NHS South Tees CCG - A&E Sustainability Plan **Appendix 3**

2013/14 Projects that will contribute to a reduction in A&E attendances and emergency admissions

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
Winter Planning & Surge	Dr Ruth Johnson	Nicola Jones		1. Learn lessons from 2012/13 2. Ensure winter planning is within Urgent Care Strategy (strategy to include Vision, current services and future preferred model) 3. Ensure winter plans are completed for all organisations 4. Daily & Weekly calls. Multi agency management	30th September 2013 4. 31st March 2014
In hours paramedic support	Dr Ruth Johnson	Nicola Jones		1. Review pilot 2. Present outcomes and propose options	1. 30th June 2013
111	Dr Ruth Johnson	Nicola Jones/Sue Prout		1. continually review implementation 2. ensure that primary care and secondary care individuals complete the Health Care Professional Feedback Form should an issue arise that they would like investigating	1. Ongoing 2. 31st March 2014
Care Homes	Dr Vaishali Nanda	Jayne Robson	Melissa Graham	1. Develop pilot and offer to practices across Tees 2. Pilot completion of EHCPs within nursing homes 3. Review feedback and develop report with recommendations 4. Present Report to CCG via Delivery Team 5. Develop plan for roll-out or alternative approach	1. Complete 2. 31st March 2013 3. 31st May 2013 4. 12th June 2013 5. 30th June - 31st March 2013
Trust - Predictive Risk Tool (re-admissions)	Dr Ruth Johnson	Julie Stevens		1. Receive a report from the Trust on the tool they recommend 2. Agree with the Trust the most appropriate predicative tool via CCG Delivery Team 3. Trust to develop an implementation plan for roll-out of the tool on wards and nursing visits 4. Evaluation report against KPIs to be submitted to CCG via Delivery Team	

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GP Practice - Risk Profiling Enhanced Service	Dr Ruth Johnson	Julie Stevens	??	1. CCGs will seek to invite and agree arrangements with GP Practices under the enhanced service by 30th June 2013 2. Where CCGs do not have an existing agreement in place with GP Practices for 2013/14 they will offer on behalf of the NHS CB, an enhanced service agreement that is consistent with the minimum requirements and funding detailed in the NHS CB specification 3. Where CCGs do have an existing local agreement in place with GP Practices for 2013/14 they will offer on behalf of the NHS CB either: a) an enhanced service agreement that supplements the existing local agreement with the aim of providing additional activity/ benefits that are proportionate to the available funding; or, b) (if GP practice agree) they can replace the existing local agreement with this enhanced service and use the local funding they would otherwise have invested in a manner that is agreed locally 4. Notify the NHS CB of participating GP Practices by 31st August 2013 so that the NHS CB can make payments under this enhanced service	1. 30th June 2013 4. 31st August 2013
QOF	Dr Vaishali Nanda	Jayne Robson	Melissa Graham	1. Identify 6 pathways for the Quality and Productivity (QP) indicators, 3 of which to relate to non-elective care 2. Practices to work in clusters to identify actions in relation pathway changes and share best practice 3. Practices to complete an A&E plan with a focus on improving primary care access	1. 30th September 2013 2. 31st March 2014 3. September 2014
Practice Support/GVIS/ GP Variation	Dr Vaishali Nanda	Jayne Robson	Vicky Donegan	1. Continued production/ circulation of practice reports - GVIS, Performance Reports, individual practice one-page reports 2. Continued practice benchmarking against evidence based practice e.g. GVIS reports, Map of Medicine, NICE etc. 3. Continuation of practice support and associated practice visits	
Doctor First	Dr Vaishali Nanda	Jayne Robson	Helen Metcalfe	1. All 12 current Doctor First practices to have 'gone live' 2. Evaluate and present recommendations to the CCG via Delivery Team 3. Implementation any recommendations	1. 31st August 2013 2. 31st October 2013 3. 31st March 2014

