| Healthier Communities Select Committee | | |
|---|---|---|
| Title | System Resilience 2014/15 | Item 3 |
| Contributors | Claire Champion, Director of Nursing & Clinical Services; Deputy Chief Executive, Lewisham & Greenwich Trust; Martin Wilkinson, Chief Operating Officer, Lewisham Clinical Commissioning Group; Aileen Buckton, Executive Director, Community Services, LBL | |
| Class | Part 1 (open) | 21 October 2014 |

## 1. Purpose

The purpose of this briefing is to provide an update on progress of the development of the System Resilience plans for Lewisham.

## 2. Recommendations

Members of the Healthier Communities Select Committee are asked to note the update on System Resilience.

## 3. Background

System Resilience Plans

3.1 The plans for system resilience were released by NHS England (NHSE) in June. The plans mark a 'shift change' in the way that NHSE envisages pressures across the system are managed and aim to set a framework by which health economies can more effectively balance elective and non-elective workloads. The guidance proposes that Urgent Care Working Groups evolve into System Resilience Groups (SRGs), which as well as having a remit to look at Urgent Care, also lead; on demand and capacity, the coordination and integration of services and are responsible for achievement of both the 95% standard and Referral to Treatment (RTT).

3.2 SRGs are chaired by a Clinical Commissioning Group Chief Officer with support from strong clinical leadership, and have representation from acute Trusts, mental health Trusts, adult social care, community services, the LAS, NHSE Area teams, and patient groups. The core responsibility of SRGs is to produce overarching system resilience and capacity plans. These plans demonstrate how the whole system is being managed to ensure delivery of key targets and will be reviewed throughout the year.

3.3 The Bexley, Greenwich & Lewisham SRG was formed in June 2014 and developed its system resilience plan for submission on 30 July 2014. The plan went through a process of risk assessment and was signed off by the regional tripartite panel (NHS England, NHS Trust Development Authority and Monitor) in late September 2014. As part of this process the Bexley, Greenwich & Lewisham system resilience plan was categorised as high risk – in reference to historical performance (financial and operational) across the whole health economy, and the level of complexity of the plans (most notably within the sections relating to capacity and performance recovery in support of Queen Elizabeth Hospital).

3.4 The plans are monitored at the SRG meetings, which are held on a monthly basis. In line with the guidance provided by NHSE, the Bexley, Greenwich & Lewisham system resilience plan includes the following principles;

- Improvements to 7 day working so that there is a consistent and coherent plan across primary, community, acute and social services.
- Extensively modelled demand, capacity and scenario plans for the whole system to ensure that all services are not continually operating at full capacity. This includes community, adult social care, mental health and primary care as well as acute Trusts.
- Spending plans for all non-recurrent monies including marginal tariffs, winter monies, Better Care Fund and CCG discretionary funding.
- Evidence that ambulatory care services, rapid assessment and treatment systems and more effective discharge planning processes are in place across all systems.
- How SRGs are planning to manage the highest intensity users within Emergency Departments.
- How 'real time' data will be used to provide a strong analytical approach to future planning, including data from non-acute settings.
- Development of whole system urgent and emergency care flow models which map out what good looks like, and how patients will flow from one service to another.
- Reviews of patient access policies for 18 week pathways and that each specialty has an expected Referral to Treatment (RTT) timeline to show when in the pathway decisions need to be made in order for breaches to be avoided.
- A validation exercise (if not performed within the last 6 months) on all RTT data, and development of a PTL that can be used across the system.
- Improvements in discharge planning, including the use of 'trusted assessors' across the system to reduce Delayed Transfers of care from hospital to the community and allow for better use of services and reduction in duplication.
- Better working with ambulance services to increase utilisation of Appropriate Care Pathways (ACPs).

Winter Funding

3.5 The allocation from NHS England across the three CCGs (Bexley, Greenwich & Lewisham) was £5.18m. The BGL SRG agreed an allocation principle of 60:40; more heavily weighted towards the schemes that are focused on providing additional resilience or capacity in-hospital, as compared with the schemes led by out of hospital providers to help reduce pressures in the Emergency Departments. This is in recognition of the on-going capacity and performance challenges, particularly at the Queen Elizabeth Hospital Emergency Department. This ratio represents a move towards greater parity of allocations for winter schemes compared with previous years, between initiatives in and out of hospital.

