System Resilience in Buckinghamshire

HASC 21st June 2016

NHS Chiltern CCG, NHS Aylesbury Vale CCG, Buckinghamshire Healthcare NHS Trust, South Central Ambulance Service NHS Foundation Trust, Buckinghamshire County Council

Resilience is the capacity to recover quickly from difficulties; toughness (Oxford Dictionary)

System Resilience Group

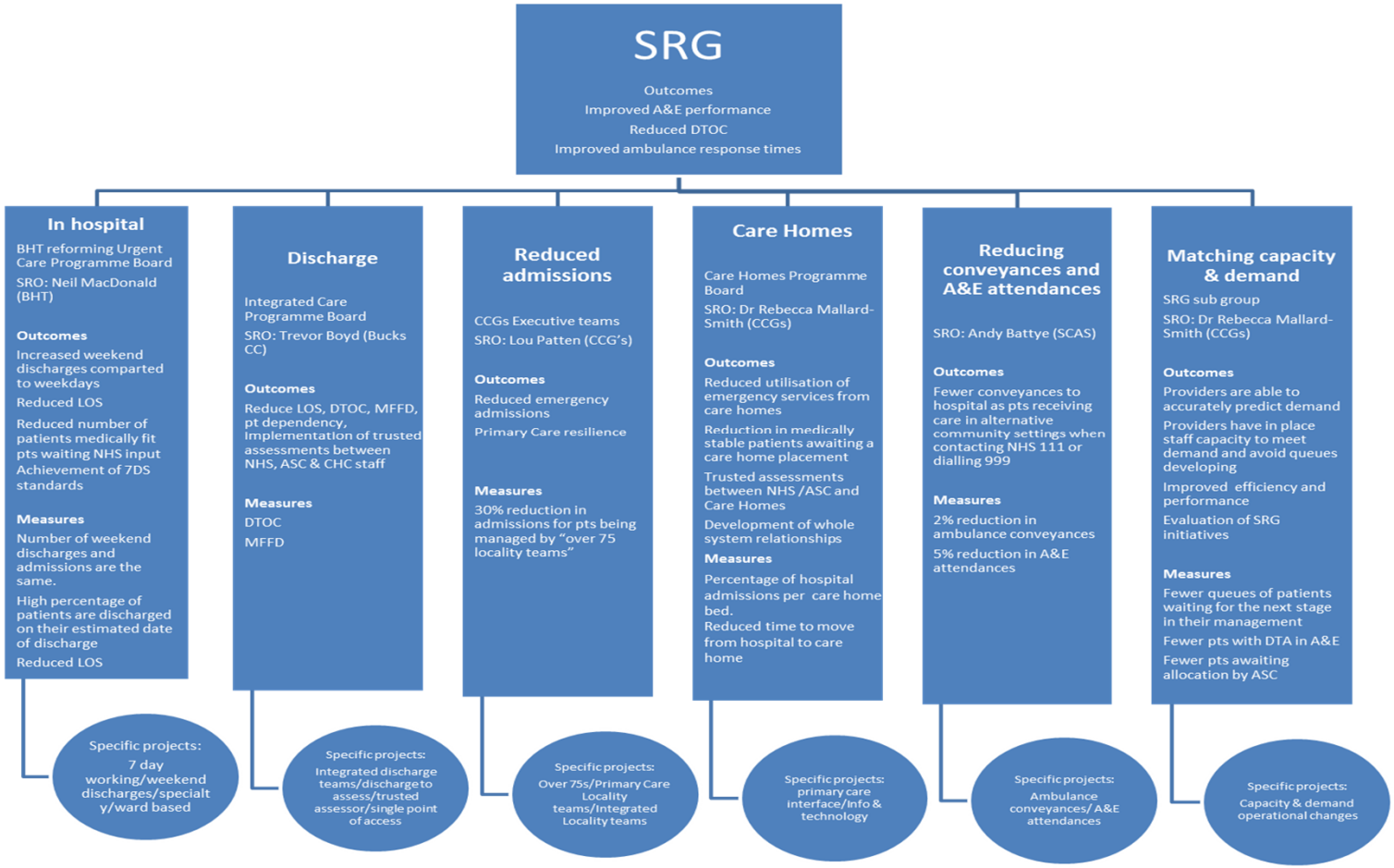
- SRG provides assurance of system resilience and plans for system pressures with the focus on:
  - Determining Buckinghamshire wide service needs
  - Uncovering and addressing issues preventing system improvements
  - Monitoring system performance
  - Delivering NHS Constitution Standards

