Winter 2021/2022 Summary

Health and Wellbeing Board

March 2022

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WORKING TOGETHER TO IMPROVE HEALTH AND CARE IN BROMLEY

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Increasing system capacity (up to Feb 22)

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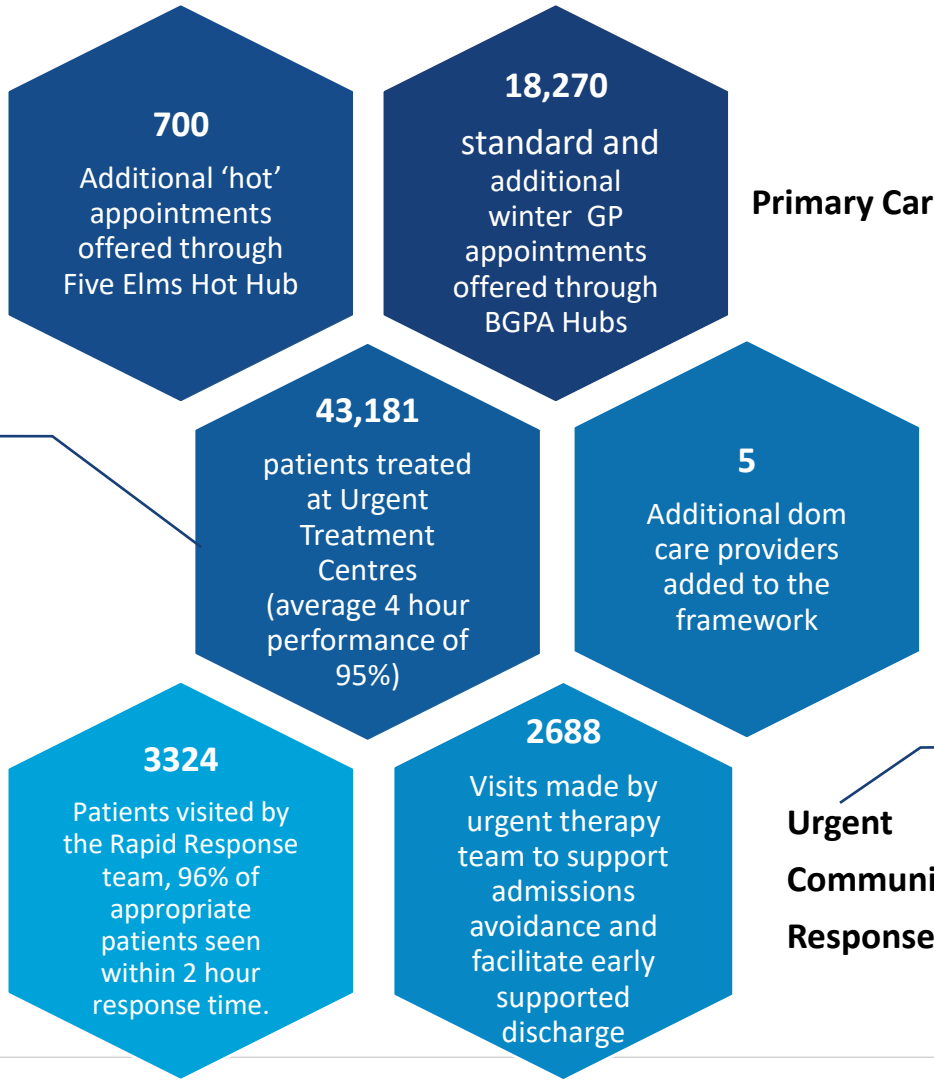
Increase System Capacity



- Utilisation of GPs who can support both injuries and illness patients providing a better skill mix.
- Additional resource added on Mondays and Thursday to reduce waiting times (based on demand analysis)
- Adjusting start times in line with demand e.g. increased activity 9am-6pm compared to 6pm-9am previously
- Expansion of UTC footprint on Monday to meet increased demand

Increase in flexible, Urgent Community Response capacity used flexibly to respond to system pressures e.g.

