



# NHS Urgent and Emergency Care Review

## Westminster City Council submission

August 2013

**Westminster City Council**

Westminster City Hall  
64 Victoria Street  
London SW1E 6QP

020 7641 6000  
[westminster.gov.uk](http://westminster.gov.uk)



City of Westminster

# Chairman's Foreword



Earlier this year the NHS Medical Director **Professor Sir Bruce Keogh** announced a review into the way the NHS responds to and receives emergency patients, called the **Urgent and Emergency Care Review**. The Westminster Adults, Health & Community Protection Committee (The Committee) wanted to examine this issue, in detail, with our clinical commissioners at our side in order to formulate a considered response to the review.

NHS urgent and emergency care services provide life-saving and life-changing care for patients who need medical help quickly and unexpectedly. We recognise that our accident and emergency departments are under increasing pressure and we want to improve the urgent and emergency care system so patients get safe and effective care whenever they need it.

Reviewing A&E is just one part of the national approach to improving the way NHS services are delivered so that patients get high quality care from an NHS that is efficient now and sustainable in the future.

The Committee's discussions on the topic showed that Members felt that there needed to be a tough love approach with both patients and GPs. There needs to be an active campaign to encourage patients to register with a GP and see their local surgery, not A&E, as their first port of call, which we can help to support. Hospitals need to think innovatively to stem the tide of non-urgent admissions - identifying regular over-users of A&E services; registering people for GPs on the spot; and sending non-urgent complaints to the back of the queue. On our part, we would hope to continue our reablement programmes, which keep older people out of hospital through social care in the home. While recognising the strong current performance of many local hospitals, the Council urged commissioners to clampdown on a minority of GP practices. Critically, some GPs do need to maximise their opening hours and appointment times to avoid people waiting weeks.

If needless emergency admissions were dealt with by GPs, spiralling costs would be slashed back but particularly those in real need would get the most immediate A&E attention. We need to make sure that people aren't being forgotten in the drive to cut costs and reach targets. We pressed the CCGs on quality of care and how they will ensure that patients' don't fall foul of target-driven process. Everyone, from social services to charities, and good neighbours too, can help ensure that the elderly and sick receive prompt medical help so that emergency admissions do not become necessary.

**COUNCILLOR DAVID HARVEY**  
**CHAIRMAN, ADULTS, HEALTH & COMMUNITY PROTECTION P&S COMMITTEE**

## **EXECUTIVE SUMMARY**

**The Westminster Adults, Health & Community Protection Committee recognises the damaging costs of unnecessary emergency admissions, not only in terms of financial pressures but also in dangerously delaying treatment for those who genuinely have urgent and clinically serious medical conditions or injuries which require immediate clinical attention.**

**The Committee recognises and welcomes the work of our Clinical Commissioning Groups, hospitals and our own Council departments. It has been shown to the Committee, that there is demonstratable commitment to controlling unplanned admissions alongside hospital re-admissions.**

**However we consider that a 'tough love' approach is required to persuade people not to go to attend Accident & Emergency departments. In the Australian healthcare model, when inappropriate non-urgent and non-emergency attendances occur, it is often made difficult for those patients to see clinicians at the emergency department. The Committee consider that this type of approach should be encouraged in hospitals and urgent-care facilities.**

**The Committee considered that there was a clear need for a public education campaign so that people are more acutely aware that they should register and attend the practice of a General Practitioner in their locality.**

**The Committee would also like to press the Council to be part of a campaign to encourage patients to both register with and attend a local general practitioner.**

