Staffordshire County Council

Local Members Interest
N/A

Health and Care Overview and Scrutiny Committee
Monday 13th December 2021

Report of Urgent and Emergency Care for Staffordshire and Stoke-on-Trent.

1.0 Background and Context

1.1 NHS and Social Care services have been under significant additional pressure since the decision to ease lockdown restrictions back in July 2021. Service provision has been adapted to comply with infection control policies, resulting in reduced bed capacity and a change in the way that other services are provided, including general practice, dentistry, diagnostics and out-patient services.

1.2 Care services county wide have seen a greater demand from people who have presented with advanced symptoms, including more acute presentations of mental ill-health as a result of now feeling safe to seek advice and care. We also now have a cohort of patients who require care and support to manage the long-term effects of Covid19. This increase in people coming forward seeking help is a positive thing, however, it does create challenges in terms of service delivery and recovery of services.

1.3 Against this background is the need to deliver an ambitious Covid19 and influenza vaccination and booster programme to all eligible across the UK. Equally there is a clear need to recover elective services and to respond to the backlog of residents waiting for health services.

1.4 For Staffordshire and Stoke-on-Trent this has translated in an 22% increase in 111 calls as the public seek advice and guidance as they navigate health services that are now provided in a different manner than pre Covid19.

1.5 Calls to 999 have also escalated currently averaging 652 calls per day, 9% up from previous years. Attendance by Staffordshire and Stoke-on-Trent residents to Emergency Departments have risen following the lifting of lockdown measures. Current data suggests that the number of attendances are similar to those experienced pre-covid for this time of year (October data), with the expectation of Walsall Manor Hospital which has seen a 31% rise in activity.

1.6 Social Care have also seen a significant increase in demand for services as residents across our communities reach crisis point or are discharged from hospital with a higher level of need than previously experienced.

1.7 Social Care colleagues have also seen increased demand for home care services through all referral routes. This is believed to be caused, in part, by the indirect impacts of Covid-19 on older people, through long periods of isolation and inactivity during the pandemic.

1.8 It is clear that the winter period of 2021-2022 will be a very challenging period for all health and care services locally. This has been acknowledged nationally by the Government and they have highlighted the significant pressure for both the NHS and Social Care services due to the restoration and recovery of services and an increase in demand due to the anticipated rise in Covid19 infections and seasonal illnesses including influenza.

1.9 All partners (NHS and Local Authorities) across Integrated Care Systems (ICS) have been mandated to develop robust plans to improve and strengthen the resilience of services, anticipating any surge in demand through well-developed modelling and shared intelligence. Staffordshire and Stoke-on-Trent ICS modelling suggests there will be an increase in demand for urgent and emergency care services from December 2021 that is sustained through until March 2022, with the peak anticipated in January 2022.

1.10 This paper provides an overview of the key areas where resources are already stretched. Whilst it references the impact that this sustained pressure could have on the delivery of care to the residents of Staffordshire and Stoke-on-Trent, it also details some of the mitigating actions the partners across the ICS will undertake in order to maintain safe service provision during winter.

2.0 Challenges and Our Local Response

2.0.1 The system has been working collaboratively for some time now. It has structured its approach into 3 main workstreams-

1. **Pre-Hospital**. This includes community-based care, primary care and ambulance service provision. The focus is to look after people in their own homes for as long as is clinically appropriate and look to provide alternative pathways that avoid hospital attendance.
2. **In Hospital**. This covers the work at the front door of the hospital through to the point of discharge. It is often referred to as ‘managing the flow’ through the hospital. It includes the management of the hospital site
3. **Discharge**. This workstream focusses on getting people to their usual place of residence as quickly as possible and supporting them to stay in their usual place of residence.

2.1 Pre-Hospital (including the Ambulance Service)

2.1.1 The level of ambulance handover delays nationwide has been well documented. West Midlands Ambulance Service NHS Foundation Trust (WMAS) have detailed a loss of over 2670 hours of ambulance time in November 2021 across Staffordshire and Stoke-on-Trent as a result of ambulances waiting outside our local hospitals.

