HOSC - JULY 2019

Essex County Council

Seasonal Operational Pressures

Summary

TOPICS COVERED TODAY

The Current Picture

2018

2019

Key Principles

- Admission Avoidance
- Delayed Transfers of Care (DTOC)

Local Delivery

Winter 2019

The Current Picture

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

2018

c£5.9m was allocated to Essex County Council for adult social care and Nick Presmeg committed to working with Health and CCGs to discuss how best to deploy some of this funding. To maximise the funds impact over winter we intended to spread the funding across December, January and February to ensure that health and social care were supported throughout the cold months.

The priority is to ensure that people are supported to live independently in their own homes as far as possible and we believe that prevention is better than cure. We wanted to invest in schemes that support the community and admissions avoidance, rather than simply buying more beds. We did not want to create dependency.

Winter planning conversations took place in the quadrants being led by the responsible DLD (director for local delivery) as we knew that the issues and challenges in each quadrant (and the respective hospitals) vary and potential schemes may be different to accommodate.

At a County-wide level we intended to do the following:

1. Incentivise providers to take on new packages of care over the winter period and over weekends.
2. Set up a scheme that supports people out of hospital with live in care for a period of time, reducing the need for interim beds.
3. Invest in longer working hours for social care employees to ensure more cover over the winter period
4. Fund extra capacity for mental health assessments
5. Invest in public health initiatives and community resilience to help prevent admissions, for example, winter warmth schemes, flu jabs and care navigators.

2019

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 but this year it does not mean it can only be spent during the winter period - it can support seasonal pressures, and also areas can invest in schemes earlier to better prepare in advance for winter.

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 30% (£1,775,848) for county-wide schemes and 70% (£4,143,646) 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

Key Principles

for managing pressure on hospitals

ADMISSION AVOIDANCE

One of the ways of reducing pressure in the system is to reduce admissions into hospitals. This can be achieved through developing community services with the aim of improving or maintaining patients' health.

This Preventative approach to managing demand is a key priority in the Adult Social Care Business Plan, and for our partners across the Health and Social Care System

TRANSFERING CARE

Often described as Intermediate Care - the principle of expediently discharging patients from hospital is essential to reduce pressures in the hospital - we are measured on the number of delayed transfers of care (DTOC).

A 'delayed transfer of care' occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed. It can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients.

Admission Avoidance

MANAGING DEMAND

Our vision is "For every adult to be able to live as independently as possible and to enjoy a good and meaningful life" and this is a vision that must continue to be supported through times of additional pressure. We want to see a transformational shift from a focus on long-term care and support to those in crisis to a focus on early intervention and enabling people to live independently for as long as possible, by making the best and most sustainable use of all available resources.

It is easy to revert to reactionary approaches when looking at how to manage demand but by holding this vision close we are able to think rationally and long-term.

A key principle of prevention enables us to focus on evidence-based interventions that can help to prevent avoidable demand on statutory health and care services especially at times of increase pressure and demand in the system

DTOC – Current Picture

Setting	West	South	North	Mid
Acute Hospitals	• Daily DTOC figures are shared and there is an opportunity to challenge if needed but there is not a formal validation meeting held daily • Weekly DTOC figures are agreed once a week in formal meeting for PAH and Addenbrookes • No Validation for Whipps Cross. • Mid Hospital team manage any discharge for West Essex patients.	• Weekly DTOC figures are agreed once a week in F2F meeting, SHUFT (Fri) and BTUH (Thurs) • Daily 'Huddle' in SHUFT led by Discharge Co-Ordinator around 'State of Hospital', MFFD & DTOC. • Weekly email to service manager with brief summary of acute.	• ASC maintain a spreadsheet with updates for discharge planning. • Daily DToC are prepared and validated between ASC and the hospital with the exception of the weekend which are completed on Mondays.. • Validation of all patients from Essex regardless of quadrant	• Weekly DTOC figures are agreed once a week in formal meeting • Complete ASC DToC tracker for acute only. • Email service manager a brief summary of both acute and community
Community Hospitals	• Daily DTOC figures are shared and there is an opportunity to challenge if needed but there is not a formal validation meeting held dailyDTOC figures are agreed once a week for Epping Community Hospital & Saffron Walden Community Hospital • *ASC tracker not completed.*	• Validation undertaken weekly (Brentwood Comm. Hospital incl. Mountnessing court & North Essex only) • *ASC tracker not completed.*	• ASC tracker completed weekly - Fyatt & Clacton Hospitals.	• "Log-arm" Validation undertaken Weekly. • *ASC tracker not completed.* • Email service manager a brief summary of both acute and community.
Mental Health	• No Validation – generally zero or very small due to the criteria & cohort.	• Weekly TeleConf, LoS Bed meeting & MDT with monthly sign-off on delays.		
Learning Disability	Throughout Essex DToC are based on the planned date of discharge agreed through CPA with the social worker. Potential DToCs identified are escalated to a *monthly* Transforming Care Operational meeting when: • The integrated plan is reviewed to achieve the target discharge date. • The LD Specialist Health Commissioner is notified for Transforming Care Performance trajectories. **Reporting and Validation** • When a DToC occurs, the health/social care responsibility is agreed at CPA. • DToCs are reported nationally through Unify and locally to the LD Integrated Health Commissioners through contract reporting. • Confirmation of social care DToCs within ECC ceased in April 2018.			
	Within the quadrants: • *No validation process.* • *No tracking of DToC or LoS.*			

