4) Recognition and Management of the Deteriorating Patient

This is a new work stream formed under Right Place, Right Time, which reflects some of the themes emerging from the Urgent and Emergency Care Review:

- Provides **consistently** high **quality** and **safe** care across all seven days of the week
- Provides the **right care**, in the **right place,** by those with the **right skills**, the **first time**

The initial focus of the work is:

1) Vital signs
2) Escalation of Patients at Risk
3) SBAR process for handover

Subsequent focus will be:

4) Ceilings of treatment and DNAR
5) Handover and Transfers of Care
6) Patient Management Plans

Primary Care ...

Supporting primary care

NHS Basildon & Brentwood CCG has set out a short term plan to tackle critical issues within primary care resources and practices:

Identifying general practices at 'critical point' by:

- Analysing usage of other services.
- Reviewing existing / emerging quality and safety concerns.
- Establishing what we mean as 'safe' from a capacity and demand perspective.

Developing a support package for 'critical' practices:

- Joint working between NHS England, CCG and Primary Care Commissioning to develop a support package for practices.
- Implement support package with pilot practice.

Alongside this work, we expect the development of the Primary Care Strategy between NHS England and Essex CCGs to inform the future approach to contractual, monitoring and safety within general practice.

The Primary Care Response to the Urgent Care Recovery and Improvement Plan can be viewed **at Appendix 1.**

Ambulance Service Integration ...

Working collaboratively with partners to deliver integrated care

Overview and context:

East of England Ambulance Service Trust (EEAST) was created on July 1, 2006 and covers the six counties which make up the East of England - Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.

Essex is home to over 1,800,000 people spread over 1,200 square miles. It is the 6th heaviest populated county in the UK. The significant operational demand is focused on the south east of the county, containing the major population centres of Basildon, Thurrock and Southend. Outside London and Manchester, this is now the busiest area for ambulance activity in the United Kingdom although Essex continues to deliver one of the lowest 999 call versus hospital admission rates in the country.

Urgent care provision:

While there are a number of extra-contractual urgent care schemes that EEAST are planning with CCG partners, these are mainly in their infancy and largely the contract surrounds the provision of emergency care.

In SW Essex EEAST is currently reinvigorating its use of the RAAS and SPOR services provided by Basildon & Brentwood CCG and Thurrock CCG. Where appropriate, it will be the Trust's intention to attempt to utilise these more fully to further support admission avoidance.

Capacity and surge:

Capacity for EEAST is not usually a risk. Surge, however, is extremely difficult to manage.

The availability of EEAST's physical resources is finite and largely immovable due to the initial contractual value. The utilisation of these resources is dependant on the performance of our urgent and acute partners. For example, a resource waiting on scene to speak to an OOH GP is unable to respond to a further call. Delays offloading at acute hospitals continue to account for hundreds of hours each week. The reinvigorated use of RRAS and SPOR will support efficient use of those physical resources whilst supporting the provision of a better quality service for the patients concerned.

In times of significant pressure, EEAST undertakes REAP (resource escalation action plan) as part of a nationally recognised way of managing service pressure alongside continuing to deliver life saving care. The EEAST Integration: Urgent Care Recovery and Improvement Plan can be viewed **at Appendix 1.**

Impact of our improvement initiatives

Basildon, Brentwood and Thurrock Health System

Urgent Care Recovery and Improvement Plan

2013/14

Managing Demand through QIPP

NHS England

Activity phasing taken from the BBCCG and TCCG UPC Workbooks embedded at Appendix 1.

Community Geriatrician Admission Avoidance Activity 2012/13						Sep	Oct	Nov	Dec	YTD (Sep - Dec)	Full Year Extrap	13/14 Target	Per Week
	Number of Patients					3	14	15	18	**50**	**97**	**360**	**7**
	Number of Contacts					3	14	15	19	**51**	**99**	**4320**	**83**
	Number of patients who had an emergency admission within 30 days					0	6	1	4	**11**	**22**	**82**	**2**
	No. Admissions Avoided					**3**	**8**	**14**	**14**	**39**	**75**	**278**	**5**
	% Admissions Avoided					**100%**	**57%**	**93%**	**78%**	**78%**	**77%**	**77%**	
	No. A&E Attendances within 30 days following contact					0	6	3	3	12	**24**	**89**	**2**
	No. A&E Attendances Avoided					3	8	12	15	38	**73**	**271**	**5**
	% A&E Attendances Avoided					**100%**	**57%**	**80%**	**83%**	**76%**	**75%**	**75%**	