2.1.2 The impact of the delays is significant and is undoubtedly impacting on the ability for the ambulance service to respond in a timely manner to the number of calls being made. This is of genuine concern and focus for all local health and care partners.

2.1.3 In response to the increasing challenge, NHSE/I have endorsed a policy for rapid transfer. This allows paramedic crews to transfer patients into specifically identified escalation capacity within local emergency departments (ED), enabling crews to respond to the most serious of 999 calls.

2.1.4 The ICS partners have also undertaken an extensive programme to increase capacity within community and home-based services to reduce the number of people attending ED where clinically appropriate.

2.1.5 Examples of initiatives sitting within this programme include the direct transfer of patients to the Community Rapid Intervention Service (CRIS) from WMAS to experienced and skilled community practitioners. CRIS have been commissioned to visit patients within their own home within 2 hours of referral and can reach some patients potentially quicker than an ambulance might, depending on the priority status of the call.

2.1.6 111 has been central to the pandemic response with a 22% increase in calls compared to the same period pre-Covid. The Staffordshire and Stoke-on-Trent area has been identified nationally as ‘leading’ in terms of working collaboratively with partners to increase access to care within community services for patients who do not require an acute service.

2.1.7 The Faster Forward programme has seen the placement of kiosks at the front door of EDs allowing patients to seek advice, guidance and care without the need to visit ED. The roll out of the programme started at the County Hospital and Royal Stoke, with Queens Hospital Burton, Samuel Johnson and Sir Robert Peel Minor injury units expected to take delivery of the units in December 2022.

2.1.8 A further example of local solutions is our approach to identifying clinical deterioration of residents in our care homes. The emphasis is upon identifying deterioration of a patient's health status as quickly as possible through a comprehensive learning package and clear routes for escalation. This is a

nationally endorsed programme of which Staffordshire is again at the forefront of delivering.

2.1.9 GP services have been commissioned to increase the number of appointments offered over this period. As detailed in a separate report there is a significant amount of work underway in relation to accessing GP services and in ensuring that we have the right blend of telephone and face to face appointments available. The demand for GP services has increased considerably and there is also concern that the change to the vaccination booster programme announced recently will also have a direct impact on the ability of local GP services to meet the demand.

2.1.10 The initiatives detailed above are proving to be successful with the level of attendance for patients who have minor illness and injury reducing within all of the acute trusts compared with the same period pre-Covid (October 2021 data). This is important in terms of the demand profile of activity across our services.

2.2 Hospital Services

2.2.1 The 'In Hospital' workstream have developed a plan which focuses upon redefining the pathways within the emergency department which is then supported by the improving flow work stream from the front door to discharge, eliminating unnecessary delays.

2.2.2 The plan articulates the actions each provider is undertaking to develop an integrated front door primary care service which will support patients to access the service which best fits their clinical need. Royal Wolverhampton NHS Trust (RWT) have placed an Urgent Treatment Centre at the front door on their ED to support patients presenting with minor illness and injury. QHB have commissioned primary care services to work within their ED as a means of offering an alternative pathway to patients who do not require acute care, County Hospital has a similar offer in place. Royal Stoke University Hospital has an Urgent Care Centre operated by Vocare within its site. Providers are working closely to refine the referral processes to enhance the offer and increase its utilisation in order to support patients accessing timely and appropriate care.

2.2.3 Providers have also developed processes within the Emergency Department which increase the pace at which the patient is assessed, and decision made regarding their plan of care. The In Hospital workstream have implemented Senior Decision Maker within ED who are reducing the referral/admission to the hospital bed base through the use of ambulatory pathways to support early discharges. At Royal Stoke University Hospital the CRIS team are working directly with ED staff and WMAS crews to identify patients who can be managed more appropriately within the community.

