HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.00 pm on 2 November 2016

Present:

Councillor Judi Ellis (Chairman)
Councillor Pauline Tunnicliffe (Vice-Chairman)
Councillors Ruth Bennett, Mary Cooke, Hannah Gray, David Jefferys and Charles Rideout QPM CVO

Linda Gabriel, Healthwatch Bromley

Also Present:

Councillor Robert Evans, Portfolio Holder for Care Services
Councillor Ian Dunn

15 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillor Terry Nathan, Councillor Catherine Rideout and Councillor Diane Smith. Apologies were also received from Lynn Sellwood, Voluntary Sector Strategic Network.

16 DECLARATIONS OF INTEREST

Councillor Judi Ellis declared that her daughter was employed by Oxleas NHS Foundation Trust

Councillor David Jefferys declared that he had been appointed a Public Governor of King's College Hospital NHS Foundation Trust to take effect from February 2017.

17 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

One written question was received from a member of the public and is attached at Appendix A.

18 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 8TH JUNE 2016 AND MATTERS ARISING

RESOLVED that the minutes of the meeting held on 8th June 2016 be agreed.

19 PRUH IMPROVEMENT PLAN - UPDATE FROM KING'S FOUNDATION NHS TRUST

The Sub-Committee received a presentation from Paul Donohoe, Deputy Medical Director, Princess Royal University Hospital (PRUH) and Sarah Willoughby, Stakeholder Relations Manager, King's College Hospital NHS Foundation Trust providing an update on the progress of the Trust and the PRUH Improvement Plan.

In considering performance across the Trust, performance against the Accident and Emergency four hour 95% target remained challenged due to multiple capacity and demand-related factors, with 88% and 82% achieved, respectively, at the PRUH in August and September 2016. Performance against cancer waiting targets continued to be good, and diagnostic waiting time performance had greatly improved, exceeding the national target of 1% in September 2016 with 0.96%. Significant progress had been made on achieving the savings target and reducing the deficit, and just under £10m of additional savings had now been identified. The implementation of the Trust's new organisational arrangements was ongoing with the aim of improving patent experience and ensuring services ran as efficiently as possible. The next steps in the implementation of the new cross-site Electronic Patient Record system were under development and Sunrise EPR would be rolled out across the PRUH, Orpington Outpatients and King's services based at Queen Mary's Hospital, Sidcup during Spring 2017.

With regard to the PRUH, excellent progress had been made in addressing the Standardised Mortality Rate which had dropped in 2015/16 to the 10th lowest out of 136 Trusts which was in the top 8% of performance. Patient experience ratings had also increased to 92% in September 2016 for standard inpatient feedback. The first case of the Norovirus for Winter 2016 had been confirmed in late October 2016, and had been appropriately isolated, managed and discharged, with additional measures in place to minimise risks of further outbreaks including extra clinical sinks in key ward areas. Emergency performance remained a significant challenge with performance reducing from 89% in August 2016 to 82% in September 2016, and the Emergency Pathway Recovery Plan was being implemented to address this. Work was also being undertaken to fill a number of vacancies in key clinical posts at the PRUH and Orpington Hospital and reduce the need for agency workers, including a recruitment campaign. The Outpatient Dermatology Service had now moved to Beckenham Beacon, enabling key development works to begin at Orpington Hospital. The new pathology service run by Viapath was also now in operation and the Local Care Record initiative that would enable electronic information to be shared with local GP practices was expected to be rolled out to 50% of GP practices by May 2017. The Care Quality Commission had recently visited the PRUH and formal feedback was still awaited.

In considering the presentation, a Member noted the challenges impacting emergency performance and asked what had been put in place to deal with winter pressures. The Deputy Medical Director, Princess Royal University

Hospital (PRUH) confirmed that a number of measures had been introduced to improve performance, including the Emergency Pathway Recovery Plan which was based around key themes including transfer of care, admission avoidance and winter planning, frailty pathway redesign and integration and Emergency Department transformation. Approximately a third of patients in the Accident and Emergency Department at any one time were waiting to be seen by a clinician or for a bed to be available. To address this, action was being taken to reduce admissions including directing patients to more appropriate health provision and introducing a rapid response team to respond to non-emergency incidents in care homes. The Transfer of Care Bureau was working to support more efficient discharge processes through initiatives such as the 'safer bundle' where clinical staff took ownership of patients' discharge process. Additional support from the community nursing team was also being provided to care homes following discharge of patients to reduce readmission rates. The Chairman noted that it was important for clinical staff to work in partnership with patients and their families to ensure that patients were returning home to a safe environment, and for estimated discharge dates to be communicated clearly.

With regard to the reduction in the Standardised Mortality Rate, the Deputy Medical Director, Princess Royal University Hospital (PRUH) advised Members that this was mainly due to better governance systems and staffing. A range of work was being undertaken in care homes around setting limits of care and avoiding unnecessary admissions, and this would help to drive further reductions in the mortality rate by supporting those receiving end of life care to remain in their own homes. The Chairman was pleased to announced that Bromley had been commended at a recent meeting of the Our Healthier South East London – Joint Health Overview and Scrutiny Committee for its work in assisting people to die in their preferred place, and led the Sub-Committee in thanking all staff involved in providing higher levels of care to those receiving end of life care.

The Chairman queried if the cleaning protocols at the PRUH had been reviewed to ensure that the risk of spreading the Norovirus infection between wards was minimised. The Deputy Medical Director, Princess Royal University Hospital (PRUH) reported that cleaning was at the forefront of infection control, and that further information regarding cleaning protocols at the Trust would be provided to Members following the meeting.

In considering other elements of the presentation, a Co-opted Member underlined the need to include the views of patients in the 'clean sheet redesign' of services across the Trust. A Member also queried whether recruitment and retention campaigns currently underway had considered availability of housing for new staff, and the Deputy Medical Director, Princess Royal University Hospital (PRUH) confirmed that accommodation was considered as part of the recruitment programme, and that local housing had been procured for a number of overseas doctors who had recently been recruited to work at the PRUH.

The Chairman requested that further visits to key health facilities across the Borough be arranged for Members during Winter 2016/7.

The Chairman led Members in thanking Paul Donohoe and Sarah Willoughby for their presentation which is attached at Appendix B.

RESOLVED that the update be noted.

