NHS
West Leicestershire
Clinical Commissioning Group

HEALTH AND WELL BEING SCRUTINY COMMISSION

REPORT OF LLR CCGs

UPDATE ON WINTER PLAN 2017/2018

Summary/Purpose of Report

1. To provide an update on winter pressures, the response of the local health and care system to winter pressures and the effectiveness of winter plans.
2. Acknowledging that the health and care system is still in mid-winter, this report to the HWB Scrutiny Commission summarises performance issues and lessons learnt to date.

Background

3 Across the health and social care system, winter planning is co-ordinated to ensure that there are robust arrangements to cope with demand and surges in activity, and that agencies are working together to manage pressures to ensure that residents continue to receive safe and appropriate care.

4 Winter planning arrangements are led by the LLR A&E Delivery Board, supported by the Urgent and Emergency Care (UEC) team hosted by West Leicestershire CCG. The UEC team led a winter planning group responsible for pulling together the LLR plan. The Winter Plan is attached to this report as Annexe 1.

5 From November onwards, daily system management calls and situation reporting (SITREPs) have been in place, reporting into the regional and national winter management system.

6 The key elements of the winter plan for LLR are:

6.1 Clear organisational and system-wide surge and escalation management protocols, with the management of system escalation levels led by the WLCCG UEC team
6.2 Multi-agency on call training in relation to escalation protocols
6.3 Multi-agency Discharge Events pre and post the Christmas and New Year period, to accelerate discharge flows and free up maximum bed capacity to cope with times of anticipated bed pressures
6.4 Use of additional escalation bed capacity when required in response to admission rates and occupancy levels
6.5 Additional social care capacity in-reach to hospitals over the winter period
6.6 Demand forecasting by individual organisations, informing rota planning with additional capacity over key days
6.7 Additional capacity in some GP practices, primary care hubs and Urgent Care Centres from December onwards
6.8 System flu plan

7 In addition to the measures outlined in the winter plan, additional NHS funding was made available in December to support STP areas in managing winter pressures. LLR received £4.2 million in total, of which £2.3 million was directed to University Hospitals Leicester to reflect the costs of winter already in Trust plans. The remaining £1.9m was allocated in response to bids submitted by LLR to deliver additional capacity and winter schemes, directed at areas of the greatest pressures in the system.

7.1 The additional winter schemes in LLR include:

- 14 additional beds at Glenfield Hospital
- Additional imaging capacity at weekends to maintain patient flow
- ED floor managers to oversee patient flow
- Additional pharmacy support
- More support within the Integrated Discharge Team
- Additional discharge capacity (discharge to assess capacity and spot beds)
- Additional clinical triage in the clinical navigation hub, including green ambulance triage within NHS 111
- Additional capacity in primary care hubs and UCCs to deliver additional clinical appointments
- Additional Home visiting capacity
- Additional EMAS vehicles to move GP patients to hospital in a timely way
- Additional patient transport capacity to ensure that transport does not contribute to delayed discharges

8. In addition to the Urgent Care winter monies, there was a national allocation of winter monies for Mental Health services. LLR received £299K to support the mental health triage car, additional psychiatric liaison capacity in ED and expansion of home treatment services.

Winter performance and key issues affecting LLR services and patients

9. Acknowledging that we are still in the winter period, the LLR system has experienced some real challenges over the winter period to date, which have been reflected in a worsening of A&E waiting times at Leicester Royal Infirmary (LRI) and some worsening in other performance indicators , such as Delayed Transfers of Care and ambulance handover times.

9.1 A summary of activity and performance across the main urgent care services, covering each day over the Christmas and New Year period is attached as Appendix 1.

