Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

LEICESTER CITY HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 12 March 2019

REPORT OF LLR Health and Social Care System

LLR Urgent and Emergency Care Resilience & Winter 2018/19

Purpose of report

1. The purpose of this report is to provide an update and overview of performance over the 2018/19 winter period to date across the Leicester City, Leicestershire and Rutland (LLR) Urgent and Emergency Care system. The paper begins the process of the review of Health performance over the winter period and the success of plans to date, and includes a brief reflection of performance last winter, what was learnt, what we did about it, and the impact to ensure we have more resilient health and social care services for patients and the population it serves. Given the timing of the year, the report is not a comprehensive review of the winter period but instead a stepping stone for a review being planned to take place in May 2019.

Policy Framework and Previous Decisions

2. N/A

Background

3. See Report Enclosed

Proposals/Options

4. N/A

Consultation

5. N/A

Resource Implications

6. N/A

Timetable for Decisions

7. N/A

Conclusions

8. In comparing 2017/18 to 2018/19, performance over the course of winter 2018/19 has demonstrated both improvement and worsening at different periods of heightened surge and demand placing significant pressure upon health and social care providers. Although severe weather has not been experienced across LLR, the system has been prepared to respond if required.

9. Through the strengthening of integrated ways of working and processes alongside a significant increase in demand for health and social care services, LLR has established a more stable and resilient system to respond to and manage pressures as demonstrated through its operational pressures escalation levels (OPEL) framework.

10. The approach to planning and managing escalation has significantly improved the way in which all LLR system partners manage collaboratively the pressure to anticipate escalation and put in place the appropriate actions to prevent issues and/or enable de-escalation to occur swiftly. The winter resilience planning process has enabled the opportunity to better engage and connect public services for patients and members of the public. Further work is ongoing to shape LLR urgent and emergency care priorities to increase this connectivity for shared learning, improved services, and better value for money.

11. The 'Help Us Help You' and 'Stay Well this Winter' communication campaign of winter messages, both national and local, as well as the winter communications plan have been comprehensive and feedback from stakeholders suggests more effective than in previous years.

12. Planning winter preparedness across dozens of stakeholder organisations is challenging, technical and complex. The plan was developed with input from three Clinical Commissioning Groups, Leicester City Council, Leicestershire County Council, Rutland County Council, University Hospitals of Leicester (UHL), Primary Care and multiple GP practices, Community and Mental Health Care Providers, Independent Sector Providers, patients and carers, Healthwatch, NHS England and NHS Improvement, as well as members of the local Leicester Resilience Forum, including input from the police, fire service, Public Health England, Health Protection, Health Education, utility companies, and several voluntary and charitable organisations through cold weather and emergency response preparations and planning. The plan incorporated demand and capacity plans, business continuity plans, flu and infection control preparedness, adverse weather protocols, as well as a variety of other process improvement and workforce-related initiatives.

13. The plan was approved by the LLR A&E Delivery Board which comprises of senior leaders across Leicestershire and Rutland in October, with subsequent additions in November to incorporate additional initiatives from both national and regional

regulators. The A&E Delivery Board will continue to monitor progress of the plan production and more importantly, will ensure that any learning as we go through winter is incorporated into updated versions for continuous improvement.

14. In light of 2017/18 performance and concerns, regulators including national and regional NHS England and NHS Improvement colleagues conducted a winter assurance visit on 22nd November including all health and social care system partners. Plans were reviewed with site visits across UHL, and regulators confirmed that LLR were in a more stable position than in previous years, highlighting the collaboration of stakeholders and tested integrated plans as a particular strength ahead of winter. In addition, during the month of February LLR commissioners have more recently been engaged by NHS England to support and contribute to wider regional learning and development to capture good practice and support winter season preparation across the region for next year.

15. Demand for and pressure on health and social care services continues to rise across LLR, and is exceeding the average census growth rate of 0.9%. This is due to an expanding population, people living longer, and advances in medical research and treatment.

16. A full review of performance over winter is being planned for May 2019, whereby stakeholders across the health and social care system will inform lessons learnt and areas for improvement to enable the collaborative approach to building system resilience. This will include an evaluation of both performance and quality, as well as patient experience.