2.2.4 In response to the increase in ambulance delays the acute trusts have put into place a number of measures which are detailed below-

- 111 Kiosks in place within both RSUH and County Emergency Departments
- Navigator at the front door to support redirection to alternative places of care for ambulatory non acute patients
- The use of GP Connect to support primary and acute provider communication
- Urgent Care Centre review along with provider Vocare and exclusion criteria review to maximize potential
- RSV surge planning with additional inpatient capacity for children as required over Winter
- Length of stay reviews for stranded and super stranded patients taking place in each division
- Regular social media campaigns to highlight alternative services on offer in the community and use of 111First
- Same day Acute pathways maximizing the use AEC and AMRA footprint
- Regular review of metrics for 15 minutes to initial assessment and adherence to CRTP along with updated actions and progress against both on the UHNM Risk register
- Separate hot and cold ambulance arrival areas to segregate COVID and non COVID ambulance arrivals in continued use over Winter
- Continued use and adaptation of Staff COVID isolation policy as national guidance changes

2.2.5 The Virtual Ward model was introduced during the height of the Covid19 pandemic response in order to support a patient's recovery at home once stabilised. The Virtual Ward allows the clinical team to remotely monitor a patient's clinical status and vital signs such as blood pressure and oxygen saturation. The virtual ward is supported via the acute medical team, and community services who provide a multi–disciplinary approach to care within the patient's home. The Virtual Ward model has been extended to provide support for patients with respiratory conditions with other opportunities to deliver care in this way currently being scoped. The utilisation of the virtual ward allows patients to return home earlier in their recovery supports individualised care planning whilst also reducing the length of time patients remains within a hospital bed.

2.3 Critical Care

2.3.1 Critical Care Units (CCUs) and the skilled staff who work within them have been crucial throughout the pandemic and continue to be as we enter one of the most challenged winter periods the NHS has known.

2.3.2 Staffordshire and Stoke-on-Trent forms part of the regional Critical Care Network, a collaborative geographical network which offers shared knowledge

and expertise along with practical support which facilitates the transfer of patients to the nearest available bed as required.

2.3.3 Critical Care capacity has increased nationally but remains challenged in regard to capacity and workforce as the demand for high level intervention continues to rise. The combination of increasing levels of Covid19 infections (predominantly of unvaccinated residents), severe respiratory illnesses and major trauma is resulting in the need for a higher number of critical care beds. This then impacts on the availability of these beds to support the restoration of surgery in order to reduce the backlog and waiting lists.

2.3.4 To respond to this additional critical care beds have been secured within the acute trusts, along with a robust clinical review process which identifies the optimum point in a patient's recovery to step down from critical care with support from the CCU team if required. The level of staffing to patient ratio within CCUs is higher due to the level of patient dependency. Securing staff who are skilled across all professional groups is challenging and does limit the number of beds made available.

2.4 Discharging residents from Hospital safely

2.4.1 During Covid the Department of Health and Social Care published Hospital Discharge and Community Support Policy and Operating Model Discharge Guidance (appendix 1) requiring all partners to work collaboratively to achieve same day/next day patient discharges.

2.4.2 Identifying the optimal time for a patient's discharge is critical in improving patient outcomes whilst also supporting flow across a hospitals bed base. The acute trusts have put in place daily patient reviews by a senior decision maker that identifies an anticipated date of discharge. This supports early discussions with the patient and their carers/families regarding discharge and allows early identification of any additional services or support required prior to the actual day of discharge. Discharge early in the day is also important with the expectation that 30% of patients are discharged by 12 noon with the remaining 80% by 5pm.

2.4.3 Senior Medical review and discharge planning is required for any patient who is deemed to be “stranded” (7+days within hospital) or “super stranded” (21+days in hospital). UHNM, RWT and QHB have each developed a process with their senior clinical teams to undertake the reviews in order to reduce unnecessary long hospital stays.

