Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Urgent Care Update

Governing Body meeting

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1 December 2016

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Is your report for Approval / Consideration / Noting

Noting

Are there any Resource Implications (including Financial, Staffing etc)?

No

Audit Requirement

CCG Objectives

1. To improve patient experience and access to care
2. To improve the quality and equality of healthcare in Sheffield

Equality impact assessment

Have you carried out an Equality Impact Assessment and is it attached? No

If not, why not? If required Equality Impact Assessments will be conducted for each of the component parts of progressing the urgent care agenda. This paper simply provides a general update.

PPE Activity

How does your paper support involving patients, carers and the public?
Not applicable to this as a general update.

Recommendations

The Governing Body is asked to:

- Note the progress to date as well as some of the key risks
- Support the approach

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1. Background

1.1. The urgent care plan and strategy document was shared with Governing Body members at the November 2016 meeting. It highlighted four key component workstreams for urgent care delivery, 6 key focus areas for immediate resilience and recovery, 3 audit areas and the key components of the winter resilience plan.

Table 1: Summary of the urgent care plan and strategy

Workstreams	Focus Areas	Audits
Primary Care Response	Additional GP capacity LCS	Urgent Primary Care Need
	Move of GP Collaborative to Helipad	
Assessment	Medical Assessment Unit Move	Clinical Review of Admissions
Internal Hospital Flow	Excellent Emergency Care Programme	
Discharge	Delayed Transfers of Care	Independent Review of IS/STIT/CIC
	STIT recovery	

1.2. This paper intends to update Governing Body members on progress since the last meeting.

2. Progress Update

2.1. Focus Areas

2.1.1. ***Additional GP Capacity:*** The LCS has been drafted and discussed by the LMC and Primary Care Co-Commissioning Committee. The offer to practices will go out this week.

2.1.2. ***Move of GP Collaborative to Helipad:*** The move will be complete by 9th December. In parallel there is work to secure GP input to the front door of A&E. Initially this will be in the form of a GP triaging and treating in A&E but will be reviewed in early January to consider ongoing need and options for providing this within the helipad facilities, aligning to the future model of urgent primary care as informed by the audit work and accompanying business case.

2.1.3. ***Medical Assessment Unit Move:*** completing in December, aim is to improve and streamline the assessment process and increase the number of

patients with a 0-1 day length of stay. In parallel to this an options paper is being developed (due first week December) to look at the payment for assessments, linked into the 17/19 QIPP programme.

2.1.4. ***Excellent Emergency Care Programme:*** An internal STH programme of work that CCG colleagues are directly involved with. The Urgent Care Clinical Director, StJohn Livesey, is actively involved in the groups progressing the work. This also links into proactively engaging in the Remedial Action Plan for Sheffield Teaching Hospitals in response to the Contract Performance Notice that was issued in November. We continue to work closely to arrive at the best approach for assuring delivery of the Remedial Action Plan, with a preference of working alongside the hospital to support delivery.

2.1.5. ***Delayed Transfers of Care:*** Additional support was secured to support the urgent care team in a focused piece of work to review the process for managing and proactively reducing the Delayed Transfers of Care. A detailed action plan has been developed with milestones and timeframes. The infrastructure to support an escalated response has been strengthened with director level attention from across the system. Ward MDTs have additional support from social care and CHC to support earlier discharge and decision making. There will be Multidisciplinary Accelerated Discharge Events during December and January. CHC is developing a new model of working that will reduce the number of patients in a hospital bed that require assessment. A Trusted Assessor approach is being taken forward to streamline the flow into nursing and residential care.

2.1.6. ***STIT Recovery*****:** work continues with local authority and Sheffield Teaching Hospitals to address the Short Term Intervention Team (STIT) and Independent Sector capacity issues with investment in resource from STHFT to support. A trajectory has been set that will see significant improvement by December, daily and weekly reports to date have demonstrated improvement. Longer term to secure a sustainable service the services to support discharge will need to be managed differently and as a whole, this has been included in the commissioning intentions and is part of an ongoing discussion.

2.2. Audits

2.2.1. The Urgent Primary Care Need audit will conclude by 20th December

2.2.2. The Clinical Review audit is being agreed along with timeframes

2.2.3. The Independent reviewer for IS/STIT/CIC is being confirmed along with scope and timeframes for the audit

2.3. Additional Information

2.3.1. Winter Plan: The winter plan continues to be developed. NHS England assessed Sheffield CCG as amber against all key elements of the plan, this was in line with assessments across all other CCGs. There is an acknowledgement that it would be impossible to achieve a green assessment for winter resilience at this point due to timeframes to properly implement some of the key components, particularly with reference to the ambulance response. The A&E Delivery Board is sighted on this and the update paper is appended to this report.

2.3.2. High Impact Interventions: A full assessment of progress against the High Impact Interventions has been repeated to enable an up to date position, key

actions to continue progress in implementation and timeframes for completing, which are in line with national expectations. A&E Delivery Board received an update on this at the meeting on 24th November. The outcome of this is not available at the time of writing the report but can be provided verbally to Governing Body Members.

