Norfolk County Council

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Winter Plan

Introduction

Winter creates an annual challenge for the local health and social care systems by placing additional pressure on services. Therefore, it is essential for organisations within the health and social care systems to create and share their plans to address and mitigate these pressures in order to maintain the safety of the local population.

The winter period is between 1 October and 31 May. While winter will have ended as a season, the system remains in an escalated state until the end of May due to the two May Bank Holidays and the added pressure experienced at these times.

This Adult Social Services Department (ASSD) wide winter plan sets out the organisation's arrangements for the winter period. Winter is not an emergency or considered an unusual event but recognised as a period of increased pressure due to demand both in the complexity of people's needs and the capacity demands on resources within the Trust and the local health and social care system.

In addition, the winter period often brings with it untoward events such as widespread infectious diseases including Norovirus and there is the risk of the onset of the unusual such as pandemic flu which can affect patients and staff alike.

The Winter Plan prepares the organisation to maintain its service during winter and support system partners in maintaining good patient flow and safety.

- Focus on prevention
- Create the capacity to meet increased demand
- Link the Winter Plan to the West and Central System Resilience Plan
- Robustly performance manage the system to maintain quality, activity, safety and experience

Norfolk County Council (NCC) ASSD provides an assessment and care arranging facility and contracts care from the region's care market. It also provides a number of in-house services such as Norfolk First Support (NFS) which aid the system to operate as smoothly as possible and minimise cost. The top four interventions within this report are:

- Reduction of social care attributed DTOC (Delayed Transfer of Care) in acute and community hospitals
- The reduction and avoidance of admissions through greater co-operation between NCH&C (Norfolk Community Health & Care NHS Trust) and services within the community, CAS (Care Arranging Service) and other ambulatory pathways within primary & community care
- Building the resilience of teams to meet demand
- Developing operational infrastructure

This document should be read in conjunction with the NCC Adverse Weather Policy, Major Incident and Business Continuity Plan, Emergency Preparedness Resilience & Response (EPRR) Policy and Service Business Continuity Plans.

Key Lessons Learned from winter 2017/18

Links with the care market

The Trusted Assessors and incentive schemes were deployed during winter 2017/18. While incentives were welcomed, their efficacy is yet to be proven. However, working with the market has identified issues which need addressing to improve access to care, especially at weekends. Homes and care providers express a lack of confidence in the quality of discharge which is heightened at weekends when accessing support from health services is perceived to be challenging.

Resilience and Escalation Plans

Norfolk County Council ASSD did not report OPEL (Operational Pressures Escalation Level) status throughout the previous winter therefore, there was no standard means of measuring operational pressures within the department from which to base decisions to take escalation actions. A learning event conducted in spring, identified the importance of conducting a regular systematic review of operational pressures linked to an escalation framework to ensure consistent responses to escalation which is communicable to other system partners.

Approach to Operations Management for Winter 2018/19

Operations Centre

Norfolk County Council, in partnership with NCH&C, will establish an Integrated Winter Operations Centre in order to create a common operational picture, monitor performance and activity, coordinate and manage escalation, and act as liaison with other system providers regarding system performance.

During winter 2018/19, the operations centre will be operational five days a week between 09.00 and 17.00 and existing on-call management will be available between 17:00 and 09:00 each day and 24 hrs a day at weekends and Bank Holidays. A request for winter funding has been made to extend the Winter Operations Room to seven days a week. The outcome of the request is unknown at the time of writing this plan.

The Operations Centre will be responsible for collating information and sharing operationally relevant information with system partners on the daily silver calls and will manage any response to service escalation. In the event of a Significant Incident or Major Incident, the Operations Centre will work alongside the incident control room.

The STP (Sustainability and Transformation Plan) will deploy a winter operations room to oversee service delivery and resilience across the region. The integrated NCC and NCH&C operations room will report into the STP operations room.