## 1.0 Introduction

- 1.1 Emergency or unplanned admissions – that is, admissions that are not predicted and happen at short notice because of perceived clinical need – represent around 65 per cent of hospital bed days in England (34 million bed days and 4.75 million emergency admissions). Avoiding emergency hospital admissions is a major concern for the NHS, not only because of the high and rising unit costs of emergency admission compared with other forms of care, but also because of the disruption it causes to elective health care – most notably inpatient waiting lists – and to the individuals admitted.
- 1.2 The Chief Executive of the NHS reports that the UK’s A&E departments are under considerable pressure: staff are saving lives and helping people recover from injury using the best clinical expertise and technologies in the world. In some cases, such as heart attack and stroke, we have learnt that patients get better outcomes by going straight to specialist centres and not to A&E. We also know that some people who present at A&E, and who the NHS treat there, would have more appropriate care and a better patient experience if they were seen in a primary or community care setting. These may be people with long term conditions that need careful management, or people who are having problems getting an appointment at their local GP surgery. However, there are also others who simply opt to go to A&E rather than a GP; some may come from countries where there is no familiarity with GP services, others may believe that they will get a better service from A&E without understanding the impact this will have on those in real need, still others may not have registered with a GP and a handful may have problems that lead them to abuse A&E services regularly. One of the fundamental issues that the NHS are dealing with is the fact that patients find it hard to navigate between primary care, hospitals and social care services. In many cases some of the most vulnerable patients need careful management and input from a number of different agencies and sometimes they, or their carers, are not able to understand and work with this range of services, and find themselves in A&E as a last resort.
- 1.3 In the first quarter of 2012-13, the majority of A&E departments across the country failed to meet the headline four hour waiting time target. NHS England responded by publishing an improvement plan for A&E in May 2013. The plan set out how local providers and commissioners should respond to the challenges facing emergency care. Introducing the plan, NHS England said:

*Despite much analysis there is **no single trend or factor to explain the deterioration and there remains a wide variation in performance both across the country and within the same areas where similar factors apply.***<sup>1</sup>

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<sup>1</sup> NHS England, the Evidence Base from the Urgent and Emergency Care Review, June 2013, p 11-12

1.4 In June 2013, NHS England published an evidence review and 12 design objectives for emergency and urgent care. This is to form the basis of their proposals for reform to be implemented from 2015-16. The review concluded that services are fragmented and that a lack of standardisation in urgent care makes it difficult for patients to understand alternative options to emergency departments. Additionally, it found that emergency departments rely too heavily on junior doctors and that there are insufficient middle grade and senior emergency consultants to meet staffing requirements on a seven day basis. The design objectives were focussed on addressing these fundamental flaws.

1.5 To the House of Commons Health Select Committee, Sir Bruce Keogh told MPs that:

***One thing everybody is agreed on is that the current position of urgent and emergency care is unsustainable and we need to do something. We need to do some things in the short term to address the immediate issues, and then we need to take a longer, more considered and deliberate view about how we address the future. [...] When A&Es were set up a few decades ago, or DGHs (District General Hospitals) came into their own, people could walk in with a problem and most DGHs were capable of dealing with it. But the inexorable advance of medical science means that now there are many common conditions that cannot be treated in an average DGH.***

1.6 The Committee wanted to assess an overview of what commissioners, the Acute Trusts and the Council itself were doing to minimise unplanned / emergency admissions across all service areas. Questions posed for the Committee's response were as follows:

- **What further local actions could be undertaken in relation to reducing emergency / unplanned admissions?**
- **Who are the key stakeholders to engage and work with in relation to reducing emergency / unplanned admissions?**
- **What are the key risks going into the (local) *Shaping a Healthier Future* reconfiguration implementation?**

