1. Demand and Capacity

1.1 Demand

Introduction
The purpose of this paper is to provide additional narrative to explain the various elements that support the North Middlesex University Hospital NHS Trust (NMUH) Health Economy A&E Recovery plan, including the step change of the BEH Clinical Strategy implementation.

The part of the BEH Clinical Strategy which is relevant to this plan is the change to the A&E service at Chase Farm Hospital. Chase Farm Hospital A&E will cease in its present form from 3am on 9th December 2013. Alternative reprovision on the Chase Farm site includes 24/7 medical cover, with an Urgent Care Centre (UCC) open for 12 hours and out of hours GP provision for 12 hours.

The unscheduled care patient flow and demand this change provokes has been modelled through the BEH Clinical Strategy.

From the estimation of A&E activity, NMUH are expecting an overall increase of circa 26,000 attendances. This will take the total attendances at NMUH to circa 176,000 per year.

Currently circa 24,000 pa of the attendances at NMUH A&E go through the UCC. In the future it is planned that this figure will rise to circa 70,000. This brings the total through A&E down to 106,000 from current 126,000 and includes adults and paediatrics. However, the acuity of the A&E patients is expected to be higher overall as a result of UCC taking a higher share of lower acuity patients.

Admissions
The current average for admissions is 40 per day and we expect that (post BEH implementation) this figure will rise to circa 54 per day. This has been factored into the numbers of beds the Trust is increasing to as from December 2013.

Impact of demand
NMUH has worked closely with improvement advisory teams to diagnose the causes of performance problems and has undertaken its own analysis of root causes which have informed the Trusts recovery plan. The main focus is on the flow of patients into beds and the need to reduce the number of long staying patients. After failing in quarter 1, the Trust aligned improvement actions to provide a trajectory that recovered from quarter 2 onwards.

Preparation to accommodate the additional non-elective activity from Chase Farm is underway, both in terms of physical infrastructure, the implementation of new ambulatory care pathways and working towards 7 day provision of key resources and manpower.
As a result NMUH are also planning a number of other pathways to alleviate the flow into A&E. These include:

- Emergency Ambulatory Care: this is currently underutilised at NMUH and additional consultant presence which will start in November 2013 will increase the throughput in the unit is estimated to reduce 5 admissions a day and more if the Trust achieves 25% as per ECIST modelling
- Older People Assessment Unit: this is being introduced in October 2013 and with the introduction of a GP hotphone (to allow direct triaging of GP referrals by a consultant geriatrician) and will further support admission avoidance. This will also prevent readmission through the continuation of the day hospital route for planned care.
- Medical Assessment Unit: currently there is no distinguishing between the very short stay patients (less than 12 hours) and the 2 day stay patients on the Acute Medical Unit. The Trust is setting up a Medical Assessment Unit for GP expected patients and those from A&E that require a short work up and assessment before discharge home the same day. This will be a fast turnaround unit to improve flow. This will open during October 2013.
- Surgical Assessment Unit: NMUH is opening a surgical assessment unit to speed up the safe transfer of surgical patients away from the Emergency Department who may just need reviewing before coming back for a planned procedure the next day.
- Early Pregnancy and Gynaecology Assessment Unit: these are existing operational services, but NMUH are taking steps to increase the throughput through these units, ensuring all appropriate activity is diverted from A&E/UCC.
- Paediatric Assessment Unit: this unit will have increased staff from November 2013 facilitating the ability to take more patients than current resources support.

NMUH are also planning changes to key patient experience pathways to change the model of care to improve flow in the hospital. These are outlined below:

**ACUTE MEDICAL PATHWAY**

<table>
<thead>
<tr>
<th>Now</th>
<th>Future</th>
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<tbody>
<tr>
<td><strong>Pathway Now</strong></td>
<td><strong>Pathway Future</strong></td>
</tr>
<tr>
<td>▪ 24hr, 7-day, 48 bedded Acute Medical Unit (AMU), includes 9 medical side rooms used for medical patients &gt;48hr LOS</td>
<td>▪ 24hr, 7-day, 49 bedded short stay (72hr) AMU</td>
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<tr>
<td>▪ No 12hr assessment unit</td>
<td>▪ Introduction of 12hr, 06.00 – midnight, 7-day week, Medical Assessment Unit (MAU) with 10 assessment trolleys. Discharge, transfer to AMU or direct to the specialty wards as appropriate</td>
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</tbody>
</table>
All types of GP referrals
- GP referral requiring Resus will go directly to Resus
- All other GP referrals seen in ED by an ED doctor, triaged and then sent as per the normal ED admission pathway to AMU or ACU

Likely Medical admissions – these are currently triaged and treated in ED followed by a medical referral and medical clerking in ED

>75 year Hotphone

AMU consultant 08.00 – 19.00hrs 7 days per week

COE consultant 4 hours per day Monday to Friday

### AMBULATORY CARE PATHWAY

<table>
<thead>
<tr>
<th>Pathway Now</th>
<th>Pathway future</th>
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<tbody>
<tr>
<td>Ambulatory Care Unit (ACU)</td>
<td>Emergency Ambulatory Care Unit (EACU)</td>
</tr>
<tr>
<td>Operating 5 days a week</td>
<td>Operating 7 days a week</td>
</tr>
<tr>
<td>Most often (15 out of 20 patients a day) patients are triaged and treated in ED with a follow up appointment made the following day for further tests and treatment in ACU</td>
<td>There will be a consultant in the ACU able to accept patients on the spot from ED triage. The team will also in-reach into ED on a regular basis to pull people out into ambulatory emergency care. The default for</td>
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</tbody>
</table>
ambulatory patients will be EACU (ambulant patients with a MEWS score of below 3)

