NHS
Bath and North East Somerset
Clinical Commissioning Group

Bath Health Community – Winter Report 2013/14

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Setting the Context – The Challenges of 2012/13

The crisis faced by many Urgent Care Systems (UCS) was overwhelming in 2012/13, leading to a significant impact on patients, staff and the 4 hour target performance of many acute hospitals. Due to the inter-dependency of health and social services the impact of a poorly function UCS was experienced across the Bath community with the system experiencing gridlock at times. This had a direct and measurable adverse effect on decision making, patient experience with increased waiting times to access care services and resulted in a number of clinical and patient safety incidents.

The Impact of Gridlock

The impact of a poorly performing system has far reaching consequences including patient experience, staff morale, provider relationships, NHS performance, NHS and social care funding. It was clear that previous approaches needed to be revaluated and that we could no longer expect the UCS to function without significant change.

The Root Cause Analysis process that formed part of the review of why the system entered Black escalation periods; identified the following:-:

- Winter planning was not adequate to cope with the increase in demand that occurred over the Christmas period.
- Lessons from previous RCAs had not been integrated into future planning
- There was a community-wide failure to escalate in the face of what was a predictable period of high demand.

The RCA team recommended a number of outcomes based on the lessons learned from the RCA, these included:

- The Health Community must plan robustly for winter, using data from previous years to determine required levels of activity and staffing
- The Health Community must develop and ensure that adequate contingencies are in place to cope with the increased demand placed on all providers in the event of periods of black escalation

- The Health Community must develop and use effective triggers for red and black escalation and take action in a timely way
- The Health Community must apply lessons learnt from previous root cause analyses into black escalation.

A key issue was a clear lack of system leadership and absence of real practical solutions when the UCS reaches Black Escalation and a crisis point. The primary responsibilities of the BaNES UCS is to ensure patients receive the most effective and high quality of care, provided within a cost efficient environment whilst achieving high patient satisfaction at all times. These requirements should not change during times of increased pressure throughout the year, but should be integral to normal system responses when pressure is placed upon it.

What Changed - A Difference in Approach

The CCG undertook a review of the previous episodes of black escalation through an agreed RCA process and reviews the behaviours of the UCS during a simulation exercise to try to understand the core underlying issues within the UCS. Alongside this the Royal United Hospital had already embarked on an internal review of working with the assistance from the Emergency Care Intensive Support Team (ECIST).

(The main conclusions for Sirona Care & Health are in Appendix A)

To further support these reviews, the CCG concluded that further system management support would be needed; this led to the appointment of an Urgent Care Network, Programme Lead.

There was recognition that system leadership was required to fundamentally change the approach at a strategic level. Although the UCS had developed good operational systems, operational teams clearly struggled to implement change without clear system leadership. Recognition of both these issues has led to changes at a senior decision making level and creation of new approaches to planning, system oversight and operational leadership. To support this new direction the CCG undertook root and branch change within the UCS structures and our approach to whole system management, these changes included:

- UCS leadership – the CCG moved to reduce the decision to action cycle by removing the previous Urgent Care Network meetings and replacing them with a senior level task and finish group, which evolved into the Urgent Care Working Group (UCWG). This was established around the RUH and made up of senior decision makers from the CCG and providers and the creation of the Urgent Care Provider Forum (UCPF) to act as the project team within the UCS.
- Planning – the CCG developed a new approach to capacity planning. This involved moving all providers from the previous single phase winter planning approach to continuous planning cycles, supported by demand predictors, centred on the demand predictions of the RUH. Some of this had been previously supplied, but without the system leadership to drive changes into operational practice. This was further expanded to ensure all providers move to Demand, Capacity & Escalation planning (DC&E).