## 2.0 Background

### What are the Clinical Commissioners and Adult Social Care already doing?

- 2.1 NHS Central London and West London CCG are the two organisations covering Westminster and which commission health services from providers of healthcare. Their role is to work in partnership with local people and stakeholders, including the Local Authority, to improve the health and wellbeing of the population of Westminster. Also, as a membership organisation of GP practices, they have a role to improve the quality of primary care and this is critical in the context of the emergency care pathway.
- 2.2 In terms of how our Clinical Commissioners are responding to increasing emergency admissions, CCGs were asked to coordinate the production of a **recovery and improvement plan** for each health community by working in partnership with providers and local authorities. Recovery and improvement plans look at each step of the patient's journey through the emergency system in three phases: firstly, prior to arrival at A&E; secondly, the patient's journey through the hospital system; and thirdly, the discharge and out of hospital care.
- 2.3 Recovery and improvement plans would need to include:
- An agreed local plan to bring A&E performance back on track by the end of Q1, including a sustainability plan, produced by the Area Team, including sign-off from Health and Social Care Partners.
  - Preparation for working on a winter plan 2013/14 to sign-off by Area Team by November 2013.
  - Evidence upon best practice from Emergency Care Intensive Support Team (ECIST).
- 2.4 The CCGs were also asked to ensure that Urgent Care Boards had been convened for all communities, which would feed into individual A&E departments. The Urgent Care Board would need to include all key stakeholders from health and social care as well as patient representatives and the appropriate clinical expertise. Importantly, the Local Authority will be represented on this group.
- 2.5 The papers submitted by the CCG to the Westminster Adults, Health and Community Protection provided detail on the CCG's 'system response', which covered the commissioner, provider and jointly commissioned services roles. It covered how they were responding to unplanned hospital admissions and readmissions. The report covers Westminster as well as the rest of the tri-

borough, and in terms of providers, includes Imperial College Healthcare NHS Trust, Chelsea and Westminster Hospital NHS Foundation Trust and the West Middlesex University NHS Trust.

2.6 In summary, the actions the CCG are taking in relation to the emergency pathway are:

- A&E national performance measures are being delivered in all the local A&E departments
- Urgent Care Programme Boards are covering all A&E Departments, which are acting as a springboard for the implementation of the changes to acute hospitals set down in the *Shaping a Healthier Future Programme* (our local hospital reconfiguration)
- A review of Winter Admissions 2012/13 has also taken place. This has been analysed and disseminated. A framework for the whole year is currently under discussion.
- Priorities to ensure a sustainable urgent care system agreed and risk assessed, with many of the supporting activities already underway
- Dashboard for identifying demand and capacity constraints in the system and monitoring of the impact of changes under development.

### **What are the Acute Trusts already doing?**

#### **2.7 Imperial College Healthcare NHS Trust**

The Trust's A&E departments and urgent care centres are located at Charing Cross, Hammersmith and St Mary's hospitals. Western Eye Hospital is dedicated to ophthalmology and offers 24-hour emergency eye care service in west London. Imperial's emergency departments and urgent care centres consist of:

- **Major illness/injury area** has resuscitation bays as well as cardiac and invasive monitoring facilities, and cares for acutely unwell patients
- **Emergency assessment unit** for patients who will take more than four hours for us to assess whether they need to be admitted as a hospital inpatient
- **Emergency short stay ward** admits patients who require only up to 24 hours of inpatient care. The short stay ward has a dedicated discharge liaison nurse, to facilitate safe, efficient discharges back into the community

- **Urgent care centre** staffed by GPs and emergency nurse practitioners, who see patients with minor illnesses and injuries, and patients suitable for GPs.

## 2.8 Emergency departments

The Trust's emergency departments at Charing Cross, Hammersmith and St Mary's hospitals consist of both A&E and urgent care centres. Overall in 2012/13, their emergency departments had 280,017 attendees and 97.2 per cent of patients were treated, admitted or discharged within four hours, which is above the national target of 95 per cent.

<b>Trust emergency department attendances by site</b>		
<b>Hospital</b>	<b>2011/12</b>	<b>2012/13</b>
Charing Cross	82,276	81,979
Hammersmith	47,949	51,944
St Mary's	140,961	146,094
<b>Total</b>	<b>271,186</b>	<b>280,017</b>

