

# Norfolk Health and Wellbeing Board

Item No

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| <b>Report title:</b>   | <b>Winter Resilience Planning</b>                              |
| <b>Date of meeting:</b>  | <b>8 October 2018</b>  |
| <b>Responsible Sponsor</b>   | <b>James Bullion,<br/>Executive Director Adult Social Care</b> |
| <b>Strategic impact</b><br>There are extreme pressures on health and social care during the winter months – and increasingly at other times in the year. Joint planning across the health and social care system has improved significantly, and the contribution that Adult Social Services makes towards supporting a stable system over winter is fully recognised.   |  |
| <b>Summary</b><br>Norfolk Adult Social Services plays a critical role in ensuring the health and social care system runs as effectively as possible during winter and other periods of intense pressure. Whilst much of the focus is naturally on the NHS, the contribution made by adult social services and the wider voluntary and community sector is significant.<br>This report asks Board members to agree the Norfolk Adult Social Services winter plan which sets out, in a single view, the department's arrangements for the winter period. The Plan prepares the organisation to maintain Adult Social Care services during winter whilst at the same time, supporting system partners in maintaining good patient flow and safety. Alongside the plan, there is a series of improvement activities, which are summarised in this report.<br>In October 2018, the Government announced additional one-off funding for Adult Social Services nationally to support winter pressures. For Norfolk, the allocation is £4.179m. This paper sets out the principles for allocating that additional funding to protect, sustain and improve health and social care. These will be considered by Adult Social Services Committee at its meeting on 5 November 2018. |  |
| <b>Recommendations:</b><br>The HWB is asked: <ul style="list-style-type: none"><li>• <b>To agree the Adult Social Services Winter Plan – attached at Appendix A</b></li></ul>  |  |

## 1. Background

- 1.1 An ageing population combined with increasing numbers of people with a long term health conditions means that demand for both health and social care is increasing, and we know that these pressures increase during winter months, particularly across the urgent care system. As we head into winter with an already pressured position across the Norfolk wide system, this winter will prove challenging for all stakeholders.
- 1.2 Adult Social Services is committed to playing its full role in supporting the health and social care system, and will be contributing to system-wide resilience plans co-ordinated by the NHS Urgent and Emergency Care board.

- 1.3 However, in addition, there is a need to have a single view of how the department will marshal its resources and prioritise interventions in line with a 'home first' culture and in line with our strategy Promoting Independence.

## **2. Review of Winter 2017/18**

- 2.1 Winter 2017/18 saw a long period of intense activity for the health and social care system. Winter, in effect, lasted until April, with a late surge of activity as a result of the Beast from the East. The prolonged summer heat also continued to see high levels of demand for hospital and community services.
- 2.2 As previously reported, the health and social care system struggled to meet challenging delayed discharges of care targets, despite greater investment in prevention and reablement, admission avoidance schemes, and stronger liaison with care homes.
- 2.3 In July, Adult Social Services organised a two-day system-wide event to look at what more could be done by health and social care to ensure people ready to leave hospital could do so without unnecessary delay. Over 80 representatives from the Norfolk and Waveney system were joined by experts from the Local Government Association (LGA) in partnership with the Better Care Support Team, National Health Service England (NHSE) and National Health Service Improvement (NHSI). Key findings from the event were:
- a) A need to break away from 'linear' ways of working which are driven by processes and not people
  - b) A need to work at all levels with a culture of 'home first' so that all professionals involved are working towards getting people home
  - c) Better communications at all levels – between different professionals, with care providers and particularly residential and nursing homes, and with individuals and families
- 2.4 The findings were reflected in the initial feedback from the Local Government Association Peer Review, commissioned by Adult Social Services, which found there was not a shared single understanding of recording of delayed discharges of care, nor of the practice to reduce and challenge current ways of working. The team's view was that there was an over prescription of care packages, particularly at the point of discharge, without timely review so the opportunities for rehabilitation and were sometimes lost.

## **3. Winter Planning and improvement for 2018/19**

- 3.1 The main objectives of our winter planning are to:
- Assure the continuity and successful response of adult social care and health services during periods of high demand and enable effective contingencies to be implemented in a planned and managed basis
  - Provide solutions that are not based on placements
  - Provide a strategic approach to demand & capacity management within the organisation by implementing new initiatives in time to deliver additional capacity to support the delivery of services to meet high levels of demand.
  - Ensure that social care and health teams have sufficient staff and access to care capacity and that commissioned providers, specifically home support services, have their own capacity management plans in place.
  - Undertake capacity planning across all hospital, community care and social care teams to ensure staff across Norfolk can be used flexibly to support elements of the system depending upon priorities

- Ensure effective communication with staff including those of external providers where there are forecasts of increased demand or potential adverse weather events affecting service delivery to support service planning and caseload management.
- Maintain effective flows and pathways of care to ensure that people receive care in the most appropriate setting and in a timely manner
- Engage key staff to embed proactive winter planning across all services including non statutory services
- Work collaboratively with other partners to ensure the winter plan meshes with other key providers including external providers to provide a coordinated and well managed response to winter pressures

