NHS

Harrogate and Rural District
Clinical Commissioning Group

Operational Resilience and Capacity Planning

2014/15

30 July 2014

Foreward

Establishing sustainable delivery requires resilience and capacity planning to be ongoing and robust. It requires all local partners to work together to achieve this common aim. Managing seasonal pressures during winter should be seen in the wider context of a year round resilience, and include plans to manage the increasing pressure on elective care waiting times.

The purpose of this document is to set out the arrangements for the health and social care system in Harrogate and Rural District Clinical Commissioning Groups geographical footprint. A key component is the evolution of a System Resilience Group from the Urgent Care Working Group:

> *"The creation of…(UCWGs) presented a unique and valuable opportunity for all parts of local health and social care systems to co-develop strategies and collaboratively plan safe, efficient services for patients. Following on from the successful work UCWGs have undertaken since their creation, their next evolution is to expand their role to cover elective, as well as non-elective care. This shift is reflected in the change in name of UCWGs to System Resilience Groups (SRGs).*
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> *SRGs are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. The group should plan for the capacity required to ensure delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers."*
>
> (NHS England, 2014)

Our plans for operational resilience and capacity in 2014/15 are congruent with the CCG Strategic Plan and Better Care Fund, including increasing overall capacity to meet anticipated demand, promoting 7 day working, facilitating integration and scaling up primary care.

Contents

Introduction

Harrogate and Rural District has a registered population of around 160,000. It is characterised by being both rural and urban in nature, having large, sparsely populated areas alongside major the settlements of Harrogate, Knaresborough and Ripon.

The Clinical Commissioning Group comprises 19 GP practices covering Harrogate, Ripon, Knaresborough, Boroughbridge and Pateley Bridge. We work in partnership with North Yorkshire County Council (NYCC) and other local organisations to improve the health of the local people through the North Yorkshire Health and Well Being Board.

The local government function is split between Harrogate Borough Council and the County Council. The District is one of the largest shire districts in England at 1305 sq km (505 sq miles). This CCG's main acute provider is Harrogate and District NHS Foundation Trust (HDFT) and accounts for around 80% of its admissions. The mental health provider is Tees, Esk and Wear Valley NHS Foundation Trust. We actively engage with local voluntary and independent sector stakeholders and public in the development of our commissioning priorities, particularly in relation to urgent care, long term conditions and the Better Care Fund.

There are clear drivers for change in the Harrogate and Rural District health and social care system:

- Society is ageing.
- People have changing health needs with more long term condition and lifestyle disease.
- There is variation in the quality and access, leading to a variation in patient outcome and experience.
- People have increasing expectations.
- The costs of providing the current model of care are increasing.
- Rurality and geography.
- Public finances are constrained.

One of our key strengths is partnership working, co-producing our vision for future models and the alignment of our collective strategic priorities articulated in the North Yorkshire Health and Wellbeing Strategy, Better Care Fund and CCG Strategic Plan. These set out the impetus for transformation of the health and social care system with a focus on:

- Prevention to reduce demand for health and social care.
- Integrated locality teams and reablement.
- High impact interventions: mental health, dementia, care home support, medicines optimisation.

We recognise the benefits and need for the development of year round, system wide planning to maintain high quality and safe services – building resilience to respond to peaks and troughs in demand and capacity fluctuations. These are no longer thought of as a purely "winter" phenomenon and have relevance year round. Various mechanisms have existed historically to manage these issues depending on the cause of the fluctuation e.g. adverse weather, pandemic influenza.

The purpose of this plan is to provide a framework for the health and social care systems across the Harrogate and Rural District area to respond quickly and appropriately to any increased needs or service pressure on the system.

Evidence shows that if there is a sustained cold spell, emergency admissions increase due to the number of incidences of heart attacks, strokes, influenza like illnesses and respiratory conditions. Vulnerable people, particularly those with long term, chronic conditions are particularly susceptible.

It is also known that the Norovirus is most prevalent over the months of October to March, the presence of Norovirus can substantially reduce the bed capacity available within the hospital and nursing/residential home sector as no admissions or discharge can be made to these areas.

All statutory health and social care organisations within the HaRD CCG area have developed individual resilience plans, based on capacity and demand analysis, with clear escalation plans and on-call arrangements where relevant. In addition individual service level business continuity plans are based on on-going risk analyses and profiling of activity conducted by all partners. The business continuity plans then describe the actions required to mitigate the risk and ensure business activity is maintained.

Lessons Learnt

Over the years partner organisations have implemented service improvements to ensure patients receive care at the right level and in the right place; whether in a hospital setting or closer to people's homes. For example Harrogate and District NHS Foundation Trust (HDFT) has implemented

- Daily **patient flow meetings** from September 2010 and these are now an established routine, playing an essential role in the flow of patients through the 'system'
- A **Discharge Lounge** that is a key factor to the Trust's success in managing within its bed base not only at times of peak winter pressure but though out the year.
- A **Patient Flow Project** that aims to ensure consistent admissions, transfer and discharge process on each ward, with a focus on planned discharge dates
- A project to introduce **Nurse led and Pharmacy led discharge**.
- A pilot to identify patients who might benefit from the use of **telehealth** monitoring as a means of providing supportive early discharge or to prevent an admission. As well as monitoring the effectiveness of the approach, the patients' experiences were gathered via a survey. During the 12 month study period:
    - 19 admissions were prevented leading to a saving of 29 occupied bed days;
    - Five inpatients had their length of stay reduced leading to a saving of six occupied bed days;
    - 45 follow up visits to CAT were prevented.