- Supporting ED to avoid admissions
- Wrapping around GPs with workforce pressures
- Responding to changing need post discharge to prevent re-admission

Source: Winter scheme monitoring

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Increase System Capacity: Primary Care

18,270 standard and additional GP appointments through P/Care Access Hubs

Month on month utilisation rates have remained above 93%, for GP Hub appointments which have increased throughout the winter period

A GP Hub model is an effective way to support pressures on primary care

Clinical Assessment Mobilisation

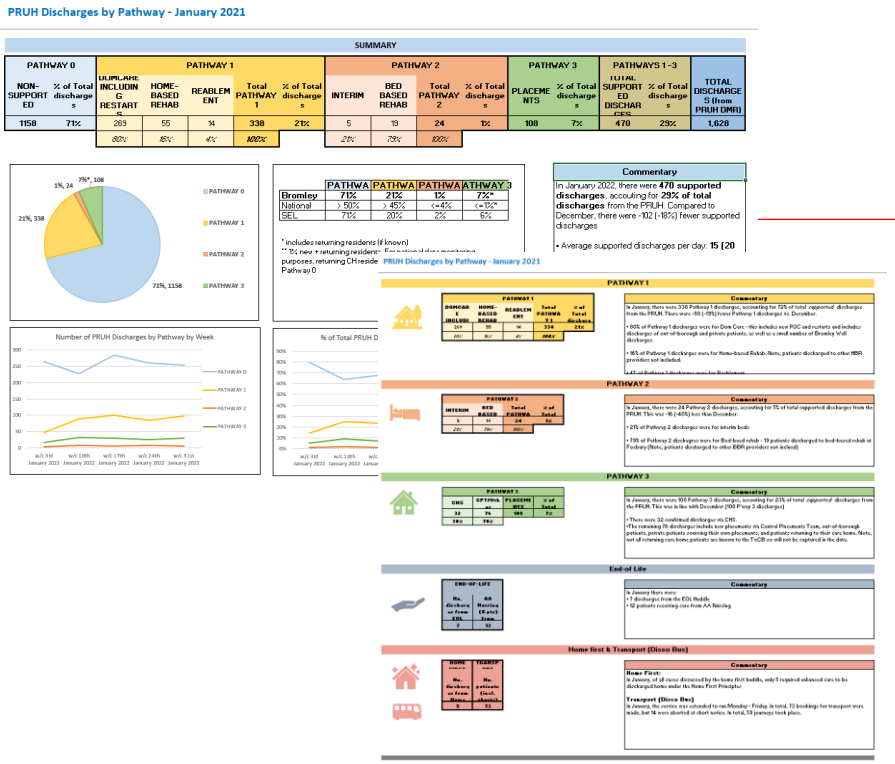
A local Clinical Assessment Service (CAS) is being piloted with the Bromley GP Alliance, further facilitating same day and rapid access to primary care services by taking responsibility for Bromley patients who have phoned 111 with primary care dispositions.

Initial findings have shown the service has had a positive impact on patient access, and reduced pressure on Urgent Treatment Centres.

The pilot will be reviewed in March to assess impact and inform recommendations for future commissioning.

Contract Extension

The Primary Care Access Hubs service has now been **extended until 30th September 2022**, in line with NHS England's revised timeline to transition these services to PCN delivery.



Data Sharing and Escalation

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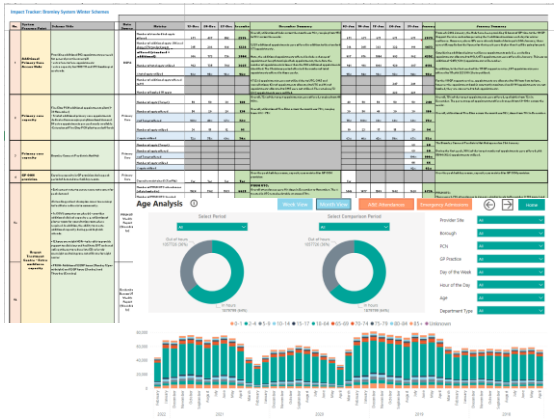
Data Sharing and Escalation: The Intelligence Hub

Winter Schemes Impact Reporting

For the first time, data from all winter schemes is collated weekly to identify and respond to any potential issues in “real-time” as well as monitor impact of investment. Monthly analysis reported to the A&E Delivery Board for discussion



Demand & Capacity (Supported Discharges) Dashboards

Two dashboards developed to monitor supported discharge activity.

Dashboard 1 for PRUH-only discharges (all patients) insights shared monthly at A &EDB and One Bromley Executive meetings.