2.4.4 The Hospital Discharge and Community Support Policy and Operating Model Discharge Guidance (appendix 2), outlines the expectation that 50% of patients admitted to hospital will be discharged with no services back to their own home. The remaining 45% of patients will be discharged with support at home to recovery and rehabilitate via a Home First model, 4% will receive

rehabilitation within a commissioned bed base with the remaining 1% transferred to a bed outside of the acute for further assessments of their long-term need. All patients who are deemed ready to transfer are expected to be discharged within the same day/next day.

2.4.5 Discharge to Assess (D2A) services are well established within Staffordshire and Stoke-on-Trent with the Home First service receiving regional and national recognition. The Home First service provides over 11500 hours of care per week and had supported same day/next day discharges for a large proportion of patients since the start of the pandemic. Due to the recent pressures in domiciliary care, the demand being placed upon the Home First service is now outstripping capacity available. The Discharge workstream team have worked collaboratively with domiciliary care providers, local authorities and voluntary sector to identify alternative ways to deliver the Home First model. However, as is the case across the country, the home care market is facing very significant workforce shortages.

2.4.6 These workforce challenges mean that local services are facing difficulties in retaining and recruiting staff following the opening-up of the economy after lockdown, and short-term reduction in staffing levels due to the requirement to isolate. These factors have led to greater competition for staff both with other sectors in the wider economy, and within the home care sector.

2.4.7 As a direct result of the domiciliary market fragility Home First is now providing a bridge for over 160 local people as they wait for their assessed longer-term services to be available. The level of Provider of Last Resort (POLR) is now consuming over 20% of the available capacity, reducing the ability for the service to respond to the increasing number of patients who are now ready for discharge.

2.4.8 In response, the Local Authorities, working with the NHS, have set out a range of actions aimed to mitigate the workforce challenges in the market. It is expected that once fully mobilised the recruitment and retention schemes designed by the Local Authorities and NHS will begin to strengthen the local market across the winter, improving flow and thereby releasing the pressure within Home First. This is not a quick fix though and we will not see immediate improvements in this position, although it is absolutely the right thing to be doing.

2.4.9 Discharge to Assess (D2A) beds have been secured following an extensive procurement exercise undertaken by MPFT, this has included escalation capacity built into existing contracts and additional community hospital beds identified within the Surge plan to open when triggered and over 27 surge beds in D2A Care Homes opened across the County. However, again as a result in the lack of capacity within the domiciliary care the number of delays is increasing, again reducing the bed base ability to respond to the level of demand.

2.4.10 Action has also been taken by partners to introduce an interim bed process to support individuals within a residential setting whilst pending the brokerage of care packages to support a transfer home. However, the ability to maintain the level of community wrap-around for beds has reached its capacity, further opening of beds will need to be considered and risk adjusted to ensure patient care is not compromised.

2.4.11 Acute Trusts have also been constrained in their ability to discharge patients who require no additional services home. This is considered to be as a result of the acuity of patients who are hospitalised and require ongoing support on discharge rather than simply returning home as we might of expected pre Covid19.

2.5 Mental Health

2.5.1 Mental health services have been under significant pressure to meet an ever-increasing demand to support our population particularly children and young people as continue to recovery and restore services stood down during lock-down.

2.5.2 Crisis activity has seen an increase since lockdown restrictions were lifted with the number of patients seeking support outstripping the available capacity.

2.5.3 Mental health inpatient services are under significant pressure with increased complexity of patients and high levels of acuity across inpatient services whilst also balancing the IPC requirements associated with Covid19. There continue to be staffing challenges across mental health services as seen in other parts of the health and social care system.

2.5.4 The Community Mental Health transformation programme, as part of the NHS long term plan, is aimed at expanding the range of services available within the community to improve access to mental health services and address the increasing demand. Services are being redesigned around neighbourhoods and integration with Voluntary and Community Sector and Primary Care networks.

