REPORT TO: Health and Adult Social Care Overview and Scrutiny Committee

Date of Meeting: 11 September 2014
Report of: Head of Clinical Developments and Health Outcomes
Subject/Title: Eastern Cheshire Operational Resilience: planning process and assurance 2014 - 2015
Portfolio Holder: Councillor Janet Clowes

1.0   Report Summary

1.1   This report outlines the Eastern Cheshire Clinical Commissioning Group's approach to operational resilience planning.

2.0   Recommendation

2.1   That Members consider the report and the arrangements for operational resilience.

3.0   Reasons for Recommendation

3.1   To ensure that members are aware of the CCG's operational resilience process.

4.0   Background

4.1   Eastern Cheshire has one of the fastest ageing populations in England. Approximately half of hospital expenditure and around half of spending on adult social care is used to support people aged over 65, who represent one fifth of the overall population.

4.2   Over the next 20 years the number of people aged over 85 is expected to significantly increase, leading to an exponential growth in care needs for people living alone and in nursing homes locally.

4.3   Over the last 18-months local commissioners, providers and patients have developed a shared vision for how health and social care services will transform and work together to provide support at home and earlier treatment in the community. This will prevent people needing emergency care in hospital, or care homes, and to deliver new opportunities to live as independently as possible.

4.4   Work has also been completed to design and implement a system-wide monitoring tool; 'Snow White', which utilises hard and soft data from a number of organisations to present a visual picture of system performance. It uses

colour codes to highlight specific pressure points and real-time assessment of whole system performance. Resulting actions taken are then targeted and monitored.

5.0   System Resilience

5.1   Delivering operational resilience during 2014-15 moves beyond planning for urgent care over the winter, and includes planned care for system wide, year round resilience. This is overseen by a System Resilience Group (SRG) with representatives from across health; social care, the third sector and patient representatives

5.2   The objective of the SRG is to ensure that the health and social care system has an understanding of urgent and planned care capacity and performance across all providers. The members hold each other to account for performance but provide an opportunity for partnership working.

6.0   Operational Resilience Planning

6.1   NHS Eastern Cheshire CCG wishes to secure £1.2M non-recurrent NHS England, system resilience funding to address whole system resilience. The CCG has implemented a robust 5-step process, to ensure effective investment of this funding on behalf of our population. This process was open to all providers and partners, including voluntary, community and faith sector (VCFS) organisations, with an extended deadline offered to VCFS to support wider discussion and involvement.

6.2   *The 5 Steps*

> 6.2.1 **Step 1;**
> Statutory sector bids were considered by the SRG on 19th July 2014. Bids were assessed using a scenario-based approach utilising 'Snow White' to ensure the bids would have the intended effect. A notional sum was ring fenced for future VCFS bids
>
> 6.2.2 **Step 2;**
> Prioritisation by the SRG members based on the output of the scenario testing. The initial bids were scored from 1-3; 1 being of the lowest priority and 3 being the highest priority.
>
> 6.2.3 **Step 3;**
> With delegated responsibility of the SRG, the Chair of the group and SRG Project Manager, approved, shortlisted submissions based on the results of step 2. Bidders were informed of the decision. Those shortlisted to the next stage were invited to attend a Panel on the 19th August 2014.
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> 6.2.4 **Step 4;**

The Panel, (commissioners, clinical and patient representatives) used an agreed set of criteria to evaluate bids to ensure the process was consistent and transparent. Panel proposals will be presented to the ECCCG Executive team on September 3rd 2014 for formal approval to proceed.

6.2.5 Step 5;

Third sector organisations were required to submit bids by 15th August 2014. The bids were shared with the SRG on the 21st August 2014 and following a process of prioritisation, successful bidders will attend a panel on the 8th September 2014. Recommendations will go to the ECCCG executive team for final approval

6.3   Successful bidders will be expected to work closely with the SRG to ensure the additional resources are implemented successfully providing coherent and responsive interventions for patients with the greatest level of need. Providers will need to work effectively with existing services and contractual arrangements. The SRG will monitor KPIs and performance on a monthly basis.

7.0   Clinical Models

7.1   In line with the national evidence base and operational resilience guidance, prioritisation has been given to initiatives which support the following areas:

7.2   *1. Rapid assessment and treatment (RAT)*
Definition: Having consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand to ensure swift, sound clinical decision-making and effective use of staffing and other resources.
Evidence of assurance: Proposed new initiatives to deliver this model:
- additional Emergency Medicine Physician and estates work, to improve integration and patient flow within ED. ***This will be funded internally by Eastern Cheshire Trust.***
- system resilience funding has been requested for an Advanced Nurse Practitioner to stream appropriate medical presentations in ED.