3.2 To strengthen Adult Social Services the following improvement themes are being implemented:

- **Operational leadership** – a senior post with accountability for adult social services hospital discharges across the Norfolk system has been assigned. As well as the remit to make changes in ways of working within the hospital discharge teams, the Assistant Director will have an influential voice on A&E Delivery Boards covering the county, and work closely with the health and social care Winter Director – a new appointment for the NHS this year.
- **Brokering and arranging care** – whilst the vast majority of people go home from hospital, we know that delays happened because of the difficulty of finding a place in a care home for people who need it. Good quality, reliable information about vacancies is critical, and this year we have invested in an improved 'Bed Tracker' – an online system where care homes can record vacancies. Bed tracker is the first point of call for adult social services in looking for vacancies, so there is an obvious incentive for homes to use that site. Analysis over the summer of ways of working have cut out duplication, and ensured that valuable social worker time is not taken up with ringing around homes for vacancies – a practice which and become too frequent.
- **Communication and liaison with care homes and providers** – trusted assessors began their roles last winter, and have developed trusted arrangements which avoid the need for care homes to carry out their own assessments before they accept patients. A joint health and social care group is working specifically on a set of actions to improve working with care homes; this will address the importance of GP alignment to care homes, medicines management for people returning to their care homes, and contractual arrangements to ensure people's places are still there for them to return to after a stay in hospital.
- **Reablement** – the expansion of reablement both home based and in special accommodation makes a significant impact on people's independence. As well as more capacity, we will be ensuring front-line social work staff are considering reablement as the default option for most people. In addition, we will be looking at how other short-term beds are used. Our research has showed that beds we commission in care homes for a short-term stay, invariably turn into a permanent admission. On occasions, this may be appropriate, but we believe with more reablement and therapy input, more people could return to their home.
- **Prevention and early intervention** – investments made last year in social prescribing, reducing social isolation, will be fully felt this winter. There is now a network of community connectors across the county, working in alignment with our own Integrated Care Co-ordinators alongside primary care. Each CCG area has in place a dedicated service designed to avoid admission to hospital and

address crisis. Norfolk's Enhanced Home Support Service helps individuals to regain their independence, confidence and resilience following a crisis.

- **Data, recording and intelligence** – our discharge teams in hospitals were last winter required to produce many returns and requests for data. This was sometimes as many as 30 different reports in a single week. Despite this level of activity, the intelligence has remained weak. Adults will be seeking to influence NHS colleagues to consolidate reporting and to have a common, consistent set of metrics collected and reported across all hospitals.
- **Communications** – the MADE event in July urged the Norfolk system to address the need for good communications. This was within and between different professionals in hospital setting, between primary care and hospitals, and between social work teams and others in the system. There is also a need to ensure that conversations with families are handled effectively, and that people receive consistent messages about maximising independence from different professionals within the system.

### **Additional one-off monies for Adult Social Services from the Department of Health and Social Care**

- 3.3 In a pre-budget announcement in October, the Secretary of State for Health and Social Care announced additional one-off funding for social care for winter. For Norfolk, this translates into £4.179m. Whilst specific funding conditions are awaited, we know the funding will need to be used to support winter resilience, specifically activities which reduce and delay the need for formal care and support the safe discharge of people from hospital.
- 3.4 We anticipate the funding will build upon the key areas identified in 2017 to protect, sustain and improve social care. Key priorities for the system are:
- a) Supporting financial pressures within ASC
    - Ensuring that the budget is managed sustainably and ensuring that expertise and capacity is available in the event of market/provider failure
  - b) Supporting capacity to manage winter pressures including embedding D2A
    - Embedding a culture of 'home first' and ensuring that services to support that are in place and effective
  - c) Bolstering short term capacity in the care market - homecare and care home markets to ensure sustainable care provision and managing potential market failures. Investment in the market to increase capacity and recruitment

**Early proposals are:**

**Invest and improve**

- Measures to avoid unnecessary delays in hospitals for people with mental health difficulties, for people with dementia and for people who are at the end of their life and want to die at home
- Additional intensive help for people in their own homes for the first critical period when they are discharged from hospital

### **Sustain**

- Additional locally targeted recruitment campaign for the independent care sector to maximise the impact of the national campaign due to be launched shortly
- Better system-wide real time information, particularly for home care to speed up discharge and sustain efficient use of capacity
- Additional reablement – expanding accommodation based reablement and reaching in to short-term housing with care beds to build confidence and skills to help people home
- Additional swifts to take on more preventative work – in addition to their highly valued reactive service which saves the NHS money through avoiding admissions
- Change management to embed the ‘home first’ culture identified as critical by the MADE event for the system as a whole

### **Protect**

- Additional protection for Adult Social Services budget in the face of sustained pressures, ensuring sufficient packages of care to meet anticipated increased demand
- Bolstering short term capacity in the care market - homecare and care home markets to ensure sustainable care provision and managing potential market failures.

