

HOSC - FEB 2020 Update
– APPENDIX A

Seasonal Operational Pressures

Summary

TOPICS COVERED TODAY

- Purpose & Key Learning from last year
- Key Principles for managing Acute Pressure
- Winter 2019 priorities
- Current Picture (Intermediate Care & DTOC)
- 2019/20
    - Countywide & Local Schemes
    - Key Themes
    - Newton Europe
    - Appendix - Local Activity

Purpose

The purpose of this update is to provide an update as to how well the system is responding to 2019 Winter pressures.

This will look at the pressures faced in A&E and emergency departments during the winter of 2019/20;

Key learnings and lessons learnt from 2018;

The extent of partnership working in continuing to address pressures (including admission avoidance) and;

Clarity over whether pressures are contained to “winter”

Key Learning from last year

Although winter is often identified as a key time for pressures it is becoming more difficult to extract it from pressure felt year-round or during other seasonal peaks.

Beds are not the only answer to managing increased demand

Admission Avoidance is a key enabler to reducing pressure on both the Health, Acute and Social Care system - this can be achieved through additional Community and prevention services

Winter 2019 priorities

PREVENTION

Focusing on Admission Avoidance, community support and prevention as much as discharge

DISCHARGE TO ASSESS

Supporting adults to maximise their potential for full recovery following admission

LEARNING FROM 2018

Looking to schemes that were successful last winter and re-commissioning them

BEDS

Ensuring that there anough beds to support discharge as an alternative to discharge to assess where appropriate

MARKET

Working with ECA to learn from 2018 and develop an approach to managing demand for 2019 together

EVIDENCE

Using data to ensure that resources are in the right place to manage demand - not working from assumptions

Intermediate Care: The current picture

There is significantly more demand in the system, so there has been increased demand over and above planned levels. Our Service Placement Team have indicated that have had to place double the amount of packages compare to this time last year:

Intermediate Care - Year on Year Movement 18/19-19/20

CCG	Community Based Provision		
	Block Commissioned	Actual Hours	Adults Supported
	% Change	% Change	% Change
Mid Essex	45%	59%	49%
North East Essex	65%	78%	44%
Castle Point & Rochford	4%	18%	15%
Basildon & Brentwood	42%	34%	41%
West Essex	27%	62%	11%
Total	**36%**	**47%**	**32%**

To help address this additional demand we are undertaking a procurement process for ‘Reablement in Lieu’ Block contracts securing 900hrs in North East Essex, 400hrs in Mid, 700hrs in South West, 850hrs in South East & 300hrs in West

DTOC: The current picture

It is important to note that the official December DTOC figures are not available until Feb 13th 2020.

- Over the course of the year (April - November), our average performance is better than the same time last year
- There have been fewer delay days in total over the course of the year.
- Our average social care daily DTOC performance is 2.06 per 100k population 18+, compared to a target of 2.4.

Essex Summary	FEB 17 (baseline)	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER
(a) Social Care DTOC (acute)	922	285	303	228	333	269	273
Social Care DTOC per day per 100,000 18+ population	5.9	1.78	2.06	2.79	2.64	1.94	2.00
Social Care DTOC per day per 100,000 18+ population TARGET	2.60	2.60	2.60	2.40	2.40	2.40	2.40
(b) Social Care DTOC (non-acute)	594	211	213	470	416	204	164
(c) Social Care DTOC (trusts outside of Essex)	410	118	219	266	193	220	253
(a+b+c) TOTAL SOCIAL CARE ESSEX DTOC	1926	614	735	964	942	693	690
TOTAL HEALTH ESSEX DTOC	2120	2064	1884	1568	1715	1714	1539
SOCIAL CARE + HEALTH ESSEX DTOC per day per 100,000 18+ population			7.35	7.1	7.70	6.75	6.46
SOCIAL CARE + HEALTH ESSEX DTOC per day per 100,000 18+ populati TARGET			8.40	8.40	8.40	8.40	8.40
TOTAL BOTH ESSEX DTOC	171	218	203	287	287	297	364
TOTAL ESSEX DTOC (Health + SC+ Both)	4217	2896	2822	2819	2944	2704	2593
% of total Essex DTOC attributable to Social Care	46%	21%	26%	34%	32%	26%	27%

- Joint DTOC values for 2019/20 have consistently been above the values for the same month last year. The rate of joint DTOCs has been increasing over 2019/20. The main reason for joint delays are:
  - ‘Awaiting care package in home’
  - ‘Awaiting nursing home placement’.