- Mainly pathway focused – ie. Specific pathways (DVT, Cellulitis) are flagged to go through ACU
  - The Consultant and team will be able to pull through into ACU any patient that would benefit from that service

### Day Hospital and ACU

- Traditional Day Hospital facility
- Activity, up to 20 per day, majority Early Supported Discharge (ESD)
- >75 year Hotphone but rarely used by GPs (2 calls per week)
- 3 consultant hours with junior doctor 9-5
- No therapy

### Planned care unit and Older Person Assessment Unit (OPAU)

- New MDT model of care
- Expand to focus on admission avoidance (AA): Hotphone, Taking patients from ED and direct from home on the day, GP referrals
- Planned 20% improvement in GP referral rates
- 6.5 consultant hours per day and registrar. In reach into ED (in conjunction with AMU COE cons)
- Dedicated Physiotherapy and OT. MDT input as needed. Review of re-attenders and discussion in teleconference.

### 1.2 Sizing additional capacity requirements

**Beds:**

A review, conducted in September 2013, examined the bed requirement within the context of health economy recovery and improvement plans with a view to using additional Winter pressures funding to best effect. The intention being to support the expected peaks in demand over the winter period. Plans include:

- PACE (LB Enfield), RAID Mental Health) and Rapid Response (LB Haringey) services will reduce the acute inpatient bed demand by 23 beds
- Length of Stay improvements will reduce demand by 11 beds
- Community step up and step down beds will increase winter capacity by 40 (21 Haringey and 19 Enfield)
- Additional acute beds for winter on the NMUH site will increase by 31
Workforce:
The North Middlesex workforce is in the process of further increases to support:
- 7 day working for therapies, pharmacy, imaging and phlebotomy
- Additional medical cover in A&E (adults and children)
- Additional trauma theatre capacity
Community workforce increases will support schemes to care for patients in their own homes or closer to home. All the above schemes will impact on efficiency and notional capacity. Impact is monitored through locally agreed acute metrics and a wider health economy dashboard is nearing completion by the CSU to monitor demand, delivery systems and getting people home.

1.3 Enhancing flow through discharge

Acute Hospital Discharge
1) Time of day
Performance standards have been agreed for morning discharges as part of our ‘10 before 10’ project. Currently the Trust is running at about 2-3 discharges before ten AM. The action plan to deliver this is well underway. The Trust has specific areas of focus including:
- Take home medication being done the day before
- Early blood tests for potential discharges
- Focused attention to patient transport needs to book transport in advance.
- Increased use of the discharge lounge
- Nurse led discharge improvements.

2) Length of stay
The NMUH Length of stay project is progressing and has recently been showing signs of improvement. The main thrusts of this campaign are focused on:
- Plan for every patient – this is an electronic plan focussed on A C E as detailed below.
  A: actions for discharge.
  C: clinical criteria for discharge
  E: Expected date of discharge.
  This has now been implemented on two wards and will continue to others over the next few weeks.
- Specific conditions focus – There is a focus of efforts on care of the elderly which the Trust recognises as an area of opportunity. The work here is around the GP hotphone for admission avoidance and better liaison with community and social care to reduce delays in transfers. There is a daily report of those patients who are ‘medically fit’ (no longer deemed to require acute hospital care) for discharge, which the Trust share with commissioners.
- Ward rounds: There is expansion of consultant time to allow more frequent ward rounds and ensure delivery against the London Quality standards.

**Haringey Community Services (Provider Whittington Health):**
Community Matrons carry out hospital in reach at both NMH and Whittington Hospital, to identify patients suitable for discharge and arrange follow-up visits.
The Rapid Response service will enhance the Emergency Department’s ability to discharge without admitting to main wards – see section 1.8.

**Enfield Community Services (Provider BEH-MHT Trust):**
There are currently hospital in-reach case finders for discharge on both sites - one in A&E and one for Early Supported Discharge; these will transition to the Older People’s Assessment Unit on opening.
The TREAT service is being implemented - two locum geriatricians are currently be sourced.

**Delayed Transfers of Care:**
**LB Haringey**
Twice weekly teleconferences review the identified delayed transfer patients and patients who have been assessed as no longer requiring an acute bed both those who are delayed and also those potentially delayed. This involves Whittington Health (WH) and NMUH discharge teams, WH rehab ward, social care from Enfield and Haringey, Enfield CCG, and chaired by Haringey CCG’s DTOC lead. The teleconferences will increase to as much as 5 per week for the winter period, depending on demand.
NMUH have employed a Continuing Health Care lead nurse, to ensure documentation is complete within 48 hours, and paperwork within 72 hours.
**LB Enfield**
Working towards implementing a twice weekly teleconference process similar to the above.