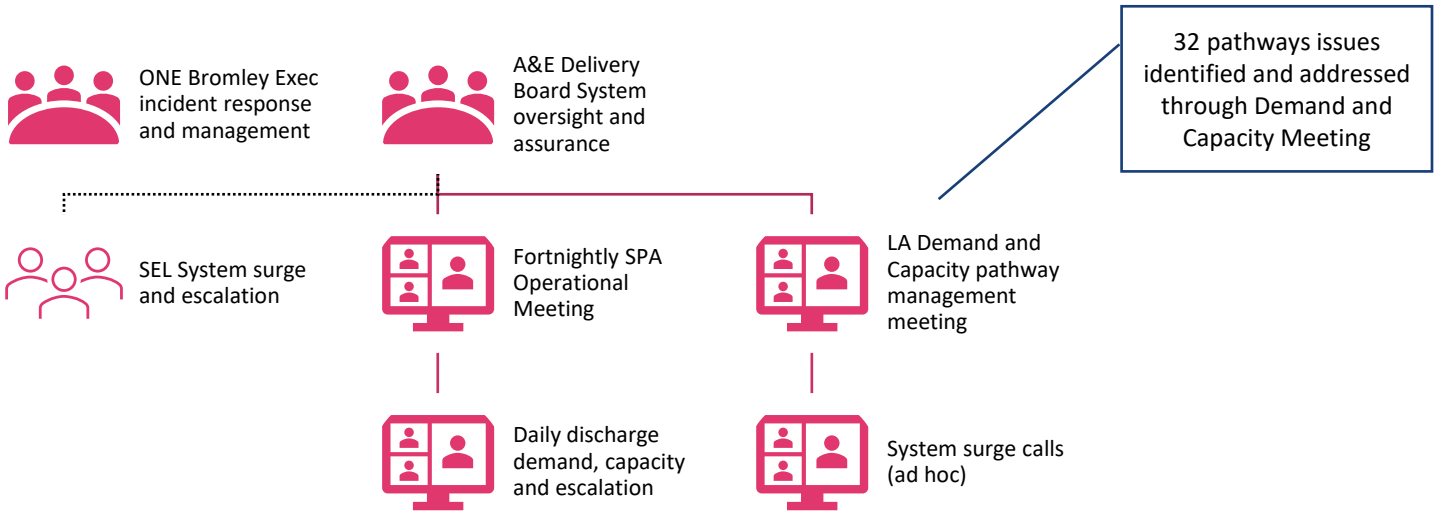
Dashboard 2 for all Bromley patients from all hospitals to give better insight into demand on local services. Presented at weekly Winter Demand & Capacity meeting to quantify demand on local services and respective teams and highlight any potential surges in activity across pathways to allow for forward planning

Ad hoc analyses

Ad hoc analyses conducted to provide quantitative insights to inform system planning.
Analyses to date include:

- PRUH Urgent Treatment Centre (October Snapshot) to better understand demand and patterns of behaviour to inform public communication campaign and focus of primary and community care expansion
- Care home LAS conveyances to influence targeted support/training (deterioration management & falls prevention),
- SEL readmissions analysis to better understand current and historic rates across each SEL Trust (leading to further exploration by Discharge working group), and
- Paediatric primary care analysis using EMIS data to help identify demand and capacity for paediatric patients across the whole system and to inform the deployment of specialist paediatric oximeters for under 2 year olds.

