Report No.
ECHS19012

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 23rd January 2019**
Title:	**BROMLEY SYSTEM WINTER PLAN UPDATE**
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Ward:	Borough-wide

1. Summary

1.1 The Bromley Winter Plan was presented to HWBB members on 27 September 2018. The overall aim of the plan is to provide a framework for health and social care partners in the Bromley 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.

1.2 This report provides a general update on the winter position to date, as well the progress made against aspects of the plan such as the surge planning, service developments and winter resilience schemes put in place by the Bromley CCG, London Borough of Bromley and King's College Hospital (PRUH site).

2. Reason for Report going to Health and Wellbeing Board

2.1 The Winter Plan update is being presented to the Health and Wellbeing Board as part of the local assurance scrutiny and assurance process. The Health and Wellbeing Board are requested to support and challenge the local system to ensure the elements included in the report are delivered and the local system works together to respond to the challenging seasonal demand.

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

3.1 The Plan included input from all Bromley partners. Specific individuals and organisations are identified throughout for their role in delivering the Plan. The A&E Delivery board has oversight of the activity delivered under the Plan.

Health & Wellbeing Strategy

1. Related priority: Not Applicable

Financial

1. Cost of proposal: 2,647,000: £646k (CCG) £1,027k (LBB), £992k (King's)

2. Ongoing costs: No Cost

3. Total savings: Not Applicable

4. Budget host organisation: Bromley CCG, London Borough of Bromley and King's

5. Source of funding: Better Care Fund

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

4.11 - Emergency readmissions within 30 days of discharge from hospital
4.13 - Health related quality of life for older people
4.15iii - Excess winter deaths index (3 years, all ages)
4.15iii - Excess winter deaths index (3 years, over 85)

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4. COMMENTARY

4.1 **Performance Update:**

4.2 For the period of October-December 2018 the Princess Royal University Hospital (PRUH) did not consistently meet the 95% 4 hour A&E performance target set by NHS England. The PRUH performance averaged at 76.62% over those 3 months, which is a slight decrease in performance compared to the previous year.

4.3 For the same time period, all Type A&E attendances have decreased slightly when compared to the previous year. This will continue to be monitored throughout the winter as it could be a consequence of the various community admission avoidance pathways such as the integrated care networks proactive care pathway.

4.4 There has also been a consistent fall through the October – December period of 'Long Length of Stay' patients (those who have been in hospital for 7+ days. This is attributable to work both in and out of the hospital that will be discussed below. This is caveated however, with an increase towards during the Christmas and New Year period, which is expected due to the Winter Pressure Months.

4.5 Positively, DTOCs continue to decrease compared to previous years and remain below the target plans for both NHS attributable and Social Care Attributable delays. The decrease in DTOCs has led to a reduction of 416 (75%) lost hospital bed days compared to the previous year. Bromley is now ranked 7th best performing Borough in London out of 32.

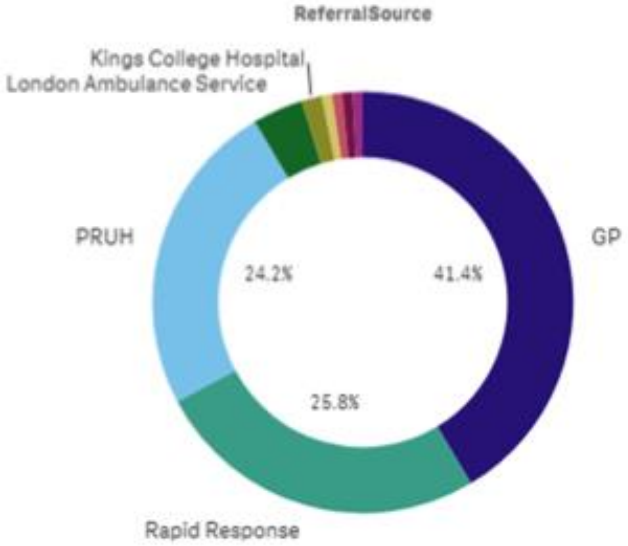
4.6 This in part can be attributed to the expansion of the Discharge to Assess Pathway Pilot which has increased the number of patients leaving the hospital earlier with temporary packages of care whilst the full assessment is done in the community. The vast majority of full Bromley Continuining Healthcare (CHC) Assessments are also completed outside the hospital. Over the past two financial quarters, Bromley CCG CHC have consistently met and surpassed the NHS England target of 85% of full Decision Support Tool (DST) assessments in the community.

