CAN DO HEALTH & CARE
Suffolk and North East Essex Integrated Care Partnership (ICP)

Suffolk and North East Essex Integrated Care System

System Learning from Winter Pressures 2022/23: Integrated Care Partnership Committee workshop September 2023

1. Reflections from our May workshop

Prof. Mark Shenton, Chair, ICS Chairs Group

Reflecting on our last workshop, our ICS Chairs Group posed some questions for today:

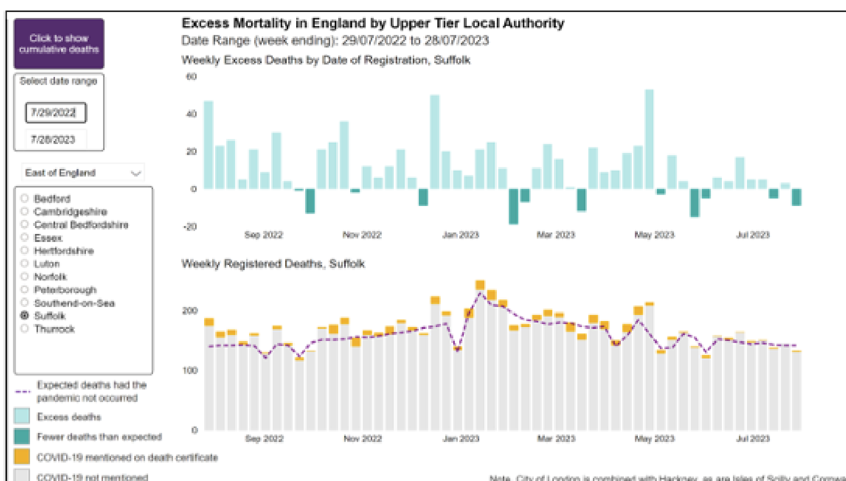
1. We know that the pressures last winter were not significantly different to other seasons, the pressures resulted from the severity of illness in those accessing emergency care. Rather than a winter plan, should we have one plan across the year that flexes when variations happen, and which we continually improve?
2. We tend to focus heavily on operational performance, how can we also be strategic in managing pressures?
3. We tend to invest in where most activity happens, but how can we also invest to become more proactive, coordinated and integrated, reducing the need for reactive care?
4. Staff cannot sustain working at high pressure long term, and are at risk of burnout. How will we give our workforce recovery time?
5. Where can partners such as the Voluntary, Community, Faith and Social Enterprise Sector, and District and Borough Councils contribute?

2. How can we use data more effectively?

Anna Crispe, Public Health - Suffolk County Council

Using the data changed people's understanding of the problem, and has prompted many different follow up conversations across the ICS, but we can make the data more useful still. If we join up data such as our population health management (PHM) dataset, we can plan ahead at patient level much more effectively. To do this, we need to be able to access data in a timely way (daily, not weekly or monthly, where fluctuations in data can appear flattened) so that we can respond to changes quickly. We must share data and analysis and the key findings routinely and systematically, as we did during the pandemic.

We must also agree what data is useful to guide action, and ensure it is being monitored and shared. We know quite a lot about demand and potential demand, but we know very little about capacity, not just in hospitals but in social care and primary care, for example. Knowing more about demand data strategically can help us to understand it and to plan and respond more effectively.



Excess deaths There were negative excess deaths (-9) in Suffolk in the week ending 28 July 2023 (most recent available data). However, in most weeks in the last 12 months there have been excess deaths, with 21 excess deaths since the end of May 2023 (last surveillance meeting).

NHS England registered death data only available up to end of June 2023.

30 fewer registered deaths in June 2023 (n=595) compared to June 2022 (n=625).

In the main the pattern of weekly registered deaths follows the expected pattern if the Covid 19 pandemic had not occurred.

Source: OHID Excess Mortality in England Report: Microsoft Power BI [accessed 10 August 2023]; **PH&C Deaths Dashboard**: Deaths dashboard - Power BI [accessed 10 August 2023]

Suffolk and North East Essex's new Intelligence Function is doing a further 'deep dive' on winter issues, supported by some in depth work on respiratory admissions done by Public Health. We can now use the PHM dataset to identify people who could benefit from preventative interventions, and have the opportunity to now do this at scale.

