Bromley Whole System Winter Plan

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Version control

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1 CONTENTS

2 Purpose of the Plan 5
2.1 Background: 5
2.2 Aims and Objectives 5
3 Approach to Escalation 7
3.1 Definitions 7
3.2 Escalation principles within Bromley 7
4 Escalation Plans for Managing Surges 10
4.1 KCH PRUH 10
4.2 PRUH and Beckenham Beacon UCC – Greenbrook Healthcare 10
4.3 Bromley Healthcare 10
4.4 Oxleas NHS Foundation Trust 11
4.5 London Ambulance Service 11
4.7 London Borough of Bromley 12
5 Winter Resilience Schemes 18/19 13
5.1 Bromley CCG and London Borough of Bromley 13
5.2 King's College Hospital PRUH site 15
6 5.0 Further System Winter Planning: 16
6.1 Infection control including flu vaccinations 16
6.1.1 Population 16
6.1.2 Healthcare Professionals 16
6.2 Process for managing repatriations 16
6.3 Improving ambulance handovers 16
....16
6.4 Minor Breach Reduction 17
6.5 Provision of an Out of Hospital borough-based service map, including referral and access criteria. 18
6.6 Further Provider Assurance Plans 18
7 Appendices: 23

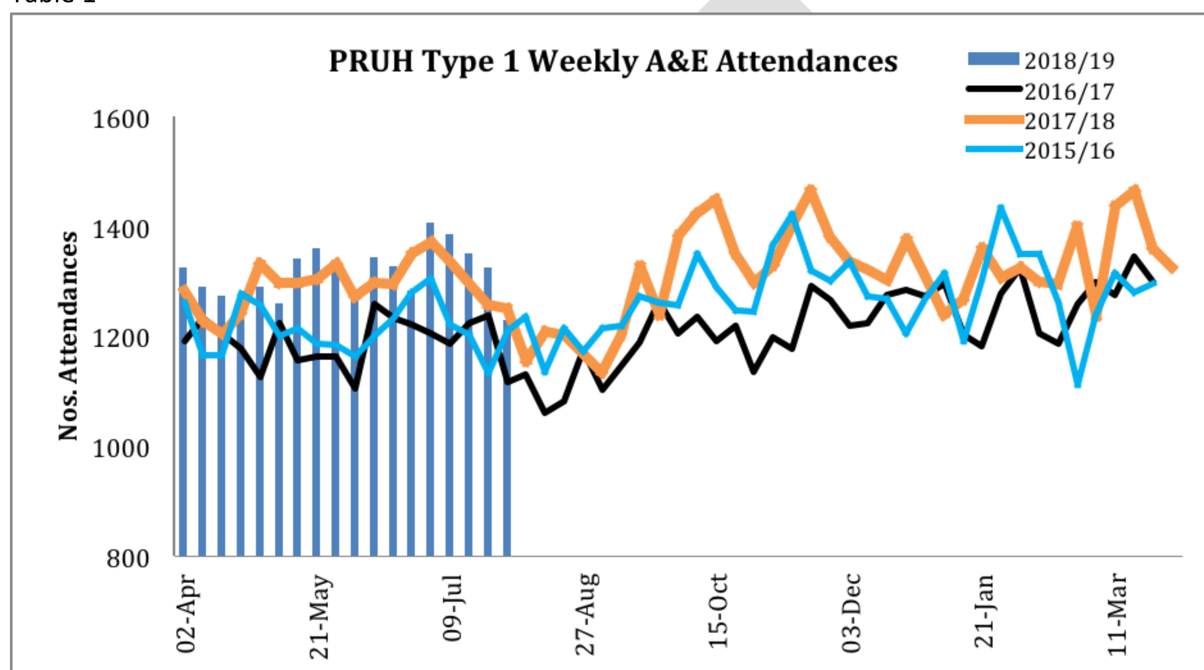
DRAFT

2 Purpose of the Plan

2.1 Background:

Over the past few years, the local health and social care system has felt the increased pressure during the winter months, with most health and social care services seeing a surge of activity and demand with a more complex range of needs challenged by seasonal presentations like Flu and norovirus. ED type 1 attendances have increased year on year during the winter period (see table 1).

Table 1



The additional pressures on the health and social care system, which are primarily from older and frail people, during the winter months presents a challenging landscape. Bromley wider health and social care system leaders have developed this plan to manage safely and effectively the additional pressures during this period.

This plan was developed through the Bromley A&E Delivery Board, which delivers a whole systems approach to planning, improved performance and the development of a coherent local service framework for urgent and emergency care. This approach includes coordinated planning for and management of winter pressures, and other periods of enhanced demand on the care system. The Board is facilitated by Bromley CCG, working in partnership with King's College Hospital, London Borough of Bromley, Greenbrook Healthcare, Oxleas NHS Foundation Trust, Bromley Healthcare, Bromley GP Alliance, St Christopher's and London Ambulance Service.

2.2 Aims and Objectives

The overall aim of the plan is to provide a framework for health and social care partners in the Bromley health and social care system to manage surge and capacity issues affecting one or more partners at both tactical and strategic levels. Furthermore, to support the local health and social care system effectively manage winter pressures, the SEL STP has asked for a winter assurance plan from

each Local A&E Delivery Board for submission to NHS England. The whole health economy is encouraged to use this plan to manage pressures on respective parts of the system.