PCAT Admission Avoidance Activity 2012/13	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD (Apr - Dec)	Full Year Extrap	13/14 Target	Per Week
Number of patients	44	69	54	89	89	98	119	94	101	**757**	**1,071**	**1,619**	**31**
Number of Contacts	44	70	56	90	91	102	124	95	113	**785**	**1,117**	**1,689**	**32**
No. Potential Admissions (40%)	18	28	22	36	36	39	48	38	40	**303**	**428**	**977**	**19**
Number of patients admitted (emergency) within 30 days	7	11	13	17	14	16	18	17	23	**136**	**194**	**442**	**9**
No. Admissions Avoided	**11**	**17**	**9**	**19**	**22**	**23**	**30**	**21**	**17**	**167**	**234**	**534**	**10**
% Admissions Avoided	**60%**	**60%**	**40%**	**52%**	**61%**	**59%**	**62%**	**55%**	**43%**	**55%**	**55%**	**55%**	
Number of A&E attendances within 30 days	3	5	5	3	7	7	2	2	4	**38**	**46**	**70**	**1**
No. A&E Attendances Avoided	41	64	49	86	82	91	117	92	97	**719**	**1,025**	**1,550**	**30**
% A&E Attendances Avoided	**93%**	**93%**	**91%**	**97%**	**92%**	**93%**	**98%**	**98%**	**96%**	**95%**	**96%**	**96%**	

Updated NELFT data is being validated, this will replace the above once received

Managing Demand through QIPP

What each of these major schemes will deliver for Basildon and Brentwood CCG (BBCCG) in 2013/14

Scheme	Start Date	Project Lead	Risk Profile (Identified savings)			Target QIPP Savings (£)	In-Year Identified QIPP Savings (£)	Unidentified QIPP (£)	FYE Identified QIPP Savings (£)
			Low	Med	High				
Community Geriatrician	Apr-13	DF	57060	93,912			150,971		150,971
PCAT	Apr-13	DF	84324	138,786			223,110		223,110
Primary Care MDT and other GP Interventions	Apr-13	DF	73924	121,669			195,593		195,593
Admission Avoidance Service	Apr-13	DF	151,538	249,410			400,948		400,948
DIST Service	Apr-13	DF		400,000			400,000		400,000
Decommissioning of Admission Avoidance Car			194400				194,400		194,400
Step Up Beds	Apr-13	DF	32,779	53,950			86,729		86,729
GP In A&E (Phase 1)	Apr-13	DF	125,081				125,081		125,081
Total Unplanned Care			**719,106**	**1,057,727**	**0**	**3,013,058**	**1,776,832**	**1,236,226**	**1,776,832**

Unplanned Care QIPP Saving by Scheme FY 13/14 net of project costs
The BBCCG QIPP Programme embedded at Appendix 1 outlines each scheme in detail.

Managing Demand through QIPP

What each of these major schemes will deliver for Thurrock CCG (TCCG) in 2013/14

Scheme	Start Date	Project Lead	Risk Profile (Identified savings)			Target QIPP Savings (£)	In-Year Identified QIPP Savings (£)	Unidentified QIPP (£)	FYE Identified QIPP Savings (£)
			Low	Med	High				
Community Geriatrician	Apr-13	PC	57060	93,912			150,971		150,971
PCAT	Apr-13	PC	84324	138,786			223,110		223,110
Primary Care MDT and other GP Interventions	Apr-13	PC	73924	121,669			195,593		195,593
Admission Avoidance Service	Apr-13	PC	151,538	249,410			400,948		400,948
DIST Service	Apr-13	PC		400,000			400,000		400,000
Decommissioning of Admission Avoidance Car			194400				194,400		194,400
Step Up Beds	Apr-13	PC	32,779	53,950			86,729		86,729
GP In A&E (Phase 1)	Apr-13	PC	125,081				125,081		125,081
Total Unplanned Care			**719,106**	**1,057,727**	**0**	**3,013,058**	**1,776,832**	**1,236,226**	**1,776,832**

Unplanned Care QIPP Saving by Scheme FY 13/14 net of project costs
The TCCG QIPP Programme embedded at Appendix 1 outlines each scheme in detail.

