Coventry City Council

Briefing note

To
Health and Social Care Scrutiny Board (5)

Date
2 March 2016

From
Coventry and Rugby System Resilience Group (SRG)

Subject
Winter Resilience

1. Purpose of briefing note

To provide Health and Social Care Scrutiny Board (5) with an update on the current challenges faced within the health economy and the management of these. Specifically, this briefing note covers:

1. Delivery of the winter resilience plan and available resources
2. Recent system challenges and contribution of winter pressures plan to managing these (including Delayed Transfers of Care)
3. Next steps in relation to Emergency Care Improvement Partnership (ECIP) and transformation programme

This briefing note will be accompanied by a presentation to the Board.

2. Recommendations

Health and Social Care Scrutiny Board (5) to note the update provided and provide any comments and feedback in relation to the current Winter Resilience Plan and other system issues covered.

3. Information/Background

A number of health and social care systems have faced increasing challenges in relation to managing pressures that create demand particularly in acute hospital settings.

Recognising that winter provides additional challenges relating to demands in health services, each year a winter resilience plan is developed in order to ensure there are actions taken to address the challenges that may present over the winter period.
The System Resilience Group brings together senior executives from the main health and social care partners and is the forum in which the winter resilience plan is signed off, performance monitored and remedial action agreed.

The Winter Resilience Plan for 2015/16 included a number of areas of activity aimed at supporting improved performance and resilience. These areas included:

- Communication, education and engagement
- Infection control
- Primary care access, prevention and self-management
- Providing alternatives to hospital
- Hospital flow
- Supporting discharge

More specifically, the plan included the continuation of a range of existing initiatives where they were demonstrating success plus some additional new investments including:

- Communication Prevention Campaign
- Social Worker in Accident and Emergency
- Wrap around Domiciliary Care possibly to include night sits to prevent hospital admission
- Additional NHS Continuing Health Care assessment capacity
- Step down beds and housing with care
- Integrated Neighbourhood Teams
- Extended GP Hours
- GP in Accident and Emergency

The total financial resource available for winter resilience for 2015/16 was £2.859m. This is reduction from £3.6m in 2014/15.

4. System Challenges – Winter 2015/16

During mid to late January a significant increase in demand was seen culminating in significant pressure in University Hospital Coventry and Warwickshire (UHCW) during week commencing 25 January 2016. This led to the trust being unable to admit significant numbers of patients from the Emergency Department and required significant escalation activity from across the health and social care system in order to free up beds for people requiring admission. Intelligence from NHS England is that there was significant pressure across the whole region at this time.

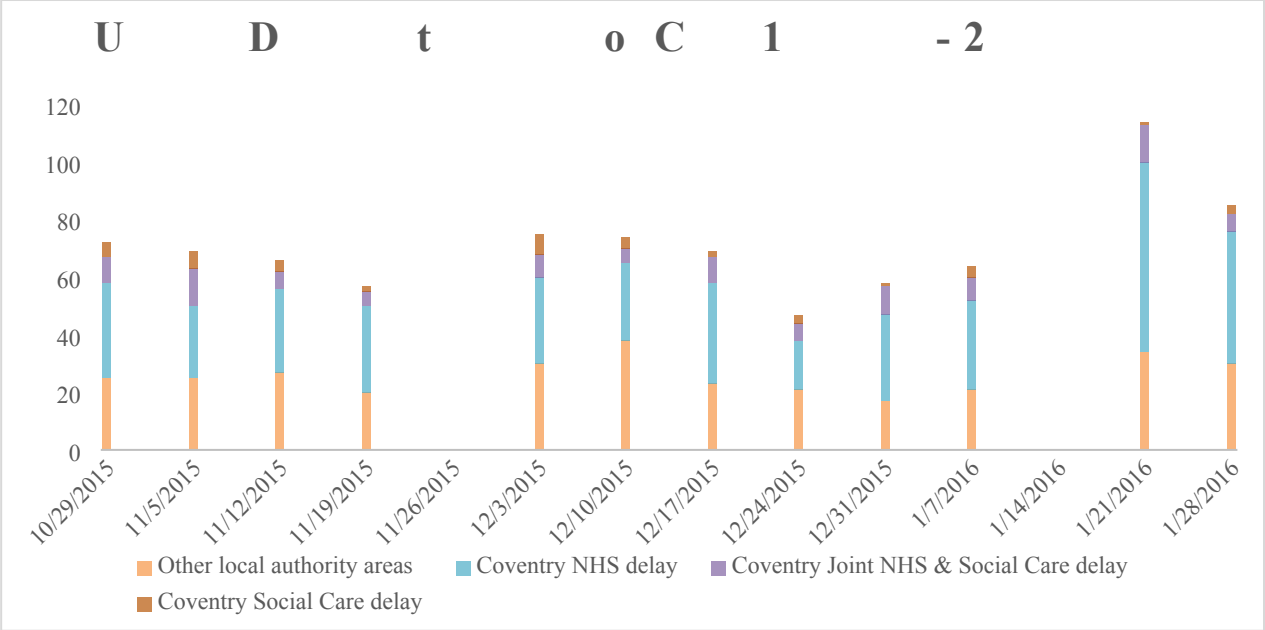
Although much of this additional pressure was not predicted more could be done to reduce the probability of this type of spike, for example: improving support to keep people at home and prevent them from coming to hospital in the first place, creating clearer connections into

services which allow prevention of admission, and increased ability to discharge patients from hospital as soon as they no longer require an acute hospital bed.

