London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**7th September 2017**
Report Title:	**2016/17 Winter Review**
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Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director Education, Care and Health Services Angela Bhan, Chief Officer, Bromley CCG
Ward:	All

1. SUMMARY

This report highlights

- *The performance of the Urgent Care System in winter 2016/17*
- *The winter schemes identified to help manage surge and lack of capacity*
- *An evaluation of each scheme and lessons learnt*
- *Schemes carried forward to continue to support the system*

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

This paper is going to the Health and Wellbeing Board for information.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

This report is to note progress

Health & Wellbeing Strategy

1. Related priority: Not applicable

Financial

1. Cost of proposal: £610k was already signed off as part of the winter funding

2. Ongoing costs: N/A

3. Total savings (if applicable): N/A

4. Budget host organisation: CCG

5. Source of funding:

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

Yes, through better preventive care for people with complex needs, reducing length of stay in hospital and thereby promoting independence

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4. COMMENTARY

N/A

5. FINANCIAL IMPLICATIONS

No new finances are required

6. LEGAL IMPLICATIONS

N/A

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

N/A

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

This report shows that there has been a significant improvement in A&E performance over recent months, which has been the result of an improved system wide approach. The impact of strengthened joint working between London Borough of Bromley and Bromley CCG has clearly shown benefits. New schemes and development of existing schemes over the coming months should put Bromley in a good position to ensure improved quality of urgent and emergency care for our residents.

Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	[Title of document and date]

Glossary

A&E	Accident and Emergency
CCG	Clinical Commissioning Group
CD	Community Matron
ED	Emergency Department
HWBB	Health and Well Being Board
KCH	Kings College Hospital
KPI	Key Performance Indicators
LBB	London Borough of Bromley
MRT	Medical Response Team (rapid response and out of hours GP services)
PRUH	Princess Royal University Hospital

RSV	Respiratory Syncytial Virus
TBC	To be confirmed
TOC	Transfer of Care
UCC	Urgent Care Centre