Managing Demand through QIPP

NHS England

QIPP Delivery

Organisation	Action/Initiative	Impact	Lead
B&B CCG and Thurrock CCG	Practice Level MDTs	Improved co-ordination of care leading to reduction in A&E attendance/ emergency admissions – assumption: around 40% reduction in emergency admissions (30 day post)	DF/PC
B&B CCG and Thurrock CCG	Community geriatricians	From Oct. 2012 – Feb 2013 avoided admissions for 78% of patients seen and A&E attendances for 76% (30 days post)	DF/PC
B&B CCG	Single Point of Referral (SPOR)	Facilitates effective initiation of community health and social care packages of care	DF/PC
B&B CCG	Primary Care Assessment Treatment Centre (PCATC).	Expectation: 100% of patients seen would otherwise have attended A&E.	DF/PC
Thurrock CCG	Rapid Response and assessment	Reduction in A&E attendances/ emergency admissions and long term residential placements	DF/PC
B&B CCG and Thurrock CCG	Community Step up Beds	Reduction in emergency admissions	DF/PC
Thurrock CCG	Telehealth	Pilot demonstrated 44% reduction in emergency admissions., for patients with co-morbidities/high risk of admission	DF/PC

The combined impact of the unplanned care initiatives is outlined below. NB. The CCGs have agreed a contract position with BTUH based on a risk adjusted of the QIPP programme. However, the CCGs aspire for full delivery of the QIPP programme (outlined below). The system Capacity Plan is based on the agreed contractual position (i.e. the risk adjusted position).

Admissions	Q1	Q2	Q3	Q4	Total
Impact of QIPP (agreed with BTUH)	-179	-231	-282	-333	-1,025
CCG QIPP Plan	-349	-449	-548	-648	-1,994

2014/15 QIPP

NHS England

2014/15 Unplanned and Mental Health initial schemes identified for scoping and costing (indicative costs where available).

Scheme	Risk Profile (Identified Savings)			Target QIPP Savings (£000)
	Low	Med	High	
Unplanned Care				
BHRT (Activity reduction & Deflator)	150			150
BTUH (Deflator)	500			500
Pathology Direct Access	100			100
Primary Care Community in-reach to Secondary Care (Savings TBC)				0
Integrated Commissioning (Savings TBC)				0
End of Life Care/Non Accute Pathway (Savings TBC)				0
Unbinding Length of Stay (LOS) for patients below 'Trim Point' (Savings TBC)				0
7 day working of community planned care programme (Savings TBC)				0
Month Audits of Acute Activity (Savings TBC)				0
Total Unplanned Care	**750**	**0**	**0**	**750**
Mental Health				
MCCH, RAID, Out of Area, Dementia Care Line (FYE)	187			187
Contract Deflator	335			335
Mountnessing Court (Phase 2 - Post Pilot evaluations)			1,000	1,000
Dementia Challenging Behaviour Pathway	440			440
Primary Care Mental Health Services (Savings TBC)				0
LD Challenging Behaviour (Savings TBC)				0
VSO Evaluation (Savings TBC)				0
Dementia Diagnostic Toolkit (Savings TBC)				0
Total Mental Health	**962**	**0**	**1,000**	**1,962**

Contracts and resources

Basildon, Brentwood and Thurrock Health System

Urgent Care Recovery and Improvement Plan

2013/14

Acute Contract Position 2013/14

Basildon and Brentwood CCG are the lead CCG for the Basildon and Thurrock Hospital contract. In conjunction with the Area Team, the 2013/14 contract has been agreed on the following parameters;

Growth

The baseline non elective activity position assumed a 4% growth on outturn (to reflect historic trends).

QIPP

The CCGs agreed the following impact of QIPP (non elective admission reductions)

Admissions	Q1	Q2	Q3	Q4	Total
Impact of QIPP (agreed with BTUH)	-179	-231	-282	-333	-1,025

Fines

The full fines and penalties clauses of the contract are applicable and will be enforced from June 2013.

Emergency Threshold Resources

Basildon & Brentwood and Thurrock CCGs have agreed £2.5m additional funding to reflect the Emergency Threshold gap across the sub economy. The CCGs are agreeing with the acute Trust how this resource is best invested as part of the overall Unplanned Care programme.

Contractual Sign-off, Levers and Penalties

General Contract Management –

Basildon and Brentwood CCG formally leads on the performance management of the Basildon Hospital contract. There are well established Contract Quality Review Groups, Contract Technical Meetings and Contract Management Meetings (the latter chaired by a lead GP).