Capacity Planning and Operational Control

Operational and commissioning teams will remain accountable for the development and delivery of their capacity plans, set during annual planning, and ensure their operating models and processes are in line with the local system they are supporting. These capacity plans may be represented as rosters and will remain responsible for the coordination of the daily work activity to deliver services. The Operations Centre will monitor these capacity plans and escalate issues, such as roster gaps or gaps in market provision, to relevant senior managers for resolution. In addition, the Operations Centre will monitor the daily work activity to ensure it meets required productivity requirements and escalate any issues, such as an increase in DTOC, to relevant senior operations and commissioning managers for resolution.

OPEL

For winter 2018/19 NCC will provide the system with a daily OPEL report which will be coordinated through the Winter Operations Centre.

All operational teams within ASSD will be required to create a daily OPEL report and submit this to the Operations Centre by 09.30. The service will be expected to take action in-line with their local escalation plans and for SITREPs (Daily Situation Reports) to be provided to the Operations Centre by 15.00 if the service has escalated to OPEL 4.

Services

Contact Service Centre (CSC) and Social Care Centre of Expertise (SCCE)

The CSC, which is also home to SCCE, provides a vital access point for those who need social services support. The department receives approximately 350,000 contacts per year via telephone, email, web and, increasingly, social media channels. Around 90% of these are managed and dealt with in the department, without the need to involve other teams.

The Social Care Centre of Expertise is managed by qualified social care staff which enables social care assessment and reviews to be conducted by phone. In addition, SCCE provides a weekend and Bank Holiday Emergency Duty Team.

The role of CSC and SCCE means it is an essential part of the service offer as well as an integral part of Adult Social Services resilience. The CSC and SCCE will monitor staffing regularly to ensure adequate staffing is available to maintain service outcomes.

ASSD support to Acute Services

Norfolk County Council provides three acute social work teams to facilitate a person's timely discharge back to their normal place of residence or the least restrictive, least costly option for long term care as well as supporting safeguarding investigations.

In-line with NCC Promoting Independence plans, the responsibility for supporting discharges from the James Paget Hospital Foundation Trust, and the staff supporting this process, will transfer to the locality team in the East and Suffolk. This change was expected to take place in August 2018, prior to winter pressures starting. The change in the East of Norfolk will be reviewed prior to changes to other teams.

The team based at the NNUHFT (Norfolk & Norwich University Hospital Foundation Trust) will work collaboratively with the acute Trust to improve current multi-disciplinary working within the Discharge Hub, particularly in respect to patients who do not clearly fit existing discharge pathways. In addition, the team will work directly with wards known to be high referrers, to introduce the 3 Conversations approach in order to reduce the number of assessment and discharge notices being issued and rejected.

To support and maintain flow through the acute hospitals during winter 2018/19 additional assessment capacity will be required. The services will aim to maintain 80% of their establishment to be at work to ensure the service is resilient.

A standard definition for DTOC will be in place across all NHS Trusts and a DTOC validation process will be fully embedded before the start of winter.

Trusted Assessors, part of the Promoting Independence and iBCF (Improved Better Care Fund) plans, were introduced during 2017/18 and continue to develop relationships with the care market to reduce DTOC. Learning from the pilot will be used to develop new action plans and business cases for the winter of 2018/19.

The Enhanced Home Support Service (EHSS) and Short Term Beds have been seen as a positive addition to the system by the acute based social work team. This will continue throughout 2018/19 to contribute to a reduction in DTOC. The capacity of these discharge options will be reviewed prior to winter.

Community Social Care Teams

The community Social Care Teams (East, North, Norwich, South and West) provide assessments for older people, people with physical disabilities and working age adults.

In-line with the Care Act and the NCC Promoting Independence strategy, the community social work teams focus on people's strengths and look for community based opportunities to support individuals and carers to maximise their wellbeing. The teams are currently trialling the Living Well: 3 Conversations approach, which is a strengths focused and preventative model supporting people to maximise their independence. These teams provide in-reach to community wards to support discharge.

The teams work closely, in an integrated way, with primary care and community health services. The teams include Integrated Care Coordinators, Assistant Practitioners, Social Workers, Practice Consultants and Social Workers. Social work is a key component of developments within community and primary care.