Background papers

N/A

Circulation under the Local Issues Alert Procedure

The report reflects impact across the entire LLR geography.

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List of Appendices

Appendix - Winter Communication Evaluation as at February 2019

Relevant Impact Assessments

Equality and Human Rights Implications

17. N/A

Crime and Disorder Implications

18. N/A

Environmental Implications

19. N/A

Partnership Working and associated issues

20. N/A

Risk Assessment

21. N/A

Title of the report:	**LLR and Winter 2018/19:** **An initial review of Health performance over the winter period and the success of plans to date.**
Report to:	Leicester City Health Overview and Scrutiny Committee
Date of the meeting:	12th March 2019, 530-730pm
Report by:	Mr Mike Ryan, Director of Urgent and Emergency Care, LLR System
Sponsoring Directors:	Ms. Sue Lock, Accountable Officer, Leicester City Clinical Commissioning Group; and Mr John Adler, Chief Executive, University Hospitals of Leicester
Presented by:	Mr Mike Ryan, Director of Urgent and Emergency Care, LLR System; Ms Sam Leak, Director of Operational Improvement, University Hospitals of Leicester

Purpose:

This paper aims to provide an update and overview of performance over the 2018/19 winter period to date across the Leicester City, Leicestershire and Rutland (LLR) Urgent and Emergency Care system. The paper includes a brief reflection of performance last winter, what was learnt, what we did about it, and the impact to ensure we have more resilient health and social care services for patients and the population it serves.

Given the timing of the year, the report is not a comprehensive review of the winter period but instead a stepping stone for a broad review being planned to take place in May 2019. In addition, a review of the quality of care and service as part of winter plans is underway to ensure the system evaluates the effectiveness of plans on both performance and quality, as well as patient experience.

System Performance Winter 2017/18 – What happened Last Year?

The winter of 2017/18 saw the local urgent and emergency care (UEC) system under intense pressure, resulting in poor patient experience and weak performance against national targets. A&E performance is typically known to drop in Dec, Jan & Feb each year, and this deterioration started in November and did not cease, with continuation through to March; it was particularly intense from February to April through the Easter Holidays.

- Hospital A&E 4-hour performance overall was below standard with an annual position of 77.7% (79% the previous year), and A&E waiting times performance deteriorated sharply from October onwards, dipping to a low of 66.9% in March with primary clinical focus on major conditions.

- Due to the number of emergency surgical cases exceeding normal levels, critical care / intensive care units were often full, which resulted in high numbers of cancelled surgical cases, some of which were regrettably cancer cases. Occasional staff sickness/absence impacted upon the ability to maintain full use of critical care beds.

- Bed occupancy was high throughout much of the winter period. This means a lack of free beds, which has a knock-on effect on internal patient flow from admissions areas, often resulting in long trolley waits. Many working days started with patients waiting for beds to become free (often termed “negative bed capacity”). On any given day we had up to 200 patients in hospital for more than 21 days, and were not as proactive as we could have been to reduce patient length of stay and the number of long stay patients.

- High numbers of medical “outliers,” (medical patients in a bed not designated for medical patients e.g. on a surgical ward) which only started to improve towards the end of March. Delivering care to patients spread across a number of wards is less efficient for clinical teams. The length of stay for medical patients at LRI increased by nearly two days from January to March 2018.

- Higher than average “non-admitted breaches” (patients who were in ED for more than 4-hours (i.e. breached the standard) but were not admitted into hospital. Delays for such patients are often due to the demand on diagnostic services, although preventing an unnecessary admission can often reflect a better outcome for the patient.

- Patients with Norovirus and/or flu resulted in many closed beds on a regular basis, at both UHL and LPT.

- There was a higher number of elective (i.e. planned care) cancellations last winter in comparison with 2016/2017 following a national instruction to all acute Trusts, as well as exceptional levels of cancellations of urgent and cancer operations.