NHS Constitution Standards

- A&E waits
- 18 weeks Referral to treatment (RRT)
- Ambulance Response times
- Diagnostic test waiting time
- Cancer treatment waits

SRG work streams

- Work streams an their SROs are responsible for the delivery of the SRGs strategy and resilience schemes



SRG funding

- Funds available to SRG to be spent on projects that are believed to improve whole system resilience especially during times of expected high pressure (usually winter)

- Funding decisions are made collectively following thorough business cases in line with SRG priorities

- Projects are monitored against KPIs to evidence projects aims are achieved

- Successful project should be implemented by the provider as BAU, based on achieved efficiencies

SRG schemes

- Centred around **avoiding admission** (reduce ambulance conveyances, REACT, primary care resilience, community healthcare teams) and **enabling discharges** (packages of care, step down placements, community healthcare teams)

- Buckinghamshire system 4 hour A&E performance above national average in 2015/16, partially owed to SRG initiatives

2015/16 SRG schemes

Initiative Name	Explanation	Benefits
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
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
REACT (Rapid Assessment Emergency Care Team)	A team of Nurses, Physios, OTs and social worker which provide an immediate response and prevention of admission at the front-door of the acute hospital.	Benefits for patients: • Patients can return home safely with required support and/or equipment • Improved independence and wellbeing Benefits to system: • 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.	Benefits to patient: • Reduced stress for patient due to avoiding A&E attendance • Safer for patient as potentially long hospital stay is prevented Benefits to system: • Reduced A&E attendances
Street Triage for Mental Health Patients	Mental Health expertise is provided to the police force in Buckinghamshire.	Benefits to patient: • Reduced stress for patient due to avoiding A&E attendance or detention • Patient to be cared for in safer and more appropriate environment Benefits to system: • Reduced A&E attendances • Reduced waiting times

SCAS as part of the SRG

South Central Ambulance Service NHS
NHS Foundation Trust

The Patient's Journey When Calling 999

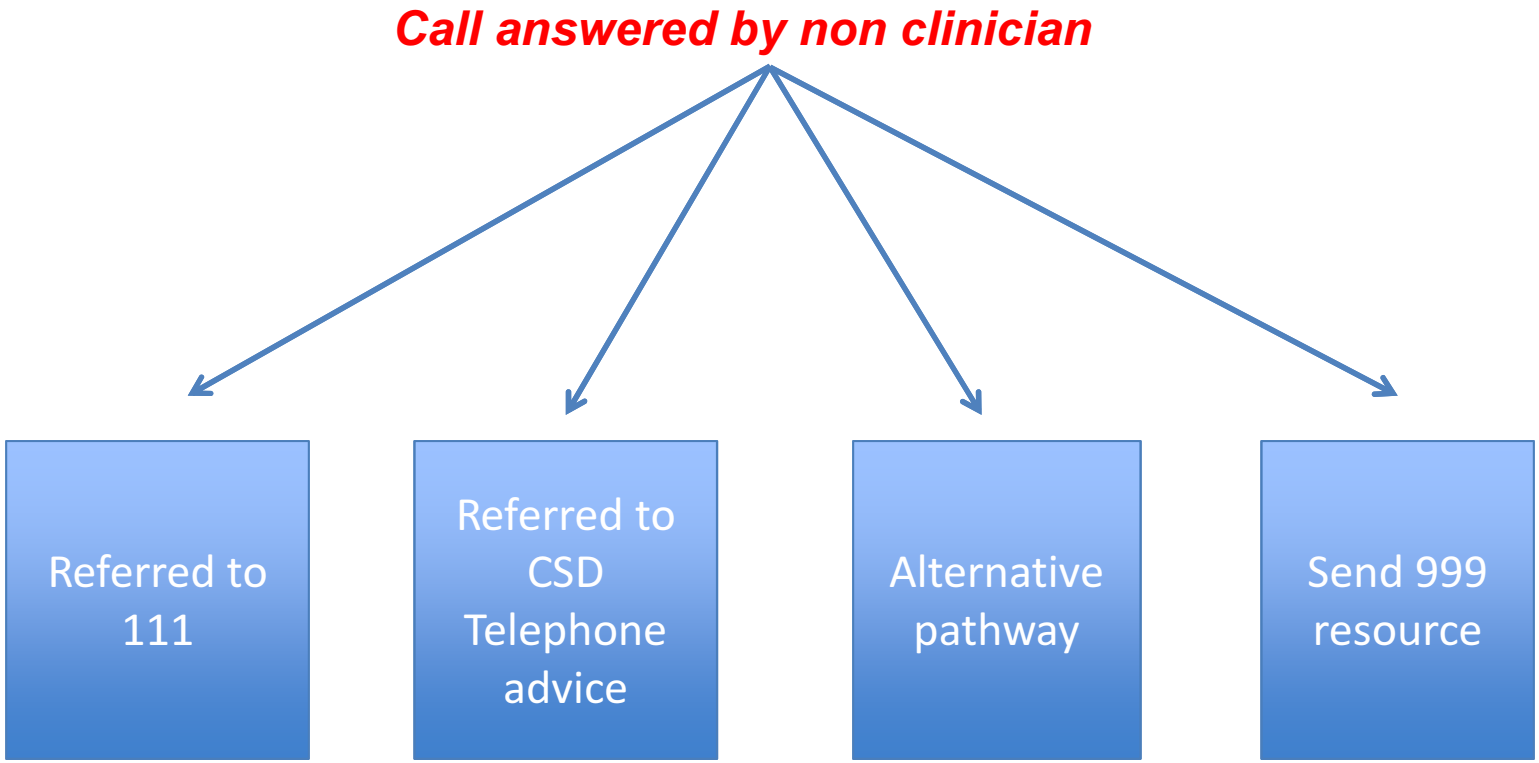
Proud to be caring for you!