- 3.5 Whilst the additional grant has been made to local authorities, there is an expectation that proposals for how it is best used will be shared with health partners, and the Executive Director of Adult Social Care will ensure this takes place.
- 3.6 The Adult Social Care Committee will be asked to agree the principles underpinning the use of the additional grant at its meeting on 5 November 2018. The additional monies complement the existing Better Care Fund and Improved Better Care Fund.
- 3.7 The Better Care Fund was set up by the Department for Health and Social Care in 2013 to further accelerate the join up health and care services so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. Whilst there was no new money from the Government for the fund, both CCGs and local authorities were asked to pool some of their existing funds and agree a single spending plan for the pooled fund.
- 3.8 The improved Better Care fund was a feature of the 2017 budget and was an allocation over three years to local authorities. In Spring 2017 a further one-off grant element of the improved Better Care Fund was announced, covering the three years 2017-2020 with an expectation that it would be used along similar lines to the core better care fund to protect, sustain and enhance the social care and health system.

- 3.9 Taken together, these funds target a range of system improvements across these themes:
- Strengthened community based services which help people stay at home and avoid the need for a hospital admission
  - Strengthened working with care homes to support the overall sustainability of independent care homes and to use their expertise to help their residents avoid the need for hospital admission and return back to their home after an episode of acute care
  - A system-wide culture of 'home first' which improves joint working between different professions in and out of hospitals.
- 3.10 Taken together the Better Care Fund and the iBCF will see £57m in 2018/19 aligned towards these joint health and social care objectives.

### **Risks**

- 3.11 The key risks the County Council's Adult Social Services department is managing this winter are:
- **Recruitment, retention and wellbeing** – sustaining staffing levels over winter in the whole care sector is vital, together with staff wellbeing which minimise short-term sickness absence. Arrangements are in place for all Norfolk county Council front-line social care staff to have a free flu jab. Nationally, there is provision for all care home staff and home care staff to access the flu jab.
  - **Market capacity** – the majority of delays attributed to Adult Social Services has been people waiting for a support package. Homecare continues to be difficult to access in some parts of Norfolk.
  - **Holding lists** – the department has made good strides in reducing the holding list over the last year; however, urgent demand from acute hospitals to support people back home can increase workloads for community teams, and allow less urgent requests to build up.
  - **Maintaining our strategy** - at peak periods, the very high numbers of people seeking urgent medical care puts strain on the capacity we have to prevent and reduce the need for formal care. We know from previous years that increased numbers of people are admitted to residential and nursing care during winter months, and whilst for many this will be the right outcome, there could be those for whom alternatives might have been possible.
  - **Financial** – at times of pressure, there is a risk that a 'safety first' culture leads to more intensive packages of support for people. If these are not reviewed there is a risk that we build in greater dependency for longer which in turn is more costly to the department.
  - **Reputation** – as a system Norfolk did not perform well last winter against key measures from the Department of Health and Social Care. It is important for the confidence of people who use our services, that the contribution of Adult Social Care is not overlooked.

### **Officer Contact**

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**Norfolk** County Council

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# Winter Plan

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## Introduction

Winter creates an annual challenge for the local health and social care systems by placing additional pressure on services. Therefore, it is essential for organisations within the health and social care systems to create and share their plans to address and mitigate these pressures in order to maintain the safety of the local population.

The winter period is between 1 October and 31 May. While winter will have ended as a season, the system remains in an escalated state until the end of May due to the two May Bank Holidays and the added pressure experienced at these times.

This Adult Social Services Department (ASSD) wide winter plan sets out the organisation's arrangements for the winter period. Winter is not an emergency or considered an unusual event but recognised as a period of increased pressure due to demand both in the complexity of people's needs and the capacity demands on resources within the Trust and the local health and social care system.

In addition, the winter period often brings with it untoward events such as widespread infectious diseases including Norovirus and there is the risk of the onset of the unusual such as pandemic flu which can affect patients and staff alike.

The Winter Plan prepares the organisation to maintain its service during winter and support system partners in maintaining good patient flow and safety.

- Focus on prevention
- Create the capacity to meet increased demand
- Link the Winter Plan to the West and Central System Resilience Plan
- Robustly performance manage the system to maintain quality, activity, safety and experience

Norfolk County Council (NCC) ASSD provides an assessment and care arranging facility and contracts care from the region's care market. It also provides a number of in-house services such as Norfolk First Support (NFS) which aid the system to operate as smoothly as possible and minimise cost. The top four interventions within this report are:

- Reduction of social care attributed DTOC (Delayed Transfer of Care) in acute and community hospitals
- The reduction and avoidance of admissions through greater co-operation between NCH&C (Norfolk Community Health & Care NHS Trust) and services within the community, CAS (Care Arranging Service) and other ambulatory pathways within primary & community care
- Building the resilience of teams to meet demand
- Developing operational infrastructure

This document should be read in conjunction with the NCC Adverse Weather Policy, Major Incident and Business Continuity Plan, Emergency Preparedness Resilience & Response (EPRR) Policy and Service Business Continuity Plans.

