Southend University Hospital NHS
NHS Foundation Trust

SEPT

Essex County Council

NHS
Southend
Clinical Commissioning Group

East of England Ambulance Service NHS
NHS Trust

southend on sea
BOROUGH COUNCIL

NHS
Castle Point and Rochford
Clinical Commissioning Group

South East Essex Operational Resilience and Capacity Plan 2014/15

How this plan has been developed

This plan has been developed by the south east Essex urgent care system, utilising a series of planning events and meetings as set out below.

Date	Event/meeting	Outcome
14.02.2014	Winter Look Back Event	Review 2013/14
31.03.2014	Risk Summit	Informed plan development
17.06.2014	Urgent Care Working Group	Informed plan development
24.06.2014	Urgent Care Working Group	Informed plan development
02.07.2014	Urgent Care Working Group	Informed plan development
07-13.07.2014	The Perfect Week	Informed plan development
08.07.2014	Resilience Funding Meeting	Agreed funding process
15.07.2014	Urgent Care Working Group	Final draft - for comments
17.07.2014	Resilience Scenario Testing	Testing of plan
22.07.2014	Urgent Care Working Group	Sign off of final plan
31.07.2014	SCCG Governing Body	For approval
31.07.2014	CPR Governing Body	For approval
21.08.2014	NHS England Assurance Feedback	For approval
26.08.2014	CP&R feedback	For approval
03.09.2014	Southend Health and Wellbeing Board	For approval

Organisational Approval

This plan has been developed by the South East Essex Health and Social Care System Resilience Group (SRG).

Name	Designation	Signature	CCG	Date
Melanie Craig	Chief Operating Officer		NHS Southend CCG	21/08/2014
Graham Wallis	Interim Accountable Officer		NHS Castle Point & Rochford CCG	26/08/2014
Kevin McKenny	Chief Operating Officer		NHS Castle Point & Rochford CCG	22/08/2014
Sally Morris	Chief Executive		NHS South Essex Partnership Trust	26/08/2014
Jacqueline Totterdell	Chief Executive		Southend University Hospital NHS Foundation Trust	22/08/2014
Simon Leftley	Director for People		Southend on Sea Borough Council	22/08/2014
Rob Ashford	Essex Locality Director		EEAST Ambulance NHS Trust	22/08/2014

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Section one: Executive summary

This Resilience and capacity plan has been developed with all partners and will be signed off by the Southend Health & Wellbeing Board.

South-east Essex health system
NHS Southend Clinical Commissioning Group (Southend CCG) and NHS Castle Point and Rochford Clinical Commissioning Group (Castle Point and Rochford CCG) commission acute , community and mental health services for a total population of around 360,000 people in south-east Essex. Across both CCG areas, the population includes a high proportion of older people.

The two CCGs plan as part of two distinct units of planning centred around their respective health and wellbeing boards. However, the two organisations work in close collaboration as they serve their neighbouring populations via shared providers.

Strategic and operational planning
In line with the requirements of *Everyone Counts: Planning for Patients 2014/15 to 2018/19*, units of planning in Castle Point and Rochford and in Southend-on-Sea have developed five-year strategic plans, underpinned by two-year operational plans.

All of the strategic and operational planning has been undertaken with the intention to create resilient health systems that have the required capacity to cope with demand for health services across south-east Essex. This is about whole system-improvement, which will have many direct and indirect impacts on urgent care and RTT performance.

This will require a greater focus on identification of vulnerable patients, enhanced provision of preventative services at primary and community level and a greater level of integration across health and social care. In line with national trends, the south east Essex system is encountering an ever-growing number of complex cases as a result of changing demographics and multiple long-term conditions. This is presenting a challenge for system capacity, both in planned care and unplanned care.

We have also identified trends of client groups presenting at A&E, where whole-system pathways and community-facing services are required to reduce demand at A&E. For example, these include:

- a high number of people with mental health conditions, attending at times when community mental health services are unavailable
- children and young families without immediate access to primary care
- young people with alcohol-related problems
- older people who have fallen

It is recognised by partners in the system that this may only be addressed through a collaborative approach to redesigning pathways, building system capacity and workforce development, which includes demand management forecasting, development of enhanced community facing services, and system partners working collaboratively to develop staff to ensure that they have multi-disciplinary skills to meet the changing and complex health and social care needs of the local population.

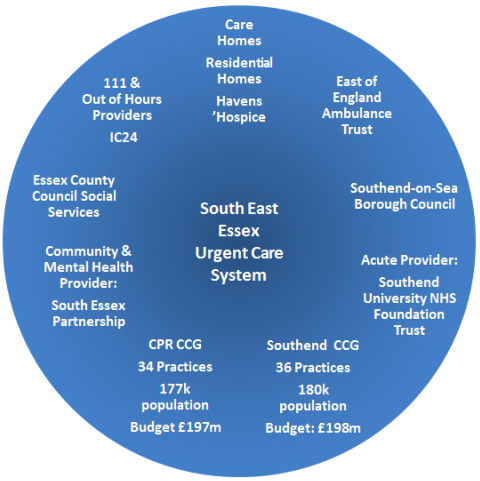
An overview of the two strategic plans can be found on the following 'plans on a page'. The plans on a page demonstrate the vision for the health systems in Southend-on-Sea and in Castle Point and Rochford, and how the systems will operate over the next five years to move to the desired state. The full plans include detailed information about the health demographics of people living in south-east Essex.

The CCGs' operational plans describe the work that the two organisations will be undertaking over the next two years to transform health services. Areas of focus include integration, long-term conditions management, mental health services, planned care and primary care engagement and development. Improvements in each of these areas are essential to support delivery of sustainable urgent and emergency care.

The primary care strategies for Southend and for Castle Point and Rochford *(available upon request)* both emphasise the key role of high quality, responsive primary care in the urgent care system.

South east Essex urgent care system

The urgent care system in south-east Essex comprises a number of health and social care commissioners and providers as well as voluntary and community sector organisations.



For the urgent care system to operate optimally, collaboration and cooperation is required from all partners.

A key element of the system's role is to reduce reliance on unplanned use of hospital services through a greater focus on identification of vulnerable patients, enhanced provision of preventative services and a greater level of integration across health and social care.

Financial Position

The South Essex health economy remains financially challenged with both Southend and CP&R in financial recovery, Southend Borough Council and Essex County Council both face financial pressure in 2015/16 and Southend University Hospitals NHS Foundation Trust reporting a deficit.

A&E and RTT performance 2013/14 and learning for 2014/15 – what will be different
In winter 2013/14, the standards for A&E performance were consistently not met. The biggest single issue was the delivery of the standard that states that patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department. This was despite the fact that overall demand for A&E services in winter 2013/14 was lower than in 2012/13. However, surges in demand during 2013/14 did create significant capacity issues.

The Baseline Position & Challenges to the System
Analysis of a three year period has been undertaken to both evidence and ensure that this plan is focused around factual data and review. Full details are included in Appendix 4 headlines are as follows;

Activity
- 5% increase in A&E attendance in Southend overall with ThorpeBay Practices up by 7% (68.7 per 100,00 – 71.9)
- 14% increase in people arriving by Ambulance(17.7 per 100,000 – 20.6)
- 16% increase in admissions (16.1 per 100,000 – 19.1)
- Mondays had the highest attendances on 33 occasions July 2013 to June 2014, with Sunday attendances being the next highest attendance on 6 occasions . (reference Good Morning Southend data)

Conditions
- 90% of individuals who attend A&E did so for reasons identified with the top 20 highest diagnosis codes.
- Attendances in the top 20 diagnosis codes increased by 3.5%
- 20% of all attendances were for lacerations, dislocation & sprains
- 48% of all attendances do not have a diagnosis code (represents an increase of 25%)

During 2013/14 the hospital struggled to maintain its RTT position, especially patients on the admitted pathway. The challenge was both capacity and managing the decision to admit from the non-admitted pathway.

In 2014/15 the hospital is implementing changes within the RTT programme, both creating head room in the admitted pathway through increased capacity and secondly improvements in their outpatient waiting lists in order to more effectively manage the non-admitted position.

The whole health system in south east Essex is committed to working in partnership to deliver sustainable, system-wide transformational change to improve performance and to manage increased demand for services.

A single performance report is presented to SRG on a bi monthly basis which brings together all the key performance metrics so that the group can track lessons learned from the various initiatives such as the perfect week and the risk summit. The SRG currently receives these as separate reports, these are now being amalgamated into a single integrated report.

Based on our learning from 2013/14, we have worked together to plan for 2014/15 and our focus will be on seven key areas that describe 'what will be different' this year. They are as follows:

1. Improved system governance
2. Improved performance management
3. Implementation of the Emergency Care Improvement Plan
4. Implementation of the revised RTT Improvement Plan
5. Implementation of the Community Recovery and Independence Pathway
6. Embedding escalation processes
7. Creation of the GP hub in Southend

Commissioning Priorities and Required Outcomes

NHS
Castle Point and Rochford Clinical Commissioning Group

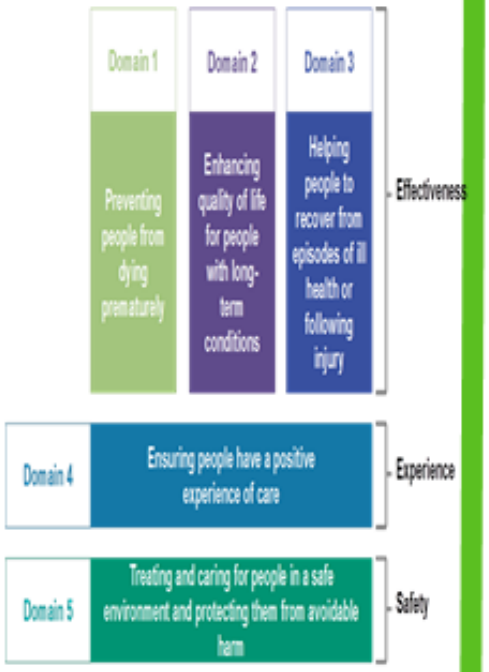
7 Priorities
To meet these

1. **To transform the care of the vulnerable elderly**
2. Delivery of **healthcare at home, not the hospital**
3. Development of **personalised and preventative care** (linked to emerging trends)
4. **Planned surgical care.** Driving higher volume through fewer centres
5. Improving and transforming **children's' health care**
6. Improve **quality in primary care through reduction of clinical variation**
7. **Innovation**: To ensure innovative solutions are central to our transformation process

7 Objectives
To produce these

1. Effective management of LTC, improving outcomes and reducing health inequalities
2. Improve patient experience for both physical and mental health services
3. Drive forward transformation of specialist services, supporting centres of expertise
4. Improve patient safety to reduce harm and increase patient confidence
5. Shifting 5% of resources from secondary to primary and community services
6. Integrating Health Social Care through partnership working
7. Strengthened collaborative commissioning and contracting

5 Domain Outcomes



Section two: What will be different this year?

We have worked together to plan for 2014/15 and our focus will be on six key areas that have been identified by the system as being necessary in order to deliver improved outcomes. These are referred to as 'what will be different' this year

One: improved system governance

We have significantly improved our governance arrangements for system resilience.

The South East Essex Urgent Care Working Group oversaw the implementation of the 2013/14 Emergency Care Improvement Plan.

Since winter 2013/14, this group has been strengthened with increased commitment from system leaders and the addition of the Chief Nurses for Southend CCG and Castle Point and Rochford CCG to the membership to ensure oversight of quality and patient safety across the urgent care system.

The group – now known as the South east Essex System Resilience Group – meets fortnightly. It provides the strategic direction for the work to create a sustainable and resilient health and social care system in the short term to manage immediate system pressures and in the medium and longer term to meet the growing and changing health and social care needs of citizens.

This will be achieved by effectively planning for demographic changes by commissioning services that are fit for purpose, provided in the right place at the right time. The journey towards this transformational change has begun through various initiatives all of which are regularly reported on to the group in order for progress to be tracked and, where necessary, challenged.

It is through this group that this operational resilience and capacity plan has been developed and will be overseen. The group is also accountable for the implementation of the Southend University Hospital Foundation Trust 2014/15 Emergency Care Improvement Plan and 18 Week Improvement Plan.

The membership of the System Resilience Group is as follows:

- Southend University Hospital NHS Foundation Trust – Chief Executive Officer and Chief Operating Officer
- Southend Clinical Commissioning Group – Chief Operating Officer
- Castle Point and Rochford Clinical Commissioning Group – Chief Operating Officer, GP lead for unplanned care and Chief Nurse
- South Essex Partnership University NHS Foundation Trust – Chief Executive Officer and Executive Director of Integrated Services
- East of England Ambulance Service – Locality director for Essex

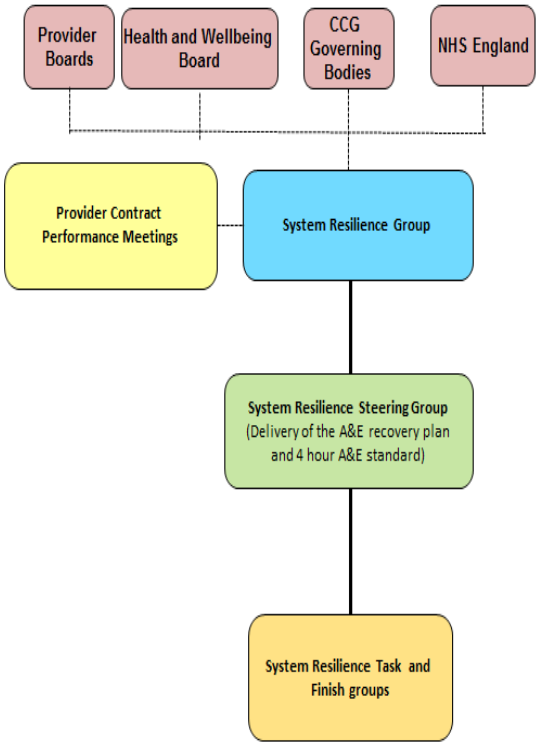
- Southend CCG – Chief Nurse
- NHS England Essex Area Team – Head of Emergency Preparedness, Resilience & Response and Direct Commissioning Representative
- Southend-on-Sea Borough Council – Chief Executive and Director for People
- Essex County Council – Head of Commissioning

The System Resilience Group is supported by a joint PMO between the hospital, the clinical commissioning groups and Southend-on-Sea Borough Council.

Governance structure

System Resilience Group

The System Resilience Group is responsible for ensuring that there is whole system approach to improving patient outcomes and the NHS constitutional standards are met.



System Resilience Operational Group

This group meets weekly to ensure operational remedial action is taken when required to ensure delivery of the four-hour A&E standard.
All providers are represented by senior operational leads, and the group is chaired by NHS Southend CCG. The group reports to the System Resilience Group.

System resilience task and finish groups

The task and finish groups are established as required to deliver schemes that impact on system performance and/or to formulate solutions to issues as they arise. For example there is currently a task and finish group that is examining the issue of perceived high number of GP calls concentrated over the middle of the dayfor urgent attendance by ambulance services; a group to develop a user friendly daily dashboard for partners and a group that has been established to find solutions to the continued issue of problems with patient transport services

In addition to the governance framework outlined above, there are a number of further governance meetings that take place across Southend and Castle Point and Rochford CCGs that contribute to ensuring the delivery of safe and effective health services. These are set out in the following table:

Group	Attendees	Remit
Joint Operational Delivery Group	Southend CCG COO CPR COO SUHFT COO SUHFT Head of Performance CPR Head of Commissioning Southend CCG Executive Lead Planned	To hold SUHFT to account for delivery of unplanned (urgent) and planned (RTT, cancer, stroke, etc.) performance, and where recovery and improvement is required, oversee the development and implementation of action plans to address shortcomings.
Clinical Quality Review Groups (SUHFT & SEPT)	CPR Chief Nurse Southend Chief Nurse Senior staff from each provider organisation	To hold providers to account for safety and quality issues and oversee the development and delivery of actions plans to address concerns.
Operational Executive	Executive leads on respective CCGs	Ensure the delivery of key QIPP programmes.
Contract Management Meetings	Southend and CPR Chief Finance Officers, Chief Operating Officers and senior staff .	Hold provider organisations to account for delivery of the contract and instigate contract management processes where necessary.
Performance Meetings (SUFHT & CCGs	Southend CCG COO and Senior officers from CCGs	To hold provider to account for delivery of RTT, Cancer and A&E targets. This also includes delivery against RAP and associated funding with RTT additional monies.
Joint Executive Group (JEG) sub group of Southend Health and Wellbeing Board	Chief executives and senior officers from SUFHT, SEPT, SCCG, CPR CCG, SBC and SAVS	Oversee progress in transformation programmes which support system resilience, including Pioneer Programme, Better Care Fund, five-year strategic plan and other system-wide programmes

Two: improved performance management

Performance management across the urgent care system is changing for 2014/15, with the use of a whole-system approach. The Surge and Resilience Operation Group will have weekly whole systems performance analytics at each meeting so that informed decisions

can be made based on factual performance across the health economy. Partners are currently working together to identify gaps in data and performance reporting so that the system can be strengthened. An example of this is that SUHFT will now collect data of care homes that do not meet their obligations to accept a returning resident after a period of assessment in A&E. This information will be collated and sent to SBC & ECC to carry out contract monitoring of the care home.

The management of waiting lists is critical to ensure the correct flow of patients throughout the system. Urgent Care can impinge upon this and has a risk to cancel and change elective lists. Therefore the Trust monitors its PTLs on a daily basis and plans bed capacity on a day by day basis through its Operations Room function. In addition to this the COO oversees the PTLs every week where the Associate Directors are both held to account for delivery of RTT, Cancer and non RTT pathways and allows for co-ordination and interaction with surges created through urgent care.

Performance management takes place every week with the hospital, providing focused oversight on the RTT and Cancer positions and ensuring delivery of the revised recovery action plan in line with NHS England revised communication.

Three: emergency care improvement plan

The South-east Essex health system is committed to delivering all of the standards set out in the NHS Constitution. However, between March 2012 and March 2014, the standards for A&E performance were consistently not met.

A risk summit was held on 31 March 2014 to address two key areas of concern. These were non-compliance against the four-hour A&E standard and leadership and concerns with the delivery of urgent and emergency care by Southend University Hospital NHS Foundation Trust.

The risk summit identified 5 key areas as the root causes of system failure:

1. Staffing - vacancies in key clinical roles within the A&E
2. Clinical decision making - timeliness of clinical decision-making in the department was poor
3. Front-end interface - a lack knowledge regarding community and primary care services, and the minors area often lacked medical input to effectively stream patients at the front door
4. Managerial capacity to support culture change
5. Ambulatory care – a lack of ambulatory care pathways who do not require acute admission is not as efficient as it could be

Health system partners immediately put in place a number of actions to support the Hospital to ensure that patients are seen and treated in A&E in a timely way:

- Increase the frequency of Urgent Care Working Group meetings (now known as system resilience group)

- Development of the SUHFT Emergency Care Improvement Plan *(available upon request)* which comprises 14 work streams that address the five key areas identified as the root cause of system failure. We have worked in partnership with ECIST to ensure national best practice is embedded at each stage of the improvement plan
- Implemented a GP streaming model to improve the A&E front end interface
- Implemented a daily system dashboard to better predict surges in demand and system
- Recruited a Director of Emergency Care to drive the improvement plan forward and transform the emergency care pathway

These actions have already had a positive impact and the A&E standard was achieved in May and June 2014.

However, the emergency care system in Southend UHFT remains fragile. In June 2014, heath regulator Monitor announced additional requirements for the hospital to undertake a series of measures to improve the care it provides to patients, and how it is run. These include implementing a credible plan to improve A&E services, developing a plan to improve the speed with which non-emergency patients receive treatment, boosting its clinical and management teams, and conducting a review into the effectiveness of its board.

The SUHFT Emergency Care Improvement Plan is an integrated plan across health and social care which underpins our journey to achieve a safe, effective and sustainable emergency and urgent care system. It builds upon initial improvements in system performance by setting out more complex actions which will take longer to implement but will bring long-term stability to the system.

The plan comprises of 14 work streams which will require the coordinated efforts of health and social care partners to be delivered successfully. The plan is available on request. We expect this plan to have the following impacts:)

- There will be a decrease in the non-elective length of stay for identified ambulatory care pathways. This will be facilitated by patients being deemed as being fit for ambulatory care unless assessed otherwise. This will be in the top quartile when measured against our peers in the East of England
- SUHFT will maintain an acute bed occupancy availability level such that it has capacity by 12 md to meet the demand predicted using the predictor tool which has recently been introduced at SUHFT and is proving to be effective
- Increasing percentage of patients over 75 discharged within 72 hours.
- Increase in the numbers of discharges early in the day – Home for Lunch aim
- Conversion rate to admission - We aim to achieve and sustain a conversion rate to admission within the top quartile for our peer group (within the East of England) by the end of March 2015
- All over 65s will be discharged within 72 hours of admission where clinically safe

- Reduction in patient moves/transfers (no patient should be moved more than twice each admission (unless for clinical reasons) - wards are currently being re-configured to facilitate this with the building work scheduled to be completed by November 2014
- Reduction in readmissions - to achieve the national target of x% by March 2015
- Workforce compliance/rota coverage nursing ratio information being compiled for national publication. See tables below for ED workforce information.
- Staff sickness rate for ED - reduced by 3% by March 2015

The plan will be monitored through the System Resilience Group, which will continue to meet weekly until there has been a sustained improvement in the performance of the urgent care system and compliance against the four-hour A&E Standard in line with the trajectory below.

Trajectory for performance against A&E 4 hour target	Period	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
	Target	90.0%	93.5%	93.5%	94.0%	97.5%	97.5%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
	Actual	**90.11%**											

We will also measure performance against the plan through a suite of KPIs and trajectories for continuous improvement.

The System Resilience Group will be holding a mini Risk Summit on 9 September to assess progress made against the issues identified at the Risk Summit on 31 March and identify further risks and mitigations.

Four: RTT recovery action plan

The hospital was not consistently compliant with the NHS constitutional standards for RTT performance in 2013/14

Performance has improved since April 2014, at aggregate level across all three pathways, although they still have challenges at achieving specialty level in the admitted pathway.

We have agreed and submitted an RTT recovery action plan see Appendix 5 which is being implemented. The RTT recovery action plan has subsequently been updated following the revised direction from NHS England to achieve aggregate compliance from September 2014 onwards and pause on speciality level compliance. This focuses upon speciality level challenges as follows:

- Admitted Pathway - backlog clearance across ENT, General Surgery, Ophthalmology and Oral (Teeth)
- Non Admitted Pathway – Out Patient waiting list reduction in General Surgery, Ophthalmology, ENT together with additional diagnostics
- Incompletes – Diagnostic capacity and pathway validation

The RTT recovery action plan was refreshed in line with revised plans communicated from NHS England and taking consideration of emergency care and also importantly delivery of cancer targets to;

- Achieve and maintain compliance from September onwards and pause on speciality level compliance,
- Tackle challenged specialities to move to maintaining speciality level compliance
- Deliver 16 week position down to level of 18 week waits from January 2013 for incomplete pathways.

The revised plan was submitted Wednesday 2 July in line with NHS England timeline and was supported by them.

Five: Community recovery pathway

In winter 2013/14 demand for admission avoidance services through the single point of referral (SPOR) and community reablement services to support discharge from hospital outstripped supply.

This meant that some citizens were admitted to hospital when they could have been managed better in a community setting and/or were unable to be discharged, despite being medically fit.

While community services and integrated services in south east Essex have provided high quality care to citizens, we identified that there was a shortage in capacity for these services particularly in Southend where it is regularly reported that there is a lack of reablement and domiciliary care capacity at the weekend This capacity gap is being addressed through the development of a community recovery and independence pathway that will include a range of services traditionally referred to as intermediate care, reablement and rehabilitation.

Rather than commissioning separate services to provide reactive, short-term interventions and support to help people maintain or regain their independence, this model represents a single pathway across health and social care. This will include a review of the SPOR to consider extending the scope of the service to include Southend-on-Sea Borough Council's access team.

The focus of the community recovery pathway will be on early intervention, prevention and maximising independence. It will deliver services aimed at preventing admissions into hospitals, reducing length of stays, preventing and reducing the need for on-going packages of care and thereby reducing long-term dependencies on care and support.

This pathway will not only support efforts to keep people out of hospital and remain independent for as long as possible, but also achieve further progress with integrated care and improve the local preventative services offer.

The service will be for adults with a primary need for short-term rehabilitation, recovery from and/or prevention of inappropriate admission to hospital following a period of illness, injury or general deterioration in condition or independence. The service will include crisis and rapid response, early supported hospital discharge, community rehabilitation and reablement, bed based rehabilitation and a falls service.

At the centre of the model will be an integrated multi-disciplinary team providing a 7-day service. The team will include occupational therapists, physiotherapists, social workers, nurses (including psychiatric liaison) and therapy assistants and support workers. The team may also include a GP and a nurse prescriber.

The team will carry out person-centred care, holistic assessment, goal setting and review to enable people to achieve their desired outcomes and reach their maximum level of independence. Staff will have a common set of core skills including assessment, planning and case coordination, as well as retaining their specialist skills and knowledge. Risk stratification will be used to identify people who would benefit from a targeted intervention to increase confidence and promote self-management.

The re-modelling of the pathway will include a review of the processes and systems across partner organisations aligned to the pathway to ensure that recipients do not experience delays in the discharge and referral process, and that services are in place to avoid people going into crisis in the community. This will have a positive impact on the number of people presenting at A&E, the time taken to discharge patients from hospital, the number of people being admitted inappropriately into residential care, achieving the optimum level of throughput thereby avoiding blockages in the system; and a reduction in the number of people requiring long term care and support.

We held three multi-disciplinary workshops during July and August to map out the current pathways and to understand what is working well and where there are weaknesses in the system. The first workshop was held on 25 July – the presentation from the initial workshop is available at Appendix One. A further two workshops are scheduled to take place in September which will scope the “to be” pathway.

Particular emphasis will be placed upon ensuring that there is sufficient capacity in the market to meet changing demand and to incorporate flexibility so that surges in demand can be met. The output from the workshops will inform the redesign of the pathway; Healthwatch, the independent and voluntary sectors and citizen representative organisations have been invited to participate in the re-modelling and to influence the development of integrated, collaborative and sustainable solutions

We plan to have the community recovery and independence pathway modelled by October 2014 to ensure that there is required capacity to meet demand for the winter. A staged approach to the delivery of the model with a focus on functional integration in the first phase will enable partners to test and evaluate the impact of the initiatives prior to considering the possibility of structural integration.

In the meantime, an urgent need for sufficient capacity in step down provision to facilitate early discharge from hospital was highlighted again during The Perfect Week exercise conducted 7-13 July 2014. Whilst step down provision is encompassed within the modelling of the Community Recovery Pathway, swift action is being taken to ensure additional capacity is secured in Southend as an interim measure in order to mitigate against the risk.

Specifications for the services required have been drafted and data has been collated to inform the capacity and locality requirements. A review of the options available to secure additional capacity has been undertaken and a decision has been made to work in partnership with Southend-on-Sea Borough Council to purchase rehabilitation beds using the dynamic purchasing system which will ensure that additional capacity is secured within one month.

Six: embedding escalation processes

Work has been undertaken to improve escalation processes *(see appendix 1)* with regard to response to surge and the speed with which recovery is achieved. However, it is recognised by the wider system that the aligned protocols, systems and procedures need to be robustly embedded to deliver real and sustainable improvement.

An analysis of the weaknesses in the escalation processes has provided the system with key areas that need to be addressed both individually for respective organisations and collectively as a system with each partner taking ownership and responsibility for delivering the escalation plan. As a system, agreement has been reached at the various stakeholder groups on the main deliverables, which are:

- To have a better understanding of the pressure points across the system in order for the escalation process to stimulate the right response to the associated risks
- A review of the RAG status for all system partners
- A review of the daily dashboard system so that it is user friendly and enables stakeholders to immediately identify the key risks
- To ensure that the communication plan is actively delivered by each partner in the system and that training sessions on the processes are delivered to appropriate staff
- For flexibility to be built into commissioned services so that they are responsive to surges in demand
- Agreement on a clear de-escalation process with effective communication to all partners

In order to provide increased grip and local knowledge the current Essex rota is being split with Southend having its own rota with senior management covering 24 hours a day.

