Planning for Winter

Presentation for the Health and Adult Social Care Overview and Scrutiny Committee

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Overview of presentation:

- Last winter – a short reminder of key issues.
- Work undertaken to understand demand by the community.
- Winter planning this year – demand led work and system challenges.

Last winter………

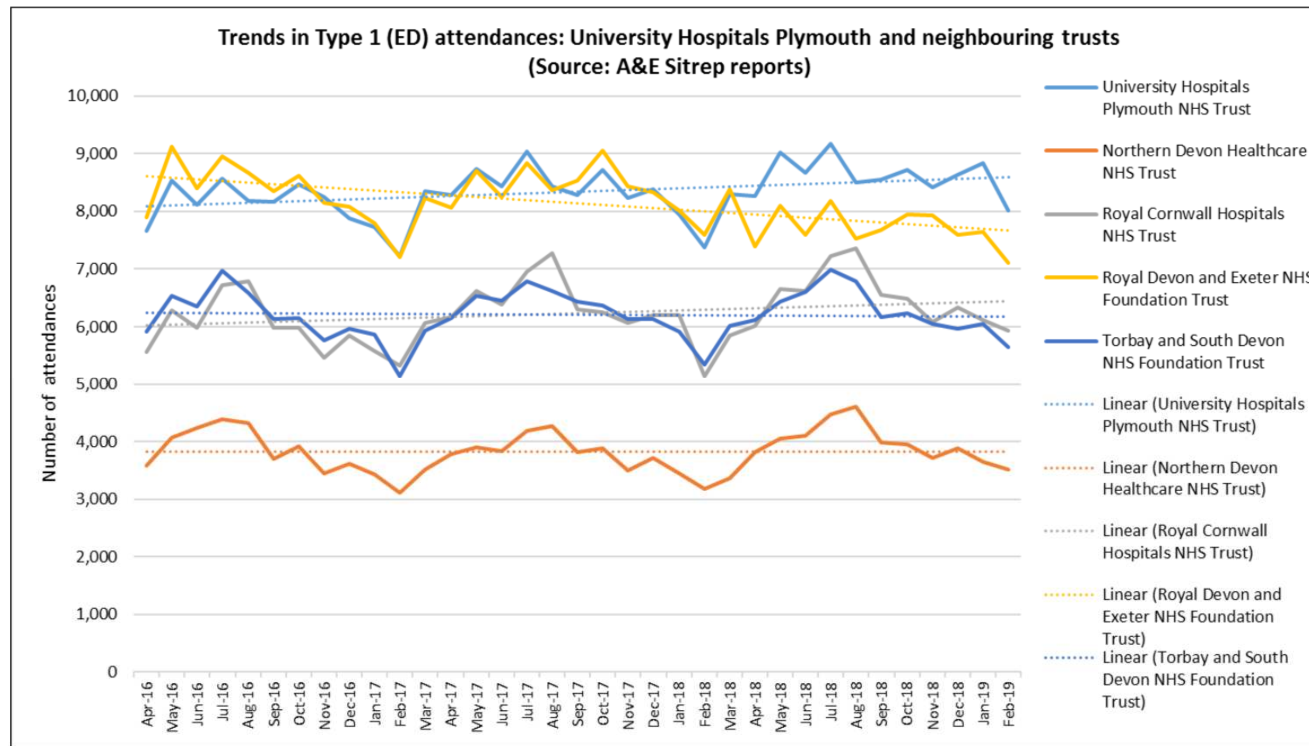
Started well

- ✓ Planning appeared to be working up to an including Christmas weeks and early January.
- ✓ Flu numbers were down.
- ✓ Weather was reasonable.