North Yorkshire County Council (NYCC) already has very good performance on delayed transfers of care, **reablement**, **extra care housing** and placing low numbers of people in residential care. It has embarked on a transformation programme for Adult Social Care which focuses on self-help, prevention, independence and integrated services.

In 2013/14 non recurrent 'winter' funding was made available to Primary Care to offer additional GP or Practice Nurse Appointments in January and February 2014; this equated to an additional 4566 face to face appointments offered and 94% of those offered were taken up. Practices reported these significantly eased pressures on appointment systems. These additional GP or Nurse appointments are likely to have significantly reduced demand on NHS111, GP OOH and A&E.

Previous analysis of weekend admission profiles to HDFT demonstrates that there are fewer admissions, on average, on a weekend and bank holidays than on week days, however, bed occupancy often rises due to the significantly reduced level of discharges. Therefore in October 2013 HDFT increased the numbers of medical staff during the weekends. This ensured that Consultant ward rounds could continue over the weekends with a view to increasing the number of discharges over the weekend period. The Acute Trust also recruited additional nursing staff to be

available on the medical and surgical wards and within a pool to support the surge and escalation plan.

The winter monies used in Secondary Care provided additional acute bed capacity, extra support for Therapy Services within Ripon Community Hospital, weekend medical ward rounds therefore supporting 7 day working. The funding also allowed extra support within the Community Fast Response team, extended hours for the Ambulance discharge crews and additional Critical Care provision (purchased by the Specialist Commissioning team). All these aided patient flow, ensuring appropriate care and support for patients in the most appropriate setting.

As a result monitoring meetings held during 2013/14 a number of improvement areas were identified:

- Patient flow: particularly for step down patients and out of area discharges.
- Communication: Piloting an electronic template to capture issues during surge periods (e.g. winter). Improved liaison with neighbouring CCGs.

Compared to other acute trusts across North Yorkshire and Humber, HDFT had the lowest bed occupancy pressures and fewest Norovirus outbreaks.

What Good Looks Like

Partner organisations have been developing a vision of what good looks like through the Health and Wellbeing Strategy, Better Care Fund, CCG Strategic Plans and Annual Public Health Report. It is one that sees local people empowered to take control of their health and independence, supported by a sustainable health and social care system which promotes health and wellbeing, and provides timely access to joined-up / integrated services.

What Good Looks Like				
	Pre-hospital care	**Emergency Department**	**Acute Care**	**Post-acute care**
Objectives	No confusion of what to do, who to call or where to go: • 999 for immediate, life-threatening conditions • NHS 111 for single point of access • Directory of Services, up-to-date, to direct the patient to the right services • Integrated Urgent Care Centre • Fast Response Teams • Neighbourhood Teams • Risk stratification and care planning • 1 GP per Care Home • Self care and a focus on prevention • Assistive technology • Seven day services • Supporting carers	Integrated Emergency and Urgent Care: • Senior clinical decision makers – secondary care and primary care • Ambulatory care pathways • Rapid access to diagnostics • Psychiatric Liaison • Paediatric pathway • Clinical Assessment Team	• Senior clinical decision makers • Rapid access to diagnostics • Consultant ward rounds 7 days / week • Estimated discharge dates • Nurse led and pharmacy led discharge • Eliminate outliers and unnecessary ward moves • Discharge lounge	• The patient's home as the main focus of care and services • Care is integrated around people rather than organisations. • Reablement to reduce readmissions. • Integrated Teams • Supporting carers • Appropriate use of community health and social care beds
Quality Standards	• Proportion of people feeling supported to manage their (long term) condition • Proportion of patients over 75 / with LTC who have an agreed / operational care plan • Improved patient experience • Improved health outcomes • Reduced social isolation • Increase in take up of housing and voluntary sector initiatives.	• 95% of patients seen in A&E within 4 hours • Reduction in emergency admissions from care homes • Reduction in emergency admissions for patients with ambulatory conditions • Reduction in paediatric emergency admissions • All handovers between ambulance and A & E within 15 minutes.	• Patient experience of inpatient care. • Expected discharge date. • Minimising delayed transfers of care • Reducing the time spent in hospital for people with long term conditions. • Reducing the time spent in hospital for people with mental health problems.	• Increasing the proportion of older people living independently at home following discharge from hospital. • Proportion of older people offered reablement / rehabilitation on discharge • Effectiveness of reablement • Admissions to residential and care homes • Patient experience of integrated teams

System Resilience Group

The Harrogate and Rural District System Resilience Group (SRG) brings together health, social care and voluntary sector partners from across the locality. It enables all parts of the local health and social care system to co-develop strategies and collaboratively plan safe, efficient services for patients. On an annual basis the SRG is responsible for monitoring and updating the Operational Resilience and Capacity Plan and ensuring the actions it contains deliver the required level of performance improvement. The SRG links closely with the work of the Better Care Fund.