Building on the Current System Management Framework

System management approaches were established in winter 2013/14 which included daily system wide teleconference calls, escalation calls as required and situational awareness reporting.

Partners have recently held an escalation workshop the outcome of which has influenced the escalation processes for 2014/15

The above processes have been refined to include senior management in the daily system wide teleconferences which take place at 10.30 each morning, 7 days per week, which includes all urgent care partners at an operational level. During surge periods Chief Officers will join the conference calls and the daily reporting will be enhanced to twice daily. In addition, senior executives are now routinely joining the fortnightly conference calls – this is providing leadership and direction to strengthen the system wide interface.

The system resilience group meets fortnightly with senior management membership from partner organisations. The group is responsible for the strategic delivery of the various projects aligned to the resilience plan and monitors progress made towards delivery.

The system resilience operational group meets weekly and membership consists of operational managers with a collective responsibility for addressing risks in the system.

The CCGs and local authorities are currently in the process of developing an integrated performance scorecard which will enable partners to be briefed on performance of services within the system.

The enhanced system management framework reflects the commitment within the system to respond to risk and the requirement to ensure that all partners are effective and compliant.

The East of England Ambulance Service's Seasonal Pressures Contingency Plan *(available upon request)* will come into effect during surge periods.

Seven: Creation of the GP hub in Southend

Primary Care is at the heart of the wider health and social care system; our vision is that it should provide a high-quality range of accessible services, centred on the citizen.

In Southend, the first GP Hub has been identified and work is currently underway with the practice to develop the target operating model. This will be an integrated approach to the delivery of services with the local authority and a range of providers from the local supply chain.

The modelling for the GP Hub will integrate a rich diversity of professionals and providers, including district nurses, therapists, mental health nurses, health care assistants, palliative care nurses and social workers, with the aim of building a range of health and social care services around citizens, to meet their needs closer to home.

Exciting new initiatives are being developed which will deliver improved outcomes for citizens, the supply chain and the health and social care economy.

The target operating model will ensure that functional integration of system partners is developed and tested. Examples of work that we are planning to undertake includes

- enhanced MDT's (children and adults)
- integrated care record
- enhanced working with care homes
- seven-day working
- mapping of all local services to facilitate more effective communication and sign-posting
- risk stratification for people with long term conditions and identification of carers
- care co-ordinators to ensure that when people need support it is effective, co-ordinated and timely
- development of the supply chain to deliver services around the needs of the local population
- Options for co-locating key voluntary sector provision such as carers services within the GP Hub.
- a workforce development programme to ensure that staff in the system have the required skills to work across health and social care

The Community Recovery Pathway will be implemented initially around the GP Hub as this will enable on-going evaluation and monitoring of the model and the effectiveness.

The first GP hub will act as a pilot for integrated primary care services in Southend and learning from this first phase will be used to scale up this model across the borough.

The GP hub is being developed and tested in Southend as part of the Pioneer programme. Castle Point and Rochford CCG will review the outcome of this initiative to consider adding aspects of it to its "GP Hub" model of a group of practices working together to provide services in such a way as to reduce demand on both planned and unplanned secondary care..

Section three: learning from 2013/14 and planning for 2014/15

As a system, we have planned for winter 2014/15, to ensure that high standards are maintained for the benefit of our citizens. As part of our planning work we have reviewed our system performance during winter 2013/14.

The table on pages 18-20 sets out how our learning from 2013/14 has informed our planning for 2014/15 and what will be different this winter within different aspects of our system

Benchmarking against minimum national standards for urgent care

The analysis of our benchmarking against the Minimum National Standards for Urgent Care identified a number of areas where the standards are being achieved. However standards relating to flows within A&E and demand and capacity management across the system were found to be only partially achieved and further work will be required to become fully complaint. Appendix 3 provides detailed analysis of the five sections: Demand Management, Flow within A&E, Hospital Bed Flow, Delayed Transfers of Care and the Urgent Care Working Group.

Where areas for improvement were identified, these are being addressed through the SUHFT Emergency Care Improvement Plan.

Winter 'look back' event

We held a winter 'look back' event on 14 February 2014. This event brought together key system stakeholders to review the success (or otherwise) of activities and programmes established in winter 2013/14, and to understand what further improvements could be made. We considered performance across the health and social care economy during winter 2013/14 –

The programme for the look back event was developed and agreed by the Urgent Care Steering Group and the event was facilitated by NHS England Essex Area Team.

Intermediate care and community capacity review

The CCGs together with system partners have commissioned a system capacity review of community intermediate care beds and community services to inform commissioning decisions over the next five years. This review will be concluded by 30 June and the first phase of the review recommendations will be in place for winter 2014.

Market shaping event

Southend CCG together with Southend Council are holding a joint Market shaping event where we can help create and steer the market place for beds and services that is more beneficial and economical across the local Southend Health economy. This event is now booked for the 17th October 2014.
In order to provide a baseline position SUFHT commissioned a LOS review and report. The report details that it is a point of prevalence study, and therefore can only reflect an 'on the day' view, however it gave SUFHT a fantastic springboard into Perfect Week.

The report was used together with ECIST feedback to our whole Urgent Care Working Group and it was the Operational Group that had organised the report, so the whole system were involved in its execution (a very important factor). As with Perfect Week, senior executive leadership is imperative, and multidisciplinary and cross organisational involvement is a must.

The report has been played into the 14 projects in the Emergency Care Improvement Plan- particularly Project 6- a comprehensive process for discharge planning- and also forms the basis of the SAFER bundle- which was the major focus for change in Perfect Week. SUFHT Resilience bids detail where the bid links to the LOS Review, and also to the draft sign-off that we have had recently from ECIST. This resilience plan includes the LOS as it will form a major guide to the success of individual schemes designed to help the whole system to be sustained going forward.

This enables a focus upon the whole health and social care system on the issues which are a 'symptom' in the hospital, but are a challenge for change in the whole health and social care economy.

Length of stay review

The Urgent Care Working Group, supported by the Emergency Care Intensive Support Team (ECIST), conducted an acute and community bed census of all patients that had a length of stay in excess of seven days. The census has identified patients who did not have a plan for discharge that was fully understood, and those who could have been managed in alternative settings, if sufficient capacity was available in intermediate care services see Appendix 8

The perfect week – 7-13 July 2014

In July 2014, Southend Hospital conducted a 'perfect week' exercise over seven days.

The purpose of the exercise was to improve performance to produce a step change in safety and patient experience by:

- Identifying and solving problems in patient care
- Working together to get patient care right by identifying and solving problems in patient flow
- Ensuring: Right care, Right place, Right people, Right Time, Every Time.
- Reintroducing all staff to the hospital's core aim of delivering the best patient care together

The exercise was focussed on reducing harm, saving lives and creating a better and more efficient working environment for staff.

The ‘perfect week’ exercise was structured around the hospital’s emergency planning model, using an operations centre as a hub to ensure momentum during week.

The week provided a test for hospital triggers and escalation processes and therefore will be used to help the health system improve its resilience planning for the winter.

At the time of writing, we are awaiting the final evaluation of the ‘perfect week’. However, the main themes identified were:

- Management of number of people presenting at A&E with mental health problems
- Discharge to assess
- Capacity of intermediate care including step-down beds
- Capacity of patient transport delaying discharges from hospital

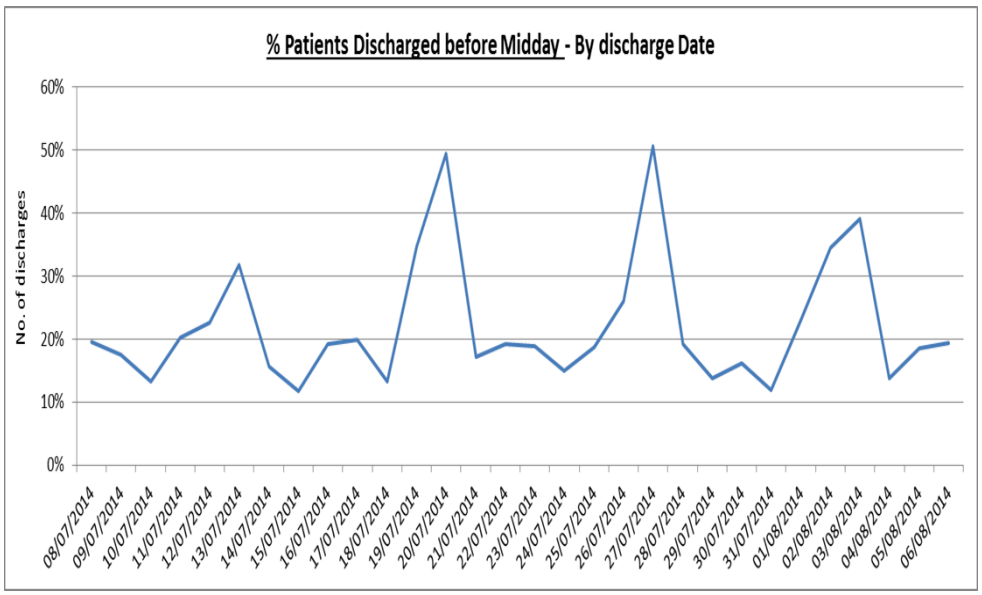
The system resilience steering group will be looking into how we can resolve these issues operationally.

In terms of mental health patients presenting at A&E, we will use the data gathered during the ‘perfect week’ and other supporting data to develop options appraisals for better managing people with mental health problems so that they do not present at A&E out-of-hours inappropriately.

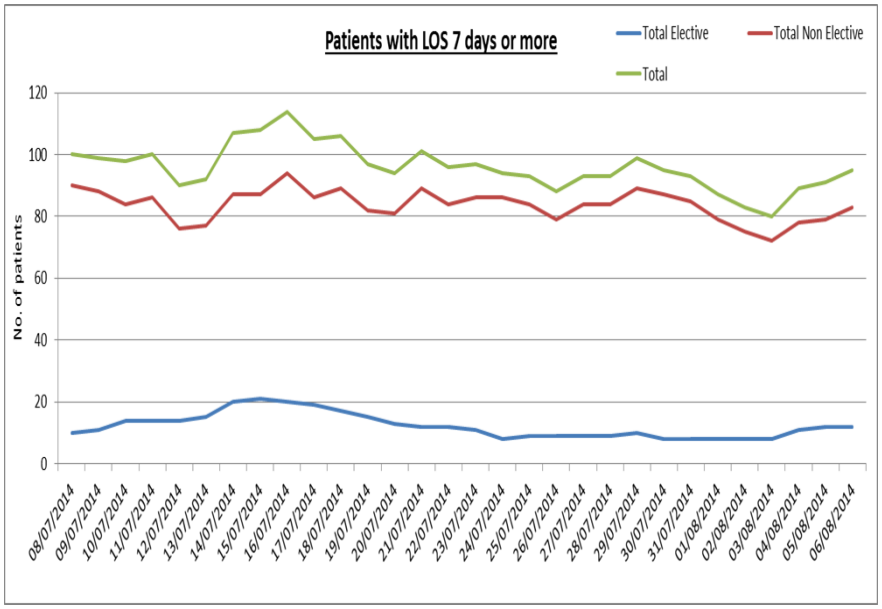
We have begun to commission additional step-down capacity, to be in place by September 14 and we are increasing reablement capacity. We have also begun to develop the community recovery pathway and the resilience grant applications to support the system are currently being evaluated.

The hospital intends to share the final report on the ‘perfect week’ with system partners so that this can inform the system resilience planning. Plans are also in place to repeat the exercise during September.
Information analysis indicates the following outcomes;

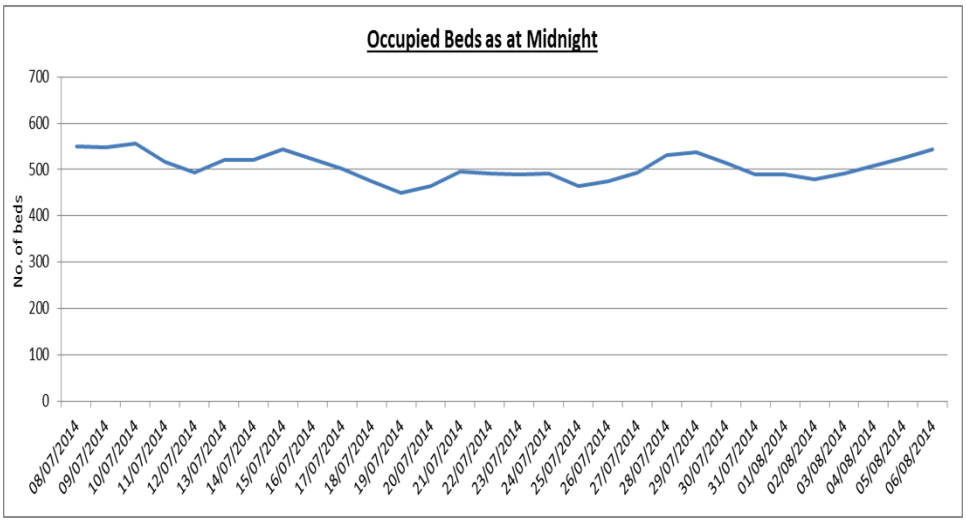
- Increase in discharges to create improved patient flow. (we need to add more text here to explain what the diagrams mean for the system and how this will feed into our strategic planning



- Graph would be better showing days of the week as peaks are at weekends
- Decline in the number of patients with length of stay greater than 7 days



- Resulting in a reduction in Occupied Bed days



Would be useful to add a line showing total number of beds available

Resilience Scenario Testing

A system resilience scenario testing session was held on Thursday 17 July to test the system escalations processes.

Representatives from organisations across the health and social care system attended this session, which was used to test our escalation processes in the event of a high demand on the urgent care system;

- Southend Borough Council
- Essex County Council
- Essex Area Team
- Out of Hours providers IC24
- Southend CCG
- Castle Point & Rochford CCG
- East of England Ambulance
- SUHFT
- Communication leads form SUHFT Southend CCG & Southend Borough Council

The objective of the testing was to validate the South Essex system wide EPRR management processes to ensure that response plans and reporting arrangements are suitable, effective and sufficient. This involved the following;

- To validate CCG system wide locality surge, capacity management, escalation plans
- To test command, coordination and leadership at local level, including activation/escalation of Chief Executive Officer arrangements
- To demonstrate cooperation and coordination with key partner organisations including daily teleconferencing and situational awareness protocols.
- To evaluate internal and external communication processes including information sharing and communicating with the public
- To demonstrate that health organisations have a combined and coordinated approach to recovery at the local level from a significant incident or emergency
- To ensure that lessons identified (including training opportunities) and areas of best practise are captured

The outcome, initial actions and learning from the scenario testing session is set out in the table below and has been incorporated into this plan and summarised as follows.

Area	Issue/gap	Action/mitigation
Capacity	Community Difficult to flex community nursing and reablement/care capacity at the	Increase SPOR to 7 days Review reablement /care provider contracts to create flex in the system for

	weekends and bank holidays.	the weekends e.g. upfront care
	Step Down 59% increase in referrals for step down beds, current capacity unable to meet demand	16 additional step down beds being secured, Current step down capacity being re-profiled to include additional stroke beds. Community pathway development will further increase capacity for 24/7 step down to recovery in the home. Review primary care cover for weekends to facilitate admission to step-down.
	Transport Lack of capacity to cope with late pm discharges during periods of surge.	Discharge pathways reviewed, maximising use of the discharge lounge. Increase ability of transport to flex capacity through the contract. Procure additional pm capacity through resilience funding
Escalation	Current system dashboard focuses on system performance	Progress the work already started to create a dashboard that will support predictive modelling for periods of surge.
	Conference calls useful for system communication but existing community capacity is unable to flex capacity at pace.	Review contracts with community reablement/care providers to facilitate additional capacity at periods of surge Increase 'Home Again Service from 8 to 12 places to support weekend discharge. Review daily , weekend & escalation conference calls
	Variable understanding of the responsibilities of the managers/directors on call when system pressures require escalation.	On call mangers across all organisations to receive training
	No single escalation pathway to chief officer level, a CCG carries bleeps, SUHFT through the switchboard, social care telephone.	Review current communication for escalation with a view to considering all organisation working to a bleep system

Communications

As part of the scenario testing session, communications leads from Southend CCG, Southend-on-Sea Borough Council and Southend University Hospital NHS Foundation Trust. They agreed the following:

- System focus should be on planned communications including general public health/preventative messaging and information about self-care/accessing appropriate care

- It may also be appropriate to provide training/briefings to staff across the system who have regular face-to-face contact with the public

- There is an opportunity to prepare and implement a schedule of preventative messaging based on historic trends and surges

- We identified opportunity to develop a map/protocol for planned and unplanned (i.e. urgent) messaging to better utilise existing tools and channels across the system to include:
  - System partners' websites, social media channels and publications
  - Hospital/council contact centres (including recorded messaging)
  - Key organisational contacts

Once the plan has been agreed all partners will simultaneously publish the plan on their respective web site and communicate this with their key stakeholder groups.

Areas of Focus	How this worked in 2013/14	What we are planning in 2014/15
Rapid Assessment Interface & Discharge. (RAID) Pilot.	This pilot successfully supported admission avoidance for patients with mental health problems.	Plans are in place to commission this service in July 14.(the pilot has been extended to March 2015 which has been funded via a resilience grant)
Reablement	Additional substantive capacity for reablement demonstrated a 10% increase from 70%-80% in the number of people being able to access reablement in a timely way for all appropriate referrals Capacity for intermediate care step down beds & home based intermediate care was insufficient with waiting lists for both services totalling 15-20 patients at any one time.	We are developing a joint approach to commissioning additional reablement capacity across Southend & Essex local authority areas with additional capacity of both step down beds and reablement (including specialist provision) being in place for October 14
Proactive Primary Care Home Pathway	Southend has a higher than national average number of care homes and a higher than national average number of people over 65. There are 466 beds (148 nursing and 318 residential) across ten care homes that have been highlighted as the top ten for emergency admissions from just under 1900 care home beds (500 nursing and 1352 residential) with recent analysis indicating that there are approximately 200 beds unoccupied from the capacity available. In 2013/14 we carried out a care homes pilot with the aim of reducing unplanned admissions from care homes and providing better quality care to care home residents, which would enable more people to die in their preferred place of care. The pilot demonstrated good outcomes for patients and reduced utilisation of health resources with no inappropriate admissions to hospital from care homes involved in the pilot.	The original pilot has been extended until the 31st March 2015 and the CCG is currently in the process of engaging with all care homes in the locality to obtain non-patient identifiable data on A & E attendances which will inform the modelling of the medium to long term solution and provide the baseline position upon which improvement can be tracked. Care homes will also be engaged in shaping the model of delivery by providing feedback to commissioners with regard to primary care solutions to issues that are impacting on the number of attendances at A & E. This is a new initiative and is a proactive approach to finding a solution to the challenges that the system is currently facing with regard to the exchange of patient information. The pilot will be extended to include CPR in 2014/15.

Increased bed capacity in SUHFT	Patient flow through beds during 2013/14 improved with a reduction in patients outlying in non-speciality wards reducing from an average of 70 at anyone time to 5-10	The system capacity review due to be published 30 June will inform commissioning of both acute and community beds as we re-model the pathways from a bed based model to one of community facing support
Day Assessment Unit:	This scheme aimed to increase same day access for frail vulnerable patients to prevent attendance at A&E or an admission. This scheme did not impact during the peak winter period with improved access only being seen since May 2014	Our planning for the coming year will focus on the development of the frailty pathway and ambulatory care pathway which are two of the key work streams that sit within the SUHFT Emergency Care Improvement Plan
Enablers	There were a number of enabling schemes that supported the flow of patients through the hospital and which facilitated the effective utilisation of beds which included: Additional pharmacy capacity, transport, spot purchasing of step down beds and 'upfront care.' surgical & medical navigators, & additional diagnostic capacity.	All partners are committed to ensuring that resilience funding continues to support enabling schemes that do not form part of core business.
GP streaming in A&E	The GP streaming pilot in A&E appears to have worked well diverting 20-25% of patients away from minors which has supported an improvement in compliance against the 4 hour waiting standard	Formal evaluation of the scheme will be completed by 1 July 2014 to inform future commissioning of the service.
Roving GP Pilot to support ambulance crews that would otherwise have conveyed patients to hospital.	The service was in place for 19 days which did not provide sufficient time to carry out a robust evaluation.	A similar pilot was in place across south west Essex which is being evaluated. The outcome of this evaluation will be used to inform our commissioning intentions.

Single Point of Referral (SPOR)	2013/14 saw an increase in the number of direct referrals from GPs for admission avoidance from an average of 40 per month in 2012/13 to 130 per month 2014/15	Partners have identified through the Urgent Care Work streams that there is an opportunity to increase the success of this service by extending cover to 7 days per week. The work currently being undertaken within the Integration Pioneer Programme and the Community Recovery Pathway will influence the co-design of a functionally integrated (in the first instance) SPOR with the Council's Access Service which will improve the pathway and deliver better outcomes.
Dementia Intensive Support team	The outcomes for patients with Dementia supported by the DIST team were good however the activity was low when compared to a similar service in South West Essex.	Clinical leads have reviewed and refined the Dementia pathway bringing together the DIST and Community dementia team into a single service accessed through the existing Single Point of Referral (SPOR).
Home Again Service	The Home Again Service (HAS) facilitated discharge from hospital, supporting people for up to 48 hours post discharge in the Southend area.	This model of working was seen as best practice and has been commissioned across Castle Point & Rochford (CPR) CCG area from July 2014
Intermediate Care step up Ward	An evaluation of the intermediate care step up ward showed that only 11% of the patients in the community intermediate care step up ward were appropriate for the setting.	We have decommissioned the intermediate step up ward and we are now carrying out further analysis to inform the bedded and home-based intermediate care capacity required. We will focus on moving from a system reliant on a bed based model of care to a community based model that strengthens community intermediate care provision to support admission avoidance and facilitate timely discharge to the right setting. This will ensure patients with more complex needs will be able to remain in their homes. Task and finish groups are being set up to review national models of good practice so that we can build on proven models of delivery

Managing admitted back log	Provided additional theatre lists to manage back log	Enhanced back log clearance with outsourcing procedures over the summer to place lists in a good position for winter. Weekly oversight of patient tracker lists by the SUFHT COO
Outpatient/non-admitted pathway	Too much focus on admitted pathway and reactive.	Planned increased outpatient capacity to reduce lists. Referrals management and service restriction policy (SRP) will support reduced referrals into outpatients

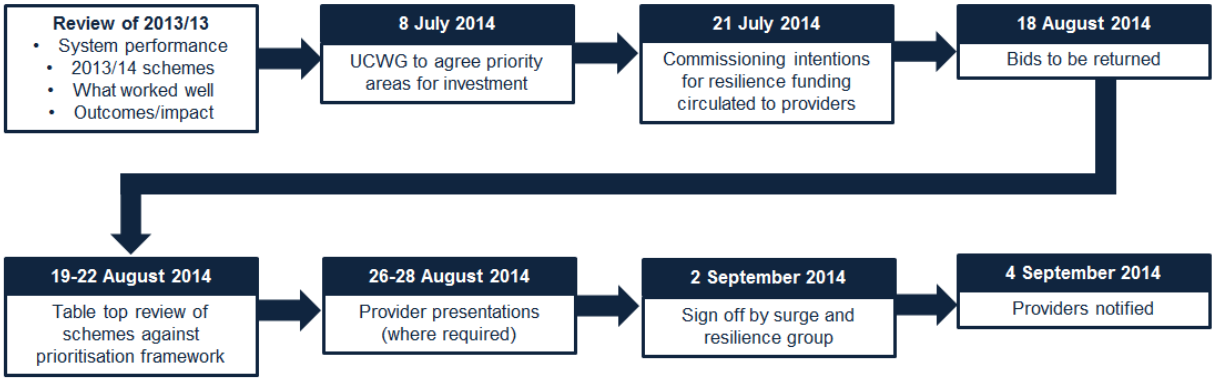
Prevention of and response to respiratory outbreaks	Uptake of the flu vaccine was lower than planned amongst frontline staff working in health and social care. Responses to respiratory outbreaks were not well tested as there were few outbreaks on account of the mild winter. However, the system plans for a response were implemented late into the season, and there was a lack of clarity about roles and responsibilities, especially in regards to care home providers.	A key plank of our planning for escalation and surge is the response that will be required to manage a respiratory outbreak (flu) in care homes. We have worked closely with our public health colleagues to ensure there are robust plans in place across both south east Essex CCGs based of the following guidance: • Managing Outbreaks of Acute Respiratory Illness in Care Homes: Information and Advice for Health Protection Units. (HPA 2012) • HPA guidance on use of antiviral agents for the treatment and prophylaxis of influenza (HPA 2012) Providers have been commissioned to deliver the whole pathway; the service specifications clearly articulate the expectation of providers: • Prior to an outbreak to ensure preparedness and resilience to deliver • In response to the outbreak including: – The management of swabbing – The distribution of antiviral medication Following an outbreak there will be a review of the effectiveness of planning and implementation to inform changes/improvements to the pathway. We will implement a programme to increase uptake of flu vaccinations amongst frontline staff in health and social care. The Seasonal Influenza Outbreak Plan 2014/15 is available upon request.

Real time data and dashboard.

The South East Essex community receives daily summary called “Good Morning Southend”. This provides high level data; attendances, breaches, ambulance off load times, admissions and discharges per day. The community also receives a weekly urgent care dashboard as shown in the following attachment.

Full data analysis available in Appendix 4

Section four: resilience monies



Grant priorities and process

The 2014/15 resilience grants will be awarded to organisations that can evidence the impact that the new projects will have on minimising emergency department attendances, hospital admissions and bed days. Providers will be encouraged to review models of good practice and develop innovative services that are responsive, flexible and support the wider system to provide additional capacity during the winter surge period.

The grant process will include a requirement for organisations to state other funding streams aligned to the bid as this will avoid duplication in the system. A panel made up of health and social care representatives will make the determinations on the recommendations for the award of grants.

A monitoring framework will be incorporated into the grant process to track the impact that projects have had against the baseline position.

The resilience grant process is available in Appendix Two.

Section five: risks

There are three main risks to the plan which are summarised below. Append 7details these risks together with RAG, mitigating actions and risk owners.

Risk one: Southend University Hospital NHS Foundation Trust

Risks to delivery of this plan from a hospital perspective include:

- Workforce across both medical and nursing within the accident and emergency department and also in medical ward areas which may impact upon timely discharges
- Escalation of serious incident status in A&E to key partners when there are no issues in the rest of the hospital has been a challenge previously and will remains a risk that needs to be managed
- For both the Hospital and community services the risk of shortages in other workforce areas needs to be managed, in particular professions allied to medicine such as physiotherapy. This becomes complex given the sub contract arrangements with Southeast Essex partnership Trust

Risk two: East of England Ambulance Service

Risks to delivery of this plan from an ambulance service perspective include the ability to manage the flow into accident and emergency department through effective intelligent conveyancing.

Ensuring that the Ambulance Trust is effectively engaged in this plan remains key risk, which will be mitigated through the use of HALO

Risk three: community capacity

A core element of this year's plan is to have a community focus rather than a hospital bed capacity focus. We need to manage the bed capacity and reablement capacity within the community, in particular the intermediate care beds and care home beds over the winter period. We will need to ensure that there are effective controls around patient flows to ensure that we can maintain bed capacity within the community and work with a number of key care home providers to manage their bed capacity. Again the ability of the community trust to flex capacity when escalation is required.

The CCGs are working with SBC and Essex CC on the re-ablement capacity and demand modelling. SCCG and SBC will be working together as part of the Community Recovery Pathway re-design to ensure that the modelling is also underpinned by process and system re-design which will facilitate compliance.

Appendix 7 details the mitigation actions, risk owners and RAG rating.

Section six: public engagement and communications

Southend CCG and Castle Point and Rochford CCG implemented a significant public engagement and communications campaign in 2013/14 with the objective of diverting activity from A&E to other more appropriate health services in the community.

Planning for the winter campaign started in the late summer with informal research that took place at Southend Hospital A&E gauging what messages around NHS 111 members of the public would respond to.

