AGENDA ITEM 8

Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

Urgent Care Winter Resilience Schemes	
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Date of meeting	22 October 2015
Report for - Information	

Purpose of this Paper

This paper has been produced with the aim of updating the Health and Wellbeing Board regarding the schemes in place, or planned to commence, to support Bristol's urgent care system through winter 2015/16. This includes schemes to support the acute hospitals, and those across primary care and the community.

Executive Summary

The schemes within this paper have been planned to impact on the key urgent care areas of admission avoidance, flow, early discharge and readmission prevention.

- **Seven Day Services** - Across the system work is ongoing to support seven day and extended hours services. The schemes detailed within this briefing will begin to embed some of the main developments identified at the recent Bristol and South Gloucestershire Seven Day Working Workshop, at which the interim direction of travel was agreed.

- **Pressure on Children's Services** - The UHB Children's Services schemes are designed to address the current increased demand at the front door, and also to support flow through the system.

- **NBT four hour performance** – The schemes funded at NBT have been carefully selected as part of a joint process with South Gloucestershire CCG, NBT, South Gloucestershire Council and Sirona in order to impact upon NBT's constitutional standards recovery plan. The NBT specific schemes are aimed at impacting immediately in order to support the target for sustained achievement of the four hour standard.

- **Discharge to Assess (D2A)** – D2A and the wider, non-acute based plans will build to provide sustainability on an ongoing basis, and will move care closer to home at an earlier point in each patient's recovery process. These plans have been developed as part of a system wide agreement,

involving partners from across health and social care in Bristol and South Gloucestershire.

A clear outcome of these actions will be a reduction in occupied bed days and improved flow through the system. Of the newer schemes some have yet to deliver their full anticipated benefits. Chiefly, it is anticipated that D2A, as supported by the Integrated Discharge Hub, will transform flow at the back door, enabling patients with complex needs on discharge to receive non-medical care services closer to home, with resulting benefits to the system of savings in occupied and excess bed days and a flowing urgent care system all year round.

These projects are governed through the Urgent Care Woking Group (UHB system) and System Flow Partnership (NBT system).

Key risks and Opportunities

- Bristol City Council's (BCC) new model for the delivery of homecare launched in August 2015 and underpins all of the discharge to assess work by supporting flow through the urgent care system. It is anticipated that once fully staffed, the four zone-based providers will pick up all package requests, as per the "no refusal clause". This will in turn deliver a zero wait for homecare, and consequent reduction in occupied bed-days. However, for now there are capacity issues which mean that the new providers are picking up approximately half of all work offered to them. Significant delays attributable to homecare remain in both acute Trusts. Updates are provided by Council commissioners via the Alamac call and the Urgent Care Working Group.
- Depleted social work capacity, particularly at UHB, has resulted in delays in patients being allocated for assessment and progression with resultant delays. A recent round of recruitment should see the team fully staffed shortly.
- The CCG (Clinical Commissioning Group) has requested a data flow from NBT on its >14 day LOS patients. Whilst this request has been acknowledged by the trust it has yet to be actioned.

Background

There are a range of projects and actions associated with avoiding admission to hospital, improving system flow, enabling discharge and reducing delayed transfers of care (DTOCs). These measures are funded in part through the Operational Resilience and Capacity Plan (ORCP) budget, as well as through the provider contracts. An evaluation of the ORCP 2014/15 schemes based on impact, cost, deliverability (workforce) and alignment with the Better Care Programme and CCG planning processes was conducted to assist in planning objectives for the 2015/16 round of funding.

Introduction

This paper has been written to provide an update on the various schemes that are being implemented or planned for the urgent care system in 2015/16. The broad areas are

1. Admission Avoidance Schemes
2. Frailty
3. System flow
4. Supporting Discharge

Unless indicated (eg UHB and NBT specific schemes) all services are for the total registered population of Bristol and are expected to have equal impact across both acute trust catchments. The main body of the paper clearly sets out each of the schemes and how it works.