The purpose of this plan is therefore to both support and enhance the effectiveness of local procedures through proactive management processes at times of pressure and provide local and national assurance of how existing and additional resources will work together to respond to the additional seasonal demand. Objectives of this plan are:

- To establish a shared understanding of different surge and escalation criteria used across health and social care services
- To define a flexible framework for response which can be utilized irrespective of situation duration, scale and type
- To define procedures and processes about escalation to be utilised in the event of an actual or potential surge and capacity issue(s)
- To provide a framework for identifying specific surge and escalation issues and for informing, coordinating and supporting the local health and social care services response to an incident
- To provide a framework for actively engaging with the public both in advance of and during surge and escalation situations with a view to assisting in the management of surge and escalation issues. Links to winter communication campaign.
- To provide a mechanism to escalate issues for joint resolution by partners at both a tactical and a strategic level
- To provide oversight of proactive work by all partners to reduce escalation of need and respond to increased pressures in the system

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3 APPROACH TO ESCALATION

System demand and capacity, including flexing staff/beds into non-elective setting

3.1 DEFINITIONS

It is recognised that, at any one point in time across our system, organisations may be at different levels of escalation in line with their view on pressures that may be individual to their organisation. However, there is agreement that armed with knowledge about the pressures across the system and using principles of mutual aid the system will be in a better position to be able to cope.

Green	Amber	Red	Black
Business as usual. Low risk to patient safety and experience, slight effect on services where early signs of difficulty are being detected requirement management intervention	Moderate effect on services. Moderate risk to patient safety and experience where increasing flow issues are being detected requiring significant additional action	Severe and/or prolonged pressure on services. High risk to patient safety and experience where demand for services is outstripping supply or patient flow is severely impeded	Extreme effect on services. Significant Incident declared. Very high risk to patient safety and experience. Services are overwhelmed by levels of demand

The above table highlights the definition of each escalation stage, from green to Black, the system wide engagement and involvement is automatically triggered at the **Amber** stage and those involved will seek to return the system to **Green**. If this is not possible senior management escalation across the health and social care economy will be triggered at the **Red** status.

3.2 ESCALATION PRINCIPLES WITHIN BROMLEY

1) Each major service provider is expected to manage the escalation and de-escalation processes at local level and this framework outlines these arrangements
2) The CCG will use whole system daily Surge Hub calls to co-ordinate a response to an escalating situation.
3) Each major service provider must have a robust, up-to-date local escalation plan signed off at Board level which dovetails into this overarching CCG wide plan.
4) The acute trust is also required to have an ambulance services handover plan and to comply with its obligations (please refer to Section 5.3 for detail).
5) Within each organisation there are clear system leaders (including identification of organisation, role/s and responsibilities) which will oversee all levels of escalation, especially those where whole system action is needed to avoid or mitigate pressure, and where

external support might be required (please refer to Appendix 1). Further escalation should be to the agreed Urgent and Emergency Care System Leader.

6) Where an organisation has undergone escalation of status a nominated staff member within each organisation will agree and lead the de-escalation process once review shows suitably reduced pressure.
7) Each organisation must have an identified individual who is responsible for ensuring that escalation plans are actioned and reviewed. This person must have suitable authority to ensure actions occur in a timely manner.
8) For any patients that are moved during escalation, plans must be in place for their repatriation (see Section 5.2).

Risk factors

The following factors increase the risk of there being a surge in demand for services:

- Severe winter weather
- Heatwave conditions
- A Major Incident with severe and multiple casualties
- Pandemic influenza or other infectious disease outbreaks
- Disruption to community care and/or social care services
- Extended Bank Holiday Weekends causing increased demand on both Acute Trust and OOHs services

Whole System Factors

Increased activity in the acute care setting could subsequently result in a delay in the community and social care settings as the demand for their services increase. Communication of a surge and the opening of escalation capacity with these groups will be essential for a return to normality following the surge. Failure to notify the following groups may further increase the surge in demand by creating feedback into the acute setting where patients are unsupported on discharge:

- GP Practices
- Social Services
- Bromley Healthcare – Rapid Response, Bed Based / Home Based Rehab and Community Nursing
- St Christopher's
- Oxleas Community Mental Health Teams
- Transfer of Care Bureau