3.6 Schemes were agreed in August 2014 by CCGs prior to submission to NHSE. In September and October 2014 the SRG reviewed implementation and readiness of the winter plans to ensure that they were; (a) are joined up across the system and development of a process for evaluating the impact of schemes. On issuing guidance for system resilience plans, NHSE specified that the release of winter funding was

dependent on their approval of system resilience plans. That approval was confirmed at the end of September and the funding will be released in mid-October.

3.7 The schemes will commence from 1st November 2014 and run through to 31st March 2015. See Appendix 1 for bids that were submitted to NHSE for the Tranche 1 funding.

*Tranche 2 – Additional Funding*

On 26th September 2014 NHSE wrote to commissioners across London to advise that a further allocation of winter resilience would be made available to SRGs. This funding is aimed at capturing additional schemes that are not currently funded – but that SRGs believe will support further improvements in the delivery of urgent and emergency care between November 2014 and March 2015. The amount of funding available to the BGL SRG in this second tranche has not been formally set by NHSE. However, it is understood to be in the region of £5m. NHSE has stated that schemes which deliver the greatest impact are likely to focus on the following;

- Additional beds
- Liaison psychiatry in A&E
- Weekend discharge arrangements
- Weekend therapy and social care arrangements
- Weekend pharmacy and diagnostic support

3.8 The BGL SRG developed a set of bids in line with this guidance, which were submitted on 1st October 2014. In the development of the bids providers and commissioners were asked to ensure against duplication across bids from community/social care and acute providers, and from bids within the first tranche funding.

Winter Campaign; *'Not Always A&E'*

3.9 The *Not Always A&E* campaign was first launched across south east London at the end of October 2013. The campaign was developed in partnership with all the south east London Clinical Commissioning Groups and aimed to;

- Reduce the number of people attending A&E
- Better public understanding of A&E use and other primary and urgent care facilities available
- Encouraging self-management
- Targeting specific groups to help reduce health inequalities.

3.10 The *Not Always A&E* campaign used the Yellow Men: a family of sculptures, painted bright yellow and measuring seven feet tall, with each figure suffering from a different ailment – from an upset stomach to unstoppable bleeding. These figures were installed in busy public spaces across south London with an accompanying launch event in each borough, creative advertising campaign and supporting multimedia (E.g. placement advertising on Buses and shelters, LBL JCD billboards) content. The independent evaluation of the SEL campaign found that; 40% of responders 'unprompted' recalled the campaign; 57% recalled the message that A&E is for

emergencies only; and 58% of responders stated that they would change their behaviour because of the campaign.

3.11 The 2014/15 campaign commissioned by Lewisham CCG will be launched in November 2014. The overall campaign message will continue to be *'Not always A&E'* and will promote key messages to the public on the appropriate use of A&E, the Urgent Care Centre, utilising GP Surgeries, Pharmacies and better self-care/management. However, the campaign will specifically emphasise the availability of and access to GP out of hour's services. This was as a direct response to public engagement events undertaken by the CCG over the past year, where members of the public demonstrated a lack of awareness and understanding of GP out of hour's services. The multimedia campaign will be similar to 2013/14 but will include a double-page in *Lewisham Life* (distributed to all households) in addition to leaflets in school bags and distribution to voluntary partners/organisations, public buildings, Pharmacies and GP surgeries.

## 4. Emergency Services Review

4.1 The Healthier Communities Select Committee (September 2013) reviewed Emergency Services in the borough and made 8 recommendations to providers and commissioners. The recommendations in summary centred on; managing demand and capacity across the system and ensuring effective service planning; providing access to appropriate out of hours and urgent care services; enabling timely discharging planning recognising the interfaces with adult social care; and developing effective messages to the public in accessing A&E and emergency services.

4.2 The 2014/15 System Resilience Plans and Winter Schemes will address and support the recommendations made by the committee. System Resilience by its very nature and as outlined Section 3.1 adopts a 'system-wide approach' to planning, managing demand and public engagement.