Priorities

For winter 2018/19 the Community Social Care Teams are focusing on prevention. This includes maximising work already underway:

- 3 Conversations (Promoting Independence)
- Reducing holding lists (Promoting Independence)
- Reducing reviews list (Promoting Independence)
- Engaging with local development groups and GP practices

There will be a specific focus on the following to help reduce pressure on acute Trusts during winter:

- Falls
- Dementia
- Social Isolation

Teams will plan to be at or above 75% of their establishment at all times to ensure they have sufficient capacity to respond to community based needs. Additional capacity in Social Work and Occupational Therapy is being recruited in order to increase responsiveness of the teams and further improve outcomes.

The Community Social Work Team supports community hospitals to safely discharge patients. In early 2018/19 the model of support was changed, and each ward has now been assigned a social worker. The ward attached social worker works as part of the Ward MDT (Multi-disciplinary Team) and is part of the daily Red to Green meetings which enables good communication and ensures long term needs are identified early in line with the HICM (High Impact Change Model).

LD and Mental Health

Learning Disabilities (LD)

The Integrated LD team works to improve the quality of life for people with learning disabilities, in their homes and communities. During winter, people supported by this team will need ongoing support from a resilient service. Like many community based services, the LD team will be affected by weather and service users will be taken ill and access acute care. The Acute Support Team (AST), which also offers support out of hours, is particularly at risk due to adverse weather and learning from winter 2017/18 could benefit from closer working with other out of hours services. A comprehensive resilience plan will be in place before winter 2018/19.

There will be times when people supported by the service will be admitted to acute care. The three acute Trusts in Norfolk are supported by a liaison nurse and acute pathways are in place to provide support and facilitate discharge back home. The pathway will be checked to ensure all parties are fully aware of how to access it prior to winter 2018/19.

Adult Mental Health

Supporting people with their mental health to remain well throughout winter is challenging. Avoiding crisis and supporting people when they are in crisis is essential for their wellbeing, as well as avoiding placing pressure on other services which, in many cases, are not always set up to meet their specific needs.

For winter 2018/19 requests for winter funding have been made and approved to support people to avoid crisis and, if they do escalate, for alternatives to the emergency department to be available.

These requests are:

- Increase day centre-based step-down capacity in Norwich to support mental health discharges for working age adults by providing a safe space for patients who need more intensive support than can be provided in their own home. This aims to enable earlier discharge and prevent unnecessary admissions
- Additional dedicated AMHP (Approved Mental Health Professional) cover to meet expected increase in demand over winter in order to improve response to requests for MHAs (Mental Health Assessments)

Older People's Mental Health

Norfolk has a rapidly aging population and is experiencing a growth in age related mental health needs. Older people's mental health is supported by the community care social work teams who work closely with Norfolk and Suffolk NHS Foundation Trust (NSFT). The social work team provides essential support to maintain flow through NSFT beds and work to avoid DTOC.

Named social workers are linked to NSFT older person wards and attend regular discharge meetings. Many cases are complex and require significant effort to identify suitable long term care. Many patients present with both physical and mental health needs and identifying discharge opportunities is challenging.

Winter funding has been requested and approved to procure additional short term beds to specifically provide step down and admission avoidance for older people with both physical and mental health needs.

Commissioning and Care Market

The care market for both home care and residential care is a dynamic environment. The NCC Market Development Team and commissioners work closely with a wide range of private providers to enable access to high quality long term care.

To enable a response to meet the highly variable demand upon the market a number of initiatives have been put in place.

- **Commissioning Manager; Transfer of Care** – this post works closely with social workers to address issues affecting discharges and causing DTOC
- **Enhanced Home Support Service** – provides flexible and enabling support for up to seven days to help support the individual at home following discharge or to prevent admission
- **Short Term Beds** – provide bed based short term placements to enable Care Act assessments to take place outside of a hospital
- **Norfolk First Support** – increases the capacity for home based re-enablement
- **Accommodation Based Reablement Units** – provide short term bed based reablement to facilitate hospital discharge and prevent avoidable admissions
- **Enhanced Health in Care Homes** – a support to providers to understand how and when to seek health intervention and training to enable providers to safely meet needs within care home settings
- **Social Prescribing Project** – provides additional community connector roles aligned to GP practices enabling GP access to VCSE (Voluntary, Community and Social Enterprise) services in the community
- **ICES – Integrated Community Equipment Service** – access to equipment for both health and social care staff will be made more responsive over the winter period

A bed tracker is available to capture available residential and nursing home capacity. This relies on homes providing their bed availability. Approximately 60% of the market is currently actively inputting their available capacity. This information is used by the Care Arranging Team to quickly locate potential placements. A new version is due before winter 2018/19 which will enable a greater range of information to be captured and enable a more efficient brokerage process. A longer term plan is in place to move to an eBrokerage system which will be developed following winter 2018/19.

