

UCN; Business improvement activities based on the 5 strategic areas for improvement (2011 / 2012)

The Urgent Care Network aims to reduce admission to acute hospitals by 20% and ensure number of DTOCs per acute is under 2.5% of available beds and that unproductive beds days for DTOC patients in acute NHS settings are reduced by 40%.

There are five strategic areas for improvement;

1. Integrated information systems
2. Third sector organisation integration into care planning
3. Community service redesign
4. Turnaround from acute emergency department and short stay units
5. Reduction in delayed transfers of care and unproductive bed days in NHS settings

Projects that the UCN will govern are listed in the programme status report.

This report identifies all related business improvement activity currently taking place across the county which will impact on patient flow

1. Integrated information systems				
Project / Workstream	Description	QIPP	Issues	Lead
1.1 Capacity Monitoring Support (CMS) tool	Capacity tool supplying information on escalation status of acute hospitals and detailing available capacity in community nhs services and independent sector services	<ul style="list-style-type: none"> - faster transfer of patients between services - reduction in time spent by CCC collating capacity information - ability to review capacity to support step up care 	<p>system is now live</p> <p>www.cms.nhs.uk user name; Cambridgeshire password: capacity</p>	<p>Ewan Kelsall</p> <p>Implementation April 2011</p>
1.2 Directory of Service	Local service directory which will provide information on health and social care services across the county and how these services can be accessed	<ul style="list-style-type: none"> - provide GPs, primary care professionals and acute staff with information on all available services in community to prevent admissions and speed up discharge 	<p>Arranging meetings with community services. Database is set up to have information added</p>	<p>Marie Kinsch</p> <p>Implementation June/July-<i>delay in this due to central software</i></p>
1.3 Urgent Care Dashboard (UCN PROJECT)	A tool which captures patient utilisation of urgent care services, raises awareness of patients on disease registers and encourages prevention work and more proactive in-reach management of patients in acute admission	<ul style="list-style-type: none"> -admission avoidance and prevention for those with high utilisation of urgent care services -integrated working with acutes to facilitate timely discharge and reduce LoS 	<p>See UCN prog report</p>	<p>Anne Heath</p> <p>Implementation June 2011 and Sept 2011</p>
1.4 Discharge Planning Dashboard (UCN PROJECT)	Centralises all information on patients in NHS services who have an ongoing care need. Identifies demand and uses information from CMS to match to capacity. Central system for transfer management	<ul style="list-style-type: none"> -better utilisation of NHS and independent services across the county -automated admin processes to support placing patients -inreach from ISPs to see demand (integration to independent sector) 	<p>Options appraisal for this to be written for July 2011 UCN</p>	<p>Anne Heath</p> <p>Implementation Nov 2011</p>

2. Voluntary organisation integration into care planning

Project / Workstream	Description	QIPP	Issues	Lead
2.1 Help at Home	Increase utilisation of help at home vol organisation to support people who are unwell at home and require support to carry out everyday tasks to avoid further deterioration of health and support those just discharged from hospital	<ul style="list-style-type: none"> - Admission avoidance - Improved discharge support - reduce likelihood of readmission - cost effective - Social inclusion 	See UCN prog report and business case	Ewan Kelsall & Hilary Johnys City and south implementation ?July 2011?
2.2 Dial-a-ride at acute hospitals	Vol transport provision in acute trusts to transport those not requiring ambulance transport from ED and inpatient areas	<ul style="list-style-type: none"> -turn around at ED, admission avoid - improved discharge support -alternative to more costly transport options 		Ewan Kelsall Implemented 16.05.2011
2.3 Cross roads carers support	Identify carers across the county and provide them with support networks as well as option for 72 hours respite care. Carers prescription model	-admission avoidance for carers and cared for	Awaiting decision from SLT on investment June 2011	Richard O'Driscoll

