LEICESTER, LEICESTERSHIRE & RUTLAND HEALTH AND SOCIAL CARE ECONOMY

WINTER PLAN

2017 -2018

Document Control	
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LLR Winter Plan 2017/2018

Contents:

1. Introduction:

This document provides planning and readiness information to support all aspects of Leicester, Leicestershire and Rutland (LLR) Service Delivery throughout the winter period 2017/18.

Winter is defined in this document as running from the beginning of October 2017 through to the end of April 2018, to include the management of surge during the Easter period.
The winter period is recognised as a time when significant additional demand is placed upon LLR Unscheduled Care Services. This relates primarily to higher prevalence of winter illness and an increase in the ageing population with co-morbidities resulting in complex care needs.

LLR urgent and emergency care economy is currently seeing increased levels of demand. Although the number of emergency attendances has remained stable (YTD against 2016), at approximately 113,500, there has been a rise of 6% (YTD against activity over the same time period in 2017) in emergency flow, specifically to short stay and through GPAU. The system experiences peaks of demand which can be fairly predictable, associated with Mondays and the days immediately after bank holidays.

2. LLR 2017/2018 Winter Planning:

2.1 Governance and Assurance

LLR A and E Delivery Board has overall responsibility for leading on surge and resilience plans , and proactively planning for the increase in patient demand throughout the winter period.

To effectively manage system pressures, the A and E Delivery Board (AEDB) acknowledge that performance is dependent on maintaining strong multi- agency collaboration; and particularly improving acute patient flow. The Board currently manage a work plan consisting of four key areas:-

- Supporting the current structure and performance of LLR urgent and emergency care economy;
- Reforming and redesigning the wider Urgent and Emergency care system
- Delivering the nationally mandated best practice guidance - the delivery of the 95% four hour wait emergency standard and the 75% standard for the 8 minute emergency ambulance response.
- Leading on assurance and oversight of plans in preparation for the winter period.

To ensure alignment to national winter planning protocols, the AEDB and A&E Improvement Group (AEIG) have developed an improvement plan and High Impact Action plan, structured around three main themes of in-flow, flow and discharge work streams. This approach incorporates:

- Demand and Capacity Plans

- Front Door Processes and Primary Care Streaming
- Flow through the Urgent and Emergency care pathway
- Effective discharge processes
- Planning for peaks in demand
- Ensuring the adoption of best practice.

As in previous years, LLR Urgent Care system, supported by the Urgent and Emergency Care Team hosted by WLCCG has taken a collaborative approach to planning for winter. The Operational Winter Planning Group, reporting into the AEDB, has representation from all relevant service providers integral to all stages of planning. This ensures that comprehensive preparation for winter challenges are in place. Historical data, and lessons learned from previous years, are also utilised to ensure robust planning for the winter period.

2.2 2016/2017 Lessons learnt and key actions taken to support winter 2017/2018

Key risks identified for the LLR System from winter 2016/2017:

In March 2017 the AEDB e undertook a review of winter 2016/2017 which identified a number of key issues and made some recommendations for winter planning 2017/2018 (Appendix A). The following section details the key learning, the known risks in the system and the actions we have taken to address those areas of risk for the coming winter.

Inaccurate demand and capacity planning in some providers:

A contributing factor of this inaccuracy was the unusual way that Christmas and the bank holidays fell. In particular, DHU (NHS111) did not have historical data for a Christmas falling on a Sunday followed by two bank holidays.

Action: Capacity plans for winter 2017/2018 will be adjusted using this learning. In particular we are mindful that there will again be a four day 'long weekend' when core general practice capacity is not operational and patients requiring immediate treatment will need to be directed to access the alternative services that exist across LLR.. We are undertaking a system wide analysis of demand and capacity, including looking at trends from last winter, and this will be used to inform operational capacity planning for winter and the Christmas and New Year period particularly. We have strengthened community based urgent care services in 2017/2018 (more details given in inflow section) which will help to mitigate the expected surge of patients after the Christmas and NY break.

Poor capacity and flow in ED leading to very long ambulance handovers:

This issue resulted in poor ambulance response times and raised risk in the community. Long handover times were a feature of the LLR system in 2016/2017 and were one of our key performance risks.