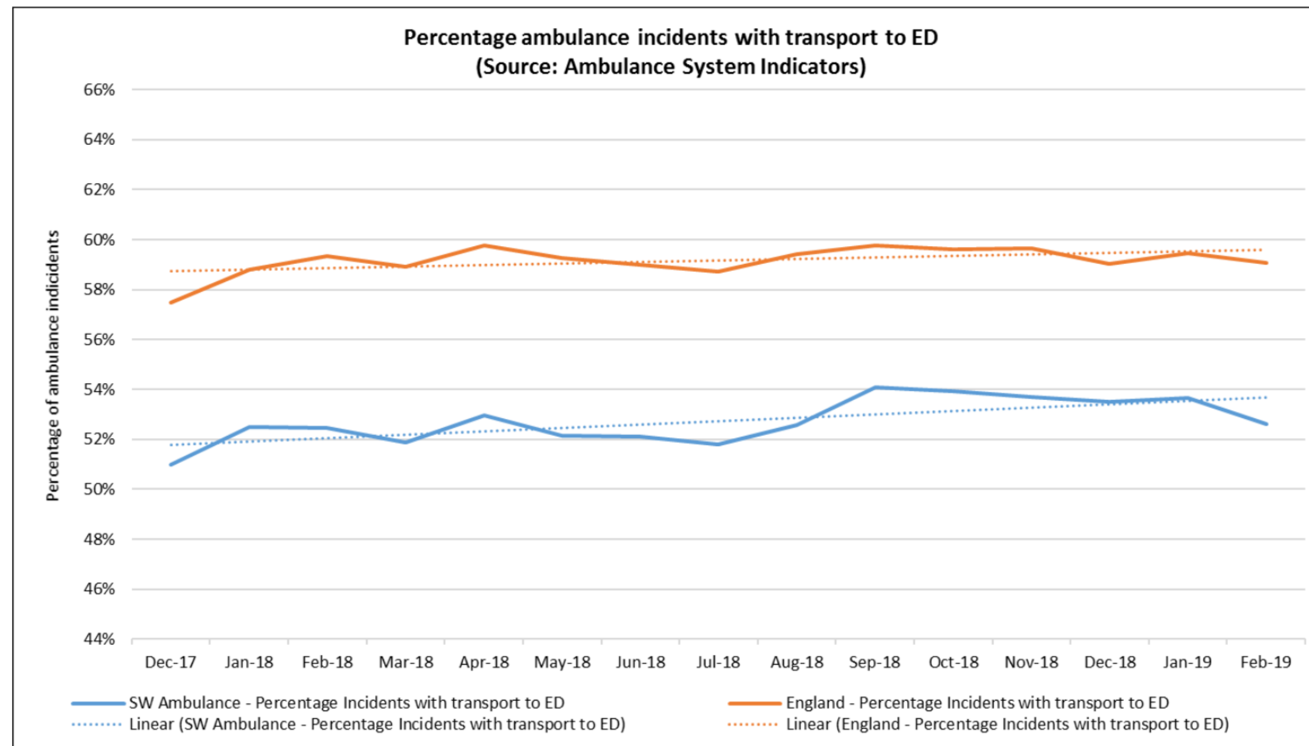
Then ….

- Started to highlight increasing demand levels in western locality – especially ambulance led demand but also higher acuity in patients, poorly and taking a while to recover.
- More than other areas in Devon
- Sustained pressure with little respite creating challenge to de-escalate
- End of February , beginning of March sub 40% performance for ED – national and local intense review of performance and patient safety.

Comparison with other communities….



Ambulance conveyances…..



Reflection….

Good…..

- ✓ D2A model for home based care worked well and increased number of people being cared for at home.
- ✓ Use of care home beds was more measured.
- ✓ Length of stay metrics were some of the best in the country- extended length of stay.
- ✓ Delayed transfers of care were at target levels.
- ✓ Modelling of capacity and demand in bed based setting was accurate. (Bed allocation plans).
- ✓ Oversight of demand and patient flow much improved on previous years.

Could have been better…..

- Workforce challenges affected every provider and prevented flexibility.
- We cancelled a lot of elective surgery.
- Flu numbers were low but level of hospitalisation and ITU usage was high.
- Frailty and ambulatory capacity was not sufficient.
- Difficulty 'bouncing back' after periods of escalation.
- Seven day capability.

Understanding Demand

Our approach:

- mix of qualitative and quantitative activity,
- GP’s going into ED to speak with patients and clinicians
- GP’s and commissioners discussing demand drivers with primary care teams
- review of ambulance conveyances
- patient safety reviews (end to end assessment of impact).
- Independent review of all data commissioned by the NHSE