3. A Perspective from Primary Care

Ruth Bushaway, Suffolk GP Federation

One example of the (sometimes hidden) amount of urgent and emergency care which takes place in primary care is our response to Strep A infections last winter. Against a background of Covid recovery, high demand and winter pressures, Strep A cases rose in December 2022 amid national high-profile reporting and concerns by parents and clinicians. Primary care saw a five-fold increase in consultations at times in some practices, these difficulties lasting several weeks. Pharmacies also very busy with first contacts, processing prescriptions and sourcing stock.

We were able to flex our model quickly to face these challenges and protect the most vulnerable. Many more patients were consulted in- and out-of-hours, and in 111, with administrators helping families to source antibiotics. We also had system support to reduce non urgent work, so we could prioritise children with Upper Respiratory Infections, learning disability health checks and other high risk areas of work. The health system provided national updates and valuable guidance, and local paediatricians updated our knowledge. Daily system safety calls involved primary care, 111, out-of-hours services and acute trusts. Microbiology colleagues published advice on swabs. We worked closely with pharmacies, and Medicines Management advised on alternatives for antibiotics with low availability.

We are now in a better position to respond to pressures in the future. Our safety calls system can be stepped up when needed, and we are working to reduce inequalities in access to services. We are progressing digital and system solutions between practices and pharmacies, and shared data and intelligence enables GPs to reprioritise focus and solutions. We have a more coordinated medicines management approach, which we can further develop to include dispensaries, hospital and community pharmacies. We also want to involve patients, carers, schools and other stakeholders to spread information and learn from patient experiences.

4. Exploring Learning in Mental Health Care

Andrew Kelso, NHS Suffolk and North East Essex ICB

At our last workshop event in May, we learned about the innovative Mental Health Urgent Treatment Centre at Basildon Hospital. I visited the unit and found that although it is located at the rear of the hospital it is welcoming, calm, peaceful and comfortable, with space in the waiting area for patients and carers, and a flow through triage and assessment which does not require the patient to repeatedly return to the waiting area. Planning for community services starts as soon as possible and most patients stay in the unit 6-10 hours, though in rare cases the stay can be up to 48 hours. The staff model is safe and effective, led by nurse practitioners with support from medical staff. Staff are willing to learn and constantly evaluate their service.

We plan to adopt a similar service locally, which provides us with a number of opportunities. We should pay close and curious attention to mental health; people deserve the best urgent healthcare in the right place. We must ensure that people using the urgent treatment centre in true emergencies, the unit is not a replacement for community mental health services. Finally, we should learn from Basildon Hospital and other evaluations, as this model is not common in the UK. Adopting the model in our ICS is an opportunity to innovate, evaluate, and continually improve.

5. Prevention and Communities Winter Warmers

Stuart Keeble, Suffolk County Council

At the last workshop we explored health prevention, we have an evidence base so we know what works, and that the challenge is how best to use it. Outcome based approaches focus on people's health outcomes and the benefits they need to achieve them. However, we find ourselves on a 'burning platform' where we tend to focus on performance and neglect to think enough about what people want for their health and wellbeing. Reframing our language can help us to refocus, for example we know people with health conditions want to stay well, so we should ask what they need to achieve that. We also need to plan not just over one year, but two or three-year periods. An outcome based approach to clinical care and the wider determinants of health enables us to keep people well and more independent.