While elements of the campaign aimed to have a wide reach to hit the broader population of Southend and Castle Point and Rochford, the campaign also included targeted activity for specific audiences that were identified through research conducted in Southend A&E namely, mums with young children and 18-24 year olds.

From this research base, a steering group consisting of members of both Castle Point & Rochford CCG and Southend CCGs' Public and Patient Involvement Groupsinvited members of the public, to help design materials for a campaign.

The following tools were utilised as part of the tactical campaign, which was delivered jointly with other Essex CCGs:

- Advertising wraps around the Yellow Advertiser newspaper in Castle Point and Rochford and Southend.
- Facebook advertisements ran between October and the end of February along with bespoke tweets from individual CCG accounts
- Business cards in display racks were delivered to GP surgeries and pharmacies in December. Posters were also sent out to a range of places including GPs, dentists, libraries, clinics and health centres, councils, children's centres, CVSs, Parish councils and supermarkets.
- Pop up banners were delivered to the five baby clinics in South East Essex with the highest footfall in December/early January.
- PVC banner adverts were delivered to Southend Hospital (outside A&E) and the Salvation Army building in Rayleigh in late December.
- Toilet advertisements were placed at the college and The Forum, running for one month in December.
- Bus Back advertisements ran for one month from the Hadleigh depot for buses going to Southend and Castle Point.
- Posters were produced in Polish, with appropriate messaging taking into account the Polish population in the area.
- Supporting media releases (all of the weekly media releases we issued from Oct to Dec received coverage in the local media)

Along with North East Essex CCG, Basildon & Brentwood CCG and Thurrock CCG, the south east Essex CCGs were also part of the www.getwellessex.com website which was widely advertised via the materials listed above.

The total cost of the campaign was £10,000 each for both Castle Point & Rochford and Southend CCGs.

However, elements of the campaign have not ended there. As well as planning for the bulk of the campaign to take place during the winter, the steering group agreed that there should be on going messaging and raising awareness of elements of the campaign such as the NHS 111 service.

To this end, one of the materials that was commissioned specifically in south east Essex was the “Birthday Bug” children’s book. Aimed at 5-7 year olds, the book tells a family-friendly story with strong messaging around using NHS 111 when it’s not a medical emergency.

Three thousand books were printed as part of the winter campaign budget, and distributed to all local schools in the area, as well as children’s centres, libraries and other public-facing amenities.

During the spring and summer on 2014, members of the patient and public participation group at Castle Point & Rochford CCG have also been visiting local schools with GP leads to read the book to children and reinforce the message to ring 111 if it isn’t a medical emergency. These visits are taking place in conjunction with further media releases about the service to keep awareness going.

As well as trying to effect a cultural change to the way that young people view the 999 emergency service in south east Essex, there has been on going work with older people as well with the production of NHS 111 branded “Bags for Life” which have the 111 logo on it as well as the key message that it’s the number to ring when it’s not a medical emergency. These have been distributed at public events the CCGs’ have been part of in the area, such as Rayleigh Market and the Castle Point Show.

An independent evaluation on the success of the campaign was carried out by a market research company which showed that, broadly, the campaign was successful. In short, the research found that:

1. The ‘Get Well Essex’ campaign appears to have been successful; prompted recall of ‘Get Well Essex’ materials is positive with a quarter of individuals (in bought-in CCGs) recognising one or both types of campaign materials.
2. The core message of the ‘Get Well Essex’ campaign is broadly understood to be that A&E should not always be the first port of call in the event of accident or illness.
3. However, one in five misunderstood the core message of the campaign with more than one in ten taking home the message that A&E should never be the first port of call. This

may demonstrate the importance of highlighting when people should pay a visit to A&E as well as when not to go.

4. Posters and bus ads are best remembered although it is thought a broader range of channels should be used in the future.
5. Individuals who are familiar with the campaign materials are more likely to strongly agree that they have a good understanding of what A&E is and isn't for than those who have not.
6. Individuals who are familiar with the 'Call 111' materials are more likely to say that they have heard of the NHS 111 service and know what it is.
7. There is an apparent preference for 'Call 111' materials which are perceived to be stronger than the 'Yellow Man' alternatives and rated as more informative and easier to understand. The lesson may be that materials should be built around more explicit instruction as to correct courses of action, removing the emphasis from what A&E shouldn't be used for.
8. There is evidence that it is worth carrying the campaign forward in the future; one in five have not yet heard of NHS 111 at all, while over a quarter have heard of it but do not know what it is. Meanwhile, almost one in ten would visit A&E in the event of a cut, minor infection, rash, sprain, strain or suspected break, and awareness of healthcare services for minor illnesses and injuries appears to be lacking.

Stemming from this research are the plans for a winter campaign in 2014. Discussions are already taking place with patient participation groups as to the design and delivery of a similar general campaign such as last year, or whether there should be more targeted activity e.g. arranging visits to care homes in the area to reinforce to staff the importance of when to call NHS 111 as opposed to 999).

There may also be a change of emphasis by making the most out of shared materials, especially in the realm of social media. For example, the shared online video "Dee's A&E Fail" which was produced by NHS Arden CSU for NHS Rugby and Warwickshire CCG was a huge success last year. This shared content may give weight to an argument about giving potential social media campaigns more weight.

Section seven: principles of good practice

The following table sets out our progress towards delivering best practice across the urgent care system.

Area	Approach	Impact
Planning	**Capacity modelling and scenario planning** SUHFT is re-profiling its speciality bed base to ensure right care right plan Weekend planning and discharges are in place to ensure adequate bed capacity on Mondays **111** Strong clinical leadership in performance monitoring of 111 services, with clinicians reviewing disposition data, reporting and following up issues through the urgent care steering group	Reduction in patients outlying in non-speciality wards
Primary Care	Work is underway to develop GP federated models. Access to primary care is being improved for care home residents through the proactive primary care pilot We are actively promoting and supporting the uptake by GPs of the 'Avoiding Unplanned Care Admissions' enhanced service	Over 90% of GP practices have signed up to deliver the enhanced service.
7day working	The south east Essex health and social care system is an early adopter site for 7 day working and is a key plank of the BCF plan We have already successfully implemented 7 day working for social work service facilitating weekend assessment and discharge We will be expanding the social work service providing an attached social worker for A&E to focus on admission avoidance. We are working towards enhancing our seven day reablement/prevention offer involving community nursing and therapists. Our Single Point of Referral providing a rapid response to an integrated health and social care assessment will be expanded to cover 7 days a week.	Facilitates weekend discharge and assessment , reducing the risk of readmissions This will ensure right care right place for patients reducing the number of inappropriate admissions and readmissions through increasing the prevention offer. More patients will be able to access integrated health and social care assessment, and management plan implemented in a timely way to reduce admissions to hospital or residential settings.

Patient Experience	Established Pathways We are developing an integrated frailty pathway that will provide integrated services across acute and community services. An integral part of the pathway will be discharge to assess bedded and home based provision to support right care right place. Ambulatory Care pathways are being extended from two conditions to five. This work is being supported by the Ambulatory Care Network SUHFT have introduced a Rapid Access and Treatment (RAT) pathway in majors and a GP streaming model.	Patients will receive a comprehensive geriatric consultant assessment within 24hours of admission and if clinically appropriate discharge within 72 hours to a community based service. More patients to have their care and treatment in the community. Patient will wait less time to be seen and treated. Compliance against the 4 hour waiting standard will be achieved.
Measurement	A daily dashboard has been developed and is used to predict demand across the urgent care system and circulated to chief officers. The A&E department has implemented a real time dashboard that can be seen across the A&E department and in the control room and a new set of A&E triggers have been developed to better predict breaches in the 4 hour waiting standard.	Once embedded the dashboard will support the prediction and planning for periods of surge and demand. Build pressures within A&E will be escalated at an early stage to ensure mitigating actions are taken to prevent breaches.

The following table sets out our progress towards delivering best practice across elective pathways.

Area	Approach	Impact
Planning	Improved management of non-admitted pathways	Improved management of admitted list.
Pathway Design	Redesigning outpatient clinic profiles based upon capacity and demand modelling	More effective and target outpatient capacity also aligned to other areas such as cancer services
Governance	Weekly oversight of patient tracker lists by SUFHT COO	Closer control of patient tracker lists are quicker targeting of resources to manage lists more effectively.

Appendix 1 – Escalation Policy

Appendix 2 – Resilience Grant Application Process

Southend and Castle Point & Rochford Clinical Commissioning Groups'

Resilience Grant Programme

2014/15

Resilience Grants Programme Framework

1. Purpose of the grants programme

Funding for resilience grants has been aligned to the priorities contained in South East Essex's Operational Resilience and Capacity Plan 2014/15.
The grant programme is intended to encourage and secure innovative service models that will assist in the delivery of the key priorities/ interventions within the plan and also the emerging Integrated Care Pathways, including the Community Recovery pathway.
The grant programme will provide organisations with short term, non-recurrent funding (up to 31/03/15) to assist them to develop and implement services that support resilience and capacity of the health and social care system in South East Essex, with the following priorities:

- Improve local preventative services
- Support efforts to keep people out of hospital and remain independent for as long as possible
- Enable community independence and recovery
- Develop integrated care

These may include services such as:

- Responsive transport service to facilitate discharge from hospital during surge periods
- Crisis and rapid response (including mental health)
- Community rehabilitation and re-ablement
- Enhanced domiciliary care (e.g. night time service)
- Bed based rehabilitation
- Falls prevention
- Services that support A & E recovery

The above list is not exhaustive and all innovative projects that meet the agreed priorities will be considered. This is an opportunity for Providers to adapt, diversify, and where appropriate to work in collaboration with other Providers to propose service models for delivery that demonstrate how proposed services will help to deliver the priorities in the plan.

1.1 ***Integrated Care Pathways***

The emerging Integrated Care Pathways in Southend and Castle Point and Rochford, include a range of services traditionally referred to as intermediate care, re-ablement and rehabilitation. The focus of which is on early intervention, prevention and maximising independence. The Pathways are intended to deliver services aimed at preventing admissions into hospitals, reducing length of stays, preventing and reducing the need for on-going packages of care and thereby reducing long-term dependencies on care and support. Effective and coordinated services will achieve longer-term benefits for the health and social care economy. Rather than commissioning separate services to provide reactive, short-term interventions and support to help people maintain or regain their independence, this model represents the commissioning of a single pathway across health and social care.
These pathways will not only support efforts to keep people out of hospital and remain independent for as long as possible, but also further progress integrated care and improve the local preventative services offer.

2. Priority areas

Proposals must be person-centred, outcomes and goals focussed and support the following:-

- Domiciliary out of hours services
- Responsive transport to meet demand during surge periods and to facilitate timely hospital discharges.
- Reducing A & E attendance

 Supporting people to manage their health conditions in the community
 Expand, adapt and improve established pathways for high intensity users
 Ensuring patients with Mental Health needs have access to improved and swifter care
 Prevention and maximising independence
 Recovery and enablement services
 Integrated care planning and delivery of care coordination cross the whole continuum of health and social care
 Crisis and rapid response, including mental health
 Community rehabilitation and re-ablement
 Bed based rehabilitation
 Falls prevention
 Consultant led rapid assessment and treatment systems
 Processes to minimise delayed discharge
 Reduction of A & E attendance and admissions (and re-admissions) from care homes

3. Working with multi-disciplinary teams

Providers will need to demonstrate ability to work with multi-disciplinary teams and to adopt a whole system approach to enable effective service delivery and best outcomes for patients. This may include working with the following:

 Hospital discharge team (social care)
 Integrated Community Teams
 Community Matrons
 Locality social workers
 Mental Health services
 Community Geriatrician
 GPs
 Voluntary sector
 Re-ablement providers
 Private sector care providers

4. Service principles

The following are our service principles which Providers may wish to consider in proposals, as appropriate:-
 Single referral route
 Promoting Single joint assessment
 Single point of referral (SPOR)
 Working with NHS 111 to secure signposting to the best service to meet patients urgent care needs
 Positive risk management
 Safeguarding principles
 Promote 7 day service
 Equalities
 Right care, right time, right place
 Care Act 2014
 Person-centred

5. Funding allocation and Governance arrangements

The neighbouring CCGs of Southend and Castle Point & Rochford share their acute provider – Southend University Hospital NHS Foundation Trust (SUHFT) – and community and mental health provider – South Essex Partnership University NHS Foundation Trust (SEPT).
The CCGs in this health system face a system-wide financial challenge and therefore welcome the allocation of additional monies to support operational resilience. This allocation of funding will be used to offer grants to providers across the health and social care economy who can successfully demonstrate ability to implement and deliver services that contribute to South East Essex's Operational Resilience and Capacity plan 2014/15.
The South East Essex CCGs are required as part of their constitution to be accountable and transparent in the performance of their obligations, including in relation to expenditure. Therefore robust quality, financial and risk management systems will be put in place for compliance.

6. Grant limit and payment arrangement

The payment of a grant to a successful organisation is conditional upon the receiving organisation entering into an Agreement with the CCG to comply with all conditions attached to the grant. In particular, please note:

Before any payment of the Grant Commissioners may ask organisations to provide a full set of audited / certified accounts for the preceding financial year, signed by two members of the organisation's committee.

Commissioners may also ask for relevant policies and procedures before the payment of a grant can be made, for example, Safeguarding.

If an organisation fails to deliver the services agreed, or, if the organisation uses the Grant for purposes other than those agreed, the CCGs reserve the right to recover all or part of the grant awarded.

Payment arrangements for the various grant limits are detailed in table 1 below.

Table 1 Grant amount	**Payment arrangements**
Up to £10,000	Once the grant conditions have been met and the agreement signed, an upfront payment will be made to successful providers for the whole amount by 30th September 2014.
£11,000 - £50,000	50% of the total grant amount will be made by 30th September 2014. The remaining 50% will be paid on 30th January 2015, subject to satisfactory performance.
£50,000 - £100,000	50% of the total grant amount will be made at the start of implementation of the service. The remaining 50% will be paid on 30th January 2015, subject to satisfactory performance.
Over £100,000	One third of the total grant amount will be made by 30th September 2014. Thereafter, and , s*ubject to satisfactory performance:-* A second payment (one third) will be paid on 30th January 2015. A final payment will be made on 30th March 2015 for the remaining one third.

Appendix 3 – Minimum Care Standards Checklist

Meeting the National Standard for Urgent Care

Minimum Standards Checklist

Essex Area Team

UCWG

This checklist sets out a number of basic requirements that need to be in place in all health systems in order that the 95% four-hour wait standard can be achieved and maintained on a consistent basis. The checklist is broken down into five sections: Demand Management, Flow within A&E, Hospital Bed Flow, Delayed Transfers of Care and the Urgent Care Working Group.

Demand Management

Action	In place	Partially in place	Not in place	Date (to be fully in place)	Brief outline of evidence/ action to be undertaken
Public Information Public information campaigns under the "Choose Well" brand should be in place.	In place				Campaign implemented , local 'Not always A&E' campaign completed . Banners on buses children's story book published & circulated to children's centres. QOF A&E improvement plans required from primary care. Further planning & Stakeholder mapping in train
Proactive Case Management There is reasonable evidence that risk stratification with an evidence-based tool such as the Devon predictive model with associated case management can reduce admissions. In order to focus resources this needs to be targeted on the very frail elderly – between 0.5 – 5% of the practice list including >75s that don't access health. The use of "virtual ward" techniques can ensure a rigorous approach to the management of this group of patients.	In place				Practice level MDTs in place, patients risk stratified using combination of professional judgement and an integrated health and social care information system called care trak which facilitates risk stratification based on a number of parameters eg nos of LTC admissions to hospital utilisation of social care ect. Community matrons case manage complex patients in the community and there is a single point of access to which all community & acute professionals can refer patients at risk of admission to hospital. Risk stratification DES offered to practices which will build on existing frameworks. Fully mobilised by September 2014
Senior Clinical Review of Care Home Residents Care home residents are at very high risk of hospital admission; a mechanism		**Partially in place**		30/9/14	The care home pilot involving weekly ward rounds medication reviews & MDT concluded 11/04/14 Evaluation to be

should be in place for senior clinical review of residents who have an urgent care need before an ambulance is called. This should be supported by elderly care physicians especially for the top 5-10 homes with high admission rates.					published 25th April . Commissioning model agreed & commissioned 30st June 2014. Fully Mobilised 30st September 2014..
Management of Ambulance Calls The conversion of an ambulance call to a conveyance to hospital should be proactively managed; this can be done by call triage at the ambulance control centre and by deploying emergency care practitioners to certain calls to avoid a trip to hospital. Conveyance rates should be benchmarked and brought to a locally agreed level. Ambulance referrals to alternative services should be actively monitored with a specific focus on those patients who are sent home from GPs to wait for an ambulance (to help reduce batching).	**In place**				Triage is in place, all ambulance crews have access to alternative pathways for patients to reduce conveyance to hospital. Ambulance crews have access to ECPs specifically trained in admission avoidance and training is being rolled out across the generic crews locally. Recently piloted a GP' telephone/ visit triage for ambulance crews who with additional advice think they may be able to prevent a conveyance to hospital. Evaluation to be published 24th April future commissioning decision by 31st May 2014
Consultant Triage Service The ability of the hospital to divert patients away from a hospital bed to a more appropriate setting is key. This can be best achieved by a consultant-provided triage service. This involves an experienced consultant taking calls from GPs or ambulance crews and giving advice on appropriate alternatives. This requires the consultant to be able to directly book patients into a community-based rapid response service, an urgent OP appointment diagnostic tests or ward visits. It is rarely practical for a hospital to provide such a service 24/7 but a 14/7 service would provide cover at peak periods. Admissions from A&E to the main hospital should then only be made after this senior review. It would be helpful to undertake a review of diagnostics that GPs can access/undertake such as, troponin levels for low risk chest pain.		Partially In place		**30/09/14**	There are currently a number of consultant vacancies in the trust which is impacting in this area. Recruitment is ongoing but there is a heavy reliance on agency staff. The CCG have put in place a CQUIN for this year to facilitate consultant triage for GP admissions. Community Geriatrician commissioned to support the community frailty pathway & reconfiguring job plans in the acute to increase the presence of community geriatricians on the emergency floor
Ambulatory Care Pathways The maximised use of ambulatory care pathways for available admissions such as cellulitis and IV antibiotics should be in place. Use of these services should be monitored. Pathways should be in place for all those conditions in the directory of ambulatory care.		**Partially in place**		TBC will be determined by work with the antioanl team	Cellulitis, DVT pathways in place, Community teams mange simple IV drugs, more complex attend the day assessment unit Hospital have joined the Ambulatory care network & will be working with the team to increase the ambulatory care pathways

					Team site visit TBC
In-Hours Access to Primary Care Poor GP access can be linked to patients directly accessing hospital or ambulance services with a primary healthcare need. Commissioners should ensure that in-hours access to a GP is acceptable including full 8-6.30 cover, easy telephone access, advance booking, promotion of walk in services etc. GPs triaging appointments will increase access and ensure that patients are accessing the GP appropriately, GPs can redirect to other services as appropriate.		Partially in place		30/09/14	Practices have individually implemented a number of schemes to increase access such as, increased opening, GP telephone triage, same day appointments however this is not consistent across all practices. Next steps will include supporting practices to develop robust lead clinician models that increase access to primary care through primary care transformation fund. There is an enhanced service in place for unplanned care, and we are implementing an improving access programme across all member practices.
Out-of-Hours Access to Primary Care Robust systems should be in place to ensure that OOH care is meeting the service standards set for GPs. GP services co-located with A&E departments should have active triage of patients from the A&E front door to the primary care service if this can meet the clinical needs of the patient.	In place				OOHs access to primary care is situated in A&E and patients are diverted as appropriate. Providers are supportive and increase capacity at peak times as requested
NHS 111 The local 111 service should be meeting relevant KPIs. The DOS developed for 111 should be widely available so primary care, community services, social care, ambulance and A&E all know what services are available.	In Place				

Flow within A&E

Action	In place	Partially in place	Not in place	Date (to be fully in place)	Brief outline of Evidence/ action to be undertaken
Seven Day Analysis of Breaches of the 95% Standard This enables the local system to analyse why breaches are occurring to aid corrective action. (Individual breaches should be analysed by reviewing the A&E record rather than relying on IT records). The urgent care working group (UCWG) should examine seven-day analyses at each of its meetings where the 95% standard is not	In place				Breach analysis by senior hospital staff is in place and short cycle improvement plans are implemented to address immediate and emerging issues.

being met locally. Short cycle improvement plans should be implemented to address root causes of breaches.					
100% Minor Cases Compliance Minor cases should not breach and 100% compliance with the standard should be in place. Exception reports should be provided for the UCWG.		Partially in place		30/06/14	Breach analysis by senior hospital staff is in place. Short cycle improvement plans are implemented to address immediate and emerging issues. Southend A&E improvement plan in place with clear trajectories to achieve compliance
Booking Patients Prompt booking of patients should take place to reduce ambulance handover delays.					
Patient Tracking and Blockages Within A&E, a computer-based system to track the patients journey through their stay within A&E should be in place together with a senior named individual on each shift whose job it is to unblock any delays in the patients journey through A&E. Decision making could be further enhanced with general manager presence in A&E over the weekends.		Partially in place		30/06/14	We have a newly installed PAS which has some A&E functionality but does not currently support the tracking of patients at all stages through A&E. Patients are tracked manually and the nurse in charge is supported by the Clinical Site Manager to unblock any delays. The A&E and Site Team are supported by general management presence 24/7 as an interim measure to
Diagnostics Waits due to delays in pathology or radiology should be rare. There should be 7 day access to diagnostics for A&E, EAU and all wards including admission avoidance schemes. Requests from A&E should be prioritised for immediate response. There should be escalation processes in place if delays are occurring.	In place				Access to diagnostics are not generally an issue. There is 7 day access, A&E is prioritised, escalation is effective and delays are uncommon.
Medical Assessments Delays due to first medical assessment should be rare. Patients should be seen by a clinician within one hour and there should be appropriate escalation where this is not delivered. This should be monitored daily with the breach analysis.	In place				This is monitored daily through the breach analysis. Delays do occur when there are shortages in the availability of senior decision makers and/or when there are particular surges in attendances. Rapid Assessment & Treatment (RAT) implemented in Majors GP streaming pilot implemented , evaluation to be published August 8th 2014
Access to Specialist Opinion Delays due to specialist medical opinion should be unusual and where this is a frequent cause of delay, mechanisms should be established to speed up access to specialist doctors, or develop		Partially In place		30/06/14	Access to specialist opinion is generally good but there are inconsistencies and these are being addressed through the development of a new escalation process.

admission right pathways from A&E. SOPs need to be in place in order that staff know when to escalate.					Revised escalation process implemented April 2014
Mental Health Liaison Effective psychiatric liaison should be in place including escalation processes with the mental health provider if required.	In place				Psychiatric liaison is in place and generally works well but there are occasions when the escalation could be improved and we are working with partners in Mental Health to make this service more robust. Rapid Access Interface Discharge (RAID) model implemented in A&E
Appropriate Use of A&E Patients who do not need the facilities of A&E should have direct access referrals to the appropriate specialty (e.g. gynae referrals direct to gynaecology, paediatric admissions to PAU, GP expected patients direct to MAU etc.). This should include redirection away from hospital if this is more appropriate.	In place				A range of direct access services are in place for direct referral to AMU, SAU and Paediatrics. There is on-going work to improve direct access for gynae patients.

Hospital Bed Flow

Action	In place	Partially in place	Not in place	Date (to be fully in place)	Brief outline of Evidence/ action to be undertaken
Expected Date of Discharge Each emergency patient should be given an expected date of discharge (EDD) upon admission with an expectation that delays in the patient journey through the hospital stay should be unblocked to allow the EDD to be met. The application of EDD and compliance against EDD should be audited and reported to the UCWG.	In place				All EDD`s are set at admission by the consultant, and documented in the medical notes and transferred to a ward white board, . Daily MDT white board meetings take place, and a report is produced from each meeting and faxed to the hospital control room. Information is given for beds planned that day, beds planned for the following day and any patients that are safe to transfer an acute speciality bed into a non-speciality bed. The information is used for efficient bed management throughout the day and night. The EDD`s are checked each day via the white board meetings and formally audited via the discharge audit.
Bed Availability The hospital will need the appropriate real time systems in order to make available the required number of empty beds to meet the days demands; these beds will comprise both those beds available at 0600 and those freed up through discharge during the course of the day. It is essential that the latter are made available during the course of the morning otherwise a logjam will result as patients sitting in A&E needing a bed	In place				A live situation of bed availability, along with immediate and future demands and capacity are available at all times in the hospital control room. Three bed comm cell meetings are held each day at 09.00 / 13.00 and 16.30. Attendance from nominated staff from each business unit is mandatory and is led by a standard operating procedure (SOP).

wait for an afternoon discharge.					A further SOP leads on the flow of emergency patients from A/E and both AMU`s to provide a safe patient journey. Three beds must be available in each AMU at all times, or this will trigger to escalate to the admission and discharge manager and the business unit manager of the day. 10 beds in each AMU must be made available for the night.
Next Day's Bed Requirements Each day the hospital should calculate the next day's bed requirement; this will then be met by empty beds available at 0600 plus that day's discharges; the latter requirement should be made up of the planned discharges of a set of named patients. Assessment for the forthcoming weekend should be completed on Thursday with escalation measures taken should predicted weekend discharges be insufficient to meet predicted admission rates.	In place				Bed requirement is planned using a bed predictor tool that has a rolling prediction of expected activity split between medicine and surgery. This is audited and discussed daily and is 95% accurate, with some slight seasonal variation. The bed availability for the next 24 hours is planned using the white board meetings and faxed forms as stated above in sec 1. Weekend planning using a directory of services is completed on Thursday and finalised on Friday. This is shared with all relevant staff including on-call staff within the organisation and the CCG. An expected EDD list is produced on Friday from ward white board planning, to show expected admission and discharge numbers for Friday, Saturday and Sunday. These are monitored, checked and audited. The weekend flows are presented to executives each week at the comm cell meeting, and shared with all ward managers, matrons and consultants.
Senior Medical Reviews Senior medical review is critical to ensure the day's discharges are made; a particular day's discharges will need to be preceded by a senior medical review early the following morning. Unless this happens, there will be insufficient beds made available during the morning to meet that day's demands. Daily consultant ward rounds and during periods of peak demand twice daily consultant ward rounds should take place.	In place				Consultant ward rounds take place at least daily on all wards, and EDD`s are discussed. Any delays in discharge planning are discussed with the discharge co-ordinators and appropriate plans made to unblock. In times of escalation, consultants undertake extra ward rounds to review the medically fit status of all patients. There have been on-going issues with the flow of mental health patients waiting assessment or transfer to mental health services. There is currently a Pilot service

					(RAID) which started on 20.01.14 to provide referral to assessment within 2-4 hours. This is being monitored and audited. There are however still some delays with access to Mental Health beds.
Morning Discharge Rates Morning discharges are key and the hospital should aim to make 70% of the day's discharges before 1300 so beds can be made available. This enables the hospital to stay ahead of demand from A&E for beds. Time of day of discharge should be actively monitored on a daily basis by ward with results reported to the UCWG. This should include weekends.	In place				Efforts are made to plan discharges before midday. Policy is in place to advise that EDD`s , section 5 notifications and TTA`s are all completed 24 hours in advance of the medically fit status, allowing timely discharge from the hospital. All patients for discharge will be transferred to the discharge lounge by 11.00am
Mental Health There should be provision of specific services for patients such as those with mental health problems.		Partially in place		31/07/14	Rapid Access Interface Discharge (RAID) model implemented in A&E. This was a winter pressure scheme which evaluated positively & continues while commissioning/ business cases are prepared Psychiatric liaison is in place and generally works well but there are occasions when the escalation could be improved and we are working with partners in Mental Health to make this service more robust Dementia Intensive support team aligned to A&E support discharge & follow up from A&E .
Use of Discharge Lounges Discharge lounges should be both available and appropriately sized. They should be a comfortable place for a patient to await discharge without occupying a much needed hospital bed.		Partially in place		31/05/14	The hospital are in the process of developing a new comfortable lounge area to take 15 patients a day to free beds.