The key principles of System Resilience Groups are:

- Ensuring system resilience is delivered whilst maintaining financial balance.
- Establishing year-round sustainable delivery for planned and urgent care.
- Enabling health and social care partners (including independent and voluntary) to proactively manage year round operational resilience through working together in an integrated approach.
- Ensuring the allocation of, and monitoring the delivery and impact of, non-recurrent monies.
- Preparing for the outcomes of the Urgent and Emergency Care Review

Membership includes:

- NHS Harrogate and Rural District CCG
- Harrogate and District NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust
- North Yorkshire County Council
- Yorkshire Ambulance Service NHS Trust
- Primary Care
- Voluntary Sector representative
- Patient representative

The Group is accountable through the Integrated Commissioning Board and members are accountable to their individual Board (or equivalent body) for each participating organisation. Members will hold each other to account for delivery of jointly agreed plans and strategies.

The Group will establish sub-groups as appropriate to manage and deliver the agreed outputs, for example Urgent Care, Integrated Care, Surge and Escalation.

Dashboard Metrics

A dashboard will be developed to support the SRG to understand the changing level of demand that occurs across urgent care over the winter and its impact on planned care capacity. There will be a clear link between the dashboard and the key metrics in the Better Care Fund.

Key metrics to include:

Urgent Care

- A&E attendances
- A&E waiting times
- Out of Hours (OOH) demand/NHS 111 activity
- Emergency admissions
- Acute bed capacity
- Delayed transfers of care
- Re-ablement
- Admissions from / to care homes
- Admissions / LOS for patients with long term conditions

Planned Care

- 18-week referral to treatment (admitted & non-admitted)
- Incomplete pathways (both size and waiting times)

- RTT Patient Tracker List (PTL)
- Diagnostics waiting time (6 week wait)

Managing Patient Safety

Managing patient safety is a key priority for all the partner organisations individually and collectively. The SRG will use performance information to review the system resilience and focus on the following indicators of quality, safety and operational standards, developed with the Francis report recommendations in mind.

Quality, safety and operational indicators:

Domain	Clinical Quality Indicator	Information source
Effectiveness of care	Number of NHS 111 calls answered within 60seconds	NHS 111 sitrep
	Longest wait for a NHS 111 call to be answered	NHS 111 sitrep
	Time spent for NHS 111 calls to be allocated to GPOOH	Contract report fromHDFT
	Ambulance response (Red 1 & 2's)	Daily sitrep and weekly fast-track report
	Time in A&E	A&E SUS data
	Emergency admission rates	A&E SUS data
	4 hour A&E target	Daily Bed State Report
	Emergency re-admission rates	A&E SUS data
	Re-attendance rates	A&E SUS data
	Average time from referral to assessment for mental health patients with no physical illness.	TEWV monthly Q&P metrics
	Planned vs. actual transfers	HDFT Discharge dashboard
	Delayed discharges	HDFT Discharge dashboard
	Daily Bed Status	Daily bed State Report and Social Care report
	Number of escalation beds open	Daily bed State Report
	Number of elective operations cancelled	Daily bed State Report
Patient experience	Percentage left without being seen. Complaints/concerns Family and Friends test	A&E SUS data Complaints received PROMS/Family and Friends Test
Patient safety	Time to assessment/treatment Mixed Sex accommodation breaches Infection Control/HCAI's (including number of beds closed) Falls	A&E SUS data The Cube/Unify The Cube/Unify Falls Prevention Report

Enablers

Engagement

We have developed a Communications and Engagement Strategy which sets out full details of our approach. We want to offer people a genuine opportunity to influence local NHS commissioning so we ran focused engagement exercises for projects that fall under each of the CCG's strategic priority areas. Some of the examples of our engagement work include:

- HaRD Net - a network of local people, patients, carers, voluntary sector representatives and other partners who have the opportunity to influence local health services
- Seeking Your Experience - Public Involvement Forum.
- Call to Action events.
- Consultation on service changes for older people's mental health service.
- Liaison with local care homes and the Independent Care Group.

A Call to Action: The story so far…

The first public involvement forum 'Seeking Your Experience' was held in July 2013 and proved to be very successful and was well supported by the local community. A total of 77 people attended the event. 52% were members of the public, 31% representing the voluntary/independent sector, 9% NHS and NYCC staff and 5% local councillors.

The second public involvement event was held on 11 March 2014. 90 people attended: 50% were members of the public, 20% representing the voluntary/independent sector, 30% NHS and North Yorkshire County Council staff. The focus of the event was to share with people the progress made by the CCG in its first year and to demonstrate how local community's feedback had contributed and helped shape the five year plan which was shared with attendees to gather their views and to see if the CCG had got it right. The evening was about members of the public guiding the CCG and helping to develop the thoughts based on their experiences and what health services they would like to see locally.

We will continue to ensure that public, patient and carer voices are at the centre of our healthcare services, from planning to delivery - informed by insightful methods of listening to those who use and care about services.

Better Care Fund

The Better Care Fund is providing the impetus for the NHS and local government in HaRD to set out a shared vision, underpinned by practical actions and joint investment, which breaks the cycle of then past. As a public services economy, we know we face the challenges that come with rurality, geography and system complexity.

Over the next four year our shared investment will:

• Improve health, self-help and independence for local people by:

- Implementing integrated prevention services.
- Supporting Carers.
- Improving access to housing based solutions including equipment, assistive technology and extra care.
- Ensuring access to a comprehensive falls service.