Melanie Craig, Suffolk Community Foundation

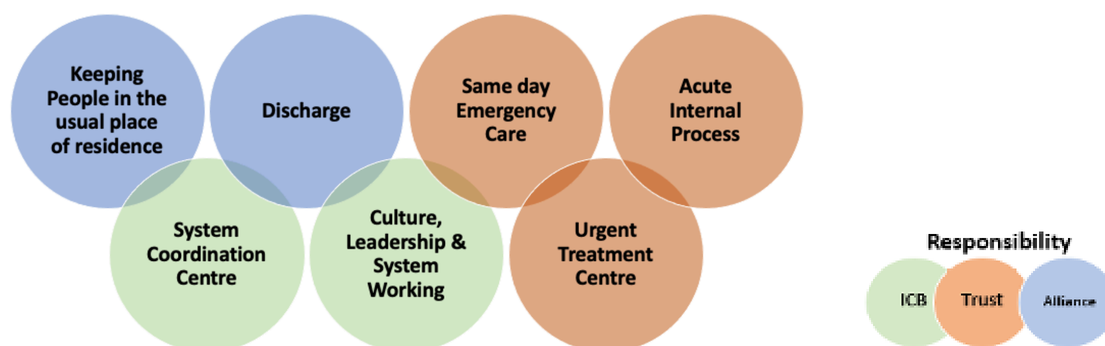
Health prevention targeting the wider determinants of health can help keep people well and prevent hospital admission. For example, a recent successful trial of prescriptions for heating for people with respiratory conditions at risk of hospitalisation was very successful. People with poor mental health might stay well with heat and company, preventing use of health and care services, and helping stay in work. For young people, heat and nutrition are vital for their education. Domestic abuse, which accounts for a third of all police activity in Suffolk, is likely also to impact the use of heath and care services in all sectors. Suffolk Community Foundation has been giving fuel payments for the past decade, and the public recognise the importance of helping those most in need; last year they donated £340K. Directing those payments to reach the most in need will have a positive impact on other services too. Let's create the conditions for autonomy and success. In the Covid pandemic we had very light touch governance, few meetings, forgiveness, and flexibility, in the context of a well understood common cause. Let's ask ourselves, what is the common cause for this Winter that we can all get behind to really make a difference?

6. Suffolk and North East Essex 'UEC One Plan'

Darren Maguire, NHS Suffolk and North East Essex

The Suffolk and North East Essex 'One Plan' has been developed to deliver national requirements as well as best practice in Urgent and Emergency Care (UEC) both in hospital and in the community.

Workstreams



We have self-assessed our system maturity against the NHS's 10 high impact interventions in UEC that reduce variation in care provision, improve access to frailty and respiratory services, improve care transfer and coordination, and enhance community-based healthcare. Delivering integrated UEC Improvement includes valuable resources showcasing good practice, 'how to' guides, workforce solutions, expert and peer support. Recovery Champions and Building Capability enables targeted assistance and support to people throughout the system who play a role in delivering improvement across integrated UEC pathways.

We are currently finalising action plans for winter, modelling the periods when pressures may rise, working with local authorities to develop Better Care Fund plans, and developing priorities and high impact interventions.

7. Ambulance Services

Kate Vaughton, East of England Ambulance NHS Trust

Since our last winter pressures workshop, we have been working with partners across our six ICSs to plan new ways to manage those waiting for emergency care. We recognise inappropriate calls to 999 represents a community need that has not been met, so we need to establish what those needs are and find different solutions. We now have a multi-disciplinary hub in each ICS area, and we are building an evidence base on alternative ways to meet people's urgent needs, constantly asking 'what next?" for each person.

Three case examples summarise the difference we are making:

- A lady in her late 80s who had been lying on the floor after a fall, would normally have been automatically conveyed to hospital. An Urgent Community Response vehicle examined her and took bloods, and as a result she was able to stay safely at home.
- A gentleman who had a fall and fluid on his belly, again would normally be conveyed straight to hospital. Using reactive transport he was able to access Same Day Elective Care and return home, avoiding admission to hospital.
- A gentleman who had a fall and was in increasing pain was able to access an x-ray through the hub, and to be prescribed muscle relaxants at home.

We are already seeing the benefits for staff, who feel liberated by their access to a diversity of services. We have also learned to not let organisational boundaries be a barrier to multi-agency work. Going forward, we want to continue to extend the clinical expertise in each bub, and to involve primary care more closely.