From the outset

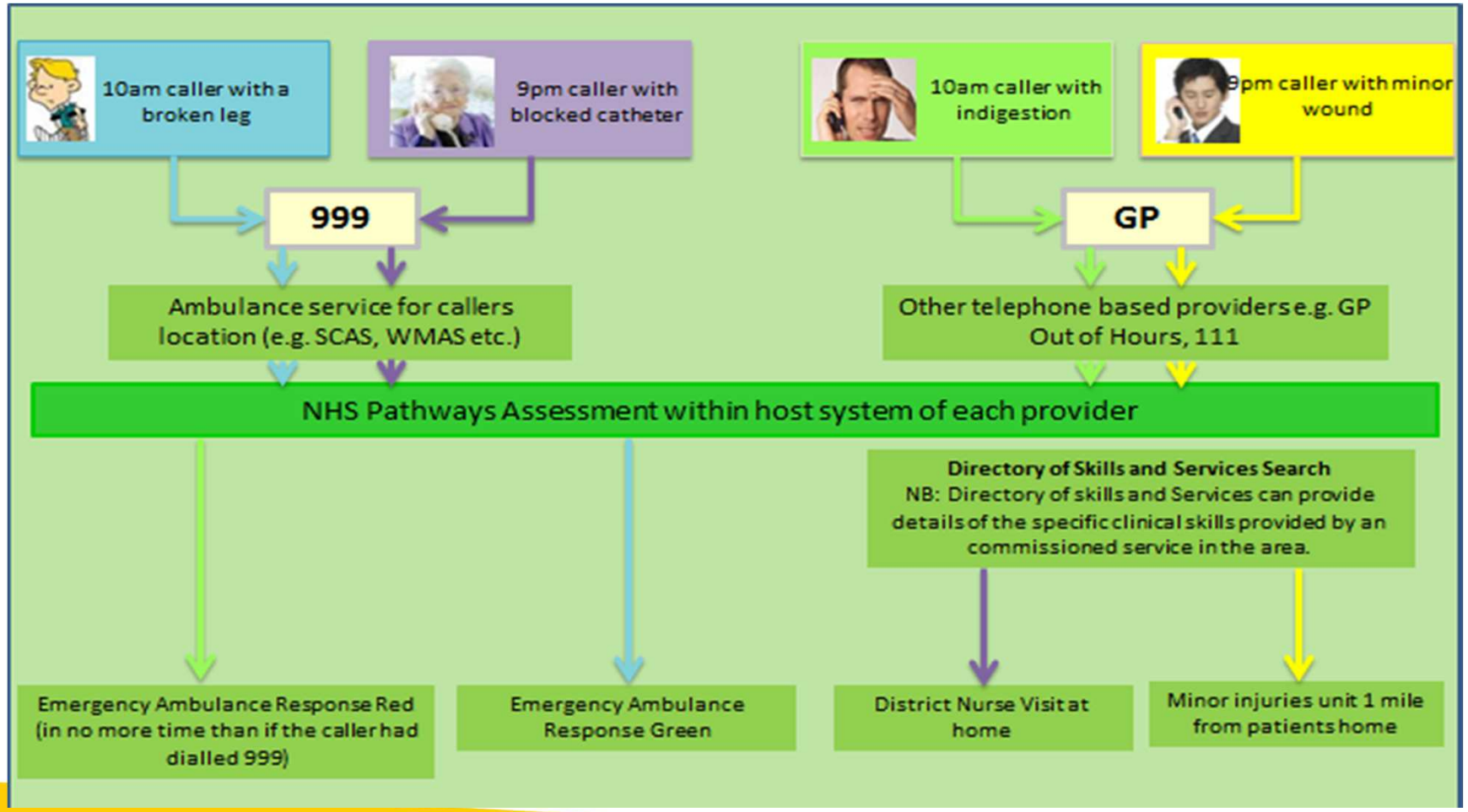
- Caller dials 999 and connects to an operator.
- As soon as the call is connected to the ambulance service telephony system, the address or grid co-ordinates display on the dispatcher's screen and an icon appears on their mapping screen.
- When the call is answered basic demographic details are confirmed.
- The Emergency Call Taker will enter a 'nature of call' after establishing whether the patient is breathing and conscious.
- Any patient whose condition is immediately life-threatening will be identified at this point and an emergency resource dispatched.
- If the patient's condition is not immediately life-threatening an emergency resource, if required, may be dispatched at a later point.
- A triage process is then commenced, which will lead to a disposition being reached.
- This disposition will determine what care is arranged for the patient.

