Health and Wellbeing Board

Item 9

Report title:	**System Winter Resilience Planning**
Date of meeting:	**30 October 2019**
Sponsor (H&WB member):	**James Bullion Executive Director Adult Social Care Melanie Craig, CCG Accountable Officer**

Reasons for the Report

There are extreme pressures on health and social care during the winter months – and increasingly at other times in the year. This report outlines the joint planning across the health and social care system which has improved significantly, and the contribution that Adult Social Services makes towards supporting a stable system over winter is fully recognised.

Report Summary

Planning for winter is well-established across the Norfolk and Waveney health and social care system and there is a strong collaborative approach which recognises and values the strengths and contributions of different organisations within the system.

This joint report summarises the learning to date, the challenges for this winter and the shared objectives for health and social care for winter and all-year round resilience.

Recommendations

The HWB is asked to:

a) Consider the challenges set out and agree the joint objectives (3.2) for Winter and all-year resilience.

1. Background

1.1 The impact of an ageing population combined with increasing numbers of people with a long-term health condition means that demand for health and social care is increasing all the year round. However, across the winter months these pressures are exacerbated, particularly across the urgent care system and primary care.

1.2 Long term condition prevalence, co-morbidity, frailty and risk of emergency admission increase with age. The more co-morbidities that a person has, the more likely they are to require care across diverse settings, and the higher the requirement for care resources. Norfolk is a predominantly rural county, with North Norfolk and South Norfolk Clinical Commissioning Groups (CCGs) amongst the most rural areas in the country. This poses a significant challenge to the delivery and accessibility of health and social care services.

1.3 Across the wider Sustainability and Transformation Partnership (STP) footprint of Norfolk and Waveney it is estimated that there are about 38,000 people with 4 or more long term conditions and that over the next ten years by 2026 this might increase to about 48,000. This in part will be driven by the aging population and if trends continue by increasing numbers with obesity

2. Review of Winter 2018/19

2.1 The Norfolk and Waveney health and social care system further strengthened its system-wide resilience planning for 2018/19 with a range of interventions, including the appointment

of a single Winter Director for the whole system, and single 'winter room' to provide strategic co-ordination across the system.

2.2 A comparison between March to April 2016/17 and March to April 2017/18 highlight the following increases in demand:

- Emergency admissions across the five Norfolk and Waveney CCGs increased by 4.7% - short stay admissions (0-1 day) rose by 8.2%, compared to a rise of 1.5% for long stays.
- Ambulance call outs rose by 4.3%, with conveyances increasing by 2.5%, it should be noted that call outs showed the highest increase in January (up 10.4%), however the YoY increase for March was a more modest 5.1%.
- Although 111 calls rose by only 0.6%, calls where an ambulance was dispatched have increased by 9.5% and calls recommended to attend A&E have risen by 12.0%. Other call outcomes have fallen by -3%.
- Despite the increase in other forms of urgent care activity, walk in centre attendances dropped by almost -10%.

2.3 A review by the Winter Director for the period identified a better culture – through improved communication, stronger working relationships, genuine collaboration, a positive problem-solving approach. This delivered:

- Improved ambulance response times across Norfolk and Waveney compared to last year
- Improvement in ambulance handover performance, particularly at the Norfolk and Norwich University Hospital (NNUH).
- Successful implementation of agreed system winter plans, particularly additional out of hospital capacity.
- Improved system co-ordination and 'team-work'.
- Improved 'operational grip' across the N&W Urgent and Emergency Care System.
- Daily N&W System 'Gold' Calls for rapid information exchange and identification of system support actions.
- Reduced 111 driven demand on 999 and A&E services in 2019.
- N&W system able to more effectively escalate, mobilise and co-ordinate recovery actions at times of increased pressure.
- Older People's Emergency Department (OPED) / Older People's Assessment Service (OPAS) at the NNUH – direct access to Consultant for advice.
- Collaborative approach to developing new pathways.

2.4 The challenges highlighted for the system were – and remain:

- All Norfolk acute hospitals remained under significant strain over the winter period and 4 Hour A&E performance did not meet the 95% standard at any of the Norfolk Acute hospitals.
- Significant demand increases (A&E attendances and emergency admissions) witnessed at all three acute hospitals.
- Mental Health capacity across the system (locally, regionally and nationally) did not always meet the level of demand.
- Care home and home care providers struggled to cope with the level of demand across the system.
- Workforce – ensuring that staffing levels within the NHS and social care are sustained remains challenging – and within the independent care sector, the issues of attracting and retaining staff is an on-going challenge.

3. Winter Planning and improvement for 2019/20 – shared objectives

3.1 The health and social care system has continued to be extremely intense over recent months, with high volumes of people helped and supported across all tiers of health and social care. It is generally recognised that there is no longer winter planning, but all-year round resilience planning.