Action: The opening of the new LRI ED in April has led to a very significant improvement in ambulance handover times, as a result of increased major's capacity and improved handover processes. In July 2017, average pre-clinical handover times at LRI stood at 18m 11 sec and, total lost hours 438. This compares to 29:43 in July 2016 and 32:18 pre-clinical handover in Jan 20/17, with 1381 lost hours in July 2016 and 1617 lost hours in Jan 2017.

The system is therefore at lower risk of ambulance handover delays compared to last winter. Where these do occur at times of pressure, there is a SOP for a cohort area in the LRI ED which has been signed off by both EMAS and UHL.

High occupancy rates/poor flow and medical capacity:

Actions:

UHL have increased medical capacity by 38 beds compared to 2016/2017 plan. Flow and discharge planning processes have been improved across both acute and community providers as a result of closer system working; and the implementation of SAFER and R2 has been rolled out across medical wards and is much more embedded than in winter 2016, where there was limited implementation, which was halted over the Christmas and New Year period.

DTOCs at UHL are historically low at around 2% of bed days, and improved system oversight of discharge processes has seen external delays drop since the processes were introduced in February 2017. More details of our plans to support flow and hospital bed capacity are contained in the section on DTOCs and in UHL's provider plan.

We have reviewed our system surge and escalation protocols, including how we escalate actions in response to raised occupancy rates in hospitals. A particular issue identified by our review of winter and the work of the AEIG, has been the need to improve discharge processes from UHL to LPT and a workshop was held on this over the summer, leading to revisions to operational processes and the escalation protocols. This should result in more balanced actions to support flow in both UHL and LPT to avoid bottlenecks in community hospitals and support more consistent discharges from UHL to community hospitals.

Aligned to this, we have undertaken **Director on Call training for CCGs,** and plan to undertake further joint training with LPT and UHL DoC teams to improve understanding of the surge and escalation plan and improve organisational response to pre-empt increasing escalation levels by ensuring that the agreed actions are taken forward at relevant points.

Insufficient communications to patients:

Specifically in relation to when GP practices are open, and communications stressing the many alternative urgent care services that are open in LLR out of hours, routes to get repeat prescriptions etc.

Action: This is addressed in our communications plan, (outlined in section 3). There is good availability of extended primary care and Urgent Care Centre provision in LLR so alternatives to GP practices and ED are open 24/7, 7 days a week. We have strengthened clinical navigation and the ability to directly book patients into alternatives to ED from NHS 111 and clinical navigation and the LRI front door compared to last winter. This will enable providers to direct patients to an appropriate urgent care service.

Lack of real time information to support system response to surges:

Action: As part of our Vanguard work, we have developed a predictive modelling tool which takes real time information from UHL and EMAS and uses it to predict forward weekly demand patterns

which will be used to plan organisational capacity and response. We expect this to be in operational use from November 2017, in time for the peak winter period.

System wide capacity and demand modelling has commenced to identify specific surge points and bottle necks, relating to individual service providers. It has been agreed by all service providers that undertaking analysis of organisational activity over the last 3 years, (focussed specifically on the winter period), will identify trends in relation to system capacity pinch points, enabling pre-emptive alignment and wider system support by all system partners. The outcomes of the system capacity and demand modelling, will enable each organisation to submit detailed plans for the festive period, outlining the service and resources gaps seen in previous years and the mitigating actions being taken to avoid duplication. The expected completion date to ensure accurate system modelling is the end of September 2017.

There is an expectation that organisations plan to increase staffing levels and discharge activity both before and immediately after the bank holidays, to provide assurance that predicted surges in activity will be effectively managed, without putting additional pressure on the system.

3. LLR System Wide Winter Plan

The following section describes out processes for managing pressures in the urgent care system for winter 2017/2018 and gives some detail on specific initiatives and services that are in place. It concentrates on some of the key themes in the winter planning guidance, and supplements the detailed provider plans by giving a system overview of the main elements of our plan.

3.1 Inflow (including primary care)

Clinical Navigation

One of the key differences in the LLR system in comparison to last winter is the embedding of The Clinical Navigation Hub forms which is an integral part of the LLR Integrated Urgent Care Model. The hub sits alongside a number of 24/7 urgent care services across LLR including LLR Home visiting service, LRI front door assessment and streaming service and NHS 111.

The hub has a single entry point via NHS 111 from which there is access to 24/7 fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, health advice, sign-posting and multi-disciplinary care and treatment.