4.3 In addition, Lewisham & Greenwich Trust in partnership with Lewisham CCG submitted bids for Tranche 2 Winter funding to support improvements to the urgent care pathway.

## Contacts

Tom Bunting, Urgent Care Project Manager, Bexley, Greenwich and Lewisham CCGs.

Diana Braithwaite, Commissioning Director, Lewisham CCG

Jo Gennari, Head of System Resilience, Lewisham & Greenwich Trust

Joan Hutton, Interim Head of Adult Assessment and Care Management Community Services, LBL

## Appendix

Appendix 1: Summary of BGL SRG Tranche 1: 2014/15 winter bids (relating specifically to Lewisham)
Appendix 2: Capacity Solutions to support patient care at Queen Elizabeth Hospital 2014/15.

**Appendix 1 – Summary of BGL SRG Tranche 1: 2014/15 winter bids (relating specifically to Lewisham)**

| Scheme | Expected Benefits |
|---|---|
| **Lewisham & Greenwich NHS Trust** | |
| Weekend Discharge Consultant (Both sites) | This project increases the levels of discharges on weekends and in particular for those admissions from Thursday/Friday who may not otherwise get a consultant review over the weekend. Senior support also provided to the medical on take teams reduces avoidable delays and supports early decision making. |
| Dedicated Nurse and HCA for LAS arrivals (QEH) | LAS waits are a regular issue for ED at QEH and a dedicated resources to support offloading and triaging this patient group. |
| Dedicated Flow nurse (Both sites) | A senior nurse on a 12 hour shift during peak activity working to manage patient flow, challenge delays and ensure all members of the team are working to expedite a patients journey through ED. |
| Additional SPR on night shift (Both sites) | Increasing the levels of senior decision makers on shift has had a significant positive impact on performance and on reducing out of hours breaches, particularly amongst the patient group who are discharged home. |
| Additional porter out of hours to speed up patient flows (Both sites) | This was highly successful in winter 2013/14 in reducing the numbers of avoidable delays for ward transfer and to diagnostic services. |
| 4 hour co-ordinator (Both sites) | This post will work alongside the flow nurse in ED to manage patient flow and ensure that referrals to specialist teams are made in a timely manner reducing the numbers of 4 hour breaches. |
| Additional nurse on night duty in UCC (UHL) | UCC increasingly busy overnight additional nurse on shift to support SPR and manage surges in activity. |
| Provision of winter escalation areas as required (Both sites) | One escalation ward per site (Foxbury/Sapphire ward UHL). |
| Weekend Therapy Intervention (Both sites) | Increase levels of assessment at weekends and reduce avoidable delays. Home Access visits at weekends to ensure discharges are not delayed. |
| Additional Vehicle to support discharges (Both sites) | On both sites late transport leads to cancelled discharges. This will provide an additional vehicle to concentrate solely on discharges at the time of peak departures from the ward reducing cancelled discharges. |
| Extended day working in Radiology (Both | The provision of weekend MRI and CT as well as an EPAU service will ensure that vital diagnostics to support decision |

