	Community and Wellbeing Scrutiny Committee 30 January 2019
	Joint Report from Brent Clinical Commissioning Group, NHS London North West Healthcare Trust, and Brent Council

Winter Pressures – learnings from winter 2017/18

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Rashesh Mehta Assistant Director for Integrated Urgent Care & Long Terms-Conditions Brent Clinical Commissioning Group James Walters Deputy Chief Operating Officer London North West University Healthcare National Health Service Trust Tom Shakespeare Director of Integrated Care Brent Clinical Commissioning Group and Brent Council

1.0 Purpose of the Report

1.0 This report provides an update for the Community and Wellbeing Scrutiny Committee on Winter Pressures – learnings from winter 2017/18 and sets out our plan as a system (with London North West University Healthcare National Health Service (NHS) Trust (LNWHT), Brent Clinical Commissioning Group and Brent Council) for 2018/19. It addresses a system-wide approach on winter preparedness in Brent for 2018/19.

2.0 Summary

2.1 Every year the winter period brings with it significant and increased pressure on local systems due to demand on Accident and Emergency Departments (A&Es), therefore impacting capacity and performance. Establishing processes and arrangements early on, taking a whole system approach and working across organisational boundaries to inform extensive planning, helps to manage the complexity and scale of demand. In recent years, seasonal pressure on health and social care services has increased and as a North West London Sustainability and Transformation Plan (STP) we have been working with our local A&E Delivery Boards (AEDB) even more closely to ensure we continue to deliver safe and high quality care throughout the winter period. Our preparation for winter started earlier which has helped us identify key themes and challenges, undertake a review of previous winter activity and likely demand assumptions for planning. This has helped inform and build our local system wide winter plans for 2018/19.

3.0 Key priorities for Winter 18/19

3.1 System wide executives from CCG, Brent Council, London Ambulance Service (LAS), NHS 111, Urgent Care Centres (UCCs) & Community Services and Local trust form the LNWHT A&E Delivery Board to jointly agree and plan for winter. It also includes participation from NHS England (NHSE) and NHS Improvement (NHSI).

3.2 For 2018/19, the A&E Delivery Boards have focused on five key initiatives against the national winter requirements 2018/19:

1. **Reducing extended lengths of stay** by reducing the number of beds occupied by long stay patients by 25%, compared to 2017/18.
2. **Development of an ambulatory emergency care (AEC) service** so that all acute hospitals provide ambulatory emergency care at least 12 hours a day, 7 days a week.
3. **Minors patients breaches reduction** so that actions are undertaken to ensure the delivery of a reduction in the number of minors patients who breach the four-hour A&E waiting time standard down to zero.
4. **Improving ambulance handovers** so that 100% of patients arriving at an Emergency Department by ambulance are handed over within 30 minutes of the ambulance's arrival; all handovers between ambulances and Emergency Departments must take place within 15 minutes.
5. **Implementing effective demand management schemes** in out of hospital services to support the management of flows into emergency care services in hospitals

4.0 Collaborative working - Brent Council, Brent CCG and LNWHT

4.1 Brent Council has a key role to play in providing support during winter pressures. Brent Council executes this role by working collaboratively with partners in LNWHT & the CCG and the A&E delivery board which is a mandated board of Executive stakeholders.

4.2 During last winter (2017/18) the domiciliary care sector was able to respond adequately to additional demand during the period and the Hospital Discharge Team

was able to expedite discharges with the number of adult social care delays between December 2017 and March 2018 being lower than the months prior to December (November 2017) or after March 2018 (April and May 2018). Referrals to Home First remained at or just below the target number during this period and care providers who provide the bridging care for home first were able to respond adequately to the demand. The main pressure point for adult social care was the lack of care home and extra care shelter capacity which had been an on-going issue throughout the year but became even more acute during the winter period of 2017/18. During Aug 2018, there have been difficulties with Social worker capacity that has had a significant impact to delays and responsiveness to reducing delayed transfers of care (DToCs). A significant drive of recruitment of social workers has helped the system cope with the increasing demand during winter pressure period.