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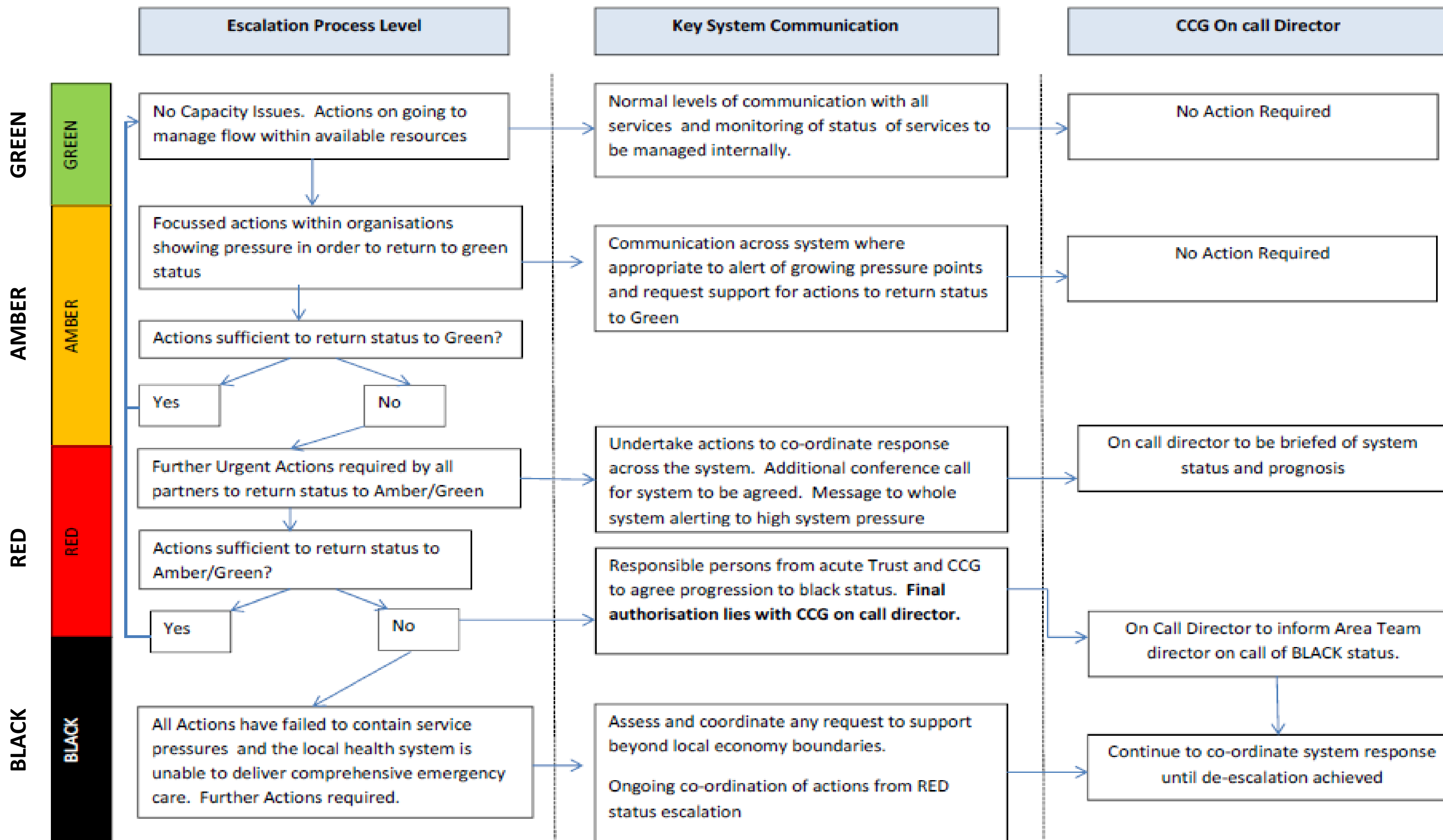
Escalation Communication Flowchart



4 ESCALATION PLANS FOR MANAGING SURGES

4.1 KCH PRUH

Appendix 2 details the Internal Incident Plan, which seeks to clarify how the Trust responds to a surge or collective number of patients within the Emergency Department which may compromise their safety, and require an advanced and controlled hospital response.

The plan is also suitable to deal with high capacity within the hospital. No two scenarios are alike; therefore, the plan is designed to provide a framework to enable staff to respond flexibly and appropriately to the situation.

The following procedure is to assist the organisation to respond in a co-ordinated uniform manner to ensure the safety of staff, the public and patients under their care and to ensure continuity of business of the Trust.

The KCH PRUH management team are currently refreshing the escalation process linked to OPEL scores, which we aim to complete by the end of the month. Appendix 3 is the PRUH Emergency Department Capacity Management Escalation Policy and action cards as an example, alongside Appendix 4 which is the full capacity dashboard which supports triggering between levels and the more general Trust internal incident process.

With regard to **system demand and capacity, including flexing staff/beds into non-elective** the PRUH site current demand and capacity shows a shortfall of c 60 beds following the closure of D2A capacity, Elizabeth Ward and internal escalation capacity. In terms of daily flexing of staff, this will be supported by the refreshed escalation/full capacity protocol.

4.2 PRUH AND BECKENHAM BEACON URGENT CARE CENTRES (UCC) – GREENBROOK HEALTHCARE

Appropriate Escalation is crucial to the safe management of the UCC. The lead nurse should ensure he/she is always aware if the status of the department and complete a Sitrep if the department is not in a Green position. Actions should be followed and documented on the sitrep form.

Greenbrook provide three times daily capacity and activity reports to the CCG and escalate to the contracts team where there may be issues with demand or capacity. See Appendix 5 for the PRUH and BB UCC Activity Escalation Plans and Action Cares.

4.3 BROMLEY HEALTHCARE

Agreed system triggers and appropriate actions

BHC has an internal 0830 resilience call where capacity and demand is discussed broadly covering Bed Based Rehab, Home Based Rehab, Rapid Response and District Nursing. The AD Operations is present on the call and relays the information to the 0930 system surge call. BHC respond to any escalation or activity required in order to support acute with flow by flexing resources wherever possible,.

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Agreed escalation process for managing surges

BHC report on the outcome of the 0830 and 0930 calls internally and any surge requirements are escalated through AD Ops to Director of Ops to CEO accordingly. BHC will dial into platinum calss when required.