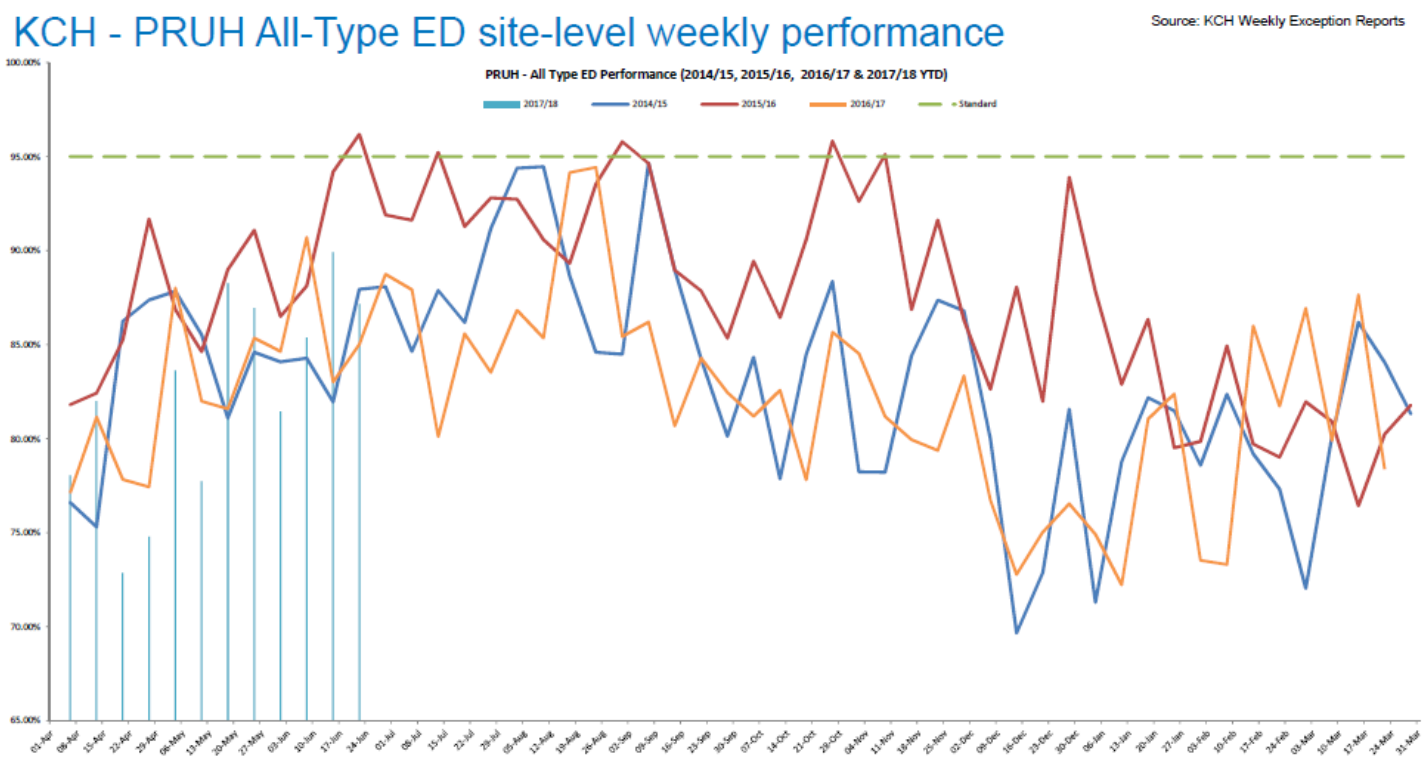
Overview

This highlight report follows the interim report presented to the Health and Wellbeing Board in on the 2nd February 2017, it provides:

- The performance of the Urgent Care System in winter 2016/17
- The winter schemes identified to help manage surge and lack of capacity
- An evaluation of each scheme and lessons learnt
- Schemes being carried forward to continue to support the system

1. Performance of the system

The graph below highlights the performance of the A&E 4 hour target for over the 16/17 winter and Q1 of this financial year with comparisons of the same period for the last 2 years



The orange line shows the performance against the 95% standard dipped dramatically against previous years from Aug 2016, hitting its lowest period in December before starting to recover.

As already known to the Health and Well Being Board, there are a number of reasons for the poor performance. It should be noted that performance has significantly improved over the late spring and summer months this year and, as a system, urgent care services in Bromley (particularly the PRUH) has developed the ability to recover more quickly than in previous years.

Reasons for sporadic performance include:

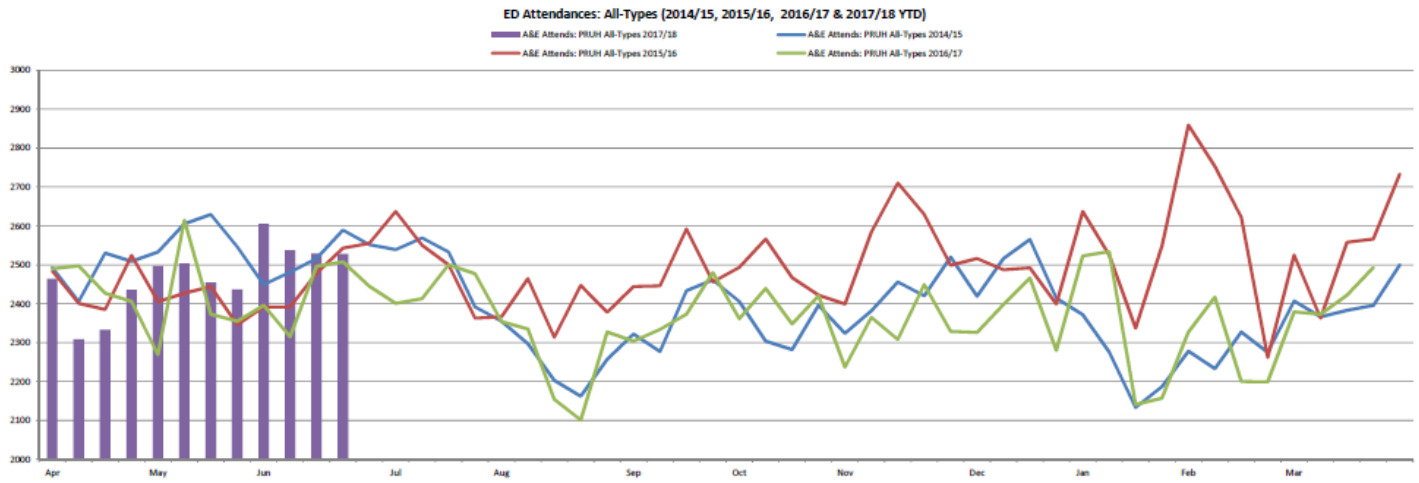
1. Demographics and infectious disease
   - Increasing age and frailty of parts of the Bromley population
   - A winter that has been particularly cold at times, with icy and (more recently) foggy conditions
   - Circulating viruses – we are seeing more cases of influenza A and also respiratory syncytial virus (RSV), as well as flu like illness caused by other viruses.
   - Increase in numbers and proportion of ambulances and 'blue light' ambulances coming to the PRUH (an indirect marker of increased acuity of patients)

2. Poor flow of patients through the urgent and emergency care system, as manifested by large numbers of patients identified as delayed transfers of care prior to Christmas week:

   - Difficulties in placing packages of care due to lack of capacity in the domiciliary care market, especially over the Christmas and New Year period
   - Availability of care and nursing home places for social care and continuing health care patients as well as for self-funders
   - Particular delays for patients in the PRUH who are the responsibility of other boroughs

3. Factors internal to the hospital
   - Staff vacancies and challenges in recruiting locum staff
   - Process issues in being able to move patients from A&E to the wards (usually because beds not available or not available early enough in the day, resulting in patients waiting longer to be seen in A&E)
   - Outbreak of norovirus at the start of winter, with ongoing associated problems.

The following graph is an updated position on the attendances of patients to the PRUH in comparison to previous years



Attendances have remained at or lower than previous years, though the 'demand' has been harder to anticipate as has been the acuity of the patients. This has been further impacted on by the outbreak of Norovirus at the beginning of winter.

2. Winter Schemes and Intervention

In preparation for winter and taking into consideration the lessons learnt from last year, the following winter schemes were implemented to help manage the surge and capacity issues.

Scheme	Description	Provider
In-reach (Medical Response Team)	A scheme that places an Advance Nurse Practitioner in the front of the PRUH to extract patients that have attended inappropriately	Bromley Healthcare
Patient Champion	A staff member working in the UCC dedicated to redirecting patients back into primary care	Greenbrooks
Community Matron in the PRUH	A matron to work as part of the Transfer of Care Bureau to help expedite patient discharge back into community services	Bromley Healthcare
GP in the PRUH	A GP working in the Transfer of Care Bureau to help expedite patients back into community services and primary care	GP Alliance
Additional Primary Care Hub appointments	An increase of additional primary care hub appointments	GP Alliance
Dressings Service	An additional dressing service 3 days a week to help manage post op dressings (located in the primary care hubs)	GP Alliance
Social Worker	An additional Social Worker at the front door to help manage social care issues	London Borough of Bromley (through the Transfer of Care Bureau)
Discharge Co-ordinator	Additional capacity in the Transfer of Care Bureau	Transfer of Care Bureau
Rapid Response	An Alternative Care Pathway focusing on care homes to help avoid ambulance callouts and ED attendances	Bromley Healthcare
Day and Night Sitting	A day and night sitting service to help patients settle at home	Age Concern

Other interventions have included:

- The purchasing of additional packages of care
- The provision of additional social care beds
- Direct booking into the primary care hubs (111, UCC and MRT)
- Additional funding for care home assessments
- Flexing of criteria for community rehab beds
- Platinum calls and meetings with the system (twice weekly)
- Additional Acute beds as part of the frailty pathway (in Orpington Hospital)
- Increased capacity for psychiatric liaison service

3. Scheme Evaluations

Scheme Name	**MRT Inreach**

Scheme Description	To provide a community Inreach service at the front end to identify and 'pull' patients back into community services as early as possible and avoid patients being admitted into 'back end' bed provision
KPI agreed	• 2 Discharges a day • Identify discharge blockages • Number of tracked patients handed over to community matron
Summary of impact	November 2016 – March 2017 In reach were referred 880 patients of which 653 (74%) were accepted and discharged back to the community with MRT the services. 107 patients that were tracked converted to discharges A further deep dive was conducted on 50 patients and found a 32% readmission rate within 6 weeks and of the 32%, 43% were readmitted within a week.
Recommendations/lessons learnt	1) Strengthened links with the developing frailty pathway as the patients who can benefit from the service are mostly frail and elderly 2) Increased multi-disciplinary approach at weekends/Bank Holidays 3) Intensive 'myth busting' of perceptions amongst acute clinical staff of what MRT can manage in the community. This is improving with time and experience but a more timely introduction of the service could be achieved by co-ordinated awareness raising sessions prior to the service commencing and conducting case by case reviews/discussions at a senior/advanced level
Scheme Name	**Community Matron**
Scheme Description	To provide a Community Matron (CM) In-reach service for 'back end' wards in the PRUH. To work with TOC GP/KCH MDT colleagues to identify pts who can be safely transferred to community health services and provide clinical challenge
KPI agreed	• Facilitate 2 discharges per day • Educate/raise awareness of community health services in Bromley • Be a reference point for KCH staff to contact for advice
Summary of impact	The service expedited and supported the discharge of 81 patients. A total of 181 assessments/advice offered – this excludes ad-hoc conversations
Recommendations/lessons learnt	• Continue with regular meetings with the PRUH discharge team colleagues to build on recent In reach education to continue communicating best practices for a safe and timely discharge process • Regular attendance on the ward to support discharge into community and smooth the discharge and patient flow by direct liaison with the team • Consider 7 day presence • Intensive 'myth busting' of perceptions amongst acute clinical staff of what community health teams such as MRT can manage in the community.
Scheme Name	**Rapid Response for care homes**
Scheme Description	The service provided rapid medical response and assistance for cases which were urgent but could be treated in the community, helping care homes and extra care housing to cope quickly and efficiently without having to call an ambulance or wait for a GP
KPI agreed	N/A
Summary of impact	The service started in January but struggled to recruit members of staff and therefore became fully operational throughout March and April. 16 patients were seen from 8 care homes. The conditions referred were: • Chesty cough: 3 occasions • Recurrent chest infection: 3 occasions • Confused: 2 occasions • Generally unwell and could not reach GP: 2 occasions • Swollen ankle • Ongoing rash • Constipation • Blocked catheter

	• Pressure sore • Leg ulcer
Recommendations/lessons learnt	1) The scheme was started late (at the height of winter) and it struggled to attract staff 2) As it was only a pilot, homes were reluctant to change their way of working for such a short period of time 3) The scheme overlapped significantly with another care home scheme implemented through the 111 services. This meant there were potentially conflicting messages issues, with homes naturally choosing to rely on the permanent national service that they used throughout the year. 4) Engaging and communicating with homes and key decision makers proved challenging, better communication links was needed