The LLR Clinical Navigation Hub offers those who need it access to a wide range of advice, assessment, care, signposting and information and support from a range of clinicians, both experienced generalists and specialists either via the telephone or referrals to face to face services, for example the Home Visiting Service, primary care hubs and UCCs.

Clinical advice is also provided to staff within care homes who have direct access to the Hub – during the Out of Hours period & where appropriate, onward referral to the Home Visiting Service.

Since the integration of the clinical navigation service in directing patients to the most appropriate care settings, positive outcomes have been seen in the reduction in ambulance demand and ED referrals (80% of green ambulance dispatches are avoided and up to 70% of ED dispositions are

directed to alternative services). This has contributed to ED attendances being down 2.2% year on year at August 17 compared to the previous year.

LRI Front Door and integrated primary care service

Alongside the implementation of the clinical navigation hub, a primary care streaming model is in place at LRI ED to support in the appropriate signposting of patients to the right pathway within the integrated ED.

The model utilises a single front door approach, which is delivered by an integrated workforce made up of nursing staff, ANP's, ENP's and GP's supported by medical staff, which incorporates previous UCC capacity and the OOH overnight base, to provide 24/7 access to urgent primary care at the LRI site.

One of the key elements of the model is its capability of redirecting patients to primary care. The front door has the ability to directly book patients into City Hubs and UCCs.

Primary Care:

Primary care capacity includes core general practice services, GP Out of Hours provision and extended primary care as well as pharmacy and dental services. Extended primary care in LLR is delivered through a combination of practice based extended hours arrangements, and activity provided through primary care hubs and UCCs in each of the three CCGs. LLR has good coverage of extended and enhanced primary care, and the changes to urgent care put in place in 2016/2017 and from April 2017 as part of our re-procurement of integrated primary and community urgent care have strengthened capacity to meet patients' needs both in and out of hours. Details of individual services and their winter plans are given in the organisational appendices for each of the LLR CCGs and Derbyshire Health United services. This section summarises some of the key services in place and actions taken to ensure there is sufficient access to primary care across LLR through the winter period.

The key services in place in LLR which supplement core general practice to provide a 24/7 model of primary care include:

- Loughborough Urgent Care Centre (24/7 walk in access plus bookable appointments, including day time urgent primary care and overnight OOH services).
- Primary care hubs in WLCCG at Hinckley and Coalville (bookable through NHS 111 and CNH)
- Leicester City CCG Primary Care Hubs (Westcotes, Brandon St, Saffron, Merlyn Vaz) delivering walk in and booked appointments, 12 hours a day 7 days a week
- ELR CCG UCC capacity including: Oadby Walk in Centre 12 hours a day 7 days a week, bookable from NHS111 and clinical navigation, and 3 additional sites providing daytime minor injury services , evening and weekend urgent care provision integrated with GP OOH services (at Market Harborough, Oakham and Melton Mowbray)
- 24/7 Urgent Home Visiting Service providing a rapid home based response to patients who require medical review and care at home. The service is accessed via NHS 111 or directly by care homes and has a strong focus on admission avoidance. From August 2017 this service

also incorporates a night time nursing service, therefore providing a fully integrated GP and nursing service across LLR.

- Out of Hours service based at LRI ED, operating 7 days a week.

There is therefore really good availability of additional services which provide additional access to same day urgent and primary care across LLR. All the a

Additional capacity in 2017/2018

Primary and community urgent care services in LLR have been strengthened since winter 2017/2018 in the following ways:

An additional 13,500 appointments in WLCCG UCCs (4,400 of which are in the new sites of Coalville and Hinckley). These appointments are also used by patients from ELRCCG and LCCG when necessary. In addition to this, from October there will be a 'test bed' of general practice in hours referral to LUCC to provide additional primary care access for Charnwood patients, using existing commissioned activity within LUCC.

643 additional appointments in ELR general practices over 8 weeks of the winter period

City Hub Challenge Fund capacity has now been consolidated into 4 hubs, including a recommissioned service at Merlyn Vaz

Increased coverage of 24/7 visiting, particularly to provide increased capacity and cover for all ELRCCG patients. Clinical staffing will be increased over key days over winter, based on modelling of activity peaks in 2016/2017 (i.e. the long Christmas weekend and immediately after the NY).

DHU intend to increase GP coverage at the LRI ED OOH service and on selected days over the Christmas and New Year period and weekends in response to analysis of activity in 2016/2017.

If additional financial resources are received by the CCGs this will be channelled through hubs and UCC services as well as to those practices which are able to offer additional appointments over the winter period.