- Activity in out-of-hospital services, including Urgent Care Centres, Primary Care Hubs, Home Visiting and Clinical Navigation services, was higher than forecast and higher than in winter 2016/17. This at times created significant pressure in these services but they were successful in preventing a significant increase in ED attendances.

- NHS111 demand rose significantly, dealing with 30% more calls than we had planned for in the period of January to March 2018.

- Ambulance services remained stretched and were regularly at a high escalation level during winter; patient handover times were higher than expectation (within 15 minutes), particularly from November through to March, although there were fewer 1 hour+ waits than in 2016/2017, and fewer total 'lost hours.'

- Staffing levels were particularly challenged over winter across all providers. In particular, medical and nurse staffing levels in hospital were variable with a higher than average sickness/absence rate during peak periods of demand.

- Although a flu jab campaign was marketed and communicated, the uptake of flu jabs by members of the public and staff was not as high as it could be.

- Processes vary across providers which influences local decision making, and there are benefits to more standardisation.

In short, both patient experience and system performance were extremely challenging in 2017/18, and lessons were learnt and applied in 2018/19. Actions were taken and improvements were implemented. Although operational winter pressures remain challenging, the work to date has resulted in an improved position year to date.

System Performance Winter 2018/19 – What's Happened This Year?

Lessons learnt were incorporated into system plans and priorities during the summer of 2018, and the winter plan further built on these to reduce the risk of similar problems for 2018/19. This included a large number of actions, the realignment of bed capacity at UHL to accommodate expected non elective/emergency demand, as well as plans to ensure safe care, manage and mitigate any forecast bed gaps, ensuring efficient discharge and transfer processes, and working with system partners.

A&E 4 hour wait performance

- Hospital A&E 4-hour performance overall has remained below the 95% 4 hour standard, however both UHL and the system have shown signs of improvement amongst a significant rise in demand and attendances by both walk in patients and ambulance conveyances. Statistically in 2018/19:

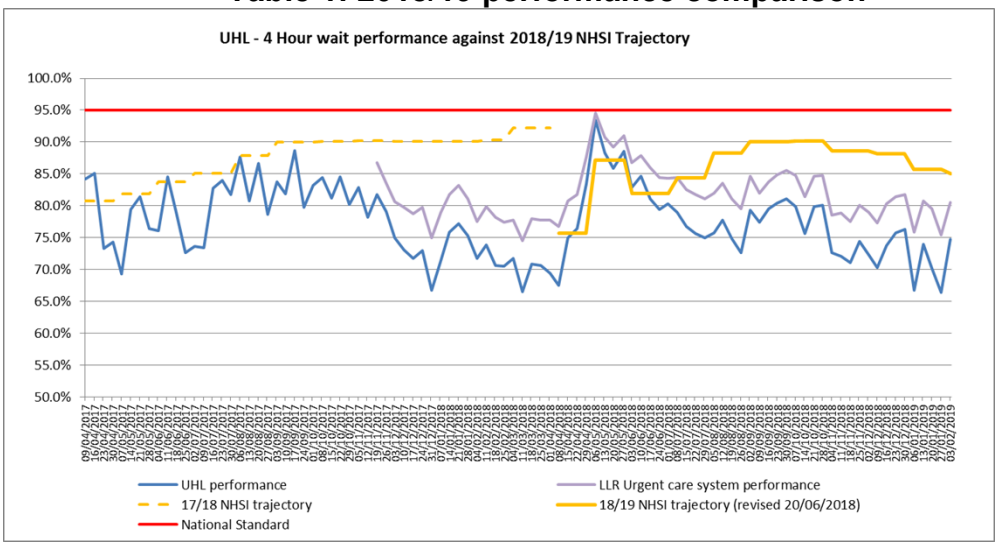
    - Nationally - approximately 9/137 A&E departments routinely meet the 95% standard;
    - Regionally – approximately 1/37 A&E departments routinely meets the 95% standard; and
    - Locally – the LLR system ambition is to achieve a trajectory of 85% based on past performance and step changed improvement.

- **The Year to date (as at 22/02/19) performance is 77.9% (UHL) and 83.1% (LLR system).** This represents a marginal improvement at a time where demand has increased significantly across urgent and emergency care services.

