NHS
Leicester, Leicestershire and Rutland

Planning for a resilient winter across the LLR health and care system

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On behalf of the LLR health and care Winter Board

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WINTER PLAN

Current context

The LLR health and care system continues to work collaboratively in order to meet the performance and quality challenges across the urgent and emergency care pathway. Whilst the system remains off-track against the challenge set to reduce ambulance handovers to less than 30 mins in September, continued successes have been noted in the impact of priority schemes across various points of the UEC pathway, particularly those focussed on demand management:

Intervention	Baseline	Actual
Number of ambulances waiting over 30 mins	2629 (April 22)	2070 (August 22)
Increase the number of F2F appts in primary care	65% (April 22)	73% (August 22)
Increase the numbers of patients diverted from the EMAS/DHU stack to a safe alternative	6-8 per day (April 22)	40-50 per day (August 22)
Reduce the number of Non-elective admissions to UHL back to 19/20 levels	8950 admissions (April 19/20)	6920 admissions (April 22/23)
Increase 2-hour urgent crisis response time compliance	69.3% (21/22)	92.4% (YTD 22/23)

Performance against discharge metrics remains variable; discharge before noon and 5pm, numbers of medically optimised for discharge patients, efficient discharge to pathway 1 and 2 services, and numbers of failed discharges remain off plan.

Winter planning

Winter planning is well underway, building on the successes and learning from both previous winters and the recent surge in activity as a result of the summer heatwave season.

Our approach to winter planning this year has been data driven, using both historic and more recent trends to understand and model predicted demand through winter 22/23. Whilst this happens annually at UHL, this year we have taken the opportunity to demand model both LPT and social care so as to understand any clear capacity gaps and therefore align actions to mitigate against these.

Building the plan across the LLR health and care system:

1. Build detailed whole-system demand model needed for ‘safe winter’, modelled on southern hemisphere flu experience and pre-COVID / summer ‘22 demand

This has been modelled in a similar manner to the SAGE approach taken through COVID. System alert levels 0-4 have been built, with assumptions made on a range of occupancy levels, predicted demand, delivery of mitigations etc. Each scenario has then been tested at organisation level and at system levels, showing a fuller picture of where resulting gaps may be.

2. Build detailed whole-system capacity model of current capacity across health and care and add where this capacity *should be* if flow were optimal

Again, built using local data, this model shows us the capacity required in each part of the system to meet the predicted demand – if every patient was in the right place, at the right time, what would capacity look like as a system? This has been added this year to ensure a collective understanding of impact on the quality of care the system could provide if we could deliver the changes needed in each part of the system.

3. Cross reference gaps with recommendations from other reports such as the 100-day discharge challenge / CQC and agree priority evidence-based interventions, mitigating gaps using monies allocated to system, whilst meeting the eight requirements set out in the NHS winter letter

Alongside this work, each ICB received a letter on August 12th *(Appendix A: Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter)* outlining eight actions for each system and six key metrics for measurement. The System Flow Partnership has recently received the CQC, Sturgess and Missed Opportunities' reviews and has been systematically working through delivery of each action; given this, our plans have considered most of the eight actions in the winter letter already. However, where there is scope to, each plan has been adjusted and **prioritised** in order to meet the requirement and address the gaps in capacity against the demand model.

4. Agree triggers / actions for 'critical' scenarios such as elective take down and actions to spread risk across the system

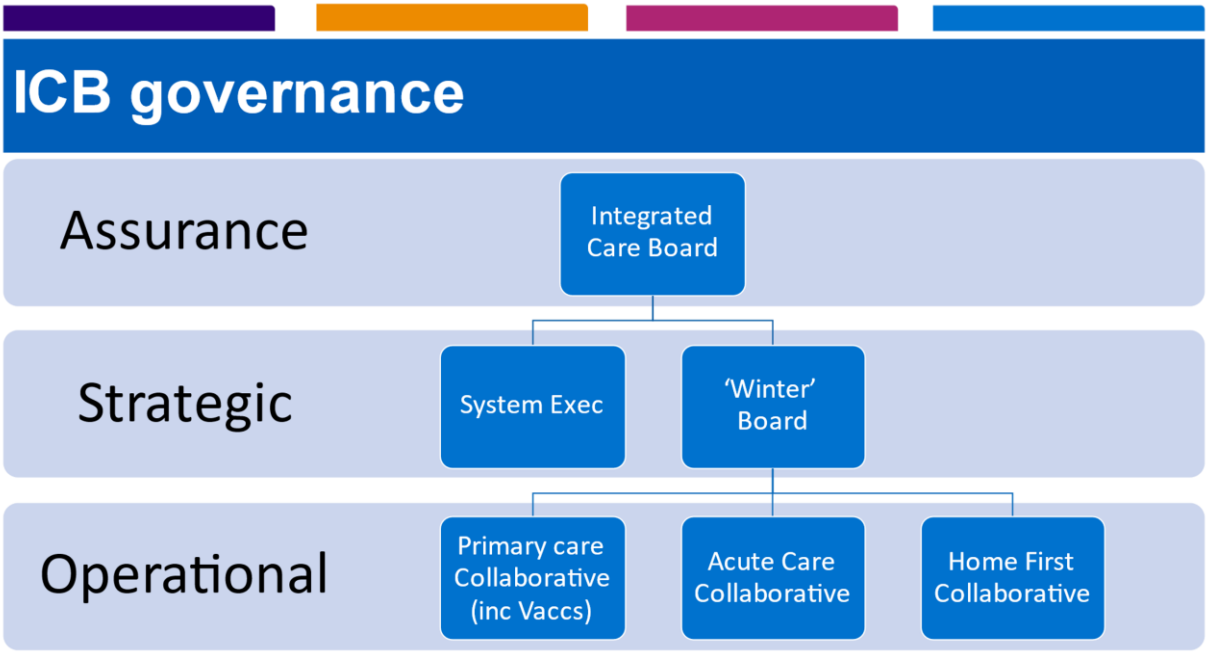
The Clinical Executive led a System risk summit on September 13th with the aim of ensuring the clinical leadership across the system were both clear on and have support to deliver the actions outlined in order to reduce the risk within the system. The Clinical Executive agreed that the actions in play are the correct actions and identified further support that the clinical community would welcome to deliver fully – actions such as patient, resident and staff communications for example.