8. Social Care

Peter Devlin, Essex County Council

We have agreed to work better together as a system with clear accountability and leadership for each scheme and implementation timescales, with project evaluations that enable understanding of the impact and outcomes of funded projects. We have funded a range of reablement provision in community and hospital settings.

System Plans include agreement to "top slice" winter funds to support reporting and evaluation; wider and earlier discussion on plans for 2023/24, aided by the earlier announcement of funding allocations; collaboration through alliances to improve governance for funding decisions at locality level; developing key principles for winter schemes to aid proposals and support decision making; and clarity on accountability and leadership for all funding proposals.

We are continuing and expanding a number of schemes:

- ***Stepping Stone homes*** offering an interim setting for adults unable to be discharged directly home in Tendring.
- ***Trusted Assessor*** a new Additional Reablement Capacity provider role to identify adults with reablement potential.
- ***Ward Led Enablement*** in the older people's wards to prevent hospital acquired decline and promote independence prior to discharge.
- ***Home to Assess*** for people who needed short term domiciliary care following a hospital stay but who were not suitable for reablement at the point of discharge.
- ***Swan bridging*** funding to reduce pressure in the Integrated Community Response Service.
- ***Provider incentive scheme*** offering additional incentives for timely and effective service delivery above that contracted in home care, residential and nursing home care.

We will also commence several new schemes:

- ***Dementia Navigator*** within the Transfer of Care Hub to support discharge of people with dementia.
- ***Technology Enabled Care in the Transfer of Care Hub*** to install Assistive Technology rapidly to aid discharge.
- **Care Workforce Retention Claims Fund** retention bonus for care provider workforce up until March 2024.

(Sharon Rodie on behalf of) Georgia Chimbani and Elissa Rospigliosi, Suffolk County Council

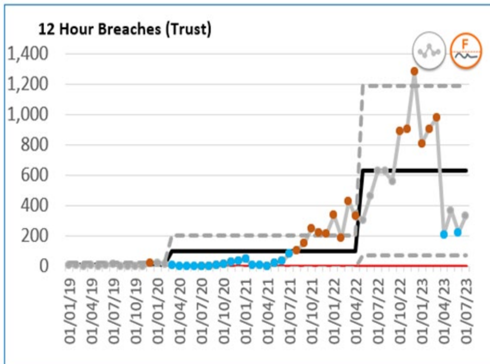
Since May, Suffolk County Council's Adult Social Care has worked with partners to agree significant investment in additional reablement capacity through the Better Care Fund discharge funding allocations, in line with Suffolk D2A (discharge to assess) principles. This focus and investment has seen further reductions in the time between referral and discharge. Latest returns to the NHS Suffolk and North East Essex UEC committee showed median times of just 1 day for both West Suffolk and Ipswich Hospitals (for all complex discharge pathways 1-3).

We have also continued work with care providers to ensure homecare capacity is available to meet need, through use of market sustainability funding to ensure adequate rates and by working with providers to target capacity at remaining waiting list cases, sustaining the low waiting list numbers achieved in Spring 2023.

9. Urgent and emergency care in our acute hospitals

Nicola Cottington and Sarah Watson, West Suffolk NHS Trust

In winter 2022/23 we saw a significant increase in 12 hour lengths of stay within our Emergency Department (ED) with a peak of 1280 patients in December 2022, and 13.2% of all ED attendances staying more than 12 hours. The average daily number of patients waiting for a bed at 08:00 within ED was 24, peaking at 54 in December 2022; we also saw increased crowding in ED at midday with growth of 34.9% and at midnight 58.65%.



In 2019 as part of an NHS programme we had stopped reporting the 4-hour standard, the time a patient attending ED should be admitted to hospital, transferred to another provider, or discharged. We decided to return to the standard from May 2023, using the NHS England target of 76% compliance by March 2024. Through our efforts we are on track for 76% compliance by February 2024. As the chart, right, shows, our breaches of the 12-hour standard have reduced significantly.