4.4 Oxleas NHS Foundation Trust

4.5 London Ambulance Service

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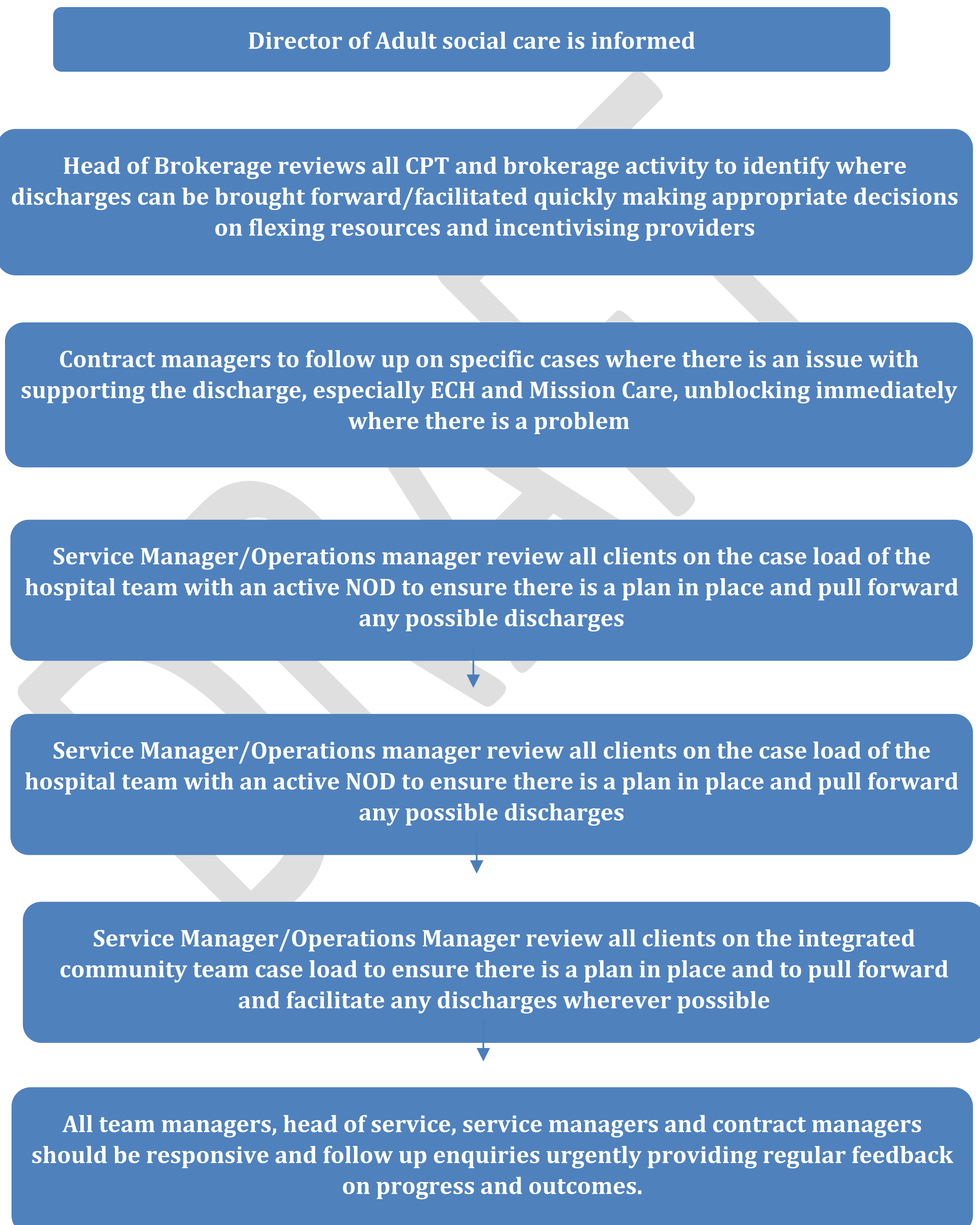
4.7 London Borough of Bromley

Response to Acute escalation:



5 WINTER RESILIENCE SCHEMES 18/19

In the past few years LB Bromley (LBB) and NHS Bromley CCG (BCCG) have made financial investment to provide additional capacity to the system during winter months. Lessons learnt from 2016/17 was that new schemes during winter were not successful and often went underutilised. Last year, the enhancement of existing resources proved much more successful and although not meeting national standards, performance across the system was better than that of previous years with responsiveness and recovery rates considerably improving. King's College Hospital have also identified winter schemes this year and are detailed below (noting that there is £973k available already in the trust baseline for spending on winter schemes at the PRUH). For financial and KPI details around the proposed schemes please see Appendix 6 attached.

5.1 BROMLEY CCG AND LONDON BOROUGH OF BROMLEY

The CCG winter resilience funding (£628k budget) and London Borough of Bromley winter resilience scheme funding (£1027k) has been allocated across the health and social care system to ensure there is additional capacity in the system to ensure patients are seen in the appropriate care setting. This includes schemes to support patients in secondary, community and primary care (i.e. the additional GP hub appointments for patients). The CCG schemes have been signed off in principle by Bromley CCG Governing Body and are being fully worked up in partnership with providers. Each scheme will have a robust monitoring and evaluation process ensuring that the agreed KPIs are delivered. The LA are replicating the same activity from the previous year following positive evaluation of the impact of this resource.