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Urgent Care Clinical Dashboard	Dr Mike Milner	Nicola Jones	Paul Whittingham	1. Continue to encourage usage of the dashboard, capture best practice and monitor usage	1. May 2013 7. May 2013 9. June 2013 10. July 2013
Review of urgent care walk-in capacity	Dr Mike Milner	Nicola Jones	Deborah Bowden/Helen Metcalfe	1. Define scope of service review and specific objectives 2. Organise contract review team meetings 3. Identify information requirements, sources and responsibility for gathering information 4. Commence and conduct data collection 5. Finalise agreed TOR, scope, objectives responsibilities 6. Share and discuss findings with review team 7. Review all collected data and information 8. Commence service review report 9. Finalise service review report, presenting options for future commissioning 10. Final Report presented to CCG DT for discussion	1. 31st May 2013 2. 31st May 2013 3. 30th November 2013 4. 31st December 2013 5. 31st March 2014
Reduction in A&E attendances (inc. A&E Triage)	Dr Mike Milner	Nicola Jones	Iain Marley/Helen Metcalfe	1. Agree format of baseline assessment and undertake this to identify patient behaviour in the use of A&E (L4/5 category) 2. Implement increase signposting in A&E to alternative urgent services where appropriate 3. Develop local pathway for triage including proposed working arrangements with other Providers (NDUC/WIC) and potential tariff based payment for this assessment and triage 4. Share pathway with CCG for approval 5. Agree roll out plan for new pathway	1. 31st May 2013 2. 31st May 2013 3. 30th November 2013 4. 31st December 2013 5. 31st March 2014
Front of House RPIW	Dr Mike Milner	Nicola Jones	Deborah Bowden	1. Scope the RPIW for Front of House (FT, CCG/NECS and NETS) 2. Conduct RPIW 3. Implement actions from RPIW	1. June 2013 2. July 2013 3. October 2013 (30/60/90 days following RPIW)

Project	Clinical Lead	Workstream Lead	Project Lead	Action	Timescales
Increase in brief interventions and reduction in alcohol related A&E attendances and admissions	Dr Steve McIlhinney	Deborah Ward	Middlesbrough LA/ PH Lead - David Jackson Redcar and Cleveland LA/ PH Lead - Vicky Whelan NECS - Sue Kirkham	1. Complete evaluation of Public Health Transformational Alcohol Worker 2. Complete baseline of alcohol related admissions 3. Outcome measures for (KPI's for current providers). Revised measures to be negotiated into current contracts 4. Alcohol DES and LESs to be reviewed 5. Data to be shared on the use of the alcohol tool at practice level 6. Work with Public Health in relation to delivery of the alcohol strategy and determine future requirements for commissioned services	1. 30th June 2013 2. 31st May 2013 3. 31st July 2013 4. 31st July 2013 5. 31st May 2013 6. 31st March 2014
COPD Admissions	Dr Steve McIlhinney	Deborah Ward	Sue Kirkham	1. Need to determine best method of delivering training for staff 2. Standardise primary care response to the management of COPD patients, focusing on variation against best practice 3. Commission a bespoke education package intended for patients living with COPD. 4. Provide supportive for general practice to utilise to improve the management of patients with COPD (i.e.. use of Telehealth) 5.Utilise CQUIN to promote smoking cessation to patients via an acute setting and/or offer NRT therapy upon admission 6. Increase the number of patients provided with self-management packs. 7.Increase Flu Vacs for COPD patients 8. Increase number of smokers who are given NRT treatment when admitted	1. 31st September 2013 2. 31st September 2013 3. 31st September 2013 4. 31st August 2013
Community Services/ IMProVE (Integrated Management and Proactive Care for the Elderly)	Dr Ruth Johnson	Julie Stevens		The CCG has been working closely with South Tees Foundation Trust and Local Authority colleagues to improve Community Services. There are a number of key changes which support this aim: - A Predictive Risk Tool which practice use to identify patients at risk of re-admission to be managed by Community Matrons - Changes to the way Community Matrons manage patients on their caseload known as the Integrated Community Care Team (ICCT) - A rapid response service to enable patients to remain in their own homes, aimed at reducing the number of avoidable admissions - An IMProVE (Integrated Management and Proactive Care for the Elderly) Workstream which includes a number of projects including: Review of existing community nursing outcome measures, review of Pulmonary Rehabilitation Services, Stroke Pathway, Respiratory Pathway, Heart Failure Pathway, Palliative Care Pathway, Intermediate Care Review and a Single Point of Contact.	
Delayed Discharges	Dr Mike Milner	Nicola Jones	Deborah Bowden	1. Develop Delayed Discharge action plan 2. Develop standard processes and role out workshops to wards at STFT 3. Prepare for and conduct an RPIW for Community Hospitals	1. 31st May 2013 2. 31st October 2013 3. 31st August 2013