1. Admission Avoidance Schemes

In operation:

- Currently there is a pilot with Care UK (NHS 111) for the delivery of escalation support to the Bristol, North Somerset and South Gloucestershire (BNSSG) system. This includes out of hours monitoring of CMS, plus facilitation (calling and note taking) of BNSSG system escalation calls when required.
- Funding to allow winter and other seasonal communications packages to be designed and procured has been agreed with BNSSG partners. These campaigns highlight and encourage the use of alternative settings to the Emergency Department, for example outlining the range of services available through pharmacies, the Walk-in Centre and the Urgent Care Centre.
- There are three admission avoidance beds each at John Wills House Nursing Home and South Bristol Community Hospital (SBCH), all managed by Bristol Community Health (BCH). The John Wills House beds prevent admissions to acute beds from the community, and the SBCH beds are used by patients attending the Emergency Department (ED) in order to prevent admission to acute beds where possible.
- Rapid Emergency Assessment Care Team (REACT) is a BCH multi-disciplinary team based within the Emergency Department, but also working across the Medical Assessment Unit (MAU) and Older Persons Assessment Unit (OPAU) at UHB with the aim of putting together a community based support package which means that patients either avoid being admitted, or can leave hospital earlier.
- Rapid Response Advanced Nurse Practitioner (ANP) in-reach is provided by BCH to the Emergency Departments in order to facilitate support for patients to return home with no need for an acute admission. This service runs on Sundays when REACT is not available. This team has received further investment via ORCP 2015/16.
- Services agreed under the Bristol Primary Care Agreement (BPCAg) with the aim of reducing acute admissions include:
    - Increased multi-disciplinary capacity over the winter months to support frail, elderly patients;

    - Increased use of telephone triage services;
    - Joined up working with the voluntary sector, such as the Red Cross.
- BrisDoc provides out of hours GP services to avoid admission including:
    - The Professional Line – which supports care home staff out of hours and at weekends by providing a full GP service, including telephone advice and face to face review where indicated;
    - Front Door support – via a full GP service within the Emergency Departments at both UHB and NBT.
- A new mental health model has been commissioned for Bristol with a focus on crisis reduction and increased community support. This includes The Sanctuary, which has been commissioned as an alternative to patients who are in lower level crisis, but who would otherwise need to use the Emergency Department.
- The Urgent Care Centre at SBCH is BCH managed, and opens daily between 9am and 9pm, offering an alternative to the Emergency Department.
- The UHB Clinical Alert Service informs the Hospital Discharge Team each time a patient who has had multiple recent admissions attends the Emergency Department. The aim of the alert is to ensure the patient is identified early on in their acute care journey so that measures can be swiftly investigated which may mean a community package of care can be better supported, and an admission avoided.
- The Red Cross front-door service offers voluntary sector support for patients attending Emergency Department with the aim of reducing admissions.

UHB Paediatric Attendances:

In operation:

- The advice and guidance service is a telephone service in Emergency Department for GPs to use. This is not formally commissioned by the CCG, we will be reviewing the long term viability of this service.
- Clinical pathways have been promoted to GPs and are also used as the basis for paediatric information and training sessions for GPs.
- Practices are encouraged to ensure that all children and young people aged 4 and over who have a diagnosis of asthma or persistent wheeze have a written management plan and an annual review.
- Community Nurses have the potential to avoid Emergency Department attendance, particularly of children with existing long term conditions by providing care in the home. There is a very small Community Children's Nursing team, and Bristol CCG has invested in increasing the capacity. Staff are currently being recruited to this extended service.
- A series of information leaflets on managing common childhood conditions are designed to be given to parents when they have attended either their GP or Emergency Department with advice on how to manage if the problem reoccurs. Paper copies have been circulated along with links to download the documents and versions in a range of

community languages. Investment will also be made in the "Handi App" which provides advice to parents and GPs on managing common childhood conditions and where to go for help. This should be available shortly.

- The Paediatric Home Intravenous Antibiotic Service (P-OPAT) comprises a clinical team supported by a Community Nurse to identify children who are clinically stable and ready for discharge but require IV antibiotics. In the period November 2014 to March 2015 the service saved around 100 excess bed days per month with an average of 13 bed days saved per patient.