2.9 Imperial consider that their key achievements in reducing readmissions in 2012/13 included the following:

- Ambulatory care pathways being reviewed with pathways now in place for renal colic, deep vein thrombosis (DVT) and cellulitis
- There has been a recurring admissions patient alerts link developed for chronic obstructive pulmonary disease (COPD) patients, which will alert specialists and primary care providers when a known patient attends A&E
- As a partner in the Inner North West London Integrated Care Pilot, the Trust has focused on individualised case management and fully integrated care between primary and secondary care providers for frail elderly and diabetic patients
- Data sharing project with London Ambulance Service and Westminster GPs on real time A&E attendances
- A link to allow electronic submission of A&E GP letters now being in place

2.10 Priorities for Imperial in 2013/14 include:

- Maintaining the delivery of the performance targets and achieving 95 per cent target for patients being treated, admitted or discharged within four hours across all sites
- Confirming the baselines for the ambulatory care quality indicators for cellulitis and DVT and agreeing with NHS England a trajectory for improvement throughout the year
- Further development of ambulatory care pathways for the other conditions set out by the Department of Health and College of Emergency Medicine that will provide alternative pathways to admission
- Further work to improve the performance against the timeliness quality indicators, particularly time in department for admitted patients and time to treatment
- Gathering feedback from A&E patients against the 'friends and family' test, which asks patients if they would recommend their facilities to friends or family members.
- Working with their community partners to reduce re-admissions and re-attends to our emergency departments

#### 2.11 **Imperial's approach to emergency re-admissions.**

This is an issue which often involves complex packages of care to an individual patient and requires support from a number of other service providers. In order to improve - Imperial are working to strengthen relationships with community services. The Trust's 2013/14 priorities for improving patient safety, clinical effectiveness and patient experience are featured in the Quality Accounts for 2012/13. They include:

- Clinical Effectiveness
  - To reduce the number of re-admissions to hospital within 28 days of discharge
- Patient Experience
  - To improve the patient experience related to discharge

2.12 The Trust would like to focus attention on re-admissions that are potentially preventable, whilst ensuring that they do not overly extend a patient's stay in hospital when it is not clinically necessary. They aim to reduce emergency readmissions to the national average and then remain below that average. The Trust reduced their number of emergency re-admissions to hospital within 28 days of discharge in 2012/13. However, they recognised that this trend was not

consistent throughout the year. When compared with their peer comparator group as presented by Dr Foster, Imperial are slightly above the average re-admission rate (peer comparator average = 6.53 per cent). This has been further broken down to those patients aged 0-14 years, with an average readmission rate over the year of 4.42 per cent and for those aged greater than 15 years, it was 6.87 per cent. The Trust has taken the following actions to improve their performance:

- Producing daily readmissions reports that are circulated to each Clinical Programme Group (CPG) for their on-going monitoring and action
- Establishing a Medicine CPG Discharge Partnership Group to work with internal and external stakeholders to support effective discharge and reduce unplanned readmissions.

2.13 The Trust's Medicine CPG has set up a partnership working group with local stakeholders responsible for the effective discharge of patients. Representatives from Hammersmith and Fulham Health and Social Care, Community Rapid Response, Central London Community Healthcare project, the Trust pharmacy and therapy services as well as medicine clinical pathway co-ordinators and consultants regularly review clinical incidents related to discharge from medicine ward areas.

2.14 The OPAL - ***older persons' assessment and liaison*** - team has been working to improve the experience of elderly patients. The OPAL team provides early, specialist assessment of elderly patients who are admitted to medical wards which helps to improve their patient experience. The team triages patients before they move to either specialist or elderly medicine wards and if they are fit to go home, they arrange for them to be discharged directly. The Trust welcomes initiatives taken by Clinical Commissioning Groups (CCGs):

- Central London CCG's 'Wellwatch' service aims to people with long-term conditions well for longer and help them avoid the need for hospital care
- West London CCG's 'Putting Patients First' initiative aims to ensure coordinated, quality care for patients with complex needs to prevent emergency admissions to hospital and ensure they are stepped up and down seamlessly from an urgent service to a managed care service.

