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Health and Adult Social Care Select Committee
21 June 2016

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Buckinghamshire County Council

Select Committee

Health and Adult Social Care Select Committee

Report to the Health and Adult Social Care Select Committee

Title: System Resilience in Buckinghamshire
Committee date: Tuesday 21 June 2016
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1. Role of the SRG

The System Resilience Group (SRG) is a Group of representatives of different NHS and social care partners involved in the delivery of urgent care across Buckinghamshire.
The main purpose of SRG is to provide assurance of system resilience.
The most appropriate overview of SRGs can be found here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/320224/Operational_resilience_and_capacity_planning_for_2014-15.pdf

The broad focus of an SRG is to:

- Determine service needs on a geographical footprint and initiate the local changes needed;
- Monitor system performance and ensure delivery of the Constitutional Standards, e.g. achievement of A&E 4 hour performance, Referral to Treatment Times (RTT), Cancer waiting times and mental health all age 24/7 psychiatric in-reach and liaison standards.
- Address the issues that have previously hindered whole system improvements

As our main urgent care commissioning group, the SRG is also responsible for improving urgent care by working collaboratively across the NHS and Social Care to benefit patients and make best use of public funds. This involves agreeing a vision for a better future state and the programme of work to deliver this.

Members of SRGs seek to hold each other to account for actions resulting from internal review, sharing intelligence and pooling resources where possible. All participants are responsible for providing staff and other resources to implement this programme, being Senior Responsible Officers for specific projects, finding solutions to issues and using measures to identify whether they are having the required impact to improve system delivery against agreed key performance indicators.

Furthermore the SRG's work is based on the 8 high impact actions as listed below.

1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

4. SRGs should ensure the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.

6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

7. Daily review of in-patients through morning ward or board rounds, led by a consultant/senior doctor, should take place seven days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

2. Membership

- The SRG is chaired by Dr Rebecca Mallard-Smith, Clinical Commissioning Director for Urgent Care, Chiltern CCG (Chair). In her absence Dr Kevin Suddes, Clinical Commissioning Director for Urgent Care, Aylesbury Vale CCG (Vice Chair) will deputise.
- SRG consists of a small core membership with representatives from NHSE, CCG, BHT, ASC, OHFT, SCAS, Bucks Urgent Care and LMC with a limited number of others invited for specific items as required, or copied for information. Appendix 1 for membership.
- If members cannot participate, nominated alternatives should attend in their place
- Additional representatives can be co-opted or invited to meetings on an ad hoc basis when their expertise is required
- The representative from NHS England will represent commissioners of Primary Care

Members are expected to attend 9 out of 12 meetings per year. Attendance may be in person, or using technology such as web or tele- conferencing.

3. SRG and 4 Hour A&E performance

4 hour A&E performance is a very prominent topic in the NHS.
Because of the increased pressure on the 4hour performance in winter the work of the SRG centres very much on planning for this period, by funding initiatives that are believed to benefit the urgent care system.
Funding decisions are made by the group collectively, and require thorough business cases outlining costs and expected benefits. Furthermore the bids have to be in line with SRGs priorities, which for 2016/17 are:

a. Creating robust out of hospital services for patients who don't need a consultant and an acute hospital to treat them, such as rapid step up domiciliary care and care home beds managed by GPs.
b. Improving primary care resilience
c. Minimising transfer of care waits

This will target resources onto the areas of greatest risk and where greatest benefits can be achieved.

Please see overleaf a small selection of initiatives that SRG funded in 2015/16 with the aim to achieve 95% A&E performance.