3. Community service redesign

Project / Workstream	Description	QIPP	Issues	Lead
3.1 Community Urgent Care provision	Introduction of new clinical model to improve urgent care provided by community teams. Easier access points and increased GP understanding of what the community services can offer	-admission avoidance -more productive workforce model -provision of improved quality of care in community		Geraldine Linehan Implement 06.06.2011
3.2 Falls Project (UCN PROJECT)	Rapid response service to assess people who have fallen	-admission avoidance	-See UCN prog report	Richard O'Driscoll Implement June 2011
3.3 Reablement	Provision of intensive, time limited, therapeutic support to reduce reliance on long term or complex domiciliary care packages	-reduce use of long term care services for patients (quality and cost impact) -facilitate more timely discharge		Richard O'Driscoll & Alison Gilbert
3.4 Assistive Technology	Promotion of assistive technology in care planning and intervention	-keeping people at home safely for longer -cost effective in terms of releasing human resource		NHSC and HIEC working together to produce plan
3.5 Care Home support	GP and primary care teams supporting care homes to avoid unnecessary admissions into hospital	-admission avoidance -care in usual place of residence	CUH to fund res home LES	John Ellis, Claire Warner, Geraldine Linehan
3.6 End of Life	Service development to improve end of life care in the community. Focus on increasing capacity in Hospice at Home sitting service	-meeting preferred priorities for care supporting people dying at home if that's their choice -reduce emergency admission at end of life		Miranda Fyfe
3.7 Hunts Health Non-	Variety of localised work streams	-admission avoidance		Liz Sargeant

elective Care strategy	being used to ensure patients are accessing the most appropriate care	-care in usual place of residence -prevention -integrated information systems		
HHCT front of house and LoS	Improving services at HHCT ED and introducing processes within the hospital to reduce LoS	-admission avoidance -reduction in LoS		Liz Pointing

4. Turnaround from acute emergency departments and short stay units

Project / Workstream	Description	QIPP	Issues	Lead
4.1 RADAR (UCN PROJECT)	Elderly care service in CUHFT. Emergency outpatient appt, ED assessment and direct hotline for providing specialist elderly care advice to primary care professionals	Admission avoidance	Business Case for June 2011 UCN	Richard Biram
4.2 Acute Medicine Clinic	Providing emergency outpatient appointments and ED reviews for patients with acute medicine needs	Admission avoidance		Mark Cranston & Paul Flynn
4.3 Increase in discharge planning provision at front door	Increase capacity for assessment and discharge from ED and short stay units	Admission avoidance		Ewan Kelsall Recruitment taking place May 2011
4.4 MH frequent fliers (UCN PROJECT)	Identification of MH cohort of patients frequently attending ED and proactive case management to avoid future admissions	-admission avoidance -reduced reliance on other emergency services	See UCN prog report	Annette Newton
4.5 MH dementia and confused patient	Provide specialist advice on treatment plans & discharge plans for dementia	-admission avoidance -reduce LoS	Business case delayed, for review in July	John Ellis & Claire Warner

(UCN PROJECT)	patients/confused brought to acute hospital by ambulance.			
4.6 GP in Emergency Department (HHCT)	GP supporting ED teams to facilitate discharge	-admission avoidance	Currently not taking place as waiting for funding decision	Liz Sargeant

5. Reduction in delayed transfers of care and unproductive bed days in NHS settings

Projects / Workstreams	Description	QIPP	Issues	Lead
SHAPED	Supporting discharge of patients with dementia to be discharged home with 24hr care support	-reduce unproductive bed days -reduce direct admission from acute to long term care		Gareth Peters Implementation 27.06.2011
Discharge planning workforce remodelling	External review of integrated workforce required to facilitate timely transfer of patients from NHS settings. Focus on moving assessments currently carried out in hospital setting out to community settings	-improve productivity of staff team -reduce delayed transfer of care -reduce unproductive bed days		Marion Goodchild
Hub models for discharge planning in acute settings	Introduction of staffing hubs to acute hospital divisions to improve integrated working and discharge planning practice	-improve awareness of discharge plans and reduce DTOCs and unproductive bed days		Lesley Thornalley
EDDs and LoS	Clinical models established in NHS settings to ensure proper use and setting of EDDs and agreed aims around appropriate LoS	-ensure patients are in the right setting for the right amount of time		Acutes and CCS
Additional funding for ICT hunts and CAT EC&F	Additional funding to increase resource within community teams to facilitate assessment and	-reduce DTOC and unproductive bed days	-currently stopped as awaiting funding decision	Cathy Mitchell

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