- Strategic and Operational Management – the UCWG developed the Operational Performance Management Framework (OPMF) to define a clear structure for both the Strategic level management of the UCS through the UCWG and also clear processes and structures to manage the daily operational response across multiple providers in the UCS.
- Whole System Measurement – the UCWG introduced a new Urgent Care Dashboard (UCD) moving away from previous approaches to now measuring the UCS flow and its component parts of Demand, Capacity, Flow and Performance. Although the dashboard remains retrospective, it has improved transparency of information across the system by supporting escalation decisions. It also has the potential to become more predictive of UCS changes. This has been facilitated with the assistance of the RUH and the ownership remains with the CCG.
- Daily Monitoring and Direction – the UCWG created new daily reporting to ensure each organisation understood their own escalation status, other provider's escalation status as well as the UCS status as a whole. This required the introduction of a system wide understanding of escalation terminology to enable consistent and uniformed measurement and understanding of escalation. The UCS recognises that this work has not been fully effective and more work in required in this area.
- Peer to Peer Challenge – to help create honest and open assurance across the UCS, all providers were asked to present their DC&E plans to the CCG and each other within a structured peer to peer event. This proved very useful to understand the challenges we were likely to face, in particular in the restrictions affecting provider capacity.
- Empowering Leadership Over Management – the UCWG led a leadership forum to share operational lessons from other organisations and experiences to enhance and empower leadership through the UCS.
- Winter Pressure Monies – the initial allocation of new non-recurring winter pressure monies to assist in supporting those UCS identified as at risk (£4.2M) was managed by the UCWG. All providers were asked to formulate proposals for the UCWG to consider and authorise. The provider forum reviewed and collectively agreed the schemes for UCWG approval; this was a very helpful step and ensured schemes supported delivery of the 4hr standard at the RUH. Whilst the money was allocated quite late, therefore impacting on the success of some of the schemes, the key areas that were funded included additional capacity across the UCS, reablement, in-reach and liaison teams and to support progress to 7 day working where possible. Some of these schemes have funded through non-recurrent monies for 2014/15l, with some being recognised as only being needed during winter.
- Post Winter Peer to Peer Review – to support the recurring commissioning of successful schemes and to understand better what has made a difference this year, the UCWG held a post winter peer to peer event to allow all to consider the winter pressure schemes and the provide open feedback.

Demand, Capacity & Escalation Planning (DCE)

To ensure Providers can bridge the gap between conceptual planning and operational delivery of effective services, the commissioners agreed to create a better understanding of the continuous cycle for DCE based on robust demand assessment through the use of strong and shared demand predictors, as set out in the Bath Health Community Demand, Capacity & Escalation Plan 2013/14.

To ensure this approach is maintained all service providers were required to complete robust Demand, Capacity and Escalation (DCE) plans to ensure they recognise and address the correct levels of demand throughout the planning cycle and incorporating appropriate service level provision at all times. Our collective assessment is that due to capacity restrictions many plans could not provide a flexible enough approach and whilst we have made progress, more work is required to develop better demand predictors and associated plans for all providers across the health, mental health and social care.