**Repatriation:**
There is a repatriation policy for patients, which is effective for both receiving and sending patients. For Stroke pathway in particular, patients are repatriated as per the pathway and there is an escalation protocol if this is not possible.

**LAS/NMUH Health Economy Local Scheme**
Winter monies will fund the development of responsive pathway management including:
- System Surge Management
- Intelligent Conveyance - implementing a robust capacity management system for managing patient flows and relieving pressure on A&E.
- Reduction in waiting times for ambulance handovers with quicker ambulance turnaround.
- Early warning process for escalation and planning of capacity management at NMUH for response to both NMUH capacity issues and
neighbouring health economies.
- Clinical Transfer – to support the transport of patients going for specialist treatment and investigation to support efficient discharge

### Potential LAS Service Schemes (which are subject to development) for Consideration
- Alternate Transport Provision – to provide alternate modes of transport to support effective conveyance to the most clinically appropriate location.
- Combined Healthcare Action Team – a team to work with local providers and Acute Trusts to improve management of chronic conditions and frequent attendees
- Pathfinder – additional training for Paramedics to help reduce conveyance rates to Emergency Departments to increase the use of alternative care pathways

### Other Potential Local Initiatives for Consideration with LAS (Identified from the LAS Winter Surge Paper)
- Alternative Management of intoxicated patients at peak times e.g. Festive Periods
- Cycle Response Unit – alternative 999 response provision with evidence of reduced conveyance rate

### 1.4 7 Day Working

#### Acute

The continuation of a successful winter scheme is an additional 4 hours per day of physician input during weekends. The BEH Strategic expansion offers the opportunity to extend 7-day working which until now has not been viable. This will include:
- Extension of physician cover from 4 to 8 hours per day
- Expanded pharmacy cover
- Expanded therapy cover
- 7-day Ambulatory Care
- Extension of acute physician cover
- Expanded CEPOD availability

The above will increase the intensity and frequency of senior clinical support on the wards which will expedite discharges and ensure even greater continuity of care. It is planned to improve the number of weekend discharges and bring the time of discharge forward. Imaging capacity increase will ensure that there is a faster throughput in A&E and on the wards during the winter months.

Planning for the above schemes is at an advanced stage, with recruitment strategies underway to ensure staff are in place to meet the additional demand when the BEH strategy is implemented later this year.

NNUH will also be opening up an Emergency Ambulatory Care unit in November 2013 from 5 days to 7 days which will improve flow and admission avoidance during the weekend.
NMUH are also tracking on a weekly basis the number of weekend discharges to ensure focus is kept on that area, and have instigated a new “weekend plan” deadline of 3pm on Friday for every patient to have a weekend plan in the notes indicating what needs to happen at the weekend to progress care and what criteria need to be met for the patient to be discharged.

**Haringey Community and Social Care**
7 day working is being extended for the following services this winter:
- Palliative Care specialist nurses
- Community Matrons with Rapid Response
- Access to new Reablement packages through Rapid Response
- Additional social workers to support A&E and Rapid Response
- Social Care Home from Hospital
- Heart Failure Community Management
- COPD Community Management

**Enfield Community and Social Care**
New services being commissioned will operate 7 days:
- PACE
- TREAT

**BEH Mental Health Trust**
- RAID

### 1.5 Planning elective workload during the winter period
The majority of elective activity at North Middlesex Hospital is undertaken as day case services. There was minimal disruption to this flow last winter and is not expected to be adversely affected throughout quarters 3 and 4. To give a scale, on average NMUH use 17 beds a day for elective activity against 200+ beds for the emergency activity. That said, NMUH have a contingency plan that is highly advanced to bring forward elective activity in the next couple of months (pending funding decision) to allow some head room to be able to stop non-urgent, non-cancer non-day case elective work during particular peak periods. The expectation is that this could give us a further 15 beds if required.

### 1.6 Learning from 2012/13
#### Level of service over the bank holiday periods
A review of the lessons learnt from winter 2012/13 was undertaken with local providers during April 2013. This information was shared with CCGs and NHS England. This work was used to inform preparation work for winter 2013 including organising winter planning events during July 2013, and supporting discussions around demand and capacity work.

Whittington Health: All key partners are involved as per their organisations outbreak management policy.
Enfield Social Services: Reviewed at Winter Capacity Group to ensure a more continuous learning opportunity for all partners.

Haringey Social Services: Haringey Adult Services - Reviewed at Capacity Planning Group

1.7 Community Services: How will these support quarter 3 and 4 capacity requirements?

Haringey

Haringey Rapid Response Integrated Care Service – This service started in late September 2013 and provides admission avoidance support at home by combining Community Matrons with the Community Reablement Service. It runs until till 10pm, 7 days a week, and if necessary overnight ‘sits’ can be provided. Patients’ health condition is overseen by the community matron, providing guaranteed follow-up visits to encourage confidence on discharge from ED or assessment beds, or from GPs referring at home. Senior Reablement Workers are experienced in patients coming home from hospital, and the risk assessments at home that are required. They are able to provide personal care, making drinks and light meals, plus practical tasks like food shopping, collecting prescriptions or equipment, as well as accompanying home from hospital. This integrated service also enables new cases to be assessed for care from the Reablement Service, 7 days a week, avoiding a wait over the weekend or bank holidays. The base funding for the one year pilot is already in place from the CCG and Section 256 funds, and further capacity is included in a winter monies bid to respond to winter surge.

