NHS
Wiltshire
Clinical Commissioning Group

Clinical Commissioning Group
Governing Body
Paper Summary Sheet
Date of Meeting: 23 July 2013

For: Decision ☒ **Discussion** ☐ **Noting** ☐

Agenda Item and title:	**GOV/13/07/12 RUH Transforming Emergency Care Business Case**
Authors:	Hester McLain Senior Commissioning Manager B&NES CCG Steve Perkins Deputy Chief Financial Officer Wiltshire CCG
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Executive summary:	The RUH have requested funding to support their response to the urgent care pressures that they have experienced over the last 12 months and to implement 7 day working across the organisation. The Governing Body are asked to review the RUH business case and covering paper, produced in partnership with B&NES CCG (in their role as lead commissioner). The key issue for the CCG is to understand the future financial impact of this going forward and to understand the impact on patient safety and quality.
Evidence in support of arguments:	The pressure that the Bath and Wiltshire health system is under at present has been immense and creates significant risk to patient safety and quality.
Who has been involved/contributed:	Clinical Executive and Finance Committee members. WWYKD and NEW GPs, B&NES and Wiltshire CCG commissioning managers, Quality.
Cross Reference to Strategic Objectives:	The business case supports the CCG's Urgent Care agenda.
Communications Issues:	Any additional investment in urgent care in advance of 2013/14 winter pressures will be positively received by the public and stakeholders across the health and social care system. There are many positive messages which will need to be handled by the

	communications team and by clinical leaders.
Engagement and Involvement:	N/A
Financial Implications:	The RUH business case asks the CCG to **i**nvest £940k in 2013/14 out of the non-elective threshold monies that have been held to support investment in urgent care services. The future funding arrangements will depend on whether the marginal rate continues within the PbR tariff.
Review arrangements:	As per the contractual terms for the RUH.
Risk Management:	Risk to patient safety and quality of service.
National Policy / Legislation:	As required of the NHS Wiltshire CCG constitution.
Equality & Diversity:	N/A
Next Steps:	Subject to the Governing Body's decision, implementation of the Business Case.

NHS Wiltshire Clinical Commissioning Group
Governing Body 23rd July 2013
RUH Transforming Emergency Care Business Case

1. Background

In 2010/11 new financial arrangements were introduced for funding emergency admissions, following concerns about growth in emergency activity. This meant that for all activity above a 2008/9 baseline, providers only receive 30% of the tariff income. This was intended to incentivise work on demand management and risk sharing to help manage growth and to reflect the fact that above a certain level of activity, additional activity can be provided at marginal rates.

Commissioners are expected to invest the remaining 70% of the tariff income in demand management and service redesign schemes to prevent inappropriate hospital admissions. NHS Wiltshire CCG (WCCG) has applied an adjustment to the Royal United Hospital NHS Trust (RUH) contract of £1.1m for this threshold in 2013/14.

2. RUH Urgent care position

In winter 2012/13 the health community urgent care position deteriorated with increasing number of A&E 4 hour breaches, increased delayed transfers of care, and two periods of escalation declared by the RUH. Across England performance against the A&E four hour target deteriorates with 63% of providers (94/148) breaching the target in the final quarter of 2012/13. At the RUH performance reached a low point of 77% in April 2013.

The national Emergency Care Intensive Support Team (ECIST) visited the RUH in March 2013 to review processes and make recommendations for change. In summary they advised a need for transformational change, with a number of detailed recommendations including:

- implementation of a rapid assessment and treatment model in the emergency department (ED)

- increased senior oversight in ED, with increased consultant cover during peak demand of 2pm – 8pm, consultant cover to 10pm at weekends and access to early consultant review for patients by specialists, particularly geriatricians

- case management approach to admitted patients with twice daily reviews of all patients to support robust discharge

- focus on discharge and rehabilitation for home

The RUH has started to implement the ECIST recommendations, in particular a 'spring to green' week in May including the establishment of the acute oncology service and surgical assessment unit model. Performance against the A&E target has significantly

improved and has been above 97% since May. Further work is required to support transformation across the Trust and prepare for 2013/14 pressures. If successful, the approach would lead to better patient outcomes with fewer non elective admissions, fewer outliers within the hospital, shorter lengths of stay and more discharges to home but would require investment and substantial changes in working processes and working arrangements to deliver changes.

3. RUH Transforming Emergency Care Business Case

The RUH has submitted a proposal to commissioners for Transforming Emergency Care, in line with the ECIST recommendations. The business case incorporates separate projects focusing on front door, flow within the RUH and discharge and reflects the local ECIST recommendations and also the King's Fund review *Urgent and Emergency care: a review for NHS South of England* which has been circulated by NHS England as a checklist for Urgent Care Boards to consider.

The current business case is attached at appendix 1, and includes:

- delivering rapid assessment and treatment in ED (increased consultant and senior input)
- development of acute assessment models for surgery and medicine, including MAU, SAU, ambulatory care, access to diagnostics and older people's unit
- enhanced therapy and rehabilitation to home

Further work is required on the business case, in particular mapping out the KPIs required to monitor implementation and impact. Funding will be contingent on agreeing a set of KPIs that meet CCG requirements. There is also detailed work required to assess the impact of changes on community services, i.e. additional numbers expected to be returned to the community.

Delivery of the KPIs would be overseen by the Urgent Care Task and Finish Group, which will become the Bath area Urgent Care Board.

4. Financial Implications

Within the 2013/14 financial plan WCCG have retained a non-recurring reserve in respect of the 70% marginal rate payment that is not paid to providers to support investment in the urgent care agenda. In 2013/14 £1.1m has retained from the RUH contract in respect of this threshold. The business case requests that the CCG invest £0.94m with the RUH to support the service changes put forward.