- UHL performance for January reflecting increased demand was 73.5% and LLR system performance was 79.7% against a planned trajectory of 85.7%. January was a significantly challenging month, with February seeing a significant improvement.

- In January 2019 the trust saw a total of 21,624 ED and Eye Casualty attendances. In comparison to January 2018 (19908) this is an increase of 1,560 patients (8%). Year to Date there has been a 5.5% increase in attendances to A&E compared to the same point last year.

Table 1: 2018/19 performance comparison

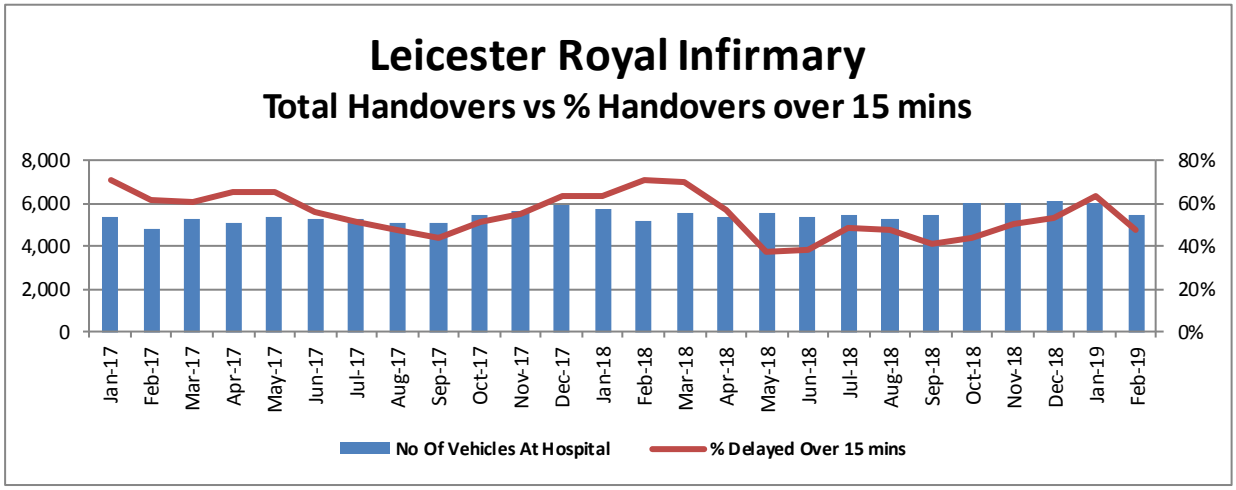


Ambulance Handover Delay Performance

The national standard is that Ambulance Handovers at hospital should be within 15 minutes of arrival, and are measured and monitored based on the time when an ambulance arrives to A&E and the time when the ambulance leaves. These include pre-handover to hospital clinical team, the length of time for the actual handover, as well as the post-handover or the time between the patient was handed over and the ambulance crew left the site.

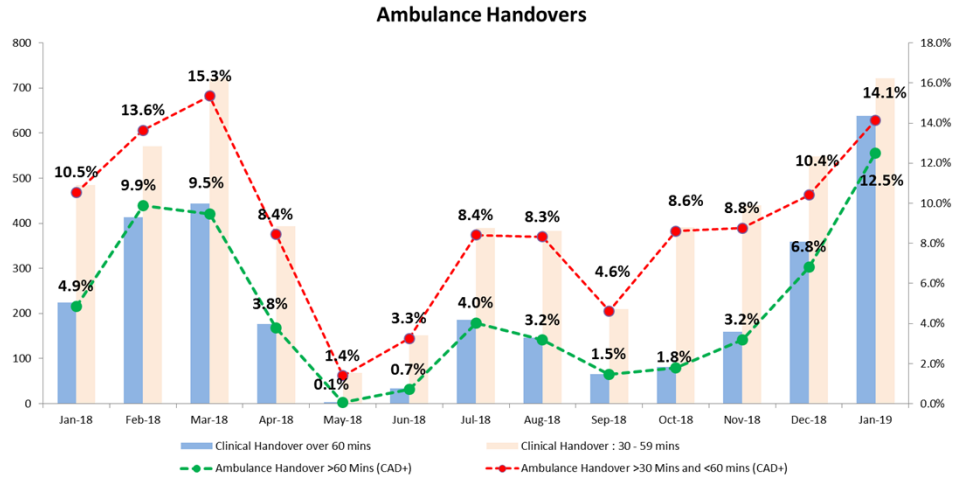
Regionally, the average percentage of handovers over 15 minutes and not meeting the standard is 55%. That means that 55% of all patients arriving by ambulance are not handed over to hospital clinical teams within 15 minutes, as per the national standard. This is a major focus for the LLR system this year, particularly as the Leicester Royal Infirmary is one of the busiest hospitals and A&E departments in the country, and has the highest ambulance arrivals in the region.