4.2 In October 2018 the Health and Wellbeing Board agreed to a revised set of priorities, with three core priorities for implementation, and three areas for scoping and development. One of the key priorities was developing an Older People's pathway. There are two key components to this priority, both of which are overseen by an Older People's Pathway Programme Board, and supported by two steering groups. The work of these groups is summarized as follows:

a) Operational hospital discharge steering group – overseeing day to day operational issues around hospital discharge and Home First, oversight and delivery of the joint winter plan

b) Strategic older people's steering group – overseeing the review of the integrated discharge pathway

c) Older people's programme delivery board – to oversee delivery and manage escalated issues from the steering groups, and to ensure alignment between the integrated discharge pathway review and the integrated care partnership work led by the CCG

4.3 **Integrated discharge pathway** - Consultants, Newton Europe, were commissioned at the end of last year and will provide specialist knowledge and support to redesign and deliver the integrated discharge pathway. The aim of this work is to streamline the discharge process through the Discharge to Assess (D2A) framework. They have initially carried out introductory meetings with key stakeholders. Plans are now in place to start data collection and analysis as well as arranging workshops to engage with staff in relevant teams. An interim report is expected in early April with recommendations for discussion and approval by system leaders.

4.4 **Winter planning** – Brent CCG and the Council jointly developed and agreed the Brent system resilience plan to cover the Winter period. This plan covered a wide range of initiatives to reduce delays and ensure timely discharge from hospital settings.

4.5 On 24 October, the Department of Health announced an additional £1.3m to be allocated to Brent Council to support improvements to timely and safe discharges from hospital. This funding is non-recurrent and a plan has been jointly agreed to provide additional capacity to the system to improve patient flow. These initiatives are as follows:

a) Purchase additional capacity including an additional 15 block beds in the system to help manage flow and provide capacity in the community (£855k);

b) Implement a pilot 'Placement Premium' initiative, with additional payments to care homes that provide timely assessment and placement of patients (£67k);
c) Additional handyman service, to enable speedier and effective adaptations to people's homes to support timely discharge (£31k);
d) Additional social worker, OT and co-ordinator capacity to scale up the Home First initiative to additional hospital sites (Imperial, Royal Free, Willesden, Central Middlesex) (£217k)

4.6 **Home First** – As outlined above, the expansion of Home First to additional hospital sites in Brent was agreed as a joint priority for the use of the additional non-recurrent funding. The jointly agreed model up to July 2018 can be summarized as follows:

a) Covers only London Northwest (Northwick Park, CMH and Willesden)
b) Focused solely on pathway 1 (simple discharges)
c) OT capacity and assessment provided by London Northwest
d) Bridging care and care packages provided and funded by social care
e) Target of 13-17 discharges per week

4.7 Following a review of the existing Home First model in August 2018, the following conclusions were drawn:

a) Adult Social Care and Short Term Assessment, Rehabilitation and Reablement service (STARRS) staff not working effectively as a 'virtual' team
b) Resource (capacity) issues- mainly relating to Occupational Therapy home visits
c) Delays in transferring cases post assessments – leading to extended bridging care costs.
d) No clear operational/clinical leadership and ownership
e) Ward staff (therapists) completing assessments on the ward
f) Difficulties for the STARRS Team recruiting and retaining Occupational Therapists

4.8 From January 2019, it is proposed that Home First is expanded on the following principles:

a) Pathway 1 patients only
b) Expansion plan to include Royal Free and Imperial hospitals
c) Relaunch at Willesden and Central Middlesex hospitals
d) Increase Home First (Pathway 1) discharges to cover 30 clients per week across the 3 NHS Trusts
e) Increased staffing capacity with Care Assessors, OT assistants (OTAs) and OTs, with all additional recruitment by the council
f) Integrated model and pathway with newly launched Housing hospital discharge service (handyman / blitz cleaning/small grants and non means tested DFGs)

4.9 Recruitment is already underway and nearly complete for the new model, ready for a full launch within January. A detailed set of service standards are being developed for agreement by the Hospital discharge operational steering group.