This approach was explained as a new planning cycle as shown in *Fig 1*

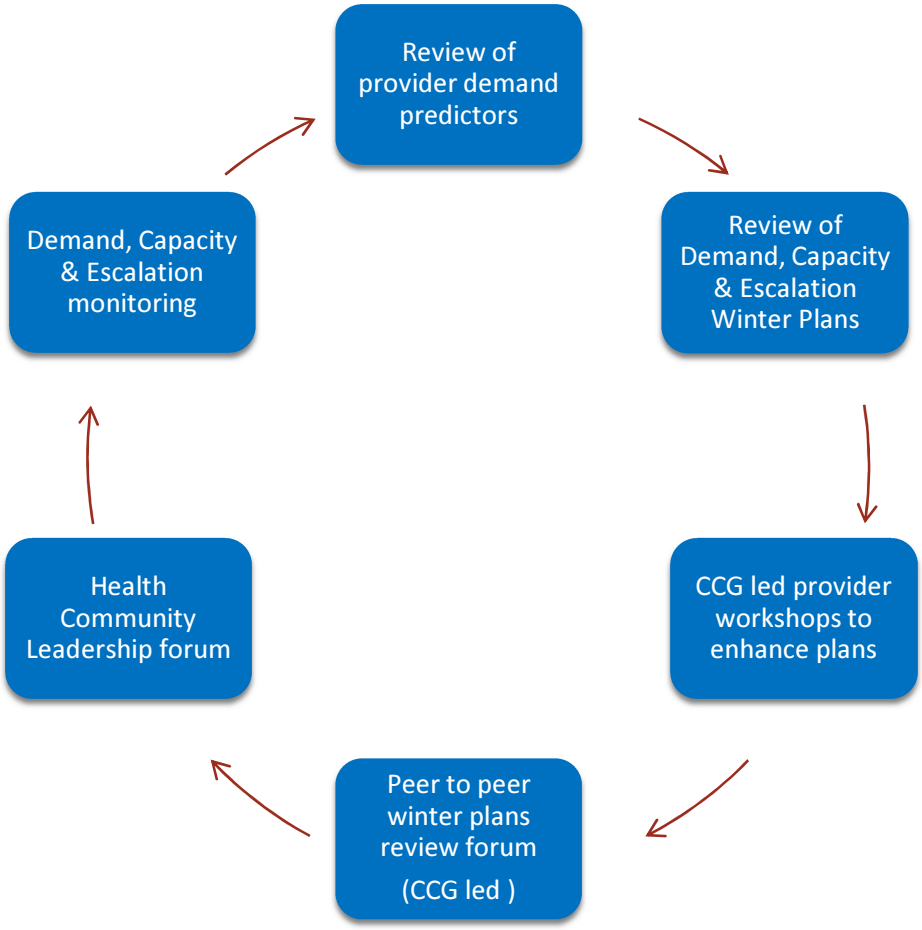


Fig 1

Operational Performance Management Framework (OPMF)

To further ensure the delivery of safe services across the UCS an UCS Operational Performance Management Framework (OPMF) was introduced. The OPMF establishes the strategic level oversight structure undertaken through the Urgent Care Working Group (UCWG) via monthly meetings and fortnightly teleconference calls.

The OPMF introduced a new level of daily operational performance management supported by greater daily UCS visibility and forecasting. To support this approach the OPMF also introduced a new daily operational status declaration processes for providers and across the whole UCS to provide daily operational leadership of the whole UCS.

The OPMF follows the continuous planning cycle approach *Fig 2,* to allow all DC&E plans to be retested and challenged within a continuous and robust process if provider escalation demonstrates a disassociation between operational reality and DC&E planning. This is to ensure all planning remains appropriate to meet the demands placed on providers and therefore the whole UCS. The real time reviews undertaken in winter will need further work if we are to build a consistent and strong approach to continuous planning across the UCS.