The proposal for this year builds on lessons learnt from the previous year and focuses on three joint strategic themes which are *Increasing capacity in the workforce*, *Increasing capacity in service provision* and ***Integrating service to prevent the need for hospital based care and streamline discharge processes.*** From the evaluation of both organisations previous winter schemes, stakeholders agreed that increasing capacity in existing services, whilst strengthening the community reactive, urgent response offer would be an effective use of resources for 2018/19. A full list of the schemes including financial investment and KPIS can be found in appendix. The following provides a brief overview of areas associated with the three strategic themes:

1) Increasing capacity in the workforce

- Providing additional Care Management and Occupational Health professionals across the community and hospital to support additional demand
- Additional Support to Urgent Care Centre (soon to be designated Urgent Treatment Centres) (CCG) to increase productivity and manage additional activity

As commissioned last year, the three elements were:

- Extended patient champion hours which supports redirection and increases use of hub appointments including advise and sign-posting to reduce avoidance attendances
- Enhanced GP rates which last year resulted in 100% Rota fill across both sites including bank holidays and weekends enabling the UCCs to support ED and see as many patients as possible

- Increasing Health Care Assistants which allows clinical staff to focus on treating and discharges more patients with HCAs completing ECGs, observations, plastering and some dressings

2) Increasing capacity in service provision

- Additional GP appointments at the Primary Care Access Hubs (CCG)

As commissioned last year and the appointment slots were well utilised. In previous years, practice access to hub appointments has mitigated the increase in UCC attendance over the winter period and helps general practice to keep patients well and therefore avert crisis and possible A&E attendance.

- GP winter home visits (CCG)

The demand for home visits has increased by over 50% in the past two years, and feedback from the vast majority of practices shows that practices are finding it more and more difficult to meet this demand without there being an adverse impact on delivery of other primary care services. The timely provision of home visits will help prevent patients falling into crisis and therefore avert potential far costlier A&E attendances/admissions. The CCG intends to commission Bromley Healthcare to provide additional health care professional capacity to provide these home visits. Practices have reported that in the past ANPs have provided high quality care for patients that they have referred to the service.

- Fast Track Personal Care (LBB)

Providing access to increased domiciliary care at home including POC within 4 hours and up to 8 visits per day, bridging for reablement or where the existing market cannot meet presenting demand . Consideration for block funding bridging capacity during key periods is underway to ensure guarantees capacity this winter

- Intensive personal care services (LBB)

Additional access to increased domicilary care offer (usually maximum 4 visits per day) including 24hr care at home, live in carer and night sits as per successfully used in previous years to support more people to remain and be discharged home. Funding will also provide access to emergency placements to also prevent social admissions or hospital attendance.

- Decluttering and access to provision to support people to return home (LBB)

Commissioning a dedicated decluttering and deep cleaning service to ensure where care or equipment is required and the home is cluttered, this can be decluttered in a timely way to prevent a delay to discharge. In addition funding will be used for wider property protection and ensuring people who no longer have capacity and don't have power of attorney or support in place are able to access food and shopping while this process is undertaken all of which will have a positive impact on supporting timely discharge.

3) Bringing together service to prevent the need for hospital based care and streamline discharge processes

- Enhanced healthcare in care Extra Care Housing

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Extra Care Housing provision is within the top 10 placements (ECH, Supported living, residential and nursing Care) in the borough for London Ambulance Service call outs. Conveyance and admissions rates however are proportionally lower then other placement providers. Extra Care housing, although has domiciliary care on site, does not benefit from a Visiting Medical Officer, and the level of care provided is considerably less then residential or nursing care. Schemes are often large in size and the level of need for many is increasing. The provision of a dedicated ANP/Community Matron will provide proactive support as part of the existing multidisciplinary team of ECH and care management staff, for provides to build capacity and ensure care plans are in place to manage declining and frail patients as well as the ability to caseload high risk, vulnerable patients with fluctuating health needs. In addition residents in ECH tend to spend longer in hospital with challenges in discharging people back to their accommodation with a number of readmissions. Support form the ANP/CM will enable early supported discharge for residents who have been admitted and ensure they are able to remain at home, preventing readmission for this group wherever possible.

- Bromley @home - will also support health and social care providers

The service aims to help prevent avoidable hospital attendances and admissions, reduce unnecessary readmissions and shorten hospital length of stay for residents of Bromley. The service will provide acute clinical care, in the persons' usual place of residence that would otherwise have to be undertaken in hospital, with the aim of providing the best possible patient experience and health outcomes enabling the patient to benefit from holistic integrated care.

Patients will be identified by LAS, GPs or community care providers as well as early identification at hospital front door assessment. The service will provide short-term medical treatment and associated monitoring supported by multidisciplinary interventions as required for any associated functional decline including physiotherapy and occupational therapy.

This pilot service model is majority funded through existed resource/capacity. Winter Resilience funding is being utilised to provide additional capacity where gaps exist in current services. Funding is currently indicative and the financial model is still being finalised with the provider(s). This service will be rolled out in a phased approached, firstly concentrating on referrals from the acute Emergency Department and GPs. This will be monitored daily with the next stage of roll out focusing on providing an alternative care pathway to London Ambulance Service, Care Homes and Domiciliary Care agencies.

Winter Communications Plan / Campaign:
There is funding set aside for local winter campaign material for the public. The CCG Communications and Engagement team will work with the national campaign team to coordinate effective and meaningful messaging to the Public before and throughout winter.

5.2 King's College Hospital PRUH site

Please see Appendix 6 for details on prioritised winter scheme spend.

