Annex A

Berkshire West Federation Urgent Care Programme Board
A&E Recovery & Improvement Plan
June 2013
V2.2

Ref	Action	Lead	Deadline	RAG Status	Comments
PRIOR TO A&E					
1	**Strengthening primary and community care for frail and elderly patients**				
1.1	Single Point of Access operating across the 3 localities ensuring ease of access to the most appropriate service.	Fiona Slevin-Brown	1-8-13	A	Single number available to RBFT by Jul-13
1.2	Enhanced Intermediate Care services: providing extended capacity and services 9am to 8pm 7 days per week.	Fiona Slevin-Brown	1-4-13	G	Service in place and being covered by interim staff whilst recruitment takes place. UCPB to monitor capacity.
1.3	Integrated care with community nurses/matrons in LTC management (includes 24 hour DN service).	Fiona Slevin-Brown	1-4-13	G	Part of the LTC model of care which includes risk stratification, integrated care and support to self-care.
1.4	ACG Care Co-ordination linked to new Directed Enhanced Service "*Risk Profiling and Care Management Scheme*" to be commissioned from GPs. This requires practices to have at least quarterly multidisciplinary meetings to review the management of patients who are predicted of becoming or who are at significant risk of emergency admission now or in the future. Patients must be identified using a risk stratification tool. These meeting will be held on a monthly basis.	Fiona Slevin-Brown & the 4 CCG Operations Directors	Jul-13	A	Start date Jul-13.

1.5	Enhance current respiratory and COPD pathway and introduce ESD for COPD patients, telehealth and increase pulmonary rehab provision.	Fiona Slevin-Brown	1-4-13	G	
1.6	Deployment of 25 extra telehealth units in the care of patients with heart failure providing preventative support in community settings.	Carolyn Lawson	1-4-13	A	Contract in place. Delay from provider in placing units – being escalated.
1.7	Improved access to EoL beds	Duchess of Kent (DoK)	31-10-13	G	Additional capacity at Duchess of Kent House.
1.8	Provision of disease specific EoL education to primary care and Nursing Homes. .	Fiona Slevin-Brown / DoK		G	Planning for education events commenced.
2	**Use of community diversion schemes**				
2.1	Expansion of Rapid Response services to provide 7 day a week access via a Single Point of Access.	Part of Enhanced Intermediate Care services (ref. 1.2)			
2.2	Extension of Specialist Community IV services to 7/7.	Fiona Slevin-Brown	1-4-13	G	In place
2.3	Development of pathway for Cellulitis and UTI.	Debbie Milligan and Fiona Slevin-Brown	30-09-13	G	
2.4	Pathway for subcutaneous hydration.	Fiona Slevin-Brown	30-09-13	G	Pathway for palliative care patients delivered by the Hi Tech team.
2.5	Pathway for oral vitamin K infusion.	Fiona	30-09-13	G	Pathway for patients to have

		Slevin-Brown			vitamin K infusions delivered by the Hi Tech team.
2.6	Pathway for rehydration via intravenous infusions.	Fiona Slevin-Brown	30-09-13	G	Scope to develop a pathway for patients not on the palliative care pathway who would benefit from this service.
2.7	Maintenance of ‘App’ and webpage providing details of all alternatives to acute admission.	Maureen McCartney	Ongoing	G	
2.8	Red Cross admission avoidance service operating extended hours from A&E – supporting the frail elderly in their own homes preventing avoidable admissions.	Red Cross	Funded for 13/14	G	
3	**Strengthening GP out of hours services**				
3.1	NHS 111 outcomes to be used to inform ‘intelligent commissioning’ of OOH Primary Care services.	Andy Ciecierski and Maureen McCartney	**Ongoing**	A	In addition to current quarterly monitoring of activity and outcomes with the aim of moving to outcome based commissioning model.
4	**Use of virtual wards in the community**				
4.1	Various ‘Hospital at Home’ initiatives in place including 7 day IV antibiotic service, 24/7 DN service, integrated Intermediate Care with extended opening hours.	Fiona Slevin-Brown	In place	G	
4.2	Wokingham CCG project on piloting a virtual ward linking in with the Community Geriatrician.	Debbie Milligan /LA/ Fiona Slevin-Brown	tbc	A	
5	**Support to care homes to avoid emergency referrals**				