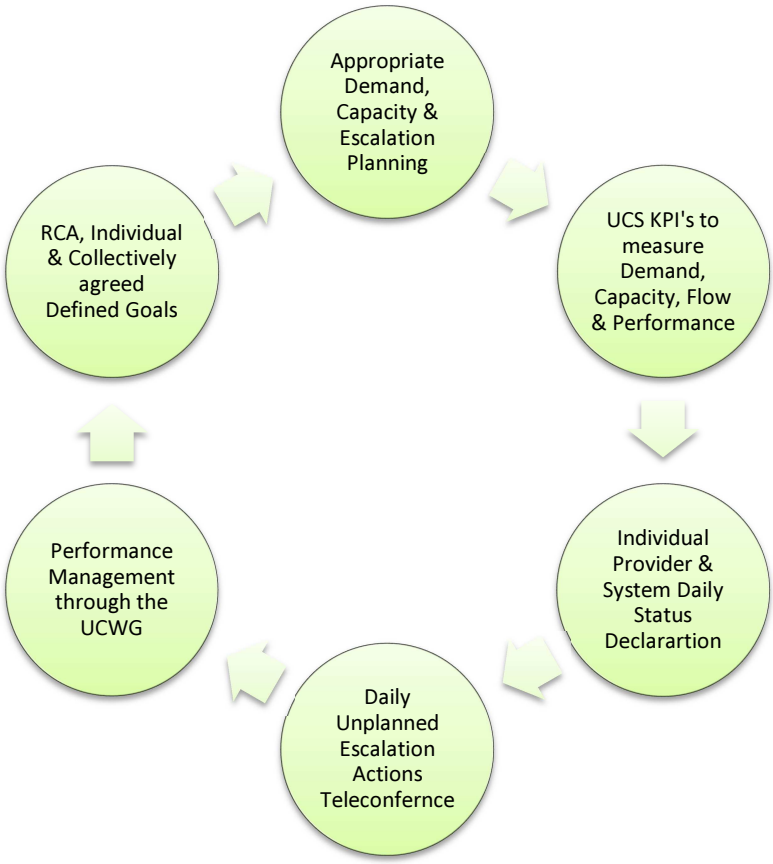


Fig 2

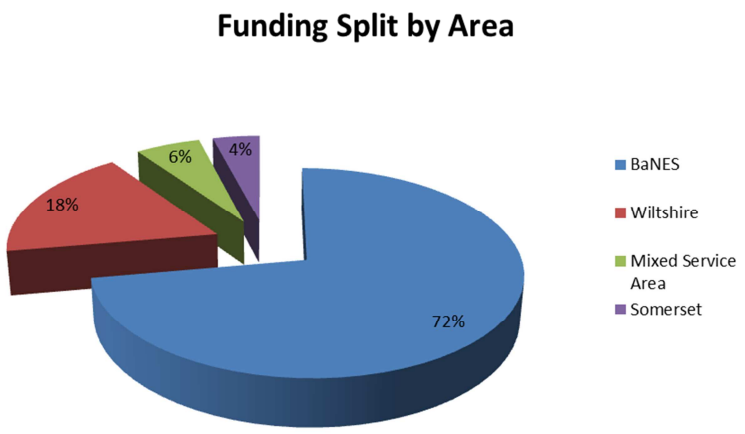
ECIST and Winter Pressure Schemes

Bath was nationally recognised as a challenged health care system based on the pressure seen in the winter of 2012/13 and performance against the 4 hour target. The Bath Health Community was allocated £4.4m of national winter pressure monies to support system performance. This money was managed through the UCWG, which included senior representation from BaNES, Wiltshire and Somerset CCGs and across Health and Social Care providers.

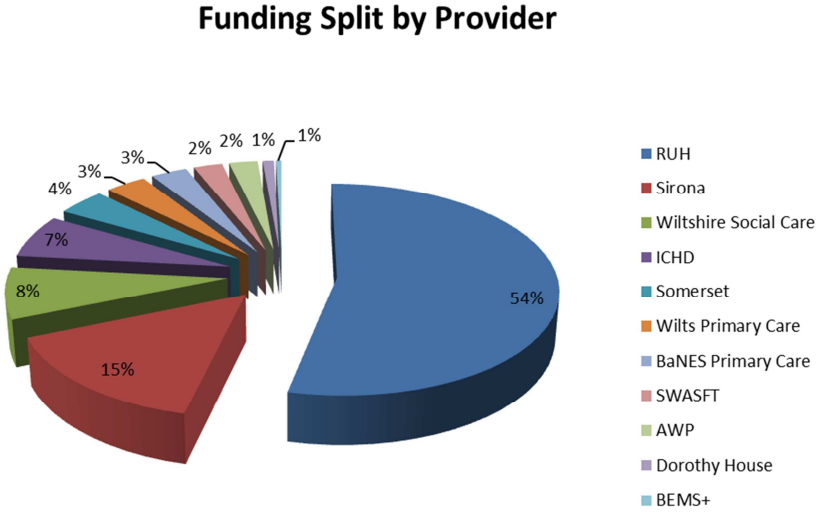
The Winter Pressure Schemes covered areas such as:

- Increasing Capacity (Increase in reablement/Stroke/Neuro/Social care beds/primary care)
- Extending 7 Day Working (AWP/EOL/Therapy/Primary Care)
- Enhancing Support (Independent living teams/Discharge Coordination)
- Improving Early Senior decision Making (RRT/RUH SWOT)
- Smoothing Demand (PSV Support)

(The full Winter Pressure Schemes are shown in Appendix B)



The UCWG took an inclusive approach to the use of the monies, to ensure projects were considered right across the areas that may impact on the Bath Health Community.



What Happened – A Winter of Two Halves

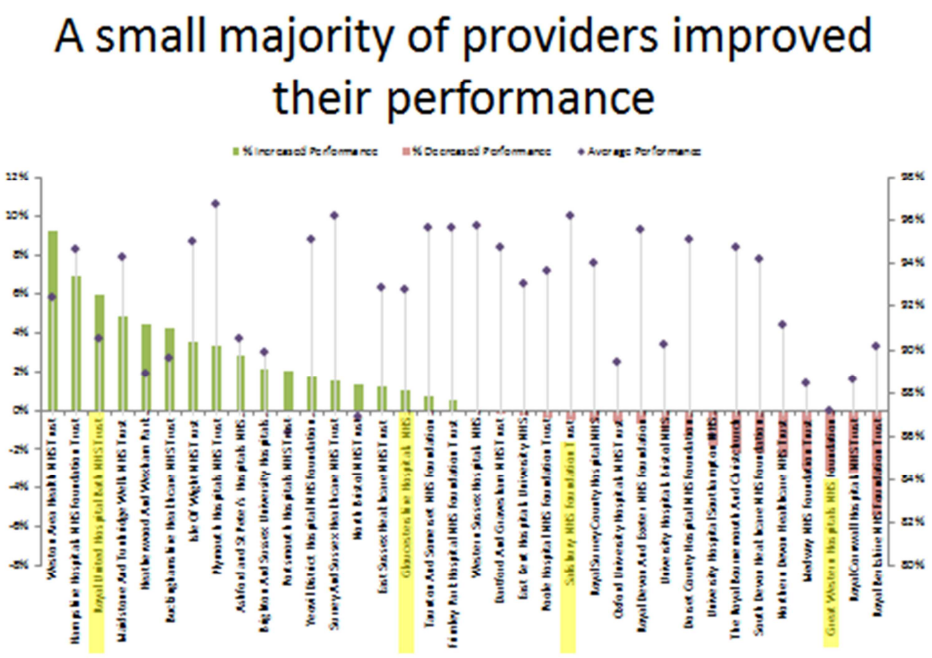
During the winter period at no time did the whole Bath Health Community enter full Black escalation, although the RUH did have Black Escalation periods and where internal flow was lost to the point that operational effectiveness was compromised. The RUH entered black escalation on 3 occasions across the winter period, consisting of 5 days in total; this was a significant improvement on last winter. (06/01/14 1 day, 17/02/14 1 day and 24/3/14 to 26/03/14 3 days)

The whole UCS improved its collaborative working to overcome these periods. Due to these changes in approach, particularly the ECIST and winter pressure schemes patients have been protected throughout the winter period. The Bath Health Community delivered very strong 4 hour performance during the first half of winter (Quarter 3, October to December), however while the whole UCS remained safe for patients, the second half of winter (Quarter 4, January to March) saw lower performance when measured against the 4 hour A&E standard, although still significantly higher than 2012/13.

Performance and Demand Data for 2013/14

A&E 4 hour (RUH) - Target 95% Q1 91%, Q2 95%, Q3 97%, Q4 92%, Year 94%

NHS England has recorded the Bath UCS and the RUH as the third most improved performance for this winter, when compared to last winter.