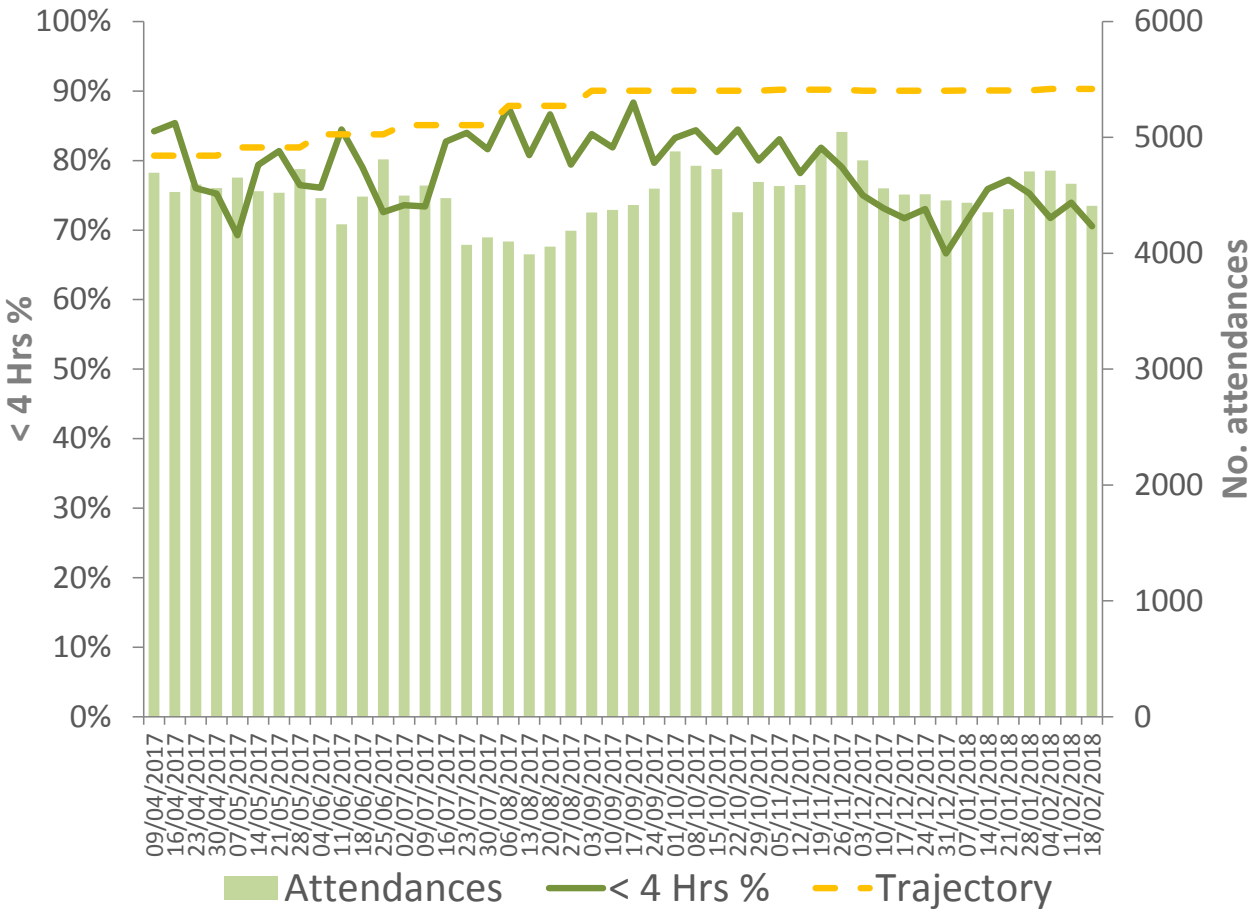
9.2 A fuller review of winter activity pressures and performance will be undertaken towards the end of March by the LLR Resilience Group, which reports into the AEDB and has representation from all the main health and social care partners. This group has responsibility for winter planning, and will use the learning in developing the winter plan for winter 2018/2019.

10. Key headlines in terms of activity and performance are:

10.1 Activity levels at LRI ED overall were not been particularly high over December, although they have increased in February. December attendances were 1% lower than the same period in 2016. There was a volatile pattern of attendances on the individual days over Christmas and New Year, which did not follow the same pattern as the previous year. For instance, Christmas Day was -7% on last year, but the 23rd December was +20%.

10.2 Performance against the 4 hour target at LRI ED over the week 25/12 – 1/1 was 66%. January performance was 75%, showing some recovery, although performance then dipped in February, 71.5% to the 21st Feb with a YTD figure of 78.5%.