5.1	Care Home work stream across BHFT/LAs/PC to co-ordinate the support to care homes bringing together provision of falls/dementia/continence and end of life care.	Fiona Slevin-Brown /LAs/PC	Rolling programme	G	
6	**Peer review of GP emergency admissions and A&E attendances**				
6.1	The Quality and Productivity Indicators in QOF have 48 points assigned to GPs reviewing data on emergency admissions, taking part in peer review of this data and the management and treatment of patients in three care pathways aimed at avoiding emergency admissions.	Maureen McCartney	Ongoing	A	
6.2	The QP and QOF indicators also have 31 points allocated to GPs reviewing data on A&E attendances, taking part in peer review of this data and each Practice developing an improvement plan that aims to reduce avoidable A&E attendances.	Maureen McCartney	Ongoing	A	
7	**Reducing ambulance conveyance rates**				
7.1	Continue focus on GP Triage scheme.	Keith Boyes	Rolling programme	G	Incentivised by CQUIN and recently re-launched by SCAS Berkshire.
7.2	Continue to ensure SCAS maintains links with BHFT and UAs and has direct access to alternatives to conveyance.	Keith Boyes	Ongoing	G	SCAS Berkshire have high rates of non conveyance.
7.3	NHS 111 will support process of directing patients to the most suitable service provider as per the comprehensive Directory of Services.	Keith Boyes	Ongoing	G	
7.4	Scoping work with Primary Care around same day access in General Practice and potential role of SCAS in supporting this.	Andy Ciecierski and Maureen McCartney	Scoping	A	

7.5	As part of the 13/14 contract SCAS are incentivised to deal with upto 30% of calls via 'Hear and Treat'. This will be achieved through employing GPs in their call centres to triage and where possible close calls with advice and providing improved training to staff.	Keith Boyes	13/14	G	
8	**Flow of GP Urgents**				
8.1	Use of the SCAS Urgent Care desk with dedicated resources to support the timely flow of GP Urgents into the acute.	Keith Boyes	Ongoing	G	Supporting rapid assessment and same day turnaround where possible.
9	**Patient education and support on alternatives to admission**				
9.1	Choose Well campaign run annually to coincide with seasonal pressures. Learn from best practice, in particular, Exeter.	CSU	Oct-13	G	
9.2	NHS 111 public launch (locally in addition to national launch scheduled autumn 13).	Keith Boyes	Jul-13	G	Patients requiring urgent care encouraged to call NHS 111 before accessing services.
9.3	South Reading CCG A&E project: work with A&E to collect data on inappropriate attendances, signpost/leaflets for patients and RAG rate attendances for practice follow up.	Elizabeth Johnston	Ongoing	A	
10	**Roll-out arrangements for NHS 111**				
10.1	Successful soft launch Berkshire West (high performance against KPIs and high levels assurance NHS England).	CS CSU/ CCGs	May-13	G	
10.2	NHSD switch off.	“”	Jun-13	G	
10.3	Berkshire Public launch.	“”	Jul-13	G	
10.4	Maintenance of comprehensive and robust Directory of Services.	“”	Ongoing	G	
FLOW WITHIN THE HOSPITAL AND A&E					
11	**Prompt booking of patients to reduce ambulance turnaround delays.**				
11.1	New handover process and Standard Operating Procedures	Sue	Ongoing	G	SCAS reporting much improved

	in place at RBFT for ambulance handover	Edees/ Keith Boyes			position and RBFT meeting contractual target.
12	**Full see and treat in place for minors**				
12.1	Nurse led see and treat well established in A&E.	Sue Edees	Ongoing	G	
12.2	Nurse led see and treat to be established in AAU (Acute Assessment Unit).	Sue Edees			Pending approval of Business Case (28.5.13)
13	**Prompt initial senior clinical assessment within A&E and rapid referral if admission is needed**				
13.1	Consultant delivered triage 0800 – 2200, 7 days per week.	Sue Edees	Ongoing	G	
14	**Prompt initiation of blood and radiological tests with rapid delivery of test result**				
14.1	Part of the STAR process: See, Treat and Refer, implemented at RBFT.	Sue Edees	Ongoing	G	
15	**Prompt access to specialist medical opinion**				
15.1	Develop fully functioning pathway with additional Acute Physician capacity on AAU.	Sue Edees			Pending approval of Business Case (28.5.13)
15.2	Functioning Elderly Care Physician of the Day model on AAU.	Sue Edees	In place	G	
16	**Full use of computer aided patient tracking and system for progress chasing**				
16.1	Part of functionality of new EPR system.	Sue Edees	30-09-13	R	Date of bed management functionality becoming operational to be confirmed.
16.2	Effective computerised patient tracking system in A&E.	Sue Edees	In place	G	
17	**Regular seven day analysis should be in place for rapid identification and release of bottlenecks**				
17.1	Expansion of Service Navigation Team to support team attending daily board rounds, next step plans for all patients, use of patient pathways and discharge check lists, early day discharge and increased use of discharge lounge.	Sue Edees	30-09-13	G	
17.2	System Resilience overview and Sitrep on a daily basis,	Carolyn	Ongoing		

