Health and Wellbeing Board

23 July 2015

Durham County Council

Winter Plan and System Resilience Update

Report of Stewart Findlay, Chief Clinical Officer, Durham Dales Easington and Sedgefield Clinical Commissioning Group

Purpose of the Report

1. The purpose of this report is to provide an update on system resilience funding and winter planning following a report produced and given to the Health and Wellbeing Board in January 2015. The role of the Systems Resilience Group (SRG) is to support and drive the delivery of operational resilience and capacity ensuring quality, performance and financial balance.

Background

2. The SRG is the forum where capacity planning and operational delivery across the health and social care system is coordinated for all urgent and emergency care services. Bringing together both elements of elective and urgent care within one planning process underlining the importance of whole system resilience and recognising that both parts need to be addressed simultaneously in order for local health and care systems to operate effectively in delivering year round services for patients.

3. In May 2015 a Winter Debrief was held with a wide range of stakeholders to examine how the health and social care system had managed over winter, feedback on what had worked and look at what could be improved for this coming winter. This report will seek to summarise these findings. It should be noted that the Health and Wellbeing Board received a report in January 2015 which detailed where the winter monies had been allocated.

Performance over Winter

4. NHS England attended the Winter Debrief and summarised the main points in terms of the performance of the system over this winter as:

    - Higher patient acuity resulted in longer length of stay especially frail elderly.
    - The impact was earlier and lasted the whole winter and the system struggled with flow through the system including discharge
    - Limited mutual aid between providers.
    - Escalation at times felt fragmented and there was variation in mitigating actions, triggers and command and control.
    - It was a relatively mild winter with no major flu outbreak which leads to the question could the system have coped under a different scenario.

- The NHS111 service faced similar unprecedented demand, dealing with 4.6 million calls this winter –which is an increase of one million calls or 27% on last winter. NHS111 call handlers and support reduced unnecessary pressures on Accident & Emergency (A&E) and emergency ambulance services by directing people to the right place for their care such as GPs, walk-in centres or pharmacists. Of all the calls triaged, just 11% had ambulances dispatched and 7% were recommended to A&E.
- It is important to note that despite the pressures organisations consistently delivered core services and did not declare a Major Incident and provided a local and regional response to support the system.

Interventions that made a difference

5. There were a number of schemes across the region and more locally in County Durham and Darlington that seem to have received good feedback and made a difference to the patient experience and the flow of the urgent and emergency system. These include:

    - An increase in work force with particular reference to more senior decision makers fronting acute services, additional paediatric practitioners, occupational therapists/physiotherapists supporting timely discharge and hospital social workers.
    - Dedicated teams for specific groups of patients such as delirium patient assessment in A&E and triage of elderly patients for assessment and early supported discharge.
    - Extension of existing services supporting improved patient flow and timely discharge such as ambulatory care, see and treat and rapid assessment units.
    - Supporting discharges with more capacity in social care and equipment as well as schemes like help to home.
    - General Practitioner co-located in A&E evaluated well throughout the Region; however there are significant issues securing and sustaining the work force and there is a need to agree a process, induction and orientation to maximise the benefits.
    - Home Visiting Service supporting Primary Care evaluated well as a key admission avoidance scheme.
    - “Keep Calm” campaign.
    - Local media coverage throughout the winter monitoring period.
    - Daily teleconferencing via Surge Management Team.
    - Daily sharing of innovation via Surge Management Team.
    - Daily review of process via Surge Management Team.

Plans for 2015/16

6. There is already a draft timetable in place for production of winter plans for 2015/16 which will need to build on the learning from 2014/15. The main points to take forward are:

   - Investment in whole system initiatives that ensure flow through system, feedback from schemes is aiding this and the SRG facilitates the discussions.
   - Sharing learning and best practice such as the, ‘perfect week’ and ways of improving discharge – this has been done at SRG and will continue.
   - Predictive modelling – ‘stress test’ plans under alternative scenario’s - this will be done in the coming months with plans being signed off by October 2015 after an assurance process.
   - Whole system management is essential and the North of England Commissioning Support Unit (NECS) Winter Surge Team can help with this in 2015/16.
   - It should also be noted that providers of NHS Services, such as County Durham and Darlington NHS Foundation Trust, have been allocated funds for winter resilience in their 2015/16 base allocation in the anticipation that there will be no further monies centrally.
   - NHS England have issued a list of eight high impact interventions which they believe will reduce pressure on NHS systems during times of Winter surge. These recommendations will be part of the criteria used to test the plans for 2015/16 (attached at Appendix 2).
   - NHS England have also made a call for expressions for organisations and partnerships to become Vanguard sites for a further new care model focusing on urgent and emergency care. The Durham and Darlington Systems Resilience Group will be putting in a bid for this by mid-July 2015.
   - The establishment of Urgent and Emergency Care Networks will also aid SRG work.
   - It was also agreed at the Winter Debrief that the North of England Escalation Plans (NEEP) would be further refined to ensure a consistent approach. In addition the Regional Flight Deck would continue to operate with flight desk data enabling predictive modelling. Finally it was also noted that more work needed to be done with local authorities to improve delayed transfers of care as well as looking at the pathways into and out of nursing homes to ensure the best possible patient experience.

Recommendations

7. The Health and Wellbeing Board is recommended to:

   - Note the contents of this report.

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Appendix 1: Implications

Finance
Providers have been allocated monies in their baseline for resilience

Staffing
No Implications

Risk
Contract variations are being put in place to ensure contractual accountability for appropriate use of the allocated funding

Equality and Diversity / Public Sector Equality Duty
No Implications

Accommodation
No Implications

Crime and Disorder
No Implications

Human Rights
No Implications

Consultation
No Implications

Procurement
No Implications

Disability Issues
No Implications

Legal Implications
No Implications

Appendix 2 - NHS England High Impact Interventions

1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

4. SRGs should ensure the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.

6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

7. Daily review of in-patients through morning ward or board rounds, led by a consultant/senior doctor, should take place seven days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the delayed transfer of care (DTOC) rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.