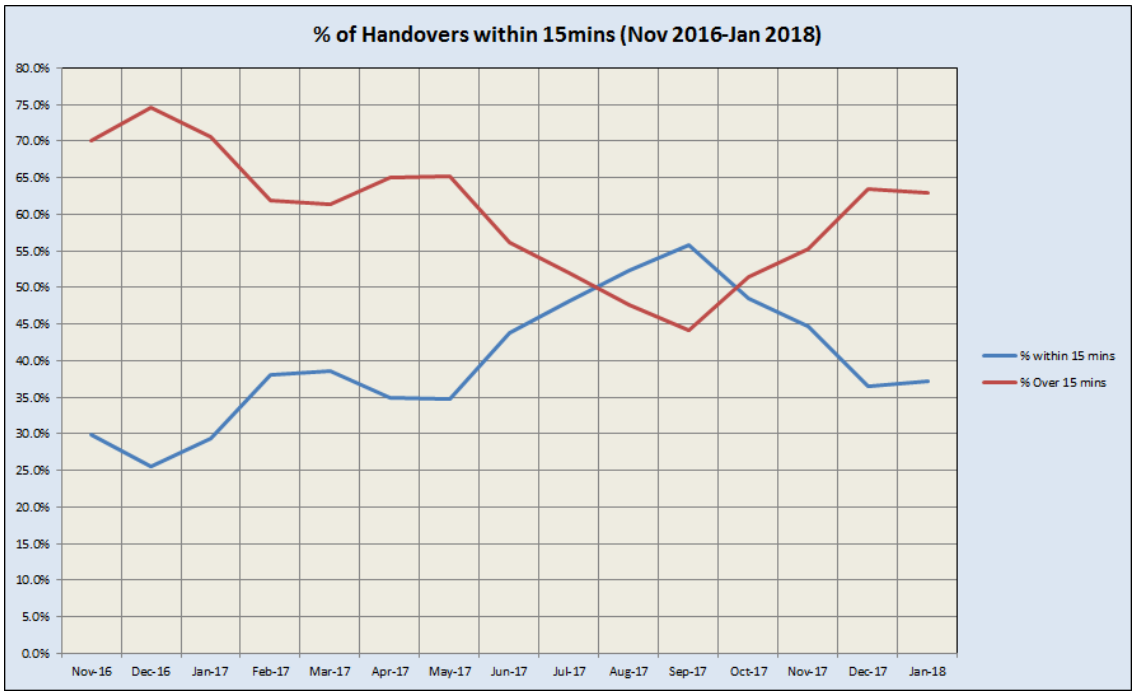
The table below shows ED attendances and waiting time trends for the year to date.

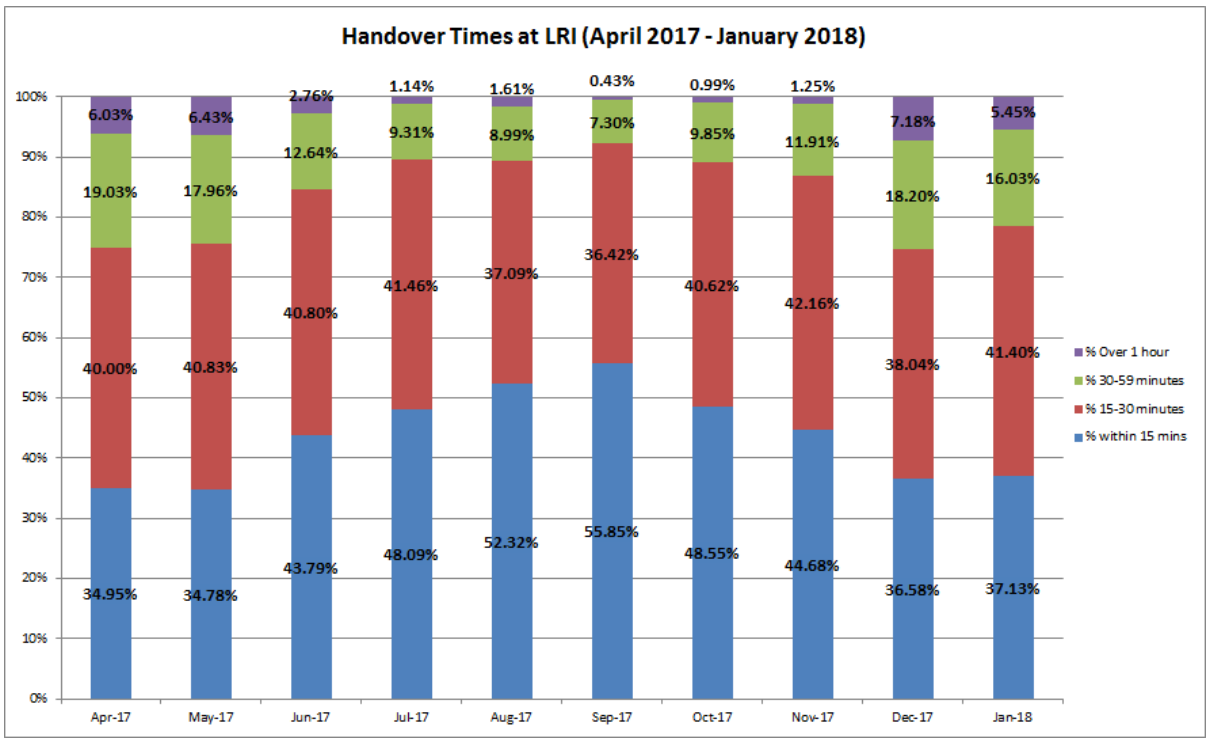


10.3 Activity in out of hospital services, including Urgent Care Centres, Primary Care Hubs, Home Visiting and Clinical Navigation has been higher both than forecast and last winter. NHS111 experienced an 18% increase in activity over Christmas. Local out of hours service activity was 11% higher than forecast, despite planned increases to capacity. This increase in out of hospital activity is in line with the Urgent Care strategy for LLR, however, at times it has created pressure on services.