The Trusted Assessors and the Commissioning Manager for Transfer of Care are working with providers to increase their confidence and address concerns. They are working with acute services with the aim of reducing the need for homes to conduct assessments and ensure appropriate health services are available and accessible in the community when required.

Service Brokerage is undergoing a review as part of the Promoting Independence Programme. The output of the review was not available at the time of writing this plan. This plan will be updated once the review is completed and published.

Norfolk County Council ASSD provides in house services under the brand of Norfolk First Response (NFR). These include:

- Norfolk First Support (NFS) – home based reablement service

- Swift Response – 24-hour unplanned needs service
- Benjamin Court – accommodation based reablement

These services aim to support people to return to independence and reduce the need for long term care.

During 2018/19 NFS received additional funding to increase their capacity by 15%. Recruitment is underway and aims to be complete by winter 2018/19. Ensuring NFS is responsive and resilient is a key action for this coming winter and work to enable rapid step down to long term care providers is underway. The additional capacity includes salaried relief staff to provide an additional level of service resilience.

Norfolk First Support is introducing an electronic capacity monitoring system which will improve efficient use of capacity. The system is expected to be in place prior to winter.

Benjamin Court will continue to provide bed based re-enablement throughout winter 2018/19; recent recruitment has enabled all 18 reablement beds to be available.

The NFS service recognises how important the relationship is between their service and the acute Trusts. A team of hospital liaison practitioners provide a critical link with all three acute Trusts in Norfolk.

Norfolk County Council ASSD requires service providers to operationally provide to the full terms of their contractual agreement. This includes having the level of staff required to deliver the service fully and safely, having a plan in place for the event of significant service impact including staff illness and inclement weather, and ensuring service users are not impacted by a reduction in regular service provision. All service providers are required to have business contingency/continuity plans in place. In the event of serious impact on service delivery, providers are required to inform the Council of the situation as soon as practical to do so.

Providers will be informed and reminded of key periods of pressure (for example, Bank Holidays) and updated on how they can help and what support is available to them.

Historically, NCC has supported local care providers to remain resilient through offering advice and support online. This information will be reviewed prior to winter and updated as part of the Winter Communication Plan.

Advice is available for vulnerable people and those looking after them (https://www.norfolk.gov.uk/what-we-do-and-how-we-work/campaigns/stay-well-this-winter). This advice includes:

- Tips for staying well this winter
- How to make homes energy efficient and safe
- How to claim financial help
- What to do if you are worried about a friend or relative

Social isolation is a significant issue throughout the year; however, winter can bring additional challenges. Norfolk County Council is working with local businesses to help combat social isolation through the "In Good Company" campaign (https://www.norfolk.gov.uk/what-we-do-and-how-we-work/campaigns/in-good-company).

District Councils offer a number of local initiatives, such as slipper swaps, access to handyperson services, benefit checks and electric blanket checks. These initiatives vary across district councils and more information will be made available as information is released.

Factors Affecting Service Delivery during Winter

Change Programme

There are no significant change projects planned that will impact on operational capacity during winter 2018/19. Programme leads have been requested to inform the Assistant Director of Operations and Patient Flow of any projects which will have an impact on operational capacity.

Infections

Infections, such as flu and Norovirus, can affect staff and access to care homes. If teams contract illnesses, then assessment capacity is adversely affected. Norfolk County Council provides Public Health services for Norfolk and ensures information regarding predicted risks and outbreaks are shared across the health and social care system.