The future implications for funding this investment are still to be clarified. If the marginal rate adjustment continues within the 2014/15 payment by results (PbR) tariff then the CCG will need to consider whether to continue to invest the threshold monies on a non-recurrent basis with the RUH. If the marginal rate is removed from the

2014/15 PbR tariff the RUH will directly receive the funding required for these investments as they will be remunerated at 100% of tariff for activity above 2008/09 levels.

5. Risks

There are a number of risks identified as part of this project, and these should be overseen as part of the Urgent Care Board work. Key risks are:

- RUH failure to appoint required additional staffing
- additional staff appointed but do not lead to change in practice or delivery of improved outcomes
- urgent care pressures of 2014/15 overwhelm the system, leading to reversion to previous practices
- lack of community and social care capacity in place to deal with patients being turned away from or discharged from the hospital
- additional costs generated by an ambulatory care model leading to financial risk for commissioners
- simulation event identifies different range of actions that should be taken to improve the local urgent care system

It is recommended that management and mitigation of these risks be overseen by the Urgent Care Board.

6. Recommendations

The Governing Body is asked to:

- Agree non recurrent investment in 2013/14 for the RUH transforming emergency care business case from non-elective threshold funds.
- Consider future agreement to fund the investment from non-elective threshold funds if the marginal rate tariff continues within the PbR tariff for 2014/15
- Note the KPIs identified and their oversight by the Task and Finish Group

7. Appendices

Appendix 1 – RUH Transforming Emergency Care Business Case

RUH

Royal United Hospital Bath NHS
NHS Trust

APPENDIX 1

Transforming Emergency Care Business Case
June 2013

Summary

Delivering and sustaining improvements in emergency care is of national and local focus. The recent news that the NHS as a whole failed to achieve the 4 hour performance standard in the first quarter of 2013/14 demonstrates that the systems and processes that are in operation can no longer respond to the level of demand – whether in terms of patient numbers or acuity of presenting illness.

This paper summarises local plans that have been developed to deliver the following objectives:

- Sustained efficiency and effectiveness of the emergency pathway
- Improved care and treatment for all non-elective admissions, in line with best practice, supporting an improvement in patient flow across the hospital
- Ensuring patients are treated by the right clinician for their needs, at the right time
- Enable patients to return home or to an alternative care setting in a timely way, reducing their reliance on health services in the future
- For all patients to receive a high quality service, across the whole patient pathway, 7 days per week

These objectives build on the recommendations made by the Emergency Care Intensive Support Team (ECIST) following their review of the RUH urgent care pathway in March 2013. The developed plans focus on 3 key areas:

1. Improving immediate assessment and treatment of patients in front door services
2. Increasing support to inpatient areas to support better flow through the hospital
3. Planning for discharge

The RUH is requesting £1.6m additional income in 2013/13 to deliver plans already fully developed as part of the Urgent Care Improvement programme, each with clear outcome indicators (KPIs). The RUH will continue to work with CCGs to monitor how benefits will fall across the health and social care system and to confirm requirements going forward to ensure safe and sustainable services in line with CCGs commissioning intentions for urgent care.

1. National Context

The 4 hour access standard for emergency care is one of the core components of the NHS Constitution. It is used as a proxy for measuring clinical and managerial effectiveness across the health system in delivering timely and safe care for patients with emergency needs.

Whilst nationally there is traditionally a drop in delivery of the standard in quarters 3 & 4 of any year, this year performance has been significantly worse at national and Trust level. In the final quarter of 2012/13, a significant proportion of both NHS Trusts and NHS Foundation Trusts failed to deliver the 4 hour access standard, with overall performance across the NHS dropping below 95% for the first time in many years. The NHS Trust Development Authority has undertaken some broad analysis of the reasons for this, identifying four key issues:

1. Volume of activity – there has been a national rise in emergency admissions of 4% for Type 1 EDs, with some areas reporting a higher increase
2. Acuity of patients –the main reported rise being in the frail/elderly group, who frequently have more co-morbidities resulting in longer lengths of stay and on-going care needs
3. Patient flow – many Trusts are reporting difficulties in discharging patients and rises in delayed transfers of care
4. Workforce capacity – there is a national shortage of specialist registrar/middle grade posts, as well as shortages of nursing and consultant posts. These shortages all have an impact on the ability of departments to process patients in a timely way

Source: NHS Trust Development Authority Board Paper – 23rd May 2013 (http://www.hsj.co.uk/Journals/2013/05/24/l/m/z/Urgent-and-emergency-care-performance-Board-23-5-2013-Paper-F1.pdf)