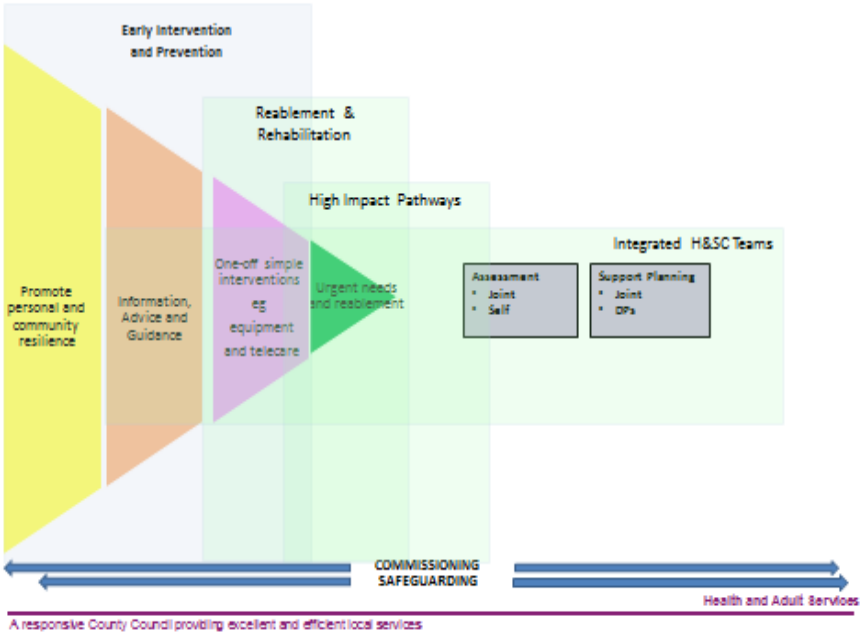
• Invest in Primary Care and Community Services:

- Creating an integrated health and social care re-ablement and integrated care service.
- Invest in core community health services to increase capacity.

- Create and grow integrated health and social care multi-disciplinary teams.
- Develop mental health in-reach services to support people in acute care and in community settings.
- Invest in dementia services.
- Better support to care homes.

• Create a sustainable system by

- Protecting Adult Social Care, maintaining and growing the effectiveness of social care re-ablement.
- Developing more alternatives to long term care for older people and those with learning disability and mental health needs.
- Investing in support to carers.
- Implementing the Care Act 2014 and ensuring that all customers, however funded, get improved information and advice.
- Increasing the reach of assistive technologies to support people at home and in care homes.
- Working with Secondary Care to secure the hospital, mental health and community services needed in HaRD.



The Care Act 2014

The Care Bill received Royal Assent on 14 May and has now been passed into law as the Care Act 2014. The Act introduces major reforms to the legal framework for adult social care, to the funding system and to the duties of local authorities and rights of those in need of social care including:

- A broader care and support role for local authorities towards the local community, giving a new duty to authorities to promote physical, mental and emotional wellbeing in all decisions regarding an individual's care needs. More emphasis than ever before on

prevention, to help reduce or delay someone developing care and support needs. This means moving to a system that focuses on people's strengths and capabilities, and supports them to live independently for as long as possible.

- There is a new duty to establish and maintain an information and advice service, covering the needs of all our population, not just those who are in receipt of care or support funded by the local authority, and needs to be tailored information for specific groups
- It introduces a new duty for the Local Authority to facilitate a vibrant, diverse and sustainable market for high quality care and support for the benefit of the whole population, regardless of how services are funded.
- The Act enshrines the right of carers in England to receive support from their local Council and introduces a duty to meet carers' eligible needs for support. This gives them the same legal rights as the people for whom they care.
- Under the new legislation there is a new duty to promote integration and a duty to co-operate. Local authorities will be required to carry out their care and support functions with the aim of integrating services with those provided by the NHS and any other health-related service (such as housing).
- The Act puts safeguarding on a statutory footing for the first time, outlining the responsibilities of local authorities and other partners in relation to safeguarding adults, including a new requirement to establish Safeguarding Adults Boards in every area. Work has begun with the Independent Chair of the Safeguarding Board to identify the implications for North Yorkshire.

North Yorkshire County Council has adopted a Programme Management approach to planning for the implementation of the Act from April 2015. The Government has indicated that implementation monies will be made available in 2015/16 as part of the new burdens funding and through the Better Care Fund. Indicative allocations for North Yorkshire are £4.813million

Non-recurrent funding for operational resilience and referral to treatment 2014/15

Following a review of 2013/14 arrangements the System Resilience Group has agreed to support the following initiatives for 2014/15:

Non Electives:

- Additional GP or Practice Nurse Appointments in December 2014 to March 2015.
- Additional medical staff at Harrogate Hospital during the weekends to ensure that Consultant ward rounds continue over the weekends. Additional acute bed capacity, extra support for Therapy Services within Ripon Community Hospital, weekend medical ward rounds therefore supporting 7 day working. The funding also allowed.
- Extra support within the Community Fast Response team to support admission avoidance.
- Extended hours for the Ambulance Patient Transport Service to support weekend discharge.

These capacity increases, combined with the new initiatives funded through the Better Care Fund, are anticipated to:

- Reduce A&E attendance and hospital admissions.
- Improve the system flow through 7 day working.
- Reduced delayed discharges.
- Support high risk groups**.**

Electives:

Referral Support Service

Funding allocated to ensure 3 specialities achieve RTT standard by the end of August 2014 (Trauma and Orthopaedics, Dermatology, Gastroenterology).