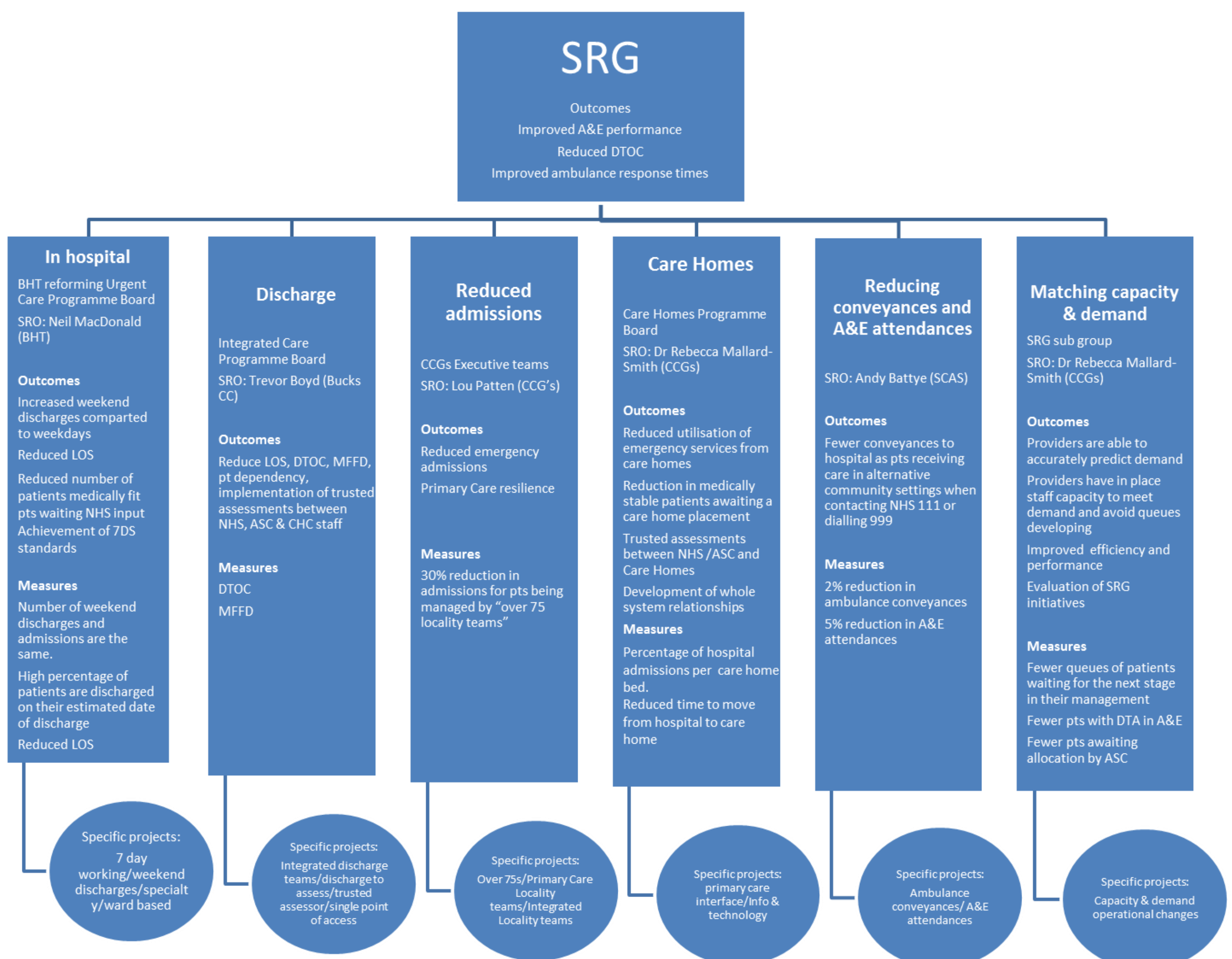
System Resilience Initiatives 2015/16

Initiative Name	Explanation	Benefits	Example/Patient experience
ACHT Reablement Support - PoCs from Bucks Care	Additional reablement capacity available to care for patients at home.	Benefit to patients: • More timely discharge of patients with reablement and care needs • Maximises the patient's ability to live independently and safely in the community. Benefit to system • Community healthcare teams' (Physios and District Nurses) capacity was freed up, which could be used for seeing patients in the community, which also prevented admissions	Patient was declared fit for discharge on 27/01/16; the planned long term care provider was unable to reinstate care until 04/02/16. Onsite Buckinghamshire Care Assessor visited ward; patient taken home & full assessment completed. Buckinghamshire Care supported until care provider was able to re-start care on 04/02/16 as planned. This reduced the hospital stay by 8 nights. This was a complex case as the lady was not weight bearing; she had a profiling bed in place. There were questions around medication. The assessment team visited on 29/01/16 & followed this up with the GP.
Step Down and step up Beds for Social Care Patients	Social Care patients not requiring a hospital bed but whose onward care (Package of Care or Nursing/Care Home) is not ready to start can move into Nursing home placement in the interim for a short time. This supports the prevention of admissions (step up placement) and facilitates discharges (step down placement).	Benefits for patients: • Patients are cared for in safe environment close to their local community Benefits to system: • Freed up hospital bed capacity • Cost savings	Patient was declared fit for discharge on 18/01/16 requiring 3 homes visits per day. The care package could only start on 27/01/2016. Social Care offered a step down placement in a nursing home close to the patient's home for the interim. The patient accepted the step down placement. The patient returned home with the planned care package on 27/01/2016. This reduced the hospital stay by 9 nights.
REACT (Rapid Assessment	A team of Nurses, Physios, OTs and social worker which provide an immediate response and prevention of admission at the front-	Benefits for patients: • Patients can return home safely with required support and/or equipment	