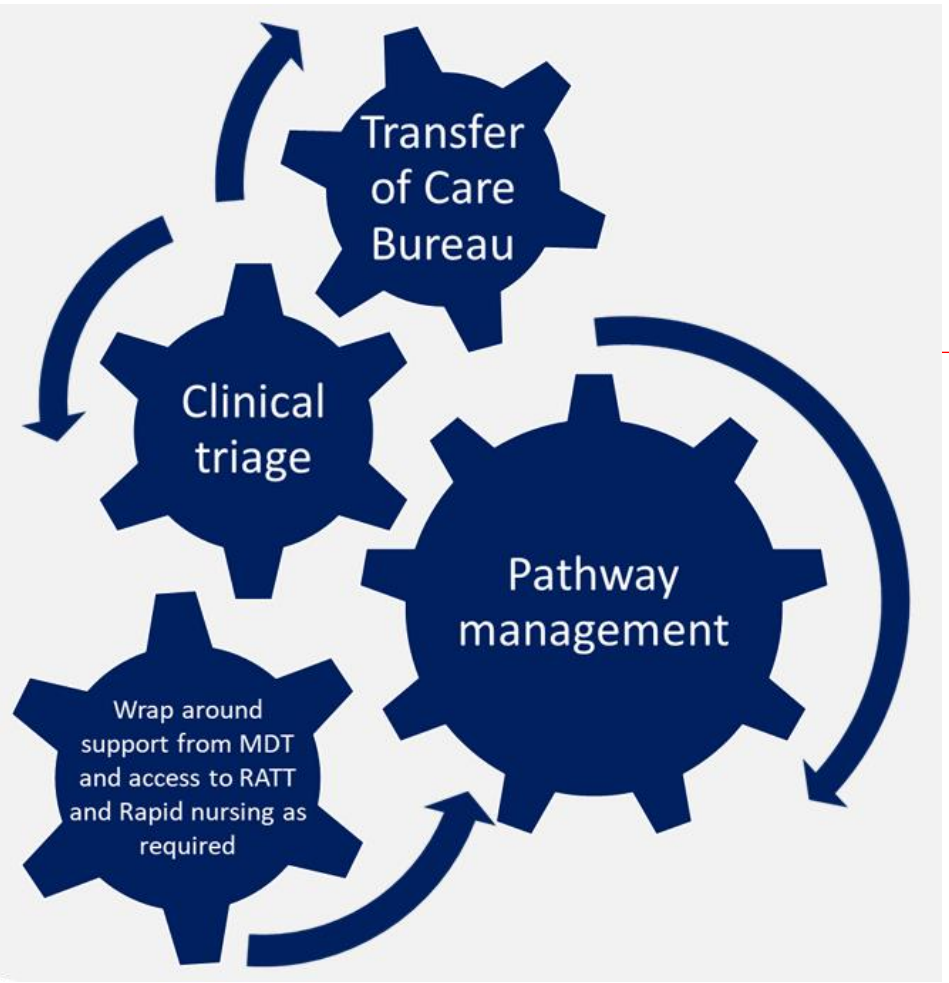
Date Sharing and Escalation: System oversight



Demands on the system were well managed through a clear governance structure that monitored and responded to system pressures, surges and issues.

The infrastructure allowed unplanned themes or issues to be responded to and addressed quickly through a whole system approach e.g.

- Increase in ambulance hand over waits
- Another wave of Covid19 with significant infection rates significantly impacting on workforce challenges
- Managing pressures in pathways through capacity realignment or mutual aid for example procuring nursing home beds with therapy input to manage bed based rehab (BBR) demand during an outbreak at Foxbury Unit
- Focusing additional resources around pressure areas in the system for example additional BGPA hub appointments and rapid response allocation for GP Practices with workforce pressures
- Community in-reach to the PRUH as part of the Stranded Reviews to 'pull' patients supporting the Trust when under significant bed pressures



SPA and Hospital Discharge Arrangements

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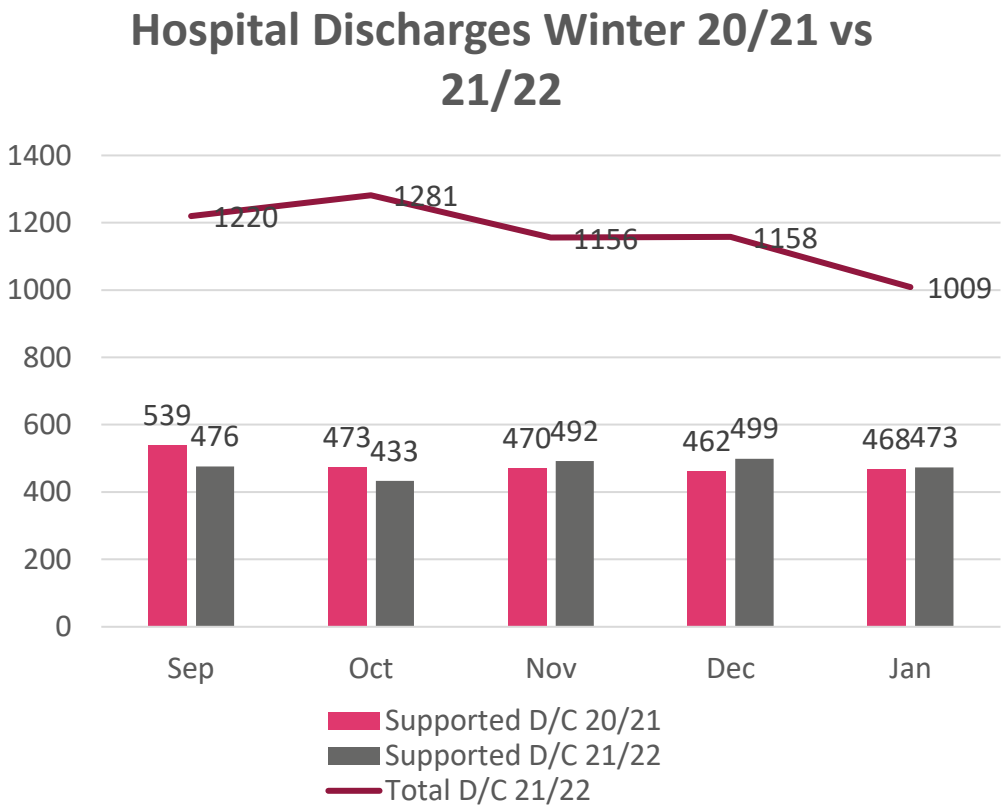
SPA and Discharge Arrangements: Activity