Plans are being put in place to ensure that we pre-empt anticipated surges in demand over weekends and bank holidays over the winter period, by working pro-actively with patients identified as being at higher risk. These patients will be given enhanced access to booked appointments at hubs and UCCs in each of the LLR CCGs and given direct access to the Home Visiting service. This scheme has developed out of a 'passport' scheme put in place in WLCC in previous winters which was effective in ensuring that patients at highest risk of admission or ED attendance are directed into alternative urgent care services.

Pharmacy

We have implemented the NUMSAS pharmacy service across LLR, accessible via NHS 111

There is an emergency repeat prescription service available from community pharmacies which prevent the need for patients to access OOH or attend ED for repeat prescriptions. NHS England has

the information on which practices operate extended hours and we expect that community pharmacies will be open to cover those hours.

Core General Practice

The three CCGs will write to GP practices to stressing contractual expectations and asking all practices to confirm their opening hours and capacity. This will enable the CCGs to ensure that access to core general practice does not dip over the holiday season.

WLCCG requests that practices which are closed on Thursday 21st December do not close.

The communications plan (see later in this document) will stress messages that general practice is open as normal, and that there are evening and weekend services available both in General practice and in hubs.

If there is additional funding we would seek to commission practices to deliver additional capacity. Increasingly, this would be done on a hub basis or via UCCs , and patients would be booked into those services by their registered practice or by NHS111.

Core general practice appointments will be directly bookable by NHS111 and clinical navigation in LLR from October, following pilots within the Vanguard and we are rolling this out over the three CCGs between October and December.

Extended Hours :

The CCGs are working with practices to make sure that the DES activity for the bank holiday and weekend days are redistributed, and where access is on 24th December practices are expected to deliver that access, as per the DES.

The changes to the EOH DES from October are still to be worked through. This could mean that some practices that are currently providing EOH via the DES will no longer be able to if they have in hours closures during the week. As this relates to registered lists the impact will be small, however,

2017/2018 Admission Avoidance Schemes:

As a part of the urgent care service improvement programme, system wide initiatives have been devised to support admission avoidance into secondary care services.

We commissioned a new 24/7 visiting service from April 2017 which incorporates daytime acute visiting and support to care homes, overnight home visiting and night nursing. The integrated service has a strong focus on avoiding unnecessary admissions and since April we have seen evidence of impact including a drop in care home admissions, particularly in ELR, where there was previously no service. As the service works 24/7 it will enable continuity of admission avoidance over the Xmas and NY bank holidays.

Other initiatives in the AEDB plan include:

PHEM GEM – training on management of frailty supporting EMAS crews and care home staff to keep patients at home or in their normal place of residence

Consultant Connect – telephone based support to primary care to prevent unnecessary admissions. We will strengthen this service by December 2017 to put in place dedicated clinical time to respond to calls, and open up the service to EMAS crews

EMAS are providing a see and treat service in Leicester town centre, to deal with individuals incurring injuries over the Christmas and bank holiday periods, specifically focused to avoid ED attendances. UHL are creating a number of admission avoidance initiatives to support the system over the winter period but also a long term solutions to support system escalation. The plans include: Increased early frailty unit's capacity and frailty at front door, specialty presence within the emergency department including therapies, increased utilisation of GPs within primary care and assessment zones and the increased utilisation of hot clinics. The Integrated Discharge Team described elsewhere will have an ED facing role to turn people around without full admission.

Social care services have planned increased staffing levels in ED to avoid admission where needs are social care, not clinical. Crisis Response Service will aim to avoid admissions by providing urgent support to people in the community and CRS/HART will take referrals and broker support until 10pm, including weekends and bank holidays.

Additional accommodation in Community services is coming online in October to help with patient flow to enable capacity throughout the urgent care system.

Care Home Support:

LLR recently completed the self-assessment against the Enhanced Health in Care Homes Benchmarking Tool (Appendix B), from which we have identified our areas of priority that are reflected within the action plan attached (Appendix C).

The implementation of the 'Red Bag' scheme across LLR care homes has been identified as a priority within the LLR Care Home Sub-Group. Currently the work is being scoped with learning from the Vanguard Site in Sutton and funding from LLR STP has been identified to support acceleration of the work through the purchase of the red bag, with the view to implementing scheme within the year.