2.15 **Chelsea and Westminster NHS Foundation Trust**

A transformational change programme has been initiated between Chelsea and Westminster Foundation Trust, CLCH, CCG Commissioners in West London (and Wandsworth), to deliver a step change to the emergency care patient pathways in this part of London. This programme of work takes place primarily over the

first six months of 2013/14, and will be led by the Emergency Care Pathway Board, a joint senior management forum which will hold partners to account for delivery of real improvements to the quality, efficacy and appropriateness of emergency care.

2.16 **Avoiding admissions.** The admissions avoidance project has been set up to deliver upon the 2013/14 CQUINS (Commissioning for Quality and Innovation Schemes). This CQUIN scheme aligns contracts for service providers to ensure a reduction of admissions into hospital, linked to a reduced payment of 5% against 2012/13 levels.

2.17 **Supporting discharge from hospital**

There is also an opportunity for patients to move to more appropriate care after the acute phase of their care, and this has been clearly shown by a 'Day of Care Audit' where 28% (71/252) of patients in the acute hospital did not meet the criteria to require acute care. This data is also supported by the C&WFT Re-admissions Audit, which showed that 19.6% of readmissions to hospital are preventable, largely by the wider health and social care system rather than the acute provider. These opportunities are clearly whole systems challenges but need to be developed as the West London health community prepares for the implementation of '*Shaping a Healthier Future*' (SaHF).

2.18 The '*Shaping a Healthier Future*' review proposed an emergency services reconfiguration, whereby Charing Cross Hospital will become a local hospital, retaining an Urgent Care Centre but losing its full Emergency Department. This would lead to some activity being transferred from Charing Cross Hospital to Chelsea and Westminster Hospital, to the level of around 18,000 major cases per year. Planning for SaHF will mean that Chelsea and Westminster Hospital will need to plan to accommodate additional activity, and this will involve close partnership working with the CCGs and CLCH, to ensure that its inpatient capacity is used to best effect, for the most acutely ill patients who really need to be cared for in hospital.

2.19 Early successes include the development of an 'ambulatory care' pilot in the acute hospital, which enables patients presenting at the Emergency Department with certain types of conditions, to not be admitted but to be treated in a planned way in a booked clinic e.g. a patient requiring an infusion of a drug. This team have also piloted the use of a 'virtual ward', which is a group of patients who are discharged from the hospital – perhaps whilst they await a result from a diagnostic test – but remain under the care of the hospital consultant. This means that they can be monitored at home whilst the hospital consultant manages their condition in a remote, but safe way. Both of these schemes enable patients to be prevented from being admitted to hospital. The 'Front-end sub group' (attendance and admissions avoidance group) has met and has identified

some key areas of focus to address, including information sharing between partner organisations (e.g. GP / Out of Hours services and LAS / Emergency Departments) and developing rapid response services within the Emergency Department (delivered by CLCH). CLCH is also working on their development of the Community Independence Scheme which enables people with known health needs to more effectively direct their care. The community teams are also aligning their services to support the whole systems model. The project is envisaged to run until the end of 2013/14 and into 2014. Metrics and Key Performance Indicators will be developed by the individual work-streams and will be agreed and monitored by the Emergency Care Programme Board (which reports to the Tri-Borough urgent care Board). These metrics will align with the 'CQUIN' (Commissioning) targets and will be stretching to ensure that the maximum possible benefit is gained from this important piece of work. Performance against these metrics will also help to inform the development of the outline business case for *Shaping a Healthier Future*, as it is important to understand the potential of the out of hospital strategy.

#### **2.20 Guys and St Thomas' NHS Foundation Trust**

Guy's and St Thomas have a range of services and initiatives within the hospital setting and also with boroughs Lambeth and Southwark as the local provider of community services. The overall aim is to reduce unplanned admissions where possible, manage length of stay and ensure that discharge arrangements are as effective as possible to avoid unnecessary re-admissions

#### **2.21 Prior to arrival in A&E**

Lambeth & Southwark CCGS have commissioned a package of community based admission avoidance schemes, which form part of the broader Southwark and Lambeth Integrated Care (SLIC) programme's frail elderly pathway. Interventions that have been implemented include the 'Home ward', Enhanced Rapid Response team, establishment of geriatrician-led hot clinics, Community Multi-Disciplinary Teams (MDTs) within each locality and the reablement programme. A number of initiatives delivered through the GSTT Charity funded 'End of Life Care Modernisation Initiative', including Amber Care bundle, have resulted in better management of symptoms and end of life care in the community and nursing homes.

