Suffolk County Council

Evidence Set 1

Health Scrutiny Committee

Date: 14 October 2015

Planning for Winter Pressures in 2015/16

Information in this report was produced on behalf of	
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Introduction

1. The Health Scrutiny Committee has asked for a report about how the Ipswich and East Suffolk and West Suffolk health and care systems are planning for Winter 2015/16, considering current issues relating to delayed patient transfers at Ipswich and West Suffolk hospitals, and how this is being addressed. The report requested does not include the work taking place within the Great Yarmouth and Waveney system, which is the subject of ongoing scrutiny by the Norfolk and Suffolk Joint Health Scrutiny Committee.
2. The objective and full scope of the scrutiny is set out in the covering report at paragraphs 2 and 3.

Focus of this report

3. The Council has been asked to provide information in response to question G.

g). How are partners working together to ensure that these issues are addressed and that people do not remain in hospital for any longer than is necessary

Main body of evidence

4. The Council and key partners are committed to close working to make sure that people are supported to leave hospital and that they do not remain in hospital inappropriately or for any longer than is necessary.

5. The Council recognises that owing to a combination of increased demand for assessment of need, some key changes in community services and current challenges in care market are impacting on arrangements to provide care and support and this is having an effect on timely discharge from hospital. A number of actions have been taken to improve this situation, as part of the work to move towards an integrated health and social care model.

6. There is work at a local and regional level on workforce supply, given that a number of health and care roles are proving hard to recruit to.

Integrated Care Networks

7. Close working has enabled the development of the whole system winter resilience plan for 2015/16. This is where the capacity planning and delivery of services across the health and social care system are coordinated all together in one plan. The Council is a member of the Integrated Care Networks (ICNs) in both East and West Suffolk. The ICNs are responsible for the planning and coordination of a joined up health and care response in East and West Suffolk all year round, and especially for the winter period, with membership from across the health, care and voluntary sectors. The Council's members are Cathy Craig, Assistant Director Social Work Services, Bernadette Lawrence, Assistant Director Well Being and Service Transformation. Meetings are held monthly in both East and West Suffolk, and decisions are made collectively by the attendees at each meeting.

8. Close working has enabled the development of the whole system winter resilience plan for 2015/16. This is where the capacity planning and delivery of services across the health and social care system are coordinated all together in one planning process in order for the whole system to operate as effectively as possible.

Health and Care Integration

9. Close working has enabled a clear model of Health and Care Integration to be agreed and developed. Partners have worked to design and put into place a system of care and support which aims to prevent unnecessary crises and admissions to hospitals, and which ensures that all agencies are prepared for extra demand. The model of working supports safe and timely hospital discharges by ensuring that discharge planning starts from the earliest opportunity.

10. A core component of the Health and Care Integration model are the Integrated Neighbourhood Teams (INTs). The INTs are multi-agency teams committed to fully understanding the needs of local people so that services are well co-ordinated around their needs.

11. The INTs' role is to ensure health and care interventions are planned, proactive, and avoid the need for crisis and urgent response. The INTs will

enable people to self-manage their conditions, support individuals to maintain their independence, prevent hospital admission, support timely hospital discharge into reabling services and provide an integrated approach to end of life care.

12. INTs will include services from community health, adult social care, primary care and mental health. The INTs will provide a simple access route for patients, customers and carers. INTs are being implemented in Sudbury and East Ipswich. Further information about "Connect Sudbury" and "Connect East Ipswich" can be found in the Information Bulletin at Agenda Item 8 of today's papers.

13. With the aim of responding quickly to prevent a crisis from escalating, and to avoid a hospital admission an Integrated Admission Prevention Multi-agency Team model is being piloted in East and West Suffolk this winter.

14. The Integrated Care Networks have identified the need to further transform the reablement journey for customers, and are working to identify the future integrated reablement services that will support a person to regain or maintain their level of independence at the earliest opportunity.

Support to Live at Home

15. The Council, together with the Clinical Commissioning Groups, has jointly commissioned the new homecare service called 'Support to Live at Home' (STLH). The new service commenced on 15 September 2015 and will provide home care support to 3000 vulnerable customers in East and West Suffolk. Support to Live at Home provides support to people across Suffolk, excluding the Waveney area. A service for this area is currently being tendered jointly with Norfolk County Council and Great Yarmouth and Waveney CCG with a target go live date of April 2016.

16. The new service is designed to deliver more personalised choices for customers, better outcomes by moving from a task and time arrangement for home care support to an approach designed to support enablement, and address inconsistent provision by services being delivered by providers responsible for services in designated geographical areas.

17. The new service will free up the Council's Home First service to be able to support people's reablement when they are ready to leave hospital as well as for those customers in the community who need support to recover their independence.

Additional Services for Winter

18. The Council has put in place additional services to support people to regain their independence and to leave hospital when they are ready to do so. This includes reablement beds and intensive support at home beds. These are supported by a specialist reablement team of occupational therapists and social workers, to help a person begin their recovery from the earliest point.

19. The Council is working with the CCG's to put in place a range of additional integrated reablement services this winter, both to prevent hospital admission and also to support people from the earliest opportunity when they are ready to return home from hospital. The Council also has in place its Supported

Hospital Discharge service which is contracted with the British Red Cross in East Suffolk and with Age UK (Suffolk) in West Suffolk.

Joint Exercises

20. The Council has been an active participant in the acute and community hospitals' 'Perfect Week' exercises. These have been held twice during 2015 at Ipswich Hospital, and once by Suffolk Community Healthcare. These have supported the development of action plans to support a more effective journey of customers through an acute and community hospital setting.

Delayed Transfer of Care (DTOC) forums

21. The Council continues to work closely with partners in regular Delayed Transfers of Care forums which seek to unblock current challenges in the hospital discharge process, as well as inform wider system resilience actions.

22. These were initially held weekly and are currently held fortnightly with senior colleagues in the Council, the hospitals, the Clinical Commissioning Groups, and community services and reviewed flexibly according to need.