4.7 **Winter Resilience Schemes:**

4.8 <u>Bromley @Home Service:</u>

4.9 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.

4.10 The service was rolled out in a first trial phase on October 16th. It has had a total of 128 referrals with around 70% from the community (GP, London Ambulance Service or community nursing) and 30% from the acute hospital. The main referral reasons have been for example patients having a fall, suspected UTIs, respiratory symptoms and generally feeling unwell. Further analysis is being completed to understand what the underlying issues were with the generally unwell cohort.



4.11 The average length of stay on the service was around four days and the majority of patients have needed less than five visits before being discharged back into the community (either to the GP, District Nursing or with a social package of care). Once the team's GP, nurse or physiotherapist has assessed the patient, the majority of follow ups have been completed by healthcare assistants.

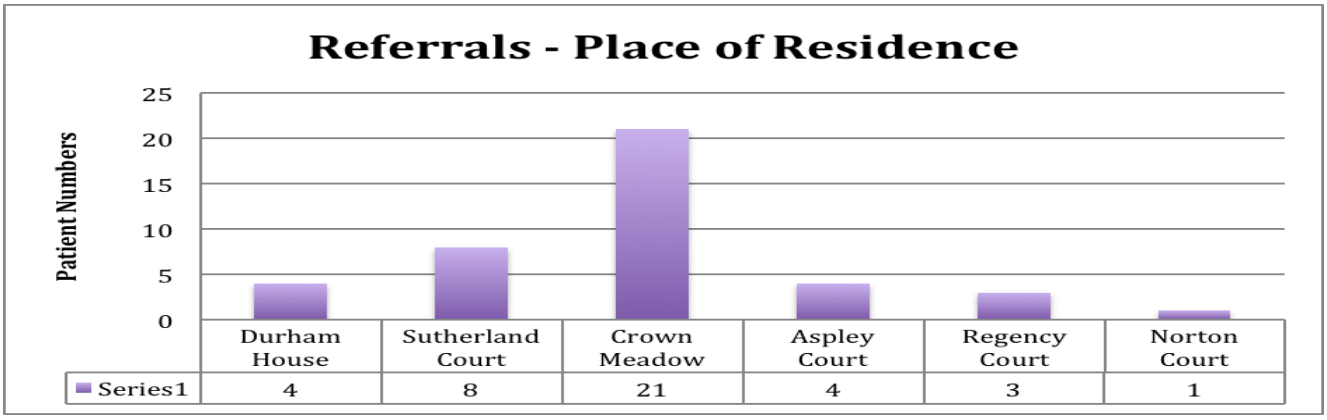
4.12 The team are hoping to expand the patient cohort to identify more patients in the community and hospital whom can benefit from the service. The team have been working closely with the hospital staff (A&E consultants, therapy teams, ward matrons etc.) to increase utilisation, for example the hospital discharge coordinators are now trusted assessors and can refer directly into the service.

4.13 This phased approach is allowing commissioners and providers to test the model by monitoring the types and numbers of patients who could benefit from the service and the types of interventions and staff required to meet the demand. A full evaluation will take place in March that will shape any future service planning.

