Integrated Commissioning: Unplanned Care Workstream

Update to Health in Hackney Overview and Scrutiny Committee
November 2020

1. Introduction and context

The Unplanned Care workstream last reported to this committee in January 2020.
Since this time, health and care partners in City and Hackney have had to respond to the CoVID 19 pandemic and resultant impact on health outcomes and inequalities. In tandem with this, we are in the process of implementing a new local health and care system structure alongside the North East London CCG merger.

For this reason, much of the existing programme governance, plus the financial and performance targets that the workstream had responsibility for have shifted.
Whilst the governing structures that have driven our work have changed (and will shift further over the next six months), our workstream objectives are still being delivered, and indeed the pressures of the pandemic emphasised their importance.

Throughout the pandemic all of the services within the scope of the workstream have remained open, continuing to deliver crucial and life-saving support to residents in City and Hackney in significantly challenging circumstances. In addition to responding to the pandemic, all services have had to rapidly adjust their service models to reduce the risk of nosocomial infection.

2. Workstream objectives

The ambitions and main areas of transformation that the unplanned care board were driving have continued to be progressed through 2020, and in many cases expedited, as the pressures on certain parts of the health and care system and resultant health inequalities arising from the pandemic further demonstrated their importance.

In 2018, the workstream agreed the following strategic priorities:

- Develop strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible
- Provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information
- Develop urgent care services that provide holistic, consistent, care and support people until they are settled
- Work together to prevent avoidable emergency attendances and admissions to hospital
- Provide timely access to urgent care services when needed, including at discharge
- Deliver models of care that support sustainability for the City and Hackney health and care system.

We established three transformation areas that the workstream was overseeing to realise these priorities: Neighbourhoods, Integrated urgent care and discharge.

We have continued to progress each of these areas, and have also put a much stronger focus on two additional areas that were always within the portfolio of the workstream but more recently have required much more focused attention owing to the pandemic; End of life care and Winter Planning.

3. Update on areas of work

The following provides updates on what we have achieved in year and what we are planning for the coming year against each of our main areas of work:

Neighbourhoods

We continue to progress our system-wide neighbourhoods programme. The neighbourhoods are working to deliver locally integrated services that respond to local population need. The eight neighbourhoods are now well established and we have an agreed operating model for neighbourhoods that all system partners are committed to implementing.

Key achievements and activities include:

Implementation of neighbourhood multi-disciplinary meetings (MDMs) which bring together a wide range of health, care, and voluntary sector partners within each neighbourhood. The MDMs support individuals that require a multi-agency response. The MDM model was being piloted in Clissold Park neighbourhood from December 2019, however we rolled the model out across all neighbourhoods during the pandemic in order to strengthen community services and support vulnerable people and those with more complex needs We are now establishing links from the MDMs into housing, welfare, debt advice, and employment services.

HCVS have co-ordinated a series of Neighbourhood Conversations which bring together VCSE partners with residents and statutory services to address key issues within each neighbourhood. Conversations have focused on topics such as: Digital divide, Health impact of COVID, signposting and connecting people to support and services and developing community connections/mutual support. The conversations have provided a forum to address key issues but also provide a structure to bring together VCSE partners within a neighbourhood.

Community nursing, adult social care and community mental health have developed and tested how they will re-organise their services to be delivered on a neighbourhood footprint. These will be fully rolled out in 2021. Further work is underway to do develop and test similar neighbourhood models for community therapies.

We are progressing a new model of community navigation. This includes better alignment between existing social prescribing/navigation services and also piloting new posts, well-being practitioners, that provide more focused support to people with complex needs. The well being practitioners pilot launched in January 2020 and is currently being evaluated. Navigation services are vital to meeting people's wider holistic needs, supporting vulnerable people and providing a link between statutory and voluntary sector services.

Integrated Urgent Care

We continue to progress our work to develop an urgent care system that:

- Triages and navigates people to the most appropriate place at every entry point into the system,
- Develops strong and effective community based services as an alternative to hospital wherever possible.