20 MENTAL HEALTH REHABILITATION REDESIGN - OXLEAS

Report CS17071

The Sub-Committee received a presentation from Adrian Dorney, Associate Director, Inpatient and Crisis Services and Iain Dimond, Service Director, Adult Mental Health and Learning Disability, Oxleas NHS Foundation Trust outlining the redesign of the Mental Health Rehabilitation Pathway which aimed to modernise the Pathway and re-balance provision of rehabilitation across inpatient and community settings.

The redesign would invest in the development of multi-disciplinary community rehabilitation services to provide care for patients in their own homes and avoid the need for admission to inpatient rehabilitation settings, and to assist those who were in an inpatient rehabilitation setting to move back to more independent settings. It also aimed to reduce the number of inpatient rehabilitation beds that were required, with the reduction in inpatient beds enabling the re-investment in community rehabilitation services including medication, tenancy and crisis support which was expected to reduce demand for inpatient care, and to meet the needs of patients in a more cost effective way. Patients who required inpatient rehabilitation would continue to receive care within this setting, and any patient moves would be conducted appropriately in line with patients' individual clinical needs.

In order to achieve the required service development, it was proposed that Barefoot Lodge be maintained as an in-patient rehabilitation unit, but that services no longer be provided at Somerset Villa and Ivy Willis Open and Closed units with funding for these units to be reinvested in a range of community rehabilitation services and third sector provision.

In considering the service redesign, the Chairman was concerned that the beds available for inpatient rehabilitation would be reduced from 46 to 15, and emphasised Members concerns around the number of patients that would be displaced into the community and of these, how many would not have existing accommodation to return to, as well as how many additional Oxleas NHS Foundation Trust staff would support them. The Local Authority had statutory responsibilities to provide housing for vulnerable people, but there was a lack of suitable housing available within the Borough which might cause difficulties in enabling these patients to receive rehabilitation services in a community setting.

The Associate Director, Inpatient and Crisis Services, Oxleas NHS Foundation Trust explained that the service redesign would initially be focused on patients with existing accommodation, but that consideration would also be given to the threshold of patients in supported accommodation that providers could care for. The Service Director, Adult Mental Health and Learning Disability reported that Oxleas NHS Foundation Trust would continue working alongside Community Options to support patients into suitable accommodation, and that work would also be undertaken to reassure prospective landlords of the high level of support that was in place, which under the proposed scheme could include daily contact. Oxleas NHS Foundation Trust was not currently planning to establish new supported accommodation but this might be revisited in future.

A Member noted the geographical size of the Borough and queried if this would be challenging to a community-based service. The Associate Director: Inpatient and Crisis Services, Oxleas NHS Foundation Trust confirmed that staff would be required to travel to patient's homes to provide support, and that this level of support would be maintained for as long as the patient's needs were assessed as requiring it. There would be a community team based in each of the three Boroughs that were covered by Oxleas NHS Foundation Trust, and the size of each team would be dependent on the current level of need and could be flexible across the three Boroughs.

The Service Director, Adult Mental Health and Learning Disability reported that an effective community rehabilitation service had been delivered in the London Borough of Bexley for a number of years which allowed Oxleas NHS Foundation Trust to anticipate the number of patients that were likely to 'step down' from an inpatient rehabilitation setting each year. Modelling had also been undertaken of those patients currently resident in an inpatient rehabilitation setting and it had been identified that over 50% did not require this level of care and were potentially suitable for community rehabilitation services.

In summarising the discussion, the Chairman noted that Members were generally in favour of intensive community rehabilitation being provided as a Step Up/Step Down service between the existing levels of inpatient rehabilitation and community care, but that more information was required on how this would work in practice, particularly around the provision of suitable accommodation and community care for those patients that would no longer qualify for inpatient rehabilitation services. A Co-opted Member highlighted the need to engage with service users in developing the proposed redesign, and the Associate Director: Inpatient and Crisis Services, Oxleas NHS Foundation Trust confirmed that inpatients and their carers had been consulted, and that patients had generally voiced a preference to move toward more independent living.

The Local Authority and Bromley Clinical Commissioning Group's responses to the consultation on the proposed service redesign would be circulated to Members of the Health Scrutiny Sub-Committee when available and Members and Co-opted Members were requested to provide their comments.

The Chairman led Members in thanking Adrian Dorney and Iain Dimond for their presentation which is attached at Appendix B.

RESOLVED that the redesign of the Mental Health Rehabilitation Pathway be noted.

21 OXLEAS RELOCATION OF LD SERVICES

Report CS17070

The Sub-Committee considered a report from Iain Dimond, Service Director and Lorraine Regan, Clinical Director of Adult Mental Health and Learning Disability, Oxleas NHS Foundation Trust outlining the proposals for a planned move of Bromley Community Learning Disability Team from Yeoman House, Penge.

The Bromley Community Learning Disability Team had moved to Yeoman House in February 2016. Shortly after the relocation, the London Fire Brigade had carried out an inspection and deemed the premises unsuitable for use by individuals with physical disabilities due to lack of adequate fire evacuation procedures. No solution had been found to address this issue, and the Bromley Community Learning Disability Team had subsequently delivered treatment through a number of existing community resources across the Borough.

Following work to identify suitable alternative premises, Oxleas Board had agreed that the service could be accommodated in purpose-built accommodation on the Queen Mary's hospital site which provided both ground floor clinical space and office space. Work had been undertaken with service users to assess the impact of a move to this site including a questionnaire, and it had been identified that a higher proportion of service users lived closer to Queen Mary's Hospital site than Yeoman House. Clinicians would continue to work with individuals to ensure there was a plan for each service user in accessing the services on the new site, and where service users were disadvantaged by the move, the Trust would continue to offer appointments in users' homes or in other Oxleas premises.

In response to a question from a Member, the Clinical Director of Adult Mental Health and Learning Disability, Oxleas NHS Foundation Trust confirmed that it was still planned to co-locate the Bromley Community Learning Disability Team with Adult Social Care to support integrated working, and that Oxleas NHS Foundation Trust would meet the costs of moving both services to Queen Mary's Hospital site.

The Portfolio Holder for Care Services noted that there were cost implications related to the lease for Yeoman House and that this was currently the subject of negotiations between the Local Authority and Oxleas NHS Foundation Trust. The services would not move from Yeoman House until this issue had been resolved.

RESOLVED that the proposals for the planned move be noted.

