Health and Wellbeing Board

25 September 2017

System Resilience update

Report of Sue Jacques, Chair of the Local A&E Delivery Board for Durham and Darlington

Purpose of the Report

1 The purpose of the report is to provide an overview of preparations for winter 2017/18 across the health and social care system for County Durham

Background

2 The Local Accident and Emergency Delivery Board (LAD B) has overall responsibility for the capacity planning and operational delivery of urgent and emergency care across the health and social care system.

3 In 2016/17 the available resilience funding, totalling £4,708,000, was split on a fair shares basis. County Durham and Darlington NHS Foundation Trust (CDDFT) received the highest amount of System Resilience Group (SRG) monies totalling £1,714,000. Funds were also allocated to support the North East Ambulance Service, Local Authority, Police and Fire, GP Federations and Tees Esk and Wear Valley Mental Health Foundation Trust as well as towards communications to the public around winter messages.

4 In spring 2017 the resilience schemes were evaluated. Those that evaluated well and were in line with the 8 high impact interventions (See Appendix 2) were rolled over to continue for 2017/18. Funding was again allocated on a fair shares basis for 2017/18 as it has been in previous years.

5 Winter Plans are in the process of being signed off by each individual organisation and will be tested in October 2017

Winter preparations

6 A key theme of the LADB winter plan is flexibility and patient flow across the whole system which includes Acute, Community, Primary Care, NHS 111 and Ambulance services. All members of the LAD B were asked to ensure that they took into consideration the document Transforming urgent and emergency care services: Safer, Faster, Better document (2015) and the Good Practice Guide; Focus on Patient Flow (2017)

7 We cannot predict winter conditions except to note that at some points there will be surges of activity beyond the norm. As a result, winter arrangements will be kept under review and resources will be directed to where they will have the maximum impact. All LAD B members are committed to this.

8 County Durham & Darlington LADB resilience funds have been agreed in the main and allocated to a range of schemes to allow additional capacity to be built into the system over the winter period.

Plans for improving flow

9 A new Operational Policy will be in place incorporating the SAFER bundles which have been developed following the ECIP (Emergency Care Improvement Programme) visit. This sets out care standards and time-scales.

10 New command and control arrangements come into effect in August 2017 providing more robust onsite senior manager cover at weekends. The Trust also continues to operate with three physicians of the day at weekends to improve the quality of care, expedite discharges and ensure “stranded” patients receive the correct attention.

11 The functionality of the Trust’s electronic clinical management system is being expanded continually and by winter will have a bed reservation module to support patient flow.

12 Across County Durham, 13 Teams around Patients (TAP) have been established, involving 69 Practices. The teams prioritise the top 2% of the most frail and vulnerable older people and those with long-term conditions who are at risk of hospital admissions. The teams agree proactive multi-disciplinary responses, so ensuring that health and social care “discharge capacity” (workforce, beds, equipment, funding) meets daily demand.

Primary Care Streaming in ED departments

13 NHS England has mandated that all emergency departments in England must have a Primary Care streaming service up and running by September 2017. This service would mean that patients who arrive at ED with a complaint that could be seen by a primary care clinician will be seen by a GP on site or possibly given an appointment to see their own GP where safe to do so.

14 The LAD B has allocated £200,000 towards this and CDDFT have received capital funds to make changes to estates to implement this service fully. The service needs to be operational from 8am-11pm seven days a week throughout the year. The risk around GP recruitment to this role has been acknowledged at a national level.

15 If significant numbers of patients are streamed off site this will have longer term implications for the health system which are being considered by the LAD B

Plans for improving discharges

16 Trusted assessors are used in social work, community nursing and can commission Intermediate Care packages, supported by a holistic health and social care assessment tool. Further extensions of this role and of levels of integration are under consideration, including discharge management team structure and functioning and integration between hospital and community Occupational Therapy (OT) and Physio services.

17 The *High Impact Change Model for Managing Transfers of Care* has been used in County Durham with work progressing through an agreed action plan. Pathways have been established to support early discharge planning in elective care and more work is being done to embed the use of expected date of discharge.