Ambulance Handover times at LRI

10.4 Ambulance handover times have been significantly better this winter than last winter, driven by improvements in handover processes and capacity since the move to the new ED in April 2017, within consistently improved performance over the summer and autumn. However, delays have increased over the winter period, and there have been some extremely difficult days in terms of ambulance handover over New Year and repeated on a number of days in February. These long waiting times are related to times of increased 'surges' of activity coupled with poor flow within the ED and capacity problems in majors.





Key actions in place to assist with handover times include:

- Utilisation of blue zone to accommodate ambulatory patients off ambulances
- Conveyance direct to GPAU from ambulances
- 'Fit to Sit' from the ambulance assessment bay to front door
- Escalation protocol in place when the ambulance assessment bay has >8 patients
- EMAS HALO presence on site to liaise with ED staff and support flow
- Additional winter funding for EMAS crews to bring GP patients in earlier, to smooth late pm surges.

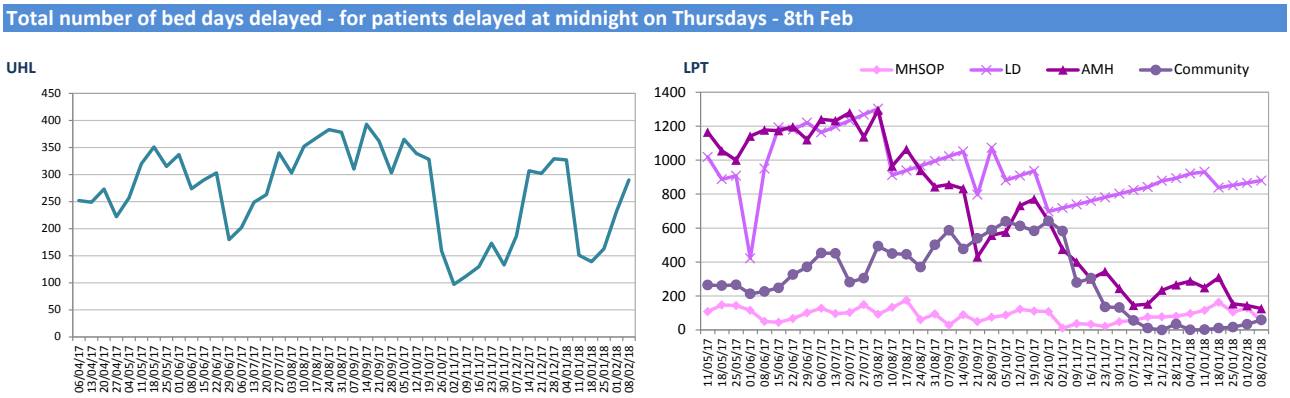
Bed occupancy and discharge delays

10.5 As part of the winter plan, the AEDB led a Multi-Agency Discharge event for a week in mid-December, followed by a week of enhanced 'Red to Green' discharge management. However, DTOC rates built slowly through December, following a period of good progress in reducing DTOCs, particularly at LPT, in November and in previous months. Some of this related to difficulties in getting packages of care initiated, or patients moved to care homes before Christmas. Patient acuity was high in the run up to Christmas, with high numbers of medically ill patients with respiratory viruses who could not be discharged, which further increased inpatient numbers.

10.6 There were some ward and bed closures due to infection control (Noro virus) at both UHL and LPT in the week running up to Christmas, with a number of beds still closed on Christmas Eve.

10.7 As a result of the above, and despite significant multi-agency efforts, occupancy rates at LRI on the 24th December were unusually high. Whereas there are normally large numbers of empty beds on Christmas Eve, which allows a buffer to absorb admissions over the following 10 days of the holiday period, this winter this has not been the case. Almost inevitably, the hospital became progressively fuller into the New Year bank holiday, with increasing numbers of medical outliers (40 – 50 on a daily basis) and the LLR system reached OPEL level 3 by the 2nd January.

