CHESHIRE EAST COUNCIL

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

Date of Meeting: Thursday 14th January 2016
Report of: Eastern Cheshire System Resilience Group
Subject/Title: Managing winter pressures
Portfolio Holder: Janet Clowes

1.0 Report Summary

1.1 Significant pressures across health and social care are expected during the winter months and there are concerns that a number of agreed key sustainability measures are not progressing at sufficient pace, including intermediate care beds procurement and rapid response services.

This is a collective risk that needs to be owned and addressed at executive level across health and social care.

Eastern Cheshire System Resilience Group (SRG), which is a collaborative group of health, social care and voluntary sector representatives, has developed a four point priority plan for winter.

The plan aims to deliver:

- A phased reduction in the number of delayed transfers of care (DTOC) to 2.5% of total bed stock by June 2016
- 20% reduction against projections in admission to hospital for groups of people including those with COPD and frailty by end March 2016
- 50% increase in discharges of people before 1pm and 80% of weekday discharges at the weekend

2.0 Recommendation

2.1 The Cheshire East Health and Adult Social Care Overview and Scrutiny Committee is asked to note the approach to managing winter pressures across health and social care.

3.0 Reasons for Recommendation

3.1 The four point plan aims to ensure patients who need it can access the urgent care system in a timely way.

3.2 The focus of the plan is to ensure people move safely through the health and social care system and receive the right care in the right place.

3.3 A significant proportion of demand for urgent care is from people with complex needs and therefore it is imperative that health and social care continue to plan and deliver services in partnership.

4.0 Wards Affected

4.1 All within Eastern Cheshire.

5.0 Background

5.1 This report is intended to provide the Cheshire East Health and Well Being Overview and Scrutiny Committee with an understanding of the work currently being undertaken by the Eastern Cheshire System Resilience Group, and the arrangements in place to support management of people's safe and effective care over the winter period.

5.2 Senior system leaders (Chief Executives) have been asked to establish an executive forum and commit their organisation to key actions for system management, escalation and governance.

5.3 Significant winter pressures across health and social care are expected during the winter months and there are concerns that a number of agreed key sustainability measures including intermediate care beds procurement and rapid response services, are not progressing at sufficient pace. This is a collective risk that needs to be owned and addressed at executive level.

5.4 To mitigate this risk, the Eastern Cheshire System Resilience Group (SRG), which is a collaborative group of health, social care and voluntary sector representatives, has developed a four point priority plan (see table one below) which focuses on clinical support in primary care, rapid access to health and social care 7 days per week, proactive management of frailty and partnership working with the care home sector.

5.5 The four point plan is based on learning from a number of recent clinical audits, internal and external reviews of processes and performance and if implemented will support delivering the following system benefits and release much needed capacity:

- A phased reduction in the number of delayed transfers of care (DTOC) to 2.5% of total bed stock by June 2016
- 20% reduction against projections in admission to hospital for groups of people including those with COPD and frailty by end March 2016
- 50% increase in discharges of people before 1pm and 80% of weekday discharges achieved over the weekend

5.6 The plan is included below however it is important to note that this is a live plan which is progressed and updated weekly by a senior group of health and social care representatives.

System Resilience Executive Forum - Four Point Plan and Update

Change/ Priority Area	Actions	Time scales	Project lead	Update
Respiratory – predict and reduce unnecessary admissions for COPD **SRO - Jacki Wilkes**	**Build capacity in primary care** – identify investment required to pump prime practices to case find patients at risk of COPD admission (e.g. frequent attenders and people with complex needs) over winter	**End Dec**	**Karen Burton** **And GP Practice Lead**	• 21 of 22 Practices signed up to proactive management programme for COPD • Practices to start identifying patients • Pump priming investment confirmed to recruit people onto winter proactive management programme • Text technology to be tested in one practice/Peer Group • Targets agreed with each Practice
	Standardise approach – send new Clinical protocol for respiratory management to every Care Home follow up with a telephone call to discuss/ensure understanding	**End Dec**	**Karen Burton**	• New Protocol written and issued to all Practices • New Protocol issued to all Care Homes
	Promote self-management – issue rescue packs to COPD patients identified at risk by Practices and follow up with regular telephone calls to check understanding and use (inform Breatheasy group of approach over winter to promote/cascade message)	**End Dec**	**Identified Practice Lead**	• Agree targets with each practice relating to rescue packs, contacts and saved admissions, reduced LOS
	Support to assess – increase medical capacity in Acute Visiting Service to see and assess patients at risk of admission in their own home	**Dec 22**	**Jacki Wilkes / Kath Senior**	• Funding available but unable to secure additional capacity
Frailty – manage people with increasing frailty to prevent unnecessary admissions and delays in hospital **SRO – Steve Redfern / Ann Riley**	**Build capacity in Frailty team** – (Primary Care, A&E and AVS) determine investment required for additional capacity to extend hours, capacity and skill mix of new Frailty team over winter Proactively case manage people with frailty. Communicate with Practices about what the Frailty team is and how they refer/ask for advice. Promote Integrated	**Dec 8** **End Dec**	**Karen Burton** **Debbie Burgess**	• Health element for the Trust to cover currently able to provide via bank staff. Agency cap issue escalated to the LAT awaiting response on any flexibility allowed • Mental health capacity will be via the intermediate care team CPN • Update on integrated working arrangements between AVS and Frailty Team needed • OT starts on 3/1/16 between 8.30 - 4.30 • physio starts 11/1/15 between