Overall, delays have marginally improved in comparison with the same time last year whilst the average number of ambulance conveyances per day on average has increased by 5% (18 per day), and on occasion A&E sees over 200 ambulances. However, over the new year and in January 2019 there were significant volumes of patients taken to hospital by ambulance due to the level of acuity and the system was extremely challenged impacting both performance and patient experience.



An immediate action plan was put in place, and February's performance has seen major improvement following LLR interventions. There is confidence that the processes in place will prevent the level of escalation seen in March/April 2018 with continued improvement and reduced delays.

- The LRI continues to have the highest number of ambulance conveyances to hospital and thus handovers in the region (average of 188/day), and in February the LRI appears to have had the highest percentage of handovers within 15mins in the region;
- The number of ambulance handovers in February was 4% higher than February last year.
- The handover performance improved greatly in February. 52% of handovers were completed within the 15 min standard, which is a 15% improvement from January and 23% better than February last year.

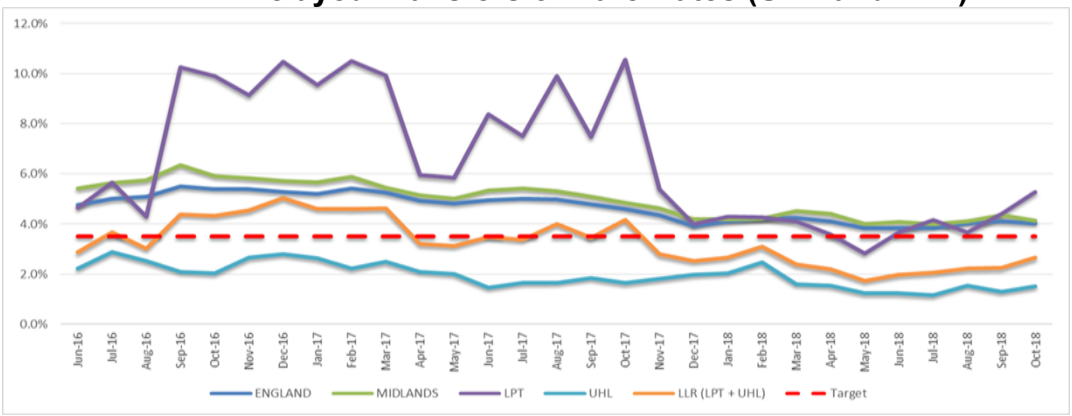


Delayed Transfers of Care (DTOC)

LLR continues to maintain excellent health and social care performance as one of the best in the country for patients in low numbers of delayed transfers of care.

- The national DTOC average is 10.5%
- Leicestershire county average is 6.3% as at Oct18
- Leicester city average is 5.3% as at Oct18
- Rutland average is 5.4% as at Oct 18

Delayed Transfers of Care Rates (UHL and LPT)



Operational Pressures Escalation Levels (OPEL)

- The level of pressure across health and social care systems are measured and modelled on the Operational Pressures Escalation Levels (OPEL) framework to ensure appropriate action can be taken dependent upon the

situation/s. The highest level of pressure is OPEL 4, and the lowest as OPEL 1 or business as usual. Extensive work was carried out across LLR over 2018/19 to avoid the same challenges from previous years including shortcomings in information-sharing and how communications are managed both within organisations internally, as well as across the system from one organisation to another. With new processes, tools, and training, teams have worked diligently to manage escalations more consistently:

- 2017/18 LLR / UHL over the winter period 1 October to 31 March was:
    - **At OPEL 1 for 0/182 days**
    - **At OPEL 2 for 17/182 days (9%)**
    - At OPEL 3 for 137/182 days (75%)
    - At OPEL 4 for 26/182 days (14%)
    - LLR was slow in noticing triggers of escalation and de-escalation was limited.
- 2018/19 LLR / UHL with new processes and business as usual (BAU) defined in August/September, and demand exceeding last year's winter demand levels, LLR / UHL has rarely been above OPEL 2 demonstrating improved process and effective action since 1 October. The LLR system has outperformed the majority of systems across the region in managing escalation and where required, de-escalation:
    - **At OPEL 1 for 8/123 days to end Jan19 (6%)**
    - **At OPEL 2 for 79/123 days to end Jan19 (64%)**
    - At OPEL 3 for 32/123 days to end Jan19 (26%)
    - At OPEL 4 for 4/123 days to end Jan19 (3%)

- The transition in declared OPEL levels is important as it differentiates the maturity of organisations and the system, as well as the level of action required across organisations to build greater resilience. For example, daily indicator/escalation reports are established for monitoring daily sitrep performance, including performance, capacity, and key indicators of pressure which further reduces confusion during periods of high pressure.

Generally whilst demand has been higher than the same time last year, performance has not seen the same significant challenges as in 2017/18 and has seen stabilisation during periods of surge;

- There has been a low number of elective or time critical cancellations with the introduction of a new system of clinical prioritisation alongside and capacity management.
- There have been zero 12-hour trolley breaches in A&E.
- There has been very minimal 'corridor care' due to extreme pressures.
- Occupancy rates have not exceeded 95% overall.

Major Causes of Pressure

In such a complex system, there are consistent themes year-on-year with several factors contributing to the pressures.

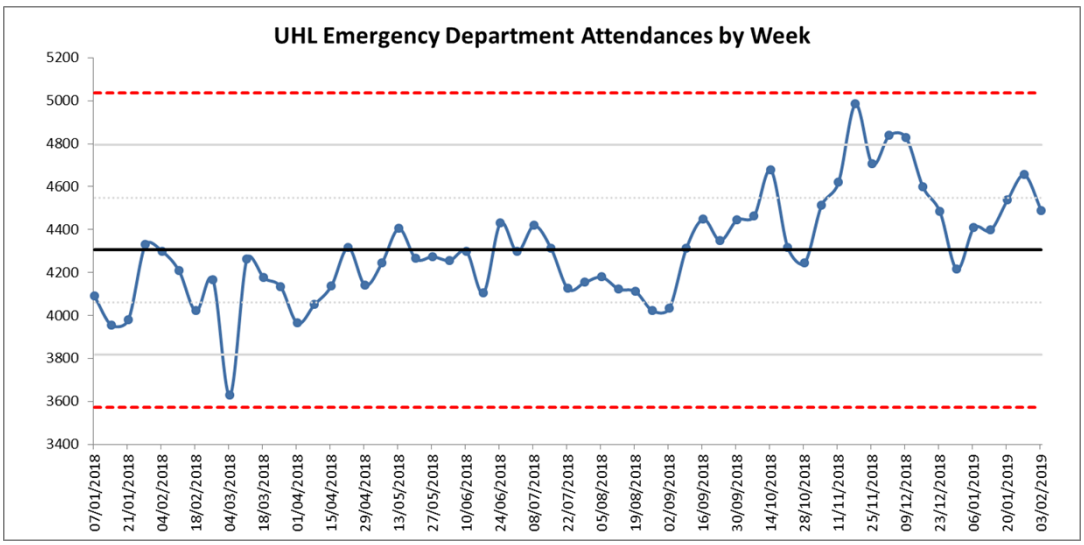
- Pressure across all parts of the system – in GP practices, GP Primary Care Hubs, Urgent Care Centres, 111 calls, Clinical Navigation Services, Ambulances Services, ED and within the hospitals. Hospital activity levels overall and emergency admissions are comparable to past years overall, but there are changes to the *type* of patient, and how poorly they were, with very high numbers of cardio-respiratory cases and paediatric cases in particular.