| | |
|---|---|
| sites) | making and discharges are not delayed over the weekend period. |
| Additional Senior Medical staff in evenings (Both sites) | Activity in paediatric ED increased in the late afternoon and evening during winter 2013/14 – the provision of senior support at this time reduced breaches. |
| Additional nurse in ED (UHL) | This will support patient flows from ED onto the wards and ensure patient safety at all times. |
| Additional ED nursing (QEH) | This will provide an additional nurse in paediatric ED to manage patient flow and liaise with HPAU. |
| Pharmacy Runner (Both sites) | This was a success in 2013/14 and ensured that urgent TTOs for discharges were not delayed waiting for the main pharmacy rounds. |
| Rapid Response HCA team (UHL) | A team of HCA who are trained to take blood and ECG and provide care wherever needed, able to respond to surges in activity under the direction of the lead nurse and reduce avoidable delays. |
| **London Borough of Lewisham/Lewisham CCG** | |
| Enablement Care Services and Equipment | To support the increase in Supported Discharge and Admission Avoidance provision we need to increase the amount of Reablement/Rehabilitation care (Enablement) provided in the community to help people reach their optimum level of independence. This will increase the capacity to allow discharges to take place during weekends and increase support to admission avoidance teams in keeping people in their own homes. A mixture of hands on care, equipment and aids to daily living will be provided to people in their own homes for up to a period of 6 weeks, closely monitored and evaluated by senior staff. |
| Enhanced Community Admission Avoidance Services | As part of winter 2013/14 Lewisham increased capacity of social workers, nurses and therapies working across the whole service and streamlined the hours of provision to cover weekend working. This scheme dovetailed with the additional capacity funded by LBL so going forward the service will be flexed across the system.<br>The aim of this is reducing admission and supporting discharge, reducing length of stay by providing support and an appropriate care package. The service dovetails with the development of the Appropriate Care Pathways (ACP) for Falls and the planned future development of COPD and Diabetes ACPs and the development of the 7/7 clinical specialist nurses in ED for Long-term conditions, providing a whole system approach to urgent care and the reduction of emergency admissions. |
| Continuing Care Assessments | We continue to see an increase in the needs of older adults particularly with dementia issues that need Continuing Care assessments completed. These assessments are complex and the quality of them needs to reflect the presenting needs. Due to the large increase in numbers in both Hospitals and |

| | |
|---|---|
| | Community we are seeing lengthy delays in decision making, thus people are often delayed in beds whilst the process is undertaken. In the community the process has not always been completed early enough which has led to patients not receiving appropriate Health and Social Care services that would prevent admissions to hospital. This could be prevented by completing the process faster and having the resources to deal with the demand. |
| **South London and Maudsley NHS FT** | |
| Enhanced Mental Health Liaison Team & Specialist Registrar cover at weekends | The proposed scheme involves the employment of an additional psychiatric liaison nurse working a twilight shift from 5pm - 2am, covering the busiest time in the ED for mental health presentations. This nurse would work differently from a normal PLN insofar as they would be based in the ED working alongside the ED Triage nurse, carrying out an initial assessment of the patient at the point of presentation. They would assess the patient using a specific assessment tool and decide whether the patient required to be referred on to the team for a full mental health assessment or if they could be re-directed from the ED in order to achieve help and support through an alternative service, such as referral back to GP, referral to a CMHT, Home Treatment Support, third sector agency etc. |

**Appendix 2** Capacity Solutions to support patient care at Queen Elizabeth Hospital 2014/15.

## 1 Introduction and background

The Queen Elizabeth Hospital (QEH) is a District General Hospital, now part of Lewisham & Greenwich NHS Trust (The Trust), providing a wide range of local services to the populations of Greenwich and Bexley. Since the closure of acute services in 2010 at neighbouring Queen Mary's Hospital (QMS) in Bexley, and due to demographic changes and other factors, the number of emergency patients presenting at the QEH Emergency Department (ED) and the number of patients being admitted has risen to an unsustainable level. There is a national picture of a general rising tide with 5.9% more attendances in 2012/13, than in 2009/10, but there is no simple explanation for this. This is matched by an increased number of acute admissions putting pressure on beds. Nationally there were 10.6% more emergency admissions in 2012/13 than in 2009/10. There is general consensus that patients presenting are more ill and hence more likely to need admission and have longer stays.