## **Key Lessons Learned from winter 2017/18**

### **Links with the care market**

The Trusted Assessors and incentive schemes were deployed during winter 2017/18. While incentives were welcomed, their efficacy is yet to be proven. However, working with the market has identified issues which need addressing to improve access to care, especially at weekends. Homes and care providers express a lack of confidence in the quality of discharge which is heightened at weekends when accessing support from health services is perceived to be challenging.

### **Resilience and Escalation Plans**

Norfolk County Council ASSD did not report OPEL (Operational Pressures Escalation Level) status throughout the previous winter therefore, there was no standard means of measuring operational pressures within the department from which to base decisions to take escalation actions. A learning event conducted in spring, identified the importance of conducting a regular systematic review of operational pressures linked to an escalation framework to ensure consistent responses to escalation which is communicable to other system partners.

## **Approach to Operations Management for Winter 2018/19**

### **Operations Centre**

Norfolk County Council, in partnership with NCH&C, will establish an Integrated Winter Operations Centre in order to create a common operational picture, monitor performance and activity, coordinate and manage escalation, and act as liaison with other system providers regarding system performance.

During winter 2018/19, the operations centre will be operational five days a week between 09.00 and 17.00 and existing on-call management will be available between 17:00 and 09:00 each day and 24 hrs a day at weekends and Bank Holidays. A request for winter funding has been made to extend the Winter Operations Room to seven days a week. The outcome of the request is unknown at the time of writing this plan.

The Operations Centre will be responsible for collating information and sharing operationally relevant information with system partners on the daily silver calls and will manage any response to service escalation. In the event of a Significant Incident or Major Incident, the Operations Centre will work alongside the incident control room.

The STP (Sustainability and Transformation Plan) will deploy a winter operations room to oversee service delivery and resilience across the region. The integrated NCC and NCH&C operations room will report into the STP operations room.

### **Capacity Planning and Operational Control**

Operational and commissioning teams will remain accountable for the development and delivery of their capacity plans, set during annual planning, and ensure their operating models and processes are in line with the local system they are supporting. These capacity plans may be represented as rosters and will remain responsible for the coordination of the daily work activity to deliver services. The Operations Centre will monitor these capacity plans and escalate issues, such as roster gaps or gaps in market provision, to relevant senior managers for resolution. In addition, the Operations Centre will monitor the daily work activity to ensure it meets required productivity requirements and escalate any issues, such as an increase in DTOC, to relevant senior operations and commissioning managers for resolution.

### **OPEL**

For winter 2018/19 NCC will provide the system with a daily OPEL report which will be coordinated through the Winter Operations Centre.

All operational teams within ASSD will be required to create a daily OPEL report and submit this to the Operations Centre by 09.30. The service will be expected to take action in-line with their local escalation plans and for SITREPs (Daily Situation Reports) to be provided to the Operations Centre by 15.00 if the service has escalated to OPEL 4.

## **Services**

### **Contact Service Centre (CSC) and Social Care Centre of Expertise (SCCE)**

The CSC, which is also home to SCCE, provides a vital access point for those who need social services support. The department receives approximately 350,000 contacts per year via telephone, email, web and, increasingly, social media channels. Around 90% of these are managed and dealt with in the department, without the need to involve other teams.

The Social Care Centre of Expertise is managed by qualified social care staff which enables social care assessment and reviews to be conducted by phone. In addition, SCCE provides a weekend and Bank Holiday Emergency Duty Team.

The role of CSC and SCCE means it is an essential part of the service offer as well as an integral part of Adult Social Services resilience. The CSC and SCCE will monitor staffing regularly to ensure adequate staffing is available to maintain service outcomes.

## **ASSD support to Acute Services**

Norfolk County Council provides three acute social work teams to facilitate a person's timely discharge back to their normal place of residence or the least restrictive, least costly option for long term care as well as supporting safeguarding investigations.

In-line with NCC Promoting Independence plans, the responsibility for supporting discharges from the James Paget Hospital Foundation Trust, and the staff supporting this process, will transfer to the locality team in the East and Suffolk. This change will take place on 1 November, prior to winter pressures starting. The change in the East of Norfolk will be reviewed prior to changes to other teams.

The team based at the NNUHFT (Norfolk & Norwich University Hospital Foundation Trust) will work collaboratively with the acute Trust to improve current multi-disciplinary working within the Discharge Hub, particularly in respect to patients who do not clearly fit existing discharge pathways. In addition, the team will work directly with wards known to be high referrers, to introduce the 3 Conversations approach in order to reduce the number of assessment and discharge notices being issued and rejected.