LB Haringey

24/7 District Nursing - Haringey CCG has recently invested in extending District Nursing to operate 24/7 from 1st November 2013. This will be provided by a newly commissioned service to be provided by Whittington Health across Haringey and Islington. This will reduce unnecessary attendances at A&E, some of whom are currently admitted, primarily for patients requiring urgent catheter care. The service will also support the extension of palliative care at home.

Palliative Care – A winter monies bid will deliver a major increase in specialist community palliative care capacity, needed to meet the palliative care standards and the end of life care strategy. The specialist palliative care team provides palliative care for residents of Haringey and patients admitted to Whittington Hospital. The expansion will provide: 7 day CNS from 8.30 – 5pm in the community and hospital; 24/7 specialist telephone advice; Dedicated Palliative Care Social Worker; additional consultant time, and pharmacist time to support the training of the care home staff and provide services there.

Ambulatory Catheter Care – Haringey CCG has recently invested in a daytime catheter care service for ambulatory patients. Previously Whittington Health’s District Nursing service did not provide for this group, a gap which meant patients unnecessarily accessing A&E. The extended service commenced in July, by adding capacity to the District Nursing Service.

Heart Failure(Management of patients with preserved left ventricular dysfunction) - This winter monies bid will provide the support, structure and systems that are needed to reduce unscheduled acute care for patients with Heart Failure due to PSF and facilitate early and
safe discharge. The additional staffing will be 1 heart failure nurse.

**Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD) pathway** - This winter monies bid will provide prompt treatment at the onset of exacerbation symptoms, which can result in less lung damage, faster recovery and fewer admissions and readmissions to hospital. The additional staffing will be 2 respiratory nurses/physio specialists and consultant time.

**MDTs & Risk Stratification** – The community MDT teleconferences are well established across all four localities, with multi-disciplinary team members joining the patient’s own GP in the teleconference. Risk Stratification is being rolled out, to replace identification of patients by A&E attendance.

**Telehealth** - Following risk of emergency admission profiling, the service provides patients with telehealth kits to improve self-management and connect to Community Matrons.

**Falls** - The new community led falls prevention and exercise service run by the ICTT, Whittington Health is now operational and classes have commenced.

**FEDS (Facilitated Early Discharge Service)** - is a Whittington Health therapy team that identifies patients in the short stay assessment ward and Acute Medical Assessment Units who may be able to return home on the same or next day. It operates 8-8 daily 7 days a week, and provides therapy assessment and any minor equipment, referrals for social care or to voluntary sector, and has a therapy technician as part of the team who carries out follow up visits or accompanies patients home to ensure that they are safe and able to manage within their home on discharge.

**ICTT (Integrated Community Therapy Team)** - has OT, PT and SLT staffing, provides a rapid response where this will avoid a hospital admission (including to care homes) 5 days per week. A winter monies bid will increase the number of therapists over the winter period using funding from the winter pressure bids.

**The Community Neurological Rehabilitation Team** in-reaches into the hospital to support the pathway for patients who need specialist neurological rehabilitation.

**LB Enfield:**

**PACE**
To work in NMUH to provide an extended & immediate/rapid social work response for predominantly elderly people awaiting discharge that need social care at home (including in care homes) to enable a return home. With community health colleagues this will form a Post-Acute Care Enablement (PACE) support service provided to patients on discharge. Its aim is to enable patients to redevelop their skills and self-
confidence in daily living, including managing their condition.
The scheme will support improved management of A&E and the inpatient discharge process, most notably improving the timeliness of discharges. As part of a coordinated health and social care intermediate care approach, the PACE support in the community will also help reduce risk of subsequent hospitalisation.

LB Enfield’s hospital-based social workers will work with hospital & primary health staff to facilitate more timely navigation of patients to community based resources, including existing intermediate care and CHC solutions, but also link with the PACE rapid response service. This combination of services will

- Enable assessed patients approaching medical fitness to be able to be discharged home earlier than otherwise.
- Reduce delayed transfers of care.

**TREAT**

To support primary care and A&E by providing extra capacity in an extended and immediate/rapid social work response for predominantly elderly people who are in the community and at significant risk of A&E attendance and subsequent emergency admission. This is a companion scheme to that of the PACE-based scheme for hospital admission, and also includes access to enablement in patients’ homes to enable people to redevelop skills and self-confidence in daily living and work with MDTs to better manage their conditions. This support includes a focus on extended work at the weekends and in the evenings to ensure rapid response as part of development of integrated care. It will have a direct impact on A&E performance, reduce the number of patients attending A&E, and improve overall acute and community bed management. As part of a coordinated health and social care integrated care approach, the scheme will also mean those supported in the community will be at less risk of subsequent hospitalisation, particularly during evenings, and admission to care homes.