**Table 1 QEH A&E attendances for the last 3 years split by CCG (top 4), further split by ED, UCC and total**

| | ED | UCC | Grand Total |
|---|---|---|---|
| **2011/12** | **91,034** | **40,057** | **131,091** |
| NHS GREENWICH CCG | 59,748 | 28,802 | 88,550 |
| NHS BEXLEY CCG | 25,514 | 8,316 | 33,830 |
| NHS LEWISHAM CCG | 1,237 | 616 | 1,853 |
| NHS BROMLEY CCG | 1,058 | 340 | 1,398 |
| Other | 3,477 | 1,983 | 5,460 |
| **2012/13** | **94,830** | **40,830** | **135,660** |
| NHS GREENWICH CCG | 61,660 | 28,982 | 90,642 |
| NHS BEXLEY CCG | 27,104 | 8,744 | 35,848 |
| NHS LEWISHAM CCG | 1,360 | 565 | 1,925 |
| NHS BROMLEY CCG | 1,153 | 397 | 1,550 |
| Other | 3,553 | 2,142 | 5,695 |
| **2013/14** | **94,484** | **43,764** | **138,248** |
| NHS GREENWICH CCG | 60,592 | 30,816 | 91,408 |
| NHS BEXLEY CCG | 27,976 | 9,699 | 37,675 |
| NHS LEWISHAM CCG | 1,194 | 605 | 1,799 |
| NHS BROMLEY CCG | 1,183 | 404 | 1,587 |
| Other | 3,539 | 2,240 | 5,779 |

**Table 2 Number of admissions via A&E for the last 3 years and by CCG (top 4)**

| Admissions | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| NHS GREENWICH CCG | 11,951 | 17,212 | 17,696 |
| NHS BEXLEY CCG | 7,669 | 11,093 | 11,107 |
| NHS LEWISHAM CCG | 374 | 589 | 461 |
| NHS BROMLEY CCG | 307 | 495 | 427 |
| Other | 1,083 | 1,753 | 1,446 |
| **Total** | **21,384** | **31,142** | **31,137** |

There is a longstanding mismatch at the QEH between acute capacity and patient demand. The marked increase in admissions between 2011/12 and 2012/13 reflects the closure of the ED at QMS. This was coupled with an increase in out of Borough admissions ( Bexley) leading to longer lengths of stay. The steadying of admissions in 12/13 and 13/14 is a reflection of the increase in patients being admitted to ambulatory care, coupled with an increase in community admission avoidance activity.

However, in the current year we are once more seeing admissions rise. Pressure on beds at QEH is also steadily increasing with the phased closure of the acute beds on the QMS site. The development of the Midwifery led Birth Centre had led to a loss of 13 beds on Ward 6. This together with other closures has resulted in the acute bed base deficit at 90% occupancy being **82** beds, based on 2013/14 activity levels and length of stay (LOS); this figure is accepted by Lewisham, Greenwich and Bexley Clinical Commissioning Groups (CCGs).

This target occupancy level is higher than recommend for Acute Medical Units where it is recommended it stays below 85-90% utilisation at all times so that it has capacity to care for the anticipated number of arrivals hour by hour. However it is mutually recognised by the Trust and local commissioners that this target occupancy level is an unrealistic aspiration at this time. *Planning for predictable flows of patients into unscheduled care systems beyond the Emergency Department: Meeting Demand and Delivering Quality. (February 2010) ECIST*

The impact of this acute bed deficit is that the ED becomes blocked with patients where a decision to admit (DTA) has been made but no bed is available. This causes a bottleneck that has an impact all the way down the emergency pathway. Patients cannot be placed in cubicles to be treated, causing long queues and overcrowded waiting areas; ambulance crews cannot hand over patients to ED staff and can queue for up to several hours - in extreme circumstances this can lead to delays waiting to off load from vehicles.

In its planning guidance to CCGs published in December 2012, NHS England highlighted the importance it puts on commissioners and providers ensuring that waiting times for patients in A&E departments are kept to a minimum. It has set out that the NHS Constitution minimum of 95% of patients to be admitted, transferred or discharged within 4 hours of their arrival must be met. The QEH cannot deliver this level of performance and meet this standard under existing conditions.

Long waiting times in ED (often experienced by those awaiting admission and hence ill patients) not only deliver poor quality in terms of patient experience, they also compromise patient safety and reduce clinical effectiveness.