- Analysis to date confirms the pressures are not generally caused only by the number of admitted patients, but by how acutely unwell they were and how long they needed to be in hospital. Many of these were older or frail patients, which have been better managed this year following the opening of the Acute Frailty Unit as well as the Frailty programme initiated in summer of 2018. Generally across Leicestershire and Rutland, older people make up approximately 20% of the population, yet at the height of the pressures, 80% of hospital beds were occupied by this group. The frailty initiatives have improved the way this cohort of patients are managed overall, and has largely helped to lessen the growth of demand in light of more people living longer and thus also requiring health and social care services for longer.

A&E Demand

- There has been a emerging trend (upward) in attendances into A&E since September. Despite a small reduction in referrals in December, there was an unusually high level of attendances in injuries, Child Majors and the Children hospital (for Child Specialty).

- Whilst the proportion of attendances via ambulance has grown significantly so has the overall volume of attendances. With resource and professionals moved to prioritise the acutely unwell ambulance arrivals this has meant there unfortunately have been occasions of long waits in injuries and primary care impacting 4 hour wait performance.



This is mirrored by an increase in attendance and utilisation of out of hospital urgent care services, as well as contacts into 111 and GP practice appointments.

Key Actions Taken in 2018/19

- Focused review and revise the system Escalation Plan. The Leicester City, Leicestershire, and Rutland (LLR) Urgent and Emergency Care Resilience Plan 2018/19 is currently under development in collaboration with key stakeholders across the city and county. This has enabled a **'one plan approach'** across organisations and sets out the features / signs of increasing levels of pressure for each organisation and what the response from themselves and other partners will be as a consequence. An effective and well-managed plan has remained key to ensuring we all take the right steps to manage the pressure but also ensures that the system can recover quickly ("bounce back") once pressure begins to decrease. This improved communication and collaboration has been a contributing factor to improved performance and stability, and established the necessary regimented discipline amongst the people and professionals who will be working within periods increasing pressure.

- The second part of the **ED development at UHL opened in summer 2018**, which provides improved patient assessment areas. This allows more investigations to be carried out to reach an early diagnosis, give rapid treatment and ideally prevent the need for admission to a ward. In addition, UHL re-aligned their bed capacity overall and created additional ward capacity to meet the expected increase in medical patient demand.

- UHL **increased non-elective inpatient bed capacity**. When agreeing the contracts for 2018/19, the CCGs and UHL worked together as a first step to forecast in detail how much emergency capacity is required. We then agreed how and when the elective (planned) activity will be delivered through the

year, including how many operations may need to be delivered by other providers, so that we can protect and maximise the number of emergency beds. Two additional inpatient wards increased bed capacity for non-elective activity, and a modular ward was established at Glenfield in February to support additional capacity for respiratory patients.

- LLR **focus on reducing the number of 'long-stay patients,'** or patients in hospital up to and over 21 days, by up to 25% overall, from 202/day to 155/day. This particularly included a person-centred approach to support patients in their journey and ensure they were on the most appropriate discharge pathway. It should be noted that LLR has one of the best levels of performance for both long stay patients (at or less than 200 on any given day) as well as one of the best delayed transfers of care (DTOC) performance in the country, and as a result is an extremely challenging ambition. To date, LLR is above trajectory and achieving 165/day average, representing a 17.5% reduction or improvement.

- A **Digital Minor Illness Referral Service (DMIRS)** was established and launched across LLR in December, which enables NHS 111 to refer patients direct to community pharmacies for less urgent and minor illnesses. Up to 1000 patients have now been referred to pharmacies instead of historically being referred to either their GP, an urgent treatment centre, or A&E.

