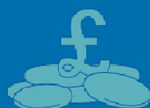
Transforming Unscheduled Care



The story so far

- Community Transformation launched
- A focus on 5 key priorities
  - A Better Community Nursing Service
  - Integrating Services in Health and Social Care
  - An Enhanced Care Coordination Centre
  - Utilisation of Alternative Levels of Care
  - Better Governance and Performance Management
- ‘Input’ and milestone focus
- Secured successfully – need stage 2
- Acute was delivering, but recently struggled

The story so far

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Priority	Successes
A Better Community Nursing Service	• Reconfigured around locality teams • Better leadership, clinical supervision and governance • Additional nurses (14 WTE) against 14/15 establishment • New IT equipment, full connectivity
Integrating Services	• Developed new IRR (merging Fast Response, ANP's) • Respiratory care pathway agreed • Investment in integrated falls and bone health care pathway • New service model for neuro rehab
Enhanced Care Coordination Centre	• Resourced to provide 24/7 cover • Hub for new supported discharge and admit prevent pathways • Develop single point of access for community nursing referrals
Utilisation of Alternative Levels of Care	• Agreed model for Community Unit to target Frail / Elderly • Discharge to Assess beds commissioned at Waterside Grange • 3 supported discharge and admission prevention pathways
Better Governance and Performance Management	• Performance framework established across all community teams • Reporting mechanisms and indicators agreed with teams • Bi-monthly meetings held between CCG and Community Teams

Current situation – an opportunity

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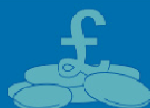
- Provider of Acute and Community services
- Community Transformation enablers
- A focus to improve within Acute
- Take a 2 to 3 year view
- Address other key enablers (Emergency Centre, 7/7 Services)
- Outcome and performance driven