2.5.5 Crisis response services are being expanded alongside mental health provision in the acute hospitals to improve access to urgent and emergency mental health care.

2.6 Workforce

2.6.1 Delivering care throughout the pandemic required a skilled, dedicated and resilient workforce, who have and continue to respond to ever increasing

demands as we move into an even more challenging winter period. This is our most significant challenge and area of risk.

2.6.2 The impact of the sustained pressure our workforce is under should not be under-estimated. Within NHS services there is a current sickness rate of **5.00%** with nursing vacancies currently at **12.87%.** Turnover in nursing is **8.85%.** This is further compounded by the need for staff to adhere to Covid19 isolation guidance affecting attendance levels. The workforce challenges for home care have been set out earlier in this paper; other sectors within social care, such as care home staffing, also face challenges in retention and recruitment. Staff morale is low with a number choosing to exit the sector taking jobs within retail and hospitality services who have been offering incentives as a means of recruiting. With these challenges in mind partners have worked collaboratively across Health and Social care to develop numerous initiatives to stimulate workforce supply, retain and support the wellbeing of our current workforce.

2.6.3 Each individual Trust and Local Authority is taking action to mitigate the workforce challenges across the system, including working collaboratively where appropriate. This remains an area of significant concern though for all partners.

2.6.4 The system has a Health and Wellbeing Strategy in place and a comprehensive programme of associated work across all providers. As our workforce is likely to suffer with ongoing/emerging adverse psychological effects from the pandemic, at individual and team levels, the ICS has invested in expanding provision of complex psychological support in the recovery phase of the pandemic. Significant psychological support is being offered within the system for both staff and the wider population. It is likely that a programme of work will be required to develop a flexible working culture and aim to offer as much flexibility to all staff in all roles and at all levels as possible.

2.6.5 System level interventions currently in place range from a Psychological Wellbeing Hub available to all staff within the ICS, including social care staff. The Hub delivers themed workshops and offers self-care resource which can be tailored to meet individual's needs. Alcohol Awareness Support Sessions and other activities are planned throughout the remainder of this year along with an ICS wellbeing week. Work is also underway to align the workforce strategy the National People offer.

2.6.6 ICS partners work together hand in hand (including wider Health and Care colleagues), to plan for surge and work collaboratively to deliver solutions to support immediate and longer-term workforce needs.

2.6.7 The Workforce Cell has been in place since March 2020 and functioning as Hub to support workforce challenges as a System. In order to ensure that the Workforce Cell are fully up to date with the workforce issues across the system members of the team attend the daily System COO Tactical Calls and also

have twice weekly meetings with Operational and Nursing leads to assess workforce pressure areas, compare Trust level initiatives, decide on which recruitment schemes to collaborate on (e.g. System wide recruitment campaigns and International Recruitment).

2.6.8 Early in the pandemic the Workforce Cell developed the System People Hub, which is a System Bank and recruits staff to deploy where needed across the System. This is currently being further developed to allow it to become fully integrated with the rostering systems of Provider Trusts via a digital solution. The SSOT ICS People Hub has successfully deployed over 500 staff locally since its formation, and those staff have filled a total of 16,686 shifts.

2.6.9 Staffordshire and Stoke-on-Trent have led the way nationally in the development of a new contingent workforce; Reserves. Currently there are circa. 900 staff on the People Hub working as Reserves in various areas: vaccine delivery, wards, care sector and in Primary Care. Since the initial development of the Reserves the workforce cell have honed the requirements for Reserves into the following categories and ongoing recruitment is being carried out to all 3:

1. People Hub Reserves – System Bank: individuals who could be clinical or non-clinical who support us on an “as and when” basis across the whole System.
2. Winter Surge Programme Reserves; staff employed on a fixed term basis to work in specific, time limited, programmes for e.g. the People Hub are recruiting 100 staff to support the Domiciliary Care challenges in North Staffordshire (through partnership with Stoke on Trent City Council via our NHS pathway) and 20 staff to support winter pressures in Community Hospitals. These colleagues will be supporting into finding permanent work following the cessation of the programme within one of our partner organisations.
3. Step Forward – “Lend a Hand” Reserves: individuals who do not require full time work or a career change. They are trained to deliver support in non-clinical but front line areas e.g. marshalling, proning, admin or feeding patients.