- Work continues to **increase the access to IT systems** so that clinicians are able to see the patient's clinical record (where permission has been given) to improve decision-making. This is through an increase in the number of patients who have agreed for their Summary Care Record to be seen, which in turn supports more informed clinical assessments and treatments.

- New, **improved protocols** are agreed between UHL and EMAS to manage better the handover of emergency patients when they arrive at hospital via ambulance.

- **Improved communication systems** developed between consultants and GPs to give advice and guidance about patients' care and whether or not they need hospital.

- We have worked with Public Health and NHS England to deliver a **proactive response to seasonal flu and generally improve and update infection control procedures.** We implemented a publicity campaign to raise awareness and encourage uptake of flu vaccines with the public, and a campaign to encourage uptake of the vaccine within eligible groups and frontline staff. There were some issues related to the availability of and the logistics of flu vaccinations which will be evaluated with NHS England later this year.

- We are introduced a "**Red Bag scheme" for care homes,** which has been shown to work elsewhere. The bag is used to keep all the patient's essential

items together including medication, personal items etc. and which can be transported with the patient if they are admitted. The scheme was slow to mobilise due to some infection control guideline concerns, and subsequently required an alternative approach. Initial evaluation has shown that care home admissions are significantly reduced, which has reduced the number of red bags in use.

- We have **supported more patients to understand and manage their conditions.** For instance with respiratory patients, we have worked to ensure that they are accurately identified on the clinical systems, that they have a care plan setting out their condition, treatment and what to do if it worsens and to ensure they have "rescue packs" i.e. antibiotic prescriptions etc. to allow them to start treatment and prevent admission. We have priorities messages of cold weather warnings, pollution alerts, and that these patients are flagged with EMAS in the event of 999 calls and are supported by a dedicated community specialist team and ongoing education programme for professionals, patients and carers.

- There are **improved discharge pathways** with a larger, multi-agency integrated discharge team (IDT) within UHL which supports both discharge and admission avoidance. These pathways and team aim to get patients out of hospital and either back home or into a suitable care setting for assessment of their future needs. Evidence shows that this is really important for maximising recovery. We continue to work collaboratively with hospitals and providers to better communicate options for older people and their families, including where end of life choices can be better made. We are also strengthening the approach to promote general health and wellbeing when patients access services, as well as what alternative services exist outside of hospital.

- We have **implemented a programme focusing on frail patients** for whom an increased level of support can prevent hospital admission. We have collaborated system-wide to design a new pathway for frail patients based upon local needs and national standards, alongside other interventions to help battle 'isolation' and engage carers and voluntary organisations. There have been 16 high impact actions of focus impacting on winter 18/19.

- We have implemented a major **programme of winter communications** and campaigns consistent with national messages but often tailored to LLR and to targeted groups of patients. The campaigns have undertaken a recent evaluation of their effectiveness to support learning, and have included:

    - NHS 111 and 111 online
    - Flu
    - LLR Prepared
    - Pharmacy
    - Keep Antibiotics Working
    - Stay Well this Winter

- Self-Care Week
- GP Extended Hours and Access

Population Growth - Health and Social Care Demand

In context, there are a significant number of factors noted as impacting on rising demand and access to health and social care services to which the system is responding:

- Patients are living longer in light of advances in medical treatment and health, alongside an aging population with resident growth into the area and lifestyle factors; all of which increase the demand for public services including health and social care.
- LLR population is circa 1.2m people in total – largest in the East Midlands; Leicester city is the largest city in the East Midlands by population.
- Avg. annual population growth (census) is 0.9% growth/year.
- As part of the strategic growth plan, LLR is building (in part has built) 96,580 new homes from 2011-2031. A further 90,500 dwellings beyond 2031. Major infrastructure change is expected.
- Universities are expanding the number of students.
- Leicester city in particular sees periods of variation – multi-cultural events such as Diwali, sporting events, etc.

Process – Comprehensive Review of Winter 2018/19 Performance

The health and social care system is currently in planning mode for a review of winter 2018/19 to take place in May. This will include a comprehensive review and workshop engaging stakeholders regarding what went well versus not so well, and what we can do differently in building greater system resilience and improving both quality and performance for patients.