A&E total attendances - 2013/14 69272 2012/13 70965 = 2.4% reduction in attendances

BaNES RTT - % of patients admitted (adjusted) within 18 weeks for treatment. Target 90%

Q1 94%, Q2 92%, Q3 94%, Q4, 93%, Year 94% (RUH cleared back logs in Q2 and missed the admitted target in July 2013, For BaNES, RUH missed the admitted target in March 2014, though the target was met at Trust level.)

BaNES RTT - % of patients non-admitted within 18 weeks for treatment. Target 95%

Q1 97%, Q2 97%, Q3 96%, Q4 97%, Year 96% (RUH met targets all year)

BaNES RRT - % of patients on incomplete pathways within 18 weeks at the end of the period. Target 92% Q1 93%, Q2 94%, Q3 94%, Q4 93%, Year 94% (RUH met targets all year)

BaNES SWASFT Red 1 Response - Target 75%, 2013/14 71.6%

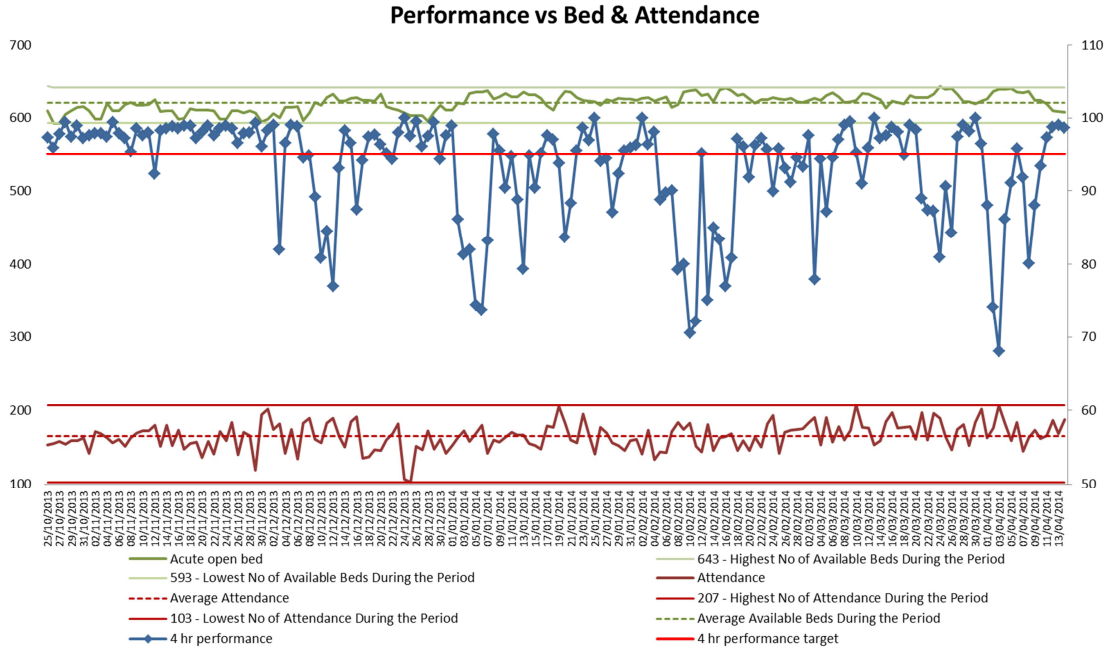
BaNES SWASFT Red 2 Response - Target 75%, 2013/14 74.1%