Scoping work for the utilisation of a telehealth solution, to support the reduction in 999 calls and Ambulance Conveyance to ED from Care Homes across LLR, is to commence within September to consider and develop a local tailored model of delivery, with a view to pilot the scheme once a viable solution has been identified.

3.2 Flow

Improving the access to emergency care is a priority within the UHL Trusts 2017/18 Quality Commitment via the 'Organisation of Care Programme'. At a high level the plan to address the gap includes:

Increase (in the short term) the bed base - New actions to increase our bed base at the LRI and GGH
Improved internal efficiency - Delivery of all pre-existing actions including, SAFER flow, red to green & GPAU expansion
A new model of step down care - UHL working more effectively downstream to care for step down patients in a non-acute setting

A new pathway for frail complex patients

This programme aims to take a more rigorous approach to improve access to emergency care for patients via 3 work streams:

- Emergency Department & Acute Medicine
- Medical and Cardio-respiratory beds
- Interface & Integration

The plans underpinning these improvements have been split into 3 work streams:

Efficient & Effective Emergency Department:

Objective – Reduce time to see a decision maker and time to decision.

The key action across the whole of the work stream is providing a solution for improving evening and overnight resilience of the demand and capacity for senior decision makers, largely senior medical staff. This is a key element of the 'September Surge' (1st to 15th September) where there is a high fill percentage of uptake for senior shifts overnight. This is expected to keep the waiting time to be seen by a decision maker lower in the evening and night.

A new standard operating procedure for Majors has now been developed by the ED teams and approved by Emergency Department Group, this describes what patients can expect at each stage of the 4 hour wait within the department. This SOP will now be monitored to assess our progress against its implementation.

The command structure has now been revised as part of the 'September surge' with changes in the meeting times and reporting of actions, along with a strengthening of the 'Silver' tier of the rota with more senior management support. This has also included basing a Duty Manager within the ED. It is forecast this will lead to more robust whole hospitals leadership and problem solving during the day.

Additional portering has been introduced to the ED for the 'September Surge' to provide logistics support to the ED clinical teams.

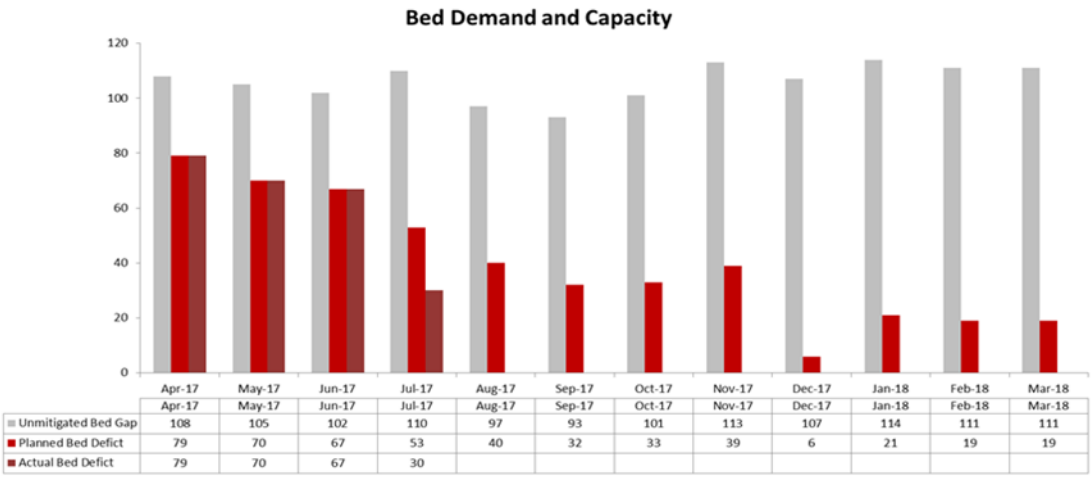
An Efficient and Effective Bed Capacity:

Objective - Mitigate the 105 bed capacity gap for 17/18 and Increase the % of patients in majors who move to a bed within 120 minutes to 95% from 78%.

The Trust commenced the year with a bed demand and capacity gap of 105 beds and had a plan to mitigate this by the opening of 55 extra beds and improving the efficiency of the specifically the medical and cardio-respiratory bed bases by c. 50 beds mainly through the rigorous roll out of 'Red to Green'. Figure 5 below shows the positive progress being made on reducing the gap. During July, an unmitigated gap would have been 110 beds and the Trust planned to have a gap of 53 beds. The actual position in July was a gap of 30 beds.