4.10 A key output of the 'integrated discharge pathway' review in April 2019 will be an approach to sustain this approach in addition to an expanded Home First across all pathways, including a sustainable financial model.

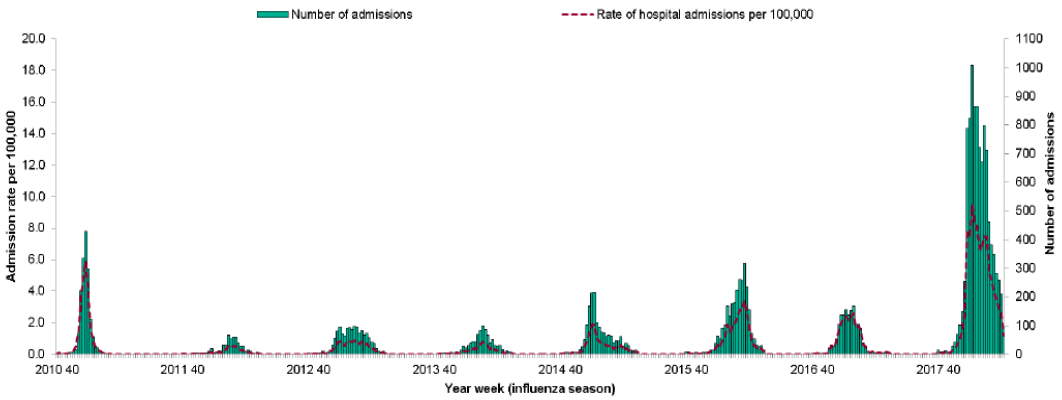
5.0 Lessons learnt from 2017/18 and winter planning for 18/19

5.1 **Primary care & NHS 111 -**The winter of 2017/18 was the most pressurised in recent history. These pressures were also felt within primary care with the weekly rates of General Practitioner (GP) consultations for influenza-like illness (ILI) increased. A number of patients contracted flu and flu-like symptoms despite receiving the flu jab which resulted in pressures within Primary and Acute sectors. The lessons learnt from the 2017/18 winter months were as follows:

- To ensure a more targeted approach to flu vaccinations;
- Better and closer working relationship between acute and primary care providers to manage demand and capacity for medical appointments
- Enabling digital communication between providers to facilitate better management of patient care for example direct and remote booking into access hub by UCC/111 providers
- Realignment of the GP access hubs to better meet patient needs and demand

The graph below shows the number of hospital admissions in 2017/18 in comparison with previous years.

Figure 14. Weekly number of influenza confirmed hospital admissions to hospital through the USISS sentinel scheme with crude hospitalisation rate for all ages, 2010 to 2018



Source:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/740606/Surveillance_of_influenza_and_other_respiratory_viruses_in_the_UK_2017_to_2018.pdf

5.2 To manage winter pressures, in particularly over the Christmas and New Year period the CCG commissioned additional GP appointments through the GP Access Hubs and through the e-Hub for on-line consultation. Utilisation in previous years was assessed to ensure demand and capacity analysis informed availability of appointment slots.

5.3 **GP Access Hubs** - As part of the CCG's winter planning activity, the CCG undertakes to ensure sufficient capacity within primary care to manage Winter Pressures by improving Access. Provision is made in Primary Care for Access to GP services over 7 days a week from 8.00am to 8.00pm, 365 days a year. Particular focus is paid to days when GP surgeries are closed e.g. Christmas Day, Boxing and New Year's Day and the days following. The GP Access Hubs at Wembley and

Willesden and other sites were providing both walk-in and pre-bookable appointments for all patients throughout the winter months.
Improvement in the GP Access Hub utilisation in 2018 compared to 2017 was as follows:

	Utilisation in 2017	Utilisation in 2018
Oct '17	58%	81%
Nov '17	61%	75%
Dec '17	53%	70%

To increase utilisation over the winter period 18/19 the following plans have been implemented:

- Direct booking GP Appointments from NHS 111 into General Practice – during practice core hours.
- Direct booking into Access Hubs has been enabled for 111 at all hubs being reserved for 111 booking. Urgent Care Centre is actively redirecting patients to the hubs
- Direct Booking into the Access hubs by E-Hub GPs to enable patients who require face to face appointment to be offered a booked appointment though one phone call.
- On-line consultation will support improve access to primary care and reduction in activity in secondary care.

An improvement in utilisation has been noted as follows since the new service has started; the CCG will continue to monitor utilisation.

5.4 **Enhanced GP Service for care homes** programme supports the pro-active management of patents in care homes. The service is provided 8.00am to 8.00pm, 7days a week /365 a year with care homes encouraged to contact the Network single point of access (SPA) line prior to contacting LAS services.

5.5 A care home pharmacist has been in post from November 2018 as part of the Medicine Optimisation in Care Homes (MOCH) work funded through by NHSE. The service is providing dedicated support to care homes by undertaking regular audit of medication reviews.

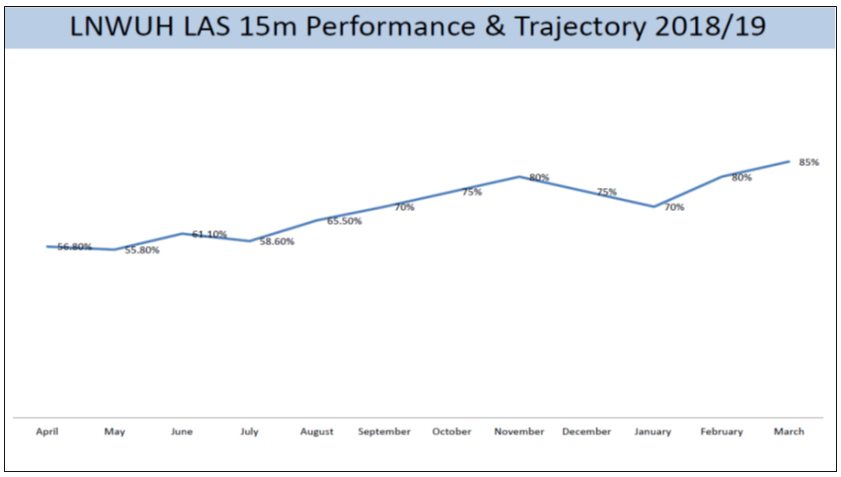
6.0 LNWHT - review of 2017/18 identify areas where planning could be improved especially around front door, improving waiting times, patient flow and discharges.

6.1 **Front door**- A number of schemes will be in place for the winter period to maintain patient flow through and safety in the A&E. This includes an increased ambulatory care offering, which provides alternative initiatives to ensure ambulance handover targets are maintained and the frailty pathway embedded into the A&E at Northwick Park site.

The Urgent Treatment Centres at Northwick Park, Central Middlesex Hospital and Ealing all have a robust streaming process in place for streaming and redirection of patients into alternative primary care services included GP extended Access Hubs.

6.2 **A& E performance & waiting times** - Overcrowding in an A&E department is something none of us wish to see. The Trust's escalation framework means that when certain trigger points are reached, the whole hospital and indeed the whole health and care economy directs support where it can. This can mean more doctors and nurses going to support the A&E department, additional patients being allocated to the wards to help manage the risk of an overcrowded A&E department and our Social Care and CCG colleagues will help review patient allocations to community beds and care packages, so that patients can get back to a community setting as soon as possible. We have recently updated our web site to provide patients with more information about the waiting time in our two A&E departments.