Scheme Name	**Day and Night Sitting Service**
Scheme Description	The Age UK Bromley & Greenwich Sitting Service was designed to support older people returning home post discharge from hospital or a rehabilitation unit for the vital 24-48 hour period whilst they settle and assimilate to their home environment especially after lengthy hospital stays.
KPI agreed	N/A
Summary of impact	The service did not see any patients in its duration because of limited referrals. Issues identified: • The service could only receive referrals from hospital staff and not families/ carers or self-referrals from patients • It took some time subsequent to going live with the service, for the exact hospital departments and locations who were to refer to be decided • When multidisciplinary professionals from wards at the PRUH did call and leave messages to make a referral it was almost impossible to get in contact with them to complete the process, and they were unable to respond or get back in touch to fully instigate the referral • There was a referral for one client mid-way in to the contract however the patient then needed to stay in hospital longer and transfer to a rehabilitation unit, thus postponing the referral • When staff did attend for the singular referral they had felt relatively disempowered because no personal care element was in place. When the client required certain support in the toilet or bathroom they were very limited as to how they could assist. Staff also raised issues regarding the domiciliary carers who were meant to provide personal care and administration of medication but failed to do so- this was relayed to the client's next of kin via Age UK Bromley & Greenwich. For ongoing practical support the service also allocated their Hospital Aftercare 6 week package of support for companionship and confidence building subsequent to the sitting time allocated.
Recommendations	• Broadening the range of who can refer for the service, i.e. not hospital staff only • Having a dedicated Coordinator who could be based at the PRUH and indeed travel between the acute, Orpington and Lauriston House rehabilitation unit to manage discharge home with the Sitting service in place. • To have a personal care element introduced and an element of handover to domiciliary or enablement agencies who would be continuing care of the client • To instil a reporting system liaising with the Hospital social work teams to report any issues related to the client care or service deficiencies so that these can be addressed in a timely manner adhering to best practice and relieving some burden from the patient and their family members, thus

	minimising the need for further deterioration in health and wellbeing and readmission.

Scheme Name	**Patient Champion**
Scheme Description	An administrator located within the Urgent Care Centre to redirect patients attending the UCC inappropriately, and to provide awareness to patients of other services in Bromley
KPI agreed	5% patients redirected
Summary of impact	From Jan-March the patient champion redirected 76 patients from the PRUH and Beckenham Beacon
Recommendations	To continue with the scheme for the next financial year, with a greater emphasis on redirection from the PRUH

Scheme Name	**GP in Transfer of Care Bureau**
Scheme Description	A team of GPs located in the Transfer of Care Bureau to help expedite discharges
KPI agreed	2 patients per day
Summary of impact	During the four month period over 109 patients were seen and the notes of a further 180 patients reviewed and advice given. The GP's initially focussed their time and attention on the wards, reviewing patients with delayed discharges, however this proved of little effect therefore attention was moved to the front of the hospital to avoid admission.
Recommendations/lessons learnt	To continue with the scheme and utilise the GP at the front of the hospital indefinitely for a range of functions. Benefits and lessons learnt included: • the ability of the GPs to do outpatient referrals, order bloods and other tests, arrange GP appointments and visits on discharge, arrange District nurse and community appointments, prescribe medication, liaise with the community pharmacy, speak with families, GP's and other professionals involved in the care of the patient, recommend the patients for addition to the practice admissions avoidance register and for MDT meetings.
Scheme Name	**Dressings Clinic**
	(i) Nurse dressing clinics for patients requiring suture removal or post op wound care
KPI agreed	N/A
Summary of impact	The clinics was originally set up to alleviate the pressure on UCC's to provide dressings, however minimal referrals was made, the decision was taken to expand provision to general practise. Once the restriction in referrals and type of referral was lifted, practices started to use the service. The scheme operated at 64% utilisation
Recommendations/lessons learnt	This scheme was ended in March as it's moved away from its original intention.
Scheme Name	Additional Primary Care Hub Appointments
Scheme Description	To provide additional appointments by opening a 3rd primary care hub (crown meadow)
KPI agreed	N/A
Summary of Impact	The third hub has been successful since its inception and now forms part of the regular hub contract. Utilisation has always been high. The appointments reserved for the UCC were underutilised. Between 1/12/16-31/3/17 only 294 appointments were used. However appointments were made available to the MRT. They utilised a further 691 and continue to book patients into the hubs when they are open instead of sending them to UCC
Recommendations/Lessons Learnt	Continue with the provision of the third hub