Delayed Transfers of Care (DTOCs)

Action	In place	Partially in place	Not in place	Date (to be fully in place)	Brief outline of Evidence/ action to be undertaken
Formal Accounting of Delayed Transfers of Care The counting of DTOCs is critical as CCGs, social care departments, community hospitals and the acute hospital itself will often have different versions of DTOC numbers on any particular day. This can be avoided by formally signing off DTOC numbers and the cause for their delay by representatives of all key organisations. An agreed breakdown of DTOC numbers and cause should always be available. This should be considered by the UCWG at each of its meetings. DTOC occupied bed days (OBD) rather than DTOC numbers should be monitored.	In place				DTOC are formally signed off each week by a nominated lead in both health and social care . All DTOCS are reported weekly with reasons and responsibilities for delays clearly identified,
Maximum DTOC Level There should be a locally agreed maximum DTOC level (OBD based) with decisive action overseen by the UCWG to keep actual numbers below this maximum. This should be below 3.5%.	In place				DTOCS are not a major issue for Southend and numbers are low. The agreed joint protocols are praised by the intensive support team
Transfers to Other Hospitals Transfers to other acute hospitals need to be initiated and managed by the transferring hospital but the CCG may need to intervene if there are unreasonable delays by the receiving hospital, or NHS England in the case of transfers to a specialist provider. SOPs need to be in place in order that staff know when to escalate, acute Trust CEO notification should be part of this process.	In place				CCG notified where delays take place, this is normally around transport issues and the CCG support to ensure timely resolution. This is not a major issue for Southend.
Transfers to Community Services Transfers to NHS community services may need the intervention of the CCG where there are unmanaged delays. Transfers should be available on a 7 day a week basis. Monitoring of flows out of community bed based services should also be in place. Arrangements should also	In place				7 day services are in place for transfer to community services , there are commissioning plans in place to increase capacity within these services during 2014/15

be in place to review/ monitor non bed based capacity to ensure that patients who are being cared for in their own homes are being reviewed regularly and care stepped up/down as needed. The whole system should know what capacity is available.					
Social Care DTOCs Delays due to social care should be dealt with under a specific local policy with the general principle that an acute hospital bed cannot be used as a temporary care home placement whilst a patient is being assessed or exercising choice about preferred social care placement. Funding sources such as national winter funds or NHS transfers to the local authority can be used to fund "discharge to assess" placements where a patient is placed in an appropriate facility away from the acute hospital whilst assessment or placement is completed. These should be available on a 7 day a week basis. This should also be in place for the management of those patients on a CHC pathway.	In place				There are facilities in place over and above existing community services and beds to spot purchase both community beds and packages of care to facilitate discharge to assess 7 days a week. The process and on-going monitoring and management are undertaken by the Hospital Admission and Discharge manager.
Patient Choice Policies Robust locally agreed patient choice policies should be in place, which are properly adhered to, with issues escalated as appropriate.	In place				Patient choice in place
Home Equipment To ensure that there are no delays in home equipment provision, local stocks should be sufficient for holiday periods and accessible 7 days a week. Home assessments and access visits need to be monitored to ensure there are no delays between the home visit and patient discharge.	In place				This is not a major issue for Southend, as we have developed a local stock with the rehabilitation department for small items.

The Urgent Care Working Group

Action	**In place**	**Partially in place**	**Not in place**	**Date (to be fully in place)**	
Implementing Actions	In place				UCWG review acute

Where the 95% standard is currently not being met, the UCWG should assess its local system against each of the checklist requirements. Where these are not in place, a date for introducing each measure should be agreed.					performance against the standards
Weekly Meetings Where there are ongoing problems in local urgent care, the UCWG should meet weekly until the problems are solved and the 95% standard met.	In place				There are daily Chief officer conference calls when pressures are significant. UCWG will continue to meet weekly until A&E standards are met and sustained.
Seven Day Analysis The UCWG should receive the seven day analysis at each of its meetings; ensuring minor cases are at 100% and non-bed breaches are minimal. Short cycle improvement plans should be implemented to address causes, and reported back to the UCWG the following week. RCAs of system failures should be owned and undertaken by individual organisations and the findings reviewed by the UCWG.	In place				RCA are requested where the trust fails to meet the standard and these are reviewed at the UCWG as well as an operational steering group
Bed Flow and Discharge The UCWG should ensure the necessary bed flow and discharge arrangements are in place, including reassignment of finance where this is necessary.	In place				Recent issues have related to A&E flows, community health and social care services have flexed capacity to ensure timely discharge of patients and minimal DTOC
ECIST A struggling hospital will usually have been visited by the Emergency Care Intensive Support Team (ECIST). The UCWG should review the results of any ECIST visit and certify that the visiting teams' recommendations have been fully implemented.	In place				ECIST reviewed with the trust the failure to meet the A&E standard. A risk summit was held with system partners, and regulatory organisations.. The outcomes from the summit and the ECIST review have been included in the Hospital A&E Improvement Plan which will be monitored through the partners and there are also weekly calls
External Intervention	In place				Monitor are working

Where an UCWG is not securing the 95% standard for a prolonged period, then there may need to be external intervention. This may include changing the chairing arrangements of the UCWG and/or referring individual providers for regulatory intervention.					with the Trust

Appendix 4 – Activity

RTT – tracking and projection. Achieved aggregate, challenged at speciality level in Admitted Pathways.

Southend			July	August	Sept	October	Nov-Mar	
ADMITTED 90% Threshold	MAIN PROVIDER	Clock Stop< 18	**1626**	**1875**	**1865**	**1704**	**8920**	
		Clock Stop >18	250	227	205	184	975	
		Total Stopped	1,876	2,102	2,070	1,888	9,895	
		% Compliance	**86.67%**	**89.20%**	**90.10%**	**90.25%**	**90.15%**	
	OTHER PROVIDERS	Clock Stop< 18	375	375	375	375	1875	
		Clock Stop >18	51	51	51	51	255	
		Total Stopped	426	426	426	426	2130	
		% Compliance	88.0%	88.0%	88.0%	88.0%	88.0%	
	COMMISSIONER TOTALS	Clock Stop< 18	2001	2250	2240	2079	10795	
		Clock Stop >18	301	278	256	235	1230	
		Total Stopped	2302	2528	2496	2314	12025	
		% Compliance	**86.92%**	**89.00%**	**89.74%**	**89.84%**	**89.77%**	
NON- ADMITTED 95% Threshold	MAIN PROVIDER	Clock Stop< 18	8920	9685	9149	7947	44351	
		Clock Stop >18	633	690	390	410	1848	
		Total Stopped	9553	10375	9539	8357	46199	
		% Compliance	**93.37%**	**93.35%**	**95.91%**	**95.09%**	**96.00%**	
	OTHER PROVIDERS	Clock Stop< 18	1170	1170	1170	1170	5850	
		Clock Stop >18	77	77	77	77	385	
		Total Stopped	1247	1247	1247	1247	6235	
		% Compliance	93.83%	93.83%	93.83%	93.83%	93.83%	
	COMMISSIONER TOTALS	Clock Stop< 18	10090	10855	10319	9117	50201	
		Clock Stop >18	710	767	467	487	2233	
		Total Stopped	10800	11622	10786	9604	52434	
		% Compliance	**93.43%**	**93.40%**	**95.67%**	**94.93%**	**95.74%**	
								TOTAL
Admitted	* Additional Activity (as per the 30/6 Submission		160	160	160	160	1283	1923
	Additional Activity Agreed Costs		£46,439	£46,439	£46,439	£46,439	£232,196	£417,952
	Non -Activity Agreed Costs (validation/Staffing)		£22,222	£22,222	£22,222	£22,222	£111,112	£200,000
Non Admitted	* Additional Activity (as per the 30/6 Submission		528	528	528	528	2643	4755
	Additional Activity Agreed Costs		£64,672	£64,672	£64,672	£64,672	£323,360	£582,048
Estimated number of >18 week INCOMPLETE			1,795	1,793	1,772	1,724		

Cancer performance – Good performance with the exception of 62 day target, predominantly Urology, Lung and Upper GI.

All cancer waiting time targets: April 2014 to date

Target		2014/15						
		April	May	June	Q1	July *	August ^	Q2 ^
14 day 2ww first seen	**93%**	93.6%	94.9%	92.9%	*93.7%*	94.0%	*93.3%*	*93.8%*
14 day symptomatic breast first seen	**93%**	86.6%	92.1%	98.0%	*91.7%*	95.2%	*95.1%*	*94.5%*
31 day 2ww rare first treatment				100%	*100%*			
31 day first treatment	**96%**	98.2%	96.4%	98.8%	*97.8%*	98.9%	*97.4%*	*98.1%*
31 day subsequent drug	**98%**	99.1%	100%	99.2%	*99.4%*	100%	*100%*	*100%*
31 day subsequent other		100%	100%	100%	*100%*	100%	*100%*	*100%*
31 day subsequent radiotherapy	**94%**	100%	100%	99.0%	*99.7%*	100%	*100%*	*100%*
31 day subsequent surgery	**94%**	94.1%	96.2%	100%	*97.0%*	100%	*75.0%*	*92.3%*
62 day 2ww first treatment	**85%**	83.4%	79.5%	81.7%	*81.7%*	79.3%	*69.0%*	*75.1%*
62 day cons upgrade first treatment		100%	0.0%	60.0%	*57.1%*	75.0%	*0.0%*	*60.0%*
62 day screening first treatment	**90%**	100%	100%	87.5%	*96.5%*	100%	*100%*	*100%*
62 day symptomatic breast first treatment		85.7%	95.0%	100%	*92.1%*	100%	*100%*	*100%*

** provisional*

^ current position

Accident & Emergency - profile tracking and comparison to previous year.

Table 1a: Overall A&E Attendances by Locality

	Locality	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Di
99G	NHS SOUTHEND CCG	4,325	4,451	4,518													13,340	13,294	▼ 46	(0.3%)	◀▶	71.9	▲	68.7	▲ 59
	Southend Group	2,515	2,673	2,686													7,861	7,874	▲ 13	(0.2%)	◀▶	71.0	▲	68.7	▲ 25
	Thorpe Bay	1,810	1,778	1,832													5,478	5,420	▼ 58	(1.1%)	▼	73.3	▲▲	68.7	▲ 33
	Services	0	0	0													1	0	▼ 1	#######	▼▼	#DIV/0!	▲▲	68.7	#DIV/0
																	0	0	-	n/a	▲▲	#DIV/0!	▲▲	68.7	#DIV/0
																	0	0	-	n/a	▲▲	#DIV/0!	▲▲	68.7	#DIV/0

Table 2: A&E Attendances by Category

	Category	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Di
	(blank)	0	0	0													0	0	-	n/a	▲▲	0.0	▼▼	0.0	▼ 0
1	First A&E Attendances	4,199	4,334	4,380													12,567	12,913	▲ 346	(2.8%)	▲	69.9	▲	67.1	▲ 52
2	Follow-up Attendances (Planned)	48	54	47													504	149	▼ 355	(70.4%)	▼▼	0.8	▲▲	0.3	▲ 89
3	Follow-up Attendances (Unplanned)	78	63	91													269	232	▼ 37	(13.8%)	▼▼	1.3	▼	1.3	▼ 11

Table 3: A&E Attendances by Arrival Mode

	Arrival Mode	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Di
	(blank)	1	0	1													0	2	▲ 2	#######	▲▲	0.0	▼▼	0.0	▼ 1
1	Ambulance (inc Air Ambulance)	1,266	1,253	1,290													3,657	3,809	▲ 152	(4.2%)	▲	20.6	▲▲	17.7	▲ 53
2	Other	3,058	3,198	3,227													9,683	9,483	▼ 200	(2.1%)	▼	51.3	◀▶	51.0	▲ 62

Table 4: A&E Attendances by Number of Previous Attendances

	Previous Attendances	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Di
	None	2,259	2,351	2,401													6,695	7,011	▲ 316	(4.7%)	▲	37.9	▲▲	35.6	▲ 43
	1 Previous Attendance	963	997	974													3,166	2,934	▼ 232	(7.3%)	▼▼	15.9	▼	16.3	▼ 72
	More than 1 Previous Attendance	1,103	1,103	1,143													3,479	3,349	▼ 130	(3.7%)	▼	18.1	▲▲	16.8	▲ 23

Table 5: A&E Attendances by Source of Referral

	Referral Source	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Di
	(blank)	1	0	1													5	2	▼ 3	(60.0%)	▼▼	0.0	▼▼	0.0	▼ 4
00	General Practitioner	215	180	212													929	607	▼ 322	(34.7%)	▼▼	3.3	▲▲	2.5	▲ 13
01	Self - Referral	3,476	3,710	3,666													10,512	10,852	▲ 340	(3.2%)	▲	58.7	▲▲	55.7	▲ 55
02	Local Authority Social Services	1	2	1													2	4	▲ 2	#######	▲▲	0.0	▼▼	0.0	▼ 1
03	Emergency Services	178	190	214													56	582	▲ 526	#######	▲▲	3.1	▼▼	3.4	▼ 50
04	Work	14	19	16													58	49	▼ 9	(15.5%)	▼▼	0.3	▲▲	0.2	▲ 19
05	Educational Establishment	11	8	14													93	33	▼ 60	(64.5%)	▼▼	0.2	▲▲	0.1	▲ 14
06	Police	21	20	33													75	74	▼ 1	(1.3%)	▼	0.4	▲▲	0.2	▲ 28
07	Health Care Provider	25	38	38													39	101	▲ 62	#######	▲▲	0.5	▼▼	3.0	▼ 45
08	Other	383	283	322													1,570	988	▼ 582	(37.1%)	▼▼	5.3	▲▲	3.5	▲ 35
92	Dental Practitioner	0	1	1													1	2	▲ 1	#######	▲▲	0.0	▼▼	0.0	▼ 2
93	Community Dental Services	0	0	0													0	0	-	n/a	▲▲	0.0	▼▼	0.0	▼ 0

Table 6: A&E Attendances by Disposal Method

	Disposal	2014/15												GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR		CHANGE FROM LAST YEAR					ATTENDANCES PER 1,000			
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		Monthly	Cumulative	13/14 YTD	14/15 YTD	# Change	% Change		3Month Rate	Flag	SE Rate	Vol Diff
	(blank)	1	6	6													7	13	▲ 6	(85.7%)	▲▲	0.1	▼▼	1.1	▼ 187
01	Admitted to Bed	1,177	1,172	1,172													3,419	3,521	▲ 102	(3.0%)	▲	19.1	▲▲	16.1	▲ 539
02	Discharged - Follow-up by GP	1,297	1,518	1,434													2,470	4,249	▲ 1,779	(72.0%)	▲▲	23.0	▼▼	26.3	▼ 610
03	Discharged - no further Treatment	901	856	990													4,291	2,747	▼ 1,544	(36.0%)	▼▼	14.9	▲▲	12.3	▲ 472
04	Referred - to A&E Clinic	199	217	212													436	628	▲ 192	(44.0%)	▲▲	3.4	▲▲	2.1	▲ 233
05	Referred - to Fracture Clinic	317	330	345													798	992	▲ 194	(24.3%)	▲▲	5.4	▲▲	4.5	▲ 152
06	Referred - to Outpatient Clinic	41	28	39													841	108	▼ 733	(87.2%)	▼▼	0.6	▼▼	1.1	▼ 88
07	Transferred to Other Provider	162	92	97													422	351	▼ 71	(16.8%)	▼▼	1.9	▲▲	0.8	▲ 201
10	Died	3	3	5													24	11	▼ 13	(54.2%)	▼▼	0.1	▲▲	0.1	▲ 1
11	Referred - to Other Care Professional	92	126	105													29	323	▲ 294	#######	▲▲	1.7	▼▼	2.7	▼ 167
12	Left - before Seen	109	55	77													170	241	▲ 71	(41.8%)	▲▲	1.3	▲	1.3	▲ 7
13	Left - refused treatment	22	46	31													344	99	▼ 245	(71.2%)	▼▼	0.5	▲▲	0.3	▲ 47
14	Other	3	2	4													88	9	▼ 79	(89.8%)	▼▼	0.0	▼▼	0.1	▼ 3

Table 7: A&E Attendances by Primary A&E Diagnosis

	Diagnosis #1	2014/15												GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR		CHANGE FROM LAST YEAR					ATTENDANCES PER 1,000			
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		Monthly	Cumulative	13/14 YTD	14/15 YTD	# Change	% Change		3Month Rate	Flag	SE Rate	Vol Diff
1	Diagnosis not classifiable	990	1,124	1,306													2,540	3,420	▲ 880	(34.6%)	▲▲	18.5	▲▲	13.9	▲ 857
2	NONE	219	211	194													1,489	624	▼ 865	(58.1%)	▼▼	3.4	▼▼	9.8	▼ 1,181
3	Dislocation/fracture/joint injury/amputation	405	395	387													1,401	1,187	▼ 214	(15.3%)	▼▼	6.4	▲▲	4.9	▲ 284
4	Sprain/ligament injury	186	214	245													876	645	▼ 231	(26.4%)	▼▼	3.5	▲▲	3.2	▲ 52
5	Laceration	225	241	278													970	744	▼ 226	(23.3%)	▼▼	4.0	▲▲	2.9	▲ 209
6	Contusion/abrasion	180	125	188													857	493	▼ 364	(42.5%)	▼▼	2.7	▲▲	1.7	▲ 172
7	Gastrointestinal conditions	247	257	237													716	741	▲ 25	(3.5%)	▲	4.0	▼	4.2	▼ 29
8	Local infection	92	94	66													754	252	▼ 502	(66.6%)	▼▼	1.4	▲▲	1.2	▲ 22
9	Cardiac conditions	144	151	148													522	443	▼ 79	(15.1%)	▼▼	2.4	▲	2.3	▲ 10
10	Respiratory conditions	208	168	173													461	549	▲ 88	(19.1%)	▲▲	3.0	▼	3.0	▼ 13
11	Urological conditions (including cystitis)	114	102	85													245	301	▲ 56	(22.9%)	▲▲	1.6	▼	1.7	▼ 13
12	Central Nervous System conditions (excluding s	0	0	0													313	0	▼ 313	#######	▼▼	0.0	▼▼	0.0	▼ 2
13	Muscle/tendon injury	152	182	148													230	482	▲ 252	#######	▲▲	2.6	▲▲	1.9	▲ 124
14	Head injury	74	100	93													230	267	▲ 37	(16.1%)	▲▲	1.4	▼▼	1.7	▼ 39
15	Ophthalmological conditions	81	107	104													169	292	▲ 123	(72.8%)	▲▲	1.6	▼▼	1.7	▼ 28
16	Gynaecological conditions	67	71	67													201	205	▲ 4	(2.0%)	▲	1.1	▲▲	1.0	▲ 26
17	ENT conditions	87	94	78													150	259	▲ 109	(72.7%)	▲▲	1.4	▼▼	1.6	▼ 37
18	Burns and scalds	44	41	27													181	112	▼ 69	(38.1%)	▼▼	0.6	▲▲	0.4	▲ 40
19	Soft tissue inflammation	184	168	152													122	504	▲ 382	#######	▲▲	2.7	▼▼	3.3	▼ 110
20	Foreign body	57	53	47													179	157	▼ 22	(12.3%)	▼▼	0.8	▲▲	0.6	▲ 51
13	**TOP 20 DIAGNOSES**	3,756	3,898	4,023													12,606	11,677	▼ 929	(7.4%)	▼▼	63.2	▲	61.1	▲ 396
14	**OUTSIDE TOP 20 DIAGNOSES**	569	553	495													734	1,617	▲ 883	#######	▲▲	8.8	▲▲	7.7	▲ 202

Table 8: A&E Attendances by Registered GP Practice (Derived)

GP Practice (Derived)		2014/15												GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR		CHANGE FROM LAST YEAR					ATTENDANCES PER 1,000			
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		Monthly	Cumulative	13/14 YTD	14/15 YTD	# Change	% Change		3Month Rate	Flag	SE Rate	Vol Diff
5VJ	SOUTH ESSEX REGION	18,000	18,812	18,338													50,714	55,150	▲ 4,436	(8.7%)	▲▲	68.7			
99G	NHS SOUTHEND CCG	4,325	4,451	4,518													13,340	13,294	▼ 46	(0.3%)	◀▶	71.9	▲	68.7	▲ 597
F81046	DR KRISHNAN	110	112	130													390	352	▼ 38	(9.7%)	▼▼	73.3	▲▲	68.7	▲ 22
F81081	DR PELTA	629	674	657													1,985	1,960	▼ 25	(1.3%)	▼	79.3	▲▲	68.7	▲ 261
F81086	DR IRLAM & PARTNERS	150	153	148													491	451	▼ 40	(8.1%)	▼▼	64.6	▼▼	68.7	▼ 29
F81097	THE VALKYRIE SURGERY	329	346	334													933	1,009	▲ 76	(8.1%)	▲▲	72.1	▲	68.7	▲ 47
F81112	DR HOUSTON	216	212	216													566	644	▲ 78	(13.8%)	▲▲	58.0	▼▼	68.7	▼ 119
F81128	DR ZAIDI	270	266	282													825	818	▼ 7	(0.8%)	◀▶	78.1	▲▲	68.7	▲ 98
F81144	DR DICKENS	304	353	331													975	988	▲ 13	(1.3%)	▲	61.4	▼▼	68.7	▼ 118
F81147	DR GEORGE & PARTNERS, CENTRAL SURGERY	130	140	137													416	407	▼ 9	(2.2%)	▼	82.8	▲▲	68.7	▲ 69
F81164	DR DAVIES & PARTNERS	193	179	214													569	586	▲ 17	(3.0%)	▲	75.9	▲▲	68.7	▲ 56
F81207	DR BEKAS	23	44	38													77	105	▲ 28	(36.4%)	▲▲	65.0	▼▼	68.7	▼ 6
F81688	DR DHILLON	43	58	56													182	157	▼ 25	(13.7%)	▼▼	67.9	▼	68.7	▼ 2
F81718	LYDIA HOUSE PRACTICE	24	38	37													129	99	▼ 30	(23.3%)	▼▼	51.2	▼▼	68.7	▼ 34
Y02177	THE PRACTICE NORTHUMBERLAND AVENUE	94	98	105													323	297	▼ 26	(8.0%)	▼▼	71.7	▲	68.7	▲ 12
F81003	DRS. VERGHESE & KHAN	102	84	73													293	259	▼ 34	(11.6%)	▼▼	63.7	▼▼	68.7	▼ 20
F81073	DR BHATTACHARJEE	128	89	104													253	321	▲ 68	(26.9%)	▲▲	87.7	▲▲	68.7	▲ 69
F81092	DR SOORIAKUMARAN	98	84	97													283	279	▼ 4	(1.4%)	▼	67.3	▼	68.7	▼ 6
F81121	DR AGHA	125	122	108													420	355	▼ 65	(15.5%)	▼▼	54.7	▼▼	68.7	▼ 91
F81159	SIDDIQUE & AGHA	91	74	106													310	271	▼ 39	(12.6%)	▼▼	81.1	▲▲	68.7	▲ 41
F81176	DR NK SHAH	44	44	40													151	128	▼ 23	(15.2%)	▼▼	57.5	▼▼	68.7	▼ 25
F81200	DR SATHANANDAN	82	72	96													296	250	▼ 46	(15.5%)	▼▼	72.3	▲▲	68.7	▲ 12
F81209	THE SHAFTESBURY AVENUE SURGERY	65	63	60													158	188	▲ 30	(19.0%)	▲▲	82.3	▲▲	68.7	▲ 31
F81223	DR MALIK	94	92	86													285	272	▼ 13	(4.6%)	▼	74.1	▲▲	68.7	▲ 20
F81613	DR KUMAR	152	173	152													518	477	▼ 41	(7.9%)	▼▼	68.6	◀▶	68.7	▼ 1
F81622	DR KHAN	61	62	71													188	194	▲ 6	(3.2%)	▲	71.6	▲	68.7	▲ 8
F81639	DR VELMURUGAN	24	17	22													96	63	▼ 33	(34.4%)	▼▼	60.3	▼▼	68.7	▼ 9
F81649	DR SCHEMBRI	70	70	73													195	213	▲ 18	(9.2%)	▲▲	63.3	▼▼	68.7	▼ 18
F81656	DR VASHISHT	91	81	92													222	264	▲ 42	(18.9%)	▲▲	89.3	▲▲	68.7	▲ 61
F81676	DR KONGAR	31	23	18													96	72	▼ 24	(25.0%)	▼▼	78.5	▲▲	68.7	▲ 9
F81684	DR MOSS	77	93	100													271	270	▼ 1	(0.4%)	◀▶	76.1	▲▲	68.7	▲ 26
F81695	ELMSLEIGH DRIVE SURGERY	29	17	32													73	78	▲ 5	(6.8%)	▲▲	60.8	▼▼	68.7	▼ 10
F81696	DR JAYATILAKA	44	64	49													138	157	▲ 19	(13.8%)	▲▲	83.3	▲▲	68.7	▲ 28
F81724	DR GUL, NEW WESTBOROUGH SURGERY	83	73	82													210	238	▲ 28	(13.3%)	▲▲	71.8	▲	68.7	▲ 10
F81733	DR CHATURVEDI	74	80	76													250	230	▼ 20	(8.0%)	▼▼	69.4	◀▶	68.7	▲ 2
F81744	DR NG	41	55	66													141	162	▲ 21	(14.9%)	▲▲	61.2	▼▼	68.7	▼ 20
F81754	THE GLOBE SURGERY	0	0	0													2	0	▼ 2	#######	▼▼	#VALUE!	▲▲	68.7	#VALUE!
F81755	THE VICTORIA SURGERY	26	41	31													74	98	▲ 24	(32.4%)	▲▲	306.3	▲▲	68.7	▲ 76
Y02707	ST LUKE'S HEALTH CENTRE	178	205	198													555	581	▲ 26	(4.7%)	▲	91.7	▲▲	68.7	▲ 146

Non Elective – profile tracking and comparison to previous year

Table 2: Non-Elective (Emergency) Spells by Admission Methods

	Admission Method	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Diff
21	Admission Via A&E	1,220	1,207	1,202													3,221	3,629	▲ 408	(12.7%)	▲▲	19.6	▲▲	16.4	▲ 593
22	Admission via Direct request from GP	230	244	210													601	684	▲ 83	(13.8%)	▲▲	3.7	▲▲	2.8	▲ 159
23	Admission via Bed Bureau	6	12	5													12	23	▲ 11	(91.7%)	▲▲	0.1	▲▲	0.1	▲ 2
24	Admission via Consultant Clinic	82	69	82													166	233	▲ 67	(40.4%)	▲▲	1.3	▲▲	0.9	▲ 75
25	Admission via MH Crisis Resolution Team	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
28	Admission via Other Means	25	16	27													264	68	▼ 196	(74.2%)	▼▼	0.4	▼▼	0.4	▼ 8
2A	**Admission via A&E Dept of another provider	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
2B	**Transfer of an Admitted patient in Emergency	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
2C	**Baby born at Home, as intended	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
2D	**Emergency Admission via Other Means	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-

Note: Codes 2A-D are in place for CDS v6.2, and replace code 28 - seperating out this code into more specific items

Table 3: Non-Elective (Emergency) Spells by Admission Day of Week

Admission Day	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Diff
Monday	240	220	234													665	694	▲ 29	(4.4%)	▲	3.8	▲▲	3.1	▲ 123
Tuesday	267	243	220													643	730	▲ 87	(13.5%)	▲▲	4.0	▲▲	3.3	▲ 124
Wednesday	252	245	228													623	725	▲ 102	(16.4%)	▲▲	3.9	▲▲	3.2	▲ 141
Thursday	248	240	221													709	709	-	-	◀▶	3.8	▲▲	3.2	▲ 127
Friday	195	249	233													641	677	▲ 36	(5.6%)	▲▲	3.7	▲▲	3.0	▲ 114
Saturday	164	184	184													484	532	▲ 48	(9.9%)	▲▲	2.9	▲▲	2.4	▲ 89
Sunday	197	167	206													499	570	▲ 71	(14.2%)	▲▲	3.1	▲▲	2.5	▲ 103

Table 4: Non-Elective (Emergency) Spells: Depth of Coding

Outcome	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Diff
Average number of Diagnosis Codes	5.59	5.72	5.57													5.9	5.6	▼ 0.3	(4.4%)	▼	5.6	▼▼	6.0	
Average number of Procedure Codes	1.35	1.39	1.46													1.4	1.4	▼ 0.0	(1.3%)	▼	1.4	▼▼	1.7	

