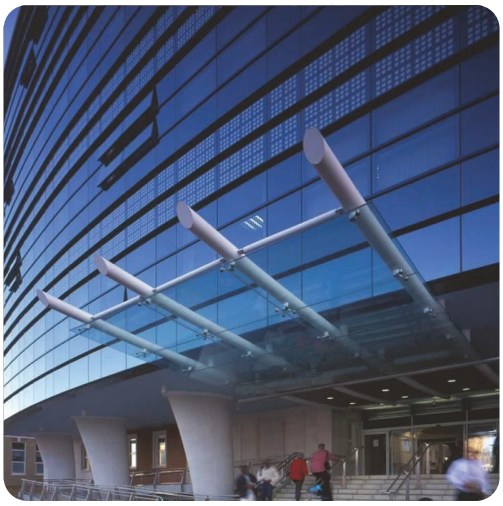
Bromley Health Scrutiny Update November 2016

Paul Donohoe
Deputy Medical Director, PRUH



Contents

Trust wide update

Finance, performance, board updates
Progress on strategy – including organisational restructure and transformation programme
Electronic Patient Records (EPR)

PRUH update

Quality – including Norovirus
ED performance
Recruitment
Service and initiative updates
Emergency pathway improvement programme

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 -

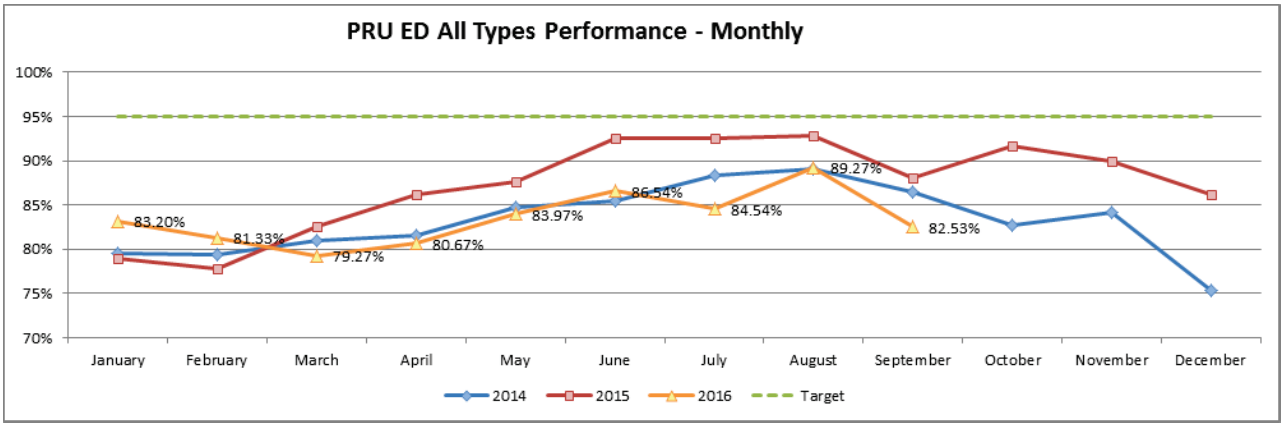
How are we doing 92% (prev 89%)