10.8 The DTOC rate trend for UHL and LPT is shown below:



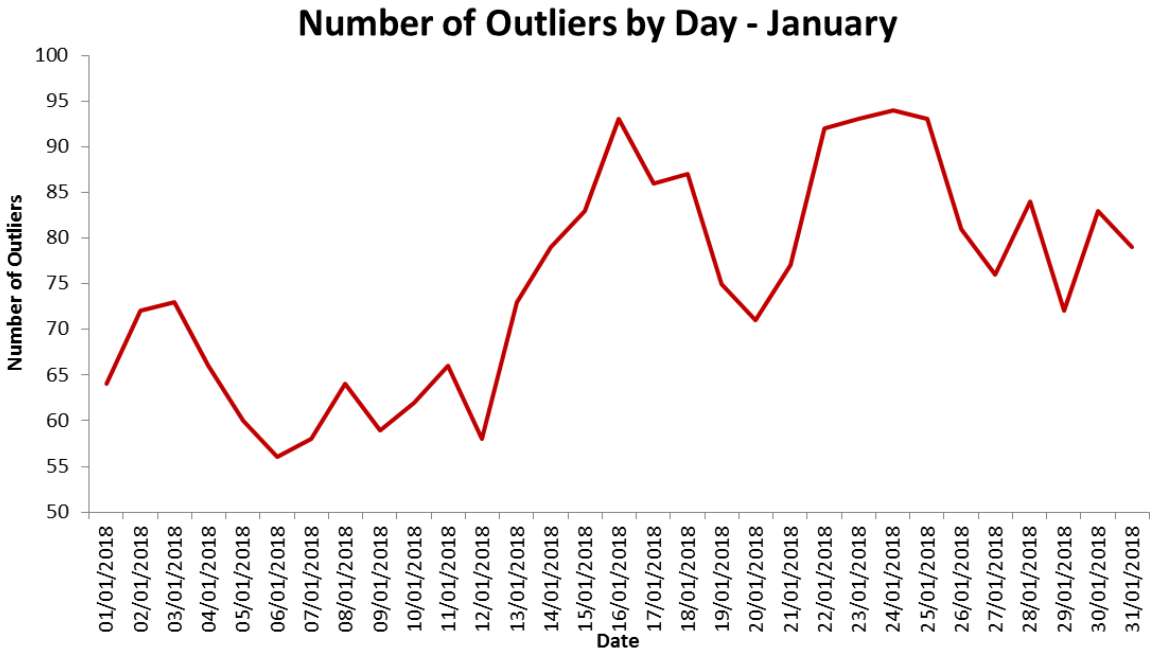
10.8.1 Note this is a combined DTOC picture for LLR. The DTOC position has been variable across County and City CCGs, with performance worse in County, generally. City DTOCs reduced in December, with achievement of the BCF target in that month.

10.9 It can be seen that there was a clear 'spike' in DTOCs at UHL from the end of November and over Christmas, which added to be pressures. The position was corrected to some extent in early January, following intensive support to UHL and LPT discharges since 2nd January. However, the DTOC rate has increased again at UHL in recent weeks. As patients have become medically fit, pressure has to some degree transferred from UHL to LPT, and the LPT bed occupancy rate has been problematic from the end of January to date. This was an expected phenomenon, to some extent, and close working between UHL/LPT and social care has been co-ordinated by the UEC team to maximise patient flow. Actions taken to support discharge and reduce bed occupancy in January and February have included:

- Securing additional care home placements to take patients medically fit for discharge
- Identifying additional case management and assessor capacity to support discharge to assess and the Continuing Healthcare (CHC) pathways
- Accelerated CHC approvals process
- Discharge 'task force' supporting UHL
- County Social Care looking for additional domiciliary care capacity to accelerate discharge flow

10.10 High occupancy rates have a direct impact on the 'flow' of patients who need admitting from ED into beds, and therefore have a negative impact on ED waiting time performance. This was experienced at LRI over Christmas and New Year this year to a greater degree than in previous years, and contributed to the performance dip over the Christmas period. Although the position de-escalated immediately after New Year, the second half of January and February has seen a further increase in pressures, evidenced by increasing handover delays and a decline in ED performance. Occupancy rates and stranded patients remains an area of concern, with action being taken to support improved discharges. UHL's analysis of stranded patients indicates that Length of Stay is increasing, and that this is linked to acuity of patients as well as to issues with discharge processes both within hospital and across the wider health and social care system.

The chart below shows the trend in medical patients outlying into other wards at UHL over January. High numbers of medical outliers create additional challenges for hospital medical and nursing staff as it creates additional problems in reviewing patients spread over a number of wards, and makes discharge planning more difficult. High numbers of medical patients outlying into surgical beds also has a knock on effect on capacity to treat surgical patients and can result in cancellations of surgical procedures. See later for more detail.