Table 5: Non-Elective (Emergency) Spells by Length of Stay (unadjusted)

	Length of Stay (Adm to Dsx)	2014/15 Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR Monthly	Cumulative	CHANGE FROM LAST YEAR 13/14 YTD	14/15 YTD	# Change	% Change		ATTENDANCES PER 1,000 3Month Rate	Flag	SE Rate	Vol Diff
0	Days LOS	366	405	415													958	1,186	▲ 228	(23.8%)	▲▲	6.4	▲▲	4.4	▲ 367
1	Days LOS	357	344	360													1,019	1,061	▲ 42	(4.1%)	▲	5.7	▲▲	4.4	▲ 254
2	Days LOS	199	157	147													509	503	▼ 6	(1.2%)	▼	2.7	▲▲	2.3	▲ 85
3	Days LOS	98	119	109													303	326	▲ 23	(7.6%)	▲▲	1.8	▲▲	1.6	▲ 35
4	Days LOS	100	77	92													222	269	▲ 47	(21.2%)	▲▲	1.5	▲▲	1.2	▲ 48
5	Days LOS	60	77	66													179	203	▲ 24	(13.4%)	▲▲	1.1	▲▲	0.9	▲ 38
6	Days LOS	58	54	51													177	163	▼ 14	(7.9%)	▼▼	0.9	▲▲	0.8	▲ 12
7	Days LOS	55	57	56													128	168	▲ 40	(31.3%)	▲▲	0.9	▲▲	0.7	▲ 36
8	Days LOS	42	41	25													107	108	▲ 1	(0.9%)	◀▶	0.6	▲	0.6	▲ 4
9	Days LOS	28	31	35													77	94	▲ 17	(22.1%)	▲▲	0.5	▲▲	0.5	▲ 9
10+	Over 10 Days	200	186	170													585	556	▼ 29	(5.0%)	▼	3.0	▼▼	3.4	▼ 67
%	% 0-1 Days LOS	46.3%	48.4%	50.8%													46.4%	48.5%		(2.1%)	▲	48.5%	▲▲	42.6%	▲ 271

Table 6: Non-Elective (Emergency) Spells by Source of Admission

	Admission Source	2014/15												GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR		CHANGE FROM LAST YEAR					ATTENDANCES PER 1,000			
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		Monthly	Cumulative	13/14 YTD	14/15 YTD	# Change	% Change		3Month Rate	Flag	SE Rate	Vol Diff
	Blank	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
19	Usual Place of Residence	1,523	1,509	1,476													4,103	4,508	▲ 405	(9.9%)	▲▲	24.4	▲▲	20.0	▲ 811
29	Temporary Place of Residence	3	3	5													7	11	▲ 4	(57.1%)	▲▲	0.1	▲▲	0.0	▲ 4
39	Penal Establishment (inc Court, Police St.)	0	0	1													1	1	-	-	◀▶	0.0	▲▲	0.0	▲ 1
49	Other NHS - High Secure	0	0	0													1	0	▼ 1	(100.0%)	▼▼	0.0	▼▼	0.0	▼ 0
51	Other NHS - General Ward	27	25	27													92	79	▼ 13	(14.1%)	▼▼	0.4	▲	0.4	▲ 3
52	Other NHS - Maternity or Neonate Ward	1	1	2													1	4	▲ 3	(300.0%)	▲▲	0.0	▲▲	0.0	▲ 2
53	Other NHS - Mental Health or LD Ward	0	0	0													1	0	▼ 1	(100.0%)	▼▼	0.0	▼▼	0.0	▼ 0
54	NHS Run Care Home	3	7	7													17	17	-	-	◀▶	0.1	▲▲	0.1	▲ 5
65	Local Authority Care or Residential Home	4	3	6													3	13	▲ 10	(333.3%)	▲▲	0.1	▲▲	0.0	▲ 7
66	Local Authority Foster Care	0	0	0													0	0	-	n/a	▲▲	0.0	▼▼	0.0	▼ 0
79	Birth (in hospital or en-route)	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
85	Private Care Home	1	0	2													37	3	▼ 34	(91.9%)	▼▼	0.0	▼▼	0.1	▼ 10
87	Private Hospital	1	0	0													1	1	-	-	◀▶	0.0	▼▼	0.0	▼ 0
88	Private Hospice	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
98	Not Applicable	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
99	Not Known / Validation Error	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-

Table 7: Non-Elective (Emergency) Spells by Discharge Destination

	Discharge Destination	2014/15												GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR		CHANGE FROM LAST YEAR					ATTENDANCES PER 1,000			
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		Monthly	Cumulative	13/14 YTD	14/15 YTD	# Change	% Change		3Month Rate	Flag	SE Rate	Vol Diff
	Blank	0	0	0													0	0	-	n/a	▲▲	0.0	▼▼	0.0	▼ 0
19	Usual Place of Residence	1,387	1,375	1,377													3,766	4,139	▲ 373	(9.9%)	▲▲	22.4	▲▲	18.0	▲ 808
29	Temporary Place of Residence	41	45	28													149	114	▼ 35	(23.5%)	▼▼	0.6	▲▲	0.3	▲ 56
30	Repatriation from High Secure Accom.	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
38	Penal Establishment (inc Police St.)	1	1	1													4	3	▼ 1	(25.0%)	▼▼	0.0	▲▲	0.0	▲ 1
49	Other NHS - High Secure	0	1	0													0	1	▲ 1	(100.0%)	▲▲	0.0	▲▲	0.0	▲ 1
50	Other NHS - Med Secure	0	0	0													1	0	▼ 1	(100.0%)	▼▼	0.0	▲▲	0.0	-
51	Other NHS - General Ward	16	19	24													67	59	▼ 8	(11.9%)	▼▼	0.3	▼▼	0.4	▼ 24
52	Other NHS - Maternity or Neonate Ward	0	0	0													2	0	▼ 2	(100.0%)	▼▼	0.0	▼▼	0.0	▼ 0
53	Other NHS - Mental Health or LD Ward	12	19	13													42	44	▲ 2	(4.8%)	▲	0.2	▲▲	0.1	▲ 20
54	NHS Run Care Home	18	9	12													38	39	▲ 1	(2.6%)	▲	0.2	▲	0.2	▲ 1
65	Local Authority Care or Residential Home	26	10	12													8	48	▲ 40	(500.0%)	▲▲	0.3	▲▲	0.1	▲ 28
66	Local Authority Foster Care	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
79	Patient Died / Stillbirth	56	66	51													159	173	▲ 14	(8.8%)	▲▲	0.9	▲▲	0.8	▲ 26
84	Private - Medium Secure Unit	0	0	0													0	0	-	n/a	▲▲	0.0	▲▲	0.0	-
85	Private Care Home	1	0	0													18	1	▼ 17	(94.4%)	▼▼	0.0	▼▼	0.1	▼ 17
87	Private Hospital	1	0	5													1	6	▲ 5	(500.0%)	▲▲	0.0	▲▲	0.0	▲ 2
88	Private Hospice	0	0	0													2	0	▼ 2	(100.0%)	▼▼	0.0	▼▼	0.0	▼ 1
98	Not Applicable	4	3	2													7	9	▲ 2	(28.6%)	▲▲	0.0	▼▼	0.5	▼ 80
99	Not Known / Validation Error	0	0	1													0	1	▲ 1	(100.0%)	▲▲	0.0	▲▲	0.0	▲ 1

Table 8: Non-Elective (Emergency) Spells by Treatment Function

	Treatment Function	2014/15												GRAPH: 13/14 to 14/15 YTD	VARIANCE TO PREV YEAR		CHANGE FROM LAST YEAR					ATTENDANCES PER 1,000			
		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15		Monthly	Cumulative	13/14 YTD	14/15 YTD	# Change	% Change		3Month Rate	Flag	SE Rate	Vol Diff
300	General Medicine	436	438	454													1,147	1,328	▲ 181	(15.8%)	▲▲	7.2	▲▲	6.8	▲ 74
180	Accident & Emergency	305	329	245													971	879	▼ 92	(9.5%)	▼▼	4.8	▲▲	2.0	▲ 511
100	General Surgery	266	302	289													724	857	▲ 133	(18.4%)	▲▲	4.6	▲▲	3.5	▲ 205
110	Trauma & Orthopaedics	120	101	96													346	317	▼ 29	(8.4%)	▼▼	1.7	▲▲	1.4	▲ 59
420	Paediatrics	89	95	76													262	260	▼ 2	(0.8%)	◀▶	1.4	▲▲	1.4	▲ 9
430	Geriatric Medicine	78	45	77													120	200	▲ 80	(66.7%)	▲▲	1.1	▼▼	1.5	▼ 78
502	Gynaecology	42	28	46													91	116	▲ 25	(27.5%)	▲▲	0.6	▲▲	0.5	▲ 28
320	Cardiology	28	26	34													134	88	▼ 46	(34.3%)	▼▼	0.5	▲	0.5	▲ 4
340	Respiratory Medicine	24	35	23													93	82	▼ 11	(11.8%)	▼▼	0.4	▼▼	0.6	▼ 38
301	Gastroenterology	20	17	35													29	72	▲ 43	(148.3%)	▲▲	0.4	▲	0.4	▲ 4
800	Clinical Oncology	6	14	6													39	26	▼ 13	(33.3%)	▼▼	0.1	◀▶	0.1	▼ 0
328	Stroke Medicine	31	21	26													55	78	▲ 23	(41.8%)	▲▲	0.4	▲▲	0.2	▲ 39
160	Plastic Surgery	17	14	13													41	44	▲ 3	(7.3%)	▲▲	0.2	◀▶	0.2	▲ 1
303	Clinical Haematology	19	13	23													38	55	▲ 17	(44.7%)	▲▲	0.3	▲▲	0.2	▲ 16
101	Urology	16	15	17													36	48	▲ 12	(33.3%)	▲▲	0.3	▼▼	0.4	▼ 22
120	Ear, Nose and Throat	14	12	20													32	46	▲ 14	(43.8%)	▲▲	0.2	▲	0.2	▲ 7
501	Obstetrics	9	6	7													13	22	▲ 9	(69.2%)	▲▲	0.1	▲▲	0.0	▲ 13
140	Oral Surgery	0	0	0													16	0	▼ 16	(100.0%)	▼▼	0.0	◀▶	0.0	-
361	Nephrology	14	6	9													7	29	▲ 22	(314.3%)	▲▲	0.2	▼	0.2	▼ 5
370	Medical Oncology	1	5	3													20	9	▼ 11	(55.0%)	▼▼	0.0	◀▶	0.1	▼ 1
130	Ophthalmology	3	6	3													9	12	▲ 3	(33.3%)	▲▲	0.1	▲	0.1	▲ 2

Appendix 5 – RTT Recovery Action Plan

RTT Recovery plan to revised trajectories

Summary

This plan provides details of how Southend CCG and Castle Point & Rochford CCG work with Southend University Hospitals NHS Foundation Trust to deliver the following revised targets for RTT issued by NHS England Monday 23rd June 2014;

Achieve aggregate level across all three pathways from beginning September.

Make this position sustainable

Reduce the current level of >16 week waiters to that of those patients waiting over 18 weeks on January 2013 for incomplete pathways

Tackle our challenges specialties to achieve Admitted at Specialty level from Q2 onwards as per our existing recovery action plan

This plan also takes into account pressures elsewhere in the elective pathway such as Cancer services and is in alignment with the Operating Resilience and capacity plan for 2014/15 which also now includes an RTT element.

There is an underlying risk of delivery of this plan is the operational team capacity to manage the delivery. The CCG and Trust are seeking to mitigate this with joint interim management to both this plan and other performance challenges.

Whilst the plan contains trajectories managing RTT remains a moving feast, therefore the Trust is managing its position through run rates and tip ins with a specific focus around the 16 – 18 week position for admitted and the Decision to Admit s' from the Non-Admitted pathways.

Whilst NHS England have agreed a pause on penalties for failing the aggregate target during backlog clearance, for the Trust this still requires agreement from Monitor.

To achieve these targets we require the following funding, as detailed in the attached spreadsheet;

£ 649,209 Admitted pathway

£ 699,353 Non Admitted

£ 189,000 Incompletes

£90,000 RTT Operational Programme Manager

£50,000 Transformational review across theatre productivity

£1,677,526 of which £93,000 is Oral surgery commissioned through NHS England

This plan should also be read in conjunction with the recently submitted RTT Recovery Action Plan.

Summary Flow to manage activity

To manage the flow and interactions between the pathways in order to maintain a sustainable position the following metrics will be used together with projected performance.

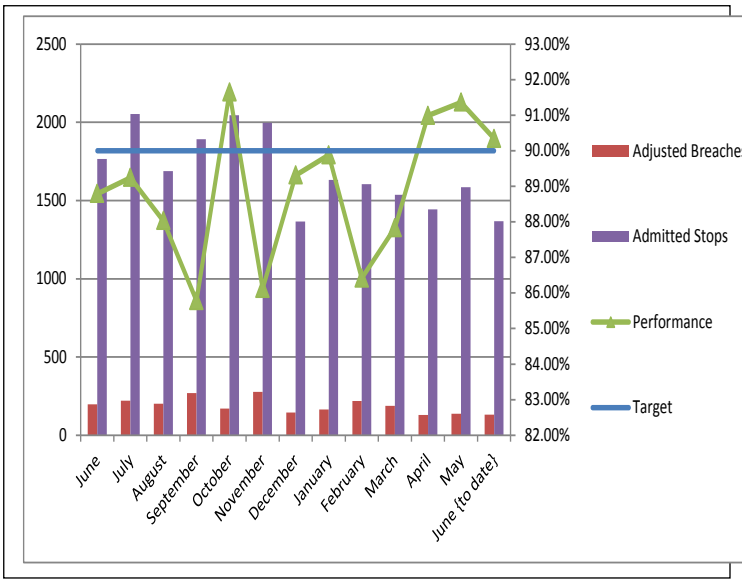
Key performance Indicators		Target	April	May		September levels to maintain sustainability
Admitted	< 18 weeks		**1313**	**1444**		
	>18 weeks		**130**	**135**		
	Performance	**90%**	90.99%	91.45%		90+%
	>52 weeks		**0**	**0**		0
	Backlog (RTT)	**140**	**173**	**190**		140
	>=16 and <= 18 weeks		**171**	**354**		250
Non Admitted	< 18 weeks		**7888**	**7761**		
	>18 weeks		**331**	**306**		
	Performance	**95%**	**95.97%**	**96.21%**		95+%
	>52 weeks		**0**	**1**		0
	Backlog (Actual)		**1,812**	**1,575**		1,200
Incompletes	< 18 weeks		**23,261**	**23,839**		
	>18 weeks		**1,955**	**1,715**		
	Total waiting list		**25,216**	**25,554**		23,000
	Performance	**92%**	**92.25%**	**93.29%**		92+%
	>=42 and <= 52 weeks		**80**	**40**		40
	>52 weeks		**0**	**0**		0

Admitted

Maintaining the aggregate position.

The Trust has found it challenging to maintain its aggregate level overall over the last thirteen months. However during the last three months the Trust has put several measures in place and has delivered the aggregate position.

Year	Month	Admitted Stops	Adjusted Breaches	Adjusted %
2013	June	1766	198	88.79%
2013	July	2053	221	89.24%
2013	August	1688	202	88.03%
2013	September	1892	269	85.78%
2013	October	2045	171	91.64%
2013	November	1996	277	86.12%
2013	December	1366	146	89.31%
2014	January	1631	165	89.88%
2014	February	1604	218	86.41%
2014	March	1537	187	87.83%
2014	April	1443	130	90.99%
2014	May	1579	135	91.45%
2014	June {to date}	1367	132	90.34%

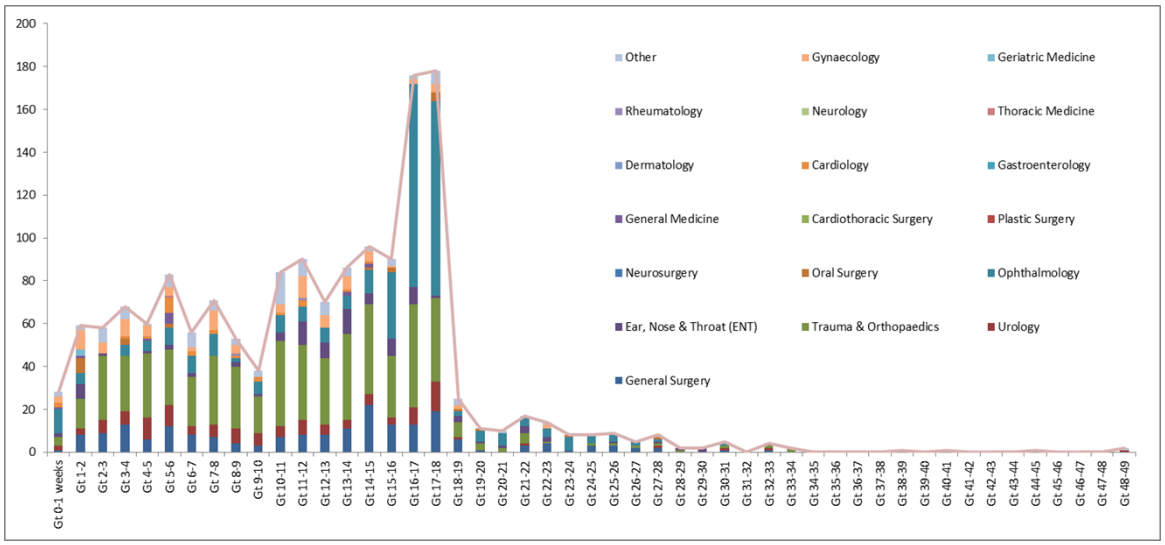


To maintain the aggregate position the Trust actively manages the “tip ins” by weekly COO oversight of the PTLs to manage the position between 14 – 18 weeks as well as managing the backlog position itself. This oversight is now extended to include monitoring of the Non Admitted position to manage the Decision To Add (DTA)to list and its Referrals run rate. Finally the Trust is currently validating its incomplete pathways and will place a focus upon these to again manage the flow of patients from incomplete on to the admitted pathway.

The following trajectory for admitted shows the current position going forward including the modeling of non-admitted pathways moving over to admitted.

Trust	July	August	Sep	Oct	Nov	Dec	Jan	Feb	March
Aggregate position	85%	70%	90%	90%+	90%+	90%+	90%+	90%+	90%+

The following chart shows the profile of the admitted pathway by specialty in order to manage the



Target challenged specialties.

There are two significant specialties that remain challenging for the Trust; General Surgery and Ear Nose and Throat (ENT). Oral Surgery fluctuates month on month and Ophthalmology remains very close to the target.

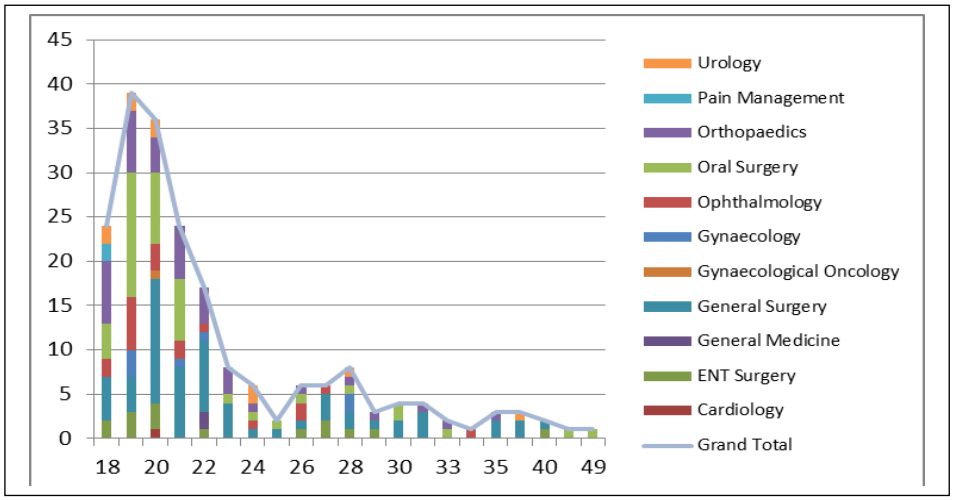
Treatment function	April				May			
	Total	Adjusted <18 wks	Adjusted Breaches	Performance	Total	Adjusted <18 wks	Adjusted Breaches	Performance
General Surgery	199	162	37	81.41%	201	172	29	**85.57%**
Urology	123	109	14	88.62%	117	111	6	94.87%
Trauma & Orthopaedics	440	414	26	94.09%	562	535	27	95.20%
Ear, Nose & Throat (ENT)	83	66	17	**79.52%**	90	74	16	**82.22%**
Ophthalmology	326	312	14	95.71%	354	316	38	**89.27%**
Oral Surgery	34	31	3	91.18%	24	19	5	**79.17%**
General Medicine	12	11	1	91.67%	12	12	0	100.00%
Gastroenterology	0	0	0	n/a	0	0	0	n/a
Cardiology	22	21	1	95.45%	24	24	0	100.00%
Dermatology	0	0	0	n/a	0	0	0	n/a
Thoracic Medicine	7	7	0	100.00%	1	1	0	100.00%

Neurology	2	2	0	100.00%	0	0	0	n/a
Rheumatology	6	6	0	100.00%	2	2	0	100.00%
Geriatric Medicine	3	3	0	100.00%	3	3	0	100.00%
Gynaecology	119	108	11	90.76%	93	87	6	93.55%
Other	67	61	6	91.04%	96	88	8	91.67%
Total	**1443**	**1313**	**130**	**90.99%**	**1579**	**1444**	**135**	**91.45%**

Backlog

As at the middle of June 2014 the Trust has a c200 backlog position. It is proposed to continue to manage patients in chronological order but with the additional funding target General Surgery, ENT, Oral & Ophthalmology in order to both reduce the back log to provide a sustainable aggregate position provide the base line for specialty level compliance.

Profile of backlog @ specialty level as at 21st June 2014



Whilst backlog clearance is in place performance will drop, in order to maintain a position from September onwards the Trust will need to clear c140 patients and take advantage of the window of opportunity in performance, as indicated in the following table. Normally outsourcing takes several months to establish, however the Trust already has an agreement in place (See existing RTT RAP), therefore is able to quickly increase the number of patients offered treatment outside the Trust. Some additional lists will also be provided from existing theatre capacity as indicated in the table below. The table also shows the monthly ongoing impact to the back log from Non Admitted decision to admit s'.

Specialty Description	Snapshot of current @ 21st June	Add'l internal	Add'l external	Estimated Projected Performance		Average conversion rate to DTA
ENT Surgery						
Endoscopy	4					
Septorhinoplasty	3	17	12	70%		15%
Grommet's	2					
Tonsillectomies	2					
Other	4					
General Surgery						
Abdominal procedures	7					
Circumcisions	16	92	-	70%		28%
Hernias	22					
Various other	17					
Ophthalmology						
Cataract	17	59	14	75%		50%
Other	2					
Oral Surgery						
Teeth extraction	34	16	26	70%		8%
Various Non Teeth extraction	9					
Urology	0	25				20%
Total	139	209				

Proposed funding requirement

Therefore to deliver the admitted pathway as detailed above the Trust will require funding for the following projects;

Backlog additional activity cost includes additional lists and extended lists through existing SLA contract with private provider.

	Up to 18 weeks	Over 18 weeks	Total Cost
ENT	25	29	£21,000
General Surgery	96	83	£88,500
Gynaecology	162	18	47,600
Ophthalmology	48	73	£37,500
Oral Surgery	34	42	£31,500
Other	0	53	£16,500
Orthopaedics	426	40	£86,609
Urology	15	44	£15,000
TOTAL	**806**	**382**	**£344,209**

Extend the use of the mobile theatre. There is an impact on the MRI replacement programme which will facilitate the need to build another pad. Use of mobile theatre is the only effective way to provide short term additional capacity in short time scale. The extension is temporary for four weeks and not a purchase. Following September when the initial short term work has been undertaken an more long term sustainable program will run to focus around providing additional theatre capacity from theatre productivity

New concrete pad	£65,000
Mobile Theatre extra 4 weeks @£35k per week	£140,000
Total	**£205,000**

Additional theatre equipment for ophthalmology theatres and recovery so that these theatres could be used for a wider range of non-ophthalmic surgery. We would then use current vacant sessions and/or move some of the ophthalmology to BMI and backfill with General surgery and ENT

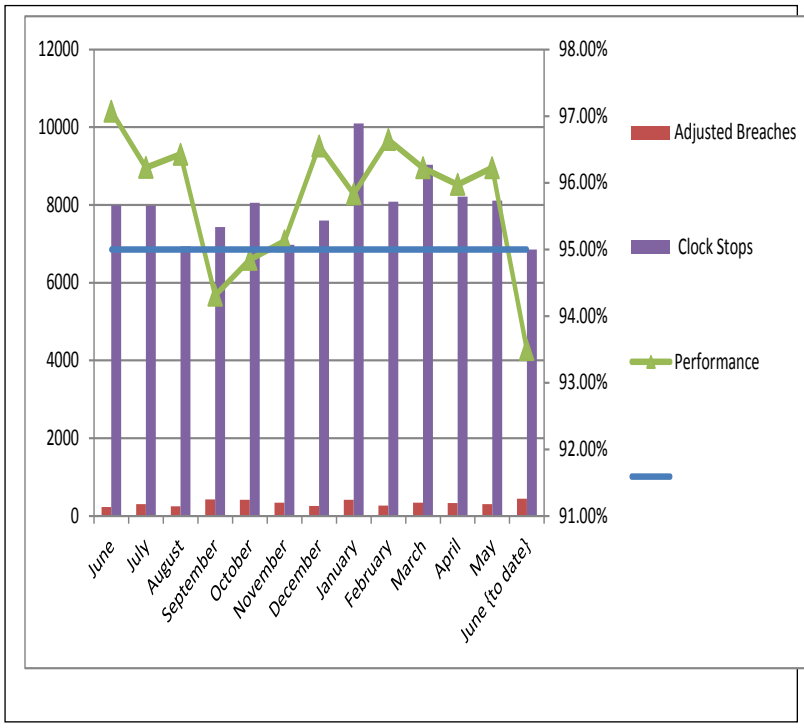
Theatres	£ 100,000

Non-Admitted

Maintaining the aggregate position.

Over the last thirteen months the Trust has achieved the aggregate position, with the exception of September and October.

Year	Month	Clock Stops	Adjusted Breaches	Performance
2013	June	7993	234	97.07%
2013	July	7979	301	96.23%
2013	August	6937	248	96.42%
2013	September	7433	423	94.31%
2013	October	8056	415	94.85%
2013	November	6973	340	95.12%
2013	December	7598	262	96.55%
2014	January	10098	421	95.83%
2014	February	8083	271	96.65%
2014	March	9030	341	96.22%
2014	April	8219	331	95.97%
2014	May	8109	306	96.23%
2014	*June {to date}*	*6856*	*446*	*93.49%*



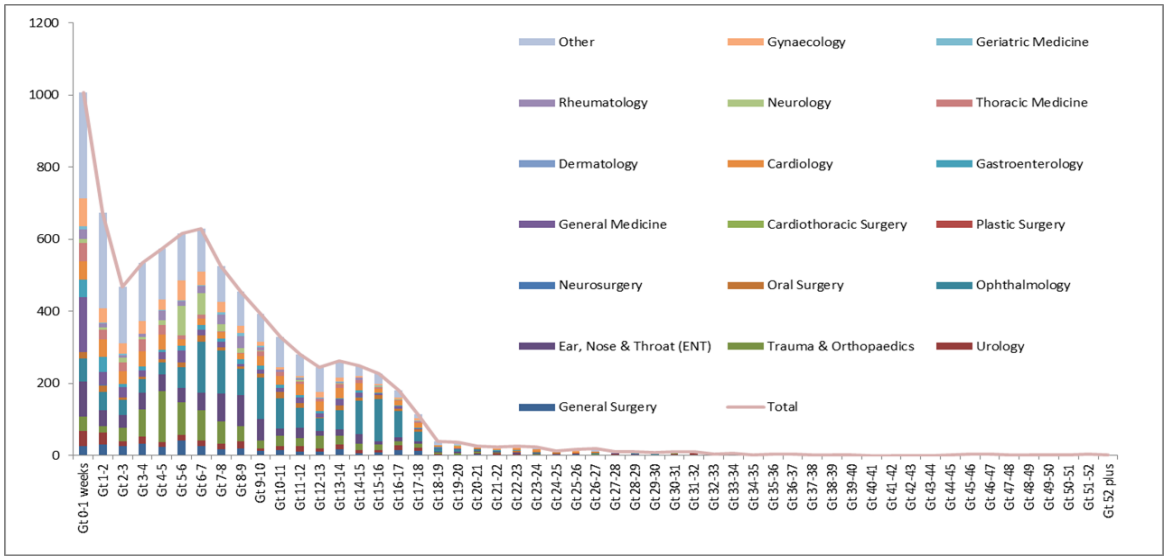
Target challenged specialties.