To support and maintain flow through the acute hospitals during winter 2018/19 additional assessment capacity will be required. The services will aim to maintain 80% of their establishment to be at work to ensure the service is resilient.

A standard definition for DTOC will be in place across all NHS Trusts and a DTOC validation process will be fully embedded before the start of winter.

Trusted Assessors, part of the Promoting Independence and iBCF (Improved Better Care Fund) plans, were introduced during 2017/18 and continue to develop relationships with the care market to reduce DTOC. Learning from the pilot will be used to develop new action plans and business cases for the winter of 2018/19.

The Enhanced Home Support Service (EHSS) and Short Term Beds have been seen as a positive addition to the system by the acute based social work team. This will continue throughout 2018/19 to contribute to a reduction in DTOC. The capacity of these discharge options will be reviewed prior to winter.

## **Community Social Care Teams**

The community Social Care Teams (East, North, Norwich, South and West) provide assessments for older people, people with physical disabilities and working age adults.

In-line with the Care Act and the NCC Promoting Independence strategy, the community social work teams focus on people's strengths and look for community based opportunities to support individuals and carers to maximise their wellbeing. The teams are currently trialling the Living Well: 3 Conversations approach, which is a strengths focused and preventative model supporting people to maximise their independence. These teams provide in-reach to community wards to support discharge.

The teams work closely, in an integrated way, with primary care and community health services. The teams include Integrated Care Coordinators, Assistant Practitioners, Social Workers, Practice Consultants and Social Workers. Social work is a key component of developments within community and primary care.

### **Priorities**

For winter 2018/19 the Community Social Care Teams are focusing on prevention. This includes maximising work already underway:

- 3 Conversations (Promoting Independence)
- Reducing holding lists (Promoting Independence)
- Reducing reviews list (Promoting Independence)
- Engaging with local development groups and GP practices

There will be a specific focus on the following to help reduce pressure on acute Trusts during winter:

- Falls
- Dementia
- Social Isolation

Teams will plan to be at or above 75% of their establishment at all times to ensure they have sufficient capacity to respond to community based needs. Additional capacity in Social Work and Occupational Therapy is being recruited in order to increase responsiveness of the teams and further improve outcomes.

The Community Social Work Team supports community hospitals to safely discharge patients. In early 2018/19 the model of support was changed, and each ward has now been assigned a social worker. The ward attached social worker works as part of the Ward MDT (Multi-disciplinary Team) and is part of the daily Red to Green meetings which enables good communication and ensures long term needs are identified early in line with the HICM (High Impact Change Model).

## **LD and Mental Health**

### **Learning Disabilities (LD)**

The Integrated LD team works to improve the quality of life for people with learning disabilities, in their homes and communities. During winter, people supported by this team will need ongoing support from a resilient service. Like many community based services, the LD team will be affected by weather and service users will be taken ill and access acute care. The Acute Support Team (AST), which also offers support out of hours, is particularly at risk due to adverse weather and learning from winter 2017/18 could benefit from closer working with other out of hours services. A comprehensive resilience plan will be in place before winter 2018/19.

There will be times when people supported by the service will be admitted to acute care. The three acute Trusts in Norfolk are supported by a liaison nurse and acute pathways are in place to provide support and facilitate discharge back home. The pathway will be checked to ensure all parties are fully aware of how to access it prior to winter 2018/19.

### **Adult Mental Health**

Supporting people with their mental health to remain well throughout winter is challenging. Avoiding crisis and supporting people when they are in crisis is essential for their wellbeing, as well as avoiding placing pressure on other services which, in many cases, are not always set up to meet their specific needs.

For winter 2018/19 requests for winter funding have been made and approved to support people to avoid crisis and, if they do escalate, for alternatives to the emergency department to be available.

These requests are:

- Increase day centre-based step-down capacity in Norwich to support mental health discharges for working age adults by providing a safe space for patients who need more intensive support than can be provided in their own home. This aims to enable earlier discharge and prevent unnecessary admissions
- Additional dedicated AMHP (Approved Mental Health Professional) cover to meet expected increase in demand over winter in order to improve response to requests for MHAs (Mental Health Assessments)

### **Older People's Mental Health**

Norfolk has a rapidly aging population and is experiencing a growth in age related mental health needs. Older people's mental health is supported by the community care social work teams who work closely with Norfolk and Suffolk NHS Foundation Trust (NSFT). The social work team provides essential support to maintain flow through NSFT beds and work to avoid DTOC.

Named social workers are linked to NSFT older person wards and attend regular discharge meetings. Many cases are complex and require significant effort to identify suitable long term care. Many patients present with both physical and mental health needs and identifying discharge opportunities is challenging.

Winter funding has been requested and approved to procure additional short term beds to specifically provide step down and admission avoidance for older people with both physical and mental health needs.