80% (4214)
Discharges within 24 hours of patient being medically fit for discharge

- Throughout Winter 2021/22 there has been a **total of 5,824 discharges from the Princess Royal University hospital** (solid red line)
- **2373 Supported Discharges** were facilitated in the period for Bromley Residents (from all hospitals), which is inline with the activity from the previous winter (-39)

Source: SPA Dashboard

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SPA and Discharge Arrangements: Commissioning

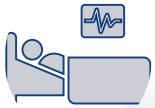
794
Dom care packages*

79
Nursing Placements*

40 residential care placements*

Increase in rehab and reablement capacity to support more people to achieve maximum independence as well as additional therapy capacity supporting residents in interim step-down beds

6 Designated Setting Beds mobilised during the third wave for isolation of Covid+ patients returning to their care home plus a further **6 step-down beds** for residents requiring an interim period of recovery in a bedded setting



Dedicated pathway to facilitate the discharge of rapidly dying patient to enable them to die at home where this is their chosen place of death

Award winning Bromley SPA formally commissioned as a permanent structure

Increase in dedicated transport supporting **157 supported discharge patients between December and February** to be discharged in a timely manner into the receiving community service

Mobilised new patch-based dom care framework in November 2021 fully mobilised and meeting demand by Christmas with 5 new spot providers brought into the system to meet increase in demand over Christmas and new year

Source: Liquid logic Covid19 report as up to January 22

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SPA and Discharge Arrangements: Operational Developments

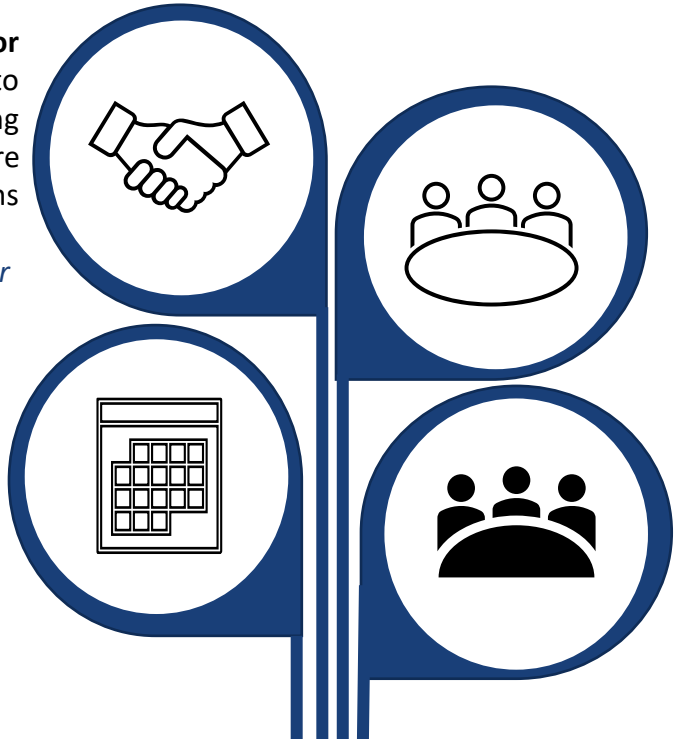
Trusted Assessor

Trusted Assessment from acute MDT to inform discharge plans reducing duplication in assessment for care homes and receiving community teams

119 Care home TA took place in winter

7 day Service

Delivered a 7 day discharge system throughout the whole of winter



EOL Huddle and pathway

End of life Huddle with dedicated dom care provider to support rapidly dying patients to be supported to die at home

29 individuals supported (20 Dec – 14 Feb)

Home First Huddle

MDT developing robust discharge plans for clients with more complex, care support and safety needs using assisted technology, specialist OT, health and medication optimisation, Mental health specialist input and care management to enable as many people as possible to recover and remain at home preventing avoidable care home admissions