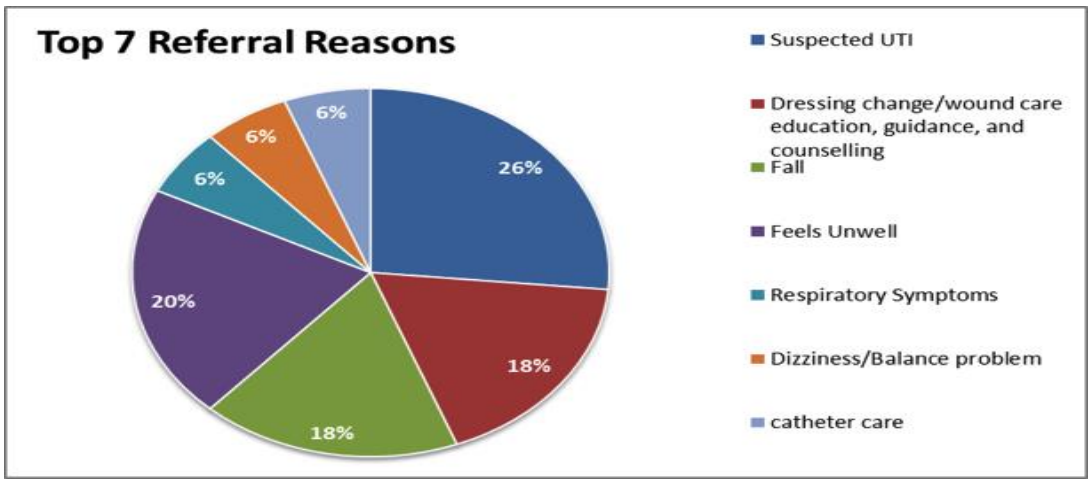
4.14 <u>Extra Care Housing Support Service</u>

4.15 The service has been commissioned to provide support for the ECH sites by seeing patients discharged from hospital to ensure they are less likely to be readmitted via means of a holistic assessment of their needs and safety. The service consists of one advanced nurse practitioner (with support from the wider Rapid Response team if required) and also carries out training and advice to the ECH site staff as well as advising on best practice and acting as a navigator for health services if required.

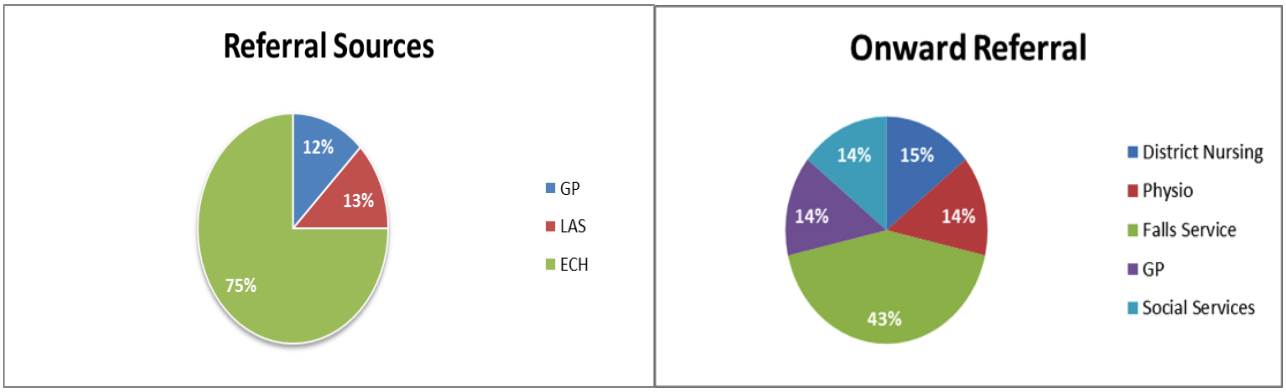
4.16 At the start of the process, the nurse met with each of the ECH managers to ascertain what their requirements were, where they thought there were issues and how we could best support them.



4.17 Up to the 27/12/2018 the service had taken a total of 44 patients. As illustrated in the charts below the patient group is largely female and made up of aged groups 75+. Referral reasons are in line with what was expected with 'suspected UTI' and 'Falls' being main reasons. There are a number of dressing change and wound care/education which was not expected and a significant number of the patients where the initial reason for referral states 'feels unwell'.



4.18 The service has made a number of onward referrals, as you can see from the graph below the Falls Service has been the service most required for this cohort. Overall the service has also carried out some significant work with staff at the Extra Care Housing sites including updates on falls protocols, sepsis and pressure area care. The majority of referrals have come from the ECHs, however there have been a small number from LAS and GPs.



4.19 An interesting case study was a patient that was having an increasing number of falls. The nurse was called out to the patient in late December and on taking history the patient had increased to 9 falls in December. After looking at the location of these falls (a history going back to May), it was established that most of these were happening falling out of bed at night.