LB Enfield’s social workers will work with A&E and primary care and community health staff to facilitate more timely navigation of patients to community-based care solutions, including existing intermediate care solutions. This scheme is an extended 7 day week service to respond to the NMUH Trust-based Older People’s Assessment Unit (OPAU). LB Enfield enablement workers will cover in, and after, these hours, the latter to ensure people are settled at home during the evening. The mobile support team will be led by a manager/assessor based in the OPAU but will network patients into primary health/social care. These functions form part of the multi-disciplinary team in the emerging integrated care model, of which OPAU is a component. This access to rapid response, assessment and social care support will help address one of the key “pressure points” in the management of patients: the number of people aged 65+ admitted as an emergency to hospital, chiefly due to the numbers of people attending A&E. the majority of this increase is associated with patients with long-term conditions that potentially could be managed in the community.

**Falls**

Both the Fracture Liaison Nurse and Bone Health Nurse are now in post and aim to target different points in the process. This includes working with practice to identify fallers, as well as those “picked up” by the community alarm services, to then reduce falls. The other target is those patients within acute who have stress fractures and working with them to reduce a fall that may result in fractured neck of femur.
**Integrated care services for COPD and HF patients**
Due to commence to provide early intervention across primary, community and acute.

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<tr>
<th><strong>1.8 Sufficient critical care capacity to cope with peaks in demand, learning from last year.</strong></th>
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<tbody>
<tr>
<td>For winter 2013/13 (Last year) Critical Care ITU capacity at NMUH was increased by 2 beds from the base position of 7 commissioned beds to 9 beds. This was not used as much as then anticipated. The ITU critical care bed capacity will increase from the present 7 beds to 10 beds from December 2013 (in line with BEH Clinical Strategy modelling) with a further contingency of 2 beds spaces in the hospital ITU for expansion should that be necessary. Additional trauma theatre capacity will be made available throughout the winter period as per the winter bids. This will reduce pre-operative length of stay by earlier access to urgent surgery and an overall reduction in total length of stay for this group of patients.</td>
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<tr>
<th><strong>2 Social Care (including housing &amp; wider Local Government)</strong></th>
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<tr>
<td><strong>2.1 Social services overall capacity, with cover to be in place to support 7 day working</strong></td>
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</tbody>
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**Haringey**
The Community Reablement Service remains a 7 day service including Bank Holidays with clear timelines (standard 24hrs from section 5 and Emergencies immediately) to ensure safe service provision. Plans for support outside of core working came into effect in November 2013. Although this is available under some circumstances from the Reablement Service. Social workers are based in NMUH and WH, and working across inpatient wards and A&E. There is the ability to spot-purchase agency provision to supplement existing resources for a short period in an emergency. Standard response is within 24hrs with emergencies responded to as necessary.

From the end of September, the Rapid Response Integrated Care Service (described in 1.8) extends the ability of the Reablement service to respond rapidly until 10pm 7 days a week, including the provision of overnight sits where necessary. This is achieved by adding two senior workers on standby during evenings and weekends. The Rapid Response service enables new short term packages of care to be agreed and commenced during the evenings and weekends, by honouring the decisions of the community matrons.

See also schemes in 2.2

**Enfield**
Support is provided Monday to Friday from 8am to 6pm through our Access Service and from 9am to 5pm from operational teams such as Hospital Social Work Teams, Care Management Service and Enablement Service (Assessment and Provision) who all provide assessment functions.

Outside office hours 7 day cover is through the Out of Hours Social Work Service who will respond to emergencies. They will co-ordinate social care support required in the evenings and throughout the weekends.
In terms of emergency domiciliary/home based support a limited service is offered through our Crisis Team from 7am to 1pm and 6pm to 10.30pm Monday to Friday. Then at weekends this service runs from 7am to 2pm and 5pm to 10.30pm. This is linked to the Enablement Provision Service that operates from 7.30am to 1.30pm and 6pm to 10pm Monday through to Sunday.

Support currently provided direct to A&E departments through the additional funding linked to NMUH. This is part of the ambulatory assessment service for Enfield and provides onsite Social Work support in A&E 7 days per week at specific times in partnership with primary care colleagues. This is viewed as enhancing existing service provision to support admission avoidance.

A proposal for a rapid response Enablement Provision Service is being developed to support the planned OPAUs. This will increase capacity to respond to a variety of other local ambulatory assessment initiatives.

LBE responds to all delayed transfers of care (DTOC’s) within agreed timescales and where possible will bring forward support to help facilitate early discharge. Enablement will provide support within 24hrs of referral. Hospital discharges are co-ordinated through the onsite Social Work Teams. Restarts will be referred via onsite team to the Brokerage Service who set a timescale of 24hrs for home care package restarts with providers. Where providers do not have capacity to do this then they are obliged to subcontract the service if they come to Brokerage or if non-contracted work through the providers to find those with capacity to take these on. Leaving Hospital to Residential Care is 48 Hours. Fortnightly Discharge Meetings are held co-ordinated by the onsite Social Work Team Managers to review any challenges experienced in facilitating a patients safe discharge. This involves primary care colleagues and secondary care colleagues meeting with Social Services.

Presently the onsite Social Work Teams respond and co-ordinate all requests for social care support. The additional funding for AA support has been used to enhance the onsite operational team and help with weekend requests for social care support.

### 2.2 Have social care provider’s demand predictions and plans to cope with surges in demand been received, reviewed, discussed and amended as necessary.