This performance better than plan was mainly associated with bed efficiency of 23 beds from both Medicine and Cardio-respiratory (which is also demonstrated on Figure 2 showing the reduction in the average length of stay in medicine). Unfortunately, some of this efficiency is being used for the

8% (662 patients) increase in emergency admissions above plan being seen by the end of July for ESM.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Unmitigated Bed Gap	108	105	102	110	97	93	101	113	107	114	111	111
Planned Bed Defict	79	70	67	53	40	32	33	39	6	21	19	19
Actual Bed Defict	79	70	67	30								

Figure 1 – unmitigated, planned and actual bed demand and capacity gap

Work on the physical bed expansion is progressing positively, with 36 beds open at LRI Medicine pathway.

Beds 'taskforces' are now in place for both LRI Medicine (chaired by the Chief Operating Officer) and GH Cardio-Respiratory (led by the Clinical Director for RRCV) to drive the improvement in 'Red to Green' They continue to focus on 3 key areas; firstly ward team reviews on their progress against the metrics, secondly ensuring the delivery of reductions in turnaround times against the top 3 delays, and finally delivering intensive support to wards that are not making required progress in this area.

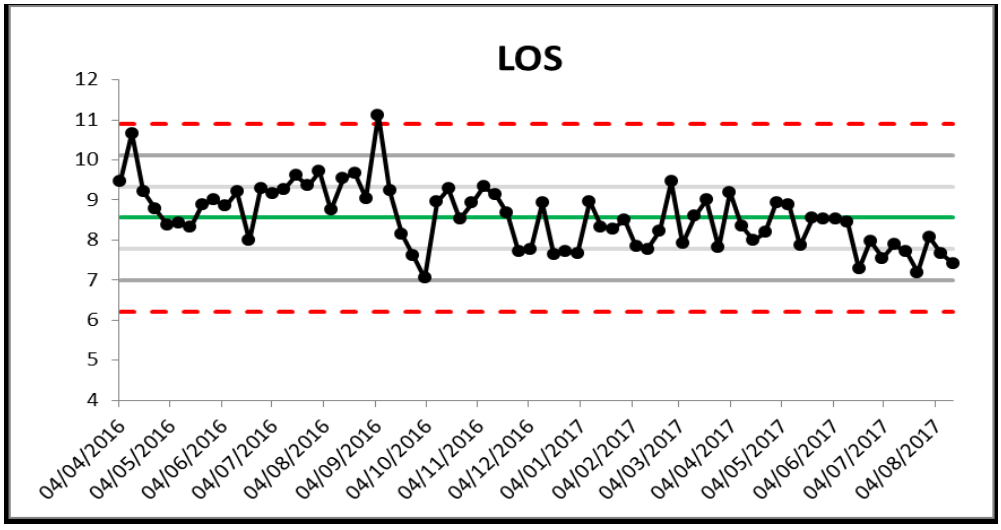


Figure 2.Average Length of stay in Medicine base wards LRI

This is having some success in reducing the length of stay for patients within medicine (as shown in figure 2) and it is now around 1 day lower than in corresponding period in 2016, but there is still work to do to ensure patients are discharged earlier in the day, as well as increasing the discharges at the weekend. These are two current focusses of Red to Green for medicine at LRI.

A plan has been developed by the Head of Service for imaging to delivery Keogh standard turnaround times (a maximum of 1 day) and a new TTO process is being trialled as part of the 'September Surge' that is likely to support the earlier prescribing and therefore production of those TTO's.

Within Cardio-respiratory, the Glenfield is much earlier in its journey on Red to Green having launched in July, but there remains a great deal of opportunity for improved efficiency which is being progressed with the teams there over the next 8 weeks.

In addition, UHL are mobilising resources to support the increasing demand going into winter. This includes:

- Additional paediatric medical shift (ST4 or above) between 1800 to 0300hrs
- Additional adult medical shift (ST4 or above) between 1800hrs to 0600hrs
- All senior nursing teams matron & above are booked into clinical sessions to support the teams
- Duty management team has been doubled up to enable one DM to be based in ED and the other to support the wards.
- Additional bed coordinator shifts have been requested as overtime.
- Requested 1 additional ambulance crew per day between 1600hrs to 12midnight via CCG
- GPAU staffed until midnight with senior consultant presence
- Additional surgical registrar on both sites 0800-2000 hours

External Interface and Integration Medical Step down Project:

Objective - To create a Medical Step down facility to support the mitigation of the current imbalance of demand and capacity gap.