3.2 Whilst pressures are inevitably most high profile at acute hospitals, short-term mitigation and longer term sustained changes are needed much earlier 'upstream' to prevent unnecessary hospital admissions, and to help people stay independent for longer. To this end, the shared objectives for the NHS and Adult Social Care are:

i. Continuing to embed **prevention in the community**, including social prescribing, public health advice and awareness, promotion of the flu jab, the work of Integrated Care Co-ordinators. We are also continuing to develop the 17 Primary Care Networks (PCNs) that have been established in Norfolk and Waveney that are bringing GP Practices together supporting more joined up working and sharing of resources with a focus on prevention. The PCNs are further enhancing access for patients through improved access and extended access which has is giving patients the ability to see primary care clinicians, early morning, evening and weekends enhancing our overall capacity for winter.

ii. Establishing and embedding across Norfolk and Waveney a consistent model that provides our residents with a **2-hour community crisis response** service. Our model is called NEAT or the Network Escalation Avoidance Team. These teams comprise highly experienced clinicians and social care professionals who receive referrals predominantly from GPs, social care and the Ambulance Service. Upon receipt of a referral they conduct a detailed triage of need and then work with community teams to deploy rapid support within 2 hours that is most appropriate to that individuals need. This approach has already been very successful in Norwich particularly for the over 65 age group in reducing avoidable admissions to hospital and is now being rolled out across our 3 localities with a team planned for each 'place' or CCG. We have seen further benefits of this fast crisis response, triage and rapid deployment in reducing the pressure on core services and in delaying / reducing the need for long term social care.

iii. Embedding **a 'home first' way of working** across the system, which aims to support people at home where possible, and work towards getting people home from hospital quickly and restoring as much independence as possible. This includes initiatives such as District Direct.

iv. Further strengthening **integrated discharge planning** in hospitals, adhering to agreed ways of working and implementing improved communications and flow of information between the community, primary care, social care and our hospital teams.

v. Liaison with **independent providers** – in particular care homes implementing initiatives as part of the Enhanced Care in Care Homes programme.

vi. During winter pressure periods we often see the impact of mental health patients attending our emergency departments (EDs) is magnified when they are seeing increased volumes of other patients. To mitigate the impact and to reduce the time our mental health patients spend in ED, when they should be in a more appropriate setting, we have commissioned an **additional 16 adult acute beds** on Yare Ward and are increasing the staffing levels in our Crisis Resolution and Home Treatment teams. For

the first time this year we are also trialling a “perfect week” with our Mental Health provider, NSFT, an initiative routinely used in our three Acute Trusts to improve flow and discharge supported by the wider system.

vii. **Investing in reablement**, delivered by Norfolk First Support, and jointly funded by social care and health.

viii. Ensuring **staffing capacity and patterns** are matched – where possible – to demand. Attracting and retaining staff across the whole system – including the independent sector – remains a big challenge.

3.3 As previously reported, despite the improvements last winter, it remained the case that the system struggled to meet challenging discharge of care targets – a measure which will continue to put the Norfolk and Waveney system under intense scrutiny. This is challenging when the sheer volume of people through our system remains high, and the main measure focuses on delays. Stronger joint working is vital to avoid the unintended consequence of more people going into short-term or long-term residential care, based on decision made at a time of crisis, which then turn into permanent residential care.

3.4 Further detail about Adult Social Services plans can be viewed here (which was submitted to Cabinet in October 2019) and those of the NHS here (which was considered by the STP Executive in October 2019).

4. Funding for winter 2019/20

4.1 Additional funding has come into the system to provide us with additional capacity and resilience as we head into a period increased pressure on a wide range of services.

4.2 From local health budgets each of our 3 localities has created a winter fund totalling c£2m. This funding has allowed a continuation of schemes from last vear that were evaluated and deemed effective. The priority areas are:

- **West Locality has prioritised:**
  - Pre-Hospital - NEAT social work support to improve admissions avoidance, High Intensity Users project
  - Post Hospital – increasing bed-based support for End of Life, non-weight-bearing, residential and resolving delirium patients to improve discharge and flow with in the hospital, District Direct.

- **East Locality has prioritised:**
  - Pre-Hospital – NEAT rollout, High Intensity Users project
  - Post Hospital – Integrated Discharge team, District Direct.

- **Central Locality has prioritised:**
  - Pre-Hospital – Enhanced wrap-a-round support for NEAT within EEAST and within HomeWard, Consultant led respiratory clinics in the community
  - Hospital – Acute Paediatric additional cover, additional cover for front door admissions avoidance and discharge
  - Post- Hospital – District Direct, Community Ops centre to improve community bed flow.

4.3 A continuation of the £4.1m winter pressures grant to Adult Social Services was announced last month. This money ensures continuation of one-off funding last year, so will allow schemes put in place last year to continue, where they are effective. The priority areas are:

- Purchasing additional packages of care, due to increased complexity of need
- Invest in market capacity to support care sector in the event of market failure.
- Investing in staff capacity to support Home First
- Extend Assistive Technology offer to Hospital Teams.
- Support for District Direct Service. (based within the three acute hospitals and offering fast-track minor adaptations and wider housing advice)
- Additional investment in Enhanced Home Support Service.
- Additional assistant mental health capacity
- Investment in Swifts.

5. Conclusion

5.1 This report sets out the System approach to winter, detailing the key challenges but also describing how the System is, year on year, improving how it is working together to support the population to stay well but also reduce reliance on acute care.

5.2 Despite best efforts however the risks detailed within this report remain. These known risks, coupled with factors outside our control, particularly the weather and the impact of flu, mean that the winter period is a critical time for people managing, working within and accessing Health & Social Care Services.

Officer Contact

If you have any questions about matters contained in this paper, please get in touch with:

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