	supplemented by system wide teleconference calls twice weekly.	Lawson/ Maureen McCartney			
17.3	Daily analysis of internal delays and blocks at RBFT.	Sue Edees	In place	G	
18	**Bed base management**				
18.1	Bed Management team in place and undertaking regular reviews of bed status and overview of patient flows.	Sue Edees	Ongoing	A	
19	**Daily Consultant ward rounds**				
19.1	Daily Board rounds in place on the majority of wards under Consultant supervision. Daily on AAU.	Sue Edees	Ongoing	A	
19.2	SNT Co-ordinators will work with doctors when planning treatments taking into account treatment and discharge schedules. They will drive the 'to do' list on each ward to reduce delays in diagnostics and referrals.	Sue Edees	30-09-13	G	Part of SNT Business Case
20	**Provision of specific services for patients groups such as those with mental health problems**				
20.1	Acute Mental Health Liaison Team commissioned to work with RBFT to support patients with a mental health need.	Maureen McCartney	Ongoing	G	
20.2	Scoping of strengthening support for dementia under way.	Fiona Slevin-Brown			
21	**Re-admissions**				
21.1	RBFT to share details of re-admissions with BHFT to enable a pro-active approach to preventing further re-admissions.	Sue Edees	30-06-13	G	
DISCHARGE AND OUT OF HOSPITAL CARE					
22	**Designation of expected date of discharge (EDD) on admission**				
22.1	Expansion of Service Navigation Team to support all patients	Sue	30-09-13	G	

	having discharge plan and EDD within 24 hours of admission (CQUIN)	Edees			
22.2	EDD shared with community and social care 48 hours in advance.	Sue Edees			
23	**Maximisation of morning and weekend discharges**				
23.1	SNT 'Safe Day of Discharge' – overseeing discharge, identifying potential problems on day of discharge, explaining medications, working with transport services	Sue Edees	30-09-13	G	
24	**Full use of discharge lounges**				
24.1	Discharge Lounge is open from 1000 to 1800 and staffed from 0945 Mon to Fri.	Sue Edees	In place	A	SNT works with the wards to identify patients suitable for the Discharge Lounge and book transport as required.
25	**Minimisation of outliers**				
25.1	RBFT have recently undertaken a bed configuration review and have ringfenced elective and non elective bed pools.	Sue Edees	In place	A	Rated amber as demand for NEL has led to medical outliers since the bed reconfiguration.
26	**Delayed transfers of care reduced**				
26.1	Service Navigation Team (SNT) commissioned to monitor delayed discharges of care and liaise with UAs to facilitate discharge.	Carolyn Lawson and Maureen McCartne y	Ongoing	A	Rated amber as DToCs above target.
26.2	Daily 'Fit to Go' list generated by SNT detailing all patients awaiting discharge to another provider (including official delays). List widely circulated and system resilience escalation linked to triggers in terms of numbers on list and "days lost".	Carolyn Lawson and Maureen McCartne y	Ongoing	A	Rated amber as DToCs above target.

26.3	RBFT project with West Berkshire UA on improvements to discharge flow.	Sue Edees / WBBC	30-06-13	G	
27	**Flexing of community service capacity to accept discharges**				
27.1	Additional flexible winter community bed escalation capacity to form part of BHFT contract 13-14.	Elizabeth Johnston	31-12-13		Planned rather than reactive opening of additional community inpatient capacity.
27.2	Community inpatient and CRT capacity reviewed on System Resilience teleconference when system escalated and capacity flexed to meet demand where possible.	Fiona Slevin-Brown	Linked to SR status	A	
28	**Reviewing continuing care processes**				
28.1	Implementation of report on CHC processes.	Gabrielle Alford / UAs			
29	**Assessment of use of reablement funding by local authorities**				
29.1	Regular monitoring and assurance via performance monitoring of Rapid Response and Reablement services.				Services offering extended hours and 7/7 working accessed via SPA.
30	**Patient Transport Services**				
30.1	In 12/13 the PCT/CCGs invested in a dedicated discharge crew for patient transport for the Royal Berkshire to manage on the day bookings and discharges. This service runs from 1000 to 1000 Mon-Fri and 1000 to 2000 Sat and Sun.				
SYSTEM RESILIENCE AND ESCALATION					
31.1	New process for determining internal system resilience status at RBFT and escalation actions required.	Sue Edees	May-13	G	
31.2	System status report and escalation status circulated daily.	Sue Edees	Ongoing	G	
31.3	List of patients clinically fit for discharge and awaiting onward care by another agency prepared by SNT and circulated 3 times per week (‘Fit to Go list’).	Sue Edees	Ongoing	G	

31.4	Escalation triggers based on numbers and beddays lost on Fit to Go list proposed and to be agreed.	UCPB	May-13	G	
31.5	Twice weekly system wide SR teleconference calls in response to escalation status – one operational and one strategic.	All	Ongoing	G	
CAPACITY AND DEMAND PLANNING					
32.1	Establish Steering Group and action plan based on the Capita work: Demand & Capacity modelling for the Berkshire West Health and Social Care economy April 2013.	Cathy Winfield	30-06-13	G	
EVIDENCE BASED BEST PRACTICE					
33.1	Complete ECIST programme of visits to Berkshire West and agree action plan based on recommendations.	Maureen McCartney and Carolyn Lawson	30-06-13	G	
33.2	Complete baseline assessment against best practice checklist contained within Urgent and Emergency Care: A review for NHS South of England, The King's Fund, March 2013.	Maureen McCartney and Carolyn Lawson	30-06-13	G	