2. Local Context

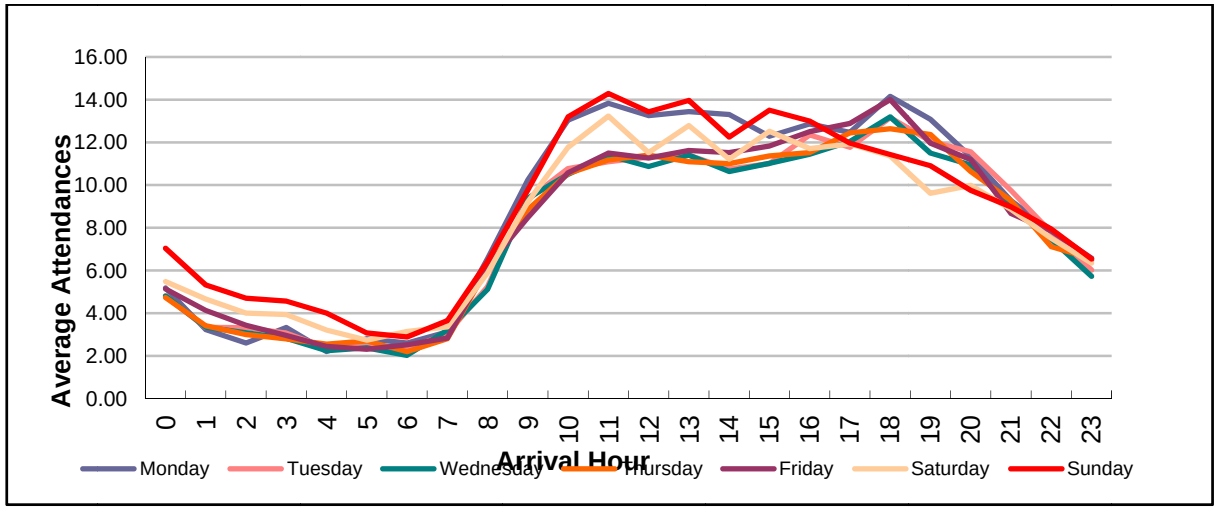
2.1 Emergency Department activity

The Emergency Department has seen a persistent rise in patients attending. Whilst QIPP initiatives across the local health community have been implemented, these have not arrested the on-going increase in attendances, which during the 18 months preceding May 2013 has been at 10%. The 111 service which launched in February 2013 has also seen an increase in referrals and attendances.

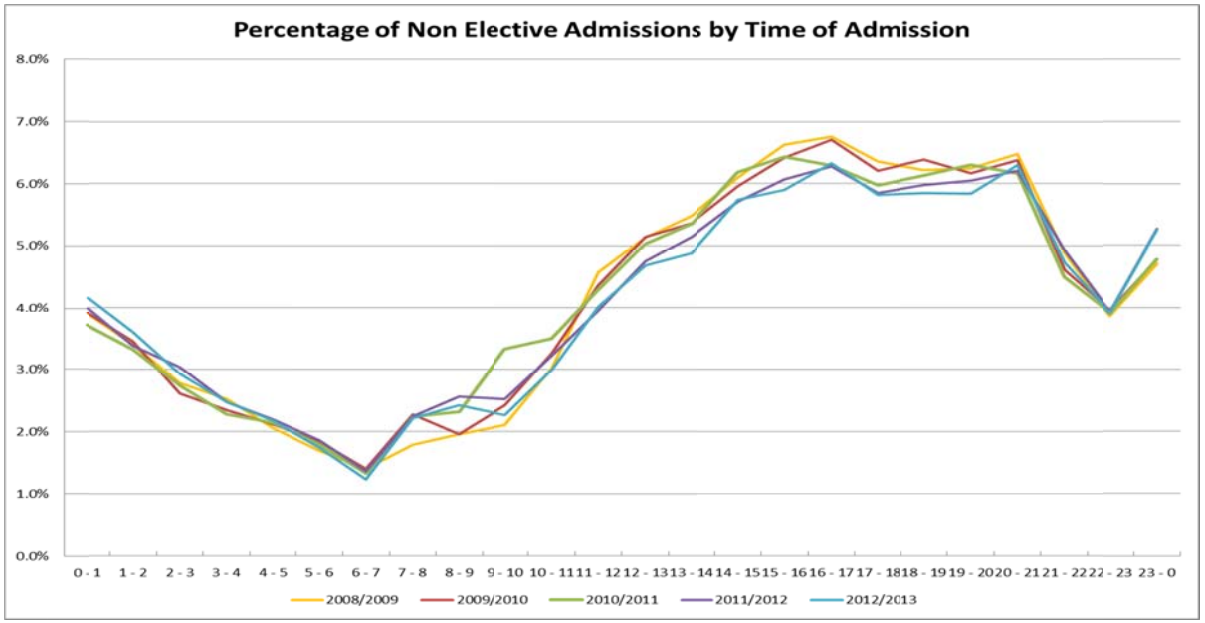
In addition to the increase in attendances, the department deals with a higher than average clinical acuity (as measured by ambulance arrivals - 40% compared to national average of 26%, and numbers of elderly patients - 25% over 70 years compared to national average of 16%). This equates to an increase in workload per patient compared to other departments with the same attendance figures. Against a backdrop of

workforce challenges amongst the middle grade, higher acuity patients take longer to be assessed and more often result in admission, utilising significant diagnostic resources potentially without the need to do so.

Current activity can outstrip available resource within the ED, particularly during evenings and weekends, resulting in significant delays to patient care during these periods. The ED department sees the following activity throughout the week.



This demonstrates that the peak periods of demand are 12noon and 8pm on a daily basis. The ED rota with 7 consultants on the following page shows that when there is an additional consultant in ED, focused on this busy period, it is still not sufficient to reduce admissions over this period. The following graph tracks admissions by time of day.



Percentage of Non-Elective Admissions by Time of Admission

With 7 consultants the current rota provides a reduced cover over the evening and weekend periods.

Time	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	Sunday
0800	0800 - 1800	0800 - 1400		0800 - 1400		0800 - 1400		0800 - 1400		0800 - 1400	0800 - 1600	0800 - 1600
1000												
1200												
1400			1400 - 1800		1400 - 1800		1400 - 1800		1400 - 1800			
1600		1400 - 2200		1400 - 2200		1400 - 2200		1400 - 2200		1400 - 2200		
1800												
2000												
2200												
2200 - 0800		On-call		On-call		On-call		On-call		On-call	On-call	On-call

As outlined above, on-going reliance on junior medical staff for decision making when consultant cover is unavailable, often results in a greater number of admissions, overuse of diagnostic interventions and consequently longer lengths of stay.