A recent deep dive was completed to ensure that efforts to reduce Delayed Transfers of Care were consistent. It was triggered because:

- Over the course of the year, our average performance is better than 17/18 and
- There have been fewer delays in total over the course of the year
- DToC rate per 100k population for March is 2.2 against our target for 2018/19 of 2.6

however….

- Performance in recent months has declined compared to this time last year; and at times fallen behind other LA's.
- Joint DToCs are consistently rising over the last three months and currently at their highest level

A set of recommendations have been made following this deep dive to ensure that performance continues to improve and that the right areas are prioritised (currently MH and LD). Governance arrangements are currently being agreed with partners to support delivery of these.

FINDINGS & RECOMMENDATIONS

97% of Essex DTOCs come from 15 organisations.

Five of the fifteen high-volume organisations are outside Essex (c15% of DTOC).

The main reasons for joint delays are awaiting care package at home or awaiting nursing home placement.

60% of our current DTOCs are non-acute (Community, MH & LD).

Essex Social Care DTOC rate compares favourably to both Eastern region (EoE) and nationally, generally having better rates with a notable exception in Oct-Dec 2018 (higher than the national rate, however better than EoE). Eastern region, national and Essex rates have all shown an improving trend since April

Following this deep dive a set of recommendations have been developed to ensure that we continue to meet the target and operate effectively to manage DTOCs :

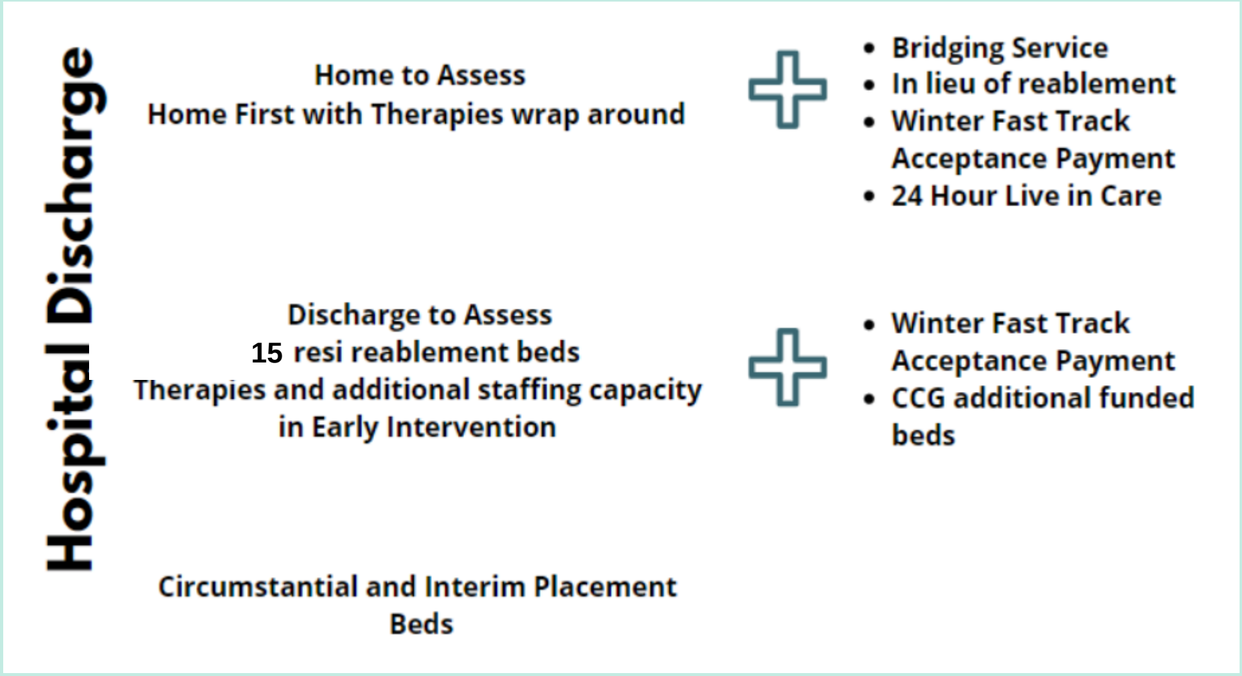
Recommendation	Delivery		What will change?
	Lead	Programme/'s	
Create a single shared vision about the truth, shifting the focus from DToC to Outcomes (All recommendations)*	ALT	• Integration/TASC • Intermediate Care Better Care Fund	Clear vision of success and what that means for the system.
Develop a clear pathway for data from frontline of decision making at individual level through to leaders at organisation & system level (Rec's 3,4,5,6,7,8,9 & 11-13)*	Data & Analytics & Service Managers	• Better Care Fund • High Impact Changes (HIC) • Digital	Clear governance & control mechanisms ensuring the best possible control at individual, service & leadership levels systemwide. "long term outcomes for the individual at the heart of every discharge decision"
Develop clear ownership of every aspect of the discharge pathways (& processes) incl. Criteria & Mechanisms for escalation* (incl. review of Internal Audit action plan in light of Deep Dive findings).	Service Managers with hospital leads	• Integration/TASC • Intermediate Care • HIC	Clear governance & control mechanisms ensuring the best possible control at individual, service & leadership levels systemwide. • Ability to challenge & agree improvements • Accurate understanding of capacity based on fact not perception
Work with East of England LGA DTOC Network to agree definitions, interpretation and use of NHSE guidance (Recs 1,2 & 8)*	Alex Green with support from the Integration & Partnership Team	• High Impact Changes (HIC) • Integration	• Consistent application of the guidance, stronger validation and more accurate data/tracking. • A shared & agreed understanding of blockages and flow issues in the system.
Ensure consistent interpretation of NHSE guidance & use of coding is in use across teams (Rec's 1,2 & 8)*	Alex Green & Service Managers with hospital leads	• High Impact Changes (HIC) • Digital	• A shared & agreed understanding of blockages and flow issues in the system. • Ability to challenge & agree improvements
Ensure processes are in place for correct & consistent validation in accordance with NHSE guidance (Rec's 2, 4, 7 & 9)*	Data & Analytics & Service Managers	• Better Care Fund • HIC • Digital	Clear governance & control mechanisms ensuring the best possible control at individual, service & leadership levels systemwide.
Ensure a consistent approach to sharing data & information (Rec's 3,4,5,6 & 10)*	Data & Analytics & Service Managers	• Digital/Integration • BCF/HIC	An agreed understanding of blockages and flow issues in the system to enable improvement.
Processes to be put in place to validate and understand the causes of delays in Community, MH & LD settings.* (Rec's 5,7,8,10 & 11-13)	Alex Green & Service Managers with hospital leads	• Intermediate Care • Digital • HIC	Agreed approach to holding professionals, services and systems to account without blame • An agreed understanding of blockages and flow issues in the system to enable improvement.