22 OVERVIEW OF PHARMACY SERVICES IN BROMLEY - CCG

The Sub-Committee received a presentation from Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group providing an overview of pharmacy services in Bromley.

The Community Pharmacy Contractual Framework was commissioned by NHS England and supported the provision of a range of essential services, including dispensing medication and appliances, delivery of public health initiatives and signposting to other services. Pharmacy contractors could also choose to deliver a range of advanced services, including flu vaccinations, medicines use reviews, which supported patients in understanding and managing their medicines, and the new medicines service, which aimed to improve patient understanding and engagement with their conditions and medicines. Public Health commissioned a number of services from local providers including sexual health and smoking cessation services, and Bromley Clinical Commissioning Group also commissioned local providers to deliver the anticoagulation service and a tailored dispensing service which provided over 2000 Bromley patients with support and compliance aids to assist them in self-managing their medicines and maintaining their independence.

There were two national workstreams for 2016/17 which would direct referrals from NHS 111 to pharmacies for both urgent medicines supply and for people who needed immediate help with urgent minor ailments. Work was also being undertaken to transform the way that pharmacies operated across the NHS for the benefit of patients over the next two years. This work would be supported by the Pharmacy Integration Fund which aimed to develop clinical pharmacy practice in a wider range of primary care settings, such as care homes, GP practices and urgent care settings. This would improve access for patients and relieve the pressure on GPs and Accident and Emergency Departments, ensuring best use of medicines and driving better value and improved patient outcomes.

In response to a question from a Member regarding medicines use reviews, the Chief Officer, Bromley Clinical Commissioning Group confirmed that pharmacists could raise concerns about a patient's medication with GPs, and that pharmacists would increasingly be based at GP practices as part of the development of Integrated Care Networks. Medicines use reviews would be included as part of the multi-disciplinary team meetings for the most vulnerable individuals, and the Bromley Clinical Commissioning Group was also exploring how to deliver medicines use reviews in care homes.

A Co-opted Member noted that Healthwatch Bromley had recently undertaken a review of Pharmacy Services in Bromley. This review had identified a number of strengths across the provision, but that there was also low public awareness of some pharmacy services. The Co-opted Member suggested

that further promotional work be undertaken and that this might be funded through the Pharmacy Integration Fund.

The Chairman led Members in thanking Dr Angela Bhan for her presentation which is attached at Appendix B.

RESOLVED that the presentation be noted.

23 PLANS FOR FRAILTY SERVICE AT ORPINGTON HOSPITAL - CCG

The Sub-Committee received a presentation from Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group and Dr Paul Donohoe, Deputy Medical Director, Princess Royal University Hospital (PRUH) providing an update on the Frailty Pathway

Work was underway across the system to co-develop a new pathway that was linked to delivering the out-of-hospital strategy and establishment of the Integrated Care Network model of care. The Pathway would help to provide support for the frail elderly population of Bromley in a more integrated and coordinated way, both in and out of hospital, using the multi-disciplinary team approach. A cross-system workshop was held in May 2016 at which all providers and Patient Advisory Group members participated, following which joint Governance had been established and weekly Frailty Clinical interface Group meetings had been held with representatives from all health partners. The Patient Advisory Group had received further updates on progress in developing the Pathway, and would assist with testing the draft Pathway.

The new pathway aimed to use a predictive case finding model and clinical judgements to identify individuals who were at high risk of future emergency admission to hospital and who would benefit from case management. An initial holistic assessment would be undertaken with the individual, usually with the Community Matron, following which an Integrated Care and Support Plan would be developed and subsequently ratified following an initial review by a multi-disciplinary team. When required, an holistic assessment would be carried out to reassess the needs of the individual and where appropriate, adjust the intensity of support that was needed, and there would be regular reviews. An audit had also been undertaken around the eligibility criteria for admission to the Orpington Beds Step Up/Step Down Facility which would provide non-acute elderly care as part of the Frailty Pathway.

In response to a question from the Chairman, the Deputy Medical Director, Princess Royal University Hospital (PRUH) advised that there would be a range of basic medical testing available at the Orpington Beds Step Up/Step Down Facility, such as blood tests and imaging, and that patients in need of more complex testing could be transferred to the PRUH. There would be 38 beds/chairs available at the Orpington Step Up/Step Down Facility when it opened in January 2017, and these could be used to provide short term respite care to vulnerable people whose carers had been hospitalised through a block-bed contract from the Bromley Clinical Commissioning Group.

The Chairman led Members in thanking Dr Angela Bhan and Dr Paul Donohoe for their presentation which is attached at Appendix B.

RESOLVED that the presentation be noted.

24 JOINT HEALTH SCRUTINY COMMITTEE - CHAIRMAN'S UPDATE

The Chairman provided an update on the Our Healthier South East London – Joint Health Overview and Scrutiny Committee which had met on 11th October 2016 to consider the future provision of elective surgery across South East London which would be delivered at two of three potential locations comprising Orpington, Guy's and Lewisham Hospital sites. A further meeting of the Joint Health Overview and Scrutiny Committee would be held in late November 2016 to allow Members to contribute to the consultation on this issue.

RESOLVED that the update be noted.

25 WORK PROGRAMME 2016/17

Report CSD16142

Members considered the forward rolling work programme for the Health Scrutiny Sub-Committee.

RESOLVED that the work programme be noted.

26 ANY OTHER BUSINESS

There was no other business.

27 FUTURE MEETING DATES

The next meeting of Health Scrutiny Sub-Committee would be held at 4.00pm on Thursday 9th March 2017

The Meeting ended at 6.24 pm

Chairman

This page is left intentionally blank

HEALTH SCRUTINY SUB-COMMITTEE
2nd November 2016

WRITTEN QUESTION TO THE HEALTH SCRUTINY SUB-COMMITTEE

Written Question to the Health Scrutiny Sub-Committee received from Mrs Susan Sulis, Secretary, Community Care Protection Group

1. With regard to Item 6: Mental Health Rehabilitation Redesign (Report CS17071), this report recommends the closure of 3 out of the 4 current Inpatient Rehabilitation Units used by Bexley, Bromley and Greenwich. Would the Health Scrutiny Sub-Committee support the following enquiries being made of Oxleas NHS Trust:

    1. Regarding the current Inpatient Rehabilitation Units:

        a) How many beds are currently provided in each unit?

        b) There is no information on current or future demand for inpatient care – why not? What are the figures?