Since June, there has been a broad programme of work in City and Hackney to deliver the 'Think 111 First' agenda. This is a national incentive that aims to increase the capability and capacity of 111 services so that they can successfully resolve more issues and are appropriately book patients directly into a wider range of hospital, community and primary care services. The national ambition is to reduce the overall pressure on hospitals where patients can be appropriately managed within primary or community services, and also introduce direct booking from 111 into EDs, in order to reduce crowding and therefore reduce the risk of nosocomial infection in departments.

Within Hackney, we have worked with local and North East London (NEL) partners to deliver this agenda, and have achieved the following:

- We have increased capacity within the NEL 111 service to improve access. We are also monitoring the service closely to ensure that it is effectively clinically triaging patients.
- We have increased the number of primary care slots available for 111 to book into, supported by improved technical interoperability between 111 and GP systems. We have also agreed a chest pain pathway which will allow 111 to safely book certain presentations of chest pain into primary care that would previously have always been conveyed to hospital. This is the first of a number of clinical pathways that we plan to launch.
- We are piloting a pathway from 111 directly into the Homerton Early pregnancy unit so that women who have complications surrounding their pregnancy can be directed straight to a specialist clinic from 111. This is our first pilot of patients being referred from 111 directly into a hospital specialist service.
- At the end of November we will enable direct booking from 111 into the Hometon ED. This means that, rather than just being told to go ED, 111 book them an appointment slot in ED within a clinically appropriate time window. This should support a better patient experience and also minimises risk of crowding in waiting rooms and EDs.

Through all of these actions there is an aspiration that people use 111 as an alternative to walking to ED. We do recognise that 111 is not used by all of our local population. We have continued to inform patients to call their own GPs during practice opening hours as we still think that this is the best entry point into the urgent care system for most people. We also continue to offer walk in access to EDs.

A new *High Intensity User Service* started 1st April 2019 to support frequent attenders to A&E and frequent callers to 111 and 999. The service is provided in partnership between ELFT, the Homerton, Family Action and the Hackney Volunteer Centre and addresses patients' physical, psychological, and social issues. A six month interim evaluation of the service showed that it is effectively supporting people and reducing inappropriate use of urgent care services, we are currently undertaking a further evaluation to determine the long term service model.

Discharge

We continue to see the benefit from bringing together hospital, local authority and voluntary sector partners to support improved discharge for our residents. Through the pandemic there was increased focus on discharge and step down services in order to reduce unnecessary pressures on hospitals and also to ensure safe and appropriate step down services.

A new national discharge protocol was launched in August. In the main, this guidance aligned to our local ambitions as it promotes a multi-disciplinary discharge service and use of the 'home first' model, whereby patients receive assessments for ongoing care at home.
The policy requires services to determine whether a patient has a 'right to reside' in hospital, and if they do not, that they will discharged on the same day. We do not think this language is helpful, and the policy does not adequately describe how patients will be involved and supported through their admission in advance of discharge. Therefore we are working locally to ensure that patients are well informed about discharge processes throughout their admission, including agreeing the expected data of discharge with them as early as possible.

Key achievement in Hackney include:

In line with the guidance we have put in place a new Discharge Single Point of Access (DSPA) which includes staff from the Integrated Independence Team (IIT), Adult Community Rehabilitation Team (ACRT) the Integrated Discharge Service (IDS) and Age UK. The team will support wards and help the system to fully embed a discharge to assess (D2A), home first model.

We are expanding the Take Home and Settle discharge support service from Age UK. This was initially a short term agreement through the pandemic, but has been extended to the end of the year. The expanded service includes more capacity in the core service, a handyman service to provide small home improvements to enable discharge and also a small humanitarian fund that staff could use to purchase anything that would better support people following discharge such as food, clothes and bedding.
It is worth acknowledging that during the pandemic Age UK worked well beyond their service criteria to provide practical and emotional support to a wide range of vulnerable people including homeless people placed in temporary accommodation who were not part of the discharge cohort.