Flu Plan

Acute based teams aim to ensure all staff are immunised against flu in-line with advice from Public Health. Care and nursing homes are encouraged to protect their staff and are provided with advice on how to access free flu vaccinations for paid carers. Clinical Commissioning Groups (CCGs) and local primary care providers are required to ensure their "at risk" populations have access to vaccinations which include those living in nursing and care homes.

Winter Plan Action Log

NOTE – actions under review by the Assistant Director Hospital Systems and monitored through the Winter Resilience Group

Ref	Issue	Required Outcome	Action Needed	By When?	Progress (18/10/18)
OPS A1	Operational reporting is not currently standardised across operational teams.	For operational reporting to be standardised and automated where possible.	Review of current operational reporting practice. Standard reporting framework established.	September 2018 October 2018	Information from all localities and acute teams has now been received. Review of reporting requirements underway. To progress once above is completed.
OPS A2	NCC does not report OPEL states.	For NCC to report daily OPEL states in line with system partners.	Development of OPEL reporting framework. Deploy framework.	September 2018 October 2018	Triggers and action cards being reviewed by Central, West and East. Changes to be made and agreed W/C 29 October. Progress on daily monitoring/reporting delayed due to OPS A1.
Acute A1	Additional assessment capacity will be required to meet demand.	Increase of assessment capacity for winter 2018/19.	Recruitment of additional social workers or agency social workers.	1 Oct 2018	Funding request has been made to use pay budget underspend or one-off funding routes. Awaiting response.
Acute A2	The NNUHFT discharge hub has not fully integrated.	For the NNUHFT discharge hub to be effective and reduce DTOC.	Form an Integrated Discharge Hub leadership group with rotating chairperson to lead discharge hub and provide cohesive leadership for teams operating in the hub. Set up senior MDT to take place x three per week to agree group plans on discharging highly complex cases with clear escalation routes if consensus cannot be achieved. Work with high referring ward to deploy 3 Conversations and	August 2018 August 2018 August 2018	In place – further work needed to improve how the collaborative team works together. In place. Delayed due to operational pressure on the NNUHFT social work team.

			collaborative working (avoidance of transactional management of discharge).		
LD A1	AST is a small team which works independently of other out of hours services which means it may struggle to meet service user needs during adverse weather.	For the AST to be resilient out of hours.	To link AST to other out of hours services such as Night Owls and NCHC OOH Nursing Service for support and resilience.	October 2018	In place – AST linked to NCHC out of hours team who will provide a "buddy" system for the AST team.
LD A2	LD discharge pathway not fully established in NNUHFT.	For LD pathway to be fully established in NNUHFT.	LD team to ensure NNUHFT Discharge Hub are aware of LD pathway and it is fully established.	October 2018	Pathway written and agreed within LD team. To engage with NNUHFT team.
MH A1	There are an insufficient number of short term beds for older people with mental and physical health needs.	Three additional beds for 22 weeks	Submit winter funding request. Commission beds.	July 2018 October 2018	Bid submitted but not approved by AEDB.
MH A2	There is insufficient capacity within day services to meet the winter need.	Additional AMHP capacity.	Submit winter funding requests. Source additional AMHP.	July 2018 Oct 2018	Bid submitted by not approved by AEDB.
Com A1	There is a delay in the discharge of nursing and residential care home residents from hospital as care home managers are not able to do assessments before agreed discharge dates.	Patients from and going to nursing and care homes are actively managed with TAFs (Trusted Assessment Facilitators) and discharge co-ordinators working closely with Nursing and Care home managers who have confidence in assessments completed by TAFs to facilitate speedy discharges.	TAFs will have visited the top 50 LGA funded and high-risk care homes across Norfolk and Waveney and be competent to complete assessments on their behalf so that DTOC are minimised.	1 October 2018	TAFs have visited and are competent to assess on over 60 care homes across Norfolk and Waveney. They are now promoting the use of the bed tracker with the care homes who have the most LGA funded beds so that we know where bed vacancies are.
COM A2	Availability of providers who will accept EMI patients (Elderly Mentally ill) particularly OoHs and over the weekend.	Increase number of EMI beds available in each locality with the expectation that they can accept referrals and trusted assessments seven days a week, and referrals up until 20:00 for returning residents.	To undertake a procurement exercise to test and put in place arrangements in each locality for EMI beds over the winter period.	Mid November 2018	Procurement exercise complete; currently work with Procurement to explore options for competitive process and putting in place block contracts.
COM A3	Supporting effective system working and business continuity through periods of system pressure and severe weather.	Ensure social care providers are kept informed of operational, commissioning and quality issues/opportunities/resources through the winter.	Produce a communications calendar for winter that will deliver key messages on actions (held by social care) in the Winter Plan with a clear.	1 October 2018	Winter communications underway, focusing in October on the flu vaccine, Bed Tracker and TAFs, communication plan is almost complete, and will be shared with Corporate Comms Team and STP.