Each of these four sections comprises the winter plan. The full plan is being finalised and will summarised on slides at the Scrutiny session, with officers present to answer specific questions.

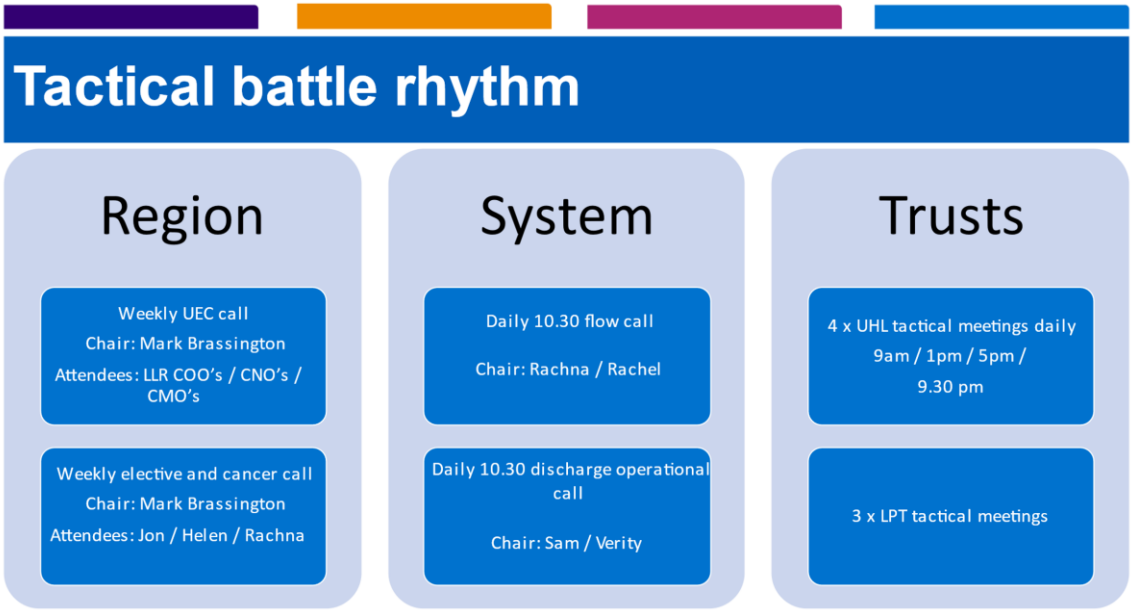
Governance

As part of the winter response, Chief Executive ownership has passed from Andy Williams to Richard Mitchell, with no change to the delivery team at system and organisational level. Rachna Vyas continues as System lead for winter with Jon Melbourne and Sam Leak as provider leads and named colleagues from each Local Authority and other provider partners included.

However, learning from last winter suggests a more agile approach is needed to governance this year, both to assure the ICB and to provide regular and accurate reporting to regional and national bodies. Therefore the System Flow Partnership will be replaced by a 'winter board' and will meet weekly on a face-to-face basis.



The ICB will gain assurance via this group. Supporting tactical arrangements are also in place, daily and weekly:



Whilst it remains clear that this winter will be difficult, mitigating actions will be put into place for the eventualities modelled. The impact of the cost-of-living crisis and fuel / food poverty are largely unknown as yet - where possible using data from public health these have been modelled in but the full scale of impact is difficult to model accurately.

The agility and ability to react therefore, at every level of the ICS, will be significant and the system will be reliant on partnership working at a scale seen only through the pandemic.