BaNES SWASFT Red 19 Response -Target 95%, 2013/14 94.7%

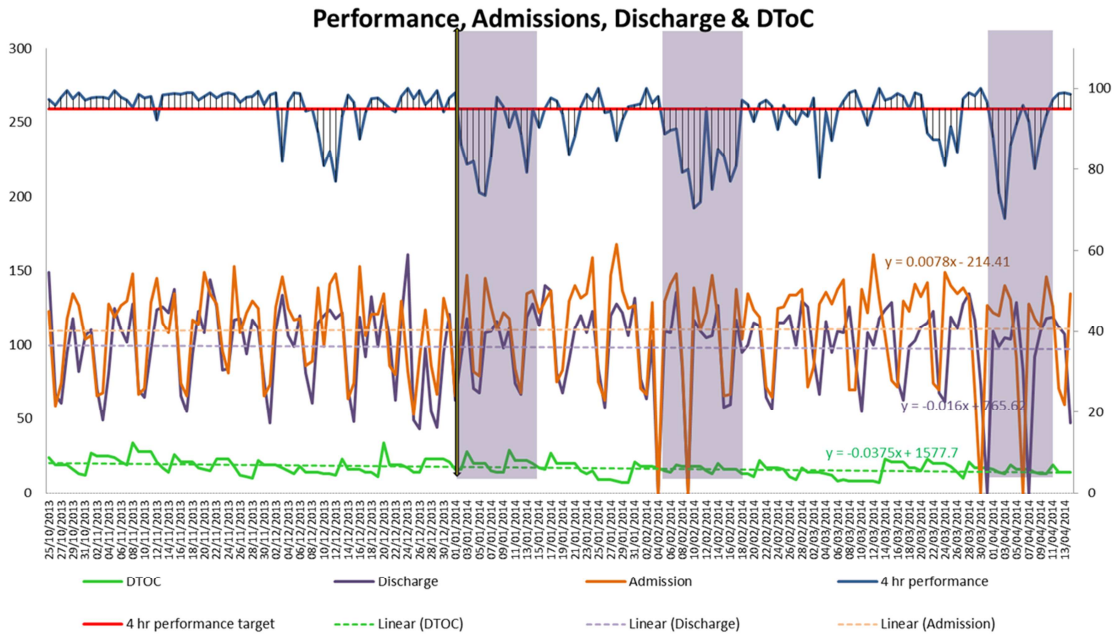
(Full Performance definitions are shown in Appendix C)

The UCS has experienced very challenging times during the winter period with the pressure on flow being the major problem which has impacted on the RUH. However these episodes have been reduced across the winter supported by far quicker system recovery driven by strong collective ownership, the impact of the ECIST, Winter Pressure Schemes and collective working across all providers. There is evidence the UCS is still very reactive by not opening enough early escalation capacity both within the RUH and across some other providers, when the UCS

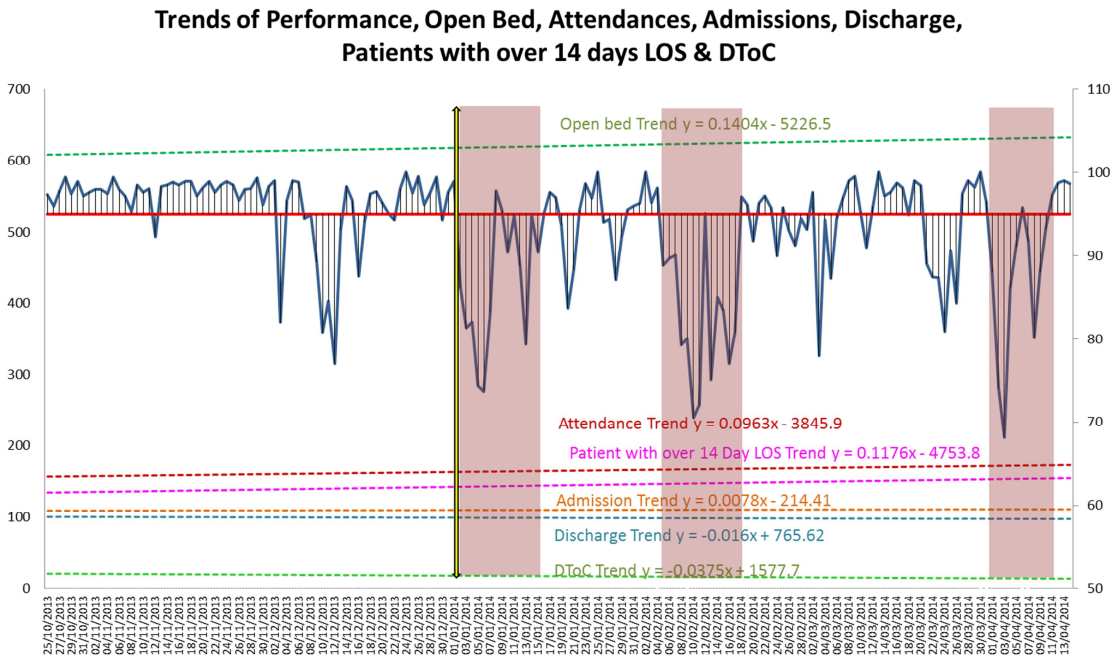
experiences pressure. Most of this pressure is predictable to some extent. There are reasons why this occurs, however we have struggled to provide the flexible enough bedded capacity required