Operational Priorities 2014/15

The CCG five year Strategic Plan articulated our vision for 2020 and highlighted the transformation priorities for 2014/15 that form the basis of our QIPP programme. These priorities are highlighted to the right.

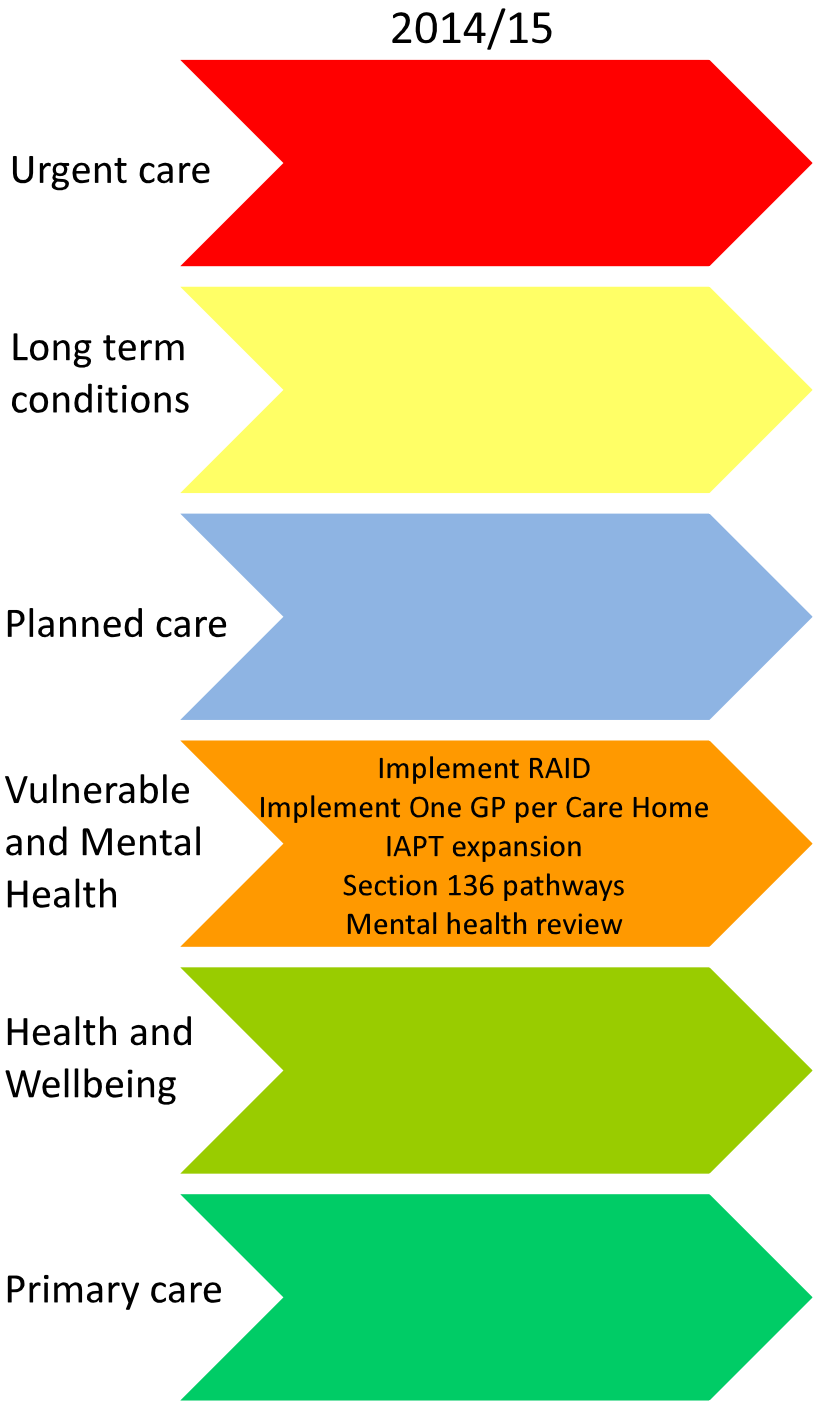
The overall aim is to shift care from hospital settings to home or community settings, when safe to do so, and promoting self-care and independent living.

In order to achieve this change 24 hour / 7 day services will be required across the range of primary, secondary and social care services, supported by access to information. This will take some years to achieve but the priorities for 2014/15:

- Improve the integration between primary and community care.
- Support the proactive management of long term conditions.
- Improve care for patients who have mental health needs.
- Support efficiencies in elective care.

Non recurrent funding will be used to manage 'winter pressures' and operational resilience. Key outcomes include:

- Reductions in A & E attendance
- Reduction in emergency admissions
- Reductions in delayed discharge
- Reductions in readmissions
- Improvements in patient experience
- Referral to Treatment standards



Non-elective Care Pathways

Planning
Locally our planning, therefore, takes into account the need to manage additional demand at a time when patient flow through bed based services can be restricted.

We are also participating in the **West Yorkshire Review of Urgent Care**, which will bring together a detailed picture and understanding of:

•patient flows;
•the number and location of emergency and urgent care facilities;
•the services they provide;
•the urgent and emergency health care needs of the population.

This will inform the future strategy regarding the structure and function of the components of the urgent care system.