2.2 Frailty/Acuity

As outlined above, the acuity and age of patients coming through the ED is higher than the national average (as measured by ambulance arrivals - 40% compared to national average of 26%, and numbers of elderly patients - 25% over 70 years compared to national average of 16%).

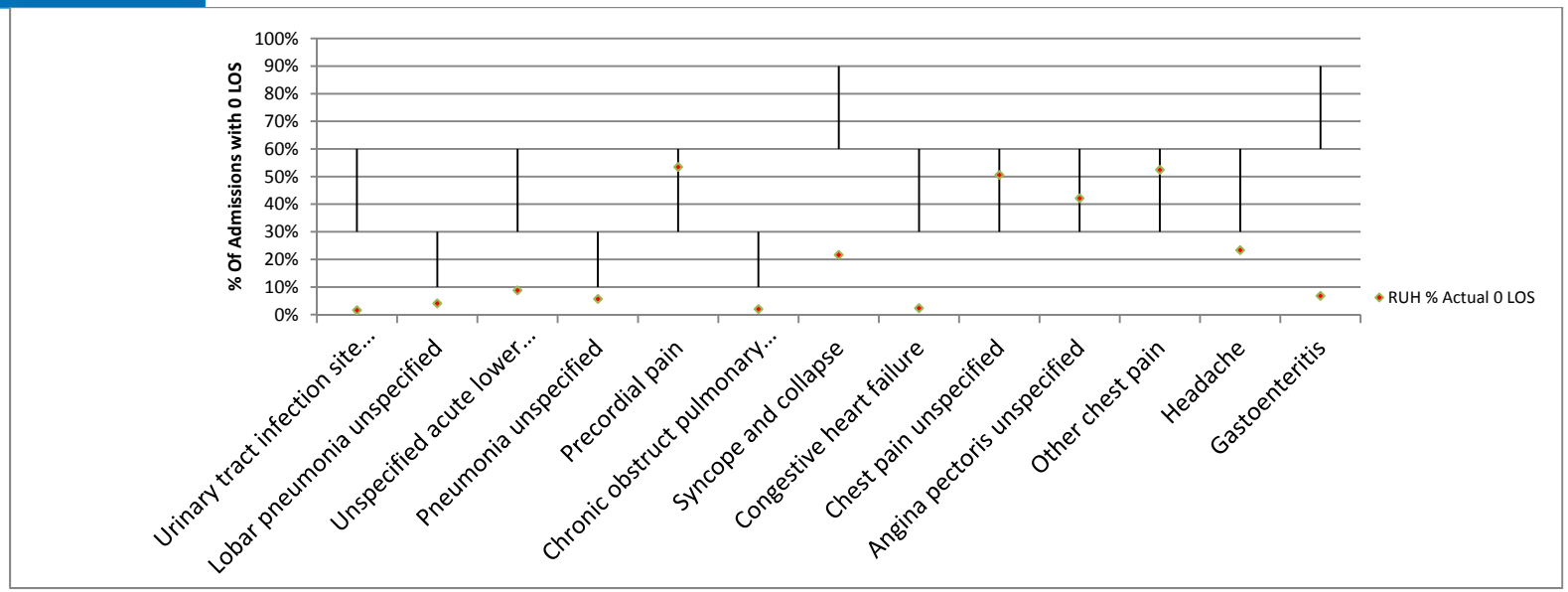
Currently the percentage of Geriatric patients at the RUH discharged with a LOS of less than 2 days averages 8%. The Trust has seen an increase in the last 12 months of delayed transfers of care, as well as an increase in those patients classified as 'Green to go' – meaning that they are ready for discharge but remain in an acute bed.

2.3 Patient flow

Flow at the front door

Ambulatory care has already been implemented within the Trust, however the impact of this has been constrained by a challenge in workforce numbers. Ambulatory care focuses on swift consultant review, the aim being to discharge patients following investigation on the same day, for follow up either in the community or in an urgent clinic/operating session.

The following graph identifies the percentage of patients treated on the same day against the national ambulatory care threshold:



The above casemix has been extrapolated from the Trust data and represents those admissions with the greatest potential to be treated on an ambulatory care pathway.

Flow at the back door

The increase in patients who are green to go is an indication of both rising acuity (i.e. patients who are not sufficiently well to return to the place from which they were admitted without additional support) and the challenges present in the local health community with their capacity.

The rise in demand at the front door is therefore mirrored by an increase in patients ‘bottlenecking’ the back door of the hospital. The competition for beds within a community setting is increasing, as a result of challenges faced by multiple providers.

Locally, there has been investment in community services across Wiltshire, Somerset and B&NES, however the impact of these has yet to be fully realised.

2.4 Workforce capacity

All emergency areas are facing challenges with workforce capacity. As outlined above, the ED faces challenges in maintaining a consultant presence as identified by the ECIST – resulting in increased admissions and longer lengths of stay within the ED. This is representative of the national picture.

For Acute Medicine, the Royal College of Physicians guidance is that no patient should wait more than 12 hours for first consultant review. With the current staffing level in acute medicine this is not possible; the last ward round takes place in the afternoon, meaning that patients admitted after 2pm are not reviewed until the following morning.

Whilst significant progress has been made across the Medical Division to deliver 7 day working, resources are still reduced over the weekend period. As a result, discharge rates drop on a Saturday and Sunday, meaning that the combined peak non-elective and elective activity on a Monday is challenging to manage in a fewer number of available beds.