We are setting up a dedicated team based in the Homerton to support hospital and discharge pathways for homeless people. The service is based on a model advocated by the Pathways charity, which sees a hospital admission as an opportunity to engage with homeless people to support their immediate health and care needs, facilitate a safe discharge and guide them into ongoing services as required. The team comprises a GP, nurse, therapist, social worker and housing officer. Whilst the work to develop this team started well in advance of the pandemic, the rising inequalities and specific risk to homeless people from the pandemic and the response to the pandemic have further demonstrated the need for this.

There has been extensive, system wide support to care homes within City and Hackney. This included ensuring each home had a dedicated GP and community services provision, including regular patient reviews, delivery of regular training to care homes on a range of issues and mutual aid support with PPE supplies. We have had very good primary care services to the nursing homes in Hackney for a number of years, however, through the pandemic we also put in place better services to all care homes, including those for mental health and learning disabilities.

End of life care

There was significant cross-system work to improve end of life care across the borough through the pandemic. This was undertaken rapidly and in very challenging circumstances, and was a real testament to clinical colleagues from St Joseph's, Homerton geriatrics and palliative care teams, community nursing, Marie Curie, Paradoc, care homes primary care and adult social care.

We developed new primary care guidance for end of life so that GPs could better support people in the community. This was enabled by access to end of life medicines in the community and on-line training on a range of topics provided by St Josephs and Homerton specialists. Homerton geriatricians and St Joseph's also provide a telephone hotline to provide advice to all health and care professionals, this was widely publicised and utilised.

We already have a well established care planning process in City and Hackney, utilising an electronic tool, 'Co-ordinate my care' (CMC) which all partners can view in order to ensure that people receive the care that they want in an emergency situation. Through the pandemic, GPs spoke to many of their most vulnerable patients to ensure that their care plans were up to date and reflected residents wishes.

In January 2020 we launched a pilot Urgent end of life care service, which provides rapid access to palliative care in the home for people that are in the last few weeks of life and want to die at home. The service is provided by Marie Curie and runs overnight, which is when there is a gap in current services. This service provided much needed support to residents, including both covid deaths and deaths from other causes.

The St Joseph's Hospice Bereavement service was expanded during the pandemic to provide services to children and young people who have suffered a bereavement, in addition to the adult bereavement service they already provide to all residents of City & Hackney. Additionally, the team has provided some specific training to local IAPT providers on traumatic bereavement. Information leaflets for the bereaved have been produced by the NEL team, and signposting to bereavement services has been included as part of the Hackney volunteer hub, while consideration of referral to appropriate (traumatic bereavement) services following a suicide has been included in the suicide response framework.

Winter planning

The ongoing pandemic and the risk of a concurrent flu outbreak as well as 'normal' winter pressures mean that the pressures on health and care services could be unprecedented over the next few months. As such, we have taken a broader and more comprehensive approach to winter planning.

Historically winter planning has been a discrete exercise involving mainly urgent and emergency care (UEC) services/partners. This year, we have taken a whole system approach to planning for and minimising the risks from the coming winter and second covid peak. This means that a wider range of services have undertaken winter planning to ensure service continuity, and also to consider their role in keeping people well over winter. This has included community health services, primary care, community pharmacy, learning disabilities and prevention services.

There has also been a much stronger, whole system focus on flu, ensuring that we are prepared for a potential outbreak and considerable work to increase uptake of vaccinations.

4. Workstream structure and governance

In March, we ceased the unplanned care programme board, initially in order to allow partners to focus on the pandemic response. We have subsequently not reconvened this

board. This is in part because the interim structures put in place during the pandemic have brought together the same partners and played an equivalent function as the unplanned care board and, in part, because of broader system structure shifts that are currently underway to form an Integrated Care Partnership Board and a Neighbourhoods Health and Care Board. Since March the workstream objectives have been overseen by the System Operational Command Group, which was initially put in place as a short term response to the pandemic, but now provides a wider role to bring partners together to support recovery from covid and covid preparedness over a six to twelve month horizon.