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6 5.0 Further System Winter Planning:

6.1 Infection control including flu vaccinations

6.1.1 Population

As part of the Bromley PMS Premium Services that Bromley GP Practices are required to deliver Childhood and flu immunisations uptake and follow up of non-responders. The national target is 75% for over 65s. This service is configured to reward both activity by the practice to increase uptake and uptake outturn and allows for a phased approach for the latter. Pharmacies in Bromley also provide the flu jab for the local population.

6.1.2 Health and care Professionals

Each provider is required to ensure that their staff are vaccinated in advance of winter, in line with the work undertaken at SEL level.

All LBB employees are able to take their ID to local pharmacies and commissioned providers to receive their FLU vaccination. All frontline workers are expected to have their flu vaccination.

6.2 Process for managing repatriations

KCH PRUH will be utilising the Surge Hub Repatriation Policy. The hospital also has an internal process that can be seen in Appendix 8.

6.3 Improving ambulance handovers

Substantial work has already been undertaken at the KCH PRUH site on improving ambulance hand over and in general the site's performance compares well. The action delivered is shown below:

No.	Area	Action	Lead & Timescale	Time scale	Progress Update	RAG Status	Impact on 4 hour standard
1.0	Improve ED Capacity/Patient Experience	Implement Fit to sit. Target to have 0 handover delays greater than 30minutes.	Chris Kerr	Feb-18	Fit to sit embedded from Feb 2018. SOP in progress to include clarification of inclusion and exclusion criteria (target date end of September) HCA and Nurse to be allocated to fit to sit area (Sept) PRUH site shows a 21% improvement in performance between January 2018 and June 2018. A shift from an average of 14.3 handovers over 30 minutes/day to 2.3.day on average in June.	Green	0.25%

6.4 MINOR BREACH REDUCTION

As part of the STP Minor Breaches Reduction plan, which forms part of the overall A & E Delivery Plan, KCH PRUH and Greenbrook UCCs are actioning the following to reduce breaches for 'minors' attendance:

Urgent Treatment Centres and Community Based Care

- 2 GP led Urgent Treatment Centres in Bromley provided by Greenbrooks one of which is on the same site as the PRUH – significant developments in partnership working and Standard Operating procedures are in place with the UTC to support effective streaming including direct access from GP referrals and LAS bypassing ED. Clinician to clinician hand overs also in place with daily huddles between clinicians to ensure the pressure and resource across the system is shared and understood
- An @home model in the community is under development to be mobilised before winter bringing together a range of existing resources to provide a responsive community based MDT to provide acute and sub-acute interventions in the community preventing attendances and avoiding hospital admission.
- An active GP out of hours service is in place with recent increase in capacity to support winter pressures. Ongoing review of supply and demand is undertaken by the CCG with flexible response to surge in activity.

Emergency Department

- Working to improve IT interface in place between Adastra and Symphony to have single system entry for all attendances seen through UCC. This will improve triage and streaming from UCC. IT project team in place and upgrade testing between the two systems completed week of 20 August. Results under review with team.
- UCC Referral to Assessment/ Ambulatory Units for Speciality Patients. Following trial of streaming patients in sub-acute to ambulatory (passed from UCC to ED), PRUH ED to work with UCC on how to directly refer where appropriate.
- An advanced nurse practitioner triage system is in place at all times with dedicated frailty nurse placed within ED to identify and stream patients appropriately
- Significant transformation activity is taking place across the PRUH including refreshed ED surgical pathway, Frailty Assessment Unit and Rapid Assessment and Treatment (RATT) to provide dedicated specialities into ED and ensure people are streamed to the most appropriate place to meet their needs.
- A frequent attenders meeting takes place with input from community services to identify interventions and support to reduce attendances. This is further supported by the Proactive Care Pathway delivered through 3 Integrated Care Networks to support more people to remain independent in the community for longer

System leadership and Governance

- The A&E Delivery Board provide system leadership to continue to reduce all type 1 breaches including level 4.
- Daily performance review is undertaken on all breaches across the system with a scrutiny report provided by providers to commissioners on reason and actions to address. Thematic analysis taking place on a monthly basis and fed into the A&EDB. Where capacity is an issue, a flexible

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approach to resources across the system is used. During seasonal and high pressure times additional primary care capacity is put in place to provide increased support to the system

- The A&E Delivery Board continues to provide oversight, scrutiny and leadership on system wide improvement around Urgent and Emergency care pathways and performance
- Within contractual agreements is has been made clear that the CCG have a zero tolerance response to breaches from all providers

6.5 Provision of an Out of Hospital borough-based service map, including referral and access criteria.

Please see Appendix 8 for the Bromley OOB Referral Process Map. This is intended to be a live document, updated as new service information i.e. winter schemes, becomes readily available. In addition the local escalation contact list (see Appendix 1) has been developed to ensure the correct professionals are in place to support any issues.

6.6 Further Provider Assurance Plans

In advance of winter, the CCG also asked providers to give assurance that there were plans in place to:

1) *Identify and proactively plan/track at risk residents and ensure all care plans are accessible should a crisis occur*
2) *Avoid emergency attendance and admissions:*
3) *Ensure timely discharge for medically fit patients requiring ongoing care and support e.g. trusted assessor, referring and assessment to community services pre-MSFT to ensure all in place once patient is MSFT, services accessed via single passport document not separate referral form*
4) *Maintain people in the community reducing escalation of need*
5) *Specific plans to ensure full 7 day service is in place*

6.6.1 Identify and proactively plan/track at risk residents and ensure all care plans are accessible should a crisis occur?