Potential Penalties –

Within the contract, the CCG will levy penalties for the following;

Single Accommodation Breach	**Monthly Report from CQRG**	**£250 per patient**
Trolley waits in A&E	Sitrep Report	> 12 hours - £1000 per breach
All handovers between ambulance and A & E must take place within 15 minutes	Ambulance Report	£200 per patient waiting over 30 minutes
All handovers between ambulance and A & E must take place within 15 minutes	Ambulance Report	£1,000 per patient waiting over 60 minutes
Duty of Candour	Monthly Report from CQRG	
Never Events	Monthly Report from CQRG	
Cdifficile		breach over 12 months
62 day Cancer wait		
A&E 4 hour target	Sitrep Report	
Zero tolerance RTT waits over 52 weeks	Sitrep Report	£5000 per patient
18 Weeks - Specialty Level Compliance	Monthly information from Trust	calculated by specialty

Application of levers –

The CCG/AT did not levy penalties in April and May as part of the overall contract settlement with BTUH. However, the a number of contract queries have been issued during the last six months including;

Contract Query No	Service/Area	Date of Query
CQN001	CQC Surgical Warning Notice Ref:-611162297	7th May 2013
CQN002	CQC Blood Service Warning Notice Ref:-RGP1-611162297	7th May 2013
CQN003	A&E Indicators	3rd June 2013
CQN004	RTT 18 Week	24th May 2013

Winter pressure money priorities

Surge Planning (including winter planning)

Based on the use of winter pressure monies in 2012/13, the following initiatives are potential priority areas:

Basildon & Brentwood CCG (total c£2m, including AT improving GP access).
- The AT would like to target GP extended hours/improved access. Costs are estimated around £500 – 750k.

In addition **schemes put forward by the CCGs** are as follows:

Acute Services:
- Additional capacity for GP in A+E Scheme (£180k)
- Additional Patient Transport provision (£35k)
- Outsourcing elective work support (£500k)
- Additional CHC Assessor Capacity (£25k)

Community Services:
- Additional intermediate care bed capacity / spot purchase of step-up or step-down beds (£390k)
- Community MDTs (£85k)
- Community Equipment (£50k)

Social Services:
- Improving Social Work and Interim Placement Capacity and Responsive (£50k)

The CCG will lead discussions with stakeholders to ensure that plans and priorities for Winter Pressures are agreed ahead of any funding being confirmed. This will enable a rapid implementation of projects when funding is announced. The anticipated timetable will be;

Anticipated Planning Timetable for Winter Pressure Monies 2013/14	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Draft Schemes									
Agree priorities through the Unplanned Care Board									

RTT

Basildon, Brentwood and Thurrock Health System

Urgent Care Recovery and Improvement Plan

2013/14

Managing Elective and Urgent Care

RTT Recovery Weekly Performance Report – week commencing 15/07/2013

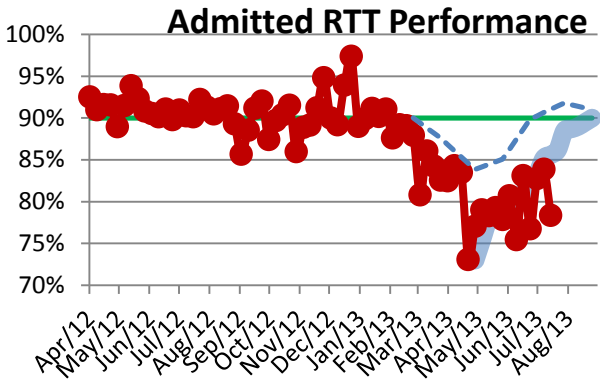
Admitted treatments within 18 weeks **78.36%**
(Target 90%); Admitted backlog 400
Incomplete pathway over 1 year

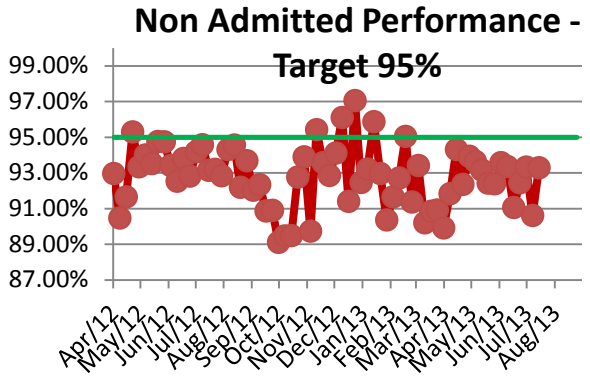
Non-Admitted treatments within 18 weeks **93.27%**
(Target 95%); Non Admitted backlog 775
92% wait to date for incomplete pathways **91.56%**
Total incomplete pathways 13924