Within surgery consultant cover is provided by the on call surgeon and is not currently managed via an ambulatory care pathway. The majority of patients are reviewed by the consultant when they are not operating or seeing ward patients. Approximately 5-10 patients are seen per day. During periods of peak non-elective demand, patients waited up to 5 days for surgery – resulting in longer pre-operative lengths of stay for a significant number of patients. The existing consultant numbers do not allow for the immediate assessment of patients, 7 days per week, resulting in patients who may not require pre-surgical admission being admitted to the hospital to await assessment and diagnosis by a consultant.

3. Emergency Care Intensive Support Team

As a result of the challenges identified above, the Trust failed to deliver the 4 hour access standard in either quarter 3 or quarter 4 of 2012/13. The Trust initiated two periods of ‘black’ escalation in early January and early February as a result of significant demand for acute services, numbers of patients waiting within the ED for admission and significant challenges in discharging patients to other care settings resulting in patient flow being significantly compromised.

The Trust engaged the Emergency Care Intensive Support Team (ECIST) in March 2013 to undertake a full diagnostic of the issues faced by the Trust and to provide recommendations as to how the Trust could make changes to existing services to ensure sustainable delivery of an efficient and effective emergency care pathway.

The ECIST made 4 recommendations to the Trust:

1. Develop and implement Rapid Assessment and Treatment in ED (RAT)
2. Continue the development of acute assessment models for Medicine and Surgery
3. Pilot a more focused approach to the management of medical outliers during the implementation of the improvement programme
4. Pilot enhanced therapy support, focusing on Rehabilitation to Home

In addition, the Trust has developed a wider Urgent Care Improvement Programme – into which the above projects will be slotted. This has been divided into 3 core areas:

- Front Door
- Patient Flow – including Length of Stay
- Back door

Work on the ECIST priorities is identified as a suite of projects within the Urgent Care Improvement Programme. Proposals to implement 7 day working are identified as a separate project, but one that is intrinsically linked to the delivery of the objectives and key performance improvements as outlined in Appendix1.

The projects outlined below summarise how the above objectives will be achieved.

Project 1 – Delivering Rapid Assessment and Treatment in ED

In order to provide increased consultant presence this project proposes increasing consultant input into the Emergency Department from 7 to 10 WTE consultants. A 10 consultant model will provide consultant cover from 8am to 10pm every day, irrespective of leave. At times of peak demand, in line with ECIST recommendations the ED will be able to implement rapid assessment and treatment (RAT). The cover from 10 consultants is demonstrated below. During periods of escalation RAT will also be provided at the weekend.

Time	Monday			Tuesday			Wednesday			Thursday			Friday			Saturday		Sunday	
0800	0800 - 1800	0800 - 1400	1200 - 1800 (RAT)	0800 - 1800	0800 - 1400	1200 - 1800 (RAT)	0800 - 1800	0800 - 1400	1200 - 1800 (RAT)	0800 - 1800	0800 - 1400	1200 - 1800 (RAT)	0800 - 1800	0800 - 1400	1200 - 1800 (RAT)	0800 - 1600		0800 - 1600	
1000																			
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1400																	1400 - 2200		1400 - 2200
1600																			
1800		1400 - 2200			1400 - 2200			1400 - 2200			1400 - 2200			1400 - 2200					
2000																			
2200																			
2200 - 0800		On-call			On-call			On-call			On-call			On-call			On-call		On-call

New 10 Consultant rota for ED cover

The aim of RAT is to provide early senior assessment of undifferentiated 'majors' patients. Majors patients will receive assessment by a consultant within 30 minutes of arrival to complete an initial assessment, define a care plan and make a decision whether the patient requires admission or referral to an in-taking specialist team. Nurses and junior medical staff will then implement the first stages of the care plan including initiation of investigations and/or treatment. This approach has a number of benefits which include a reduction in unnecessary investigations due to early senior input, patients for admission are identified earlier and can leave the department more quickly and the clinical risk associated with undifferentiated patients waiting for senior review is reduced.

Project 2 – Development of acute assessment models for Medicine and Surgery

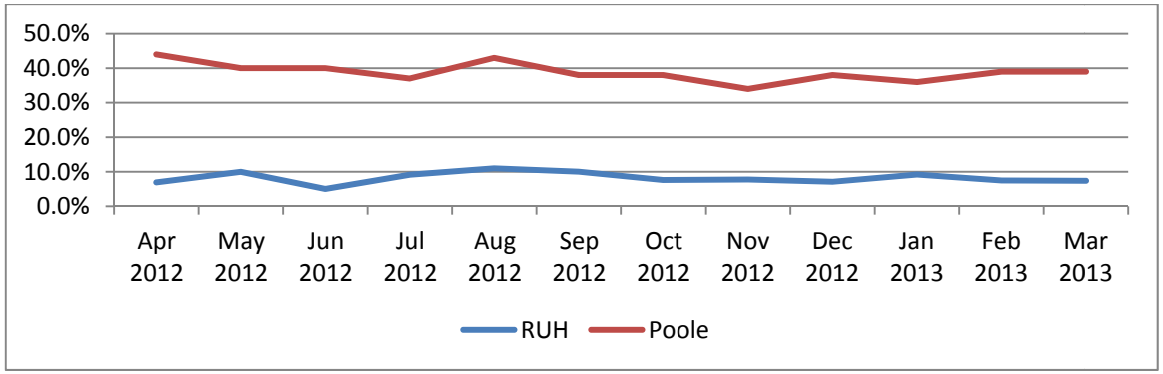
Division of Medicine Projects

There are three elements to the acute medicine vision, the development of a frailty unit, expansion of ambulatory care and earlier senior decision making on MAU with weekday evening ward rounds. These are dependent on the increase in MAU consultants by 2 WTE, with the intention to recruit consultants that are Geriatric trained.