    2. Regarding the proposed closure:

        a) What are the expected savings from these closures, and the estimated costs of tendering out the replacement services?

        b) How do we know that there are suitably qualified providers available to take on this work when it is privatised? (Remember Winterbourne View?)

        c) Why is this report lacking essential financial/critical information?

    3. With regard to the provision of care:

        a) We repeatedly hear tragic cases reported where patients have desperately needed acute inpatient care, but beds have not been available. Can Oxleas confirm that this will not be the case?

        b) The covering report/Summary Briefing does not explain what the impact might be on carers and relatives. Please clarify this

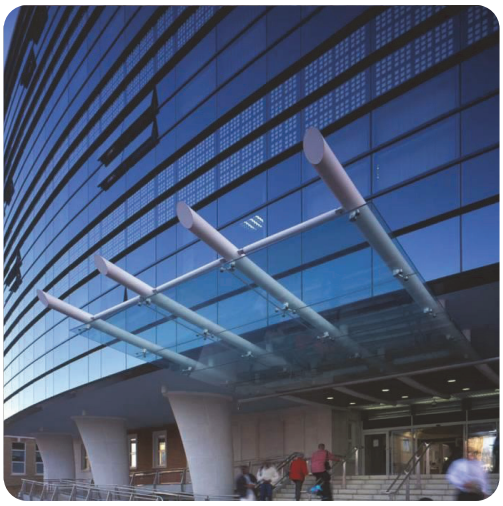
    Reply:

    The Local Authority agrees that it would be helpful in the interests of clarity for Oxleas NHS Trust to provide further information regarding this proposal, including the enquiries raised.

This page is left intentionally blank

Bromley Health Scrutiny Update November 2016

Paul Donohoe
Deputy Medical Director, PRUH



Contents

Performance, Finance and Board updates

Performance

- ED performance against 95% target across the Trust remains challenged due to multiple capacity and demand related factors. Trust four hour target in ED – around 88% in August, 82% in September.
- RTT continues to be a priority improvement area for the Trust. There were 146 patients waiting 52+ weeks at the end of September 2016, just above the 144 patients waiting at the end of August. RTT incomplete pathways performance was at 80.79% in September down from 82.20% in August.
- We continue to do well for cancer waiting time targets. E.g. 86% in Q2 against 85% target for 62-day GP referrals.
- Diagnostic waiting time performance has greatly improved from 1.95% of patients waiting over 6 weeks in August. We are now exceeding the national target of 1% as we achieved 0.96% in September.

Finance

- Significant progress has been made on achieving our savings target this year and reducing our deficit. We have so far identified just under £10m of additional savings. However there is still more work to be done and we continue to develop further plans to deliver savings for the rest of the year.

Board

- New Chief Nurse – Shelley Dolan has now joined, from the Royal Marsden
- All board posts are now filled

Progress on our strategy – BEST Care Globally

Organisational restructure

- Implementation of our new organisational arrangements is ongoing
- Focusing on talent and succession
- Building skills – the King's Academy

Progress on our strategy – BEST Care Globally: Transformation programme

Clean sheet redesign

- To improve patient experience and ensure our services run as efficiently as possible we are going back to the drawing board and redesigning our services from scratch.
- We are working closely with all departments and service to take this project forward

King's way for wards

- King's Way for Wards is looking specifically at our wards across all sites.
- In planned phases we are working with each team on the wards to make sure they all follow the same processes, they are a pleasant place for patients to be treated and for staff to work, and that they have the skills to be able to solve problems or issues that arise.

King's Academy

- The King's Academy will train staff in how to improve our services and processes from the inside, and give our leaders the right skills.

Progress on our strategy – BEST Care Globally

Electronic Patient Record (EPR)

- Supports the strong foundations part of our strategy by ensuring robust IT and information
- The next steps in the implementation programme are currently under development. This phase will include the rollout of Sunrise EPR across PRUH, Orpington outpatients and King's services based at Queen Mary's Hospital, Sidcup. EPR is already up and running in Orpington inpatients

PRUH Update

Quality (1)

- **Recent CQC visit –** awaiting formal feedback
- Excellent progress in addressing PRUH Hospital Standardised Mortality Rate (HSMR) which has dropped (2015/6) to 10th lowest out of 136 Trusts (top 8%). In 2012/3, PRUH was ranked 45th lowest out of 136 Trusts.

Quality (2)

Patient experience Sept 2016 -

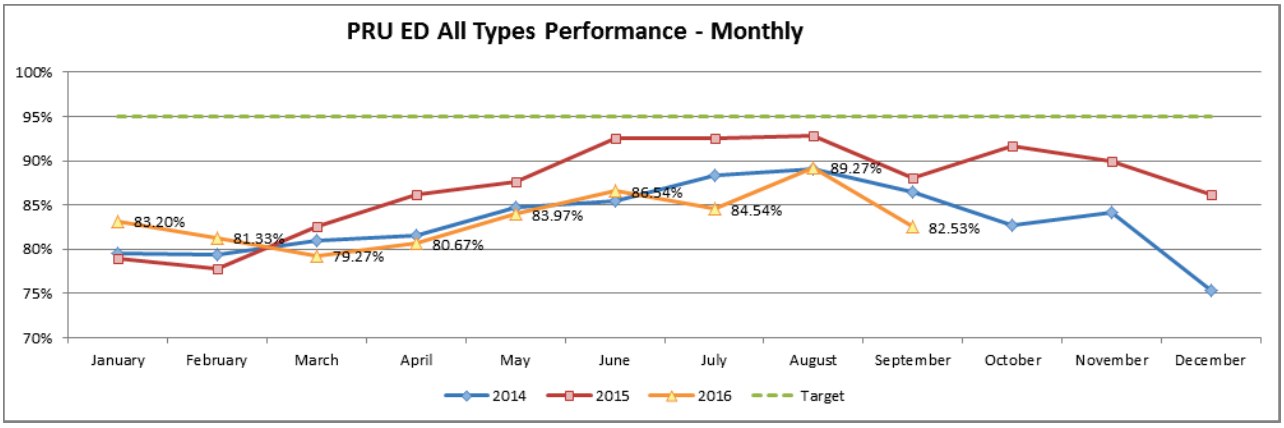
How are we doing 92% (prev 89%)

Friends & Family inpatients and day case 95% (prev 92%)

Friends & Family ED 82% (prev 85%)

Norovirus – 1st Winter 2016 case confirmed last week. Community acquired, appropriately isolated, managed and discharged. Additional measures now in place to minimise risks of further outbreaks. Extra clinical sinks in key ward areas. Handwashing campaign has been launched.

