Ageing Well

in good health
The Norfolk and Waveney Health and Care Partnership

Urgent Community Response

Background

In early 2020, the Norfolk and Waveney Health and Care Partnership (our STP) was awarded Ageing Well Accelerator status – and some funding - to develop our urgent community response model. We are using the lessons gathered as part of the current existing community-based "Network Escalation Avoidance Teams", to enable a swift response to the immediate unplanned care need and a multi-disciplinary team approach towards follow up treatment and support. This supports individuals to remain safe at home and often avoids admission to hospital, as well as supporting individuals to return home upon discharge from an acute stay.

The national 'ask'

- All residents in England to have access to an urgent model of community health & care by March 2023
- Deliver urgent Health and Social care within 2 hours and reablement services within 2 days
- Standards to apply to Health and Social Care
- Simplified access to system with coordinated Multi Disciplinary Team (MDT) approach to assessment, prioritisation, scheduling and dispatch of intervention teams
- Official addition of "Discharge to Assess" to Ageing Well scope of activity

What has happened?

The Ageing Well programme was paused to support the NHS response to the COVID-19 Pandemic. We've now re-started the programme and it's full steam ahead.

- We've been working together on this project, engaging with leadership from across the system and acting on feedback from frontline staff to build the model.
- We've had really positive engagement with Norfolk and Waveney Locality and Place based leadership to generate an agreed Guiding Principles document [pdf] to set clear expectations for strategic delivery.
- Agreed governance in place for the Programme of the planned delivery
- Established place-based (locality) teams to support development of operational structures.
- Generation of condition criteria to support the urgent response and update the directory of service used by 111 & 999 is being developed - with a view to enable community services to provide an urgent response alongside current provisions supported by primary care and emergency departments.
- Trialled and implemented a centralised coordination team for OOH Community Nursing, enabling teams on the ground to concentrate on supporting individuals. Enabled the coordination team to support the referral process, and allocation of work for the Central and West locality teams. Conversations on-going to support the East locality teams

See page two for updates from local areas…

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Locally-focused information

West

- The NEAT team was expanded to respond to the requirement to cover initial Discharge to Assess needs. All staff have shown great resilience support for patients / service users across West. Senior managers and practitioners will continue to participate in the development of future models of community response teams in order to deliver D2A, urgent response and reablement.
- OOH community nursing in West will be aligned to the management of the central team at the end of August and are now included in the central coordination. The team will remain integrated in the West.
- Developments are underway with GP practices to participate in the enhanced care home support and implementation of care home MDTs.
- Clinical Operations Managers and Clinical Leads are working together to realign staffing structures for the Fens & Brecks PCN.

East

- East Place continues to develop our Primary Care Home (PCH) model with all our ECCH teams stepping up, through the process of redeployment, to support our PCH teams in addition to NCC and SCC locality teams during the pandemic and to maintain essential core services
- Working on capacity issues at a place based level to help ensure that the teams are able to meet the current demand, including working more closely with colleagues in the acute hospitals.
- We will also look at the processes that underpin our Discharge to Assess (D2A) work to ensure that they are as streamlined as possible.
- Integrated care coordination function supporting 2 hour and 24 hour response
- Daily dashboard implement to monitor response times and achievement against target
- Senior clinical review within 24 hours of discharge to ensure clinical efficiency and effectiveness
- 7 day clinical leadership for senior decision making

Central (North, South, Norwich)

- A Central Norfolk Steering Group has been established and is currently working through available data to develop what the future model might look like to meet the new admission avoidance and discharge to assess (D2A) targets. We are not starting from scratch; there is already strong integrated services in place and we will take the learning from these as we develop a new model.
- We are keen to ensure we support people through immediate crisis and enhance some of the existing MDT approaches already seen across PCNs for follow up care to prevent a future crisis.
- For both D2A and Admission Avoidance work, we are considering what activity might be undertaken at both a central (known now as Locality) footprint and at a more local footprint (now known as place).
- A draft operating model for the Central Locality ready to share in September for review with system partners. It's envisaged that the model will evolve over time as we engage with staff, system partners and identify areas for change.

Questions

We will continue to keep you updated on our progress.

If you have any questions in relation to this activity of work, please contact your PCN Place leads or contact AgeingWell-STPProgrammeTeam@nchc.nhs.uk