Winter 2016/17 Summary

The performance graph at the beginning of the report highlights an improvement against the 95% 4 hour A&E target from Mid-December onwards. This time period correlates with the majority of winter schemes being in full operation and supporting the system as planned. This is further evidenced by the dip in attendance at the same period, as many of the schemes centred on admission avoidance.

At the end of March when the majority of schemes were scheduled to end, the decision was taken to extend the following services to continue supporting the urgent care system:

- In-reach MRT
- GP in Transfer of Care Bureau
- Third primary care hub
- Patient Champion in the UCC

Winter Schemes 2017/18

Learning from the previous winter became critical when identifying what initiatives were required to support this winter. The earlier graph highlighted activity over the last few years has relatively remained the same therefore enabling a more accurate forecast of demand for this winter.

After evaluating the supporting data and consulting the wider Urgent Care System, the following initiatives have been proposed for this winter

Scheme Name	**Front door team**
Scheme Description	A multi-disciplinary admission avoidance team at the front door of the PRUH to help redirect patients back into the community - consisting of the GP (role used last year), a social worker, community matron (used last year) and discharge coordinator
KPI agreed	Tbc
Summary of potential impact	Will run from October 17 to March 18 and provide primary care working with secondary care

Scheme Name	**Patient Champion extension**
Scheme Description	Providing an additional patient champion and ensure the service operates 7 days a week
KPI agreed	Tbc
Summary of potential impact	Increased redirection of patients back into the community
Scheme Name	**Patient Champion**
Scheme Description	A multi-disciplinary admission avoidance team at the front door of the PRUH to help redirect patients back into the community - consisting of the GP (role used last year), a social worker, community matron (used last year) and discharge coordinator
KPI agreed	Tbc
Summary of potential impact	Will run from October 17 to March 18 and provide primary care working with secondary care
Scheme Name	**HCA**
Scheme Description	Provide additional administrative support to each UCC
KPI agreed	Tbc
Summary of potential impact	Provide additional capacity
Scheme Name	**GP Uplift**
Scheme Description	An agreed uplift to enable a fully staffed rota between Christmas and New Year in the UCC
KPI agreed	Tbc
Summary of potential impact	Greater capacity

Scheme Name	**St Christopher's**
Scheme Description	A member of St Christopher's working in the Transfer of Care Team to help identify appropriate patients for their end of life pathway
KPI agreed	Tbc
Summary of potential impact	Will run from October 17 to March 18

Scheme Name	Communication
Scheme Description	A communication campaign focusing on self-care messages and directing patients to the most appropriate service
KPI agreed	Tbc
Summary of potential impact	Patients receiving the right care in the right place

In addition to the schemes identified other measures will be adopted to further support the system, this includes:

- Purchasing of additional packages of care
- Additional Primary Care Hub appointments
- Direct booking into Primary Care Hubs
- Revision of escalation processes between providers
- Discharge to Assess pilot supported through existing schemes and specifically identified 10 discharge to assess beds.
- Further development of the Transfer of Care Bureau, including new management and operating arrangements
- Links between urgent and emergency care (and reactive approaches) will be strengthened by further improvements in the Integrated Care Networks operating model (which has traditionally been focussed on proactive care)

Ongoing Governance and development 2017/18

It is clear that the improved joint working between London Borough of Bromley and Bromley CCG in recent months has improved and further developed the initiatives aimed at ensuring that patients flow through the hospital and urgent care system much better than previously. Joint appointments between LBB and the CCG are supporting the new approach.

The winter schemes will be directly managed through the Bromley A&E Delivery Board and will overseen by the evolving joint commissioning arrangements being developed between the commissioning organisations.