**London Borough of Haringey**

**Rapid Response**

Funding from Section 256 and the CCG has commissioned the Haringey Rapid Response Integrated Care Service commenced at the end of September, combining community matrons with additional capacity in the Community Reablement Service, including two senior workers on standby to provide extra capacity in the evenings and weekends, including overnight sits.

The following Winter plans will provide additional 7 day week capacity:
Reablement
Increased capacity required to deal with anticipated increased referral activity through the winter period, both from inpatient wards as well as A&E. Current funded services are operating at maximum capacity and will not manage additional anticipated demand. Reablement in Haringey has already shown demonstrable benefit in supporting people to maximise a return to living as independently as possible – either without the need for on-going community health services and social care, or where it is needed, at a reduced level. The additional capacity required includes: Additional specialist reablement home care hours; Additional therapy capacity – OT and physiotherapy; Additional pharmacy capacity.

Home From Hospital
To provide short term volunteer led befriending and home visiting service for people who are discharged from A&E or hospital. Service would ensure e.g. basic food items available for individual on return home, heating is on etc.

Additional social work assessment capacity
To support A&E and Rapid Response, and have a specific remit in early identification of people who present in A&E that have an underlying drug or alcohol issue, resulting in attendance at A&E on a regular basis. This capacity would be focussed on weekend and out of hours working, enabling rapid access to community services.

London Borough of Enfield
Response times to commission services do not change in the event of a surge. We attempt to predict surges and problems such as Christmas & Summer Holidays and work with providers to ensure that they have the capacity to meet demand at these times. Contracted providers are required to have in place plans to deal with fluctuations and increases in demand with agreed timescales.

PACE
The business case for the PACE service was approved by the UCB, and went live on 12 September 2013. This service is contracted from CLCH (to manage Barnet patients), with ECS subcontracted to manage Enfield patients.

TREAT
TREAT and the Older People’s Assessment Unit will be key parts of the community services provision to support discharge/admissions avoidance.

Extended Social Care Support for Hospital Avoidance in Primary/Integrated Care
The aim is to support primary care and A&E by providing extra capacity in an extended and immediate/rapid social work response for predominantly elderly people who are in the community and at significant risk of A&E attendance and subsequent emergency admission. This
is a companion scheme to that of the PACE-based scheme for hospital admission, and also includes access to enablement in patients’ homes to enable people to redevelop skills and self-confidence in daily living and work with MDTs to better manage their conditions. This support includes a focus on extended work at the weekends and in the evenings to ensure rapid response as part of development of integrated care.

2.3 What arrangements are in place to reduce emergency demand from nursing and residential homes?

**Haringey**

Haringey has around 20 care homes registered under older people category, with a total bed number of about 650. 10 residential care and Haringey’s only 3 nursing homes are included in a care homes project which is managed by Haringey CCG. This team of two full time nursing staff are specifically tasked with reducing avoidable admissions from nursing and care homes in a number of ways. This is achieved through regular visits to locations providing expert advice, clinical input and signposting to appropriate professionals, e.g. GPs or district nursing. Specific standards are monitored including, for example, numbers of falls, pressure ulcers, UTIs. Where they are found to result in avoidable admissions, locations will be supported to develop ways to prevent reoccurrence. The team also works to improve networking and communication with other key providers to support the work of reducing admissions and reducing length of stay in acute services.

Additional support is included within the winter monies bid for palliative care: CNS, consultant time and pharmacist time to provide support and training to staff in care homes.

**Enfield**

Enfield CCG commissioned an MDT, led by Consultant Geriatrician, as a partnership between providers, to assess and deliver care to residents of those care homes with high levels of admissions and readmissions. There is a north service aligned to BCF and a south service aligned to NMUH. This has been effective in improving patient outcomes focusing on medication reviews and prescribing, end of life care planning, falls reduction, tissue viability. There has been a reduction in A&E attendances compared to those for all 65 years and above and the level of increase in emergency admission is significantly less than those for all 65 years and above.

2.4 What contingency plans are in place should a private sector home become unable, at short notice, to provide on-going care for residents?

**Haringey**

Haringey Adult Services - Adult Commissioning and Personal Budget Support Services have established a system to monitor care home capacity at any given time. A review of provider business continuity plans is planned for October 2013.

The CCG’s Care Homes and Safeguarding team have been working with a particular nursing home where new placements have been halted...
for a time. There have already been improvements and once these are fully embedded this could be a location where additional beds would be available within Haringey.

Should it be necessary to identify additional resource, beds both within and without Haringey would be considered and approved at short notice where required.

**Enfield**
The CCG already has the Safeguarding contingency plan in addition to the LB Enfield service providing cover in the home through the employment of staff as required. Where private sector homes have been unable to provide on-going care for residents, a multidisciplinary team will be mobilised to plan an urgent response. In these situations safeguarding, care management, and the in house provider co-ordinate a support team to provide on-site support. The complexity of this support, engagement with residents and other stakeholders is designed by the multidisciplinary team and fed back to this team by the on-site support unit to implement.