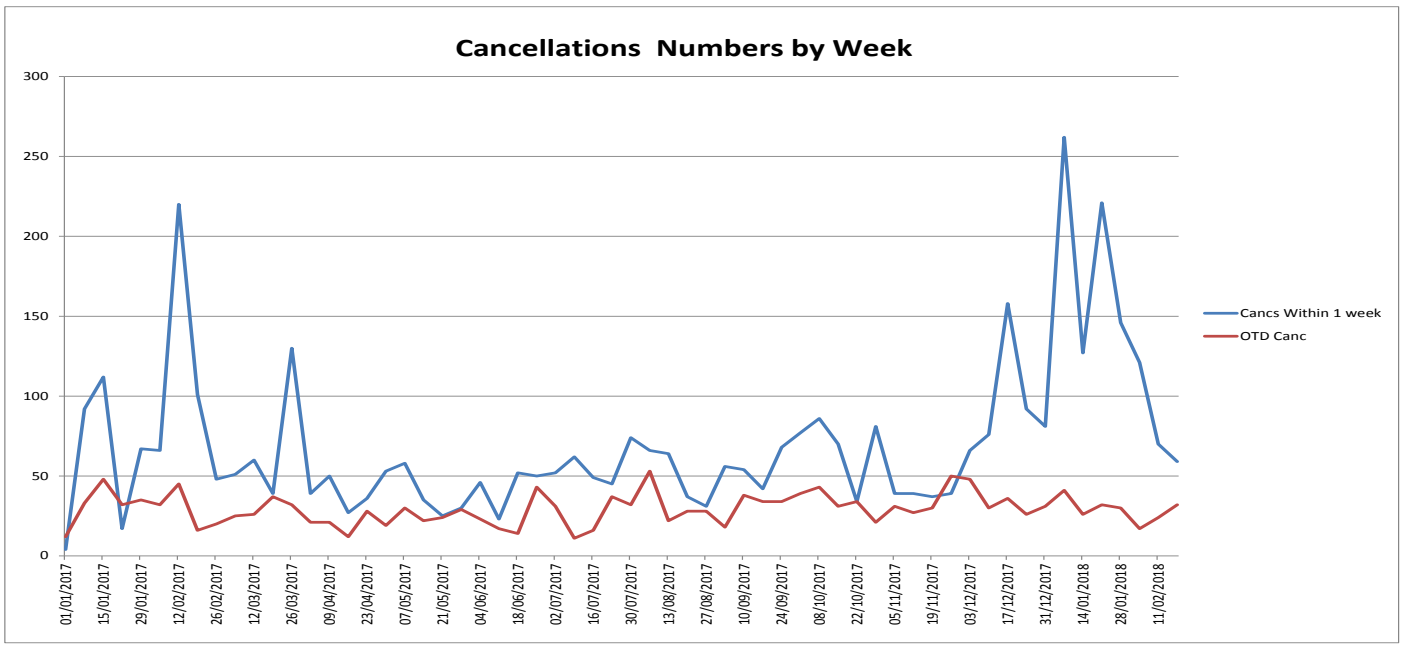
Elective and non-elective cancellations

10.11 NHS England issued instructions to all A&E Delivery Boards and NHS providers that they should stop undertaking elective activity through January in order to free up capacity (beds and staff) to respond to emergency demand. Elective activity is normally stepped down over the Christmas and New Year period anyway, but this year, the national direction was for a significantly extended elective slow down.

10.12 Within LLR, UHL has responded to this requirement. Elective inpatients in most cases were cancelled, although day cases and operations which would not have an impact on emergency care were continued. In addition, there were some urgent and cancer cancellations made in the first week of January. These were made following a review of ITU and recovery area capacity, and led to a number (32) of cancer cancellations between the 2nd January and the 8th January.

All patients who had their procedures cancelled were subsequently been treated within the month. There have been further, albeit small numbers of urgent procedures cancelled on the day over January and February, with decisions to cancel made only when there is no capacity to operate or provide a bed for patients , and Chief Executive sign off is required for cancer cancellations. It is recognised that cancellations of urgent and cancer procedures are extremely regrettable and are avoided wherever possible. UHL are undertaking an internal review of the cancer cancellations in January.

The chart below shows all UHL cancellations over the past year, which includes elective as well as non-elective cancellations. The chart shows cancellations within a week of surgery as well as on the day cancellations. It can be seen that the numbers of advance cancellations this year have been significantly higher this January than the previous ones, largely in response to the NHS England directive. On the day cancellations have not been significantly higher this winter,



10.13Winter funding notification was received on the 18th December, which allowed very little time to implement schemes before the Christmas holiday. However, despite this, some schemes were mobilised in the run up to Christmas, such as additional capacity in the Urgent Home Visiting Service. The AEDB has reviewed all 13 winter schemes, and where recruitment difficulties have made the original scheme impossible to mobilise in a timely way, the AEDB has agreed modifications to schemes, aiming to achieve the maximum impact on reducing system pressures. The UEC team are monitoring the implementation progress on schemes fortnightly, and all schemes are now on track.

Flu

11.0 Nationally and locally, flu cases have been higher this winter than they have been for a number of years. This has had an effect on the health and care system, affecting both staff and patients. However, there has been no epidemic level of infections to date and transmission rates appear to have peaked by the end of January.