The ED and the emergency care pathway at QEH were identified within the Care Quality Commission (CQC) in January 2014 as "inadequate" therefore LGT's most serious quality and safety risk, affirming the Trust's own concern with this area. They summarised:

- *On the Queen Elizabeth site the A&E environment is not considered by the inspecting team to be fit for purpose.*
- *Space in some areas, e.g. A&E at Queen Elizabeth site, was limited, and the volume of work had risen significantly. Ambulance staff were frequently delayed or unable to hand over patients to the A&E team.*
- *We saw a shortage of beds for admission to the hospital. This created a block in the system particularly for patients from A&E. This meant that their admission was often delayed.*
- *Care and treatment at QEH was not always responsive. There was normally a lack of bed capacity at the hospital despite escalation wards being utilised.*

The Trust, along with partners in the health economy under the governance of the local System Resilience Group (formerly known as the Urgent Care Board) are developing a range of approaches to address the QEH capacity deficit. A number of schemes are being developed or are in place:

- to review care before attendance at ED.
- to give an alternative to inpatient admission.
- to review flow though hospital and reduce acute length of stay.
- to review discharge arrangements and use of out of hospital capacity.
- to develop some temporary and permanent additional capacity.
- potential transfer of complex elective inpatient activity from QEH to UHL (long term scheme).

There is extremely limited potential to create new permanent ward facilities at the QEH. A twelve bed Clinical Decisions Unit is being created to be an integral part of the ED, but this is the only new inpatient capacity that can be developed under existing arrangements.

**'Doing nothing' is not an option, and the Trust - in partnership with CCGs and other health and social care providers - needs to ensure that additional capacity is delivered as soon as possible to ensure that patient safety is maintained at the QEH site.**

## 2 Capacity considerations

2.1 Elective activity: The Trust has frequently had the suggestion presented to it at times of peak pressure to limit elective surgery to support emergency activity. The latest guidance *Operational resilience and capacity planning for 2014/15, 13 June 2014. Prepared by NHS England, the NHS Trust Development Authority, Monitor, and the Association of Directors of Adult Social Services* makes it clear that elective care and performance against the 18-week Referral to Treatment standard should not be compromised simply to deliver emergency care standards. In any case, very little inpatient elective surgical care takes place on the QEH site now as the emergency pathway has become dominant. The majority of elective surgery including non-complex inpatient surgery takes place under a hosted arrangement with Dartford and Gravesham NHS Trust at QMS, and this inpatient work will transfer to UHL in November 2014. (The change in the elective surgery pathway was undertaken by the

predecessor organisation South London Healthcare NHS Trust as one measure to reallocate beds at QEH to emergency patients.) There are no escalation areas available for this winter at QEH, as the surgical day care unit has been taken over for inpatient care continuously for the past year as the numbers of patients awaiting admission has remained consistently higher than the number of beds available.

2.2 Alternative use of UHL space: A number of clinical options have been considered and piloted to ease the situation, including making medical ward capacity at UHL available to QEH patients. This summer the Trust trialled a 'treat and transfer model' for lower acuity inpatients, and for new patients requiring admission, as well as a redirect model for ambulances. For a variety of reasons it has been very difficult to make such models useful in a sustained way. The clinical pathways are difficult to manage, and clinical risk is increased by adding a hospital transfer for non-clinical reasons in an acute patient's pathway.

## 3 Other capacity schemes

The pressure will be eased from the QEH ED by improving the environment and creating capacity through a number of different schemes. These are being presented to the Board in a separate paper but a brief summary is given here.

a) The fracture clinic adjacent to ED will be relocated in order to create a 12 bed Clinical Decision Unit (CDU) from which patients can either be admitted to a ward bed or discharged. This does not directly increase the bed stock for admitted patients though it will greatly improve the flow of patients through the ED department and increase the supervision of those requiring observation and investigations.
b) A discharge lounge is being created along the West corridor that will be larger and bespoke in order to manage the flow of patients from the ward areas thereby creating beds earlier in the day.
c) As inpatient elective surgery moves off the QMS site and to UHL the 28 bedded ward will be used for elderly patients who require nursing care prior to further placement or discharge. This will increase the bed stock available to QEH by 28 beds, but for lower acuity patients who do not require constant medical attention.
d) There are a number of schemes underway by both LGT and the commissioners to reduce the need for beds through reducing length of stay or avoiding admissions altogether through enhanced community services. These are in motion now and over the course of the year should release up to 9 beds by April 2015, increasing to 16 beds over 15/16..
e) The Eltham Community Hospital for Greenwich is planned to open by February 2015 offering a further 14 beds into the wider system for patients with rehabilitation or sub-acute needs who do not fulfil the criteria of current community beds.