5. Outcomes and Performance

Historically, the two key performance metrics that the workstream oversees were the A&E four hour wait, and delayed transfers of care (DToC).

Since March 2020, hospitals were asked to stop reporting DToC numbers in order to reduce bureaucracy and reporting burden on hospitals and local authorities. DToC is unlikely to be re-introduced as a metric, and will likely be replaced by something that aligns to the new national discharge policy. Locally, the Discharge team in the Homerton have maintained a log of patients that are ready for discharge in order to support operational delivery. Now that the new service is in place we will reinstate appropriate local reporting on discharge delays in advance of a national measure.

Performance against the A&E four hour wait has continued to be reported, although there has been no national or regional scrutiny on this metric. Homerton continues to report excellent performance, in 2020/21 the trust has achieved 94.39% patients treated and left the department within 4 hours, against 79.78% across NEL.

Preventing emergencies and reducing inappropriate use of emergencv services is a key measure of success for the workstream, and we monitor ED attendances and emergency admissions as a measure of success. However, this year, emergency activity has been driven by the pandemic rather than services or interventions by the workstream therefore this data is not a useful comparison. There was a large reduction in emergency admissions from the end of March throughout the summer, which gradually increased back to the levels of previous years by September. The reduction was the result of the pandemic and the lock-down, with far fewer accidents taking place and reticence to seek health care by many people.

Significant work was undertaken through the summer to both reassure people that the NHS was open and safe to attend, and also by GPs to undertake reviews of vulnerable people and those with long term conditions, in order to identify any deterioration in conditions through the initial lock down.

6. Financial Performance

As part of national emergency measures, all NHS trusts were given a nationally prescribed block of funding for 2020/21. This means that there is no possibility for the system to either overspend or make a financial saving if hospital activity increases, or is within plan. Furthermore Trusts, CCGs and Local authorities have also, at various points, been given some additional resources for specific elements of the covid response.

As such, the normal financial arrangements that underpin the workstream have not been applicable this year. Each organisation has continued to work to deliver a balanced budget.

The financial regime for 2021/22 has not yet been set.

7. Risks and Challenges

Although the workstream board is not meeting, risks are monitored by the workstream team and have continued to be reported to the Integrated Commissioning Board. The following are the top rates risks within the scope of the workstream.

Issues, risks and challenges:	Progress/ Actions being taken to address:
Risk that there is an increase in non-elective acute demand - either driven by a return to normal levels of admissions or a further peak in COVID-19 demand.	• Delivery of the 'Think 111 First' to reduce A&E attendances • Implementation of a wide range of measures to strengthen community support including Neighbourhood Multi-Disciplinary Teams, Primary Care Long Term Condition Management and the Urgent end of life care service • Escalation plans in place in HUHFT in advance of further COVID-19 peaks. • Bed modelling in place across North East London to understand demand and capacity in relation to a second peak and winter – this is refreshed weekly • Comprehensive Winter Planning Process in place.
Risk that we do not understand and/or do not reduce the impact of health inequalities for local populations across the workstream, and this is exacerbated in the context of the COVID-19 pandemic.	• The neighbourhoods programme is focused on addressing inequalities: • The neighbourhoods approach means that we take a population health approach across a small population of 30-50,000, which allows a very local focus on health needs and inequalities • Work with the voluntary sector within each neighbourhood to identify of inequalities and in-reach into particular communities • New and enhanced services for our most vulnerable residents, including homeless people and those in care homes • Use of the City and Hackney inequalities matrix and equality impact assessments to support planning and any changes to services

8. Conclusions

The work described in this report will continue to be driven by partners in City and Hackney through the remainder on 2020 and into 2021. Looking forward, we will be supporting the development of new system structures in City and Hackney. We will also be working with services to manage within the context of the continuing pandemic.

Whilst 2020 has brought unprecedented challenges to the health and care system, the commitment, compassion and dedication shown by staff across health and care services over the last eight months cannot be overstated.

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Unplanned Care workstream director,
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