The key focus for Patients on the Non Admitted pathway remains the reduction in waiting times down to six weeks. The challenged specialties in out-patient waiting list terms are;

Ophthalmology 1,304

ENT 741

Orthopedics 803

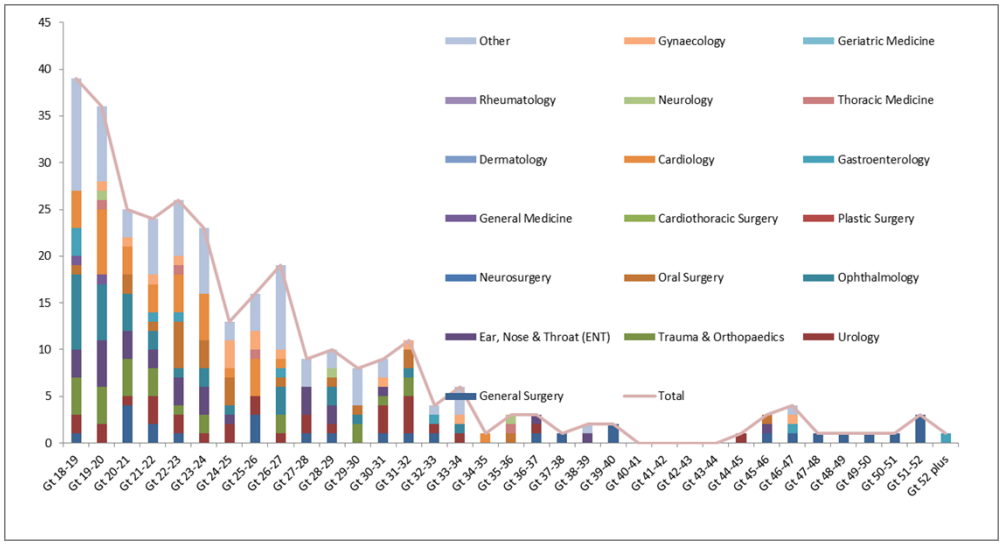


Given the current level of decision to admit to list from Out Patient appointments across these specialties there is a potential increase to the admitted pathway resulting from undertaking additional activity to both bring the average waiting time down to 6 weeks. The Trust is unable to out source additional out patient clinics at the current time through their existing contract. Therefore the Trust is seeking additional capacity from its current clinic lists. As previously detailed in the original RAP the Trusts is re profiling its clinics in order to bring waiting times down. Once this re profiling has been completed, a review will be undertaken to evaluate any potential need for additional external capacity and contracts negotiated as appropriate.

Specialty Description	Add'l internal
ENT Surgery Diagnostic clinics General clinics	10
Orthopaedics Knee clinics Shoulder Clinics MSK clinics Various other	14
Ophthalmology Cataract Glaucoma	12
Total	36

Back log

Again managing the back log will need a focused upon the same three specialties as identified above.



Proposed Funding

Increase in Out patient clinics both out sourced and internal

Speciality	**Up to 18 weeks**	**Over 18 weeks**	**Cost**
ENT	115	96	£27,000
General Medicine	197	0	£58,500
General Surgery	249	249	£52,500
Gynaecology	225	9	£78,930
Ophthalmology	87	81	£25,500
Oral Surgery	209	269	£61,500
Other	326	95	£71,988
Rheumatology	165	0	£14,685
Thoracic Medicine	138	0	£55
Trauma & Orthopaedics	1,149	0	£63,195
Urology	110	147	£25,500
TOTAL	**2,970**	**946**	**£479,353**

Further equipment to allow increased volume of Out Patient capacity

Additional Outpatients Equipment in Gynaecology	£ 30,000

Increase our imaging capacity

Waits for CT and MRI scans are currently at 6 weeks. This waiting time is being maintained by fire-fighting, utilising ad hoc additional sessions to ensure no avoidable breaches. A reduction in these waiting times will directly impact on RTT performance in terms of faster diagnostics. The capacity shortfall for radiographers

and radiologists must also be addressed to ensure sustainability of the service; otherwise there is a risk that the waiting times would increase once more.

CT

To reduce the CT backlog to a waiting time of 4 weeks would require clearance of approximately 400 scans. It is proposed this is done by the recruitment of 2 x Locum radiographers facilitating extended days in current scanners. The reporting of the additional scans would be done by our radiologists reporting during additional paid sessions.

This would take approximately 4-6 weeks to complete with a 6 week lead time for staff co-ordination and recruitment of locum radiographers. This funding (contingent on being able to secure agreement of existing team and availability of appropriately trained locums) would see the wait for CT scans reach 4 weeks within 12 weeks.

MRI

To reduce the MRI backlog to a waiting time of 4 weeks would require clearance of approximately 550 scans. The existing scanners are heavily utilised and are currently experiencing higher than usual amounts of downtime as they are due for replacement.

It is proposed that an agreement be made with an external service provider to bring in a scanner and staff to clear this backlog of scans. This would include the reporting of these additional scans. This would require an additional pad to be built to allow the continuation of the additional scanner and mobile theatre (See Admitted pathway section for details)

The capacity shortfall for radiographers and radiologists must also be addressed to ensure sustainability of the service; otherwise there is a risk that the waiting times would increase once more.

Ultrasound

To provide a reduction in delays for ultrasound diagnostics across all three RTT pathways and improvements in interventional radiology such as biopsies / drainages and one stop clinics which will also support delivery of the Cancer targets. In addition this will also have a positive impact upon admitted patients with increased capacity for Surgical Assessment and Accident & Emergency

Bid for capital funding for an additional ultrasound scanner to provide additional daytime ultrasound scanner capacity.

This will allow for improvements in service provided for inpatient scans, one stop / DVT / SAU / A&E capacity.

Modality	Cost
CT - reduce waiting times to 4 weeks and clear 400 scans	£ 30,000
MRI - reduce waiting times to 4 weeks and clear 550 scans	£ 80,000
Ultrasound	£ 80,000
Total	**£190,000**

Incomplete pathways

Maintaining the aggregate position.

Again the Trust has managed to maintain its aggregate position over the last thirteen months. The table below indicates the specialty breakdown for the last two months high lighting that whilst the Trust achieved the aggregates there remain challenges in General Surgery and Oral Surgery. Therefore no further additional action is required in order to maintain the aggregate level.

	April				May			
Treatment function	**Total**	**Under 18 weeks**	**Breaches**	**Performance**	**Total**	**Under 18 weeks**	**Breaches**	**Performance**
General Surgery	2,344	1,933	411	**82.47%**	2446	2033	413	**83.12%**
Urology	1,422	1,277	145	**89.80%**	1449	1324	125	91.37%
Trauma & Orthopaedics	3,186	2,954	232	92.72%	3296	3,126	170	94.84%
Ear, Nose & Throat (ENT)	1,939	1,759	180	**90.72%**	1938	1,791	147	92.41%
Ophthalmology	4,455	4,362	93	97.91%	4,603	4,492	111	97.59%
Oral Surgery	1,242	953	289	**76.73%**	1,390	1,023	367	**73.60%**
Neurosurgery	3	3	0	100.00 %	5	5	0	100.00 %
General Medicine	792	786	6	99.24%	792	782	10	98.74%
Gastroenterology	457	456	1	99.78%	489	488	1	99.80%
Cardiology	1,537	1,482	55	96.42%	1,624	1,569	55	96.61%
Thoracic Medicine	491	480	11	97.76%	483	467	16	96.69%
Neurology	420	419	1	99.76%	452	452	0	100.00 %
Rheumatology	373	350	23	93.83%	354	353	1	99.72%
Geriatric Medicine	323	319	4	98.76%	278	276	2	99.28%
Gynaecology	1,538	1,424	114	92.59%	1473	1,374	99	93.28%
Other	4,694	4,304	390	91.69%	4,482	4,284	198	95.58%
Total	**25,216**	**23,261**	**1955**	**92.25%**	**25,554**	**23,839**	**1715**	**93.29%**

To reduce the number of over 16 week waiters until they meet or improve upon the number of over 18 weeks at January 2013.

The following table indicates that we need to remove 2,408 pathways to achieve the objective.

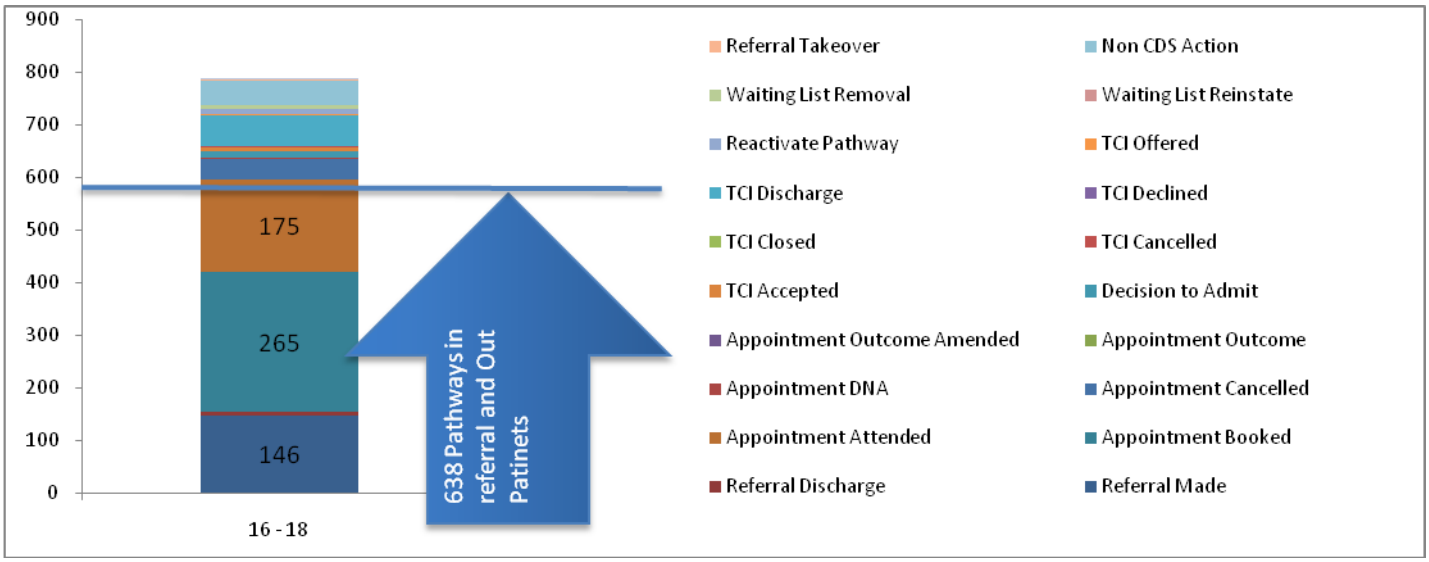
Trust	Jan 13	May 14	Variance
Total list	23,136	25,554	2,408
RTT >18 weeks	1,045	1,715	670
RTT >16 weeks	1,645	2,424	778

To deliver this a review of the pathways shows the following waiting list profile indicates that this could be achieved through increasing the validation of pathways and provision of additional Out-patient clinic capacity.

Validation of pathways to reduce areas such as fully deceasing patients.

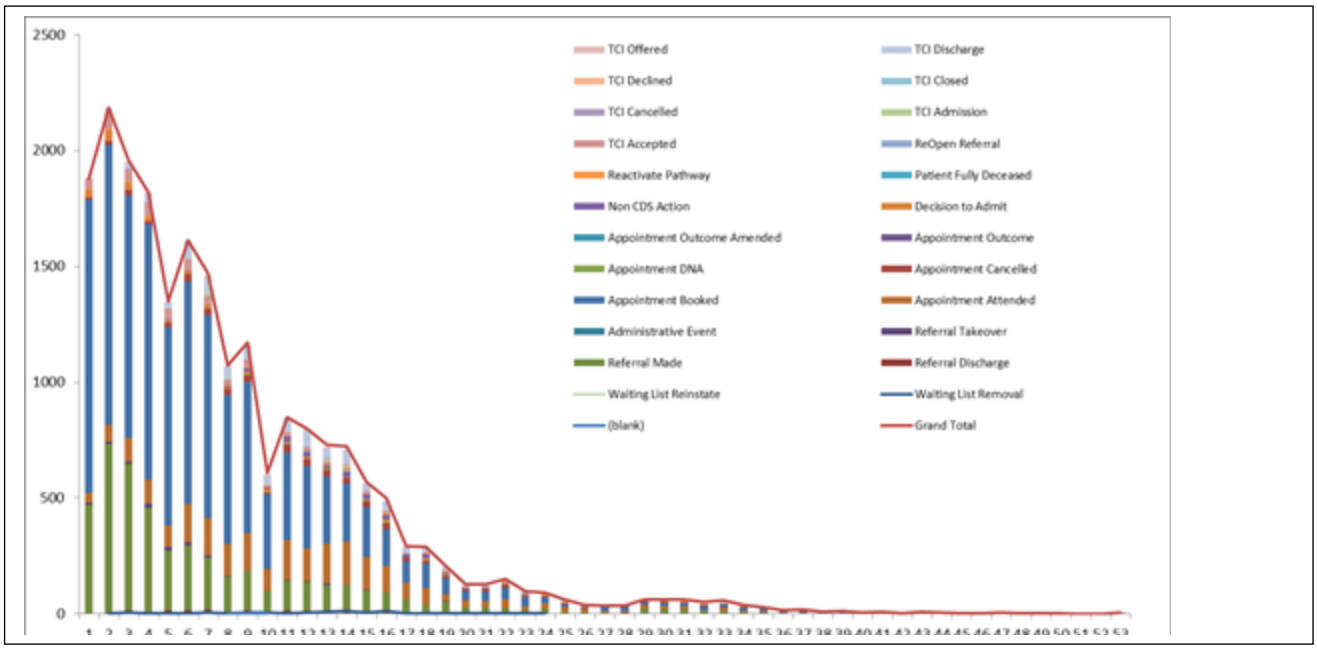
Training to ensure that accurate data entry is used in order to reduce the level of validation required.

Additional Out-patient capacity for General Surgery, Oral Surgery and provisionally ENT (provisional subject to validation outcome).

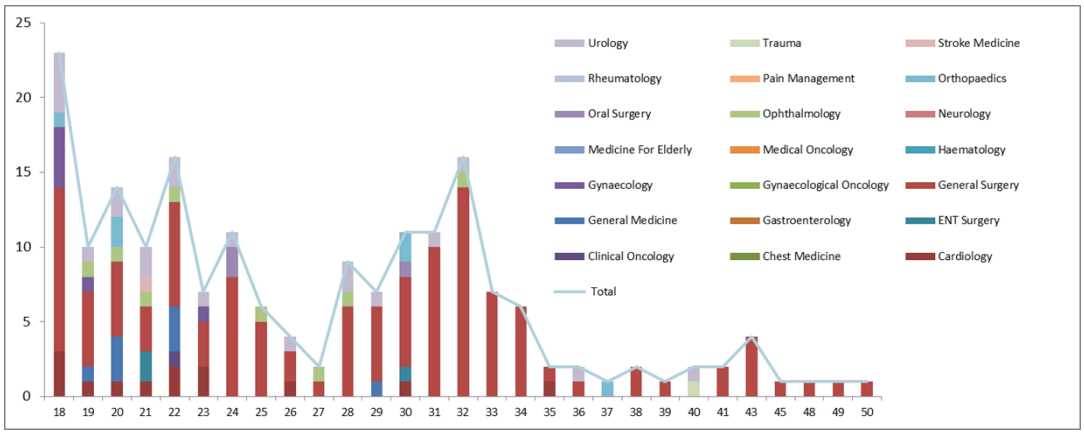


Back log

The following chart (@21st June) shows the profile of the incompletes by type of transaction following the flow from referral through to, To Come In (TCI) actions. Again the majority of the pathways are relating to Out-patient flow.



The following chart shows the detail of the incompletes. There are some Admissions within the back log that probably have an impact upon the admitted position, but again require validation. As can be seen from the chart below a significant majority are General Surgery. Therefore further out sourcing is to be included within the admitted pathway post validation.



Proposed Funding

Increase external validation of pathways to reduce areas such as fully deceasing patients and duplicate pathways (within Medway PAS you have to go through two process to record a deceased patient). Increase Training to ensure that accurate data entry is used in order to reduce the level of validation required.

Description	Rate	Days	Cost
RTT Trainer	300	180	£ 54,000
Validators x 3(3 x180)	250	540	£ 135,000
Total			**£ 189,000**

Additional Out-patient capacity for General Surgery, Oral Surgery and provisionally ENT – see costs in Non-Admitted section.

Additional Diagnostic capacity so support clearance of pathways in the Out-patient process – see costs in Non -Admitted section.

Both the increased validation and training will be run alongside the PAS upgrade, currently scheduled in September.

Governance arrangements

It is proposed that the management of performance of RTT overall remains within the existing performance framework through weekly performance meeting's with the Trust and monthly contractual meetings. The delivery of this plan will be monitored through this process with updates on investment against delivery tracked and reported with escalation as required. The additional activity detailed in this plan will be s

Appendix 6 – SSG Terms of Reference

SYSTEM RESILIENCE GROUP (SRG)

TERMS OF REFERENCE

1. ROLE OF THE GROUP

Purpose

For the South East Essex Health and Social Care System to co-develop strategies and plan safe, efficient urgent and elective services for patients

Objectives

The System Resilience Group (SRG) is responsible for:

- determining service needs on a geographical footprint leading to the development of collaborative operational resilience and capacity plans
- Continuous analytical review of the drivers of system pressures
- Improving system delivery against agreed key performance indicators
- Initiating local change required to improve service delivery and patient experience and clinical outcomes based upon quality improvement cycle methodologies
- Addressing issues that hinder whole system improvements
- Making recommendations to the Clinical Commissioning Groups' Governing Bodies for the allocation of non-recurrent funding, including Resilience Funding and the use of Marginal Rate Tariff funding.

Key Deliverables

The SRG will ensure that:

- All key national standards are met or exceeded with regard to Planned and Unplanned Care.
- Escalation and communication policies are in place and regularly tested.

- All relevant quality standards are adhered to.
- The South East Essex health and social care system produces:
  - An *Operational Resilience Plan* and associated delivery plans
  - Escalation plans and an enhanced situational awareness/ intelligence tool.
  - A successful 18-week RTT programme.
  - A successful cancer treatment programme.
  - A successful 7-day working programme.

2. ACCOUNTABILITY

Accountable to:

The SRG is not a statutory body; however individual Group Members are responsible for reporting outputs to their respective organisations' governance frameworks.

Accountable for:

The SRG is responsible for monitoring the effectiveness of the Urgent Care Operational Group.

The SRG will receive reporting from any task and finish group that may be established to deliver specific areas of work.

3. DECISION MAKING

The SRG is not a statutory body and functions within the delegated authority given to its members by the relevant statutory bodies

4. MONITORING AND REPORTING

Monitoring Arrangements

The SRG will receive:

- Performance Dashboard based on agreed Key performance indicators
- System Performance Data
- Exception Reporting from Urgent Care Operational Group

- Updates on use of non-recurrent funding

Reporting arrangements

The minutes of the group will be formally recorded and circulated at regular intervals to SRG members who will be responsible for their communication in accordance with their respective organisations' governance arrangements.

6. MEMBERSHIP

Core Members

The membership of the SRG will be formed by executive stakeholders from across the South East Essex health and social care system with relevant clinical and patient group representation. The Group will be chaired by Southend CCG's Chief Operating Officer. The Castle Point and Rochford CCG Chief Operating Officer will be the Deputy Chair.

Due to the responsibilities delegated to the SRG representatives from providers will be of sufficient seniority to commit to actions on behalf of their organisation subject to the governance arrangements referred to above, including agreeing to an overarching direction of travel for the whole of South East Essex Health and Social Care economy.

Voluntary Services/Patient Group Representatives

To be invited as appropriate

Southend Clinical Commissioning Group (*)

Chief Operating Officer

Chief Nurse

Clinical lead for Urgent care

RTT Lead

Castle Point and Rochford Clinical Commissioning Group (*)

Chief Operating Officer

Chief Nurse

Clinical Lead for Urgent Care

RTT Lead

Southend University Hospital Foundation Trust (*)

Chief Executive

Chief Operating Officer

Ambulance

Essex Locality Director

South East Essex Partnership Trust

Director of Integrated Services for Adults & Older People

Executive Director of Integrated Services – Essex and Suffolk

Director of Mental Health

Southend on Sea Borough Council (*)

Chief Executive

Director for People

Essex County Council

TBC (as appropriate)

The group meetings will be administered by Southend CCG

7. QUORUM

A quorum of 4 of the core organisations (marked *), with members who have decision making responsibilities subject to the respective organisations governance arrangements plus the Chair or Deputy Chair must be present to constitute a valid meeting.

8. MEETING FREQUENCY

The SRG will meet initially on a fortnightly basis with regular review to increase / decrease frequency as the situation requires

9. REVIEW OF EFFECTVENESS

The SRG will develop a workplan that prioritises and monitors the delivery of its objectives. This workplan will be monitored regularly and will be formally reviewed on an annual basis. This review will form part of an annual report which will be provided to the member organisations as part of their assurance of the group's effectiveness

10. REVIEW OF TERMS OF REFERENCE

To be reviewed annually.

Appendix 7 – Risk Log

The key risks to implementation of the South East Essex Operational Resilience and Capacity Plan and the action being taken to manage risk are summarised in the table below.

The risks have been rated Red, Amber, Green in accordance with the following risk rating system:

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25

4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Key Risk	**Potential Consequence of Risk**	**Action to Manage Risk**	**Owner of Risk Monitoring & Management**	**Low** **Moderate** **High** **Extreme**
SUHFT - Workforce capacity issues across both medical and nursing within the accident and emergency department and also in medical ward areas.	Potential to impact upon timely discharges, flow through the hospital, higher conversion rates, quality of care.	GP triage in place at front door. Recruitment packages developed by SUHFT HR team and additional staff currently being recruited to key posts. Recruitment options for overseas candidates in place. Workforce plan has been implemented throughout year including changes in skill mix.	SUHFT	**Impact: Major** **Likelihood: Possible** **(High)**
SUHFT - Escalation of serious incident status in A&E to key partners when there are no issues in the rest of the hospital has been a challenge previously and will remains a risk that needs to be managed.	Adds additional pressure to other services within the system. Extra capacity cannot be sourced early enough to make an impact.	Escalation plan in place and requirement to escalate to serious incident status reviewed with host commissioner. Perfect week exercise tested escalation plans and further perfect week planned later in Autumn. Additionally the hospital testing its escalation plan on half day session. CCG on call rota has been changed to a South East rota to ensure more local knowledge and ownership.	SUHFT	**Impact: Major** **Likelihood: Possible** **(High)**

Key Risk	Potential Consequence of Risk	Action to Manage Risk	Owner of Risk Monitoring & Management	Low Moderate High Extreme
For both the Hospital and community services the risk of shortages in other workforce areas needs to be managed, in particular professions allied to medicine such as physiotherapy. This becomes complex given the sub contract arrangements with South East Essex partnership Trust.	Staff shortages impact upon service delivery, patient experience and achievement of NHS Constitution standards.	Workforce plans in place to recruit to vacant posts, with, links to education and training programmes to ensure that sufficient expertise remains within the system.	SUHFT/SEPT	**Impact: Major** **Likelihood: Possible** **(High)**
EEAST - Ability to manage the flow into accident and emergency department through effective intelligent conveyancing.	Increased pressure on emergency department preventing delivery of urgent care standards.	Ensuring that the Ambulance Trust is effectively engaged in this plan through senior leadership and presence at both weekly operational group and fortnightly strategic group. Mobilise EEAST internal surge escalation plans	EEAST	**Impact: Major** **Likelihood: Possible** **(High)**
SEPT - Ability of the community trust to flex capacity when escalation is required.	Slow discharges impacts flow	1. Commission additional bed capacity and reablement capacity within the community, in particular the intermediate care beds and care home beds over the winter period. 2. Ensure that there are effective controls around patient flows in order to maintain bed capacity within the community 3. Work with a number of key care home providers to manage their bed capacity.	CP&R CCG/SCCG/ SEPT/ECC/SBC	

Key Risk	Potential Consequence of Risk	Action to Manage Risk	Owner of Risk Monitoring & Management	Low Moderate High Extreme
CCGs - Achieving sufficient pace for change to deliver required reductions in emergency attendances and admissions.	Planned efficiencies and demand reduction are not realised, placing greater pressure on the system.	Joint QIPP Programme Director post currently being considered. PMO arrangements within CCGs currently being established.	SCCG/CP&R CCG/SUHFT/ SEPT	**Impact: Major** **Likelihood: Possible** **(High)**
System - Clinical change does not happen at required pace.	Continued variation in practice Clinicians disengage with process	1. Ensure engagement of key clinical leaders from across the health economy in the process from the start. 2. Engage GP clinical leadership. 3. Ensure meaningful integration of quality and productivity programmes across the health economy. 4. Where appropriate look at the use of incentives to encourage ownership of change.	SCCG/CP&R CCG/SUHFT/ SEPT	**Impact: Major** **Likelihood: Possible** **(High)**
Insufficient capacity and capability within primary care.	Increased attendances and emergency admissions in hospital	1. Care home pilot to increase proactive management of patients. 2. Review of GP opening hours 3. Proactive leadership by GP Federation	SCCG/CP&R CCG	**Impact: Major** **Likelihood: Possible** **(High)**

Appendix 8 – ECIST Length of Stay review

Interim Management and Support

Sent by email: 14th July 2014

Report from a Length of Stay review undertaken at

Southend Health Community

1. Introduction

A Length of Stay (LOS) review was undertaken on the 17th June with an associated feedback and discussion session provided on 23rd June 2014. The purpose of the LOS review is to capture local intelligence of *perceived and actual patient* flow issues by capturing first hand information from ward staff, namely the person in charge of the ward. This report reflects the observations and discussions from a predominantly acute perspective. Other agencies may have a different perspective on some of the issues facing the local healthcare community. A wide range of issues were observed and discussed which will need to be addressed collaboratively to improve appropriate and safe movement of patients through the local health system.

The review also provided an opportunity to talk with ward staff about what they feel needs to work differently to improve patient flow. Each ward manager or representative was asked if they had a 'magic wand' what would they change both internally and externally to improve the flow of patients.

2. Structure

The review was facilitated by Liz Sargeant of the Emergency Care Intensive Support Team (ECIST) with a high level of system engagement. The review was completed by practitioners and service leads from the acute trust, community services, social care, GPs and commissioners. Liz briefed the team before the review to ensure consistency of approach across the team undertaking the review. The reviewers are encouraged to ask the question about plans for patients as if they were the patient or their relative. There are four key questions that all patients should expect staff on the ward that is caring for them to be able to answer:

- What is wrong with me?
- What is being done next to make it better?
- What do I need to be able to do or what needs to have happened for me to be able to go home?
- When am I going home?

We asked reviewers to note how clearly the person in charge of the ward could describe the clinical and discharge plans for patients. We know that for patients to understand what is happening good communication at ward level is essential.

A patient list was generated by the acute trust to capture all medical inpatients with a LOS >7days across both hospital sites. To support the generation of quantitative information a definitions chart, see Appendix 1, was given to reviewers to code responses gained from discussions with ward staff. The most comprehensive outcomes are from the qualitative information gathered during the review process and from discussions with ward staff. Ward staff were asked what the clinical plan was for

each of the patients. What was the next thing patients were waiting for on the day of the review? In addition to this the group made observations of ward processes and discussed the themes highlighted.