11.1 During the second week of January there was an increase in flu cases across the Country including LLR. Flu B was the dominant strain at this point and this was not covered by the triple vaccine which was being administered by GPs and all pharmacies other than Boots. At this point Flu B in the elderly was presenting with minimal symptoms which made it difficult to spot. The CCG and PHE put in place anti-viral procedures should this turn into a pandemic situation. UHL began screening patients for flu from 10 January which in turn showed higher cases of flu within the Trust. However, inpatient flu cases did not impact on bed availability or ward closures.

11.2 Further communications were sent out to the public and care homes stressing the need to be vaccinated. LPT and UHL also ran further vaccination clinics for staff that had been missed and UHL offered the quadrivalent vaccine to staff in high risk areas (ITU, Oncology etc). Social Services also encouraged any staff that had not yet been

vaccinated to take up the offer of the flu vouchers. NHS staff vaccination rates have been variable, 71.99% in UHL and 51.5% in LPT (below the target).

Next Steps – Winter review

12.0 An initial analysis of winter has been carried out, as reflected in this report. A further review of the LLR activity and performance data will be undertaken in early March, covering the period November – February. This will inform a 'winter de-brief' workshop, led by the AEDB Resilience sub-group, to identify key lessons learnt.

12.1 Winter planning for 2018/2019 will begin in March, earlier than in previous years, in response to national planning guidance. The winter plan for 2018/2019 will need to clearly set out demand and capacity modelling to ensure an improvement in performance compared to 2017/2018.

A number of actions or system changes to improve winter 2018/19 have already been identified, including:

- Review of thresholds for admission to community hospitals
- Review of community hospital bed capacity
- EMAS 'non-urgent' dedicated crews to reduce late pm ambulance presentations
- Improvements to UHL and LPT LOS to create capacity
- Improvements to the transport booking and interface process at UHL
- Further multi-agency escalation training
- Review of UHL internal escalation protocols and plans
- Improved 'discharge to assess' pathways to be put in place before winter
- Risk sharing arrangements between CCGs and Local Authorities to fund discharge to assess pathways
- Redesign of the ICS to develop integrated home based rapid response/re-ablement support

Resource Implications

13.0 None other than detailed in the winter monies section 7

Conclusions

14. Winter performance has been challenging in LLR, particularly in relation to ED waiting times at LRI. Overall, the urgent care system has seen more patients outside of hospital this year than in previous years. Some improvements have been seen, such as improved ambulance handover times.

High medical bed occupancy and increased delayed discharges have contributed to the challenging position, although action taken to reduce delays has started to take effect over January.

Background papers:

LLR Winter plan (previously shared with HWB) Annexe 1

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List of Appendices

Appendix 1 – summary of system activity and performance over Christmas
Annexe 1 – LLR Winter Plan

APPENDIX ONE

Urgent Care System Heat Map - Period 23-Dec-17 to 07-Jan-17

System.	23-Dec-17	24-Dec-17	25-Dec-17	26-Dec-17	27-Dec-17	28-Dec-17	29-Dec-17	30-Dec-17	31-Dec-17	01-Jan-18	02-Jan-18	03-Jan-18	04-Jan-18	05-Jan-18	06-Jan-18	07-Jan-18
NUMBER OF CALLS OFFERED NHS 111.	1622	1526	925	1509	777	738	872	1791	1621	1421	797	744	787	876	1319	0
NHS 111 ACTUAL % ANSWERED.	83.8%	81.4%	89.0%	91.9%	90.9%	91.1%	89.4%	76.3%	77.2%	90.4%	83.7%	92.5%	90.9%	89.6%	91.7%	0.0%
111 No. OF ED DISPOSITIONS.	52	52	34	53	40	47	51	63	57	55	50	48	54	42	0	
Sum of 111 No. OF ED DISPOSITIONS %	3.8%	4.2%	4.1%	3.8%	5.7%	7.0%	6.5%	4.6%	4.6%	4.3%	7.5%	7.0%	7.6%	5.4%	0.0%	
111 No. OF AMBULANCE DISPATCH CALLS.	115	123	102	137	83	81	104	132	108	146	87	97	81	76	85	
Sum of 111 No. OF AMBULANCE DISPATCH CALLS %	8.5%	9.9%	12.4%	9.9%	11.8%	12.1%	13.3%	9.7%	8.6%	11.4%	13.0%	14.1%	11.3%	9.7%	7.0%	
Total EMAS (LRI) Handovers	175	196	160	191	205	195	205	198	185	201	186	191	197	204	189	188
EMAS (LRI) Handovers >15 mins.	96	134	90	118	154	142	142	146	140	152	143	122	136	119	129	116
EMAS (LRI) % Handovers >15 mins.	54.9%	68.4%	56.3%	61.8%	75.1%	72.8%	69.3%	73.7%	75.7%	75.6%	76.9%	63.9%	69.0%	58.3%	68.3%	61.7%
SYSTEM OPEL.	2	2	0	2	2	3	3	3	3	3	3	3	3	3	3	3
ED Attends (total).	667	661	449	668	727	683	665	689	576	654	683	599	668	662	594	577
ED PERFORMANCE.	75.4%	70.3%	73.5%	74.3%	63.3%	65.7%	67.7%	59.8%	64.9%	66.2%	62.4%	67.9%	70.4%	77.8%	73.6%	82.8%
East (VoCare) Type 3 Total.	202	194	68	177	72	88	94	201	194	168	100	102	100	102	220	149
West (DHU) Type 3 Total.	176	173	103	144	113	114	127	188	160	171	136	128	123	102	139	122
Type 3 Combined % < 4Hrs.	95.0%	94.3%	98.8%	89.7%	94.6%	97.0%	99.5%	93.1%	96.3%	96.8%	100.0%	100.0%	93.7%	93.6%	98.1%	97.8%
CNH.	730	582	358	587	150	170	199	637	678	480	143	136	152	202	603	522
HVS.	178	187	107	173	103	113	139	181	214	149	125	108	112	120	187	181
LUCC (walk in).	176	173	103	144	113	114	127	188	160	171	136	128	123	102	139	122
M VAS.	116	190	86	102	62	75	64	212	223	134	65	85	50	81	167	162
UHL OCCUPANCY RATE.					86.9%	89.9%	87.7%	86.5%	89.5%	93.8%	95.6%	94.7%	92.1%	92.5%	92.2%	90.6%
ICS Occupancy.					76.0%	78.0%	79.0%				84.0%	87.0%	93.0%	92.0%		