#### **2.22 Discharge and out of hospital care**

Bed management models are used by GSTT to monitor occupancy and capacity, with escalation processes in place to implement changes as required. GSTT have reviewed elective bed requirements and have plans in place to reduce Length of Stay (LoS) and internal delays via the Patients Waiting project. GSTT also have systems for setting consultant-led 'Expected Dates of Discharge' which are audited regularly. There are multi-disciplinary services in place to assess and support discharge of frail elderly patients e.g. Enhanced Rapid Response, Kings

Older People Liaison team. GSTT have plans to improve discharge planning. GSTT is launching a 'Length of Stay' work stream focussing on management of complex discharges as part of the Fit for the Future transformation program.

2.23 Step down facilities are also available for *very dependent patients* needing rehabilitation and restorative care, however this is limited in terms of capacity and covering housing & social care needs. Community teams are able flex capacity to accept some patients who may otherwise need step down beds. Redesign projects underway which aim to improve capacity and effectiveness of community health and social care provision, with expected outcomes to include reduced readmissions and referral times, for example the mobilisation of the Home Ward – which focuses on the three components of admission avoidance, early discharge and Case Management and Enhanced Rapid Response with Supported Discharge Team, which responds same/ next day when needed rather than 48 hr standard referral to start up time. GSTT Community Health Service also provides homeless intermediate care at Bondway which supports admission avoidance. Reablement capacity has also been increased.

2.24 Actions identified within the GSTT emergency department recovery plans include:-

- **Bed capacity:** detailed review of general medical and respiratory bed usage over a 24 month period undertaken to plan a flexible bed base for winter 2013-14
- **Increased clinical capacity:** appointment of four consultants & nurse recruitment completed, in addition to a review of junior doctor pool to explore increasing cover at peak times
- **Hourly monitoring** of occupancy leading to early identification of problems and development of actions/trigger points
- **Paediatrics:** review of paediatric discharge processes, joint Paediatrics & Adult medical post to be advertised and use of occupancy tool to manage surges in pressure

### **What are Council departments already doing?**

2.25 The Housing service commissions a range of services which help older and vulnerable people to remain independent within their homes. The out of hospital strategy presents opportunities to work more closely across a range of provision and with a greater number of providers to ensure that people are enabled to lead healthy and productive lives accessing services appropriately when required.

## 2.26 **Independent living**

Provision of specialist housing and housing related support makes an important contribution to the objective of promoting equality of opportunity and enabling vulnerable people to lead healthy lives and participate fully in the social and economic life of their communities and to lead healthy lives. A key priority for housing services is the provision of a range of housing options for older people to help them achieve better outcomes with improved health and a better quality of life. There are over 2,000 units of sheltered housing in the City. Both community alarms and telecare are key features of living in sheltered housing ensuring that an older person has access to support if and when they need it. Many of the sheltered housing schemes act as satellite hubs and deliver a range of preventative services for tenants and those living in the surrounding areas. The residential and nursing care strategy is seeking to increase the provision of extra care in the City. Complementing this, a review of sheltered housing provision is underway to ensure that the City Council can meet the future housing and care needs of older people.

2.27 CityWest Homes are piloting an Internet Protocol TV scheme in the Lillington and Longmore estates where all households will be provided with free access to the internet via television sets. The development of a range of additional services through IPTV are being explored including the following:

- Healthcare benefits, such as virtual surgeries, warden call systems

## 2.28 **Homelessness**

Compared to the general population, homeless people have complex health needs, use A&E to access basic healthcare, are more frequently admitted to hospital, have high rates of re-admission<sup>[1]</sup> and higher support needs<sup>[2]</sup>. *“Work with statutory partners to deliver outcome focused, targeted and cost effective interventions for rough sleepers, particularly for the most entrenched”* is a key priority of the recently published **Westminster Rough Sleeping Strategy**.