Call to SCAS 999

- The NHS Pathways System (NHSP) is used to triage patients calling both 999 and 111.



How does it meet the needs of the patient



Frequent alternative care pathways in Buckinghamshire

- MuDAS – *Frail and elderly are able to be referred to MuDAS including simple falls, cellulitis, conscious confusion, infusions, IV antibiotics, blood transfusion and fluid therapy.*
- Mental Health – *MHPs in the 999/111 operational centre to improve mental health urgent care pathways (in line with National MH Crisis Care Concordat). Able to stop Ambulance attendance and offer alternative care pathway.*
- GP Surgery – *Patients that require further assessment – non-critical and will benefit from staying at home. In previous years, all patients would have been taken to the ED*
- OOH GP – *As above during out of hours and Bank Holidays*
- Falls team – *SCAS attending a frail/elderly fall will complete a "falls referral" sent centrally to our falls team who will alert the local falls prevention team*

Bucks non conveyance

	2015/16	YTD
Hear & Treat	10.4%	10.2%
See & Treat	34.8%	35.9%

BHT as part of SRG

Buckinghamshire Healthcare NHS
NHS Trust

REACT

Based in the Emergency Hub at Stoke Mandeville Hospital, REACT (Rapid Emergency Assessment and Care Team) is a multi-disciplinary and multi-agency team which has ensured patients, particularly older people or those with complex needs, receive an early comprehensive needs assessment to enable a safe discharge from A&E, Assessment & Observation Unit (AOU) and the short stay ward.

The primary focus is on avoidance of hospital admissions, and secondly to support discharges from hospital.

REACT was cited as an area of outstanding practice in the last year's Care Quality Commission inspection.

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every time

REACT Case Study

Avoiding hospital:

'Emily' is found by her case worker lying on the floor and cold after falling at home. She is taken to A&E with a suspected pubic rami fracture; confirmed upon arrival at the hospital.

She is visited by the REACT team whilst in A&E and a full multi-disciplinary assessment is undertaken by the REACT team including social care. They agree a package of pain relief, therapy and equipment plus short term increase in care package whilst the fracture heals and Emily regains independence.