Emergency Care Team)	door of the acute hospital.	• Improved independence and wellbeing <u>Benefits to system:</u> • Reduction in attendances to hospital, reduction in admissions. • Reduced length of stay in acute and community hospitals with effective rehabilitation in the home	
SCAS referrals to MuDAS	Ambulance crew can refer frail older people directly to MuDAS.	<u>Benefits to patient:</u> • Reduced stress for patient due to avoiding A&E attendance • Safer for patient as potentially long hospital stay is prevented <u>Benefits to system:</u> • Reduced A&E attendances	Ambulance crew arrives at 76 year old patient's home after fall. The patient responds well to all tests by ambulance crew, but would like a doctor to check the patient. Instead of taking the patient to A&E, the crew is able to refer him directly to MuDAS in Wycombe for further assessments.
Street Triage for Mental Health Patients	Mental Health expertise is provided to the police force in Buckinghamshire.	<u>Benefits to patient:</u> • Reduced stress for patient due to avoiding A&E attendance or detention • Patient to be cared for in safer and more appropriate environment <u>Benefits to system:</u> • Reduced A&E attendances • Reduced waiting times	

The key areas (work streams) for realising these projects within the SRG are:

- In hospital – BHT internal work with the aim to improve hospital flow and A&E performance
- Discharge – improving discharges from hospital by developing interim options that can be accessed by health and social care
- Reduced admissions – strengthening of community services, so patients don't have to go into hospital in the first place
- Care Homes – to facilitate more joint working with care homes to reduce admissions and to improve discharges
- Reducing conveyances and A&E attendances – to support the improvement of the ambulance service's performance
- Matching Capacity and Demand – to pre-empt and plan for surges



Apart from planning for winter, SRG also focuses on long term improvement of the Urgent Care system in Buckinghamshire, which is also the task of the work streams.

The System Resilience Group is also a forum for cross organisation working and for improving partnership working. An example of this is the ongoing work between SCAS and Stoke Mandeville Hospital to reduce the number of ambulance handover delays, which impact negatively on SCAS' performance. This was flagged up at SRG and a workshop between both providers was initiated, which led to the development of specific actions to be taken by both providers.

Appendix 1

SRG Membership

Core attendance	
Dr Rebecca Mallard-Smith (Chair) **RMS**	GP, Urgent Care Clinical Director, Chiltern CCG
Dr Kevin Suddes (Co Chair) **KS**	GP & Urgent Care Clinical Director, Aylesbury Vale CCG
Lou Patten **LPa**	Chief Officer, Aylesbury Vale CCG
Dr Annet Gamell **AG**	Chief Clinical Officer, Chiltern CCG
Ali Bulman **AB**	Bucks County Council
Neil Macdonald **NM**	Chief Operating Officer, BHT
Philip Murray **PM**	Chief Finance Officer, Chiltern CCG
Mark Begley **MB**	Area Interim Manager East , South Central Ambulance Service
Natasha Bartlett **NB**	General Manager, Bucks Urgent Care
Gill Beck **GB**	Bucks LMC
Gurmit Sandhu **GS**	NHSE
Samantha Robinson **SR**	Head of Service, Buckinghamshire Adult Mental Health Services, Oxford Health NHS Foundation Trust
Gary Passaway **GP**	Urgent Care Commissioner, Bucks CCGs
Franziska Barth **FB**	System Resilience Manager, AV and Chiltern CCGs
By invitation as required	
Nikki Malin **NM**	Comms & Engagement, South Central & West CSU
Phil Jones **PJ**	Bucks County Council
Lisa Maclean **LM**	Director of Nursing and Quality, Chiltern CCG
Isobel Day **ID**	Assistant Chief Operating Officer, Integrated Medicine, BHT
For information only	
Lesley Perkin **LPe**	Programme Director, Integrated Care, Bucks CCGs
Syed Hasan **SH**	Consultant Physician for Integrated & Elderly care, Buckinghamshire Healthcare NHS Trust
Jonathan Pryse **JP**	Medical Director, BUC
David Williams **DW**	Director of Strategy, BHT
Damian Haywood **DH**	Out of hospital care network manager, Oxford AHSN
Claire Gourlay **CG**	Comms & Engagement, South Central & West CSU
Judith Collyer **JC**	Thames Valley Emergency Access, South Central Ambulance Service
Katherine Woolley **KW**	Health Intelligence & Analytics Manager, South Central & West CSU
Sally Aldridge	Buckinghamshire, Local Pharmaceutical Committee