3. Recommendations

The Governing Body is asked to:

- Note the progress to date as well as some of the key risks
- Support the approach

Paper prepared by Nicki Doherty, Deputy Director of Strategy and Integration

On behalf of Peter Moore, Director of Strategy and Integration

24 November 2016

APPENDIX 1: A&E Delivery Board Update Paper

A&E Delivery Board
24th November 2016

Winter Resilience and Implementation of the Five High Impact Changes

Background:
Local winter resilience planning has continued to build on the successful citywide partnership working developed during last year's winter planning cycle. As part of this process (and in order to provide assurance of a resilient local health care system at a regional level) the Sheffield system (along with all others in the region) has been assessed by NHSE with a particular focus on the following;

- That the local system (along with regional partners) has implemented key best practice - the 5 High Impact Changes (HICs).
- The local system is supported by robust governance and leadership via the establishment of a local A&E Delivery Board.
- There is clear local understanding of demand and patient flows through local data sets and dashboards.
- There are robust local plans for the provision of care outside of the acute setting.
- There are robust local plans for winter resilience (including escalation/de-escalation triggers and resulting actions).

Outcome of Assessment Process:
Sheffield provided NHSE with an initial baseline assessment on 30th September and on 27th October; Sheffield received a rating of 'partial assurance' across all areas.

The assessment process identified four key risks and issues and from these three key mitigating actions were highlighted. Along with these the areas of governance and leadership, capacity demand and data analysis, non-acute demand and winter readiness were also highlighted as needing additional development in order to provide full assurance.

Subsequent Actions Undertaken Following Initial Assurance:
Following the initial assurance process, additional detailed feedback has been sought from NHS England and a significant amount of work has taken place to address the risks and areas identified as requiring additional development; these are summarised below (note in some cases there is overlap with areas identified and so supporting actions may impact on more than one area).
The table below summarises areas highlighted for further development and key supporting actions and timescales across the programmes (note the High Intervention Changes dashboard provides greater detail with regard to the individual projects). Furthermore a detailed plan against the High Impact Interventions has been developed.

Winter Assurance Assessment

High Impact Intervention/Supporting Function	Overall Assessment	ED Streaming	Increase in NHS 111 calls	Ambulance Response	Improving Flow	Discharge	Governance & Leadership	Capacity, Demand & Data Analysis	Winter Readiness
Assurance Status NHSE 27.10.2016									

Key Risks and Issues Identified

Risk/Issue	Actions Taken
A&E Delivery Plan requires further work in respect to priority actions and timeframes for delivery	Key milestones and timeframes for implementation have been agreed (see High Impact Changes dashboard for details).
Winter money investment allocations agreed - no specific allocation for STH	An additional £1m has been allocated to STH to support over the winter period.

System wide escalation framework focus on triggers not actions	Action cards have been developed and have been shared with system wide EPRR leads for final comments prior to wider circulation. Local escalation plans now reflect the national OPEL framework.
Capacity in step-down health and social care services to support complex discharges	This is a known issue and has previously been escalated to CEOs citywide. A recovery plan with trajectory linking with the Active Support and Recovery programme (part of the BCF) has been agreed with weekly monitoring (director level) and supported by daily data sets.
Governance & Leadership	The Board has now met on a regular basis as planned and is supported by revised terms of reference ensuring the transition from SRG to A&E Delivery Board.
Capacity, Demand & Data Analysis	The metrics shared with the board have been further developed following feedback. This is further supported by a schematic detailing patient flow across complex pathways (weekly) and daily data sets detailing flow into step-down care.

Sheffield Health System Winter Priority Service Changes
In addition to the above Sheffield is focussing on six key areas of priority service change:

1) Additional Activity within Primary Care
The CCG have found additional funding to invest £350k into primary care to buy an additional 16,000 episodes of non-recurrent activity in the form of additional primary care appointments. This activity is targeted to either; reduce A&E attendances, prevent complex admissions or facilitate better handover arrangements when STH discharge complex patients.

2) Move GP Collaborative into the Helipad and Trial GP Triage at front of A&E (PCS)
STH are moving the GP Collaborative into the space under the Helipad in order to co-locate with A&E at the Northern General. PCS are going to utilise their additional GP capacity to provide a triage process to support the better streaming of patients who can be treated by a GP rather than within A&E.

3) Introduction of the Assessment Process within STH.
The revised assessment process provides a more intensive, earlier senior review of the patient and is intended to discharge more patients home than the current facility. This should provide additional capacity to ensure that patients will not have long waits following A&E decision to admit and that 20% of GP 'bed bureau' patients are no longer admitted but continue to be supported in a non-acute setting.

4) STH Excellent Emergency Care Programme
Targeted interventions are required to deliver reductions in length of stay, better ward rounds and reduce DTOCs to longer stay patients; this is being supported by STH's Excellent Emergency Care Programme and the Vital Room.

5) Disproportionate effort into reducing DTOCs
DTOCs have doubled since April 2016. In part this is due to IS capacity but there needs to proper effective whole system management of 'complex patients' who require multi agency support to get out of hospital. An external consultant joint funded by the CCG, STH and SCC has been appointed to provide additional support to this area. Early actions include supporting daily citywide telephone conferences to support complex discharges and MDT supported MADE events.

6) Ensure CICs, STIT, and Independent Sector flow.
Weekly operational meetings and fortnightly CEO meetings have led to a range of joint actions to ensure that by mid-December the independent sector will have sufficient capacity.