- **Essex compares favourably against the East of England region & nationally – Our average daily delay rate has been below the EoE rate and the England rate every month this year**

DTOC Recommendations

NHS Improvement – a DTOC Masterclass was held in Dec 2019 with NHSI; the recommendations from this include:

- **DToC/Length of Stay (LLoS) Reporting –** Internal (ECC) and system wide. The focus of the work will be on improving confidence in the data and qualitative information reported.
- **Mental Health DToC/LLoS –** The development of an agreed process for validation and reporting of under 65's & over 65's (EPUT/ECC). Given the differing structures and commissioning arrangements robust systems for the validation & reporting of delays and Lengths of stay are required to ensure timely and appropriate discharge for individuals at an operational level and to provide confidence in the data/performance being reported across the system.
- **Mental Health Discharge planning/MDTs –** Further work is needed to ensure an integrated approach to discharge planning is embedded for all Essex adults experiencing MH Inpatient Care in/outside of Essex. Clarity is required in relation to the interpretation of guidance and "start/stop" processes
- **Community DToC/LLoS** – The development of an agreed process for validation and reporting of community inpatient DToC/LLoS.
- **Community Discharge planning/MDTs** – Further work is needed to ensure an integrated approach to discharge planning MH Inpatient settings is embedded for all Essex adults experiencing MH Inpatient Care in/outside of Essex.
- **OOA Inpatient Care (all care settings) -** The development of an agreed process for validation and reporting of community inpatient DToC/LLoS. Given the differing structures and commissioning arrangements robust systems for the validation & reporting of delays and lengths of stay are required to ensure timely and appropriate discharge for individuals at an operational level and to provide confidence in the data/performance being reported across the system.
- **OOA Inpatient Care (all care settings) -** Further work is needed to ensure an integrated approach to discharge planning MH Inpatient settings is embedded for all Essex adults experiencing MH Inpatient Care in/outside of Essex.

2019/20

2019 Winter Budget

In 2019 c£5,919,494 for social care has been included as part of the Better Care Fund. The funding is to support social care and winter pressures. During 2019 this budget is no longer restricted to being used for winter demand management, but can be spent throughout the year to support wider seasonal pressures. This flexibility also allows for better planning for Winter and high-demand months.

As in 2018 it has been agreed that a countywide and local approach is the best way to manage this fund and agreement has been made with partners that it is split 27% (£1,571,823) for county-wide schemes and 73% (£4,347,671) for local schemes

Although there will be local differences in schemes, it is important that ECC has a consistent set of outcomes we want this money to achieve for us. We expect the £5.9m funding to prioritise improvements in the following areas:

1. Prevention: including admissions avoidance for health and social care; investment in carers; and community resilience
2. Early Intervention and enablement: including reducing rates of permanent admissions to residential care and reduced social care DTOCs
3. Safeguarding: including keeping people safe and free from harm
4. Care market quality and sustainability

Countywide and local schemes should then show a link to these outcomes. Local schemes would be subject to local discretion and agreement with local partners

Countywide & Local schemes

All partners in Essex have worked together to develop plans for winter 2019/20; these plans were submitted and approved as part of the Better Care Fund in September 2019 (and approved nationally in January 2020). These plans included full commitments against the winter funding allocation – and have ensured that capacity is at least the same as in winter 2018/19 (some additional capacity has been commissioned within local systems where there has been the need)

The Integration & Partnerships team lead on the system-approach with partners to plan for peak periods (which are now all year around, rather than just winter) and we liaise day-to-day on any capacity issues.