The second half of winter saw a siginificant change to the previous close correlation between admissions and discharges. After 1st Jan, admissions and discharges appeared to be unsynchronised with larger gaps between them than they were before 1st Jan.



Where the RUH entered into a period of lower performance lasting more than two days there was a clear measurable time lag of one to four days between the drop in performance and the opening of additional escalation beds. This would indicate that we are still reactive to internal bed pressure and opening up escalation beds is not in time to fully protect patient delays in the ED department.



Our significant difference in approach taken this year has been recognised by other UCSs and the NHS, resulting in local UCS reviews to understand our approach. Some of this learning has now fed into the wider NHS transformation projects.

(Southern CSU full data analysis is shown is Appendix D)

Conclusions and Recommendations

1. Patients and high quality patient care must be at the heart of our approach and we must learn from our review of winter.
2. Leadership is a core and necessary component of any successful UCS. Systems need continued support and leadership at times of change and pressure.
3. Operational teams must be supported by strategic leadership to allow quick decision making.
4. We are better together – the collective and uniformed approach across all providers and the UCS has clearly benefited patients, particularly the joint approach to agreeing the Winter Pressure Schemes and funding.
5. We require a full paradigm shift in our approach to the delivery of UCS services to build highly responsive out of hospital services that meet the needs of the majority of patients through new levels of combined health and social care working both prior to admission and after acute intervention.
6. Early intervention and senior clinical decision making supported by 7 day solutions makes a sizeable impact on patient outcomes and experiences.
7. Delays in the transfer (DToC) of older patients, directly adversely impacts on their care, their experience and their long term outcomes. This may result in a greater demand for long term care, which is unsustainable in outcomes and cost. UCS transformation must address this fundamental issue.
8. Overall system capacity at times may not be sufficient and flexible enough to meet need in periods of escalation while improved across this winter is still not providing the required level UCS response to meet the needs of high complex demand and this has funding implications for all organisations.
9. We need to enhance our oversight, predictability and measurement of action taken within the UCS as a whole system.
10. Demand, Capacity & Escalation planning needs embedding and Escalation status needs to be consistent and driven by capacity measurements and most importantly action from all providers with greater commissioning understanding of the barriers creating this.

New Collective Primary Lines of Enquiry

- Increased demand, where this has occurred by type and nature
- Increased acuity/complexity
- Redistribution of demand by area and time
- Increased volatility in demand
- Reduced capacity in Trusts to meet demand
- Increased resource use in response to demand

National Direction and Key Conclusions and Recommendations

NHS Assembly Commissioning footprints

- Strategic Urgent Care Networks
- Operational Urgent Care Networks

National Urgent Care Governance Group

Urgent & Emergency Care Review (UECR) - Key messages

(Urgent & Emergency Care Review (UECR) - Key messages, Appendix E)