The plan is discussed with Emily and her family. Emily is very keen to get home, but the family are anxious and seek reassurance that the care package is sufficient. Through our BRaVO (health and social care reablement) single point of referral, immediate interventions are agreed with the Trust's Adult Community Healthcare Team (ACHT) reablement ream and Bucks Care. The plan is agreed with the A&E team and Emily is able to be discharged home – thereby avoiding an unnecessary admission into hospital.

With support in place, Emily returns home and remains there whilst her fracture heals. Her pain is well controlled and she makes a full recovery. An alarm is arranged for her to call local services she falls again and her care package is reduced to once daily as before.

Based on a typical scenario

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Pre-paid packages of care

Bucks Care and the Trust's Adult Community Healthcare Teams (ACHT) working together to provide interim packages of care to bridge the gap for patients who were ready to be discharged from hospital but where a start date for longer term packages had not yet been identified.

Benefits include:

- Improved system flow
- Provision of high quality domiciliary care focussed on the need of the patient in the right environment for the patient .
- Patients no longer needing any long term care / reduced long term care.
- Reduced hospital stay.
- Improved response times from ACHT for clients in the community to prevent admissions and take patients from hospital to support discharges.

Pre-paid packages of care – case studies

Case Study 1:

'Betty' was assessed as fit for discharge, but planned care provider was unable to reinstate care for another month. Onsite Bucks Care Assessor visited ward. Betty was taken home & full assessment completed. Bucks Care supported until care provider (full social care package) was able to re-start care planned.

This reduced the hospital stay by 8 nights.

Betty continued with support from Bucks Care. Feedback was that she was improving & able to "do" things for herself. She was discharged as independent 4 days later. This reduced the need for Betty to receive a social care package – good for her as she regained independence, good in reducing pressure on social services and good for the whole health economy.

Case Study 2:

'Jim' initially requesting twice weekly calls for a shower. Less than a month after receiving pre paid package of care (PoC)he was able to do this independently & no longer needed on-going support. No need to move to longer standing package of care.

Case Study 3:

PoC started for Peggy for morning calls only to support with personal care & dressing needs & medication. Within three weeks Peggy was managing this by herself & no longer needing on-going support.

** All names have been changed*

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County Council as part of SRG

Adult Social Care Assessment and Discharge Planning

- **Discharge Pathway Options:**
  - Reablement – up to 6 weeks support
  - 24/14 – two weeks support and assessment
  - Re-implementation of Care and Support – this is discontinued if an individual remains in hospital for over 10 days
  - Implementation of Care and Support – where Reablement is not an option
  - Long-term Residential or Nursing Care

- **Care and Repair**

  - Facilitates timely discharge through the provision of safe home arrangements.
  - Impacts on the following pathways:
    - Reablement
    - 24/14
    - Re-implementation of Care and Support
    - Implementation of Care and Support

- **Additional Staffing**

  - Additional Social Work staff in the Hospital Social Work teams has resulted increased assessment productivity
  - Additional Social Work Assistants has resulted in timely re-assessment at the end of a Reablement programme – maintaining Reablement capacity
  - Impacts on the following pathways:
    - Reablement
    - 24/14
    - Re-implementation of Care and Support
    - Implementation of Care and Support

- **Step Up and Step Down Placements**

  - Block placements in Care Homes and Nursing Care Homes enable the transfer of people from the clinical hospital environment to a more homely environment – own bedroom and en-suite facilities
  - Creates capacity within the Hospital
  - Impacts on the following pathways:
    - Re-implementation of Care and Support – where there is a domiciliary care pressure
    - Implementation of Care and Support – where there is domiciliary care pressure
    - Long-term Residential or Nursing care – where the home of choice is not available immediately

- **REACT**

  - Provides Social Work support to a multi-disciplinary team that focuses on Admission Avoidance at the front-door of the Hospital
  - Impacts on the following pathways:
    - Re-implementation of Care and Support
    - Implementation of Care and Support

- This service links to Step Up placements – utilising Residential or Nursing care as an interim solution and an alternative to Hospital Admission

- **Optimising Domiciliary Care Project**

  - The Project is focused on reviewing and re-assessing service-users who have double-handed care and support – the team consider equipment and technology that could be applied to reduce physical support – creating a more dignified approach to care and more domiciliary care capacity in the market-place.
  - Impacts on the following pathways:
    - Reablement
    - 24/14
    - Re-implementation of Care and Support
    - Implementation of Care and Support