Plans for managing for peaks in demand over weekends and bank holiday

18 Demand and capacity planning takes place throughout the year. A formal system wide desktop exercise will take place by October 2017.

19 The Primary Care hubs in Durham Dales, Easington and Sedgefield (DDES) are open over weekends and Bank Holidays. Additional GP and nurse/ Health Care Assistants (HCA) appointments will be available from 6.30pm to 8pm each weekday evening and weekend and every bank holiday mornings (9am to 1pm) in North Durham.

20 Primary Care Streaming will be in place by September at both sites.

21 A proactive home visiting service will be in place across the system offering vulnerable patients a primary care visit to ensure they can stay at home where appropriate.

Adverse Weather Planning and flu

22 At a national level, the NHS England Cold Weather plan provides trigger levels and examples of good practice for organisations to implement and this has been shared with LADB members.

23 Individual health and social care providers put in place their own adverse weather and business continuity plans detailing trigger points and escalation processes. For example: North East Ambulance Service (NEAS) have an Adverse Weather Plan and obtain routine weather information from the Meteorological Office, the Environment Agency, and from frontline crews or other agencies/organisations.

24 During adverse weather CDDFT plans include: Arranging rotas so that there are enough staff on each shift who live only a short distance from their work-base to maintain essential services in the event of severe weather; seek volunteers who live close to a Trust site to offer emergency accommodation to

staff who cannot get home; arrangements for 4x4 transport; staff who cannot get to their normal work-site will be asked to attend the site nearest their home if possible; Estates and Care Groups to co-ordinate contingency plans for staff to sleep overnight on Trust premises. Where necessary refer to Business Continuity plans, and services will be prioritised.

25 Plans are in place to promote the uptake of influenza vaccination in eligible populations across communities and the health and social care system through:

- Local authorities promoting uptake of flu vaccination among eligible staff groups and those staff providing care for people in residential or nursing care, either directly or through local providers.

- GP practices, community pharmacists and other providers educating patients, particularly those in at-risk groups, about the appropriate response to the occurrence of flu-like illness, ensuring that all those eligible for the flu vaccine are invited personally to receive their vaccine and encouraging and facilitating flu vaccination of their own staff.

- All employers of individuals working as providers of NHS services ensuring access to flu vaccination and to maximise uptake among those eligible to receive it.

System wide escalation plans

26 Provider and Commissioning organisations across the North East have plans in place which include triggers for both escalation and de-escalation built on a standardised framework aligned with the new National Operational Pressures Escalation Levels (OPEL) framework. The regional Flight Deck highlights region-wide ambulance and acute pressures. Providers will use it to work collaboratively to address pressures and priorities.

Collaborative operational planning with social services and mental health services

27 CDDFT plan to use existing links to promote timely mental health assessments for patients in A&E and in-patient areas. Tees, Esk and Wear Valleys (TEWV) mental health liaison staff are available on-site to reduce discharge and A&E delays whilst awaiting mental health assessment. In addition, TEWV and CDDFT are introducing multi-agency Care Plans for 27 regular attenders at A&E who have mental health problems.

28 Integrated Health & Social Care teams (including intensive support from Intermediate Care Plus provide support at home to vulnerable patients 7 days per week. Several beds are now available in Community Hospitals for Intermediate Care purposes.

Communications plan

29 Internal and external communications plans in place to ensure that staff and the public are fully informed on the preparations for winter and of the services available to them. The national Stay Well campaign will be boosted by regional uplift. The communications period will also be extended to run from November 2017 to April 2018. All out of hours details, Christmas opening times and pharmacy opening times will be provided regionally.

Oncall arrangements

30 Within office hours North of England Commissioning Support (NECS) acts for the Clinical Care Groups (CCGs) in the North East and Cumbria to deliver the operational management of surge and escalation throughout winter.
During the Out of hours and on bank holidays a single on call rota operates across the 11 North East CCGs. Routine regional conference calls are co-ordinated by NECS. Local Authorities on-call staff are accessible through the relevant Council
NEAS has a 24/7 Control Room Duty officer backed up by an Executive on-call rota
Acute Trusts have a Manager and Director on-call 24/7 available through the Trust switchboard.