Findings……

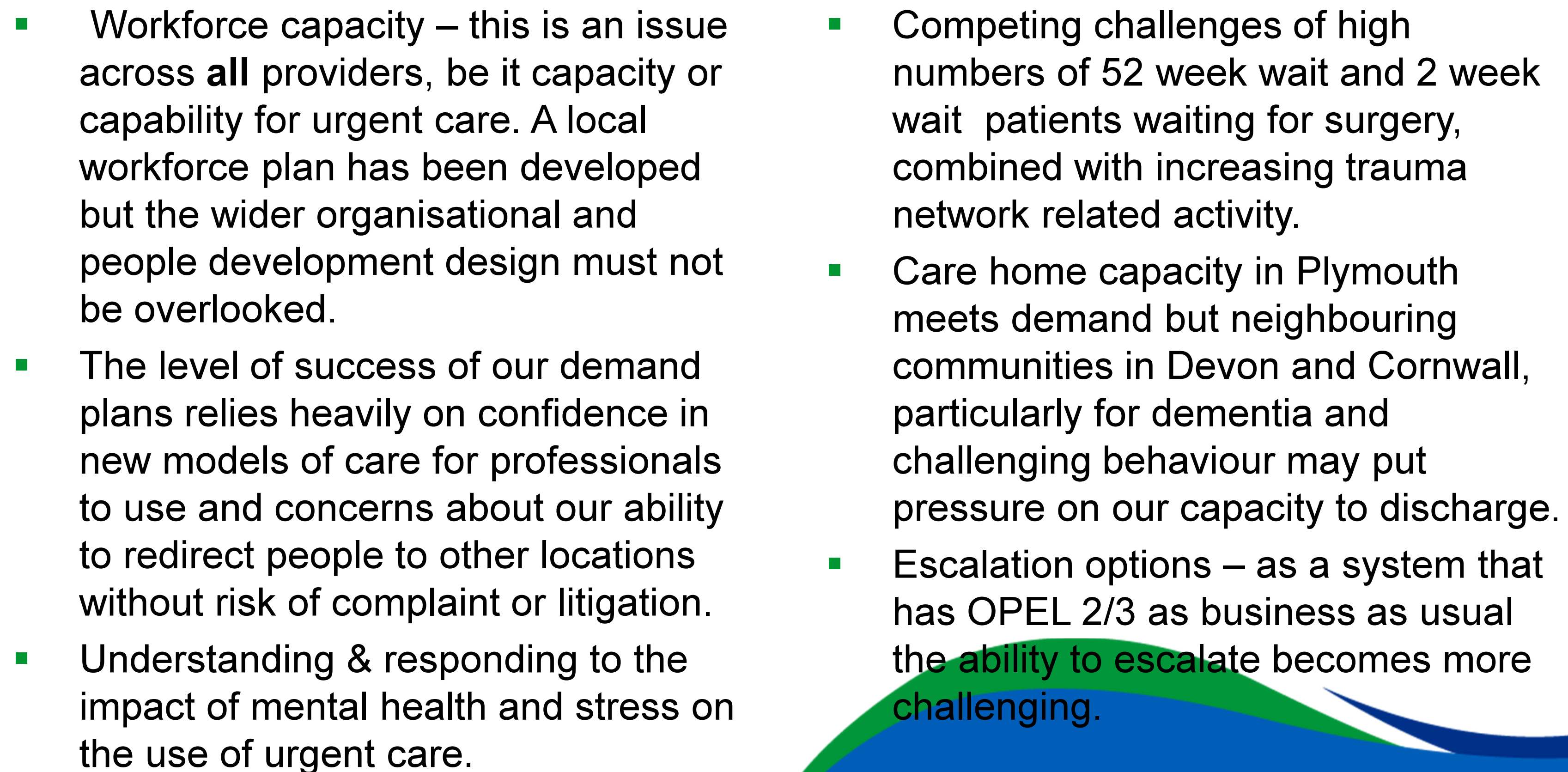
Overall the increase in demand is real…….

- There has been a gradual increase in ED activity at UHP over the last three years but a more dramatic change in four hour performance.
- In a number of measures UHP and the local health economy is better than the England rate for things that should reduce the number of ED attendances. These include: the percentage of ambulance calls that result in ED attendance, 111 advice to attend ED and a reduction in the number of self-referrals to ED.
- Trends that are moving in the "wrong" direction are: an increase in GP referrals to A&E, A&E HRG complexity, growth in the elderly population and four hour performance.
- The continued story of primary care unable to manage demand is influencing the public, to the extent that they choose not to try their own practice.

Demand led work for the system…

- Applying the learning from the Coastal Locality team who have reduced their admission rates significantly by providing wrap around community services, identification of high-risk patients, and rapid access to intermediate care and frailty services.
- Targeting people with respiratory disease to prevent unnecessary admissions when care could be better provided through preventative measures and ambulatory care.
- Reducing the numbers of people unnecessarily being admitted to hospital or attending ED because of poor communication around end of life care.
- Supporting diminished primary care capacity to assess and manage on the day care, through operational and digital support.
- Increase the ability to provide same day emergency care services – frailty services, ambulatory care, extension of the Cumberland Centre capacity.

Winter planning this year - key challenges



- Workforce capacity – this is an issue across **all** providers, be it capacity or capability for urgent care. A local workforce plan has been developed but the wider organisational and people development design must not be overlooked.
- The level of success of our demand plans relies heavily on confidence in new models of care for professionals to use and concerns about our ability to redirect people to other locations without risk of complaint or litigation.
- Understanding & responding to the impact of mental health and stress on the use of urgent care.
- Competing challenges of high numbers of 52 week wait and 2 week wait patients waiting for surgery, combined with increasing trauma network related activity.
- Care home capacity in Plymouth meets demand but neighbouring communities in Devon and Cornwall, particularly for dementia and challenging behaviour may put pressure on our capacity to discharge.
- Escalation options – as a system that has OPEL 2/3 as business as usual the ability to escalate becomes more challenging.

Conclusion:

- There has not been any dip in activity to allow teams to regroup this year, demand has been relentless. **Winter will be challenging for all stakeholders.**
- Winter & resilience planning is an incremental process, learning from previous experience, keeping the options which work and moving on from those which don't.
- We need to keep continuing to improve in key areas e.g. discharge planning, length of stay reductions, ambulatory care, frailty services. Innovation & new ideas are important but we must still keep fine tuning services that work and ensure they derive the maximum benefit.
- This year we have spent a considerable amount of time focussing on trying to get behind the drivers of demand and obtaining a shared commitment that we are doing the right things together.
- This year we have invested time and prioritisation to those actions which link the wider community with urgent care and build on last ' successes and are seeing some good progress so must keep going! e.g. .
  - High intensity users offer - linking with social prescribing
  - Wrap around community services to support the ability of primary care to keep people at home (CCRT, paramedics, frailty specialist services in primary care
  - Proactive care home visiting with time to care for primary care