4.20 After some discussions with staff and the patient as well as recommendations on suitable techniques and equipment to manage this patient (falls matting, risk assessment of the ECH flat and a holistic assessment of the patient) the falls for this patient have reduced to just 1 so far in January.

4.21 <u>Same Day Home Visiting Service</u>

4.22 To support GP practices in the winter pressure months, the CCG has commissioned 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. The service began in mid November and will continue until the end of March. The first data report is due at the end of January, but the service has been well utilised in line with commissioned capacity.

4.23 GP Access Hubs

4.24 The additional appointment slots (10% more slots) were well utilized over the Christmas and New Year period. 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. The additional slots have been commissioned until the end of March whereby utilisation analysis will be completed. In General utilisation of GP Hub slots remains high, steadily remaining at 96% of all appointments being booked (based on April-November data received from provider)

4.25 Additional support for Urgent Care Centres

4.26 As commissioned last year, the three elements are:

- 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

4.27 Greenbrook Healthcare are currently undertaking the first report to analyse the patient champion and healthcare assistant activity and as well as the GP Rota shift fill.

4.28 Performance Matron

4.29 The CCG have agreed to fund a performance matron for post acute medicine to be responsible for the management of the patient pathways, supporting the clinical site manager and clinical staff to optimise patient flow. The main key performance indicators that will be measured are:

- Increasing number of early discharges
- Identification of reasons for delayed discharge.
- Quality improvement of community healthcare discharges (specifically Bed Based / Home Based Rehab).
- Reduction of 'medical outlier' patients.

4.30 The post started on January 7th and will run for four months. The CCG and PRUH Head of Post Acute Nursing and General Manager for Post Acute are currently finalising the monitoring and evaluation.

4.31 **London Borough of Bromley Winter Schemes**:

4.32 Fast Response Personal Care Provision

4.33 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

4.34 Intensive Personal Care Services

4.35 Additional access to increased domiciliary 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.

	Target in 4 months		% so far	
	Users	Amount	Users	Amount
Fast Response Personal Care Provision	100	£ 81,600	**6%**	**3%**
Intensive Personal Care Services	70	£ 75,000	**39%**	**60%**
	170	**£ 156,600**	**19%**	**30%**

4.36 **King's College Hospital (PRUH site) Winter Schemes**

4.37 **Surge and escalation plan**

The PRUH site surge and escalation plan has been developed with and tested with internal stakeholders. Key aspects include the boarding policy and roles and responsibilities of senior on call managers across the winter period which have been embedded to maintain site safety and improve flow, particularly at weekends. Cross site pressures communication and action card response is now being strengthened.

4.38 **Ambulatory streaming**

Ambulatory care is has been extended to an 8am to 8pm service, 7 days a week in line with plans. We have implemented Emergency Department and Urgent Care Centre streaming process changes and are monitoring service utilisation, efficacy and impact. As part of our commitment to continuous improvement, the Ambulatory Emergency Network is continuing to assist in embedding the pathways for admission avoidance for medicine and surgery, while NHS Improvement's ECIST team is working with the Emergency Department to further improve the triage process.

4.39 **Discharge lounge**

The PRUH discharge lounge moved and expended to accommodate 3x stretchers and 15 chairs. We successfully delivered the new estate and opened 7 December 2018, which will expand to six days a week on substantive staffing by end January 2019. PRUH Perfect week January 2019 identified further work with wards to embed discharge handover process and to increase 'pull' from wards. This is paired with work on our wards to identify 'golden patients' who will be discharged early the following day and who can be transferred to the discharge lounge. This paired with daily tracking of transport and patient activity before 10:00 in the discharge lounge is a key indicator of improved morning site flow. Through winter the Discharge Lounge has been staffed and open 7 days a week, including on the weekends 08:00 to 17:00.

4.40 **AMU resilience**

A Trust business case was approved for an additional AMU consultant to support the extended hours in Ambulatory as well as the additional cover for AMU to support admission and out of hours working. Recently this resource has been used to provide an on-site consultant as part of a multi-disciplinary team reviewing and discharging patients over the weekend. Shifts are being covered by internal locum, while substantive recruitment continues.