In the event that service users need to be moved from a home urgently or in an emergency, all resources would be put into finding the suitable alternative placements for all residence in other residential and Nursing homes both in Enfield and outside (Procurements / Brokerage) working with the relatives and care management. This requires a co-ordinated response to provide holistic information on service user’s needs, health issues, equipment required, risk assessments for transport and support required, working with providers to facilitate transfers effectively, or working with them on action plans and providing multi-disciplinary support to facilitate the return of the service to its full function / quality etc.

The on-site unit provides support for as long as determined by the multidisciplinary team. If decant of residents were being considered for any reason, In House residential voids would be considered as well as other vacancies within the wider market. Wider strategy regarding safeguarding, best interest, and business continuity are continually reviewed by the multidisciplinary team.

### 2.5 Please describe the system in place to enhance access to primary care?

**Haringey**
Reducing inappropriate A&E attendances is a priority for Haringey CCG. Attendances at A&E during the core hours of general practice are increasing year on year and went up by 5.6% in 2012-2013. The Urgent care LES is designed to facilitate GP practices to review and make changes to the way they respond to patients who request same day appointments for an urgent need. It offers a range of evidence based recommendations and principles to apply to the practice’s operating model and framework, which can help maintain patient safety whilst reducing workload. In designing this LES, information and evidence was taken from the Primary Care Foundation, local research into the use of A&E by Public Health Department and discussions with clinical leads, local GPs and practice managers.

It is estimated that this scheme will reduce A&E activity during core hours of general practice by 20%, which is a reduction of 2808 attendances.
Minor Ailments scheme in pharmacies to create 600 extra consults per month

**Enfield**

Enfield CCG Primary Care Strategy implementation to create 2000 extra appointments per month - this is a mixture of additional appointments available in GP practices (live since Feb 2013); in addition a further 2WTE GPs (0.5 WTE in each of four localities) are providing additional capacity for one year.

Minor Ailments scheme in pharmacies to create 600 extra consults per month

### 3 Intermediate Care

#### 3.1 How are you assured that planned levels of capacity within intermediate care schemes are sufficient to meet forecast demand for the quarters 3 and 4?

**Haringey**

Planned investment levels for intermediate care bed capacity (21 beds) have been based on 2012/13 levels plus 40%.

**Enfield**

19 step up and step down beds have been identified as required and are currently being sourced. These beds are to be used flexibly between step up and step down for periods of up to 6 weeks per patient. These services are available to all Enfield patients using services at NMUH.

#### 3.2 What agreement has been reached within the local health economy on the funding to support additional capacity if required?

**Haringey**

Investment in reablement services has increased in 2013/14 by approximately 20% from 2012/13, an additional £110k to support reablement capacity. This capacity is to be used flexibly across health and social care commissioned services.

**Health step-up / step down:**

There are two main rehabilitation pathways for discharge from NMUH:

- Stroke inpatient rehabilitation which is provided on Graham Ward located in the Homerton University Hospital for patients who require inpatient rehabilitation for a longer period than is provided on the acute stroke unit.

- General rehabilitation which is provided on Cavell Ward located in Whittington Health and focuses mainly on care of the elderly. Over the course of the winter period, this scheme will ensure that both rehabilitation pathways operate effectively through the provision of step-up and step down beds and a community therapy team which will oversee the pathway.
Health step down beds will be provided for clients who are not able to actively participate in reablement and rehabilitation mainly due to lower limb Plaster of Paris in situ.

Social care step-up / step-down (for all of Haringey):

It is proposed that additional step-up and step-down capacity is made available to support A&E and Rapid Response. Current services are operating at maximum capacity. The additional capacity would contribute to 7 day working, through accessing appropriate and safe bed-based services over the weekend to avoid admissions from A&E and to enable discharge planning from the wards to take place over weekends. The additional capacity would also support Rapid Response through GP referral and/or identified through GP teleconferencing, where people who are risk of breakdown in the community, however do not need an acute admission to hospital. The capacity will also be used to support informal carers at risk of breakdown in the community, providing a necessary break rather than to present at A&E in crisis (either themselves, the cared for person, or both). Access and management to be social care led (Haringey Social Services).

Therapy:

Within the winter bids is a proposal to increase therapist capacity for the in-patient rehabilitation beds, in order to increase throughput by reducing length of stay. (It is not possible to increase number of beds) this will in part be achieved through more capacity to provide therapy 7 days per week. The plan is that these therapists will also support the additional step-down/step up beds which are within the Haringey social services bid, and can inreach to the NMUHT to screen patients awaiting intermediate care beds, and ensure that they are moved to the appropriate bed (if bed-based assessment or rehabilitation is required).

Enfield

Step up and enablement, TREAT, PACE, RAID. CCG funding for 30 day readmission and threshold monies. Funding for intermediate care service by the CCG in 2013/14 increased to £2.1m for bed based services, £0.9m for home-based IC services, and £1.6m for enablement; this represents a circa10% increase in budget from the previous year. Budgets are not pooled between health and social care.

The Integrated Care business case assumes joint commissioning between Enablement, Intermediate Care, Social Workers, step up and step down beds.

3.3 Are services organised on a 24/7 basis? If they are not, how are they organised and how are you assured that this is adequate to meet local needs?

Acute: Service at NMUH are organised on a 24/7 basis, and where some instances there are gaps, e.g. diagnostics, these are being enhanced through the winter period to provide better 7 day care.
Intermediate care beds: These are all 24/7.