Frailty Unit

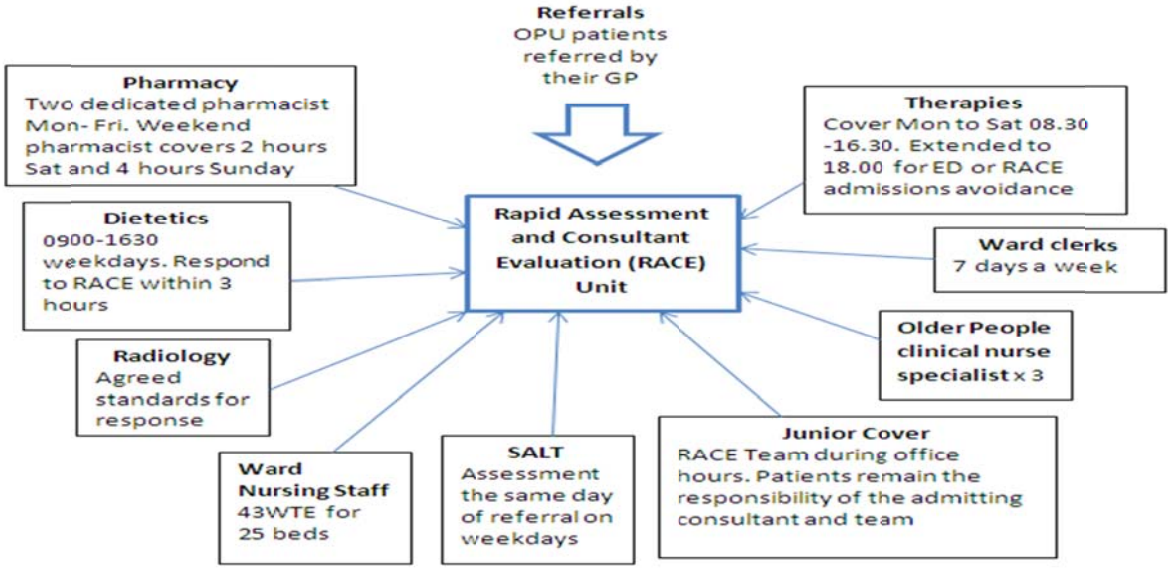
Poole Hospital NHS Foundation Trust has already implemented a unit for rapid assessment of patients at the front door. They have found that with a consultant driven care pathway and intensive nursing and therapy input they have been able to significantly increase the number of patients discharged with a LOS of less than two days. Poole have identified a number of benefits which include accelerated initiation of appropriate treatment, a reduction in the number of admissions to inpatient beds, more appropriate placement of patients and a reduction on patients admitted to other clinical specialty beds.

Currently the percentage of Geriatric patients at the RUH discharged with a LOS of less than 2 days averages 8%, in Poole this averages 38% demonstrating the significant increase in early discharge that it is possible to achieve with this model.



% of patients discharged with LOS <=2 days (Non Elective Geriatric Medicine Patients) comparing RUH with Poole Hospital

The RUH would introduce the frailty unit model mirroring the work done at Poole hospital where their unit is called RACE – Rapid Assessment and Consultant Evaluation Unit. The diagram below outlines the services which support the unit.



Outline of the RACE model at Poole

The key to the model working is a consultant led board round at 8.30 each morning, reviewing all RACE patients and OPU outlying patients to ensure patients identified are still on track to go home within 48 hours. This is then followed with a multidisciplinary meeting at 11am which includes social services and community services to expedite discharge for 48 hour patients.

Ambulatory Care

Ambulatory Care provides a location for the assessment of less sick patients who are likely to be able to return home the same day focusing on admission avoidance.

These pathways are being reviewed with the intention of moving this work from MAU to ambulatory care. The care will primarily be provided by the MAU Medical Nurse practitioners with input from the MAU consultants for senior decision making.

MAU

Regular review of admitted patients by senior clinicians is essential to ensure prompt decision-making, diagnostic and initiation of treatment. Investment in an additional 2 consultants Monday to Friday will enable evening ward rounds to be undertaken by acute medicine consultants.

Division of Surgery Projects

These projects focus on working with Theatres and Surgical Assessment Unit (SAU), and have identified a range of opportunities to improve non-elective care for surgical non-elective patients. These will impact on a number of areas from the avoidance of non-elective attendances through ED, to improved access to theatres and reduced length of stay.

There are five elements to the acute surgical assessments unit vision to improve ambulatory care pathways.

- Rapid access clinics
- Access to U/S
- Access to diagnostics
- Cat D
- Development of Urology Nurse Specialist role

Rapid Access Clinics

Many GPs are faced with patients who present with conditions that raise sufficient concern to warrant an expert, secondary care opinion very soon. Often, this opinion may not be needed immediately, but neither can it wait until the next available routine outpatient appointment. Some

GPs seek telephone advice from medical staff or the senior nursing staff on SAU but others feel that the only option is to send patients to the RUH for an immediate surgical opinion. The implementation of rapid access emergency outpatient clinics would provide a means for patients to be seen within 24 hours without needing to attend ED or wait for a long time in SAU.

Currently, the on call general surgical consultant sees between 5 to 10 patients daily, when they are available between emergency theatre and ward commitments. This would be formalised into daily set clinics for up to 12 patients with a guaranteed senior review and decision making process.