The proposal of this scheme is to define the cohort and number of patients who would be applicable to use the medical step-down facility and then develop the clinical model and staffing model to support these patients outside of a UHL acute setting. An options appraisal will confirm the best location for the new facility and finally a business case for any new facility and deliver the new facility by November 2017. This scheme also has a key role in the system wide STP and hence is also reporting into the 'Home First Board' as one of the work streams of the STP ensuring that is in line with the overall approach to home first for patients.

As the Medical Step Down Project seeks to close the gap between demand and capacity (amongst other things), there is a key interdependency with the overall reconfiguration projects.

This project seeks to improve flow throughout the hospital which benefits all reconfiguration projects. This project will support the newly opened Emergency Department by helping to ensure performance does not decline over the winter.

SAFER and Red to Green Alignment

UHL:

A work stream to ensure alignment to the Red to Green principles is in place. Its remit is to:

- Review of current implementation on medical wards at LRI for learning with reference to a re-launch on these wards
- Refocus the implementation of Red to Green and SAFER as a priority on the Medicine wards at LRI relentless tackling the top 3 delays (including the implementation of Inter professional standards)
- Rigorous implementation of SAFER/Red to Green at Glenfield Cardiology & Respiratory wards
- TTO project started with an aim of achieving standards relating to TTO writing 'day before' and discharges before noon
- Review of AMU performance against SAM guidelines ensuring demand & capacity are optimised.

The project began in June 2017 and is on course to be fully implemented by the end of December 2017.

LPT:

Although the SAFER Patient Flow Bundle was designed to support acute adult inpatient wards, the principles outlined have been adapted by Leicester Partnership Trust (LPT) Community Hospital wards to ensure a consistent, all system approach to inpatient bed management across Leicester, Leicestershire and Rutland (LLR)

The implementation of the Red to Green approach commenced in March 2017 and the aim is for the roll out to be completed by the end of December 2017. The full roll out plan is attached as Appendix D.

Monitoring and managing 'stranded patients' – MADE

We plan to undertake a Multi-Agency Discharge Event (MADE) in preparation for Christmas, to create improved discharge flow in the second half of December and again in January, to maximise medical capacity over Christmas and to assist with coping with the surge in admissions in early January. One of the aims is to get as many patients into packages of care before the Xmas break as possible, as care agency response has been known to slow down over the holiday weeks. This will build on the process we have already put t in place for the weekly escalation of discharge delays, and bring together senior leads from each agency to activity plan for escalated discharge activity in anticipation of and response to the peak period of admissions after the New Year.

The continuous support of all services throughout the winter period includes the ability to utilise flex bed capacity effectively. Flexible bed options are available within UHL to manage increased demand, which is in turn supported LPT community based services, increasing their flex capacity to divert activity into lower settings of care. Where appropriate patients are discharged into interim beds whilst awaiting the procurement of appropriate services to support discharge .In addition there are flexible bed and service capacity available within Adult mental health and Learning disability services for both step up (admission avoidance) and step down purposes, for utilisation in times of significant pressure.

3.3 Discharge

Discharge processes and reducing delayed transfers of care

The Eight High Impact Changes for Managing Transfers of Care tool was implemented across LLR in September 2016, with a system wide review and update in May 2017. Furthermore, many service and system leaders attended the locally arranged regional event on 5th July where speakers from across England came to share service developments. (Document attached as appendix E).

Health and Social Care discharge capacity

A bed based patient step down audit was completed across UHL and LPT beds in July 2017. The review demonstrates where additional capacity may be required across the discharging services and where existing beds could be used differently. Plans are being discussed to create short term actions for Winter (e.g. review criteria for access into community services such as OPAT and ICS) and medium to longer term plans for the rest of the financial year (e.g. procurement for an improved discharge to assess service). The review will provide data and insights for the following pieces of work:

- ICS review
- Community Hospital bed utilisation plans
- STP bed based work streams
- Pathway 3 – Discharge to assess plans

An Integrated Discharge Team commenced within LRI Medical Wards on 3rd July 2017. The team brings together existing staff groups in Social Care, Primary Care Coordinators and Hospital Discharge Sisters to work as a single team to manage and progress complex cases and provide ward teams with skills to plan simpler discharges (such as re-starts of domiciliary care packages).