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

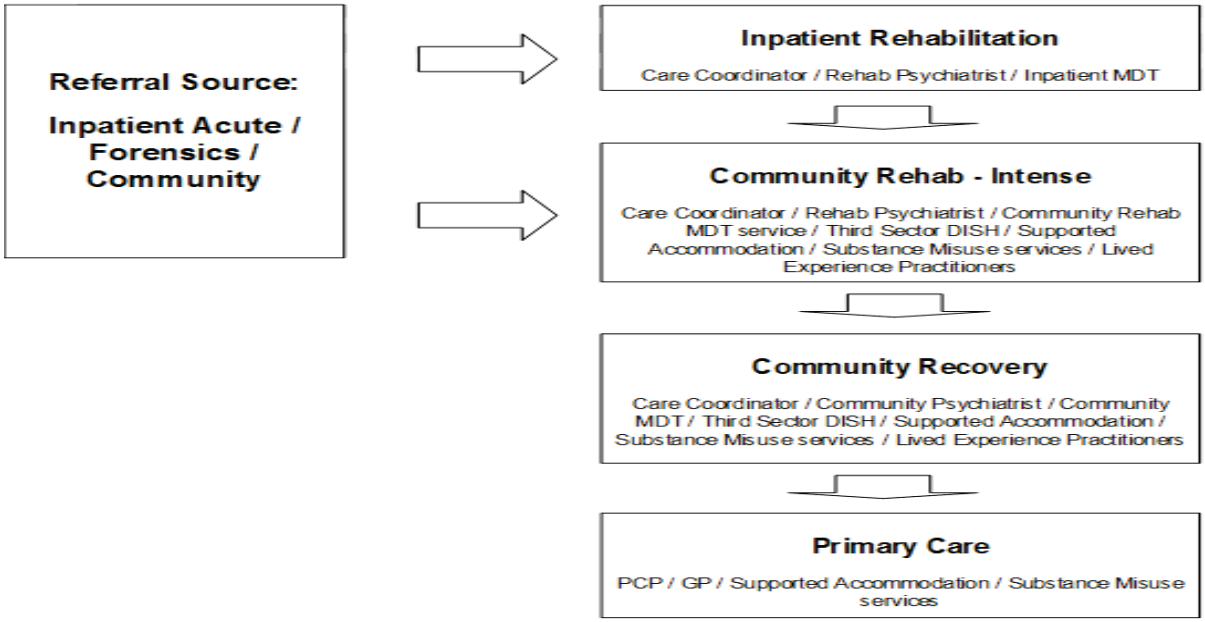
WHY REDESIGN THE SERVICE?

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

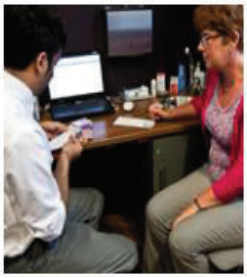
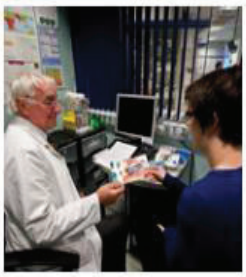
Essential services

(offered by all pharmacy contractors)

NHS
Bromley
Clinical Commissioning Group

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.

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

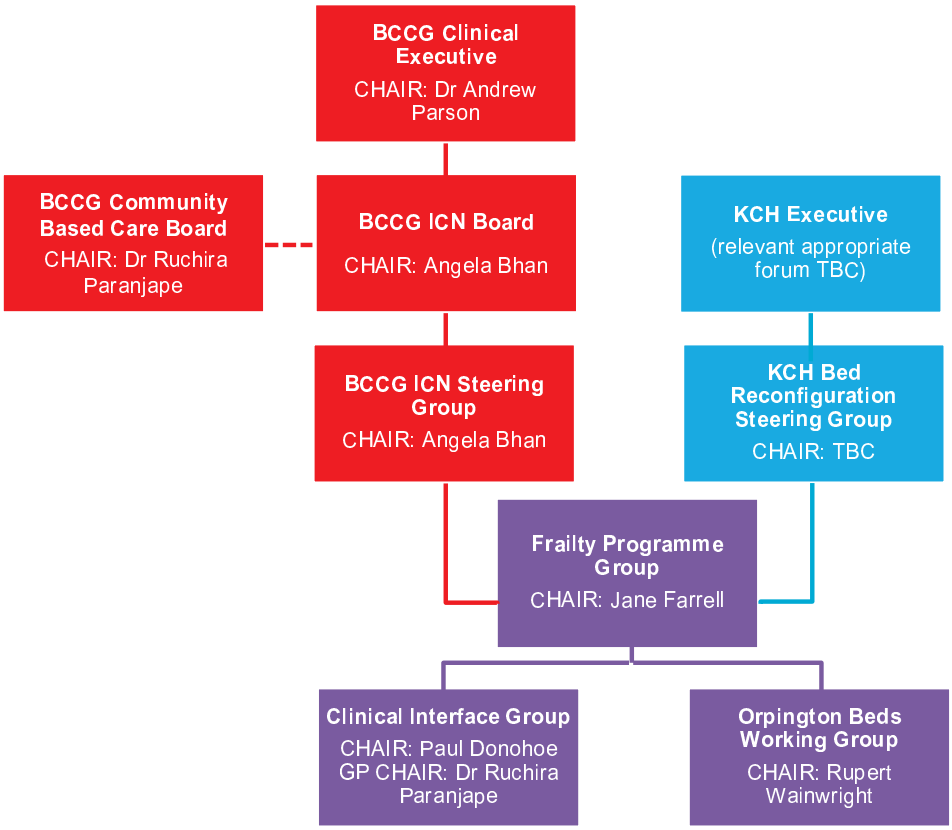
2 November 2016

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.