			communication lead for operational teams		
COM A4	There are many care providers in the region and greater intelligence on their services will enable timely action to take place.	For NCC to have detailed intelligence in place for each provider to support efficient sourcing of care and prompt hospital discharges. To include: • Availability of beds and prices (if not accepting NCC rates) • Mobile contact details for current assessor • Availability for accepting discharges	Update bed tracker to include this information requirement; Trusted assessors to help compile local intelligence.	October 2018	Bed Tracker due to be launched 30 October for care and nursing homes across Norfolk and Waveney; all required outcomes achieved; vacancy report to be shared with brokerage teams in CCGs; engagement planned throughout Winter to secure providers use the tool.
COM A5	Lack of availability of equipment is causing delays in discharge from acute hospitals.	Access to equipment will be facilitated so that delays waiting for equipment are minimised.	Same day deliveries made to acute hospitals over the Christmas period. Prescribers able to prescribe equipment for people going into care homes. NFS able to access peripheral stores and collect equipment from care homes.	December 2018	Setting up process for same day delivery around seasonal Bank Holidays; new 'Equipment in Care Homes' process in development; working with Peripheral Stores and Providers to improve resilience and communications.
COM A6	EHSS is benefiting the system, further work is required to ensure up-take of current capacity and strong links to admission avoidance teams.	For EHSS to support admission avoidance work and ensure that the service capacity is utilised to support step down referrals.	Continue to promote the EHSS Service and ensure that the service is used to its full capacity. Continue to simplify and streamline EHSS systems including the referral process.	November 2018	Engagement work with acute social work teams, Brokerage Service and other operational teams underway and ongoing; planning underway to simplify EHSS community and referral process.
COM A7	NFS are holding packages of care. This is using capacity which could be used to avoid admissions, avoid DTOC and reduce amount of long term care being commissioned.	For commissioners to review unmet needs list and find solutions to areas of unmet need working in tandem with NFS.	To reduce holding list so that unmet needs are resolved within seven days per locality	November 2018	Unmet needs list has validated so now have clarity on where 'real' unmet needs are.
COM A8	NFS is not fully established.	For NFS to be fully established, including the additional 15% and BCU staffing.	Recruit to establishment.	October 2018	Northern and Southern SCS teams brought into NFS team to meet immediate demand; recruitment campaign underway to meet future demand; currently working on establishing a career pathway and introducing an apprenticeship framework.

Appendix 1 – Domiciliary, Residential and Nursing Capacity across Norfolk

Provider Type	Number of Providers Across the County	Number of Hours/Beds	Notes
Domiciliary Care		Approx. 63,000 hours per week across the county	
Residential/Nursing Care	**Norfolk:** 362 Homes 299 Residential 63 Nursing **East:** 47 Homes 38 Residential 9 Nursing **Central (North/Norwich/South)** 258 Homes 212 Residential 46 Nursing **West** 57 Homes 49 Residential 8 Nursing	**Norfolk:** 9,655 Beds 6,911 Residential 2,744 Nursing **East:** 1,014 Beds 767 Residential 247 Nursing **Central (North/Norwich/South)** 6,855 Beds 4,812 Residential 2,043 Nursing **West** 1,786 Beds 1,332 Residential 454 Nursing	Nursing = home is registered for nursing, estimate is that c.50-60% of beds only are "nursing" beds in these homes Geographic area = CCG derived, Norfolk only