3. The Length of Stay (LOS) review process

Matrons, ward managers and duty staff were aware that a LOS review was being completed. All responses shared in this report are anonymous. The aim is to capture the perceptions and evidence of known patient flow issues in order that improvement programmes can be refined and focused on issues that staff identify as consistent constraints. The primary objective was to ascertain what the patient was waiting for on the day of the review; this review is neither clinical nor correlative to the delayed discharge notification processes.

Patients whose reason for being in hospital is on-going rehabilitation, with no other acute medical or nursing needs, are identified as being in the 'fit'' category. The question is whether this care could be provided in other settings if the relevant services were available? Research evidence shows clearly the harm that occurs as a result of unnecessary extended hospitalisation, particularly for older people.

Gill et al (2004) studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity. Kortebein P et al. (2008) noted the functional impact of 10 days of bed rest in healthy older adults included a large loss of skeletal muscle particularly from the lower extremities. This factor combines with the physiological stress and other factors associated with hospitalization. The overall impact is that an unnecessary extended length of stay in hospital of 10 days equates to an associated 10 years of physiological muscle ageing.

Within this report 'medically fit' relates to the coding used, see Appendix 1 for further details. 'Not Fit' codes were used to highlight patients who were still in an acute stage of their illness and/or recovery. 'Fit' codes were assigned to patients that were deemed not to be in an acute phase of illness; beyond this no assumptions relating to 'best place of care' have been made.

We would like to thank the team of reviewers who worked with us for their enthusiasm and clear feedback on what they had heard and observed. Patient data used was either returned to the Trust or destroyed following the electronic recording of results. No patient identifiable outcomes are recorded in this report.

4. Qualitative Feedback

The Length of Stay review teams found the ward leaders to be welcoming and open with information. The ward leaders had, almost without exception, an impressive level of knowledge on what was planned for their patients. Our assessment was that this was one of the best examples of empowered nurse leadership that we have seen across the country. This was particularly impressive as, although ward leaders have been supernumerary in the past, they are currently often working within ward numbers due to nurse staff shortfalls. We observed excellent practice on some wards including: clinical criteria being set for discharge; enhanced recovery approach adopted in surgery and evidence of forward planning for discharge.

There was good system engagement in undertaking the review including a high level of commissioning input and good primary care representation. Overall there were significantly less issues highlighted at the interface than in other systems we have reviewed across the country. It was clear to us, from both the length of stay profile and our observations on the day, that the system is working relatively well. Our assessment is that if the local health community is committed to building on this foundation to develop a full "Choose to Admit" / "Discharge to Assess" approach that Southend Local Health Community could become a national reference site for good whole system patient flow.

4.1 Internal Issues observed/heard

- The white boards were generally well-presented and included expected dates of discharges (EDDs) and medically fit for discharge dates. There were data quality issues on some wards but this was not common.
- We felt that there was a lack of consultant leadership to support timely decision making on the wards. The Trust has set a local standard that a registrar or above should lead daily board rounds. However senior ward rounds for every patient were often largely dependent on registrar support and were not consistently delivered on a number of wards.
- There were a number of patients without clear management plans. Consultant engagement in setting EDDs on admission and communicating with nursing staff appeared to be variable and sometimes limited. A number of patients were highlighted as awaiting medical review.
- There was a relatively high level of internal waits for various tests. We know that you already monitor internal waits on a daily basis but were not clear on how themes behind delays are escalated and addressed. We **recommend** you should continue to review and escalate internal waits on a daily basis with thematic delays highlighted to executive leads to support rapid resolution.
- We observed variation in how IV antibiotics were prescribed and suggest there is potential for more patients to be managed on oral antibiotics within the community.
- Our assessment was that some of the current inpatients could also be managed in ambulatory or outpatient settings. In particular the complex wound unit is managing care on an acute inpatient basis in a way that we have not seen elsewhere in the country. We **recommend** you review the complex wound pathways to reduce inpatient provision to a minimum level whilst developing alternative acute and community provision.
- A number of patients were receiving rehabilitation within an acute setting. We queried whether there is a default referral to therapists and **recommend** that you move to a "Choose to Admit" / "Discharge to Assess" model as an alternative to starting therapy assessments on acute wards.
- There is a specific challenge for therapists to consider the best place to assess and rehabilitate patients taking into account the adverse impact of hospitalisation on older people.
- TTOs appeared to be written up late in the day on a routine basis which increases the likelihood of a failed discharge.
- Lack of early appropriate clinical streaming appears to drive multiple patient transfers with an associated increase in length of stay. There appeared to be significant difficulties in getting patients into the right bed first time.
- The fractured neck of femur path was reported to work well from the ED. However concerns were raised that planned reconfiguration might adversely impact on the pathway. We **recommend** that you consider whether this is a significant risk and if so take action to mitigate the potential risk.

- The ortho-geriatric pathway was described as being provided within a shared care and multi-disciplinary model which is good. However we were told that the medically optimised date often did not align with the rehab fit date and that "fit" patients were being managed in hospital on a regular basis. We **recommend** that you review the ortho-geriatric pathway with the aim of reducing the "fit" days that patients spend in the acute hospital.
- Patient family choice was highlighted as a significant issue. We did not feel that clear expectations were being set with families early in the admission.
- Transport was highlighted by a number of staff as a significant constraint.

4.2 Pathway and Process Issues - Interface

- Our overall assessment is that the current arrangement where the hospital provides an effective outreach service into the community is working well with some of the smallest number of patients waiting in the discharge processes that we have seen across the country. This is good practice which we **recommend** should be incorporated within any future planned models.
- We observed some social care delays but significantly lower levels than in other hospitals. We felt that relationships with local partners were good and there was clear evidence of proactive joint working. We were told that social workers sometimes work to section 2s which is excellent practice. However there was also the suggestion that there were too many section 2s and a low level of conversion. We **recommend** that you review the numbers and appropriateness of section 2s and that social workers continue to respond to section 2s. It is relevant to note that as a result of the 2014 Care Act that the notification process will be changed with effect from 1st April 2015 and your local policies and procedures will need to be amended to reflect this.
- We felt that there was some reliance on bed based pathways with staff highlighting the need for more community/bed based routes. We **recommend** you consider whether your current balance between bed and home based care is appropriate.
- There were a number of therapy delays reported. We **recommend** that you front load functional assessments by moving some therapists and some of the discharge team to the ED/AMU to set a plan for discharge at the point of entry. The same team should then follow the patient on their admission to achieve an early discharge through one member of the team joining the morning board rounds each day. This initiative would improve patient management at the same time as managing family expectation.
- There were a number of issues with regard to achieving timely transfers to tertiary centres – cardiology was a specific issue raised.
- We noted that there were also significant delays across the neuro-rehab and brain injury pathway. There was a suggestion that a local pathway might be commissioned which we felt would be a good way forward.
- CHC processes were not raised as an issue within the review but were raised as an area of concern during the feedback session.
- There appeared to be some avoidable admissions from nursing and residential homes. The evidence base on the impact of initiatives to reduce admissions from home is good and we **recommend** that you consider local options to reduce these admissions.
- Overall we **recommend** that you consider the potential to develop a full "Choose to Admit/Discharge to Assess" model. The Better Care Fund could be used as a lever to optimise the pace of implementation.

We reiterate key recommendations at the end of this report that we think it would be helpful to focus on as priorities across the local health community.

5. Quantitative information

5.1 Two hundred and thirty two patients were identified with a length of stay over seven days and were reviewed on the 17th June 2014 across both hospital sites. The table below shows the numbers who were judged by the review team to be 'fit' or 'not fit' from the information they were given. This was obtained from the person in charge of the ward, by asking the questions 'what is the plan for the patient?' and 'what is the next specific step they are waiting for?' The coding used is set out under Appendix 1.

	Fit	Not Fit	Grand Total
Southend Hospital	91	112	203
Community Hospital	26	3	29
Total Patients	117	115	232

Table 1: Numbers of patients judged to be "fit" or "not fit"

Chart 1: Numbers of patients seen on each ward across both hospitals

Chart 2: Numbers of patients 'Fit' and 'Not Fit' by ward across both hospitals

Age	Fit	Not Fit	Total
0-9	0	0	0
10-19	1	1	2
20-29	0	2	2
30-39	0	3	3
40-49	4	5	9
50-59	13	11	24
60-69	14	15	29
70-79	22	29	51
80-84	26	16	42
85-89	15	20	35
90-94	14	11	25
95-99	1	2	3

Table 2: Ages of Patients reviewed across both sites

Table 2, above, and Chart 3 overleaf highlight that the 80-84 year old age group appear to have the greatest potential to reduce length of stay overall. We have attached the raw data so you can pivot the data by hospital and specialty within the acute hospital to drill down to specific areas or into specific issues. We can offer further support with the raw data if that would be helpful.

Chart 3: Ages of patients 'Fit' and 'Not Fit

5.2 Coding Outcomes for Southend Hospital

"Not Fit" Patients

Not Fit Patients	
5	End of life and wants to die in hospital
61	Active on-going (non-specific) clinical treatment (not as sick as below)
21	Waiting for test, investigation, specialist opinion or review
13	NEWs score of 5 or above, unpredictable erratic, intervention acute
11	Intravenous therapy that cannot be given in the community
0	Infectious a risk to others therefore cannot discharge
1	No Plan

Table 3: Detailed coding for Patients who were assessed to be "not fit"

Of the 112 patients who were assessed to be "not fit" where this is defined as being in need of care that could only be provided in the acute trust:

18 (16% of 112) were deemed to be seriously ill, or dying with a short prognosis and wished to be in hospital. Some patients had infections that meant they could not be discharged to another care setting.

61 (55%) were still 'medical', not as sick as the 18 above. Peer review of the management of some of the patients who stay longer in an acute setting may show that this is associated with variation in patient management. We **recommend** that a regular clinically led peer review should be undertaken of all inpatients with a LOS over 7 days.

21 (19%) were still needing medical interventions but the next step was not known. Decisions were delayed while waiting for internal responses to tests, investigations, specialist opinion from another specialty or review by their own consultant.

"Fit" Patients

Fit Patients	
4	Waiting for transfer to Acute Hospital for treatment- fit to travel/tertiary
8	Waiting for community hospital/other bedded intermediate care setting
1	Waiting for continuing health care/social care panel decision
4	Waiting for continuing health care package
1	Waiting for equipment / adaptations
1	Housing needs / homeless
5	Waiting for patient/family choice
2	Waiting for internal discharge referral processes e.g. checklists, section 2 and 5
6	Waiting for occupational therapy/physiotherapy approval for discharge
22	Ready for home today
1	Waiting for hospice place
4	Waiting for internal transfer - ward to ward

8	Discharge planned for tomorrow - what is stopping them going today?
3	Waiting for social care reablement or intermediate care at home
7	Waiting for internal assessments/results before discharge
3	Waiting for external agency assessment - social care,MH,RH,NH etc.
2	Waiting for Start Domiciliary Care Package - long term packages
0	Out of county/borough assessments
0	Waiting for placement Nursing/Residential Home CHC, Social Care, Self
7	No clear plan of clinical care and/or what is needed for discharge
2	Safeguarding

Table 4: Detailed coding for patients who were deemed 'fit'

Of the 91 patients reviewed deemed to be "fit" according to the ECIST codes:

22 (24% of 91) were going home on the day of the review or the next day. The review took place on a Tuesday which is a common day for peaks in discharges in many trusts. Reducing the variation by day of week of discharge will improve flow across the system. We **recommend** that the Trust monitors discharges on a daily basis as a measure for improvement. We **recommend** that expected discharge rates should be profiled and monitored on a daily basis so that it is clear what level of discharge is required to remain in balance.

Of the remaining 69 patients who were deemed to no longer need acute care within the Trust using the ECIST codes:

7 (10% of the 69) were described as having no clear management plan.

6 (9%) were described as needing physiotherapy or occupational therapy assessments or treatment before the next step towards discharge could be undertaken.

5 (7%) were in the process of making a decision about what they wanted next. This included waits for families to attend meetings to discuss options. It appeared that there were delays in families and patients making decisions particularly

related to 'homes of choice'. Once patients and families have been offered a suitable solution the onus should be with the Trust to manage the patient/family expectations and behaviours through a robust 'Patient Choice Policy'. Within the Direction of Choice it should be clear that remaining in an acute hospital bed is not one of the available choices. The setting of patient's and carer's expectation should commence from the point of admission using Welcome Card type approaches. We **recommend** that the Trust reviews any choice policy they have. If there is no agreed policy in place then one should be agreed with partners in social care as a matter of priority.

27 (39%) patients were waiting for some kind of external input. 6 patients were waiting assessments from external agencies. While 21 patients were waiting for a community based long or short term solution:

- 14 were awaiting a long or short term bed based option
- 7 patients were awaiting a home based option.

5.3 Coding Outcomes for the Community Hospital

The Community Hospital review was undertaken at the same time as the Southend review. Our overall impression was that the Community Hospital appeared to work within a traditional model. This often has an associated loss of pace for patients following transfer from the acute hospital. We would question whether the level of therapy provided within the hospital stay provides patients with a net benefit taking into account the adverse impact of the continued hospitalisation as we noted earlier in this report.

The detailed coding for the Community Hospital Length of Stay review is provided overleaf.

"Fit" and "Not Fit" Patients

Patients		
Fit	Not Fit	
	1	Active ongoing (non-specific) clinical treatment
1		Housing needs/homeless
	1	Waiting for test, investigation, specialist opinion or review
2	1	No clear plan of clinical care and/or what is needed for discharge
3		Waiting for equipment / adaptations
13		Waiting for occupational therapy/physiotherapy approval for discharge

1		Discharge planned for tomorrow – what is stopping them going home today?
1		Waiting for internal assessments/results before discharge
2		Waiting for patient/family choice
1		Waiting for Start Domiciliary Care Package - long term packages
2		Waiting for placement Nursing/Residential Home, Social Care, Self Funder

Table 5: Detailed coding for patients at Community Hospital

6. Interface Recommendations

The evidence for the impact of hospitalisation on older people in terms of immobility, nutrition and hydration are well described, as noted earlier. The culture of a bed being 'safe' needs to be challenged and services developed to see home as the preferred route with appropriate and sometimes short term significant support. This is possible if the investment in beds is reduced and services to support people at home increased. Professionals need to work with patients to assess and describe a plan which can be implemented by a pool of well trained and supervised care workers who can offer personal care, reablement and rehabilitation.

The systems across the country that appear to flow best have less reliance on bedded options for discharge and more support to get people home and to continue their recovery and assessment for long term care needs in a home based setting with support from well-trained carers. This support allows reablement and rehabilitation to continue in the place where the person is most comfortable and generally more motivated. This requires a flexible and responsive intermediate tier of services.

Accessed through a single point where needs are described by referrers rather than services. This allows on-going assessment after discharge to ensure that people receive the right package of care in the longer term if they still require something after this intervention.

7. Conclusion and Next Steps

We **recommend** that you future proof changes in the context of delivering a "Choose to Admit"/ "Discharge to Assess" mind-set with no decisions about long term care being made in hospital:

- Develop the current board rounds to provide a consultant review of all patients on a daily basis. Consider scripting the board rounds to: incorporate a flow bundle approach; provide increased clarity and consistency of outcomes and begin to embed robust board rounds into clinical practice.
- Translate agreed EDDs into definitive actions for the multi-disciplinary team to deliver to support the planned discharge.
- Undertake clinically led peer reviews of all inpatients with a LOS over 7 days.
- Drive early discharge from admission through assertive multi-disciplinary front door assessment including relevant therapy assessments and follow up on admitted patients to facilitate early discharge.
- Review patients on IV antibiotics and consider what would need to be different both in terms of the treatment plan and community services to reduce the number of inpatients.
- Review TTO issues and transport constraints to consider if these constraints can be designed out of the system.
- Escalate internal waits on a daily basis and develop a thematic executive review to identify options to fast track solutions to the key constraints.
- Board to Ward – focus on every patient and every carer being able to answer the four questions.
- If you agree to implement a "Choose to Admit" /"Discharge to Assess" model it is essential that you also manage patient and family expectations early. This should be focused on communicating the local agreement that decisions about long term care will not be made in the acute setting and whenever possible will be made at home.

The underlying principles that support effective system working and against which solutions need to be tested are:

- Person centred care
- Blurred organisational and professional boundaries, networks of care
- Easy access to advice and information to allow people and their carers to be in control of their care.
- Simple information flow, sharing of information owned by the patient (children's red book principles, bus pass possibility)
- Effective, efficient, proportionate, timely assessment – reduce duplication, massive productivity and quality improvement opportunity
- Simple access to services, that always say 'yes'.
- Proactive rather than reactive management of patients – top 5% of practice population on risk stratification
- Continual system wide feedback loops with agreed system metrics to monitor impact of change and manage unintended consequences

Recommendations from this review should be shared with commissioners and provider services in order that actions plans can be aligned/updated with the intelligence collected from this review. Further length of stay reviews could be considered by the health system stakeholders to increase awareness of system constraints and better inform operational and commissioning decisions. ECIST can offer further support if required.

With regards

Diane and Liz

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Ask the person in charge of the ward for each patient – What is the plan for the patient and is there an Expected Date of Discharge /Predicted Date of Discharge?
F 1 Waiting return to other Acute Hospital – fit to travel
F2 Waiting for transfer to Acute Hospital for treatment – tertiary fit to travel
F3 Waiting for community hospital placement or any other bedded intermediate care
F4 Waiting for continuing health care panel decision
F5 Waiting for continuing health care package
F6 Waiting for equipment / adaptations
F7 Housing needs / homeless
F8 Waiting for patient/family choice or input to decision making
F9 Waiting for internal CHC processes e.g. checklist completion, assessments
F10 Waiting for occupational therapy/physiotherapy approval for discharge
F11 Ready for home today – are they confident nothing will stop discharge?
F12 Waiting for hospice place
F13 Waiting for internal transfer – ward to ward
F14 Discharge planned for tomorrow – what is stopping them going today?
F15 Waiting for social care reablement or home based intermediate care time limited
F16 Waiting for internal assessments/results before discharge agreed
F17 Waiting for external agency assessment – social care/MH/RH/NH
F18 Waiting for Start or restart of domiciliary care package – long term packages
F19 Out of county/borough assessments
F20 Waiting for Residential or Nursing Home, Social Care or Self Funder
F21 Fit and no clear plan of what is needed for discharge
NF1 End of Life Pathway/ End of Life and wants to die in hospital
NF2 Active ongoing clinical treatment non-specific and not as sick as categories below
NF3 Waiting for internal test, specialist opinion or similar – state what
NF4 NEWS score 5 or above, unpredictable and erratic condition that may require immediate intervention. Care only available in the acute setting

NF5 Intravenous therapy that cannot be given in the community – can it be given elsewhere?
NF6 Infectious a risk to others therefore cannot be discharged
NF7 No clear plan
NF8 Other please free text
NF9 Other – waiting return to another acute trust not fit to travel
NF10 Other – waiting transfer to another acute trust for treatment and not fit to travel

Appendix 9 – Report on "the perfect day"

Whole Health and Social Care Economy Issues raised as part of Perfect Week- 7th-13th July 2014.
1. Lack of CICC beds

The lack of available Intermediate care has caused delays in discharge from Southend Hospital. The aim for safe and timely discharge is right patient, right bed, right time. This was raised as part of our ECIST Length of Stay review, and in Perfect Week.

The number of wasted bed days waiting for an Intermediate care service has increased from an average of 30 days per month in 2013-2014 to 116 days per month from April to May 2014
There are issues related to the transfer process where the rehab staff recommend a bed at CICC or Rosedale and this decision is questioned by the accepting rehabilitation staff which results in more time spent re-assessing or justifying decisions. Days can be lost with numerous emailed questions back and forth. A joint assessment form has been developed to reduce duplication and time, but on occasions, time is wasted with the referral process.
The rehabilitation staff in the hospital provide information to patients regarding their onward plans, and when these are not accepted, the patient loses faith and confidence in the process.

During April to May 2014 – delay days to CICC alone were 137 and delay days to Rosedale were 18

A major reason for delay is lack of ability to cope with more than 6 neuro rehab patients at one time. Rosedale has no neuro rehab input, and all patients go to CICC whether from Southend or RRCP areas.

The discharge to assess process should allow a smooth transfer of patients from hospital to Intermediate Care with onward decisions made out of the hospital setting.

Decisions made by the hospital MDT should be accepted, and further assessments can be provided following transfer.

2. Transport

Prior to April 2014, Southend Hospital had a transport booking office onsite that was able to liaise with all departments and staff. PTS crews called into the office, and were able to discuss individual details of patients and all journeys were planned onsite. This system provided a responsive pro-active flexible service.
Since April 2014, the CCG and EEAST have introduced a new contract for PTS hospital discharge transport. This new service has caused numerous delays in discharge and suffered an increase in patient complaints related to late or non-available transport.

Since April, the booking and planning of journeys has been based in Chelmsford one stop booking centre for all Essex patients. The wards have had difficulty contacting the central office as there are delays answering the phone.

Due to the remote service, the wards are unable to provide a time to patients for their transport home.
The Control Room have no details of who has had transport booked, or what time the patients will be collected.
There is frequently an issue where PTS ring late in the afternoon to inform the hospital there is a lack of capacity to discharge patients.

The CCG have refused to fund any "extra bookings" for transport to speed up discharges unless the hospital are extremely short of beds. Then an elongated process is undertaken involving the Clinical Site Manager contacting the Senior Manager On-Call who then contacts the CCG Manager On-Call to authorise an extra vehicle. The Clinical Site Manager then rings several private providers. This process in itself causes delays and is time consuming for staff when

beds are already under pressure. By the time the transport has reached agreement, it is late in the day and difficult to commission extra ambulances from private providers.
At weekends, the PTS crew bring in renal patients for their dialysis into the dialysis unit, which further delays discharges, as it can result in the first discharge occurring after midday. This backlog causes delays in admissions into the beds.

3. Discharge to assess

Currently the hospital have a very low percentage of delay days from the point of medically fit, due to good working relationship with partner agencies, and the use of the step-down beds or care packages. The spot purchase process currently in use allows patients to be transferred to an alternative setting to undertake further multi-disciplinary assessments. There are approximately 15 to 20 patients at any one time discharged under the umbrella of step-down. However there are still delays in some patient pathways that result in far too much time spent providing assessments for patients to access certain discharge destinations.
The continuing care process involves the discharge team undertaking 63 page Decision support tools to access funding for on-going care. This is the wrong time and place to undertake these assessments, and this results in inappropriate use of health funding. This is a vulnerable time is a patients recovery, immediately after an emergency acute episode. Many of these patients may well improve with a period of recuperation.
As stated above, there are delays with intermediate care, as too much emphasis is place on the very comprehensive assessment tool to identify an on-going need. It is well documented that patients change rapidly with 48 to 72 hours out of hospital, and some improve and some deteriorate, but it is very difficult at the point of discharge to predict an on-going need accurately.
Assessments are safer out of the hospital setting, and agreement should be made for a Reablement package to reduce long term care needs straight from hospital and further assess in the community, whether this be at home with care or in a bedded setting.

4. **Psychiatric Patients**

Southend Hospital does not have psychiatrists or CPNs. A limited RAID service was commissioned for the wards but not for A&E. Issues:

Pre-hospital

GPs have a helpline and clinically diagnose that patients do not have a physical illness, but do require mental health assessment. Because the mental health service do not recognise that a GP can make that diagnosis, they insist that all patients are brought to A&E, where they have to be screened fully for a physical illness before the mental health service will come to A&E to assess them. During the evening and night, patients have to wait until FROM 9am the next day to be assessed and/or sectioned. This has been happening almost every night for the past few weeks and was becoming more frequent before that. The A&E is being treated as a 'Place of Safety' for psychiatric patients when the commissioned service does not have capacity. These patients always breach the 4 hour quality standard, are completely unsuitable for either an ED Department or a busy assessment ward, we cannot get CPN cover to nurse the patients effectively whilst they are waiting, SUI's given to SEPT detail all issues including one patient who absconded after 9 hours of waiting to be sectioned in the A&E which is a serious clinical risk. We are being asked why we are not admitting patients, and it is because we do not have psychiatrists to admit them under, nor do we have CPNs.
In Perfect Week an anorexic patient requiring a Specialist bed had to be treated in a busy Medical Assessment Ward Bed for a week whilst services argued about whether she was a mental health patient or needed physical health care due to a low BMI. Eventually she was offered a bed in Glasgow, and then the bed was lost due to an inability to arrange the transfer in time, and then she had to wait again for another bed to become available.
We are dealing with very physically sick patients, especially on our acute medical unit. Dealing with patients who have psychiatric illnesses and patterns of behaviour that are uncontrollable is very distressing for other patients, takes nursing time++ away from other patients and takes a heavy toll on security staff, who are often the only people who can contain the patients whilst the patients are waiting to be seen by appropriately trained staff.

All of the issues above are worrying the clinicians in the Trust as they believe that patients are not being cared for in the right place by the right people with the right skills at the right time. We believe this is a serious clinical risk.

Whilst Project 14 has brought the right people together to commission a new service in the long term, clinical pathways also need to change and there has been no progress on this therefore the Resilience Group members have undertaken to attend a meeting on September 1st to ensure that the health and social care community work together to effect a change to ensure that psychiatric patients are cared for effectively.
Report Prepared by Sandra Steeples, Patient Admission and Discharge Manager, and Claire Old, Director of Emergency Care.

Appendix 10 – Flu Plan

Southend Clinical Commissioning Group

DRAFT

SEASONAL INFLUENZA

OUTBREAK PLAN

2014

KEY CONTACTS

Seasonal Influenza Outbreak Plan

NAME	POSITION	LANDLINE	MOBILE
Dr A Atherton	**Director of Public Health**	01702 212803	**07771 996527**
Linda Dowse	Executive Nurse Southend Clinical Commissioning Group	01702 314300	
Simon Williams	CCG AD Medicines Management	01702 314300	07970 730913
Wanda Wilson	Pharmacist (Cover for AD)	01702 314324	07970 669460
Health Protection Unit (HPU)	**Public Health on Call**	**01245 444417 (Pager services)**	**0845 1550069**
Sian Olivo	Infection and Prevention Control Lead SEPT	01268 739752	07983986591
Kim Shaw	Infection and Prevention Control Lead SEPT	01268 739721	07814 672247
SEPT	**Manager on call**	**N / A**	**07506 873579**
District Nurse Liaison	**District Nurse on call**	**01702 608250**	
Kathy Ramsay	Infection Prevention and Control Nurse PCT	**01268**	07966 766547
Microbiology	Addenbrookes Hospital	01223 257036	
Consultant Microbiologist	SUHFT	01702 385211 01702 435210	
Microbiology Department	SUHFT	01702 435555 Ext 2526	
Sandra Steeples	Discharge Manager SUHFT	01702 507129 01702 507175	
Infection control team	SUHFT	01702 435555	

		Ext 6608	
Pharmacy	SUHFT	01702 385224	
Essex County Council	Social Care Emergency Duty Team	0300 123 0778	
Essex County Council	Social Care – Care homes Team		
Karen Peters	SBC Social Care (Contracts Manager	01702 534513	07500 126493
or Carol Cranfield	SBC Social Care (Group Manager	01702 534408	
Sarah Range	SBC Social Care (Safeguarding Lead)	01702 534404	

Bold = out of hours contact provided

Seasonal Influenza Outbreak Plan 2014

Normal Working Hours

ALERT

Incident lead Anglia & Essex Public Health England Centre (Essex) Team

alerted to potential outbreak of influenza–like illness

Activation record sheet completed by Provider (SEPT) **(Appendix 1)**

INFORMATION CASCADE

Incident Lead Anglia & Essex Public Health England Centre (Essex) to inform:-

Provider lead-South Essex Partnership Trust (SEPT)/ Infection Control Nurse

Executive Nurse Southend Clinical Commissioning Group (SCCG)

Associate Director Medicines Management

Director of Public Health Southend-on-Sea Borough Council (SBC)

Discharge Manager Southend University Hospital NHS Foundation Trust (SUHFT)

CCG Emergency Planning Manager

Adult Social Care SBC

INITIAL ASSESSMENT

Anglia & Essex Public Health England Centre (Essex) to contact care home and complete pro-forma with detailed clinical history of symptomatic residents/staff (**Appendix 2)**

ARRANGE VIRAL SWABBING

SEPT Lead Manager to arrange staff team to undertake viral swabbing of all symptomatic persons (including staff) as per guidance (**Appendix 3)**

Individual microbiology request form to be completed for each patient **(Appendix 4)**

Provider ensures completed swabs are delivered to Microbiology Department at Addenbrookes Hospital Cambridge using commissioned courier service advise Anglia and Essex PHER centre of time of dispatch (TBA)

INFECTION CONTROL ADVICE

SEPT **Infection Prevention and Control Nurse** to advise nursing home on appropriate infection control measures (in line with any specific recommendations from PHE Anglia & Essex Centre) if advised by Public Health England Centre on call doctor, advise care home on closure to admissions or transfer procedures.