Access to Ultrasound

The RCS published *'Emergency Surgery – Standards for unscheduled surgical care'*, in February 2011. One of the key points raised in the document highlighted that:

Fast access to imaging will be cost effective in the longer term. Assessing, prioritising and rapidly treating patients requiring emergency surgery will result in reduced mortality, fewer complications, and shorter lengths of stay and provide a more positive experience for patients.

The availability of an advanced sonographer portable ultrasound machine in the SAU will lead to a significantly speedier access to diagnostic information, which has a major impact on length of stay. The reduction in times will also have additional effects in reducing complications and morbidity, as well as enhancing patient satisfaction.

A study of 33 patients having US examination in SAU was undertaken, see table below. This study demonstrated the ability to significantly reduce LOS with access to US in SAU. A US machine has now been purchased for SAU with daily support from the Radiology Department.

Length of stay

	Number	Hrs (mean)	Bed days (mean)	Bed days (total)
US in SAU	33	106 hrs 31 min	4.4	146.6
US in Radiology	33	159 hrs 17 min	6.4	212.1

(Statistically significant - p <0.0001)

Access to Diagnostics (CT)

Further protocols in relation to rapid access CT are required to ensure timely review of patients within SAU. Agreement is to be sought to facilitate access within 2-3 hours in line with the MAU, facilitating early decision making and admission avoidance. Opportunities to develop robust pathways to allow diagnostics within 2-3 days would further support admission avoidance for some patients.

A review of SAU CT scan requests for a 12 month period showed that only 57% were performed on the same day as requested. 29% waited 1day and 14% 2 days or more. Abdominal requests accounted for 42% of the overall number, and of those 28% were performed on the same day and led to subsequent discharge. Having scans and their results available on the same day resulted in a saving of 51 bed days.

As a result SAU would require access to four ring fenced CT scan slots daily to ensure timely scanning and reporting of CT requests. The results will be reviewed and shared as soon as possible following the pilot (Spring Green Week 13-17 May)

Category D Theatre Lists

Emergency patients awaiting surgery are categorised in line with NCEPOD guidance as follows:

- Immediate
- *Urgent (category C patients)*
- *Expedited (category D patients)*
- Elective

Patients currently classed as category C & D within the trust need urgent or expedited care within the most recent NCEPOD classification. These patients may not need an immediate procedure but cannot wait for a routine elective list.

In the first six months of this year, it is estimated that over 263 bed days were used by patients waiting to be operated upon. Much of this capacity would be released and postoperative LOS would also fall if additional emergency theatre capacity was available.

Looking at pre-operative length of stay only, BIU have calculated that potentially 6 beds per day can be saved by not delaying these category C/D cases.

The project will release an extra 3 sessions of ring fenced emergency theatre capacity. Although this capacity would largely be required for general surgery these lists would be available to all surgical specialties pending their surgeon availability to undertake the case.

Development of Urology Specialist Nurse role

The element of the surgical plan will support the recruitment of two specialities nurses to improve the management of urethral and suprapubic catheters across the Trust. These nurses will predominantly work in the RUH but will also to support primary care, with the aim to reduce catheter use and complications both in the hospital and community, resulting in improved quality of care, along with reduced LOS, morbidity and inappropriate emergency admissions. The posts outline is as follows:

- Be available on mobile phone to respond to all inpatient and primary care requests for advice. Divert patients from A+E/SAU to Urology OPD where possible
- Attend the Urology ward round daily to troubleshoot and anticipate problems. Review all "problem" patients prior to a weekend to ensure catheter management plan in place
- Visit A+E daily, and be first port of call to deal with catheter/nephrostomy problems (approximately 30-50 attendances per month)
- Manage and run TWOC clinics to deal with current demand (offering an extra 300 appointments per year)
- Provide urological education for RUH staff, district nurses and GPs
- Manage and develop the RUH "Continence Ambassadors" project

Project 4 – Enhanced therapy – Rehabilitation to Home

The ECIST made a recommendation to review therapy discharge processes across the Trust, with a view to increasing the therapy team's focus on getting patients home and reduce the current number of patients waiting for a community hospital. This patient group represents a significant volume of patient delays in the RUH. A snapshot review, undertaken on the 16th April 2013 by the Head of Medicine and the Clinical Lead for OPU identified 42 patients who were on a community hospital pathway. A further review, led by the ECIST was held on 24th May to review all those patients who had been in the RUH for longer than 7 days. This has provided further areas for improvement which will be incorporated into the plan.

The RACE model will be a significant development that will require additional therapy to ensure it can be effectively implemented. Before the final model for RACE at the RUH is implemented, it is proposed that an additional project to trial 'Rehabilitation to Home' is piloted. When the RACE project is fully established these additional therapy staff will be used to support this operational model.

Additional therapy staff will be incorporated in the current OPU therapy team, with the specific aims to increase discharges home and decrease LOS for OPU patients. The team will work with the OPU consultant team to identify patients on admission, who will receive focused rehabilitation, the selection criteria for this group will be:

- Approximate medical and therapist predicted LOS for 7-10 days,
- Requiring physiotherapy as demonstrating a decreased 'realistic' change in baseline function
- Mild to moderate deliriums,
- Possible mild to moderate dementias,
- Medical plan for amber - green within 48-72hrs of admission,
- Potential demonstrated by 'just failed' 48hr patients from Front Door Therapies team (DAT/DATE) on MAU,
- Existing care packages/community support sufficient to restart.

The team will work over 7 days, and will manage the 'virtual ward' of patients across the RUH. It has been estimated the team will be able to see 20-30 patients daily.