% patients discharged to their usual place of residence

	All HWBs	London	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
2019-20 Actual ave	92.8%	92.7%	84.1%	92.5%	79.0%	95.6%	80.5%	95.6%
2020-21 Actual ave	91.9%	92.9%	91.2%	92.9%	92.2%	94.8%	92.8%	95.8%
2021-22 Forecast ave	92.4%	93.8%	94.6%	92.8%	95.3%	95.5%	95.6%	96.9%

Bromley continues to perform in line with the national and London average on % of patients discharged to the usual place of residence. *NOTE this indicator is not weighted for population type therefore is not adjusted to recognise Bromley's older population.*

Source: BCF Exchange

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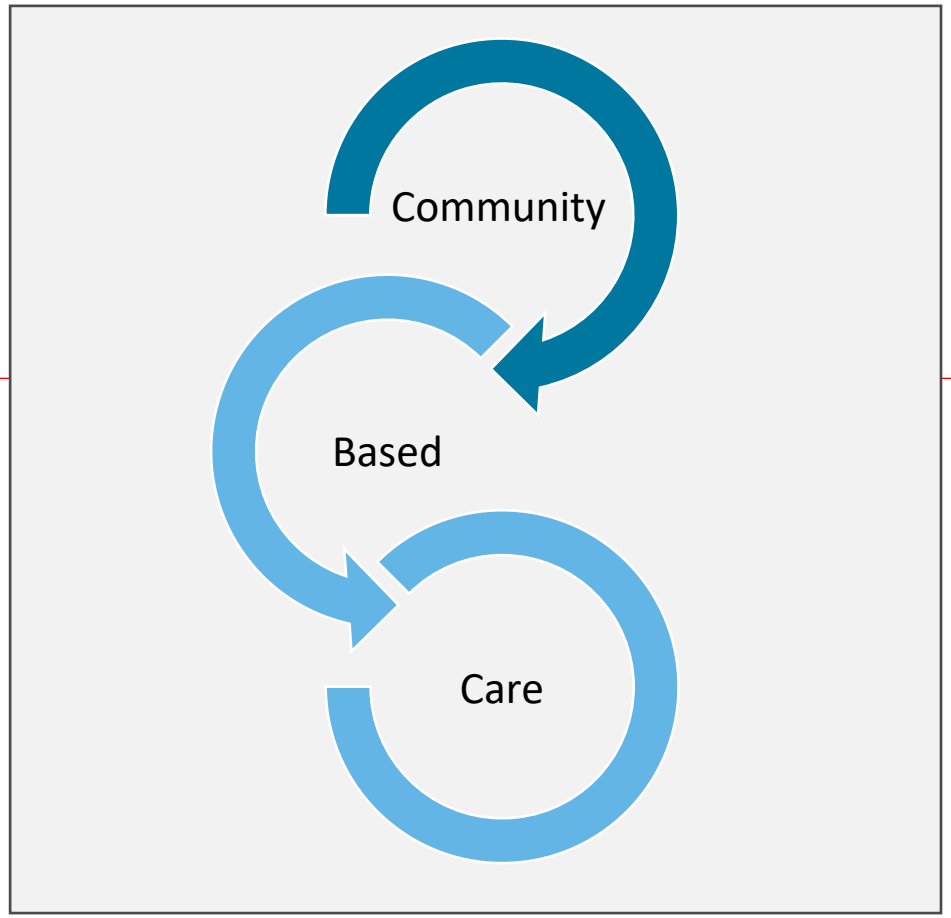

Admission Avoidance

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Admission Avoidance: Intravenous Antibiotics (IVAB) at Home

Intravenous Antibiotics (IVAB) at Home

The pilot service is currently focussed on admission avoidance and early supported discharge from the PRUH allowing patients to receive intravenous antibiotics for simple infections (cellulitis, lower respiratory tract infection and urinary tract infection) at home rather in hospital.

The pathway has seen linear growth in utilisation, increasing from 1 patient seen in November to 7 patients per day by mid-February.

It has conducted over **347 home visits**, **removing at least 150+ hours of activity from PRUH Ambulatory** – allowing the hospital to focus on sicker patients and for patients to receive their treatment at home, in line with their preference.

Between December and February the average number of home visits per patient rose from 13 visits per patient to 25 visits per patient (+69%). This has enabled patients to be treated in their own home rather than receiving treatment in hospital.

Patients identified for the pathway in January were more complex than initially envisaged (either requiring three times a day IVAB or for a longer course of treatment). This is accommodated through clinician to clinician agreement for patients to enter the pathway, and additional twilight staffing in the community team. In general, three times a day patients are more likely to be patients with an exacerbation of their long term condition and often would prefer treatment in their own home which this service has been able to provide.