NHS Bromley Clinical Commissioning Group

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:

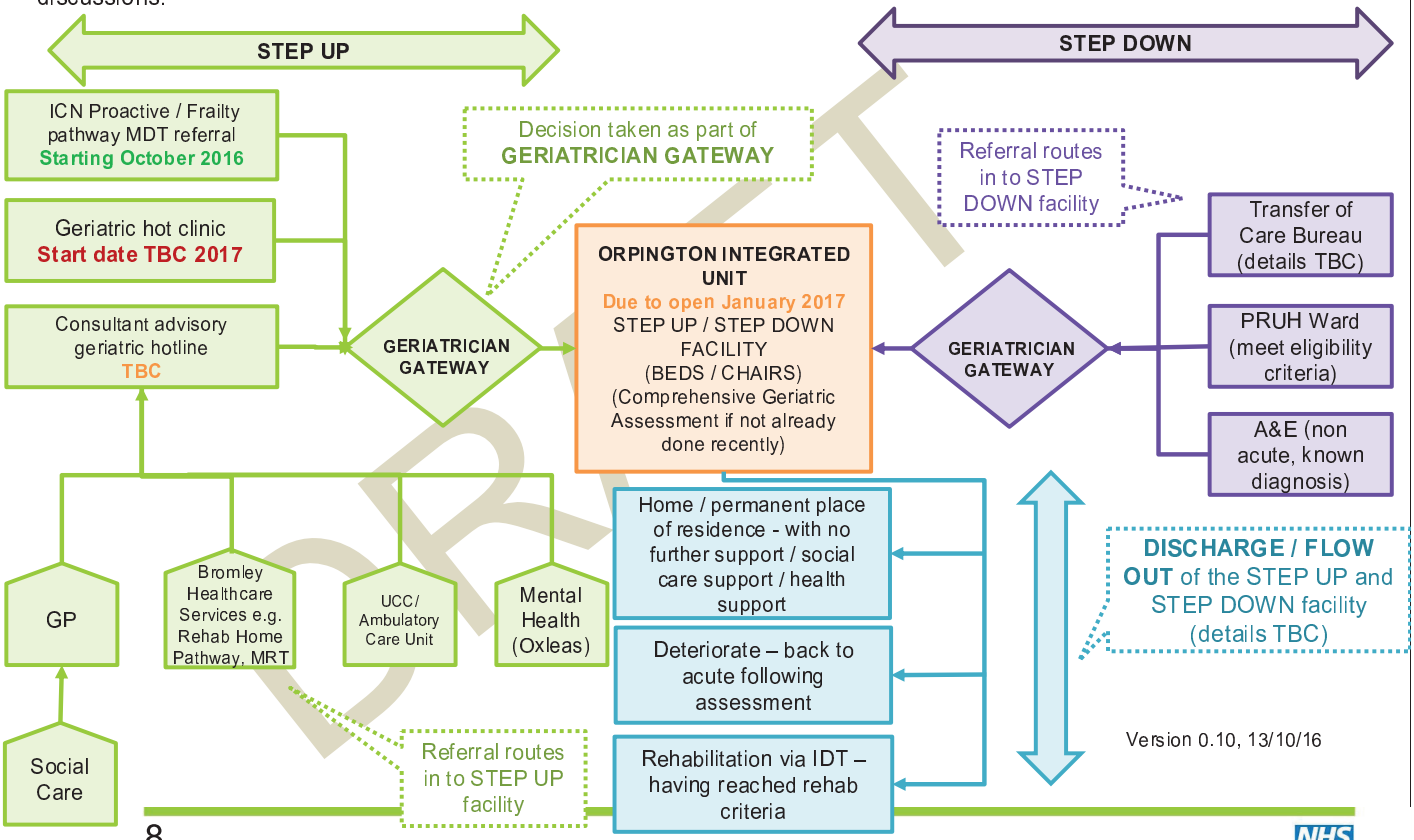
- Eligibility criteria for admission to the Orpington Beds Step Up/ Step Down Facility

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

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