6.3 **Ambulance Handover and Performance-** the Trust has greatly improved its performance since last year. The number of long waits to formally handover patients reduced. Where a large number of ambulances arrive in close succession, a waiting time can still develop, but it's important to note that all patients are checked in straightaway when they arrive in the department, so that their care is tracked and overseen by our clinical team as soon as they arrive.

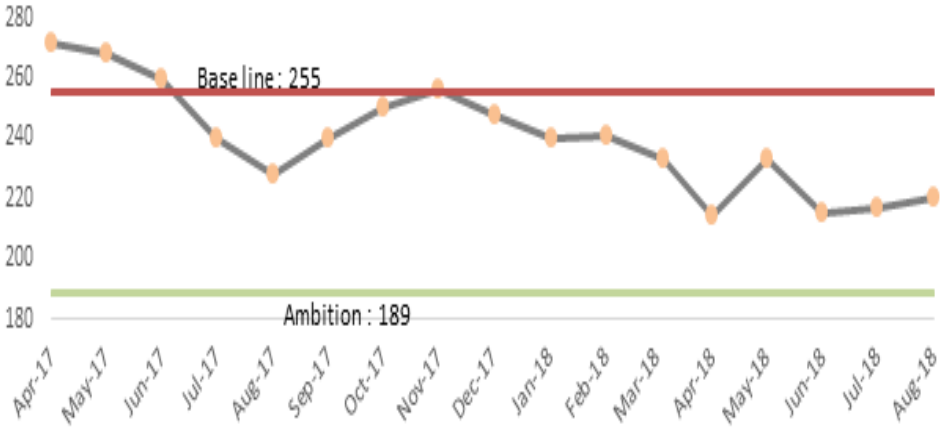


6.4 During this winter, LNWHT received funding from NWL of £117,468 to provide targeted support at Northwick Park in order to improve handovers between LAS and A&E. A hospital handover plan has been developed to assist with the timely offloading of patients ahead of winter, this will include:

- an advanced initial assessment area to triage, including safe numbers and escalation procedures.
- Additional paramedic or nurse to assist with timely triage of patients.

Both initiatives will run for 6 hours per day for 6 months.

6.5 **Extended Length of Stay (LoS) Plans and trajectory -** A long stay patient is defined as an adult patient who has been in an acute bed for 21 days or longer. There is strong evidence that long stays in hospital lead to patient deconditioning, harm to patients and unnecessary additional demands on health services. The aim is to therefore discharge patients as soon as they will no longer benefit from acute hospital care, ideally to their original place of residence. Delayed Discharges result in poor experience and greater risk for the patients concerned and prevents others accessing appropriate care settings for treatment in a timely way.



Some patients can remain in hospital for longer than they should, because of a range of factors, social or economic. The term 'stranded' signifies the serious risks for patients if they are unable to leave hospital in a timely way. Each week the whole health and care economy comes together in Brent, Harrow and Ealing to review patients who are experiencing an abnormally long length of stay. Whilst we always try to respect the sometimes life changing decisions that patients and their loved ones are having to make, we try and balance that with the risks of healthcare acquired infections in a busy district general hospital. Our formal Delayed Transfers of Care reduced over the period from 270 as at April 2017 to 189 as at December 2018.

However, we still need to improve the number of patients remaining in hospital for 21 or more days as this has remained relatively static for the same period. Weekly Stranded Patients Review is on-going to sustain continuous improvement in ELOS which is attended by partner organisations.

6.7 **Discharges (inc. patient flow)** - patients' experience upon discharge from hospital is very important to the Trust. We always aim for a seamless handover between our acute and community services. Being an integrated healthcare provider, that provides both services within the hospital and in the community helps to support this. This year the Trust updated its Discharge Policy and worked closely with Brent Council to develop our approach to patient choice where care homes or care packages are a feature of the discharge arrangements. In Brent, the Trust along with system partners is providing a number of services this winter, to help support patient discharge from hospital, or to avoid an admission to hospital in the first place. All of these services are designed to maintain patient flow in the hospital, so that when urgent and emergency care is required, it is available as quickly as possible:

- STARRS – admission avoidance provides a specialist medical, nursing and therapy team that supports patients in the community. It's there as a rapid response service for GP's to dispatch as an alternative to a patient coming into a hospital bed.
- Early Support Discharge – supports medically fit patients who need additional care to return home, rather than spend another night in hospital
- Frailty – After a successful proof of concept service during 2017/18, which was funded by Brent CCG, the Trust has continued to invest in its approach to frailty to connect vulnerable patients to a Consultant Geriatrician and a team dedicated to the type of care they need as quickly

as possible in the A&E department. This year we further developed that approach to launch our Older People's Short Stay Unit where an admission to hospital was still needed. Our Frailty Team work seamlessly with our Brent STARRS team and the other services listed here to try and reduce the risks of re-admission to hospital

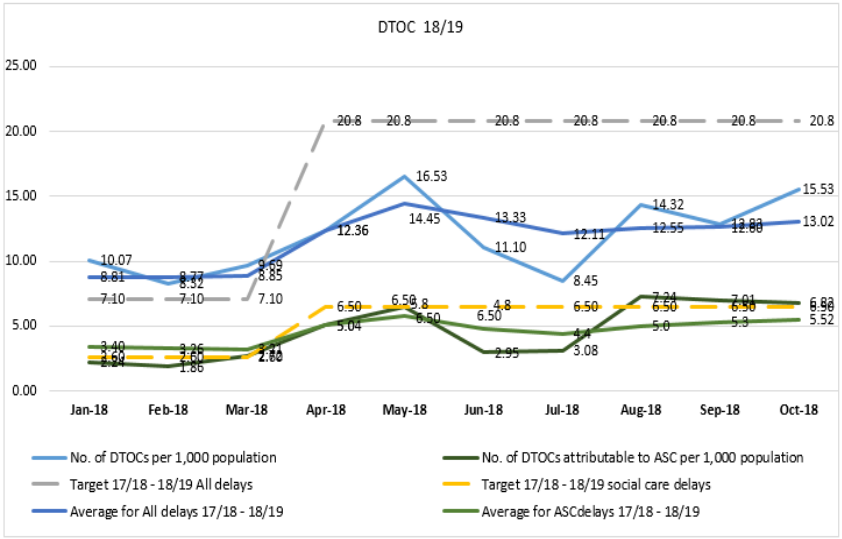
- Step down beds
    - Community bedded support for patients who are unsafe to return home and need step down rehabilitation: The pathway aims to deliver a simple pathway for same day / next day transfer, 7 days / week through a trusted assessor model.
    - A total of 77 community beds funded through by NHS Brent CCG (55 x IC beds) and Better Care Fund (22 x step down beds) jointly with Brent Local Authority
- Discharge to Assess (D2A) Home First – part of the simplification of the discharge pathways from hospital to community from 17 discharge processes into 4 main simplified pathways:
    - Pathway 0 (nurse-led)
    - Pathway 1 – home first - trajectories were previously set at 17 discharges per week which now have been changed to 20.
    - Pathway 2 – community bedded support
    - Pathway 3 – complex cases / requires continuing health care
    - This is joint working between the CCG, Trust, and London Borough of Brent.
- IRRS – Integrated rehabilitation and reablement service based in the community, enabling people to regain independence, also supporting Home First

7.0 Delayed Transfers of Care (DToC) - System wide stakeholders have an established process to report DToCs which includes twice weekly calls to discuss and validate DToCs, during the winter. The commitment to improve patient flow is against a challenging performance backdrop. Weekly stranded patient meetings continue throughout winter and the meetings are likely to become more frequent throughout winter.