Community: see section 1.8

### 3.4 Are there robust multi-agency arrangements for planning, co-ordination and review of services before and throughout quarters 3 and 4 period?

The Urgent Care Working Group for the NMUH health economy has full multi-agency membership and attendance, and oversees planning, performance metrics and review of services.

Reporting to this is the Demand and Capacity Group, which will undertake monitoring of progress and action on issues which arise.

Multi-agency teleconferences are held, for example reviewing acute flow and DTOCs, at an increasing frequency to reflect the level of pressure in the system.

### 4 Alternatives to accessing A&E (UCC, NHS 111, alternative conveyance)

#### 4.1 What plans do you have to offer patients an alternative to A&E attendance?

Please see section 1:1

In addition to the schemes and pathway improvements identified in section 1:1 the expansion of the UCC is key to unlocking maximum productivity. Pathways have been agreed with LAS around UCC usage for appropriate ambulance calls.

NHS 111 has not been forecast to have any impact on A&E or non-elective activity at North Middlesex in this year's contract. If there is an impact from NHS111, it is anticipated that this will be UCC attendances more than A&E, in the best case mitigating some of the demand for emergency services.

#### 4.2 Mental health

BEH-MHT’s HTT operates 24/7 including Christmas and New Year.

Intake single point of referral operates during working hours and then the Acute Assessment Centre (AAC) takes over the responsibility out of hours, the AACs operate 24/7.

Presently the Mental Health Trust has 3 Band 7 Mental Health liaison nurses working at NMUH A&E as part of the North Middlesex Liaison service. Also included is a Consultant psychiatrist (part-time) and junior medical and administration staff. The A&E service is provided over 7 days (not 24 hours.)

NMUH continue to report difficulty in accessing Mental health expertise which contribute to waiting times in A&E and inappropriate use of
Haringey CCG A&E Recovery and Improvement and Demand and Capacity Plan 291113

Acute beds. Plans to mitigate this are:

The Rapid Assessment, Interface and Discharge (RAID) model provides an innovative liaison psychiatry service which will improve quality of care, drive down lengths of stay and reduce readmission rates across the whole spectrum of mental health co-morbidities in the acute hospital including dementia, self-harm and substance misuse.

There are two key components:
- Direct assessment and treatment of patients presenting with overt mental health problems, allowing the existing NMUH pathways to function smoothly and reduce unnecessary delays, similar assessment and treatment of patients who present with co-morbid mental health problems such as dementia
- High quality education & support for the NMUH staff through both formal teaching and informal techniques, to rapidly skill up NMUH staff in identification of patients who might benefit from RAID input and improve their own care of such patients.

The 18.5 WTE multi-disciplinary delivery team will be Consultant-Led and made up of a mix of Consultant Psychiatrists, Consultant Psychologist, Social Workers, appropriately skill-mixed specialist Psychiatric Nurses and Graduate Mental Health Workers. The team will be managed by a Clinical Manager who will undertake some clinical commitments together with appropriate administrative support.

The new proposal will provide:
- A nurse delivered on-site service to A&E, mainly focusing on adults with mental health presentations;
- A 9 am to 9pm dementia focused service to the wards (9am to 5pm at weekends);
- Support for other non-dementia clinical areas such as Substance misuse and Deliberate Self Harm, and finally;
- It will deliver a continuously ongoing programme of education and mentoring to the acute trust staff which also provides them with on-site mental health subject matter expertise to assist with any difficult decisions.

The RAID model is predicted to reduce demand by 12 beds in the demand and capacity plan.

4.3 UCC

The UCC is about to be tendered to increase its capacity to circa 70,000 patients a year. This will take the percentage from circa 20% now to a minimum of 40% of A&E attendances seen in UCC.

The Trust is also pursuing a change to the hours of the current UCC pilot, and the way patients presently flow through it, to increase the percentage of attendances seen in UCC ahead of commissioning the new UCC.

4.4 Alternative conveyance

Haringey CCG has an Alternative Care Pathway in its final stages of agreement, to enable direct referrals from LAS to the district nursing
Further work is underway to agree this for Rapid Response.

**Enfield** CCG has a well-established Alternative Care Pathway in operation for Intermediate Care. An ACP for the falls services has been developed and is awaiting authorisation and final sign off. In addition, work has begun with LAS to look at ACP for the Older People’s Assessment Unit to ensure a direct access for patients into OPAU rather than ED or UCC.

There are complimentary services described by NMUH in sections 1.1 and 4.1.

### 5 Staffing

5.1 **Given historical issues relating to reliance on agency, and problems of delivery when needed, what plans are in place to increase staffing levels if demand is higher than anticipated?**

The CCGs coordinate the compilation of the Winter Plan, which includes business continuity and staffing plans for all services.

There are business continuity flu plans in place for all providers, and the current the Winter Funding bid and subsequent funding allocation is fully aligned to the A&E Recovery Plan. Flu vaccines are encouraged by providers to minimise sickness during the winter period.

Business continuity plans are in the submitted winter checklist.

In particular, NMUH has a strong recruitment plan surrounding and supporting the BEH Clinical Strategy/expansion including initiatives of recruitment within the European Union and auto-enrolling staff on the bank.