## 4 The Stroke Service

The measures outlined above do not close the 82 bed gap. A review of bed occupancy at QEH was undertaken to assess whether any patient cohorts were unnecessarily placed in these beds. The stroke service was identified as deserving consideration because early investigations demonstrated improvements to care could be made if there were changes to the stroke pathway. Currently the majority of stroke patients go first to the Hyper Acute Stroke Unit (HASU) either at King's College Hospital NHS Foundation Trust's Denmark Hill site

(KCH) or the Princess Royal University Hospital in Bromley (PRUH), and then move to an Acute Stroke Unit (ASU) bed within their local hospital if they require further medical care. Greenwich and Bexley both have an enhanced early discharge service in order to avoid moving patients from the HASU to a local hospital and instead placing them back in their own homes with intense support from therapists and nurses to maximise rehabilitation potential.

For those patients not suitable for a directly discharged pathway, there is a serious issue with the Trust's ability to repatriate patients from the HASUs in a timely way. Once a patient is medically fit for transfer and the referral is accepted, transfer should take place within 24 hours. LGT rarely achieve this, and this is particularly difficult at QEH because of the poor bed availability profile. Patients can wait many days or even weeks to be repatriated. At the last Stroke Unit Assessment, UHL only admitted 61% of patients in the required timeframe. QEH was only able to admit 43% of patients in that time frame.

Table 3 shows the total number of patients admitted to the ASU at QEH from PRUH HASU in 2013/14.

**Table 3**

| BOROUGH: | From PRU HASU | From KCH HASU | TOTAL |
|---|---|---|---|
| **Bexley** | 74 | 5 | 79 |
| **Greenwich** | 47 | 23 | 70 |
| **TOTAL** | 121 | 28 | 149 |

Table 4 shows the number of patients discharged from the PRUH's HASU to out of hospital care in 2013/14. There were 47 Greenwich stroke patients admitted to QEH's ASU after leaving the HASU, however 57 Greenwich stroke patients altogether were admitted to a ward. We assume that the other 10 patients were admitted to UHL because of vagaries in the 'look up tables', although patient level detail has not been investigated. 51 Greenwich patients (47%) were discharged to out of hospital care settings. There were 74 patients from Bexley admitted to QEH's ASU from the PRUH, and 74 (50%) of Bexley patients admitted to the PRUH HASU for the year were discharged to out of hospital care settings.

This data is not currently available for KCH HASU patients, but is expected to be broadly similar. However, Oxleas and LGT do not run an in-reach pathway to KCH so potentially the number of patients who were discharged home is smaller.

**Table 4**

| Greenwich 2013/14<br>Discharge Destination from PRUH HASU | Total |
|---|---|
| NHS Hospital - Ward for General Patients or the Younger Physically Disabled | 57 |
| NHS Run Nursing Home, Residential Care Home or Group Home | 2 |
| Usual Place of Residence | 49 |
| **Grand Total** | **108** |

| Bexley 2013/14<br>Discharge Destination from PRUH HASU | Total |
|---|---|
| NHS Hospital - Ward for General Patients or the Younger Physically Disabled | 74 |
| NHS Run Nursing Home, Residential Care Home or Group Home | 2 |
| Non NHS Residential Home (other than Local Authority) | 2 |
| Temporary Place of Residence | 1 |
| Usual Place of Residence | 69 |
| **Grand Total** | **148** |

The Trust is therefore piloting a plan to consolidate the stroke service within LGT by moving the ASU (28 beds) based at QEH onto the UHL site in November 2014. In the proposed pilot, patients who are fit for discharge from the HASU but require further inpatient medical care, would come to a combined ASU at UHL, before moving to a community setting or back to their home. The unit will serve Greenwich, Lewisham and Bexley residents.

An additional ward is being developed at UHL in a 'mothballed' paediatric ward (following the move of children's inpatient surgery to GSTT a few years ago) that is being designed to meet the needs of this group of patients, with therapy services designed into the new ward layout in the same way that the existing stroke ward is designed. This will significantly improve the facilities available for stroke patients from Bexley and Greenwich. The number of beds remains the same, but amalgamated on one site. As more patients are discharged from the HASU to home, or reduced length of stay in the ASU is achieved, capacity will be available to improve our ability to repatriate patients requiring admission to the ASU.