PRUH ED performance since 2014



- Emergency performance is currently a significant challenge across the sector. Performance at the PRUH has dipped as we approach Winter from around 89% in August to 82% in September.
- Emergency pathway recovery plan underway.

Recruitment

- Recruiting substantive post holders to key clinical vacancies at the PRUH and Orpington Hospital is a priority for the Trust, as well as reducing need for agency workers. Big retention drive underway.
- Large overseas recruitment drives for nurses and doctors
- Vacancy rates medical 21% from 22%, nursing 14% (stable) and admin and clerical 14% from 12%
- Bespoke recruitment campaign for PRUH and South sites, targeting the London and Kent market. Elements include:
  - Open Days for nurses – all bands and specialities
  - PRUH focused marketing campaign including local advertising – will launch by early December 2016
  - Integrated recruitment campaign with CCG

Service and initiative updates

Dermatology service relocation

- The Outpatient Dermatology Service has now moved to Beckenham Beacon enabling key development works to begin at Orpington Hospital. The majority of the service is up and running however further work is required to upgrade the current theatre to ensure all Dermatology surgical procedures can be carried out on site.
- Contingency plan is in place ensuring patients receive the treatment they need - excision surgery taking place at PRUH and Denmark Hill in the interim period.
- Work is underway to ensure the full service is resumed at Beckenham Beacon as soon as possible.

Service and initiative updates

Pathology service

The new pathology service run by Viapath is now running. Clinical lead for the service has been appointed providing the interface between the laboratory and clinical departments.

Local care record

Initiative now underway which supports integrated care, by enabling electronic information sharing with local GP practices. Phased approach to roll out, with selected GP practices coming on board.

Emergency Pathway Improvement Programme at PRUH: current focus

- Transfer of Care, admission avoidance, Winter planning
- Frailty pathway redesign and integration
- ED transformation
- Ambulatory Care
- Senior analysis of delays patient by patient to reduce LoS
- Ward accreditation process, King's Way for wards

Sum of many incremental changes

Designed to hit target trajectory

King's

Questions?

Oxleas NHS

Inpatient Rehabilitation Service Redesign

Improving lives

Adrian Dorney
Associate Director
Inpatient and Crisis Services

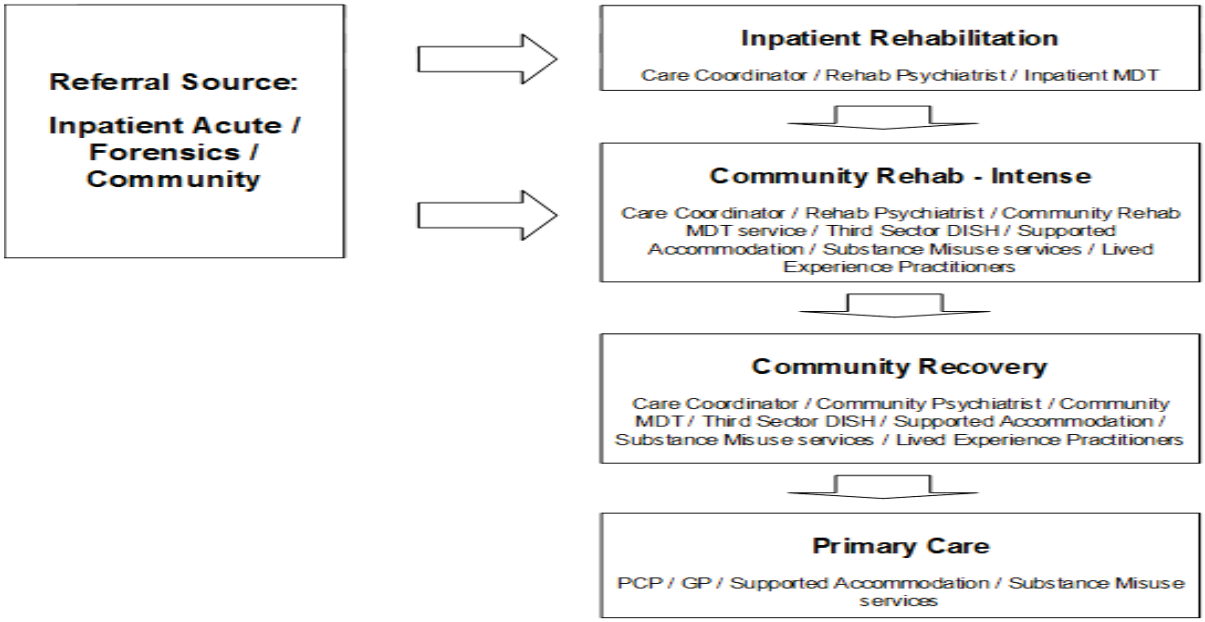
WHY REDESIGN THE SERVICE?

The focus of this service redesign is:

- **To deliver a modern rehabilitation service and reflect current best practice guidance (RCPych)**
- **More balanced provision of rehabilitation across inpatient and community settings**
- **Provide patients with the right level of care, in the setting appropriate to their needs. Avoid the risk of losing tenancies**
- **Enable a more seamless patient journey on the clinical pathway.**

Oxleas NHS
Improving lives
Rehabilitation Review

Rehabilitation Care Pathway



DEVELOPMENT OF REHABILITATION PATHWAY

The key developments in improving the rehabilitation pathway are:

- **Maintain an appropriate level of Inpatient Rehabilitation**
- **Establish Adult Mental Health Community Rehabilitation services**
- **Develop Supported Accommodation**

Oxleas NHS
Improving lives
Rehabilitation Review

IMPORTANT ASPECTS OF THE COMMUNITY REHABILIATION MODEL

- **Medication support – To patients and services**
- **Tenancy support (finance/budgeting, managing environment, third sector engagement)**
- **Dispersed support into community**
- **Crisis support**
- **Working with voluntary sector providers in different way**

HOW WILL WE ACHIEVE THIS THROUGH REINVESTMENT?