Origins of the programme

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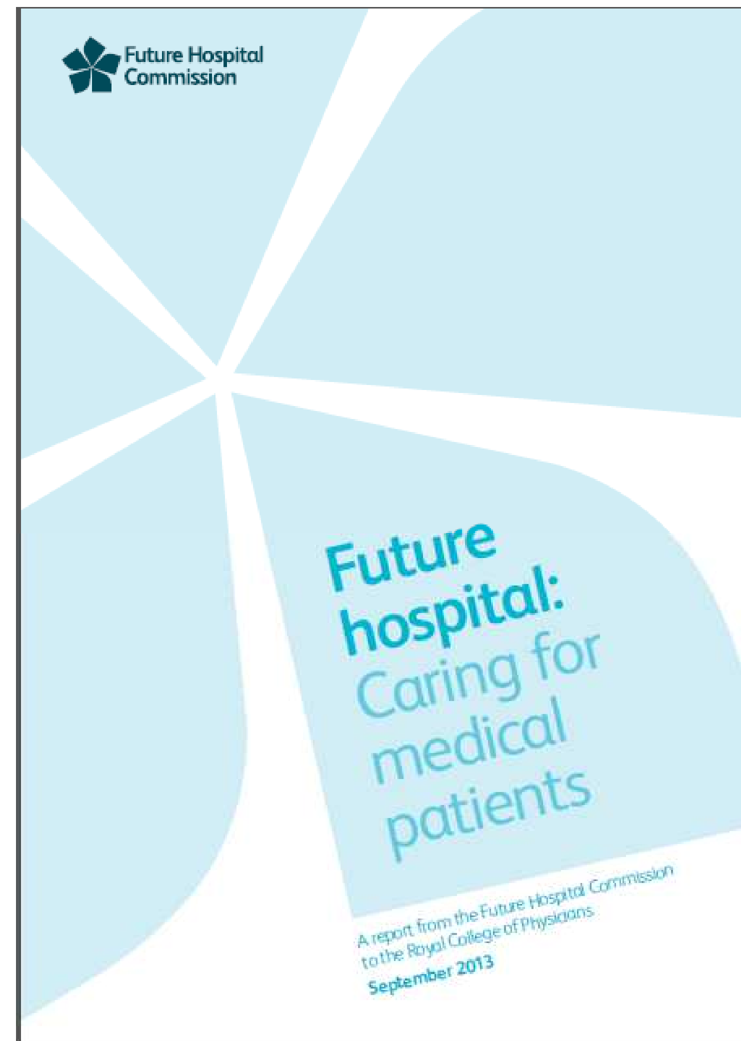
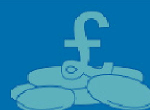
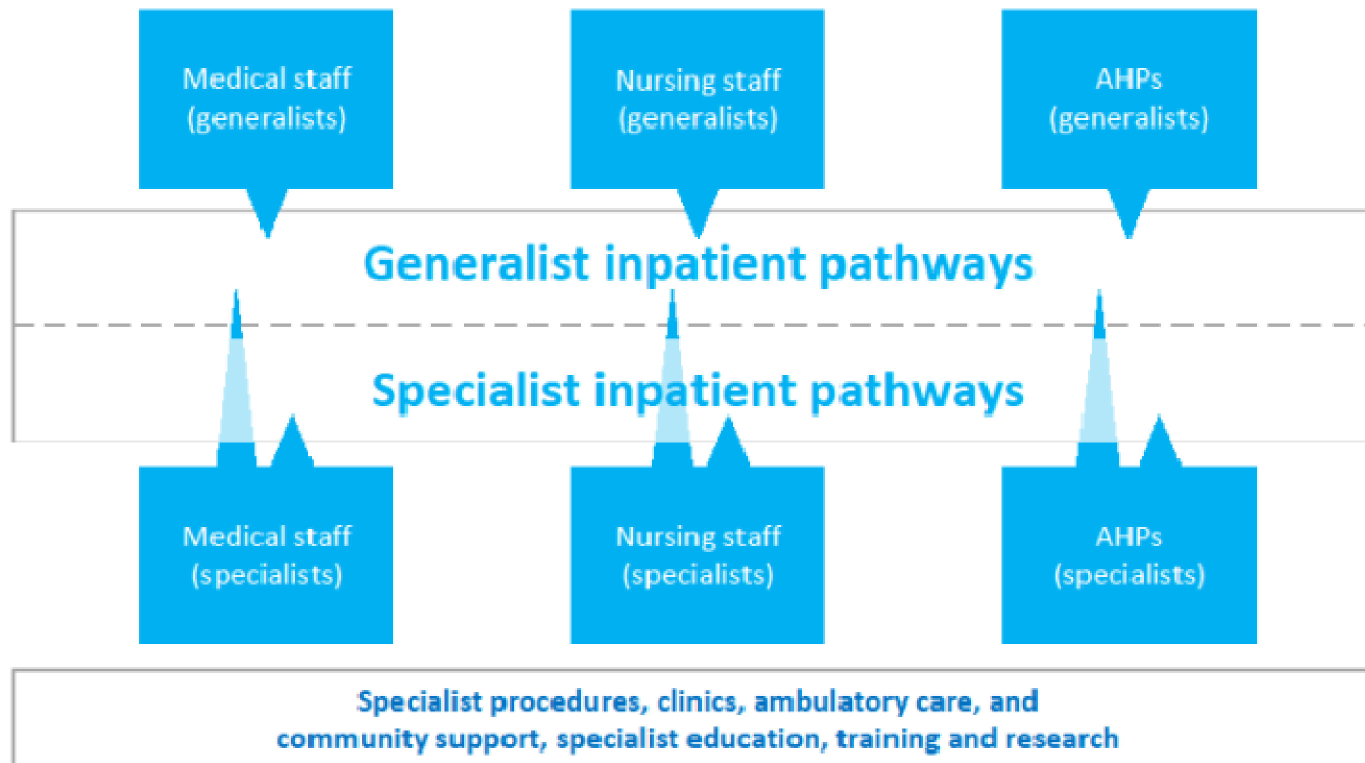
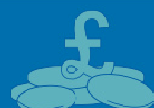