	working between the AVS and the Frailty team			8.30 - 4.30 • Second physio will be covering OT and Physio at the weekend • After 5pm the Integrated Discharge Team will cover ED and undertake basic assessments with access to equipment to support discharge. • Locum social workers have been identified and telephone interviews will take place on 3/1/16 • Capacity for community reviews will be provided from specialist nurses and nurse bank
	Increase capacity of wraparound care : model requirements and secure rapid access domiciliary care reablement and psychiatric liaison/mental health	**End Dec**	**Pete Gosling/ Ann Riley** **Gill Sydney**	• External procurement for long term rapid access Dom Care in place by mid Jan. Block contract approach - confirm additional capacity this will provide? • Changes to workforce to support short term dual role: rapid reablement / Dom care now available • Commenced monitoring of availability of care packages
	Commission additional bed placements agree criteria/need to inform model (e.g. support to assess) consider alternative providers (housing association) continue to work with private sector to build capacity invest in health and social care community teams and third sector to provide intensive support at home	**End Jan**	**Jacki Wilkes** **Kim Cundiff** **Neil Evans / Ann Riley**	• 16 of the 30 intermediate care/ assess beds secured • Utilise shortfall to fund other community support services e.g. intermediate care at home, additional primary care • NE has met with Peaks and Plains to explore options for additional capacity in supported accommodation. Possibility of short term 'assisted living' facility for people waiting for respite at home. • Cheshire East support requested - Ann Riley to speak to Sarah Smith regarding arrangements required for the assisted living capacity
Reduce delays in patient journeys by increasing 7 day working **SRO - Steve Redfern**	**Deliver the time to go home initiative** to increase discharge at the weekend by at least 20% and 50% more discharges before 1pm	**End Jan**	**Steve Redfern**	Update needed KS to determine the measures of success for this initiative
	Invest in Pharmacy to increase and extend capacity over 7 days to complete TTOs within 2 hours following decision to	**Dec 21**	**Kashif Haque**	Update needed

	discharge (Cross reference Care Homes)			
	Increase access to equipment Establish process improvements to expedite access to equipment	**End Dec**	**Debbie Burgess / Jo Allcock**	Update needed
	Transport - commission additional assistive transport to expedite discharge	**End Dec**	**Karen Burton**	Funding identified to support additional capacity. Trust to use local trusted taxi service
	Discharge led protocols in place for all patients	**End Dec**	**Steve Redfern / Kath Senior**	• Discharge- led Protocol in place for all patients • Update on progress needed • Spot audit planned for January?
Targeted support for Care Homes to reduce unnecessary admissions **SRO – Julia Curtis**	**Implement new respiratory protocols**	**End Dec**	**Karen Burton**	• Written and shared.
	Implement new respiratory protocols	**End Jan**	**Julia Curtis**	• Follow-up needed to ensure protocol understood and being followed • Review call data to residential care home from NWAS to identify residential homes for targeted support
	Implement new respiratory protocols	**18 Jan**	**Julia Curtis**	• Share protocols with residential homes and offer targeted support • Review call data to residential care home from NWAS to identify residential homes for targeted support
	Employ additional nursing and GP staff in targeted care homes to improve care and pull patients back from hospital following admission (cross reference 7 day working)	**End Jan**	**Julia Curtis**	• Offer to care homes with adequate staffing models and no quality/safeguarding issues to fund additional nursing time on weekends/bank holidays. The condition is that they receive new/existing patients OOH and undertake assessment on the day of request. Julia to work with Kate at CEC to identify homes • New respiratory protocols shared with care homes and to be overseen by care home GP • Limited response from care homes regarding additional support. Re issue invite in the new year
	Increase primary care medical services in care homes over winter. Target homes with high admission rates. Consider via AVS/	**Jan 15**	**Jacki Wilkes**	• Only One practice offered to open on weekend/bank holidays • ECCCG has identified funding for additional capacity in OOH

	increased visits OOHs		**Steve Redfern/ Kath Senior**	over the holiday period • ECT to advise on approach to increasing capacity in OOH • GP OOH approached to provide additional primary care during these days only but issues with rates of pay • ECT to determine the way forward • Unable to recruit additional capacity before New Year. Explore again in January

11.0 Access to Information

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

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