In order to achieve the required service development the following changes are necessary:

- Maintain Barefoot Lodge as Inpatient rehab unit
- Cease operating Somerset Villa, Ivy Willis House Open and Closed units
- Reinvest funding in Community rehab / third sector provision

Barefoot Lodge at Goldie Leigh Hospital will be maintained as the inpatient rehabilitation service for the Bexley, Bromley and Greenwich. This service will be accessed on a cross borough basis, as is currently the practice.

Oxleas NHS
Rehabilitation Review
Improving lives

Thank you

Any Questions?

NHS
Bromley
Clinical Commissioning Group

Community Pharmacy Contractual Framework

(commissioned by NHS England)

Dr Angela Bhan
CCG Chief Officer

2 November 2016

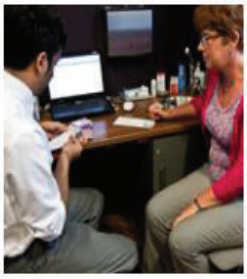
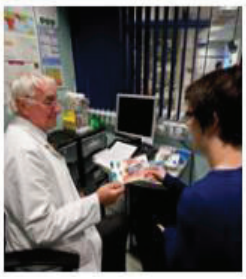
helping the people of Bromley live longer, healthier, happier lives

Essential services

(offered by all pharmacy contractors)

Advanced services

5 additional services which pharmacy contractors can choose to provide. Most pharmacies provide MURs and the NMS

Flu vaccination		Medicines Use Reviews (MUR)		New Medicine Service (NMS)
Stoma Appliance Customisation (SAC)		Appliance Use Reviews (AUR)		Funding for Advanced Services

Medicines Use Reviews (MURs)

A MUR is not a full clinical review but will support patients in their self-management. Between 30-50% of patients do not take their medicines as intended.

This service aims to:

- improve patients' understanding of their medicines;
- highlight problematic side effects and propose solutions where appropriate;
- improve adherence; and
- reduce medicines wastage, usually by encouraging the patient only to order the medicines they require.

New Medicines Service (NMS)

- It has been reported that 61% of patients feel they have insufficient information after starting a new medicine.
- The service aims to improve patient engagement with their conditions and medicines, reduce waste and reduce the risk of hospital admission.
- The service offers specific patient consultations to support patients with long-term conditions initiated on new medicines.
- Target groups include those with asthma, chronic obstructive pulmonary disease (COPD), high blood pressure, type 2 diabetes and those on blood-thinning medication.

Locally commissioned services
- Bromley CCG

Anticoagulation service (provided by Boots)

- Assessment for appropriate anticoagulant medication
- Warfarin monitoring
- Improved access and follow up for patients in the community

Tailored dispensing service

- Provision of support and compliance aids, helping patients to self-manage their medicines and maintain their independence
- Examples include medication reminder charts, eye dropper aids, “dosette boxes”
- Over 2000 patients are currently being supported by this service

Locally commissioned services
- Public Health

Examples include:

- Sexual health
- Smoking cessation

Community Pharmacy in 2016/17 and beyond

- A Pharmacy Integration Fund (PhIF) has just been announced to support pharmacy to transform how it operates across the NHS for the benefit of patients over the next two years.
- The aim of the PhIF is to support the development of clinical pharmacy practice in a wider range of primary care settings, such as care homes, GP practices and urgent care.
- This will improve access for patients, relieve the pressure on GPs and accident and emergency departments, ensure best use of medicines, drive better value and improve patient outcomes.

NHS
Bromley
Clinical Commissioning Group

Pharmacy and urgent care

2 national workstreams for 2016/17:

1. Direct referral from NHS 111 to pharmacies for urgent medicines supply (200,000 calls are received each year for urgent repeat prescription medicines)
2. Referral from NHS 111 for people who need immediate help with urgent minor ailments where appropriate for community pharmacy

Thank you

Any questions?

NHS
Bromley
Clinical Commissioning Group

FRAILTY PATHWAY UPDATE (including MDTs)

Dr Angela Bhan, CCG Chief Officer
Dr Paul Donohoe, Deputy Medical Director, King's