Priorities for 2014/15
Clinical Assessment Team – 7 day service
Having senior clinical decision making at the front end of the system ensures swift assessment and onward movement through the emergency pathway by having senior assessors available to make decisions, treat promptly and transfer patients back in their homes as soon as they are medically fit, with appropriate support, or refer them on for the correct specialist treatment. By recognising that blockages in A&E are actually a symptom of the wider healthcare system failures, they are able to reduce costs, save lives and move care to where it most suits the patient.

The Better Care Fund (BCF) plan includes additional resource into the Clinical Assessment Team (CAT) so that it is a 7 day service with speedier access to diagnostics and appropriate medical assessment for more patients.

We are undertaking a **paediatric urgent care pathway review** to provide recommendations for the management of children presenting at A&E with acute breathing difficulties.

Long Term Conditions
A significant proportion of admissions to hospital are related to long term conditions, such as diabetes, asthma and congestive heart failure. Maintaining health and independence in the community helps to prevent deterioration in conditions and results in better health outcomes and patient experience. For patients with long term conditions it is possible to prevent acute exacerbations through active, planned management: better self-management or lifestyle changes, behavioural change programmes, social prescribing, case management and care co-ordination by integrated health and social care teams.

Our programme includes:
- Community services review
- Risk stratification
- Integrated Care Teams/Community Hubs
- Patient owned care plan
- Accountable GPs for the over 75s (senior clinician for long term conditions)
- Social prescribing
- Self care
- Assistive technology

We have been working with North Yorkshire County Council, community providers and the voluntary sector to develop our Better Care Fund (BCF) plan for a single pooled budget to support health and social care services to work more closely together in our local areas.

Mental Wellbeing

Psychiatric liaison services provide mental health care to people being treated for physical health conditions in general hospitals. **Rapid Assessment Interface Discharge** (RAID) is an award-winning service which offers comprehensive mental health support, available 24/7, to all people aged over 16 within the hospital. The service is being jointly commissioned and funded by the Better Care Fund.

This reflects our goal to have crisis services, including liaison psychiatry services, which are as accessible, responsive and high quality as other health emergency services.

Clinical outcomes have been evaluated:

• Very strong patient and staff satisfaction ratings

• 14% increase in the proportion of older people at home 91 days after discharge

• 97% increase in discharge rate of older patients into their own homes rather than institutional care

Financial outcomes have been evaluated:

• 74% lower readmissions rate for mental health patients using RAID compared to those not using it

• 8.7% reduction in inpatient bed-days

Adult community mental teams from Harrogate and district have been brought together under one roof, providing a **single point of access for adult mental health referrals**. The following teams are now based at Valley Gardens Resource Centre:

- Harrogate Community Mental Health Team
- Consultant psychiatrists
- Psychology services
- Ripon Community Mental Health Team
- Primary Care Mental Health Services
- Community Alcohol Team
- Early Intervention in Psychosis Service.

The move will support the full integration of adult community mental health services in Harrogate and district.

One GP per Care Home

Currently many Care Homes may have as many as 10 GP Practices looking after residents in the Home, and each Practice may have patients in up to 20 Homes. This discourages regular review, anticipatory care, good doctor/patient relationship and close working with the Care Home staff. We want to see designated GP Practices linked to Care Homes and enable GPs to provide a level of care over and above that commissioned through their current contract.

Primary Care

A modern model of integrated care is needed for vulnerable and elderly people. We will support general practices to provide a comprehensive and coordinated package of care on over-75s and those with complex needs and provide funding to reduce avoidable admissions. It is proposed that additional CCG funding (around £5 per head of practice population or equivalent to £50 for patients 75 and over) should be given to practices to commission additional services to improve quality of care for older people. In future years this is likely to be extended to those with long-term conditions. We are currently finalising the details of this investment locally.

All of these measures will support delivery of the NHS Constitution Measure that patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (target 95%).

Discharge Planning

Discharge is a quality priority for HDFT with a refocused Discharge Improvement Steering Group with a focus on:

- Attainment of key performance indicators in relation to discharge planning e.g. patients discharged with electronic discharge summary.
- Effective patient flow through hospital wards and departments.
- Improved communication systems across health and social care including:
    - Improvements to discharge letters.
    - Improving safety and efficiency by reviewing patients readmitted following discharge.
- Facilitate appropriate discharge and improve patients' independence and self-care through the provision of a high quality community equipment service.
- Improving the patient experience of discharge.

The Discharge Lounge, combined with extra support for Therapy Services within Ripon Community Hospital and Harrogate Hospital, weekend medical ward rounds therefore supporting 7 day working all support discharge planning arrangements over the winter period.

There are approximately 74 care homes, with up to 2117 beds, in the locality offering a mix of residential and nursing facilities for older people, dementia, younger adults, learning disability, physical disability, sensory impairment. Step up / step down beds are commissioned locally from the care home sector, utilising a mix of local authority and independent care home capacity.

Increasingly extra care housing, including converted properties and purpose built accommodation, is becoming available in the locality with 8 schemes and 215 properties. Some of these developments are for sale, others to rent, and some are a mixture of both through shared ownership schemes. Extra care housing is run by housing associations and charities, or private sector providers.

Elective Care Pathways

Planning

Recently we have seen a rise in elective care with outpatient referrals currently rising by 13.8% compared to 2012/13. Commissioning for Value has adopted the NHS Right Care approach, which is to focus on clinical programmes and identify value opportunities, as opposed to focussing on organisational or management structures and boundaries. The process began with a review of indicative data to highlight the top priorities (opportunities) for transformation and improvement. Triangulation of the data balances Quality, Spend and Outcome and ensures robust assessment.