We achieved this cultural change through collective ownership, co-production and collaborative working. The 4-hour standard is a barometer of how our system is working, a quality standard for our patients, and adherence to Professional Standards. We consulted partners across the system and used data to support improvements and divisional ownership with a live dashboard. We ensured a smooth flow through the hospital system, including utilising the various services and pathways, increasing hours in the discharge lounge and early referrals and reviews. We also developed a Trust-wide communication strategy and education sessions for all staff groups.

Shane Gordon, East Suffolk & North Essex NHS Foundation Trust

Last winter our UEC services saw a slight increase in Emergency Department (ED) attendances, and whilst the 4-hour standard was not met, our level of response was sustained. However, patients' average length of stay rose and bed occupancy was extremely high, placing significant pressure on our capacity. Reasons include the trend, highlighted at the last ICP workshop, for patients to be more unwell on arrival at the ED, and that people living in areas of deprivation (in Colchester, Tendring and Ipswich) use emergency services more often than those in less deprived areas.

In the last 4 years there has been significant variation between our hospitals in the number of people attending ED in a mental health crisis, and in the length of time they stayed.

Blue: non-admitted
Orange: admitted
Grey: transferred

We found that a number of new schemes were effective in reducing risk to patients. We cohorted ambulance patients awaiting assessment into other areas of the hospital so they could be cared for more safely. Additional hospital beds in our acute and community hospitals enabled us to increase capacity. We also found that those patients who were treated using our surgical robots were discharged sooner, reducing length of stay. Crucially, however, the challenges we saw last winter have not gone away, even now, which should normally be the least pressured period of the year.

10. System and Quality Improvement

Andrew Kelso, NHS Suffolk and North East Essex

NHS Suffolk and North East Essex

We have talked a great deal today about quality improvement, and it is fundamental to our roles, but it can feel hard to do alongside our regular work each day. We need to continually learn from everything we do, in our experiences in our roles as well as when things go wrong. However, improving services cannot simply about doing things faster and harder, as the momentum will falter, and staff will burn out. To create a continuously improving system we should:

- Give our people the tools to improve, make them available and accessible to all.
- Be focused – we cannot do it all, so we need to be clear about what we want.
- Enable those with direct experience, who know what works, to lead improvement locally.
- Create performance management that supports improvement and does not segregate it from the outcomes we want.

11. Further Opportunities

Focus on the causes of poor health outcomes, and the causes of the causes

- Explore why people seek urgent and emergency care, have multiple hospital admissions, or reach a mental health crisis, and together improve community-based support that prevents their needs escalating.
- Join up and use the data we have to identify non-clinical interventions to support people to stay well.
- Allocate resources to support those for whom early intervention is not successful.
- Draw on the resources and expertise across the whole system, and all sectors, to integrate health prevention.

Set priorities not targets

- Understand the difference between priorities and targets, focusing on outcomes for people not performance.
- Set clear priorities so that everyone understands how they contribute to achieving them.

Plan and allocate resources early

- Start winter planning from the end of last winter, listening to people and staff to learn from their experiences.
- Understand our existing system assets and capacity, and allocate additional funding early and efficiently.

Hear, empower and support our workforce

- Listen to our staff and give them the time, power and tools to make things better.
- Identify what causes staff burnout, and change those ways of working and systems that cause pressure.

Work in partnership across the health, care and wider system

- Simplify and integrate plans, being flexible with routine service requirements as demands on resources change.
- Ensure plans and multi-agency activities are co-produced and inclusive of all partners in our system.
- Identify and share the information partners need, do not assume they know already.
- Develop shared culture, system and practices, to avoid 'us and them' and siloed working.
- Understand hyper-local needs and co-produce grant-funded flexible, responsive solutions with communities.

Provide sensitive, compassionate care

- Develop our estates to provide separate, welcoming, caring spaces for those in mental health crisis.
- Provide joined up support for those receiving both NHS and social care services, and their families and carers.

Learn from experience

- Explore variation and inequalities, understanding the data and people's stories to identify what works and why.
- Rediscover the changes we adopted during the pandemic that worked well.

Be creative, supportive leaders

- Change the conversation to focus on how we can help each other.
- Enable people on the ground to lead change – they are agile and can adapt better to local needs.