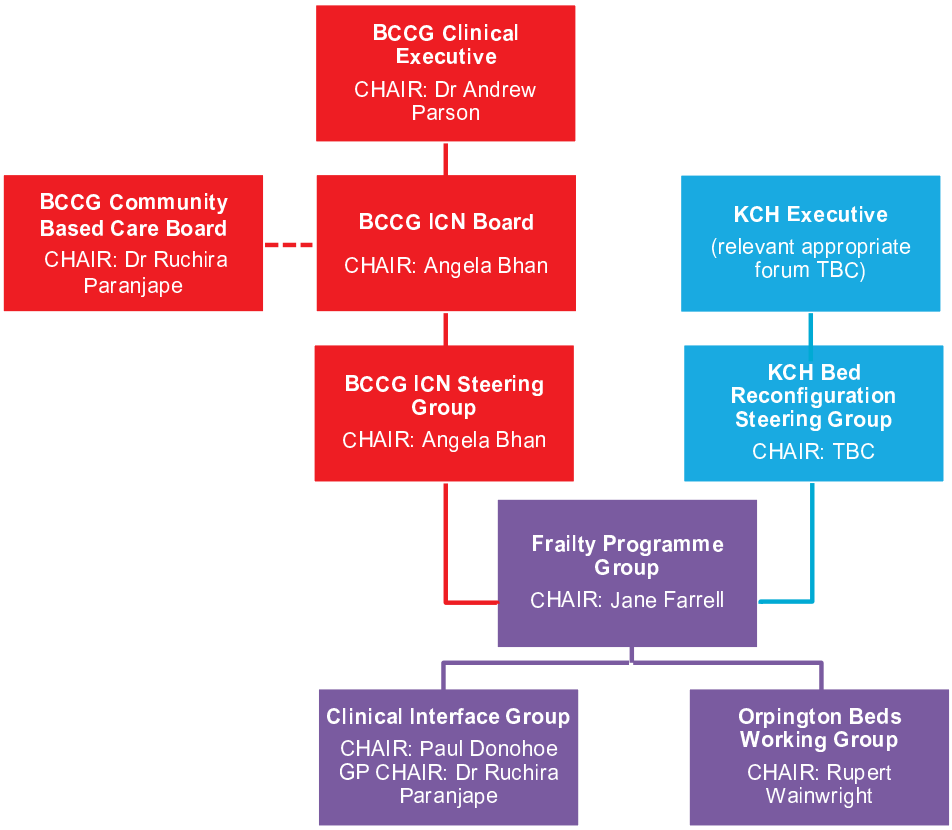
2 November 2016

helping the people of Bromley live longer, healthier, happier lives

BACKGROUND

- Work is underway across the system to co-develop a new pathway that is linked to delivering the out of hospital strategy and establishment of the Integrated Care Network ("ICN") model of care.
- This pathway will help to support the frail elderly population of Bromley in a more integrated and coordinated way, both in and out of hospital, using the multidisciplinary team (MDT) approach
- Development of this pathway commenced with a cross system workshop in May 2016 where all providers and PAG members participated.
- Since then joint governance has been put place and weekly Frailty Clinical Interface Group meetings have been taking place (with representatives from KCH / PRUH, Bromley Healthcare, Oxleas Mental Health FT, The Bromley Third Sector Enterprise ("BTSE"), The GP Alliance, St Christopher's and Bromley CCG)
- PAG have received further updates and the aim draft pathway will be tested with the group.

FRAILTY GOVERNANCE STRUCTURE (V0.6)



NHS Bromley Clinical Commissioning Group

PATIENT IDENTIFICATION

1

All **HEALTH AND CARE PROFESSIONALS** will case find and identify High Risk, High system users and provide their details to the **MDT LIAISON COORDINATOR** (via the Bromley Healthcare Single point of entry). *N.B. In Year 1 only GPs will be actively case finding*

The **MDT LIAISON COORDINATOR / CARE NAVIGATOR** provide **CARE NAVIGATION** and **CARE COORDINATION** support at an ICN level

PATIENT IDENTIFICATION AND CASE FINDING

2

The **MDT LIAISON COORDINATOR** support GPs in updating EMIS for any additional patient information, and where required a **NOMINATED GP CHAIR** will apply clinical judgement to non-GP identified cases to ensure consistency of assessment *(from Year 2 onwards)*;
If system capacity becomes an issue the **NOMINATED GP CHAIR** will prioritise who has the highest clinical and social priority for **INTEGRATED CASE MANAGEMENT**

CLINICAL GOVERNANCE AND DEMAND MANAGEMENT

3

Based on individual organisation consent policies, by this point the relevant **HEALTH AND CARE PROFESSIONAL** or the **MDT LIAISON / CARE NAVIGATOR** will have checked that the **PERSON** is happy to be put on the **PROACTIVE CARE PATHWAY**

PATIENTS IDENTIFIED AS REQUIRING PROACTIVE CARE PATHWAY will be placed on pathway for initial holistic assessment via a Community Matron, with the referral being managed by the **MDT LIAISON COORDINATOR**

PATIENT CONSENT

To ensure an intervention is most effective, resources must target the individuals at highest risk, and any case-finding method needs to be able to identify individuals at high risk of future emergency admission to hospital.

In practice, most programmes use a combination of a predictive case finding model and clinical judgement; the model is used to flag individuals who are at high risk, and the clinician then makes a judgement as to whether a person is likely to benefit from case management.

PROACTIVE CARE PATHWAY

4 

An initial **HOLISTIC ASSESSMENT** (Guided conversation) is carried out with the patient by the most relevant person, who will usually be the Community Matron

INITIAL ASSESSMENT

5 

An **INTEGRATED CARE AND SUPPORT PLAN** will be developed by the Community Matron with the patient, supported by the **CARE NAVIGATOR** role (when required)

INTEGRATED CARE PLAN

6 

A **MULTI-DISCIPLINARY TEAM** carries out an initial review of the person, updates and ratifies the **INTEGRATED CARE PLAN**, and assigns a **CLINICAL LEAD** based on the agreed **PRIMARY NEED** of each person

INITIAL MDT MEETING

7 

The **NOMINATED GP CHAIR** will Chair the MDT meetings to ensure all the patient's needs are considered and actioned, ensuring that the best interests of the patient are considered and prioritised

CLINICAL GOVERNANCE

8 

The **CLINICAL LEAD** is the first point of contact for the patient for their **PRIMARY NEED**, supported by the **MDT LIAISON COORDINATOR** who will be the main point of contact for all other needs (including self-management support)

POINT OF CONTACT

9 

The updated **INTEGRATED CARE AND SUPPORT PLAN** is shared with the patient by the most relevant person and the care plan is implemented, overseen by the **CLINICAL LEAD** and coordinated by the **CARE NAVIGATOR** with support from the **MDT LIAISON COORDINATOR**

PATIENT INVOLVEMENT

10 

The **MDT LIAISON / CARE NAVIGATOR** arrange **MDT** reviews at the intervals set out in the **INTEGRATED CARE AND SUPPORT PLAN** to review the care plan progress and make changes to the patient's care as required (70% of patients will require discussion at a 2nd MDT)

REGULAR REVIEW

11 

When required an **HOLISTIC ASSESSMENT** (guided conversation) is carried out to re-assess the needs of the person, and where appropriate reduce the intensity of support they need

RE-ASSESSMENT

ICNs – commencing MDTs

- ✓ Delivered through the MOU and funded, locally developed model of care
- ✓ First short session with a few patients to trial the system
- ✓ GP incentive scheme to identify patients and participate in process
- ✓ What was different?
  - - very thorough community matron assessment
  - - geriatrician picked up one patient for hot clinic assessment
  - - medicines reconciliation/nutrition support/constipation avoidance
  - - preparation of patient for end stage renal failure
  - - bereavement support
  - - provision of personal alarm to increase confidence
  - - no increase in social or personal care required
- ✓ EMIS and omnijoin – GPs need two screens!