King's College Hospital PRUH

- Early identification of people with frailty on presentation to UCC.
- Re-run audit of patients attending 5 or more times in the last year. Will engage CCG to write to GP and, where relevant, nursing or care home where the patient resides. Request GP review care plan for the patient.
- Staff in hospital aware of and using information through red bag scheme. (Clarifications required around discharge information)

Bromley Healthcare

- BHC Wrap around services: Proactive Care Pathway-linked to ICN hubs; Respiratory Team; Community Matrons; Children's Community Nursing Team; District Nursing Teams; Night nursing; Neuro Rehab team; Bed and Home Based rehab.
- BHC will ensure these wrap around services winter plans are in place at an early stage.
- BHC will ensure all patients and carers have relevant contact details and will ensure administrators in the CCC are briefed with regards to our winter plan.

London Borough of Bromley

- Care & support plans uploaded onto CareFirst (data systems), accessible across the organisation as well as to health colleagues via Multi-Agency View (MAV) of CareFirst
- Proactive work with carers to ensure care and support plans and effective contingency plans are visible on both the carer and adult they care for record

Oxleas

- Admission prevention: tightening up on crisis and contingency plans - programme in place with clinical reference board for each team to come to and discuss plan. Everyone on CPA but also include paragraph for outpatients. Oxleas can also now access the local care record to access patient record.

St Christopher's

- All patients known to St Christopher's, with patient consent are added to Coordinate My Care which can be accessed by healthcare professionals including LAS, GPs and KCH palliative care team.

6.6.2 Avoid emergency attendance and admissions:

King's College Hospital PRUH

- Geriatrician advice line available to community healthcare professionals.
- Internal professional standard for specialty response to ED to enable early senior input to patient admission/discharge plan. Additionally, the Trust does not admit patients who are likely to be able to go home from the ED to avoid a breach of the emergency care quality indicators.

Bromley Healthcare

- Additional funding to provide the extension of the GP winter visiting scheme which was successful last winter (see CCG winter schemes)
- Additional funding for a Community Matron / ANP to work with the Residential Homes and Extra Care Housing to carry out Geriatric Assessments and review via MDT via the Proactive Care Pathway. Provide direct clinical care to patients to prevent ED attendance where possible. Also link in with the other ICN strategies including End of Life and Heart Failure for these patients. Provide support to homes regarding patient deterioration and education(see CCG winter schemes).
- Obtain data from LAS and PRUH regarding the top 10 homes with high LAS transfers and admissions including presenting conditions to ensure that we pro-actively support patients to prevent ED attendance and avoid admission.

London Borough of Bromley

- Social Workers in Integrated Care Networks (ICN) to proactively support people at risk of decline
- Use of Winter Resilience funding to provide immediate access to 24 hour care at home, additional and enhanced fast response personal care and access to emergency placement where it is not safe for someone to remain at home in order to prevent an admission.
- More intensive community oversight to avoid admissions for vulnerable clients
- Dom-care providers are able to increase the level of care required for urgent & additional care as well as to remain with a client while a contingency plan is put in place to prevent hospital conveyance wherever possible
- Trusted assessor for access to domiciliary care via the Bromley@home service
- Developed policy and process for avoiding emergency admissions via emergency placement for people who attend hospital enabling social attendances to be turned around at the front

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- Targeted work with ECH providers including care management staff to identify vulnerable ECH residents, additional health support being provided as part of the MDT to proactively identify vulnerable residence and ensure they have required health input to prevent decline in need and clear expectations of providers on people returning to ECH settings.

Oxleas

- Mental Health Crisis line (24/7) in place for Bromley. This has been developed across Oxleas NHS Trust provision for Bexley, Greenwich and Bromley which is in its infancy will help to support our meeting the needs of individuals who are best served outside of ED, Psychiatric Liaison or the HTT.

St Christopher's

- St Christopher's responds to calls from patients throughout the 24 hour period. I believe St Christopher's staff will be able to refer into and take referrals from the new Bromley@home pilot service, which would avoid a hospital admission.

6.6.3 Ensure timely discharge for medically fit patients requiring ongoing care and support

(e.g. trusted assessor, referring and assessment to community services pre-MSFT to ensure all in place once patient is MSFT, services accessed via single passport document not separate referral form)

King's College Hospital PRUH

- Internal professional standards in place: Board rounds will be performed by 9.30am, Monday to Friday, led by a consultant, registrar or specialty doctor. Expected discharge dates and diagnostics required before discharge will be identified as will referrals to therapies/social services.
- Standardised board round process, tools and training (fully live on growing number of wards at PRUH and Orpington with roll out to all wards by January 2010).
- Regular MADE and Stranded Patient reviews in place.

Bromley Healthcare

- All referrals go through the single point of access ('Care Coordination Centre')
- Support the PRUH with the rehab referral pathway by sending a daily sitrep of accepted patients pending them being MFFD or as required by the ToCB.
- Home Based and Bed Based Rehab Teams are working with our partner agencies to ensure that patients meet the criteria for admission to ensure patient flow continues and also working with partners to try to prevent any unnecessary delays in the pathways. There are daily board rounds to ensure that each patient is reviewed each day

London Borough of Bromley

- Discharge to Assess (D2A) is in place and being mainstreamed across the system
- Additional Extra Care Housing step down units funded through iBCF are now in place to support more people to be discharged to ECH from hospital. Targeted work to ensure the flow through these units is within the required timescale is also being mobilised form October so there are no delays
- LBB has increased general block nursing bed capacity to 70 bed space. Demand mapping has concluded that there will be capacity in the local market over winter 2018/19, with potential to offer providers short-term enhancements if necessary to assure bed space available on discharge.