The Essex health and wellbeing board area comprises 5 acute trusts and we can confirm the following:

1. **Princess Alexandra Hospital/West Essex**: an additional 19 beds will also come on stream from 20 January 2020
2. **Southend and Basildon hospitals/South Essex**: ECC have increased the domiciliary offer by increasing the bridging service from 20 starts across the South last year to 40 starts this winter (this is working very well).
3. **Mid Essex**: on top of additional capacity already in place for winter 2019/20, a Hospital-led bridging service is due to go live in January 2020, generating an additional 20 visits per week.
4. **East Suffolk and North Essex Foundation Trust/North Essex**: extension of the successful Early Intervention Vehicle, extension of the Home from Hospital navigator service, and funding of wrap-around services providing 24 hour care for c8 adults up to 6 weeks each or 24 adults up to 2 weeks.

It is important to also state that although the winter funding element (which is extremely helpful and crucial for affordability and sustainability of councils) is only a small part of overall adult social care spend to manage demand - In Essex, we spend over £500m a year on adult social care.

Another challenge has been continued price inflation in the residential and domiciliary care markets during 2019/20. Since the winter funding allocation is the same as in 2018/19, it can afford less in 2019/20. Even with the increases in the Better Care Fund, the county council is currently funding a £4m over-spend (primarily purchasing domiciliary care) over and above the amount identified from the Better Care Fund.

Winter 2019 allocations – Key Themes

Bridging

Hospital led bridging service to support an adult at home until their package of care can start/ restart to allow an individual to return home sooner and increase capacity in the acute.

£1,026,240

IP Beds

Interim Placement Beds to allow for an assessment of need to take place outside of the acute setting. Increasing capacity within the acute.

£1,673,039*

Therapy input IP Beds

Therapy Input into Interim Placement Beds with individual and agreed goals. Enabling shorter stay in beds, increase likelihood of returning home.

£233,228*

Admission Avoidance

Including Dedicated Social Work presence within A&E and the Integrated Discharge Teams, Early Intervention Vehicle & CTT support.

£642,220

Carers

Additional support through existing contract with Carers First

£100,000

Market Pressures

Care market pricing & BCF allocation

£5m+

*West IP Therapy costs amalgamated into IP bed allocation

Appendix – Local Activity

North East Essex

Winter schemes in North East Essex aim to balance providing extra capacity, along with piloting new ways of working, which if prove impactful can be scaled for future seasonal pressures.

In addition to the core schemes, both Community 360 and Tendring CVS are funding a variety of small scale winter schemes such as ‘winter readiness packs’ funded through the NEE Alliance and Essex County Council.

Activity funded winter 2019/20

- Residential Reablement Beds including Therapy
- Reablement offer on care of the elderly wards
- Bridging
- Physio support for IP placements
- Wrap around service (admissions avoidance)
- Home from Hospital Navigator
- Early Intervention Vehicle (Falls) extension

Both Community 360 and Tendring CVS have received money through the Alliance and ECC to help with seasonal pressures. A flavour of the work:

- Tendring CVS – have completed ‘door knocking’ exercises in a number of areas identified as those most at risk due to seasonal pressures. The door knocking, coordinated by the CVS, has pulled together a range of partners including Fire and Rescue, housing and health. Households are asked how they are preparing for winter and signposted as appropriate to support.
- Colchester Community 360 – have created a bid process for the funds linked to the Live Well domains that support people to live well through winter.

Mid Essex

Mid Essex ASC has agreed its governance re decision making with system partners for winter money expenditure via the BCF Partnership Board. This is made up of partners from ECC, CCG, Acute , MSE hospital group and Community Health Providers.

Mid Essex engaged with the Economic and Social Research Council to support via a Challenge Lab and a research project to complete capacity and demand mapping for the system.

The aim was to find research driven solutions to focus attention to deliver system-wide change. This is in order to build improved whole system resilience as part of the winter planning process

In particular we wish to:

- Understand the demand that currently comes into the mid Essex health and care system for the acute and community
- Understand the capacity that is available both in the acute and community to manage the identified demand including primary care
- Use data to allow more informed decision making regarding if health and social care resources are in the correct place to manage the demand Identify any gaps in services and solutions within the mid Essex capacity Explore the potential for predictive analytics to identify future anticipated demand increases
- Use data to recommend how mid Essex should use their collective resources to manage the demand based on the finding of the research.

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West Essex

PAH have faced some real challenges with demand and have struggled with the ED performance targets. DTOC however has remained low (as a result of the Discharge to Assess approach) and there is a robust approach to transfer of care which our integrated discharge team and integrated SPA are central to.