A future model of care





A future model of care

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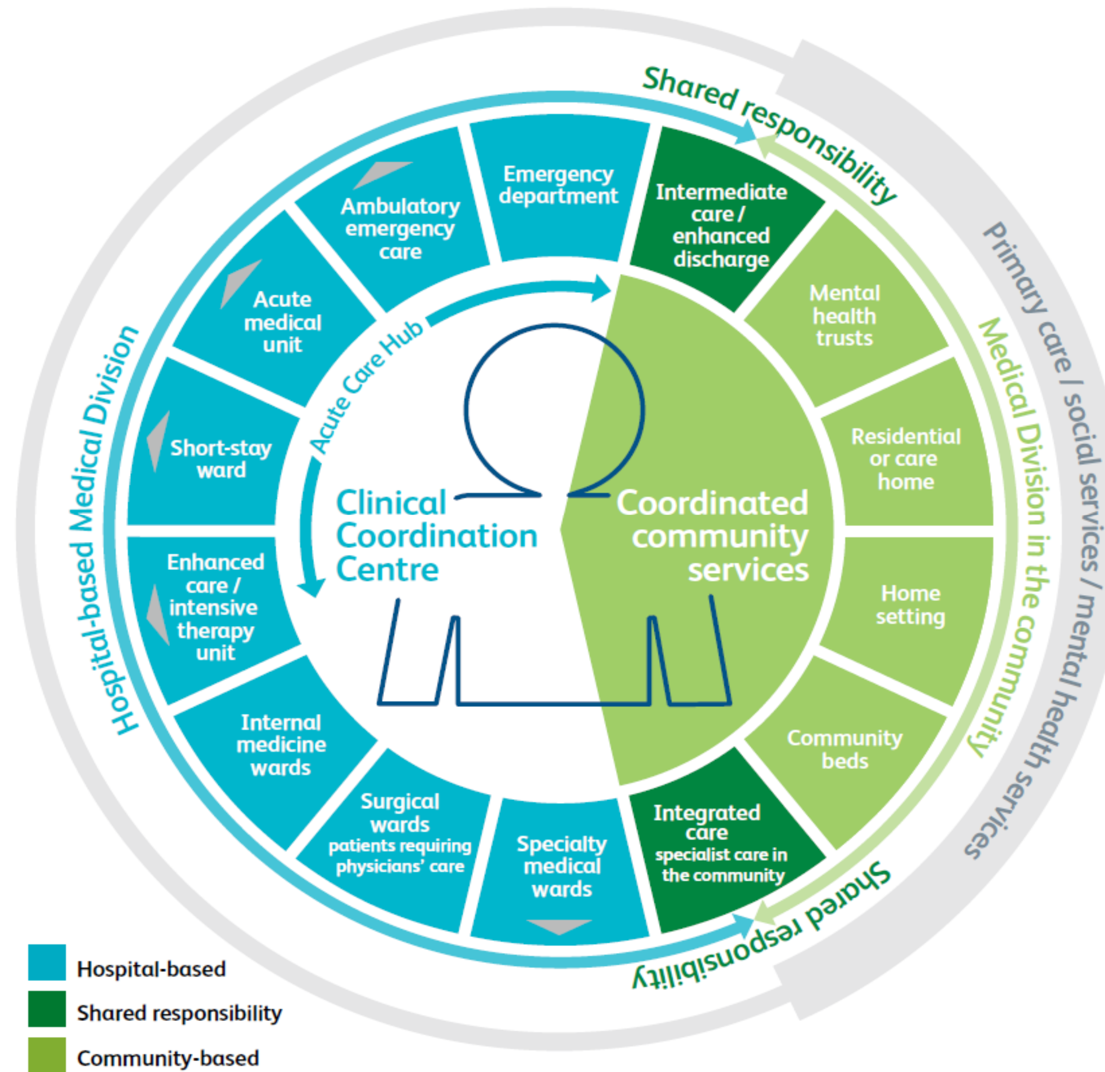

A proposed future state

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	24/7/7 Working	7/7 Working	5/7 Working
	Generalists / HCOP	Specialist	
Hospital	Emergency Centre; AMU / SAU; Male Ward; Male Ward; Female Ward; Female Ward	Stroke Unit; CCU; Cardio / Resp; GI Bleed; Haem	Elective Care
	Ambulatory Care		
Intermediate	Step down care / Nursing Homes / Intermediate Care	NH / RH alignment; Clinics	Community Follow-up
Community / Home	District Nursing / Locality Leads / Pathway Integration	Virtual Ward; Clinics	

The ambition

- Strengthened acute take and ambulatory care
- Ward reconfiguration and reduced bed base
- 7 day assessment of appropriate patients
- Community physician support for localities
- Reduction in acute length of stay
- LOS at home / UPOR to be main indicator
- Primary, secondary and community partnerships

5 key priorities

1. Emergency access and admissions
2. Structured and systematic management of in-patient beds (acute and intermediate)
3. Embedding admission prevention and supported discharge pathways
4. Integration of Acute & Community Care Pathways
5. Partnerships with social care, mental health, voluntary sector partners

Year 1 Priorities

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Priority	Focus	Outcomes
Emergency Access & Admissions	- Frail Elderly Assessment Unit - Alignment of A&E / GP services - Redesign of Acute Take (24/7/365) - Redesign of AMU	- No. of patients seen by GP - No. of admissions >65yrs - Increase in the number of ambulatory patients
Inpatient Bed Management	- Programme of 'Perfect Ward' - Management of Outliers - Ward re-configuration (Medicine, MAU, SAU, B3) - 7/7 services - Site coordination, site team & CCC	- No. of weekend discharges - No. of acute beds - Reduction in number of long stay patients
Admission & Discharge Pathways	- Implement IRR and Frail Elderly Unit - EMI Step down provision - Embed pathways 1, 2 and 3 with acute - Nursing home alignment by locality and formal alliance	- No. of GP admissions to MAU - Utilisation of ALOC beds - No. of attends from care homes

Year 1 Priorities

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Priority	Focus	Outcomes
Integration of Acute & Community Pathways	- Embed 7 locality physicians - Implement integrated pathways from Community Transformation (Neuro, Falls / Bones, Respiratory) - Priority and visibility of care plans	- Admits for respiratory patients - LOS for Neuro patients - No. of >55 years with fragility fracture
Partnership Working	- Develop protocols with Social Care for Community Beds - Develop arrangements for EMI patients with RDASH - Align community nursing teams with care homes - Integration of Voluntary Sector within acute	- No. of DTOC's - LOS for dementia patients - Hospital LOS for care home residents