2.29 It is known that rough sleepers often do not access health support until a critical stage, frequently going straight to A&E rather than addressing issues earlier.

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<sup>[1]</sup> The most recent Joint Strategic Need Assessment carried out by Inner North West London (INWL), looking at Westminster, Kensington & Chelsea or Hammersmith & Fulham, estimated that between January 2010 and December 2011 the costs of rough sleepers to INWL was over £2.4 million, this includes A&E, inpatient and outpatient admissions. Rough sleepers are 7 times more likely than the general population to attend A&E.

<sup>[2]</sup> Of those contacted by outreach teams or arriving in accommodation only 26% had no alcohol, drugs or mental health support needs and 56% had either been in the armed forces, care or prison. (CHAIN annual report for Westminster).

Westminster has a long standing partnership relationship with NHS and jointly commission a number of services. In the City we have three specialist health services targeted at rough sleepers, which provide GP care in two specialist surgeries, and in-reach primary care in our commissioned day centres to target interventions at an earlier stage. This homeless health team work to improve the health, healthcare and social inclusion of Westminster homeless population, working in day centres to access and treat homeless people, help them register with GPs, and signpost and refer them onto specialist treatment where necessary.

- 2.30 In Westminster we have 8 front line hostels who accept referrals straight from the street, all of these have in-reach primary care and as part of a resident's induction process a comprehensive health assessment takes place. Westminster also commission 8 move-on hostels where referrals come through the front line hostels, in this provision the Council looks to link clients into mainstream primary care provision. Throughout the hostel pathway the authority commissions and funds specialist health services (mental health, substance misuse etc) that provide in-reach within hostels. All hostel residents have an annual health check and a care plan approach is adopted for those with significant problems. Westminster have introduced a number of health and well being courses in hostels including British Military Fitness, an annual inter-hostel football competition and a running club with a number of residents recently completing the three peak challenge.
- 2.31 To ensure that the Council are able to assess gaps more readily, they have agreed with NHS North West London a comprehensive health assessment tool which will be introduced in the next year within all commissioned hostel services. This will enable the authority to gain a greater picture of the health needs of the rough sleeping population to ensure they have the right set of targeted health interventions within commissioned provision to provide early intervention and prevention. They are also working with each hostel to reduce their A&E admissions, reviewing these on a quarterly basis through contract monitoring to see if there are any patterns in relation to hospital use and to target high tariff users to see if additional support is required. As a result of this additional nursing input in two hostels is being piloted this has been running for 3 months and already is showing a reduction in A&E admissions.
- 2.32 For those still sleeping on the streets we are looking at ensuring that all clients have access to primary care and ensuring that outreach target and signpost client effectively. The street facing teams are currently being recommissioned with a contract award in April 2014; a key outcome for the new services will be around linking in more effectively with health. Poorly planned discharges from hospitals can result in rough sleepers arriving back on the street without plans in place which often leads to swift re-admission. Work is ongoing with the Clinical

Commissioning Groups (CCGs) to explore intermediate care for rough sleepers in order to improve the health and well being of service users and ensure that there are accommodation pathways in place as part of discharge plans. Recently the Department of Health announced the Homeless Hospital Discharge Fund to improve the hospital discharge process for homeless people. The City Council is currently working with the CCG and NHS North West London to review and select the strongest bid(s) to be submitted.