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- Developed joint working of mental health Care Coordinators & hospital Social Workers/ToC Bureau to support discharge for people admitted to the PRUH with mental ill health ensuring equality of discharge support
- St Christopher's Trusted Assessor model in place
- Re-starts available directly from the ward reducing the need for Care Management input improving productivity and timeliness of discharge through direct work with brokerage.
- Additional domiciliary care provision being put in place through procurement from current provider market. The service will include:
  - Packages to start within 2 hours of request
  - No refusals
  - Length of package between 1 or 2 days up to 6 weeks (in 2017/18 average package was 21 days)
  - Single or double handed packages
  - Hospital to provide client information to providers via the 'passport'
  - All work to be delivered during normal working hours 7am to 10pm, BUT service must be available 7 days a week and be prepared to take on new packages at weekend
  - This dedicated capacity will be available from 1st November
- All contracts, including Mission Care and ECH includes 7 day admissions to ensure people can be admitted or return to their place of residence 7 days per week.
- Dedicated work with broader providers to ensure 7 day admission including offer of additional 'resource' to enable this to happen on a weekend

St Christopher's:

- In Reach staff post at the PRUH to facilitate early discharge working alongside D2A team and visiting wards to proactively identify MSFT patients. Ensures knowledge of community teams including capacity is effectively communicated with hospital discharge team and ward staff.

Oxleas:

- Additional psychiatric liaison nurse being put into BH@H which could provide additional capacity in Psych liaison service in the PRUH ED if required.

6.6.4 Maintain people in the community reducing escalation of need

Bromley Healthcare

- The care of all BHC Priority 1 patients are covered within our Business Continuity Plan in case of internal incident, bad weather, extreme staff sickness etc. We run a Health Roster report weekly and archived in case of IT failure to ensure we know which staff are available to enable movement of staff when required. Priority patients schedules are also run and archived in case of an EMIS failure to ensure they are seen.
- We will Pro-actively ensure any at risk patients are referred through the relevant ICN stream including, Proactive Care Pathway and End of Life.
- EMIS BHC/GP shared care records are utilised to obtain up to date clinical information as well as the local Care Record to ensure recent clinical history and information is updated.
- Ensuring that all at risk patients have had a pre-winter care plan review where appropriate.
- Work with the Care Managers and Heart Failure Nurses (from mid-October) attached to the ICN Hubs to support patients at risk over winter. Both specialists can attend the weekly MDT in the DN teams to identify patients at risk of deterioration and support at an early stage.

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- On-going plan to increase reablement capacity to support people to maintain their independence including those who have had a hospital admission
- Contingency plan in the care & support plan of adult carers
- Early intervention service for people with declining needs
- Social Workers now also in the Integrated Care Network (ICN) to proactively manage people with complex health and care needs
- Extra Care Housing (ECH) – tolerance policy (i.e. increase care for up to 2-4 weeks as trusted assessors)
- Targeted plan to ensure all Care and support reviews are up to date by the end of September
- Aim to achieve zero social admissions by:
    - Care Managers working within the Integrated Care Network MDTs
    - Access to emergency placements
    - ASC involvement in Bromley Hospital@home service
    - Avoiding social admissions policy for the hospital
    - Work with domiciliary care providers to report health concerns via 111 *6

Oxleas:

- Additional capacity put into the community 24/7 Home Treatment Team.

St Christopher's:

- St Christopher's Bromley Care Coordination proactively case finds and manages end of life patients so that they can stay in their preferred place of care. St Christopher's record their patients care plans and wishes i.e. DNAR documentation through Coordinate My Care, which LAS can access if the patient go into crisis. As St Christopher's offer a 24/7 advice and visiting service, LAS can redirect patients to their care.

6.6.5 Specific plans to ensure full 7 day service is in place

King's College Hospital PRUH

- Where recruitment / rotas allow services will operate 7 day.

Bromley Healthcare

- Rapid response Team, Rehab services, District Nursing and CCNT are all full 7 day service (accessible from wider trust hospitals for Bromley patients)

London Borough of Bromley

The following operate on a 7-day basis:

- Transfer of Care Bureau (TOCB) Care Managers
- Reablement
- Mental Health Home Treatment Team
- Day centre - Withmore Road
- Dom-care services
- ECH 7 day admission
- Mission Care contract includes 7 day admissions.

  Dedicated work with broader providers to ensure 7 day admission including offer of additional 'resource' to enable this to happen on a weekend

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St Christopher's:

Oxleas:

7 APPENDICES:

Appendix 1 – Escalation Contact Information

Appendix 2 – King's College Hospital Foundation Trust Cross Site - Internal Incident Process

Appendix 3 – PRUH ED Department Capacity Management Escalation Policy

Appendix 4 – PRUH ED Capacity Dashboard

Appendix 5 - PRUH- BB UCC Escalation Plan 1819

Appendix 6 - Overall Winter Scheme Spend - CCG-LBB-KCH PRUH

Appendix 7 – KCH PRUH Internal Process for managing repatriations

Appendix 8 – Out of Borough Hospital Referral Process Map

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