NHS
South West London

Keeping People Out of Hospital

Healthier Communities and Older People Overview and Scrutiny Panel
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Keeping People Out of Hospital

Three Stages of Intervention:

- Primary Care
- Community-Based Services
- Acute Services

This presentation focuses on the first two elements as acute services are mainly hospital-based

Keeping People Out of Hospital –

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1. Primary Care

Three Broad Areas of Work:

a) Access
b) Proactive Care
c) Prevention

A - Primary Care Access in Merton

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Primary Care Services available 8am-8pm, 7 days a week
Appointments can be booked via practices, NHS 111, Emergency Departments (ED)

- 21 GP Practices
  - Core Hours 8am-6:30pm Monday – Friday
  - Additional hours – varies by practice
  - 85,000+ appointments a month
- 6 Primary Care Networks (PCNs)
  - Enhanced Access: Network Standard hours: 6:30pm-8pm Monday to Friday; 9am-5pm Saturday
  - Additional hours – varies by PCN
  - Available to all patients registered at practices within the PCN
  - 4000+ appointments a month
- 2 Borough Wide Extended Access Hubs
  - Friday 4pm-8pm; Saturday/Sunday/Bank Holidays 8am – 8pm
  - Delivered by Merton Health Ltd from Wide Way Medical Centre & The Nelson Health Centre
  - Available to all Merton registered patients
  - Offers GP and nurse (specifically wound care and childhood immunisations) appointments
  - 800+ appointments a month

Additional Capacity December & January to cover Christmas / New Year / Industrial Action

- Over 1000 additional GP Hub appts.)
- Weekend telephony service on 3 weekends (over 1000 calls answered)

New Access Requirements

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NHS England Delivery Plan for Recovering Access	GP Contract Requirements
Empower patients to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.	Offer of assessment will be equitable for all modes of access. Patients should be offered an **assessment of need, or signposted to an appropriate service, at first contact** with the practice, with practices no longer able to request that patients contact the practice at a later time.
Implement **Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment	Patients seeking routine care should have an **appointment within two weeks** of contact where appropriate
Build capacity to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.	**Prospective (future) record access** to be provided by 31st October 2023
Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients	Mandated use of a **Cloud based telephony** (CBT) national framework

Improving Access in Merton

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- 75% Practices already using Cloud Based Telephony
- All practices have Online Consultations available
- Promoting use of NHS App
- Digital Change Managers to support practices
- All PCNs had Capacity and Access Improvement Plans approved
- All practices on track to enable prospective records access by 31st October 2023
- Recruitment and Retention programmes in place
- Use of Additional Roles e.g. Clinical Pharmacists, Social Prescribing Link Workers, Mental Health Practitioners, Paramedics, First Contact Practitioners
- Patient engagement including through surveys, patient groups; Patient communications on new roles and changes to access routes

B - Proactive Care

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- Enhanced Health in Care Homes
- End of Life and Complex Patients Local Scheme
- Integrated Locality Teams
- Medication Reviews and Medicines Optimisation
- Annual reviews for Long Term Conditions (e.g. Diabetes, asthma, COPD)
- Annual Health Checks (inc. Serious Mental Illness (SMI), Learning Disabilities)
- Multidisciplinary working

Proactive Care: Enhanced Health in Care Homes

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- 869 Care Home Beds covered by 10 practices
- Lead Practice for each Care Home
- Named Clinical Lead
- Weekly “Ward” Round
- MDT Reviews
- Care Planning and Reviews for all residents
- Structured Medication Reviews
- Universal Care Plans developed

Proactive Care: End of Life and Complex Patients

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- Cohort of Patients (Complex including severe frailty / in last year of life)
- Individual case review (approx. 4000 pts discussed per year)
- Care planning and review
- End of Life planning where appropriate
- Integrated Locality Teams - MDT input and reviews (approx. 240 MDTs per year)

C - Prevention

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- **Merton Health & Care Plan 2022 to 2024** – Prevention of hospital starts with good health and care which starts from an early age. The plan sets out priorities for Start Well, Live Well and Age Well. This gives an overview of ambitions for the borough, which should be reflected in Public Health initiatives and the services on offer. The plan reflects a commitment from health and care organisations to work together, with a shared vision of a more locally focused, person-centred model of care.