Sitrep data for October 2018

Brent DToC position 2018/19

Top 4 delays at October:
20.6% - DI RESIDENTIAL HOME
19.6% - C FURTHER NON ACUTE NHS
19.6% - DII NURSING HOME
10.6% - I HOUSING



Brent Clinical Commissioning Group

DTOC April 18 to March 19
The Targets for DTOC are:
13.8 - NHS delays
0.5 - Both delays
6.5 - Social care related delays
20.8 – Total Delays

DTOC April 18 to March 19

As at October 2018
7.68- NHS delays
1.04- Both delays
6.82 - Social care
15.53 – All delays

The average delays to date are:

7.01- NHS delays
0.49- Both delays
5.52 - Social care
13.02 – All delays

7.1 The national sitrep (daily situation report) data for November has not been released, by the time of filing this report. Adult Social Care records show that there were 258 discharges in December compared to 276 in November. Records from the agreed weekly validations with London North West show that there was a remarkable improvement (57%) in the DToC position in December in comparison the previous month (November)-further details as follows:

- 59% reduction in DToC position for ASC
- 28% reduction in NHS delays
- 66% reduction in placement delays for ASC
- 27% reduction in placement delays for NHS
- No public funding delays for both ASC and NHS
- 35% reduction in delays waiting for further NHS services
- 83% reduction in housing delays

Delays by hospital								
	Both		NHS		Social Services		**Total**	
Hospital	Clients	Days Delayed this Month	Clients	Days Delayed this Month	Clients	Days Delayed this Month	**Clients**	**Days Delayed this Month**
Central Middlesex	0	0	8	52	5	29	13	81
Northwick Park	0	0	12	60	12	53	24	113
Willesden	1	6	15	78	7	17	17	91
Grand Total	**1**	**6**	**35**	**190**	**18**	**89**	**54**	**285**

Delays by Reason- December				
Delay Reason	**Both**	**NHS**	**Social Services**	**Grand Total**
A) Completion of assessment	0	0	0	0
B) Public funding	0	0	0	0
C) Further non acute NHS care	0	50	0	50
Di) Residential Home	0	0	54	54
Dii) Nursing Home	0	64	35	99
E)Care Package in own home	0	7	0	7
F) Community Equipment/Adaptions	6	0	0	6
G) Patient or family choice	0	55	0	55
I) Housing	0	8	0	8
Grand Total	**6**	**190**	**89**	**285**

7.2 A deep dive of delayed transfers of care (DToCs) was undertaken over a 3 month period between July and September 2018 and the major cases of delay identified waiting for care placements and in particular patient / family choice as the major cause of delay for both health and social care. There are also some delays relating to housing and accommodation issues. This has informed our plans for 2018/19 and hence the commissioning of additional block care home beds and development of the choice and discharge protocol. Funding has also been secured for the recruitment of an additional 1 FTE Housing Discharge Worker and recruitment is in process.

8.0 NWL Winter Communications Plan

8.1 A sector wide communications and campaigns plan is in line with NHS England's guidance. We are working in partnership with our local CCG colleagues and Trusts who are feeding in the needs and views of their residents. The NW London campaign will support that campaign although many of our messages will run throughout the season. The campaign aims are:

- To educate about self-care during winter
- To encourage people to use alternatives to A&E and 999 when appropriate:
  - To encourage the use of local pharmacies

    - To increase the awareness of NHS 111
    - To inform people about improved access to GP and nurse appointments
  - To increase the number of people getting their flu vaccination.
  - To remind patients with repeat prescriptions to make sure they have enough medication over the Christmas period.

9.0 Conclusion

9.1 Our System wide winter plan takes into account learnings from 2017/18, to support pressures in 2018/19. It specifies additional measures and steps to be taken as a system in response to surge pressures. With all the best and joint efforts and endeavours we are still seeing rises in patients' numbers to Northwick Park especially via ambulance, and the hospital remains under considerable pressure especially post-Christmas with higher acuity and incidents of flu. Despite this our plan ensures a sound operational resilience during the winter months maintaining patient safety, patient experience and clinical effectiveness across the system. Brent's System wide plans will be expanded from national directives available to guide the system in navigating our responses to current winter pressures and planning for winter 2019/20. As a system we will carry on learning year-on-year to improve provision and resilience every winter period moving forwards.