Making these changes will provide a further 28 additional acute beds at the Queen Elizabeth Hospital for patients who need to be admitted for treatment after being seen in the emergency department. This is vital for our plans to improve emergency services and the emergency pathway, while also enhancing patient safety and the patient experience.

The acute nature of the work undertaken on a stroke unit would preclude the use of Queen Mary's Hospital as an option as there is an inadequate infrastructure to support the acuity of the patients. On admission to a stroke unit patient needs can still require an intense level of support and thus on safety grounds this unit needs to be located on an acute hospital site with full medical and critical care support available 24 hours a day.

This scheme will commence in November 2014 when the new ward at UHL is commissioned and handed over to the Trust. There are no cost savings being identified as a result of this plan and the new ward can be re-commissioned to provide other acute services should the pilot fail.

## 5 Benefits to Consolidating Stroke Care at UHL

UHL was the first London Acute Stroke Unit (ASU) to gain the top stroke quality and performance standards several years ago, and has maintained this position ever since. The only areas where the Trust requires improvement are in repatriation referred to above, and reducing length of stay. Although the QEH unit is now accredited, it has many more significant areas noted to require improvement, and lacks the facilities available at UHL. The two wards at UHL will provide this level of quality care to all patients, with a greater concentration of specialist medical, nursing and therapy staff to manage the specialist needs of these patients and patient access to specialised equipment, together with a purpose built rehabilitation gym, kitchen and social area.

By consolidating specialist services on one site, the Trust aims to reduce length of stay and support earlier discharge, which will release capacity to significantly improve/reduce our repatriation waiting times.

Oxleas and Greenwich social workers have already agreed to support this group of patients at Lewisham and plan to review this position on a week by week basis with LGT operations team to ensure we maximise benefits and manage any issues jointly. Bexley currently supply an allocated Social worker to work on the stroke ward, and we are actively engaged with Bexley social services to reach agreement to transfer this service to Lewisham. We support Bexley's request for resource to manage this and other demands and understand that this is likely to be supported through resilience funding. Lewisham has a long history of partnership working across Health and Social Care, and we would expect to extend this approach to building robust discharge pathways with both Bexley and Greenwich colleagues.

## 6 Travel times

The Trust expects more patients will be discharged home from the HASU, mitigating the additional travel time for visitors. Improved repatriation from the HASU will also mean patients treated at KCH are closer to home sooner. We recognise that ease of transport access will be a consideration for families and carers, especially for Bexley residents. Public train transport from Erith, Slade Green, Abbey Wood and Belvedere all run directly to Lewisham. There is also an 89 bus, which currently takes visitors from Bexley to QEH and continues on to Lewisham. This will add some additional time to the journey, but the Trust believes the patient care advantages to patients outweigh this disadvantage. The Trust recognises the importance of visitors to patients, and visiting times will be carefully reviewed to ensure that visitors can attend the ward at times that suit them and the patients. A full Equality Impact Assessment (EIA) considering issues such as access and travel times will be undertaken during the pilot phase and before the final review of the scheme.

## 7 Implementation

A project team has been set up that involves senior clinical and operational staff from LGT, Oxleas, Greenwich and Bexley Social Care to plan and manage this project.

The communications team have set out a communications strategy and are liaising closely with the executive team to ensure that this is managed appropriately.

The Whole Systems Improvement Groups on both QEH and UHL site are involved in overseeing the implementation of this service, and feedback directly to the Systems Resilience Operational Board.

Approval for the pilot has been obtained from the Trust Board and operational managers will work with the Strategic Clinical Network (cardiovascular and stroke) to ensure that the service is meeting quality standards, and with KCH to ensure that pathway changes from the HASU are well managed and deliver improved patient care.

We will formally review this pilot service model in Quarter One 2015/16, and will ensure that this is a whole systems review including activity, length of stay, outcomes, multi-agency impact, and patient experience.