7.3   *2. RAID*
Definition: Delivering rapid response to mental health crises 24/7, via a single point of contact, with team fully integrated into acute hospitals
Evidence of assurance: Proposed new initiatives to deliver this model:
- extended Psychiatric Liaison Services to a 7-day service within ED.
- extended and increased capacity within Hospital Alcohol Liaison Services to a 7-day service within ED linking with community-based follow-up support.

7.4   *3. Hear & Treat and See & Treat*

Definition: Reducing the need to despatch ambulances to patient and the need for ambulances to convey patients to hospital respectively.

Evidence of Assurance: There is existing CCG funding for this model and therefore no additional system resilience funding has been agreed. Existing initiatives are as follows:

- continued investment in the GP Acute Visiting Service, to support the NWAS pathfinder scheme, ensuring an urgent 2 hour response for GP assessment and treatment.

- the CCG is part of a team working across Cheshire Warrington and Wirral with NWAS to address factors affecting performance and identify solutions to support achievement of the targets in 2014/15.

- the CCG quality incentive plans will support an increase in 'Hear and Treat' and 'See and Treat' and to reduce the need for people to be taken to hospital.

- community care plans / patient passports are being completed for patients with complex health and social care needs. This will describe the patients preferences and agreed crisis plan and will be available for all partners to use

7.5 *4. Primary care in A&E*

Definition: Co-location of primary care and A&E so patients can be signposted after assessment.
Evidence of Assurance: Existing initiatives are as follows:

- GP Out-of-Hours is co-located within ED and supports partnership working

Proposed new initiatives to deliver this model:

- The 'Think Pharmacy Minor Ailments' service to enable more patients to access NHS funded medicines without requiring a GP or A&E appointment to provide a prescription. Supporting 7-day working, whilst also freeing up appointments elsewhere in the system.

7.6 *5. 7-day cross-system working*

Definition: Providing more responsive and patient-centred delivery seven days a week, including arrangements to facilitate hospital discharge, and in line with Better Care Fund principles.

Evidence of Assurance: All initiatives which support 7-day working have been prioritised including:

- therapy services
- social care
- hospital pharmacy
- liaison psychiatry
- range of VCFS services to support patients with complex health and social care needs

7.7   *6. Facilitating and minimising delayed discharges*

Definition: Processes to minimise delayed discharge and good practice on discharge across organisations to support patients with complex needs.

Evidence of Assurance: Proposed new initiatives are as follows additional:

- stretcher transport to facilitate timely discharge hospital to home.
- Occupational Therapy and Physiotherapy in-reach service over 7-days
- Social Worker service over 7-days to support rapid assessment.
- bed-based rehabilitation services to support step-up and step-down patients.
- VCFS proposals prioritised to support discharge of people back home

7.8   *7. Alternatives for high risk patients and data-sharing*

Definition: using software tools to gain identify people with complex needs and commission appropriate alternatives to hospital care.

Evidence of Assurance: Existing initiatives are as follows:

- agreements in place with all local GP Practices to share data within protection guidelines.
- interim software solution in place which uses primary and secondary care data.
- multi-disciplinary neighbourhood teams in place and aligned with GP Peer Groups.
- primary and community care plans for complex care patients.

Evidence of Assurance: Proposed new initiatives are as follows:

- procure software tool (iRIS) which incorporate a range of social indicators that impact upon a person's level of need and risk. This will enable care professionals to identify people prior to crisis and support the implementation of a more proactive model of care.
- additional therapy and community services support, including the third sector will be aligned to neighbourhood teams to ensure targeted support is available to enable people to remain safely at home during times of increased need.

7.9   *8. Preventing admissions from residential and nursing homes*

Definition: Planning for regular health surveillance of care home residents (especially those with chronic conditions) to decrease the risk of hospital admission.

Evidence of Assurance: Prioritisation has been given to initiatives which focus on community services. The outcome will be proactive management of patients in residential and nursing homes and an increase in the proportion of older people who remain in their care home 91 days after discharge from hospital:

- Additional capacity for Speech and Language Therapy in-reach service over 7-days to support rapid assessment and follow-up of patients with swallowing difficulties.

- A proactive care model to ensure continuity of care for all care home residents. The service will provide management of long-term conditions, mental health and dementia care, ambulatory care sensitive conditions and support for end of life care.

- The GP Acute Visiting Service provides additional urgent care to care home residents.

- The CCG is also working with South Cheshire & Vale Royal CCGs to improve quality in care homes

8.0   Conclusion

8.1   The plans contained in this paper will be monitored via the system resilience group, specifically to evaluate their impact across the whole urgent care system. Initiatives which support a shift from hospital to home will inform our local integration programme which in turn will inform future commissioning for services.

8.2   Final proposals will be presented to the ECCCG executive committee for authorisation ahead of the final submission deadline of 23 September 2014 to NHS England.

9.0   Access to Information

The background papers relating to this report can be inspected by contacting the report writer:

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