Wherever possible we have tried to focus on schemes that prevent admission to hospital in the first place and the admission avoidance scheme demands a fast response time to referrals from the community to enable this to happen.

We also know that older people are much more likely to be admitted to hospital if there is a lack of MDT frailty services working with A and E, so we have also supported that.

DISCHARGE TO ASSESS

- For the adult to maximise their potential for full recovery with a view for the individual to maintain or regain their ability to lve at home.
- To ensure the adult needs are met in the right place at the right time by staff with the right skills and competencies
- To reduce the level of an adult deconditioning within the acute setting by reducing their length of sta
- To be part of a full system wide Intermediate Care model that meets the needs of all the adults within West Essex whatever their pathway Increase flow through the system maximising system capacity, resource and manging financial demand.
- To develop a fully integrated model of care around the adult utilising current resource from the community including speech and language therapist, Social Workers, physio and occupational therapists, community nursing and primary care

South Essex

Winter Learning sessions took place with providers, partners & frontline staff which then fed into comprehensive Winter Plans with a consistent approach across the Mid & South Essex (MSE) Group.

Both BB & CPR have established BCF/iBCF Partnership Boards to provide a decision making framework regarding local winter money expenditure. Additionally the South East Essex Partnership Board (CPR) and recently established Basildon & Brentwood Alliance provide strategic oversight from partners across the South system. These forums have developed further over the past 6 months with agreed changes to the governance structures to ensure engagement with wider local government and community stakeholders.

Areas of focus are:

- Prevention and Reducing Inequalities
- Community Model of Care/Locality Development
- System Resilience
- System Integration

Relationships across partners within the South system remain strong and discussions continue regarding working together to jointly commission services to support the system as a whole. An example of this is the Joint South Bridging service in conjunction with the two CCGs, ECC & the MSE Trust.

Partners are particularly keen to take on board learning from the Newton Europe diagnostic work in helping to inform future decision making and are extremely engaged in the process.

Discharge to Assess - the focus for this year will be less on beds and more focused on getting people home, through the use of bridging, before assessing.

The Trusted assessor for care homes has demonstrated good reduction in length of stay for patients returning to a care home. Relationships with care homes has improved and demonstrated better co-ordination and communication.

Mid & South STP - Community Treatment Team

Mid Essex and South Essex STP are working together in relation to a Community based pilot project that commenced in July 2019. The project is part of the Admission Avoidance work stream that is one of three key areas within the STP.

Aim of pilot

The service aims to support and empower adults over the age of 18 years, to remain at home or in another community setting by optimising the individual's level of function by maximising independence. The service will provide timely multi-disciplinary assessment and intervention to reduce the number of adults conveyed to A&E by ambulance/admitted to Acute Hospitals by rapidly mobilising community services.

Objectives

- To provide immediate multi-disciplinary assessment for adults experiencing a health crisis (within 2 hours)
- To provide timely, effective and holistic treatment and access to intermediate care services as needed
- To empower adults and their family/carers through prevention, education and closer support to lead as healthy a life as able/self- manage their condition
- To maintain good communication with the adult, carers and multi-agency partners
- To reduce the number of adults accessing acute services (reduce the 10% of Category 2/3 patients who would have been attended to be EEAST either for assessment or conveying to Acute)

Referrals

Senior community team staff will for part of each day, base themselves at the EEAST Control Centre in Chelmsford and work with call handlers and clinicians at EEAST, so where clinically appropriate, offer a potential alternative to the deployment of an ambulance, which frequently results in the transfer of the person to Emergency Department and admission to hospital.

54 patients have been treated by CTT
77% of all referrals were accepted

All patients received treatment within **3 hours 30 mins** of their 999 call

The CTT has saved an **estimated 87.5 hours of patient time** just in those who were considered high acuity calls. This is likely to be higher if low acuity calls are also included

So far approximately **89% of patients are believed to have remained at home. 25 patients are suspected to be hospital admission avoidance** as they are likely to have gone to hospital

The CTT has saved a conservative estimate of **£65K** in admission avoidance, plus if all falls were not attended to within 5 hours this saving could be closer to £105,000