### **Commissioning and Care Market**

The care market for both home care and residential care is a dynamic environment. The NCC Market Development Team and commissioners work closely with a wide range of private providers to enable access to high quality long term care.

To enable a response to meet the highly variable demand upon the market a number of initiatives have been put in place.

- **Commissioning Manager; Transfer of Care** – this post works closely with social workers to address issues affecting discharges and causing DTOC
- **Enhanced Home Support Service** – provides flexible and enabling support for up to seven days to help support the individual at home following discharge or to prevent admission
- **Short Term Beds** – provide bed based short term placements to enable Care Act assessments to take place outside of a hospital
- **Norfolk First Support** – increases the capacity for home based re-enablement
- **Accommodation Based Reablement Units** – provide short term bed based reablement to facilitate hospital discharge and prevent avoidable admissions
- **Enhanced Health in Care Homes** – a support to providers to understand how and when to seek health intervention and training to enable providers to safely meet needs within care home settings
- **Social Prescribing Project** – provides additional community connector roles aligned to GP practices enabling GP access to VCSE (Voluntary, Community and Social Enterprise) services in the community
- **ICES – Integrated Community Equipment Service** – access to equipment for both health and social care staff will be made more responsive over the winter period

A bed tracker is available to capture available residential and nursing home capacity. This relies on homes providing their bed availability. Approximately 60% of the market is currently actively inputting their available capacity. This information is used by the Care Arranging Team to quickly locate potential placements. A new version is due before winter 2018/19 which will enable a greater range of information to be captured and enable a more efficient brokerage process. A longer term plan is in place to move to an eBrokerage system which will be developed following winter 2018/19.

The Trusted Assessors and the Commissioning Manager for Transfer of Care are working with providers to increase their confidence and address concerns. They are working with acute services with the aim of reducing the need for homes to conduct assessments and ensure appropriate health services are available and accessible in the community when required.

Service Brokerage is undergoing a review as part of the Promoting Independence Programme. The output of the review was not available at the time of writing this plan. This plan will be updated once the review is completed and published.

Norfolk County Council ASSD provides in house services under the brand of Norfolk First Response (NFR). These include:

- Norfolk First Support (NFS) – home based reablement service

- Swift Response – 24-hour unplanned needs service
- Benjamin Court – accommodation based reablement

These services aim to support people to return to independence and reduce the need for long term care.

During 2018/19 NFS received additional funding to increase their capacity by 15%. Recruitment is underway and aims to be complete by winter 2018/19. Ensuring NFS is responsive and resilient is a key action for this coming winter and work to enable rapid step down to long term care providers is underway. The additional capacity includes salaried relief staff to provide an additional level of service resilience.

Norfolk First Support is introducing an electronic capacity monitoring system which will improve efficient use of capacity. The system is expected to be in place prior to winter.

Benjamin Court will continue to provide bed based re-enablement throughout winter 2018/19; recent recruitment has enabled all 18 reablement beds to be available.

The NFS service recognises how important the relationship is between their service and the acute Trusts. A team of hospital liaison practitioners provide a critical link with all three acute Trusts in Norfolk.

Norfolk County Council ASSD requires service providers to operationally provide to the full terms of their contractual agreement. This includes having the level of staff required to deliver the service fully and safely, having a plan in place for the event of significant service impact including staff illness and inclement weather, and ensuring service users are not impacted by a reduction in regular service provision. All service providers are required to have business contingency/continuity plans in place. In the event of serious impact on service delivery, providers are required to inform the Council of the situation as soon as practical to do so.

Providers will be informed and reminded of key periods of pressure (for example, Bank Holidays) and updated on how they can help and what support is available to them.

Historically, NCC has supported local care providers to remain resilient through offering advice and support online. This information will be reviewed prior to winter and updated as part of the Winter Communication Plan.

Advice is available for vulnerable people and those looking after them (<https://www.norfolk.gov.uk/what-we-do-and-how-we-work/campaigns/stay-well-this-winter>). This advice includes:

- Tips for staying well this winter
- How to make homes energy efficient and safe
- How to claim financial help
- What to do if you are worried about a friend or relative

# STAY WELL THIS WINTER

Social isolation is a significant issue throughout the year; however, winter can bring additional challenges. Norfolk County Council is working with local businesses to help combat social isolation through the “In Good Company” campaign (<https://www.norfolk.gov.uk/what-we-do-and-how-we-work/campaigns/in-good-company>).



District Councils offer a number of local initiatives, such as slipper swaps, access to handyperson services, benefit checks and electric blanket checks. These initiatives vary across district councils and more information will be made available as information is released.

## Factors Affecting Service Delivery during Winter

### Change Programme

There are no significant change projects planned that will impact on operational capacity during winter 2018/19. Programme leads have been requested to inform the Assistant Director of Operations and Patient Flow of any projects which will have an impact on operational capacity.