The pilot will require 3 WTE band 5 therapists supported within the OPU team, both Physiotherapy and Occupational therapy.

Implementation of 7 day working

Developing 7 day working is a cornerstone of plans for the NHS as a whole and the local health economy. The proposal to support 7 day working has been developed by the 7 day working group and sits across all the identified ECIST projects.

This proposal has three core areas:

- Increasing senior support
- Increasing nursing support
- Developing new roles

Whilst medical wards currently have a level of consultant staffing across the weekend period, there is a gap in OPU staffing. Mindful of the rising age and frailty of the casemix coming into the hospital, increasing OPU cover to ward areas over the weekend has been identified as a key priority. Investment in additional consultant cover will enable consultant support to all wards, 7 days per week.

It is likely that there will be limited Deanery support to junior posts in the coming 5 years. It is difficult to staff non-training grade posts, as a result, the Trust has successfully developed the role of Medical Nurse Practitioner in the last 3 years. This has proved successful in supporting the Medical Assessment Unit and non-elective pathway. The proposal for 7 day working aims to increase the number of nursing staff in this role – to cover the 7 period – and also develop this post in surgery.

The final element of 7 day working is the appointment of a new role within both the Medical and Surgical divisions – that of Doctor's Assistant. This role is designed to support the junior medical and nurse practitioner workforce, undertaking tasks such as phlebotomy. This post enables a more effective use of the more skilled workforce across 7 days, supporting the delivery of swift review, assessment and discharge from all points of the Trust.

Whilst the implementation of the ECIST projects will have a measurable impact on quality and efficiency of care for patients, the options identified have been based on weekday working only. The Trust has developed 7 day services where possible, with a consultant presence at weekends in key specialty areas, however to realise more far reaching benefits – such as bringing discharge levels at weekends in line with weekdays to reduce length of stay further – implementation now needs to take place at greater scale and pace. Full implementation of 7 day working will be required across the whole patient pathway (including community based services) to avoid bottlenecks developing.

Summary

The CCGs are requested initially to fund the ECIST improvement projects and support initial steps in 2013/14 towards 7 day working across the Trust. Work will then continue to further develop the urgent care model and the contract to reflect these new ways of working. For example increasing the scope of ambulatory care and agreeing local tariffs for this. The projects that have been developed focus on delivering better care for patients, in the right place at the right time. They have been developed both in line with national best practice, peer review recommendations and local priorities – to create a sustainable, high quality and effective emergency pathway for all patients.

Appendix 1:
Urgent Care Improvement Programme: Key Performance Indicators

The tables below detail the Urgent Care Improvement Programmes KPIs for each project. The programme board is in the process of agreeing both the 13/14 target and trajectories for each project, when available these can be shared with the CCGs. The Trust would also be happy to review these further at the Urgent Care Task and Finish Group where we are considering the whole urgent care scorecard.

These have been split between the programmes three work streams:

- **Front Door**
- **Flow**
- **Backdoor**

Work Stream	Project	Metric	Baseline	Target 13/14
Front Door	Ambulatory Care Medicine (MAU Area B)	Number of Non-elective patients seen in ambulatory care, per month	107	175
		Number of patients discharged from MSSU with 0-3 days LOS	71	90
	Surgical Emergency Pathway	Number of patients seen in urgent clinics	0	160
	Acute Oncology	Review by an Acute Oncology Team within 24 hours of admission (CQUIN)	0%	90%
		Number of patients whose admission was avoided through consultant lead intervention.	0	68
	ED Implementation of RAT	% of patients time to treated ≤60 minutes	44.4%	55.0%
		% of patients admitted	38.7%	37.3%
	Implement Internal Professional Standards for response to ED/MAU/SAU	Time to doctor review in ED (30 minutes)		TBC
	OPU model for a RACE unit at the RUH.	% of RACE patient group with LOS ≤2 days	25.1%	35.0%
		RACE patient group average LOS (days)	11.2	8.0
	Urology Specialist Nurses	New project. KPIs to be agreed		

Key Performance Indicators: Continued

Flow	Ward Standards	Review of all inpatient adult wards by Head of Division and Assistant Director of Nursing. KPIs to be agreed.		TBC
	Access times to Cath Lab	No patients waiting over 96 hours (stretch target of 72 hours) weekly	20	0
	Escalation Policy	Average number of escalation beds open (midnight snapshots)	35	TBC
		Maximum number of escalation beds open (midnight snapshot)	98	TBC
	Fragility Hip Fracture Pathway	% of FHF BPT patients discharged to their usual place of residence	35.6%	45.0%
		Average LOS for FHF BPT patients	15.6	12
	Dementia Challenge Initiatives	LOS for patients admitted with dementia	12.0	9.0
		Reduce falls for dementia patients		By 20%
	Medical Therapies Unit (MTU)	Number of cardiac elective patients through MTU per month	82	120
		Number of non-cardiac electives through MTU per month	36	122
	Surgical Emergency Pathway	Pre-op length of stay for cat C/D theatre list	5	0
		Number of patients detioriating from C/D lists to A/B due to theatre 1 capacity		5
Back door	Green to Go	DTOC at 1%	4.3%	1.0%
	Review of Section 2/5 & CHC process (Supported by ECIST)	Review to be completed on 25th June 2013. KPIs to be agreed after recommendations received.		
	Implement Community Wide Choice Policy	Policy approved, to be launched mid July. KPIs to be agreed with community teams.		
	Therapies pilot – Rehabilitation to Home	Decrease in referrals to community hospitals		TBC with ATC
		Reduction of NEL adult inpatients >14 day LOS	14.1%	6.0%