If affected home closes to admissions / transfers SEPT **Infection Prevention and Control Nurse** to inform Discharge Manager at Southend Hospital of the closure.

ACTION PLAN - INFLUENZA OUTBREAK CONTROL

Incident lead for PHE Anglia & Essex Centre liaise with Provider (SEPT) develop and agreed action plan, notify Director of Public Health for Southend Borough Council

ALERT HOSPITAL PHARMACY

Provider (SEPT) to liaise with CCG Medicines Management team/ contact hospital pharmacy (or holder of antiviral medication if stored elsewhere) to obtain medication for potential influenza outbreak

INITIATE TREATMENT AND PROPHYLAXIS

Designated lead PHE Anglia & Essex Centre liaise with Provider to decide on basis of clinical judgement to start treatment \prophylaxis (The results of swabs will be considered as part of this judgement)

NB treatment is most effective within 48hours of onset of symptoms or contact with an index case

Appropriately labelled medication to be delivered (either by courier/ medicines management team/Provider (TBA) to location. Provider staff (SEPT) assess, supply and write up in patients notes (including care home staff)

Copies of the antiviral medication supply form for each person given treatment

or prophylaxis to be faxed to person's GP.

SWAB RESULTS

PHE Anglia & Essex Centre inform Provider Outbreak Control team /SBC DPH and Care Home Manager of swab results

NB If negative - discontinue treatment

CLOSURE

PHE Anglia & Essex Centre to stand down team, arrange de-brief and liaise with Provider to produce a brief report

Provider to liaise with CCG Medicines Management team to arrange for any unused medication to be returned to pharmacy for disposal

SEPT Infection Prevention and Control Nurse (Provider) to advise care home and liaise with PHE Anglia & Essex Centre regarding re-opening and reinforce importance of influenza immunisation

SEPT Infection Prevention and Control Nurse (**Provider**) to advise Discharge Coordinator at Southend Hospital that the Care Home is open to transfers and admissions

SEPT Infection Prevention and Control Nurse (Provider) to ask Discharge Coordinator to ensure that information regarding outbreak is cascaded to the relevant hospital social care teams

Seasonal Influenza Outbreak Plan 2014

South Essex Partnership Trust

Out of Hours Procedure

If the SEPT Community "Manager on Call" (Provider) receives notification of a suspected Influenza like Illness (ILI) outbreak after 18:00 hours **(or on a Saturday, Sunday, Bank Holidays)** they should notify the PHE Anglia & Essex Centre. The on call public health doctor will liaise with the Provider to assess the severity of the situation. In general no action will normally be initiated until 08:00 hours the following day.

The SEPT "out of hours" procedure is set out below. This procedure will normally be initiated inline with guidance and direction from the PHE Anglia & Essex Centre.

CARE HOME OUTBREAKS (INFLUENZA-LIKE ILLNESS)

The management of "outbreaks" in care homes is important and the correct procedure must be followed in order to minimise spread of infection.

The SEPT On call manager (Provider) informed of potential outbreak of respiratory illness in a residential care setting

***Actions to be taken by on call manager**

- Complete the influenza outbreak activation record sheet, ensuring the name of the home, the number of beds and the contact details of the duty manager are recorded

- Contact PHE Anglia & Essex Centre public health on call on **01245 444417, ask for the public health person on call to be paged.** (Document the name of the PH on call).

- Clarify that they are aware of the possible outbreak and the action to be taken.

- Upon advice from the PH on-call obtain swabs, discuss with the arrangements and proposed time of delivery of swabs to the pathology laboratory at Addenbrookes University Hospital Foundation Trust.

- Inform District Nurse Liaison on **01702 608250** to instruct a member of the District Nursing staff on duty to obtain **viral** nose and throat swabs from up to six symptomatic residents (include symptomatic staff) and request a full respiratory screen.

- A supply of viral swabs, specimen bags and request forms can be accessed from District Nurse Liaison

- If anti-viral prophylaxis and treatment is required a supply of Oseltamivir (tamiflu) and Relenza can be accessed at **SUHFT pharmacy**. Contact on-call pharmacist. Additional supplies of antiviral medication may be accessed from secure storage at (TBA)

- Contact District Nurse Liaison (as above) who will have a list of nursing staff who are on duty and are trained to administer anti-viral medication. Request that nursing staff are deployed (depending upon the number of residents within the home) to attend the home and administer the prophylaxis.

- Liaise with the home manager/person in charge to inform them of what will be happening, document name of person informed.

- On call manager to inform infection control team of the incident the next working day by calling **01268 464545/615** or **07983986591**

***NB.**

- **The Provider will liaise with the PHE Anglia & Essex Centre person on call with regard to initiation of any actions between 08.00 – 18.00hrs.**
- **Prophylaxis with Oseltamivir (tamiflu) will normally only be commenced following cases confirmed by laboratory Testing or following advice from the designated incident Lead for the PHE Anglia & Essex**

ACTION CARD 1 Designated Lead for of Anglia & Essex Public Health England Centre

The following actions (not in priority order) should be undertaken by the PHE Anglia & Essex Centre in the event of an outbreak in a care home etc.

ITEM	ACTION	DATE COMPLETED
	Ensure that the CCG designated Lead /Executive Nurse is aware of the outbreak	
	Ensure SEPT (provider) have been contacted to request the implementation of the response procedure	
	Ensure the Director of Public Health Southend Borough Council is advised of the outbreak.	
	If viral swabs indicate a **positive** result, determine the treatment / prophylaxis programme to be followed	
	Consider the need to hold a meeting of the "Outbreak Control Team" (SEPT/CCG/PHE/Local Authority PH)	
	Ensure that the SEPT Infection Prevention and Control Nurse is aware of the situation	

	Ensure that the Consultant in Microbiology at SUHFT is advised of the situation to ensure they aware of the potential for admission of symptomatic persons	
	Liaise with Provider to ensure the Discharge Manager at SUHFT is appraised of the status of the care home affected (is it open or, closed to admissions etc)	

ACTION CARD 2

Southend Clinical Commissioning Group

ITEM	ACTION	DATE COMPLETED
	If alert of ILI is received by SCCG (not directly from PHE Anglia and Essex Centre) ensure PHE Anglia and Essex Centre are notified. **Call 0845 1550069 or, for paging services 01245 444417**)	
	Notify SBC DPH on the Location and extent of the outbreak.	
	Provide commissioning support to the Outbreak team (Anglia & Essex PHE Centre) as required to facilitate management of the outbreak	

ACTION CARD 3

CCG Medicines Management

On being notified of an outbreak, AD Medicines Management will undertake the following actions to ensure a proper response to the incident.

ITEM	ACTION	DATE COMPLETED
	To liaise with the PHE Anglia and Essex Centre, SEPT (Provider) to decide on basis of clinical judgement to start treatment \ prophylaxis of affected persons (should additional guidance be required)	
	Liaise with Provider and PHE Anglia and Essex Centre, to facilitate access to/supply of, appropriate medication to manage potential influenza outbreak (hospital pharmacy (**01702 385224**)	

	Arrange for any unused medication to be returned to pharmacy for disposal	

ACTION CARD 4

Infection Prevention and Control Nurse

On being notified of an outbreak, the Infection Prevention and Control Nurse will undertake the following actions to ensure a proper response to the incident.

ITEM	ACTION	DATE COMPLETED
	If necessary advise nursing home on appropriate infection control and advise on closure to admissions or transfers (in line with discussions with PHE Anglia and Essex Centre).	
	Liaise with PHE Anglia and Essex Centre and advise care home, regarding re-opening and reinforce importance of influenza immunisation	

ACTION CARD 5 –

SEPT (Provider) Infection and Prevention Control Lead

Upon notification from the Public Health Team of an outbreak, the following actions must be undertaken to ensure a prompt response to the incident.

ITEM	ACTION	DATE COMPLETED
	Ensure that the following are informed of the outbreak and briefed regarding the potential impact upon resources; • Chief Operating Officer • Director of Clinical Services/Executive Nurse • AD Clinical Services and Nursing	

	• Manager Acute Services	
	Instruct the flu coordinator (Modern Matron) covering locality) to arrange for viral swabs to be collected from symptomatic cases and be transported to the microbiology laboratory at Addenbrooke's	
	Ensure that the flu coordinator is aware that if the cause of the outbreak is identified as influenza, staff will be required to be deployed to administer antiviral prophylaxis and treatment.	
	Inform the flu coordinator of the result of any swabbing as soon as it is received in order to stand down/mobilise staff as necessary.	

ACTION CARD 6

SEPT (Provider) Flu Outbreak Coordinator (Modern Matron covering locality)

Upon notification of an outbreak, the following actions must be undertaken to ensure a prompt response to the incident.

ITEM	ACTION	DATE COMPLETED
	Upon notification of an outbreak arrange staff to attend nursing home and collect nose and throat specimens from symptomatic residents and staff using viral swabs	
	Instruct staff to transport the specimens to the microbiology laboratory at Addenbrooke's and obtain replacement viral swabs in order to replenish the stock used.	
	According to the size of the home, commence allocation of a sufficient number of staff who have undergone Oseltamivir and Relanza PGD training to administer antiviral prophylaxis and treatment if swab results are positive or if advised by PHE Anglia and Essex Centre,	
	Deploy staff/stand down staff when results received	

	If results positive liaise with home manager to inform them when staff will be arriving to administer antiviral treatment and prophylaxis.	

Appendix 1

INFLUENZA OUTBREAK

RECORD SHEET

Date:

Time:

By:

Care Home Name:

Care Home Address:

Care Home Manager/Contact:

Care Home Telephone number:

Care Home Fax number:

Number of symptomatic residents _____ Total Number of residents _____

Number of symptomatic staff _____ Total number of staff _____

Action record to be completed by SEPT Coordinator

SEPT Coordinator:

Swabs taken? (Circle as appropriate) YES / NO Date

Swabs sent to Microbiology laboratory YES / NO Date

Swabs returned Date

Swab Results No of swabs Positive Negative

HPU / Director of Public Health advice or instructions -

All actions completed YES / NO Date_____

APPENDIX 2

SUSPECTED FLU OUTBREAK - PATIENTS INFORMATION COLLECTION FORM

Name	Age /DOB	NHS Number	Gender	Date of onset of symptoms	Symptoms	Existing medical conditions	Medications	Flu Vaccination	GP

SPECIMEN COLLECTION
VIRAL SWABS (GREEN TOP)

All staff involved with the collection of specimens must have knowledge of and adhere to the Infection Prevention Control guidelines

Please note expiry date of the viral swabs as they have a short shelf life

All specimens should be collected using Standard Universal Precautions i.e. wearing of appropriate gloves, disposable plastic apron and washing and drying of hands before and after the procedure. For further detailed information see the infection prevention control guidelines

NASOPHARYNGEAL VIRAL SWABS

Nasopharyngeal swabs should be taken from symptomatic patients only.

Explain and discuss the procedure with the patient and ensure privacy while the procedure is being carried out.

Swabs should be obtained from both nares and the throat

Nose Swab

- Moisten the swab beforehand with sterile water/ or the transport medium.
- Move the swab from the anterior nares and direct it upwards into the tip of the nose.
- Gently rotate the swab through several rotations.

Throat Swab

- Ask the patient to sit in such a position that he/she is facing a strong light source.
- Ensure visibility of the area to be swabbed.
- Quickly, but gently, swab the posterior pharyngeal wall
- Avoid touching any other area of the mouth or tongue with the swab.

Place swabs into the tube containing the specimen transport medium, and firmly secure the cap.

Place the samples into the sealable plastic bag and seal. Complete the request form as described and place in the transport box.

Ensure that the collection of specimens is recorded in the patient's records.

Place all PPE into clinical waste bag (orange) and dispose as clinical waste and decontaminate hands.

DOCUMENTATION

Specimens must be accompanied by a microbiology specimen request form, which should include the following information:

- Patients name
- Date of birth and sex
- NHS number

- Date and time of collection
- Sample type ie viral swabs
- Investigation type

  Full Respiratory virus screen

  Influenza A and B incl swine flu

  Respiratory screen incl swine flu

- Any antimicrobial drug being taken by the patient.
- GP name
- Date of onset of illness
- Part of suspected flu outbreak

Without full information, it is impossible to examine a specimen adequately or to report it accurately.

Incorrectly or unlabelled specimens will normally be discarded.

TRANSPORTING SPECIMENS

To ensure the specimen remains viable make sure the specimen arrives at the laboratory as soon as possible. The sooner a specimen arrives in the laboratory, the greater is the chance of organisms present surviving and being identified.

The Health Services Advisory Committee 1991 guidelines for labelling, transport and reception of specimen's state-

"Specimens transported outside hospital must be secured in a primary leak proof container, leak proof secondary container and an outer box with UN Packing Instructions 602, therefore when transporting specimens back to laboratory the specimens should be collected and sealed in the appropriate container and placed in the double plastic bag with the completed request form. This should then be placed in a suitable dedicated carrier for transport back to the clinic or laboratory."

When delivering specimens to microbiology, please request they provide you with replacement swab kits (TBC)

SAMPLE VIRAL SWAB REQUEST FORM (SEMI COMPLETED (new form required)

Addenbrooke's		MICROBIOLOGY
INFORMATION FOR MEDICAL PRACTITIONERS		*HOSPITAL NUMBER AND*
PLEASE PRESS FIRMLY USING A BALL POINT PEN IF LABELS USED APPLY TO ALL COPIES		*NHS No*
LABORATORY HOURS MON - FRI 08:30 - 17:30 SATURDAY 08:00 - 12:00 URGENT WORK ONLY		*SURNAME*
		FORENAMES
Theraputic Drug Monitoring		*D.O.B* WARD **PCT** SEX M F
Body Weight / Dose	☐ Gentamicin	**DO NOT PLACE LABEL BELOW THIS LINE**
Time of last dose / Time of sample	☐ Vancomycin	CONSULTANT / GP REQUESTING / BLEEP No / IS THIS A PRIVATE PATIENT YES / NO
Trough time / Peak time	☐ Other (state)	DATE / TIME : / Plebotomists INITIALS
		SAMPLES TYPE: **VIRAL SWABS (Nose and Throat)**
O.D. Getamicin trough 6-18 hours post dose B.D. TDS Gemamicin: trough - just before dose Peak - 1 hour post dose Vancomycin trough - just before dose peak - 2 hours post dose		INVESTIGATION(S)
RESULT ENQUIRY Ext CONSULTANT Ext 01223 216 816 INFECTION CONTROL Ext 01223 217 497 OUT OF HOURS - PLEASE CONTACT MAIN SWITCHBOARD 01223 257 034		CLINCAL DETAILS: **PART OF A SUSPECTED FLU OUTBREAK** LOCATION OF SUSPECTED OUTBREAK DATE OF ONSET OF ILLNESS: ANTIMICROBIAL THERAPY
MICROBIOLOGY		

Appendix 11 – Real time data

The following data is provided daily and summarised weekly to all Southend Partners.

"Good Morning Southend" - Cumulative data received by all partners across the Southend Health economy.

Good Morning Southend

Daily 9am A&E Sitrep

Thursday 21/08/2014

		A&E Activity			Ambulance Patient Handover						Admissions & Discharges						
Date	Day	A&E Attends	Over 4h breaches	Perf Target 95%	handover less than 15 mins	Over 15 mins	Over 30 mins	Over 60 mins	% with handover time <30 mins	Data completeness	Non Elective Admissions	Non Elective Discharges	Difference	Cumulative difference	Specialty Boarders	Medical Outliers	Friends & Family (A&E)
28/07/2014	MON	295	12	95.93%	35	17	10	0	84%	83%	114	95	-19	-35	24	1	24
29/07/2014	TUE	252	3	98.81%	36	19	1	0	98%	92%	86	122	36	1	26	1	16
30/07/2014	WED	271	5	98.15%	41	31	2	0	97%	86%	112	113	1	2	24	1	16
31/07/2014	THU	238	1	99.58%	51	15	6	0	92%	96%	100	118	18	20	19	0	15
01/08/2014	FRI	232	9	96.12%	46	20	3	0	96%	97%	110	114	4	24	7	0	16
02/08/2014	SAT	253	5	98.02%	50	21	1	0	99%	92%	75	70	-5	19	6	0	18
03/08/2014	SUN	268	3	98.88%	57	19	1	0	99%	96%	76	54	-22	-3	8	0	18
Total w/e 03/08/2014		1809	38	97.90%	316	142	24	0	95%	92%	673	686	13	-3	114	3	123
04/08/2014	MON	271	6	97.79%	52	29	2	0	98%	94%	90	85	-5	-8	12	0	19
05/08/2014	TUE	262	8	96.95%	50	14	6	0	91%	90%	77	79	2	-6	9	0	19
06/08/2014	WED	238	3	98.74%	44	24	1	0	99%	90%	96	87	-9	-15	14	0	11
07/08/2014	THU	259	10	96.14%	38	33	5	0	93%	92%	106	107	1	-14	17	0	22
08/08/2014	FRI	251	8	96.81%	37	21	10	2	83%	95%	112	121	9	-5	19	0	11
09/08/2014	SAT	241	17	92.95%	52	4	2	0	97%	91%	69	66	-3	-8	26	5	11
10/08/2014	SUN	269	3	98.88%	52	3	0	0	100%	90%	77	56	-21	-29	28	12	11
Total w/e 10/08/2014		1791	55	96.93%	325	128	26	2	94%	92%	627	601	-26	-29	125	17	104
11/08/2014	MON	243	5	97.94%	47	15	11	5	79%	91%	93	87	-6	-35	26	11	15
12/08/2014	TUE	273	41	84.98%	22	18	25	10	53%	80%	105	113	8	-27	20	11	18
13/08/2014	WED	238	36	84.87%	26	27	18	2	73%	81%	105	101	-4	-31	24	6	13
14/08/2014	THU	228	14	93.86%	41	24	2	0	97%	86%	98	94	-4	-35	22	6	18
15/08/2014	FRI	221	6	97.29%	42	38	1	0	99%	89%	95	108	13	-22	21	6	9
16/08/2014	SAT	211	0	100.00%	54	15	9	1	87%	100%	77	73	-4	-26	26	1	9
17/08/2014	SUN	263	3	98.86%	35	15	6	0	89%	90%	69	57	-12	-38	26	1	21
Total w/e 17/08/2014		1677	105	93.74%	267	152	72	18	82%	88%	642	633	-9	-38	165	42	103
18/08/2014	MON	242	5	97.93%	54	8	5	0	93%	97%	101	95	-6	-44	27	1	12
19/08/2014	TUE	201	7	96.52%	45	10	3	0	95%	94%	98	109	11	-33	18	1	10
20/08/2014	WED	256	3	98.83%	51	9	15	0	80%	96%	97	62	-35	-68	8	0	0
21/08/2014	THU																
22/08/2014	FRI																
23/08/2014	SAT																
24/08/2014	SUN																
Total w/e 24/08/2014		699	15	97.85%	150	27	23	0	89%	96%	296	266	-30	-68	53	2	22
25/08/2014	MON																
26/08/2014	TUE																
27/08/2014	WED																
28/08/2014	THU																
29/08/2014	FRI																
30/08/2014	SAT																
31/08/2014	SUN																
Total w/e 31/08/2014		0	0		0	0	0	0			0	0			0	0	0

Month	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
	90.11%	95.67%	96.26%	96.56%	95.80%							
Quarter	Q1			Q2			Q3			Q4		
	94.14%			96.32%								
YTD	2013/14						% Ambulance patients with handover time recorded YTD. (Target 85%)			MONTH TO DATE (MEDIAN)		
	94.93%									94%		

Urgent Care System Daily Dashboard

Urgent Care Weekly Dashboard.xps - XPS Viewer

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URGENT CARE SYSTEM DAILY DASHBOARD - 20/08/2014 (Wednesday)

South East Essex Region: *NHS Castle Point and Rochford & NHS Southend CCG*

111 Commentary - Wednesday 20th August

NHS 111 showed a percentage of triaged cases **sent to Ambulance or A&E Services slightly higher than** recent averages
Overall **volumes** of 111 Calls were **notably lower than** recent averages- continuing a 2 week low trend on thursdays
Performance of calls answered in 60sec was shown at **c100%** - compared to the 95% standard .

Acute Commentary - Wednesday 20th August

Acute 4 hour standards were met, with **c98.8%** of patients treated within 4hrs - compared to the standard of 95%
The **number of A&E attendances** returned to average levels
The percentage of **Handovers** occuring within 15 minutes were **in line with** recent averages
Conversion to Admission from A&E was **in line with** recent averages.

There were fifteen (15) ambulance delays over 30mins - of which none (0) were over an hour.

Headlines

3	**A&E Four (4) Hour Standard Breaches** *Patients waiting beyond 4 Hours standard to be treated*
98.8%	**A&E Four (4) Hour Performance** *Performance of service to meet 4 hour standard*
256	**A&E Attendances** *Number of Patients Seen at A&E Dept.*
68.0%	**A&E Ambulance Handovers within 15 minutes** Percentage of ambulance handovers occuring within 15 mins.
32.4%	**A&E Conversion Ratio to Admission** Percentage of patients admitted from A&E
21.8%	**NHS 111 Cases sent to A&E or Ambulance** Percentage of triaged cases directed to A&E or Ambulance services
313	**NHS 111 Calls** Overall Number of Calls to NHS111
100.0%	**NHS 111 Calls Answered in 60 seconds** performance measure of service

Weather (SOS)

Date	High	Low	precip	Snow	Forecast
Thu 21/08/2014	19°	12°	0 mm	0 CM	Sun and clouds with a shower
Fri 22/08/2014	19°	10°	1 mm	0 CM	Partly sunny with a shower
Sat 23/08/2014	18°	9°	1 mm	0 CM	Partly sunny with a shower
Sun 24/08/2014	19°	12°	3 mm	0 CM	Times of clouds and sun
Mon 25/08/2014	20°	15°	2 mm	0 CM	Occasional rain and drizzle
Tue 26/08/2014	21°	12°	1 mm	0 CM	Clouds and sun with a shower
Wed 27/08/2014	18°	15°	24 mm	0 CM	Cloudy with a touch of rain
Thu 28/08/2014	22°	13°	0 mm	0 CM	Mostly cloudy
Fri 29/08/2014	21°	13°	1 mm	0 CM	Variably cloudy with a shower

*sourced from accuweather

Central Eastern Commissioning Support Unit
Phoenix Court, Christopher Martin Road, Basildon SS14 3HG,

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23:17 21/08/2014

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URGENT CARE SYSTEM DAILY DASHBOARD - 20/08/2014 (Wednesday)

Castle Point and Rochford Clinical Commissioning Group

Basildon Billericay Brentwood Clinical Commissioning Group

NHS 111 - South Essex

	Latest Figures	
	Wed 20/08	Prev/ Week
No. of Calls Offered	313	358
% of which Out of Hours	54%	62%
No. of Calls Answered	307	352
of which % Triaged	84%	84%
% Answered within 60secs	100.0%	96.9%
% Passed to Clinical Advisor (of Triaged)	38%	30%
% sent/directed to GP in Hours	14%	15%
% sent/directed to OOH	29%	30%
% sent/directed to Community	0%	0%
% sent/directed to Ambulance	19%	17%
% sent/directed to A&E	0%	0%

Total Number of 111 Calls Offered: Previous Wednesdays

% Calls Answered within 60s (yesterday)

% Ans in 60sec SPC Chart (previous Weeks)

% Triages sent to A&E + Ambulance

Outcomes: Yesterday and Prev 7 Wednesdays

compared to previous 28 Wednesdays

Ambulance (999)

	Latest Figures	
	Wed 20/08	7 Day Avg
No of Patient Journeys to Southend Hosp	76	75.2
Number of Handovers Recorded	71	68.7
Percentage Compliance	96.2%	90.6%
% Arrival to Handovers within 15min	68.3%	62%
% Arrival to Handovers within 30min	75%	75%
% Arrival to Handovers within 60min	86%	86%
% Arrival to Handovers over 30min	22%	23%
No of Delays (30-60mins)	13	6.3
No of Delays (>1hr)	0	0.4
% Handover to Clear within 15min	35%	40%
% Handover to Clear within 20min	59%	72%
% Handover to Clear within 30min	85%	93%
% Handover to Clear over 60min	15%	7%
% Arrival to Clear within 15min	9%	9%
% Arrival to Clear within 30min	42%	54%
% Arrival to Clear within 45min	72%	80%
% Arrival to Clear over >2min	28%	17%

Number of Patient Journeys to Southend Hospital (latest 8 days)

Number of Ambulance Delays

30 - 60 Mins	15
1Hr+	0

Arrival to Handover Times (Latest 8 days)

% Handovers within 15mins (Yesterday)

Southend University Hospital NHS

Accident and Emergency

	Latest Figures	
	Wed 20/08	7 Day Avg
No. of Attendances	256	239
of which aged over 65	65	70
No of Attendances seen by SAU/EC	53	47
Percentage patients Treated < 4 Hours	98.8%	95.6%
% Ambulance Handover < 15mins	68.3%	62.2%
No. Cancelled Operations	TBC	TBC
No. of Admissions from A&E	83	74
No. of EM Admissions not from A&E	13	12
No. of EM Readmissions	4	9
No. of Discharges	86	84
No. of Delayed Transfers	no data	no data
of which Social Care related	no data	no data

Daily A&E Attendances - SPC Chart

% Treated within 4hrs (Yesterday)

Daily Conversion Rate - SPC Chart

Temperature / Volume Comparison

Daily 4hr Performance - SPC Chart

SEPT

Community Care

	Today
	Thu 21/08
CIC & Rowaide	
CIC Empty Beds (Female)	5
CIC Empty beds (Male)	4
CIC Planned Discharges (Female)	1
CIC Planned Discharges (Male)	-
CIC Planned Admissions (Female)	-
CIC Planned Admissions (Male)	-
CIC Patients Waiting in Community (Female)	-
CIC Patients Waiting in Community (Male)	-
CIC Patients Waiting in Hospital (F)	-
CIC Patients Waiting in Hospital (M)	-
Rowaide: Empty Beds	1
Rowaide: Planned Discharges	-
Rowaide: Planned Admissions	-
Rowaide: Patients Waiting in Community	-
Rowaide: Patients Waiting in Hospital	-

Community Care

	Today
	Thu 21/08
Rehab and Reablement: START, CCT & Southend	
Referrals for Rehabilitation and Reablement	5
START: Current Caseload - Single Handers	18
START: Current Caseload - Double Handers	12
START: Current Caseload - Mobilises	3
START: Waiting List - Single Handers	-
START: Waiting List - Double Handers	-
START: Waiting List - Mobilises	-
CCT: Current Caseload - Single Handers	6
CCT: Current Caseload - Double Handers	3
CCT: Current Caseload - Mobilises	3
CCT: Waiting List - Single Handers	1
CCT: Waiting List - Double Handers	3
CCT: Waiting List - Mobilises	-
Capacity Indicators	
CAPACITY: START	Now
CAPACITY: CCT	Limited
CAPACITY: Southend Reablm Ability Care+	Limited
CAPACITY: Southend Reablm: Dedicated sgh	Limited
CAPACITY: Southend Reablm: Care Home	LIMITED

CIC + Rowe Pets Waiting in Hospital

CIC + Rowe Pets Waiting in Community

CCT & START Pets Waiting

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