KEY AREAS OF FOCUS

Key areas of focus have included:

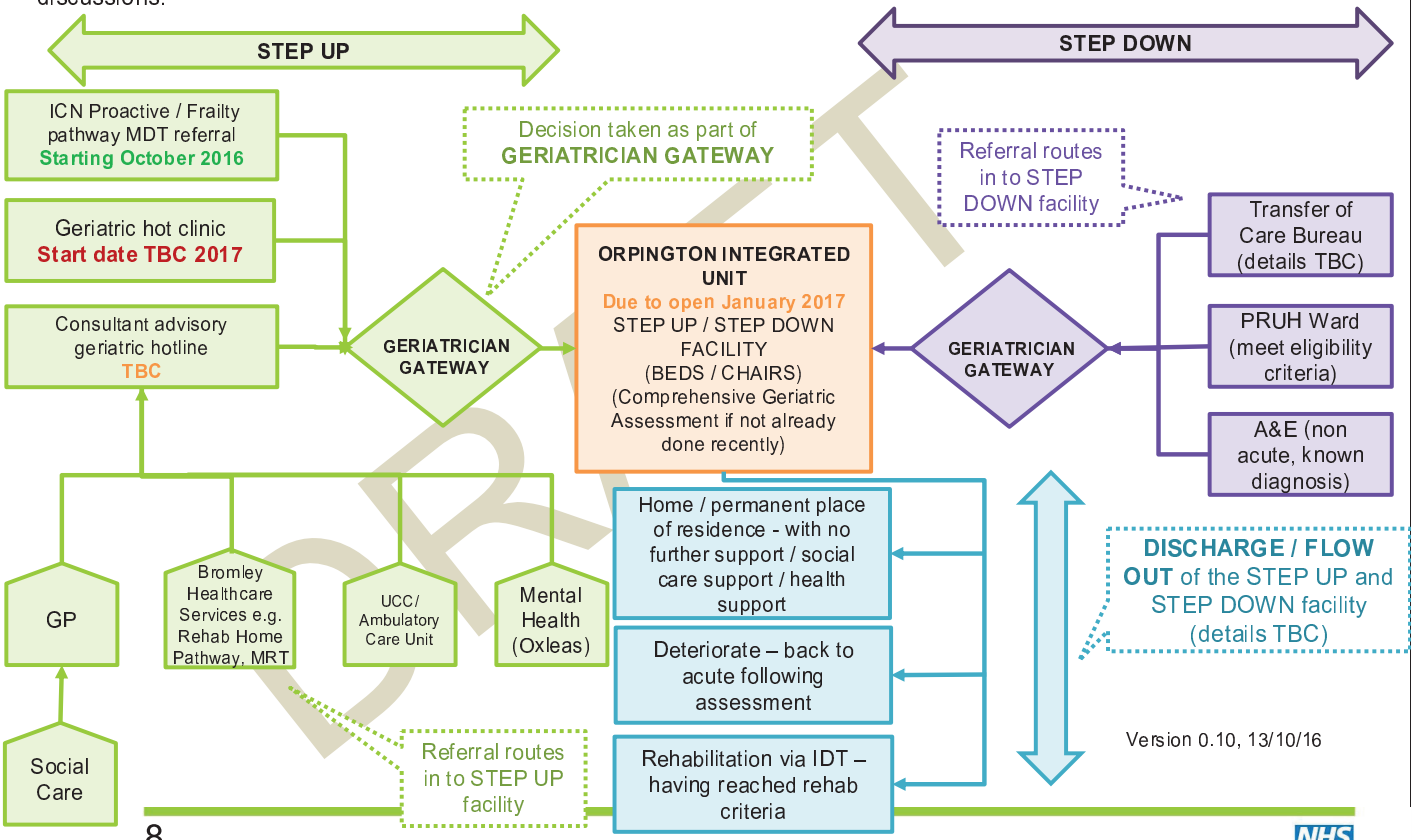
- Eligibility criteria for admission to the Orpington Beds Step Up/ Step Down Facility

An audit against the eligibility criteria took place at the end of September at the PRUH across all 23 wards and ED to identify a snapshot of the patients who would have been eligible for the Orpington facility if it were in place. The Eligibility Criteria from a community perspective have been looked at by Bromley Healthcare and by using existing analysis by the CCG

- Workforce and identification of resources
- Discharge from the Orpington Beds & interface resources
- Use of Hot Clinics and eligibility to access them
- Comprehensive Geriatric Assessment
- Linkage to Proactive Care Pathway
- Older Person's Assessment & Liaison ("OPAL") Team
- Interface with Out of Borough Patients
- Patients with mental health needs

FRAILTY PATHWAY – DRAFT LINK TO STEP UP / DOWN FACILITY

The following is the current version of the Frailty Pathway that has been developed as part of the weekly clinically focused discussions:



FRAILTY PATHWAY – DRAFT ELIGIBILITY CRITERIA TO STEP UP / DOWN FACILITY

KEY REQUIREMENTS

- Non-acute elderly care
- Patients whose condition is likely to require some medical input
- Level of Frailty: scoring at least 6-7 on the Rockwood Frailty Scale (age not deciding factor)
- Hours of decision making for referrals: proposed 8am-5pm based on availability of Geriatrician
- Patients with a Bromley GP (test impact after 2-3 months)
- Access – via step up or step down through Geriatrician gateway
- Unit is consultant led with a MDT approach - TBC
- 7 day access

STEP UP

- Referral through one of the following Gerontology gateways:
  - Geriatrician hot clinic
  - MDT referral from Proactive Pathway
  - GP referral via geriatric hotline where patient has been suitability assessed as not requiring admission to acute site
- Patients with known diagnosis or ongoing needs but cannot be treated at home, requiring a stay of less than in the region of 7 days
- Patients with delirium or dementia who require non-acute support can be discussed and considered for this support
- Step up via Rehab Home Pathway or MRT for patients who are not safe to be supported at home and require inpatient rehabilitation
- Management of venous ulcers and patients with long term conditions that have been gradually failing with an identified cause e.g. increased leg oedema
- People discharged, where the package of care is inadequate or there was a non-acute reason for the package of care not being supportive (recurrent admissions)

STEP DOWN

- All step down patients will have had a Comprehensive Geriatric Assessment started before transfer
- Recuperation/rehabilitation for patients whose condition is not currently reaching Lauriston criteria (slow stream)
- People who are medically stable but require support because their carer has been admitted
- Minor illness and falls not covered by the current fracture pathway
- Resolving Delirium / Dementia (slow stream requiring longer length of stay) - TBC

Version 0.10, 13/10/16, Updated following Frailty Clinical Interface Group 26/9/16

NHS Bromley Clinical Commissioning Group

Next steps

- Ongoing work with key stakeholders
- Confirm go live date for any new areas of pathway and communicate
- Confirm any additional resources required and funding arrangements
- Finalise frailty pathway
- Put in place performance arrangements to monitor progress and impact

This page is left intentionally blank