The programme areas that appear to offer the greatest opportunity in terms of both quality and spending are: Circulation Problems (CVD), Cancer and Tumours, Neurological System Problems, Respiratory System Problems and Musculoskeletal System Problems. In depth analysis of these priority pathways is being undertaken to determine the current and the optimal system for the service area.

HDFT will complete a review of the **patient access policy** by August with sign off and publication to follow in September 2014.

Priorities for 2014/15

Referral to Treatment Standard

Additional funding has been provided to ensure that the Referral to Treatment (RTT) standard is met by the end of August in three specialties: Trauma and Orthopaedics, Dermatology and Gastroenterology.

HDFT provide 18 weeks **training** to new starters in the organisation, as required. Refresher training is provided to existing staff as required during 2014/15.

Referral Support Service

Harrogate and Rural District CCG experiences approximately 29,394 GP Referrals and a further 4,447 'Other Referrals per annum, the vast majority of which go to Harrogate and District NHS Foundation Trust. Analysis suggests a proportion of patients could be managed by alternative care pathways.

The Referral Support Service (RSS) is being developed to ensure:

- Patients are placed on the most appropriate care pathway.
- Patients are offered choice.
- GPs are supported by their peers to improve the quality and appropriateness of referrals.
- Reduce unnecessary or inappropriate referrals resulting in efficiency savings.
- Local and community based pathways and associated services are supported and utilised.

The RSS will provide a **single point of access** for all GP referrals to hospital or other agreed services. The service will provide real time data capture. Alongside business intelligence activity data this will inform the development of patient care and referral pathways. Through clinical triage, signposting and Choose and Book bookings patients are involved in the decision making process and have a choice which will improve levels of patient confidence and satisfaction with the referral process. From October 2014 onwards the RSS would enable Harrogate and Rural District CCG to have 100% implementation of Choose and Book.

The service will be implemented in a phased approach for 12 specialties:

1. General Surgery
2. Dermatology
3. Trauma and Orthopaedics
4. Cardiology

5. Opthalmology
6. Gynaecology
7. Urology
8. General Medicine
9. Breast
10. Neurology
11. ENT

Once piloted and proved to be successful all other specialties will be included.

Shift parts of elective care into the community and improving access We have already identified an opportunity for repeat prostate specific antigen (PSA) testing to be performed and monitored within General Practice rather than by secondary care. We will look at diabetic outpatient services to explore whether there are opportunities to move more care into practices, and ensure care is delivered closer to home.

We are exploring whether endocrinology and dermatology pathways could be revised so that fewer referrals are needed and more is investigated in primary care.

Implementing Patient Decision Aids We have already embarked on a pilot of Patient Decision Aids for GPs and are exploring other opportunities for their use in secondary care and other settings (e.g. optometrists). We recognise that patients who have better information make better decisions and are happier with the outcome.

Wider Planning Considerations

Paediatric Services
There are five key drivers for improving paediatric services nationally:

- Rising demand for healthcare: the increasing prevalence of long-term conditions such as asthma, diabetes, epilepsy and children with disabilities.
- Needing to do more with less: the reality of financial pressures.
- Meeting national service standards: Addressing paediatric workforce sustainability issues.
- Improving service access: Placing appropriate services into the community.
- Improving patient experience and empowering the public to shape and influence services.

We have been involved in the West Yorkshire Review of Paediatric Services that has identified a number of opportunity themes to provide care closer to home for sick children and prevent avoidable A&E or short-term admissions through improved long term condition management and patient / parent / carer education. These will be considered as part of the CCG commissioning cycle.

Flu
The objective of the Public Health England flu programme is to minimise the health impact of flu through effective monitoring, prevention and treatment, including:

- Actively offering the flu vaccination to 100% of all those in the eligible clinical risk groups, and vaccinating at least 75% of those aged 65 years and over and healthcare workers with direct patient contact.
- Providing direct protection to children by extending the annual flu immunisation programme over a number of years so that eventually all children aged two to less than 17 years will be offered flu vaccination.
- Monitoring flu activity, severity of the disease, vaccine uptake and impact on the NHS.
- Enabling the prescribing of antiviral medicines to patients in at-risk groups.
- Providing public health information to prevent and protect against flu.
- Managing and implementing the public health response to incidents and outbreaks of flu.
- Ensuring the NHS is well prepared and has appropriate surge and resilience arrangements in place during the flu season.

Patients should expect frontline healthcare workers to be vaccinated against seasonal influenza. Immunisation protects healthcare workers and reduces the risk of them transmitting the flu virus to vulnerable patients. Arrangements are in place for staff directly involved in front line patient care to be vaccinated and for uptake to be monitored.

Norovirus
During 2013/2014 services in both acute and community settings in the Harrogate and Rural District locality saw outbreaks of Norovirus. Norovirus can cause much disruption, such as bed or ward closures, cancelled admissions and delays in discharges that can reduce clinical activity for the duration of the outbreak. It therefore needs to be managed and dealt with appropriately and swiftly. Infection control measures are in place to address the differing needs of the most likely range of infections including norovirus, Clostridium difficile, influenza and MRSA.