2.6.10 UHNM have successfully carried out international recruitment from India and are supporting 95 colleagues to gain their Pin numbers. We are in discussion as a System re the potential for joint International Recruitment for Mental Health Nurses as this remains a challenge area for us.

2.6.11 In addition to these activities the following System wide schemes have been developed in partnership between Health/Care providers to support delivery of immediate workforce supply to support Winter

2.6.12 The Staffordshire and Stoke-on-Trent People Programme team are leading the project management and recruitment to these schemes in partnership with Health/Care organisations. As outlined above the staff recruited will be deployed as required via the System Workforce Cell deployment process.

The workforce cell is also tackling bank rates collectively and taking an approach to enhanced (Winter escalation) bank rates. As national guidance is developed, we will also be tackling Agency Spend as a System.

2.6.13 To monitor the success of our initiatives, the workforce cell has agreed a set of system wide workforce performance metrics (sickness, turnover and vacancies) to assess the success of these schemes. Dashboards have been developed and are reviewed at System People and Culture Board on a regular basis. The dashboards have been expanded to include the key metrics outlined within the System Oversight Framework and the next development is to include social care key workforce indicators.

3.0 Governance and Oversight

3.1.1 Staffordshire and Stoke-on-Trent Urgent and Emergency Board has overseen the development and delivery of a comprehensive improvement plan set to tackle the challenges and issues impacting upon the delivery of responsive and effective care aligned to the NHSE/I UEC flow Priorities and Principles 10-point plan (appendix 2)

3.1.2 The UEC improvement plan has been developed to represent the 3 key areas of focus outlined above within the 10 Point Plan, Pre-Hospital, In Hospital and Discharge.

3.1.3 The ICS has also developed a comprehensive Winter/Surge Plan which outlines the anticipated level of demand and the actions ICS partners will undertake to mitigate where possible to reduce the pressure.

3.1.4 A number of the actions identified within the Improvement Plan and the ICS Surge/Winter plan overlap with the extensive programme of work the ICS partners have undertaken to positively impact on delivery.

3.1.5 The UEC Board, System Assurance meeting and Operational Cell have oversight of all plans monitoring impact, identifying areas where rapid action is required and ensuring synergy across all plans.

3.1.6 The system wide surge plan has been presented to the full ICS Board and has been supported by all partners across the system.

4.0 Summary and Recommendations

4.1 The Overview and Scrutiny members are asked to:

- Note that the Department of Health and Social Care has indicated that the winter of 2021/22 may well be the most challenging one that the NHS and Social Care have experienced. The issues identified within this paper are not uniquely local, reflecting the national challenges.
- Receive assurance that the Staffordshire and Stoke-on-Trent ICS has a comprehensive and detailed winter/surge plan which has been collaboratively developed to respond to the challenge and mitigate the known issues as far as is possible.
- Recognise that the workforce challenges are significant across both health and care. Note that there is no simple fix in terms of the collective workforce challenges.
- Note that there is a degree of flexibility and reactive approach required to respond as issues evolve, which may result in a variation or additional actions not represented within this paper or the ICS Winter/Surge plan.

Link to Strategic Plan

Please refer to the relevant strategic priority.

Link to Other Overview and Scrutiny Activity

This section could include any past, current or planned work by other Overview and Scrutiny committees.

Community Impact

Refer to CIA guidance on the Learning Hub

Staffordshire County Council

List of Background Documents/Appendices:

Appendix 1 – Hospital discharge
Appendix 2 – Urgent and emergency care recovery 10 point action plan

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