2. Frailty Work

In operation:

- The CCG South GP Consortia are working closely with the Care of the Elderly consultants in developing the Rapid Access Clinic for Older People (RACOP) with practices releasing a GP from each practice for 4 weekly sessions to provide a clinical education update and development.
- The Bristol CCG Primary Care Agreement (BPCAg) has supported primary care in developing new roles with Advanced Nurse practitioners undertaking home visits to support patients in their own home thereby preventing admission. In addition the BPCAg has increased capacity of NHS England's Directed Enhance Service and supported continuity of care.
- As part of the Better Care Design proposals a new community ward (within UHB bed base) will host a complex care multi-disciplinary team. The primary objective of this ward which has been funded through the ORCP and team is to reduce the number of patients waiting in an acute bed unnecessarily and to manage community patients who have been identified as being at risk of admission. As part of the proposed pilot, the GP surgeries based in South Bristol will be used in the task of identifying the most vulnerable and medically at risk patients to be referred to the ward. UHB will substantively recruit staff to run the ward, rather than using agency workers. At the end of the project, or at its scaling down, staff will be transferred to work elsewhere within the Trust to fill vacant posts, or to vacancies in the community. In this way the model will be scaled down as new community services are implemented, thereby fitting, for example, with the timeframes for Better Care Bristol funded schemes. The model will not therefore need to be funded long term as part of its purpose will be to provide a transition to more community based models of care.
- The NBT Complex Assessment Unit (CAU) went live on 1st September 2015. The CAU is 32 bed ward being run by a multidisciplinary team dedicated to providing prompt comprehensive and holistic assessment of patients with complex needs, empowering them to become as independent as possible and carefully planning a safe and timely discharge. The aim is to ensure patients have comprehensive geriatric assessment and rehabilitation from this team, with a view to prompt

acute stabilisation and medical management, and early supported discharge.

3. System Flow Schemes

In operation:

- The continuation of the Alamac performance management system, including a review of the measures recorded and the format for chairing the daily system wide conference call.
- Weekly Patient Progress Multi-Agency Meeting at UHB which aims to unpick complex discharge issues and progress discharge to assess and spot purchased pathways.
- Daily Navigation Meetings at NBT which bring together members of the newly forming Integrated Discharge Service (NBT case managers, social care, BCH) to update on and progress complex discharges.
- Seven day working is being rolled out across urgent care. Through the ORCP Bristol CCG is funding the following acute care schemes in UHB:
  - 7 day consultant delivered working
  - Children's Services - OPATS
  - 7 day diagnostics in surgery, heart failure and radiology

  And in NBT:
  - Discharge Lounge
  - Weekend therapy
  - Diagnostics
  - Acute Frailty Pathway Development

  Social Care and BCH are working seven days within both acutes, though there is work to do to develop other community services which are required to support discharges at weekends, for example through primary care, care brokerage care home management etc.
- Within both acutes, that CCG has funded the development of the Community Discharge Co-Ordination Centre (CDCC). This is a BCH service which acts as the front door to all community rehab and reablement services. As part of this development the whole rehab pathway has been reviewed in order that BCH manage referrals into and out of SBCH. This will ensure in future that only the most appropriate patients use this facility, and that a good level of flow is maintained throughout the rehab pathway be enabling patients to step down sooner and more frequently to more appropriate settings. Bristol CCG has given notice to other users of SBCH which has secured 5.1 beds net back for use by Bristol patients.
- Within UHB an internal project rolling out "Ward Processes" is focussing on internal flow and discharge, and includes early use of the discharge lounge, discharges before 12pm, and appropriate use of escalation mechanisms.
- The Care Home Support Team is a nurse-led, CCG commissioned service which provides support to care homes with the aim of bringing previously unused or closed (eg due to safeguarding concerns) capacity back into the system.

Planned:

- Plans are underway for an integrated therapy services across the community and UHB and NBT, which will reduce handovers and LOS (through a more positive risk management approach), and increase opportunities for patients to step down from acute beds.

4. Supporting Discharge Schemes

In operation:

- The key vehicle to the delivery of occupied bed day reduction is the transformational project Discharge to Assess (D2A). The aims of this project are to improve flow across the acute care system, reduce length of stay in acute and community beds, and reduce excess bed days and delayed transfers of care (DTOCs). The Integrated Hospital Discharge Hub/Service facilitates the transfer of patients on the day they are medically optimised to the most suitable step-down option so that assessments and onward care planning can be completed from the community. There are three broad pathways:
    - Pathway 1 – Home with Support (care and / or rehab / reablement)
    - Pathway 2 – Community Rehab Bed (including inpatient rehab)
    - Pathway 3 – Complex Assessment Beds (social care or full CHC assessments)