The pilot has brought significant learning to the team and system in terms of the type and scale of community IVAB required in Bromley, alongside an increased communications campaign within the PRUH to direct simple infection into the pathway.

Immediate next steps will be to expand support to nursing homes and end of life care services.

Metrics	Nov	06-Dec	13-Dec	20-Dec	27-Dec	03-Jan	10-Jan	17-Jan	24-Jan	31-Jan	07-Feb	14-Feb	21-Feb	28-Feb
Number of IVAB home visits in the community	6	9	0	16	10	8	13	40	38	48	36	56	58	47

Admission Avoidance

Avoiding social admissions through Care Management presence in ED on a weekend

87% patients seen during the 3,324 visits by the Rapid Response service avoided an admission

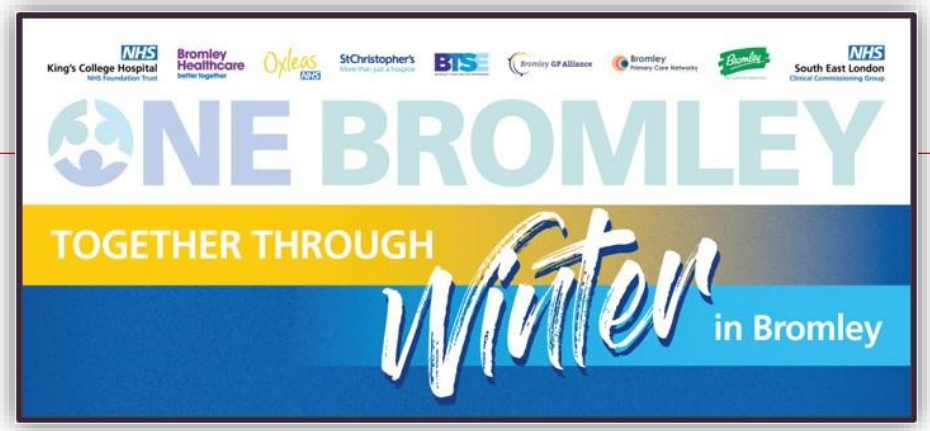
Enhanced End of Life support into the system

From January 4th, additional St Christopher's capacity to support care home residents, conveyed palliative patients and those rapidly dying at the point of discharge, by:

201 Residents who were rapidly deteriorating received palliative care in their care home through St Christopher's Winter Support Team working with Bromleag Care Practice

20 Advance Care Plans undertaken for care home residents post discharge to establish clear escalations of care

8 Admissions avoided through joint working with the A&E department and the Frailty Unit with intervention delivered in the community.



Communication and Engagement

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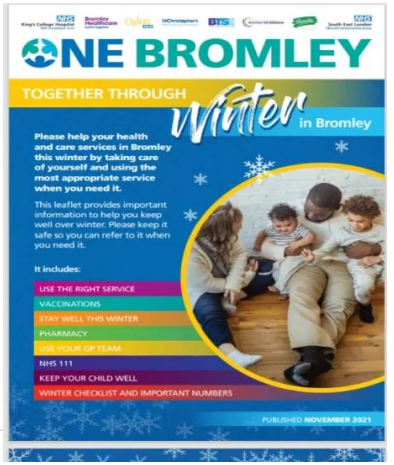
Comms and Engagement

- Comprehensive One Bromley winter plan developed to deliver national, regional, south east London wide and borough specific information regarding flu, COVID-19 and winter health.
- One Bromley winter branding developed and applied to all winter communications.
- One Bromley staff event launched the winter campaign and encourage working together and referrals to different parts of the system to help with winter pressures.
- Videos produced of main winter schemes to help promote the availability and how to refer across the local system.
- New monthly One Bromley Together through Winter e-bulletin for the local system to give information about resilience schemes, winter challenges and pressures and share key information.
- Winter health leaflet delivered to every household in Bromley before Christmas providing information on vaccinations, using the right service, children's health and self care.
- Regular advertising to promote winter health messages through newspaper advertorials, digital and social media.