Performance and trajectories

31 Performance has improved against a number of changes in the activity across the urgent and emergency care system for 2017 compared to the same period in 2016. The urgent care services across Durham Dales Easington and Sedgefield CCG were changed in early 2017 to move more urgent care towards a primary care setting. In Quarter 1 Type 3 walk-ins were 22,362 (2016: 39,747) a fall of 43.7% and a loss of 17,385 attendances at A&E. In the same quarter there was a rise in Type 1 attendances (1.1%), 0.5% rise in ambulance attends and a 3.8% rise in admissions via ED. Despite this change in activity the 4 hour A&E standard (NHS Improvement trajectory of 92.87%) was achieved.

32 Ambulance handovers have improved considerably compared to 2016. For quarter 1 in 2017 22,540 minutes were lost by NEAS (36,919 in 2016). Handovers taking less than 30mins were at 87.7% for Quarter 1 compared to 83.3% for the same period in 2016) During the perfect month of March 2017 the 4 hour wait was 96.47% (88.61% for same time in 2016) and handovers were 90.2% under 30mins compared to 69.9% for the same time in 2016.

33 Delayed transfers of care remain low and CDDFT exceeded the target in June and lost 77 non acute and 15 acute bed days in June 2017.

34 The team from ECIP (Emergency Care Improvement Programme) were heavily involved in working with the system to implement the Perfect Month in March 2017. All of the recommendations have been incorporated into CDDFT's Transforming Emergency Care Programme and ECIP are confident their scrutiny is no longer required due to progress made. Examples of some of the sustained improvements made include

- Full Capacity Protocol agreed and implemented
- Extended w/end command and control structure
- Co-location of Urgent Care and ED in Darlington
- Ambulatory Care now open 08.00-22.00 daily
- Discharge lounges open daily except Sunday

35 Quarter 2 performance is at risk (93.68%) and below trajectory (95.16%) Without the changes made in Urgent Care performance would currently be 95.3%. Non elective admissions are a pressure still with July figures showing rises in Medicine +1.5%, Trauma +6.8% and Gynaecological +9.9%. The LAD B meeting on the 18th of August 2017 focused on looking to see what Executives across the system could do to improve flow to try and ensure the 95% target is met for Q2.

36 There are three more "Perfect Months" planned for September, December and March. The Perfect Month is an improvement tool used in the NHS to focus the efforts of all staff on agreed operational improvements. In this case, the focus was on improving A&E performance: in particular, 4-hour waits and ambulance handovers. The key actions included:

- Non-essential meetings were scaled back or cancelled to allow operational staff and managers to focus on improvement activities.
- The Trust's Bronze Command rota was extended to cover the w/ends when a lot of patient flow pressures build up
- Non-clinical volunteer staff were allocated to spend time helping Patient Flow staff deal with blockages, such as liaising with wards and departments to minimise discharge delays.
- CCG staff were also drafted in, and heightened co-operation was obtained from Social Services and other external agencies, to escalate and deal with delays rapidly
- Through its Transforming Emergency Care Programme the Trust had been developing and piloting SAFER Care bundles, which basically consist of a set of standards for wards and departments defining things like when Ward rounds will take place, discharging more patients earlier in the day, minimising waits for medication or for diagnostic tests. These were piloted in March and have since been refined in the light of lessons learned.

37 The initiative in March proved to be so successful that the Trust plans to repeat it quarterly for the remainder of the year commencing in September.

Recommendations

38 The Health and Wellbeing Board is recommended to:

a. Note the preparations that are well underway for preparing the system for Winter 2017/18 and the improvement in performance compared to the same time in 2016/17

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Appendix 1: Implications

Finance – Winter funds are put into the system creating a positive impact.

Staffing – Providers in receipt of SRG funding to support resilience schemes in 2017/18 will be expected to ensure appropriate safe staffing arrangements are in place to support each of their projects.

Risk – Contract variations will be put in place to ensure contractual accountability for appropriate use of the allocated LAD B 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 – Eight High Impact Interventions for Urgent and Emergency Care

No.	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 to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, 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	System Resilience Groups (SRGs) should ensure that 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 Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
7	Consultant led morning ward rounds should take place 7 days a week so that 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.