### Infections

Infections, such as flu and Norovirus, can affect staff and access to care homes. If teams contract illnesses, then assessment capacity is adversely affected. Norfolk County Council provides Public Health services for Norfolk and ensures information regarding predicted risks and outbreaks are shared across the health and social care system.

### Flu Plan

Acute based teams aim to ensure all staff are immunised against flu in-line with advice from Public Health. Care and nursing homes are encouraged to protect their staff and are provided with advice on how to access free flu vaccinations for paid carers. Clinical Commissioning Groups (CCGs) and local primary care providers are required to ensure their “at risk” populations have access to vaccinations which include those living in nursing and care homes.

## Winter Plan Action Log

**NOTE – actions under review by the Assistant Director Hospital Systems and monitored through the Winter Resilience Group**

| Ref      | Issue   | Required Outcome   | Action Needed   | By When?  | Progress (18/10/18)  |
|----------|---|--|---|---|--|
| OPS A1   | Operational reporting is not currently standardised across operational teams. | For operational reporting to be standardised and automated where possible. | Review of current operational reporting practice.<br><br>Standard reporting framework established.  | September 2018<br><br>October 2018                | Information from all localities and acute teams has now been received. Review of reporting requirements underway.<br><br>To progress once above is completed.                          |
| OPS A2   | NCC does not report OPEL states.  | For NCC to report daily OPEL states in line with system partners.          | Development of OPEL reporting framework.<br><br>Deploy framework.   | September 2018<br><br>October 2018                | Triggers and action cards being reviewed by Central, West and East. Changes to be made and agreed W/C 29 October.<br><br>Progress on daily monitoring/reporting delayed due to OPS A1. |
| Acute A1 | Additional assessment capacity will be required to meet demand.               | Increase of assessment capacity for winter 2018/19.                        | Recruitment of additional social workers or agency social workers.  | 1 Oct 2018  | Funding request has been made to use pay budget underspend or one-off funding routes. Awaiting response.   |
| Acute A2 | The NNUHFT discharge hub has not fully integrated.                            | For the NNUHFT discharge hub to be effective and reduce DTOC.              | Form an Integrated Discharge Hub leadership group with rotating chairperson to lead discharge hub and provide cohesive leadership for teams operating in the hub.<br><br>Set up senior MDT to take place x three per week to agree group plans on discharging highly complex cases with clear escalation routes if consensus cannot be achieved.<br><br>Work with high referring ward to deploy 3 Conversations and | August 2018<br><br>August 2018<br><br>August 2018 | In place – further work needed to improve how the collaborative team works together.<br><br>In place.<br><br>Delayed due to operational pressure on the NNUHFT social work team.       |

|        |  |  |   |                               |  |
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|        |  |  | collaborative working (avoidance of transactional management of discharge).   |                               |  |
| LD A1  | AST is a small team which works independently of other out of hours services which means it may struggle to meet service user needs during adverse weather.                        | For the AST to be resilient out of hours.  | To link AST to other out of hours services such as Night Owls and NCHC OOH Nursing Service for support and resilience.  | October 2018                  | In place – AST linked to NCHC out of hours team who will provide a “buddy” system for the AST team.  |
| LD A2  | LD discharge pathway not fully established in NNUHFT.  | For LD pathway to be fully established in NNUHFT.  | LD team to ensure NNUHFT Discharge Hub are aware of LD pathway and it is fully established.   | October 2018                  | Pathway written and agreed within LD team. To engage with NNUHFT team.   |
| MH A1  | There are an insufficient number of short term beds for older people with mental and physical health needs.  | Three additional beds for 22 weeks   | Submit winter funding request.<br><br>Commission beds.  | July 2018<br><br>October 2018 | Bid submitted but not approved by AEDB.  |
| MH A2  | There is insufficient capacity within day services to meet the winter need.  | Additional AMHP capacity.  | Submit winter funding requests.<br><br>Source additional AMHP.  | July 2018<br><br>Oct 2018     | Bid submitted by not approved by AEDB.   |
| Com A1 | There is a delay in the discharge of nursing and residential care home residents from hospital as care home managers are not able to do assessments before agreed discharge dates. | Patients from and going to nursing and care homes are actively managed with TAFs (Trusted Assessment Facilitators) and discharge co-ordinators working closely with Nursing and Care home managers who have confidence in assessments completed by TAFs to facilitate speedy discharges. | TAFs will have visited the top 50 LGA funded and high-risk care homes across Norfolk and Waveney and be competent to complete assessments on their behalf so that DTOC are minimised. | 1 October 2018                | TAFs have visited and are competent to assess on over 60 care homes across Norfolk and Waveney. They are now promoting the use of the bed tracker with the care homes who have the most LGA funded beds so that we know where bed vacancies are. |
| COM A2 | Availability of providers who will accept EMI patients (Elderly Mentally ill) particularly OoHs and over the weekend.  | Increase number of EMI beds available in each locality with the expectation that they can accept referrals and trusted assessments seven days a week, and referrals up until 20:00 for returning residents.  | To undertake a procurement exercise to test and put in place arrangements in each locality for EMI beds over the winter period.   | Mid November 2018             | Procurement exercise complete; currently work with Procurement to explore options for competitive process and putting in place block contracts.  |
| COM A3 | Supporting effective system working and business continuity through periods of system pressure and severe weather.   | Ensure social care providers are kept informed of operational, commissioning and quality issues/opportunities/resources through the winter.  | Produce a communications calendar for winter that will deliver key messages on actions (held by social care) in the Winter Plan with a clear communication lead for operational       | 1 October 2018                | Winter communications underway, focusing in October on the flu vaccine, Bed Tracker and TAFs, communication plan is almost complete, and will be shared with Corporate Comms Team and STP.   |