Local Delivery

North East Essex

Winter Schemes in NE Essex aim to:

- Enable swifter hospital discharge
- Ensure efficient patient flow throughout the system
- Embed a home first culture with assessments and longer term decision-making taking place in an adult's own home
- Increase the consistency of reablement/therapy.
- Explore the use of therapies alongside interim placement beds upto 20/21
- Organising ECL and in lieu providers
- Ensuring that Home to Assess continues to operate as effectively as possible through the reablement service



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 are engaging 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 is 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.

The challenge lab will take place on 25th July 2019 and will define the pathway that the system wants to focus on. The session will also draw out the outline commissioning intentions for the system. The project has been discussed with Newton Europe, and they have advised that although their research will touch upon some of these objectives, they would not deliver fully against these as in scope services for the winter demand mapping project may not be intermediate care.

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

In South Essex the A&E Delivery Boards continue to analyse acute data to determine trends (daily/weekly) in A&E attendance in comparison to previous years & across region. Winter Learning sessions have taken place with providers, partners & frontline staff.
Directors of Operations across the MSE group are beginning their Winter Planning imminently, linking with EEAST ambulance service and exploring how they can best utilise the patient tele-tracking system & predictive data analytics.

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 newly established Partnership & Integration Forum (BB) provide strategic oversight from partners across the South system. Partners are particularly keen to take on board learning from the Newton Europe diagnostic work in helping to inform future decision making.

- 'In Lieu' of Reablement services to manage demand and ensure capacity - Based on winter last year this will be at least £200k
- Extra staffing will be commissioned as it was last year but learning has shown that the roles need to be for a minimum of 6 months to enable training, improve quality of candidates & cover Easter as well as winter.
- In 2018 24 hour care schemes were not utilised to the level expected - this was due to a mixture of awareness and identifying need. This will not be re-commissioned in 2019.
- Bridging will be an area of spend for South Essex and the model for this is currently being developed.
- 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 beds commissioned last year will continue to be available.
- the development of a Hoarding Forum is high on the agenda
- Using learning from other quadrants discussions around commissioning an Early Intervention Vehicle have just begun

Winter 2019

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