Key / Target		
> 1155	1040 - 1155	< 1040
< 90%	90 - 95%	> = 95%
> 12%	8 - 12%	< = 8%
> 12%	8 - 12%	< = 8%
> = 80	72 - 80	< 72
> 12%	9 - 12%	< = 9%
> 192	172 - 192	< 172
> 15 Minutes		
3 & 4	2	1
>719	589 - 719	<589
< = 85%	85 - 95%	> = 95%
> = 139	125 - 139	< 125
> = 139	125 - 139	< 125
< = 85%	85 - 95%	> = 95%
> = 396	356 - 396	< 356
> = 149	134 - 149	< 134
> = 139	125 - 139	< 125
> = 117	105 - 117	< 105
> = 92%	85 - 92%	< 85%
> = 92%	85 - 92%	< 85%
Average	10% less	>10% under

Notes & Assumptions

NUMBER OF CALLS OFFERED NHS 111.	No plans for Dispatch Calls - Average calls for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of calls, Amber between Average & 10% less, Green 10% under - resource should be available
NHS 111 ACTUAL % ANSWERED.	
111 No. OF ED DISPOSITIONS.	**Target 8% of Total Dispositions/Calls**
Sum of 111 No. OF ED DISPOSITIONS % (Target 8% of Total Dispositions/Calls)	**Target 8% of Total Dispositions/Calls**
111 No. OF AMBULANCE DISPATCH CALLS.	No plans for Dispatch Calls - Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
Sum of 111 No. OF AMBULANCE DISPATCH CALLS % (Target 9% of Total Dispositions/Calls)	**Target 9% of Total Dispositions/Calls**
Total EMAS (LRI) Handovers	Reporting the % of Handovers >15 mins - **All Red(?)**
EMAS (LRI) Handovers >15 mins.	Handovers for >15 mins - will always be Red(?) could use a percentage / range to RAG rate(?)
EMAS (LRI) % Handovers >15 mins.	Handovers for >15 mins - will always be Red(?) could use a percentage / range to RAG rate(?)
SYSTEM OPEL.	OPEL Escalation levels
ED Attends (total).	Average Daily attends for Dec'16 of 654 + 10% tolerance used as the target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
ED PERFORMANCE.	Target > = 95%
East (VoCare) Type 3 Total.	No plans for Attends - Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
West (DHU) Type 3 Total.	No plans for Attends - Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
Type 3 Combined % < 4Hrs.	Target > = 95%
CNH.	No plans for Attends - Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
HVS.	No plans for Attends - Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
LUCC (walk in).	No plans for Attends - Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
M VAS.	No plans for Attends - Average attends for the Dec/Jan two week period used as target - key used based on this value - Red >Average No. of attends, Amber between Average & 10% less, Green 10% under - resource should be available
UHL OCCUPANCY RATE.	85% occupancy used as benchmark - > 92% = risk
ICS Occupancy.	85% occupancy used as benchmark - > 92% = risk