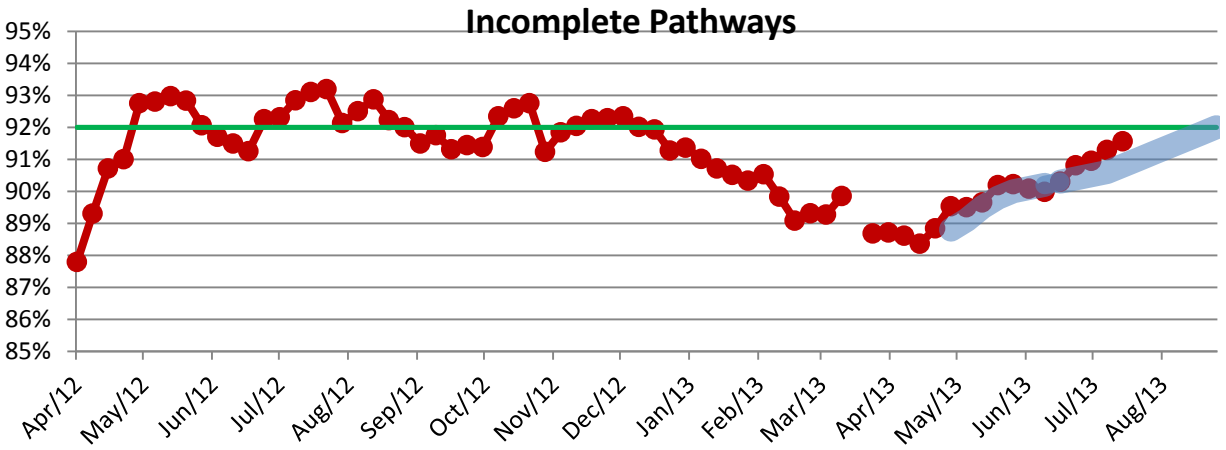
RTT: Progress/Remedial Action

BTUH achieved compliance with the Non-Admitted Performance Target of 95% in May and June. Whilst the Non-Admitted Performance graph at 15 July shows 93.27%, this is the un-validated position and it is expected that compliance with the 95% standard will be retained in July.

A recovery plan is in place to sustain compliance. The UCPB is now closely monitoring delivery of the RTT recovery plan to ensure the agreed trajectory is delivered.







Managing Elective and Urgent Care

NHS England

RTT Governance

Risk	Mitigation
There is currently a significant backlog on the admitted and non admitted pathways	Fortnightly performance meetings in place between the CCG and BTUH
Several specialities remain high risk (General Surgery, T+O and Gynaecology)	Service redesign underway in specialities with consistent capacity problems
Outsourcing is currently in place but this is limited in terms of the complexity of patients that are suitable	Consideration of outsourcing to NHS providers where more complex cases can be managed
Surgery levels within BTUH have only just returned to planned levels due to winter pressures	Winter planning will account for a period of reduce elective capacity due to forecast constraints
New PAS System – migration issues	Early identification of potential problems and on-going liaison with supplier to address them

Key Checklist

- System strategic meeting in place
- Contract complete/Activity agreed
- Urgent Care Board established
- HWBB agreed plan
- CCG Boards agreed
- Acute Trust agreed
- All parties agreed
- ECIST recommendations included in Trust action plan
- ECIST checklist reviewed and monitored by UCPB
- 111 Service established 100%
- Situational Awareness model in place
- Desktop exercise to test Surge Plans etc.

Date	Complete
1/4/13	
10/4/13	
1/3/13	
Sept 13	
Sept 13	
Sept 13	
Sept 13	
May 13	
June 13	
Sept 13	
July 13	
Sept 13	

Under development

Moved from June to Sept 13

Appendix 1

Basildon and Thurrock University Hospital Trust Urgent Care Plan (sent to Monitor 1st May 2013)

This plan is predicated on an array of actions but focus is on:


BTUH Urgent Care Plan

- Trust Right Place Right Time change programme
- The shortfall in beds required ranges from 107 if there is no change in current practices and process across the health economy, to a shortfall of 40 beds if the QIPP schemes and LOS reductions are delivered in full

South West Essex (Basildon and Brentwood CCG/Thurrock CCG and partners) QIPP Programme

- A CCG/System QIPP programme that will impact on all critical metrics , reduce the overall demand for acute unplanned care services and negate the need for 40 beds:


QIPP Plan Basildon and Brentwood CCG


QIPP Plan -Thurrock

Care for frail older people in South West Essex

- Sub economy jointly commissioned Frail/Elderly review undertaken by 20:20 Strategy


Adobe Acrobat Document

The system (and the oversight of the above plans) will be overseen by the Urgent Care Programme Board (UCPB) for

SW Essex. UCPB Terms of Reference (ToR)


Urgent Care Programme Board (UCPB

EEAST Integration: Essex Urgent Care Recovery and Improvement Plan


Microsoft PowerPoint Presentati

Primary Care Response: Urgent Care Recovery and Improvement Plan


Microsoft PowerPoint Presentati