  Home will be the default care setting for all patients unless considered and deemed unsafe or unsuitable. For patients on the rehabilitation ("rehab") pathway access appropriate community rehab beds will be facilitated through an expanded Community Discharge Co-ordination Centre (CDCC). All three pathways have recently launched across Bristol. This work includes significant investment through Better Care Bristol in reablement services, plus health and social care investment in community rehab and complex assessment beds. Data is being collected and reported via Alamac to map the demand and capacity for these pathways. For patients requiring care in a bedded setting Bristol as an established network of options as below:

Bed type	How to Access Beds	Name of Provider	Total Number of Beds
Admission Avoidance	**Rapid Response Tel: 0117 903 0202**	John Wills House	3
		South Bristol Community Hospital	3
		Total	**6**
Discharge to Assess Pathway 2 Community Bed with Rehab/Reablement	**Community Discharge Coordination Centre Tel: 0117 342 6667**	John Wills House (The Beeches)	6
		Hartcliffe Nursing Home	7
		North Bristol Rehab Centre	20
		South Bristol Rehab Centre	20
		Orchard Grove - Reablement	12
		South Bristol Community Hospital Rehab Beds	53
	Social Work Team Tel 0117 342 7670	Westleigh Resource Centre	17
		Total	**135**
Discharge to Assess Pathway 3 Complex Discharge Beds with no rehab	**Social Work Team at Each Acute Trust UHB Tel: 0117 342 7670 NBT Tel: 0117 414 4444**	The Westbury - Nursing	5
		John Wills House - Nursing	6
		Druid Stoke - Nursing	5
		Field House - Nursing	5
		Total	**21**
		Frenchay Park	3
		Hartcliffe	5
		Total	**8**
CHC Fast Track End of Life Care Beds	**Fast Track Nurse Assessors Tel: 0117 9828551**	South Bristol Community Hospital	4
		John Wills House	3
		Robinson House	1
		Garden House	3
		Total	**11**
		Grand Total	**181**

- An established Integrated Discharge Hub at UHB (hospital discharge team, social care, BCH, Care Home Selection, voluntary sector) which works as a team to progress all aspects of complex discharge planning.
- Care Home Selection (CHS) has been commissioned directly by UHB and NBT in order to assist patients who need onward care home or package of care services. CHS work with self-funding, Continuing Healthcare and local authority assisted patients. CHS aim to place patients in a home of their choice within five working days of referral.
- BrisDoc Services out of hours GP services to facilitate discharges include pre-bookable weekend appointments. These reviews support patients to leave hospital at an earlier stage by providing the reassurance that a full GP service is available.
- The community IV service can support patients at home who need (multiple) IV therapy administrations, meaning they do not need to remain in hospital until completion of the course of IV medication(s).
- The community equipment system has recently been recommissioned, and now includes a larger resource. For patients requiring discharge dependent equipment, there is an established principle that requests do not need to go through the funding panel.

Planned:

- The CCG receives a daily secure data feed from UHB with details of all of its patients with a length of stay (LOS) over 14 days. This is being analysed for trends, and a further piece of work will help to support patients who require complex discharge planning. This will be achieved through a BCH provided scheme which has brought experienced

community nurses into both trusts to link complex needs patients with community and primary care services. A further piece of work will shortly see a commissioning manager working with social care and hospital discharge staff to commission alternatives to hospital for people who have more bespoke needs and cannot easily be discharged out to the D2A bed base.

- The Integrated Discharge Service at NBT will be fully operational from circa the end of October. A plan is being scoped as to whether funding is available for a senior leader (? band 8c) to lead this integrated service and further develop hospital discharge processes and links with the community across BNSSG.
- A bridge to Better Care Bristol – The overall network of schemes will build a firm basis for the transition to plans being progressed by Better Care Bristol. In particular the community ward at UHB will provide a basis for integrated work between acute and community. The ward is planned to host community MDTs with primary care colleagues and will recruit a substantive, skilled workforce which will be available to transfer into community facing posts as the ward starts to wind down in 12 to 18 months' time. The schemes will also support the integration of some of the acute and community workforces, beginning with therapy staff, as a way of reducing handoffs and increasing flexibility across the system-wide pool of resources.
- The BPCAg (Bristol Primary Care Agreement) will work to link GPs with their patients as part of a fully integrated discharge plan. Dr Peter Goyder is leading the workstream to review the BPCAg specification. One of the areas discussed as part of this is to have a clear link between hospital admission and a flow of acute clinical information out to primary care.

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12.10.15