Medicines Optimisation
Work has been undertaken to continue to optimise the way medicines are used at HDFT, especially using technology, to ensure safe and

effective treatment of patients. MedChart Electronic Prescribing and Medicines Administration (ePMA) system, the ICE electronic discharge system and access to the Summary Care Record are used to facilitate this aim.

Map of Medicine provides the local health community with customisable care maps, consolidating local service information and best practice into easy to use, online flow charts. It offers the following benefits:

- reduced unwanted variations in care
- reduced unplanned admissions
- more appropriate referrals
- adherence to QOF defined best practice
- continuing professional development.

Map of Medicine pathway development work with all GP practices will be a focus during 2014/15.

Marketing and Communications

Last winter NHS England launched **'the earlier, the better'** campaign that aims to reduce pressure on the NHS urgent and emergency care system. Its focus was to influence changes in public behaviour to help reduce the number of people requiring emergency admissions through urgent and emergency care services, particularly A&E departments, with illnesses that could have been effectively treated earlier by self-care or community pharmacy services.

Communication of wider public messages, for example on weather resilience, will be managed by the North Yorkshire and Humber Commissioning Support Unit (CSU) communications team. Locally communications to the general public will utilise a range of media including internet, social media e.g. Twitter and local newspapers and radio.

The CSU are part of a network of communications teams across all of the partner agencies party to the operational resilience framework. The teams will work together to coordinate and share information that can support and inform delivery of the framework.

The impact of all communication and marketing campaigns will be evaluated as part of any debriefs the SRG conduct.

Escalation and De-escalation Process

Metrics and Reporting Mechanisms

Various whole system metrics will be used to monitor capacity and demand across all partners in the HaRD. These metrics will be reported monthly in the System Resilience Dashboard.

Additional reporting information (daily and weekly alerts) will be obtained to help the SRG understand what pressures are being experienced in the system and to determine the system wide level of escalation.

Escalation Levels

All partners have made a conscious decision to use a similar language to Yorkshire Ambulance Service (YAS) when communicating levels of pressure and demand. This is a system known as Resource Escalation Action Plans (REAP). REAP consists of 5 levels and allows for the integration of a series of triggers that have the potential to impact on the partners ability to maintain business as usual. These can include bed occupancy, acute attendances, staffing issues, infectious disease outbreaks, failures of diagnostic services adverse weather and major incidents. All partners have given assurance that their individual plans are in line with other partners and are synchronised/work in partnership.

Linked to the above, the YAS Emergency Operations Centre (EOC) operates a Demand Management Plan (DMP). This aim of this procedure is to manage the 999 calls coming into the EOC and where these exceed normal parameters it describes the escalation action required to deal with additional activity. The REAP and DMP work together as part of YAS's operations business continuity management system. Local escalation arrangements are in place between YAS and HDFT should turnaround times escalate beyond acceptable parameters.

Hospital triggers for escalation are defined in HDFT's winter resilience plan. The hospital Trust patient placement meetings will be the forum in which the Trust's escalation level is determined. The chair of this meeting will activate escalation and de-escalation plans as necessary with the representatives of the multi-agency discharge group. The discharge group will communicate out to the wider partner organisations via the CCG using the emergency escalation email.

In addition, any other of the partner agencies can alert to triggers, escalation and de-escalation using this email address.

The local health and social care partners have agreed to work with these definitions and triggers to ensure a system wide understanding of levels of escalation. An over-arching HaRD CCG escalation level will be established based on an assessment of the service pressure levels within the HaRD area Health and Social Care organisations. The System Resilience Group will consider the pressures faced within the partner organisations and the collective contribution the group can make to support them. Each individual organisation will have its own specific pressure levels, at any given time.

All HaRD Health and Social Care organisations have a responsibility to:

- know the current escalation level
- communicate any increasing pressure within services between stakeholder organisations and to the CCG
- understand the escalation plan and to have a corresponding escalation plan for their service area
- take meaningful action, with the appropriate urgency, as the surge plan escalates.
- Communicate to the partners when de-escalation has occurred

Surge Plan Triggers

Not all services will be exposed to the same pressures; however peaks in illness and weather conditions are likely to be common across all organisations. This provides reassurance that all organisations' plan's use the same REAP system and are aligned.

A number of Action Cards outlining organisational triggers, responsibilities and mitigating actions have been developed to support operational delivery.

Escalation and De-escalation Principles

The following principles will underpin employment of escalation / de-escalation across the partner organisations.

- Capacity will be managed within organisations and as a coordinated system across the health and social care economy.
- Capacity management is a whole system issue and that may affect any of the partner agencies and this framework will be employed to support health and social care services out with the hospital system
- No action that would undermine the ability of any other part of the system to manage their core business will be taken by another one of the partner agencies without prior discussion.
- Managing patients at a time of increased escalation will require accepting and managing additional risk across organisations, as individual decisions on patient's care are taken, and competing pressures/targets are prioritised.
- Decision-making and actions in response to escalation alert will be within agreed timescales.
- The point of De-escalation will be communicated and agreed by all partners.

Planning Timetable

Action	**Deadline**
Operational Resilience and Capacity Plan (ORCP) Guidance published	13 June 2014
System Resilience Group meeting	22 July 2014
Plan agreed by local partners submitted to NHS England	30 July 2014
Assurance of plan by NHSE	September 2014
Plan published on CCG website	September 2014
Refresh of plans as necessary	October 2014
Winter reporting commences	November 2014
Scheme trackers submissions commence	December 2014