The escalation activity that took place facilitated the discharge over 300 people over a two day period at UHCW. The fact that the escalation activity facilitated over 300 discharges in two days demonstrated the ability to respond to the issue in hand and use resources flexibly to manage the situation. A proportion of the winter resilience fund was also used to secure additional social care capacity where required to help facilitate discharge where a care service was required.

The three main performance indicators that act as a barometer for the performance of the local health economy are 4 hour waiting targets for Emergency Departments, the 18 week Referral to Treatment Target and the numbers of Delayed Transfers of Care.

The Delayed transfers of care (DTOC) are measured at 12:00AM on Thursday with only the last Thursday of every month being required to be reported nationally. DTOC had stabilised throughout December but had risen during January with a peak in pressure on the snapshot days of 21 and 28 January. (Data is missing for 26/11/2015 and 14/01/2016).



Whilst the number of DTOC is the performance figure that attracts the most attention which most attention is placed in, the total number of days lost is a critical figure. For the period 22 to 28 January 416 days were last across 55 patients. The two most prominent reasons based on bed days lost appear to be NHS assessments and further non acute NHS care.

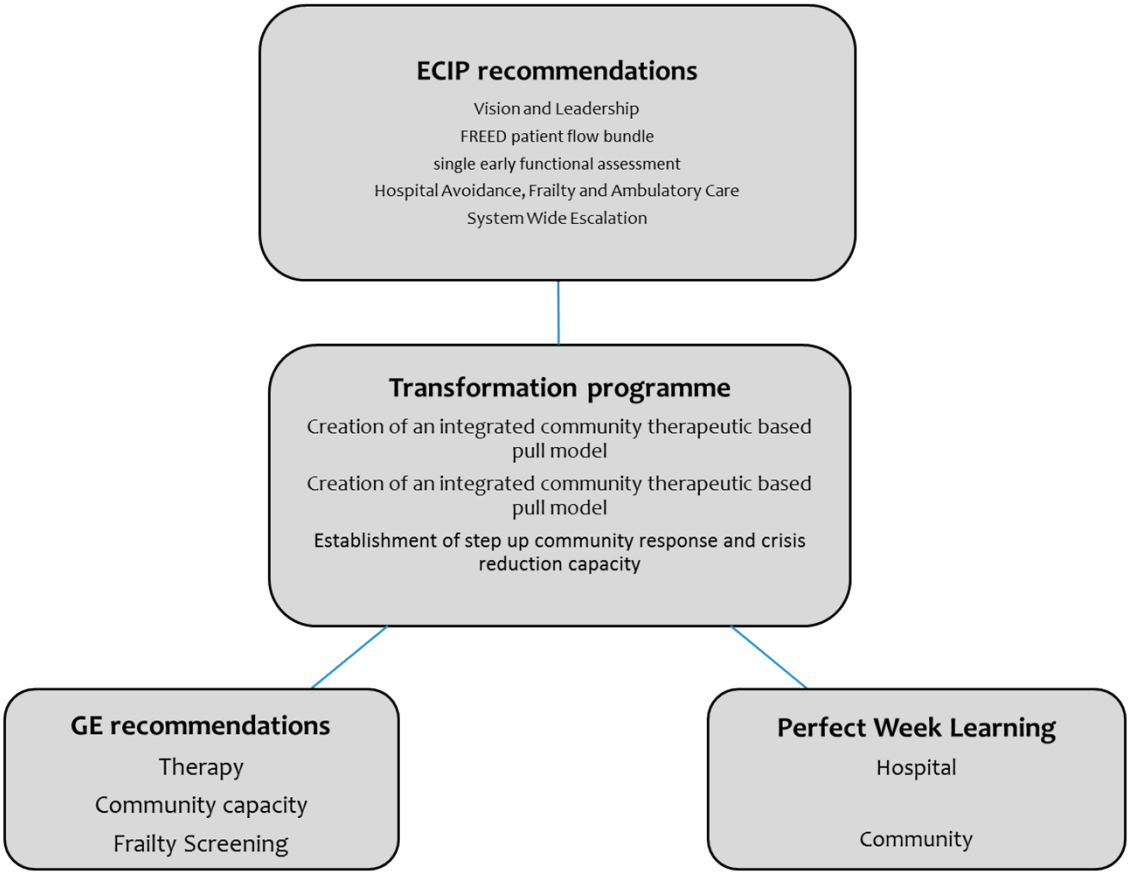
5. System Improvements – Emergency Care Improvement Partnerships (ECIP) and Transformation Programme

The local health and social care is working to deliver sustainable improvement. The challenge is to incorporate all of the learning from the ECIP review, the capacity planning work from GE Finnamore completed in 2015, our experiences and learning from perfect week and our existing transformation programme into one coherent improvement plan, the different dimensions of which are shown diagrammatically below.

The relationship between these different improvement streams and the management of this activity was considered by SRG at its January meeting which will continue to be the key forum for managing improvement progress.

In terms of identified next steps to support sustainable improvement the following actions are being pursued:

- Piloting an Ambulance Service Accredited Urgent Care Centre taking up to 25 ambulances per day away from UHCW
- Creating a single point of access to community services for secondary care
- Running INT's at scale, alignment with Frailty and Urgent Primary Care Assessment Centre Pathways to ensure a more seamless step up/crisis community intervention pathway
- Developing frailty services across the system so that they work seamlessly and effectively



Pete Fahy
Director of Adult Services
18 February 2016