|        |  |   |  |               |   |
|--------|--|---|--|---------------|---|
|        |  |   | teams  |               |   |
| COM A4 | There are many care providers in the region and greater intelligence on their services will enable timely action to take place.                                      | For NCC to have detailed intelligence in place for each provider to support efficient sourcing of care and prompt hospital discharges. To include: <ul style="list-style-type: none"> <li>• Availability of beds and prices (if not accepting NCC rates)</li> <li>• Mobile contact details for current assessor</li> <li>• Availability for accepting discharges</li> </ul> | Update bed tracker to include this information requirement; Trusted assessors to help compile local intelligence.  | October 2018  | Bed Tracker due to be launched 30 October for care and nursing homes across Norfolk and Waveney; all required outcomes achieved; vacancy report to be shared with brokerage teams in CCGs; engagement planned throughout Winter to secure providers use the tool. |
| COM A5 | Lack of availability of equipment is causing delays in discharge from acute hospitals.   | Access to equipment will be facilitated so that delays waiting for equipment are minimised.   | Same day deliveries made to acute hospitals over the Christmas period. Prescribers able to prescribe equipment for people going into care homes. NFS able to access peripheral stores and collect equipment from care homes. | December 2018 | Setting up process for same day delivery around seasonal Bank Holidays; new 'Equipment in Care Homes' process in development; working with Peripheral Stores and Providers to improve resilience and communications.  |
| COM A6 | EHSS is benefiting the system, further work is required to ensure up-take of current capacity and strong links to admission avoidance teams.                         | For EHSS to support admission avoidance work and ensure that the service capacity is utilised to support step down referrals.   | Continue to promote the EHSS Service and ensure that the service is used to its full capacity. Continue to simplify and streamline EHSS systems including the referral process.  | November 2018 | Engagement work with acute social work teams, Brokerage Service and other operational teams underway and ongoing; planning underway to simplify EHSS community and referral process.  |
| COM A7 | NFS are holding packages of care. This is using capacity which could be used to avoid admissions, avoid DTOC and reduce amount of long term care being commissioned. | For commissioners to review unmet needs list and find solutions to areas of unmet need working in tandem with NFS.  | To reduce holding list so that unmet needs are resolved within seven days per locality   | November 2018 | Unmet needs list has validated so now have clarity on where 'real' unmet needs are.   |
| COM A8 | NFS is not fully established.  | For NFS to be fully established, including the additional 15% and BCU staffing.   | Recruit to establishment.  | October 2018  | Northern and Southern SCS teams brought into NFS team to meet immediate demand; recruitment campaign underway to meet future demand; currently working on establishing a career pathway and introducing an apprenticeship framework.                              |

## Appendix 1 – Domiciliary, Residential and Nursing Capacity across Norfolk

| Provider Type            | Number of Providers Across the County   | Number of Hours/Beds  | Notes  |
|--------------------------|---|---|--|
| Domiciliary Care         |   | Approx. 63,000 hours per week across the county   |  |
| Residential/Nursing Care | <p><b>Norfolk:</b><br/>362 Homes<br/>299 Residential<br/>63 Nursing</p> <p><b>East:</b><br/>47 Homes<br/>38 Residential<br/>9 Nursing</p> <p><b>Central (North/Norwich/South)</b><br/>258 Homes<br/>212 Residential<br/>46 Nursing</p> <p><b>West</b><br/>57 Homes<br/>49 Residential<br/>8 Nursing</p> | <p><b>Norfolk:</b><br/>9,655 Beds<br/>6,911 Residential<br/>2,744 Nursing</p> <p><b>East:</b><br/>1,014 Beds<br/>767 Residential<br/>247 Nursing</p> <p><b>Central (North/Norwich/South)</b><br/>6,855 Beds<br/>4,812 Residential<br/>2,043 Nursing</p> <p><b>West</b><br/>1,786 Beds<br/>1,332 Residential<br/>454 Nursing</p> | <p>Nursing = home is registered for nursing, estimate is that c.50-60% of beds only are “nursing” beds in these homes</p> <p>Geographic area = CCG derived, Norfolk only</p> |