631 recipients of the together Through Winter eBulletin with 92% open rate

200 staff logging in to live Winter Launch event



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Covid vaccinations

- Since December 2020, over 500,000 vaccinations delivered across borough
- Currently operating bookable and walk-in services from 12 sites across Bromley
- Co-administration with flu vaccine offered wherever possible during 21/22 season

Age Bands	Population Size	% 1st Vaccine	% 2nd Vaccine	% Booster Vaccine
80+	19,988	95.37%	94.41%	92.47%
75-79	14,066	95.34%	94.68%	92.24%
70-74	15,038	93.78%	92.99%	89.67%
65-69	16,298	91.74%	90.85%	85.05%
60-64	20,794	90.47%	89.41%	81.25%
55-59	25,163	88.78%	87.53%	76.27%
50-54	25,554	86.49%	85.15%	72.26%
45-49	25,537	83.28%	81.64%	66.89%
40-44	27,675	80.26%	78.35%	60.61%
30-39	49,564	74.46%	71.51%	49.79%
18-29	43,521	71.37%	64.94%	35.74%
16-17	8,209	61.15%	33.52%	1.30%
12-15	17,645	38.60%	15.34%	0.22%
05-11	30,570	0.29%		
0-4	15,278	0.01%		
Total	**354,900**	**69.92%**	**66.23%**	**52.86%**

From SEL Discovery Dashboard, 21/02/22

- Multiple satellites and pop-up clinics, housebound and care home visits, and engagement activities to ensure comprehensive provision, access and to address health inequalities
- OneBromley collaboration has been central to achieving excellent uptake
- Nearly 5000 vaccinations administered for 12-15 year olds in 37 schools, including special schools
- Currently delivering at risk 5-11 year old vaccinations
- Future model due to be confirmed by NHS England

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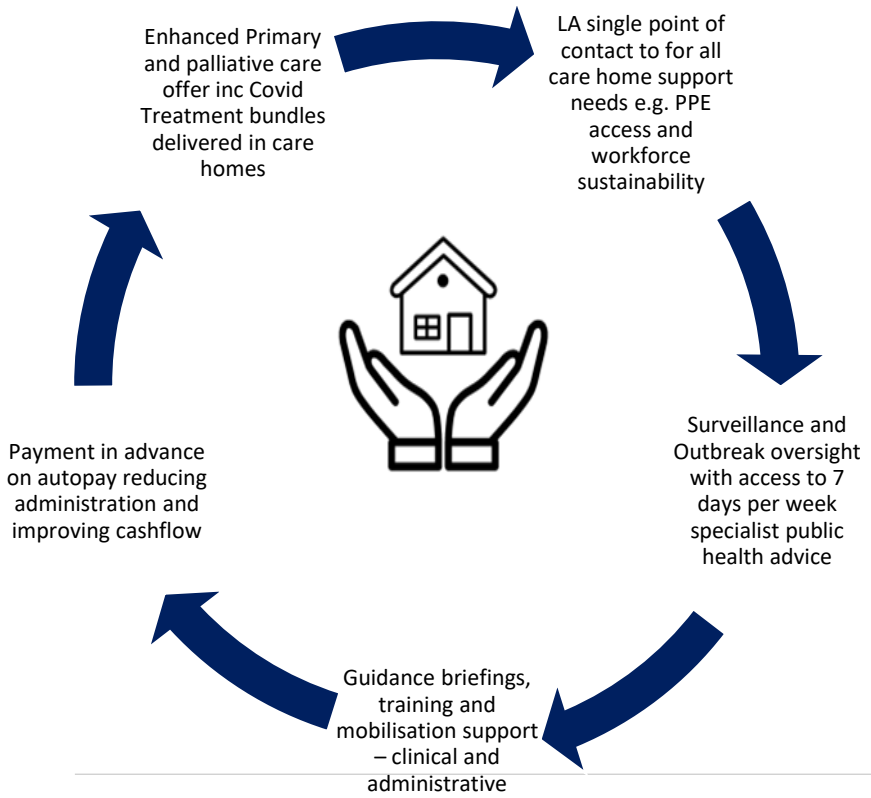
Covid Outbreak Management in Care Homes

An integrated, wrap around offer, utilising surveillance and intelligence to manage the spread of infection working in partnership with the care home market to provide the best possible care and support to residents throughout the pandemic.

Supporting care homes through wrap around support



109 outbreaks across care settings including dom care, supported living, ECH and Care homes between September and February

Effective support around care settings to manage outbreaks resulting in minimal disruption

Significant grant funding received into the system and deployed directly to providers

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Next Steps

- Tapering of additional winter capacity back to business as usual levels
- Review of winter through system reflection workshop to identify:
  - What has gone well this winter i.e. schemes , processes, governance
  - Analysis of unpredicted issues that emerged, what was the impact and how were they addressed and feed into relevant organisation's business continuity plans.
  - Recommendations for system resilience / improvement and recovery throughout the summer
  - Recommendations for next winter