- 2.33 Changes within the wider commissioning structures of key partner organisations, such as CCGs and with the police presents further opportunities for the commissioning of integrated services to prevent rough sleeping and achieve better outcomes for people with complex needs. An action plan is being developed to take the strategy forward through the health and well being board and supported by the tri-borough homeless health group.
- 2.34 There is a dedicated nurse commissioned by Tri-Borough Health at Westminster's Church Army hostel, which is a female only hostel in the north of the borough. The overall aim of the post is to engage hostel residents into primary care and to reduce the need for ambulance call outs to the hostel. Every client is fully assessed including diet, mental health and lifestyle and the role involves linking clients into appropriate primary health services.
- 2.35 We commission a number of single homeless services and in particular a supported housing scheme for ex-service personnel. The service works in partnership with the Tavistock Clinic the UK's leading provider of outpatient psychotherapy services. All clients have access to a range of therapeutic support to help them overcome complex trauma.
- 2.36 **Young Persons**  
The Children Act 2004 places a duty on local authorities to make arrangements to promote-co-operation between agencies and other appropriate bodies in order to improve the well-being of Children. Five outcomes have been used to measure against the success to improving children's well-being and housing related support services have played a key role in measuring these in particularly 'being healthy'. Westminster have set targets to ensure that every young person moving into housing related support services is registered with a GP. All services are required to identify the young person's health support needs and offer appropriate specialist support. The Local Authority have strong links with Westminster's CAMHS service ensuring that all 'Looked after Children' and care leavers, where required, are linked into the service. In addition Turning Point and North Westminster Drug Service provide satellite services offering support around mental health and substance misuse to our young people. As part of the Council's performance framework, health outcomes are monitored in partnership with Tri-Borough Children Services to ensure that the well-being of

the most vulnerable young people is improving as they move through the housing pathway stages.

### 2.37 **Domestic Violence**

Work is going on across the health economy (commissioners and providers of health care in Westminster) to introduce a safe and systematic approach to identifying survivors of domestic violence and supporting them and referring them appropriately, by introducing what is known as 'routine enquiry'. Routine enquiry refers to asking about the experience of domestic violence of all people within certain parameters (e.g. women aged over 16), regardless of whether or not there are signs of abuse, or whether domestic violence is suspected.

2.38 Westminster's Public Health team consider that an aspirational goal would be to train all health professionals in domestic violence awareness and routine enquiry, with a phased approach, as there are several different health trusts and providers delivering healthcare in Westminster and to Westminster residents. At present, midwives working at Imperial College Healthcare NHS Trust and Chelsea and Westminster NHS Trust have trained their midwives and are starting to embed routine enquiry within their practice. Central London Community Healthcare (who provide community healthcare services in Westminster) have also just updated their Domestic Violence Guidelines and are currently beginning a comprehensive training programme of routine enquiry for all their health visitors. Part of the next phase of the work is with A&E departments that serve Westminster residents via their safeguarding leads to develop training programmes for their staff around domestic violence.

## 3.0 **Committee Discussion**

3.1 The Westminster Adults, Health & Community Protection Committee recognises the damaging costs of unnecessary emergency admissions, not only in terms of financial pressures but also in dangerously delaying treatment for those who genuinely have urgent and clinically serious medical conditions or injuries which require immediate clinical attention. The Committee recognises and welcomes the work of our Clinical Commissioning Groups, hospitals and our own Council departments. It has been shown to the Committee, that there is demonstrable commitment to controlling unplanned admissions alongside hospital re-admissions.

3.2 However we consider that a 'tough love' approach is required to persuade people not to go to attend Accident & Emergency departments. In the Australian healthcare model, when inappropriate non-urgent and non-emergency attendances occur, it is often made difficult for patients to see clinicians at the emergency department, particularly if that patient has a track record of this

behaviour. The Committee consider that this type of approach should be encouraged in hospitals and urgent-care facilities.

- 3.3 The Committee considered that there was a clear need for a public education campaign in order that people are more acutely aware that they should register and attend with a General Practitioner in their local area.
- 3.4 The Committee would also like to press the Council to be part of a campaign to encourage patients to both register and attend with a general practitioner. This should certainly include interaction at A&E, up to an including initiating the registration process there and then.