- **Primary Care Delivered Prevention Services**
- Immunisations
  - Including Childhood imms / Flu / Covid / shingles / pneumococcal
  - Covid Autumn campaign: Merton 43% Uptake (SWL 44.5%; London 37%) as of January 2024
  - Flu: Merton 43% Uptake (SWL 47%; London 40%) as of December 2023
- Cancer Screening
  - Cervical / breast / bowel
- Smoking Cessation
- Weight Management
- Social Prescribing

2. Community/Integrated Care Services

Universal Care Plans

- An NHS service that enables every Londoner to have their care and support wishes digitally shared with healthcare professionals across the capital.
- This helps with a more coordinated approach to health and care.
- The numbers of UCPs in Merton are increasing.
- Social Prescribing service is one of the providers helping support promotion of this offer.

Carers

- Unpaid carers play a vital part in the health and care for Merton residents.
- Primary Care continues to increase identification and provision of carer friendly services, including health checks for unpaid carers.
- All carers are supported through improved access to social prescribing & voluntary services to reduce social isolation and to reduce emergency presentation. Unpaid carers are identified and supporting during their cared -or person's hospital admission and subsequent discharge.

Community/Integrated Care Services

SWL 111 Service

- A free to use telephone number and website, offering healthcare advice and the ability to refer patients to the appropriate care setting.
- The SWL 111 service usage has improved this year,
- A new way of managing more urgent primary care cases, reduces the number of handoffs that a patient experiences in their interaction with the 111 service.
- The 111 service also provides a clinical assessment service helps give advice to health care professionals, helping to avoid admissions.

SWL Mental Health –

- Supporting people in mental health crisis / reducing attendances at EDs.
- Work is being undertaken at SWL level, to review the crisis support offer available in SWL and how this model might improve for greater coordination across boroughs.

Community/Integrated Care Services

Virtual Wards and Hospital at Home

- Virtual wards (also known as hospital at home) allow patients to safely get the care they need at home.

- The Hospital at Home Virtual Wards help to avoid admissions, whilst Centrally Remote Monitored (CRM) Virtual Wards facilitate earlier discharge. We are increasing the uptake of these by:
  - Changing the operational model and clinical thresholds for access from both primary and secondary care
  - Continuing to engage with clinicians, to build their awareness of and confidence in the use of Virtual Wards
  - Introducing a ‘pull’ model on wards with assigned staff and/or Electronic Patient Records (EPR) systems proactively identifying patients suitable for discharge to CRM Virtual Wards.

- Initial thinking on virtual wards supported an earlier supported discharge model. However more recent activity has shown that the bigger opportunity is in the prevention of admission (hospital at home).

Community Services

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- **Community Health Teams** – A wide range of services are provide by Central London Community Healthcare, our community provider (e.g. district nurses, case managers, care navigators, dementia specialist nurses, end of life care nursing).
- **Urgent Community Response Service** – Urgent community response teams provide urgent care to people in their homes, which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours. This includes access to physiotherapy and occupational therapy, medication prescribing and reviews, and help with staying well-fed and hydrated. The UCR service provides an alternative to hospital, which helps reduce the need for ambulances to take patients to hospital. The pathways for ambulance and 111 services are being reviewed to make it easier for the services to access UCR successfully.
- **A new 'Integrated Care Transfer Hub**' team is being implemented at St. George's hospital. The team brings together the expertise of social workers and community therapist partners, working together with the hospital staff. The team will help support earlier and more effective discharge planning for patients, which will help to reduce readmissions to hospital.
- **Intermediate Care** – An Intermediate Care (IC) Seminar was held on 6th December 2023, reviewing a proposed new service model for Integrated Urgent, Rehab and Reablement. The seminar was well attended by partners across the Wandsworth Health & Social Care System. The group were supportive of developing a new model that better helps the whole system.

Community Services

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- **Age Well Programme**

  - Enhanced Support to Care Homes – Remote monitoring, digital initiatives, use of voluntary sector services, staff training. Implement telehealth services to enable healthcare professionals to conduct assessments, referrals, and consultations remotely. This can bridge the gap in reduced access to on-site healthcare professionals during evenings and weekends.

  - Falls – falls training. 9% of all non-elective admissions are for falls. this is a significant growth in admissions beyond what is expected and represents a greater opportunity to manage mild / moderate frailty cohorts more effectively in the community via rapid response. Based on the current trend, by March 2025, the number of people being admitted to hospital with a fall in SWL will have reduced by around 30 a month to on average 250.

  - Dementia – dementia adviser service and BACSS Behaviour and Communication Support services.

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