4.41 **RATing**

Progress has been made on delivery of Rapid Assessment and Treatment 12:00 to 17:00 Monday to Friday, with shifts out to team to extend from 17:00 to 22:00 weekdays and 5 hours Saturday and Sunday. Data collection on impact and work with NHS Improvement ECIST team

under way to ensure consistency of delivery and to link with front door frailty assessment model to further enhance early decision making.

4.42 **Frailty – front door and ambulatory frailty**
Front door frailty assessment model: The multidisciplinary frailty team in the Emergency Department and Clinical Decision Unit incorporates specialist nurses and therapists to identify frail patients early in their pathway to inform most appropriate pathways, including to home with community follow-up and the ambulatory frailty service. Recruitment concerns have meant needing to tweak the staffing model to ensure consistency of service. To go live by end January 2019.

4.43 *Ambulatory frailty:* The pilot has been designed to deliver specialist gerontology hot clinic service for the community, Emergency Department and post acute wards at the PRUH. The service will go live at Orpington hospital, pending freeing of required bay on Churchill ward and receipt of equipment. This service will provide the front door team a service to which to re-direct suitable patients.

4.44 **Other Joint Partnership Working**

4.45 Acute / Community Workshops and Discharge Planning Events

4.46 Two workshops were facilitated by the CCG in which external providers and stakeholders presented their services to PRUH ward staff ahead of winter. The key outcome was to raise awareness within the hospital of the Bromley community discharge pathways and processes and to give the ward staff a chance to query community providers. The workshops have resulted in further pathway specific workshops arranged to ensure there is clarity at all levels of the hospital on the discharge pathways and also roles and responsibilities.

4.47 PRUH Multi Agency Discharge Events (MADE) and 'Perfect Week'

4.48 Due to the operational pressures developing during the Christmas Holiday period and predicted challenges during the New Year and further into January, it was agreed with NHSi that both Denmark Hill (DH) and Princess Royal University Hospital (PRUH) would run a MMADE event on 31 December 2018. MADE was run in parallel at Orpington Hospital as part of the PRUH event. External support was provided by Healthy London Partnership (HLP), Lambeth and Southwark CCG, Bromley CCG, Bromley Healthcare and members of the Transfer of Care Bureau (TOCB).

4.49 The site started the day in a challenged position with a small number of predicted discharges and a number of potential patients with delays in A&E. By the end of the day, the multidisciplinary teams had managed to enable 76 discharges (compared to an average of 33 discharges for the previous 7 days). Another has taken place on 17 January which resulted in 82 discharges from the PRUH.

4.50 NHS Improvement Emergency Care Intensive Support Team

4.51 Further to the above, ECIST is working with the PRUH team to maximise flow through the hospital. This includes ensuring robust challenge is happening at ward board rounds to ensure every patient has in place the plan for the next steps for their treatment and discharge. This is a key part of the nationally recognised work to ensure "red days" where no progress is made on a given day for the patient is changed to a "green day" where they make progress on their pathway. ECIST are also working closely with the PRUH to systematically review every patient with a long length of stay (over 21 days) and ensure blocks to discharge, including wider system imediments, are escalated and resolved.

4.52 Hunter Consultancy Support

4.53 Working with NHS Improvement, King's College University Hospitals NHS Trust has appointed Hunter Consultancy to support the rapid improvement of key parts of the emergency care pathway. A dedicated three person team is allocated to the PRUH as part of this work. The team will focus at the PRUH on emergency department flow, maximising the opportunity provided through ambulatory care, the frailty service and overall discharge flow. Hunter are working with the hospital's teams, and relevant partners, until May 2019.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 The Plan ensures the system are held to account in their role in ensuring Bromley residents have access to timely, high quality health and social care when they need it preventing. In particular the plan ensures there is appropriate resource for frail and elderly residents who are particularly vulnerable to seasonal illness. Click

6. FINANCIAL IMPLICATIONS

6.1 The CCG and LBB Winter resilience funding is part of the agreed Bromley Better Care Fund. King's winter resilience funding is part of their contracted baseline

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

7.1 The Bromley A&E Delivery Board is responsible for the oversight and management of the Bromley System Winter Plan

Non-Applicable Sections:	Legal Implications and Comment from the Director of Author Organisation
Background Documents: (Access via Contact Officer)	Not Applicable.