The team are working towards acting as trusted assessors on behalf of each other's services, which will provide a flexible capacity to complete assessments and procure services for discharge and reduce duplication of effort and reduce confusion about which local authority should be involved with the patient. The Integrated Discharge Team approach will roll out to specialty medical wards and an approach will be designed for surgical wards. These plans are in discussion with a completion date for delivery by March 2018.

The Urgent and Emergency Care Team has commissioned a system flow modelling tool which the first draft has been demonstrated. It aims to give predictive modelling for the acute trust for 7-10 days in advance. The model provides enough information to predict a surge in community hospital beds and a surge in requiring discharge assessment teams.

Commission additional home-care packages

There is capacity within the discharge to assess domiciliary care packages (Hart for the County and ICRS for the City) to take more patients during surges in demand. Full capacity is not currently utilised due to a number of internal actions that need to be completed especially for 'health' patients. (See appendix F – DTOC action plan for details of actions).

Implement a 'placement without prejudice' process

LLR already has a discharge to assess process which has agreed funding structures with the CCG, for placing patients into a non-acute bed whilst their CHC needs are assessed. There are further actions to enhance this within the LLR DTOC action plan (see appendix F for details).

Trusted Assessor Guide

The LLR Tiger Team for IDT is aware of the trusted assessor guide and is building it into the Trusted Assessment training and development within the IDT. Programme leaders are in the process of attending the webinars, and links have been made with Lincolnshire to view the service they provide.

Trusted assessment is already in place for the majority of current Discharge to assess placements into care homes, and for reablement domiciliary care packages.

4. Whole System Resilience / Escalation Arrangements

LLR has in place a system to provide daily capacity and performance monitoring of operational pressures, across providers throughout the year (not just the winter and Easter periods).

LLR manages surge and capacity utilising a whole system approach, which acknowledges predictable peaks in demand, for example over the Christmas and New Year period (As well as unusual peaks in demand as experienced throughout the year). Our commitment is to ensure that we have adequate 'system wide' resilience plans, to respond to operational difficulties in parts of the system, occurring in isolation or as a building pressure across LLR.

The key element is each organisations response to escalation. A common escalation policy has been agreed with each organisation and an agreed definition set to aid consistency and communication.

The LLR Surge and Capacity Management Plan seeks to have in place:

- Clear identification of the escalation process, agreed by all partners
- Key organisational contacts are identified
- That potential risks have been identified and contingency measures agreed
- That the provision of high quality patient services are maintained through periods of pressure
- That national targets and finance are managed during pressured periods
- That processes are in place to meet local and National reporting requirements

The underlying principle is that sufficient capacity has been planned to be in place to enable providers, under expected levels of planned activity and within expected levels of tolerance, to provide emergency care services and planned elective capacity in accordance with agreed targets.

Each organisation within LLR has developed their own internal Surge and Capacity and winter resilience plans and provides detailed confirmation of their preparedness across a number of areas.

Any organisation within LLR is able to 'call' for a health economy wide alert, but it is the responsibility of the CCG's as the lead commissioners for health services to 'declare' the health economy status.

Without prior discussion, no action will be undertaken by one constituent part of the system, which may undermine the ability of other parts of the system to manage their core business. The CCG will communicate system pressures to NHS England.

To support all organisations in the safe management of patients in times of high escalation, the LLR system wide escalation protocol enables a multi organisational approach to risk sharing.

4.1 Operational Pressures Escalation Levels (OPEL) Framework:

The LLR escalation policy is based upon an integrated status report, which details differing levels of capacity availability and trigger indicators. Listed below are the summary actions:

Escalation level 1 actions summary

- Situation monitored to prevent escalation
- Potential whole-system causes of escalation identified and dealt with
- Communication of any actual escalation

Escalation Level 2 actions summary

- Situation monitored to prevent further escalation
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Plan formed and being acted upon to re-establish level 1 working

Escalation Level 3 actions summary

- Situation monitored to prevent further escalation
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Command and Control within individual organisations and co-ordinated through LLR Emergency Care Director /CCG Director level, plan formed and being acted upon to re-establish level 1 working.

Escalation Level 4 actions summary

- Situation monitored to prevent system failure
- Action to improve situation carried out
- Potential whole-system causes of escalation identified and dealt with
- Command and Control led by CCG Managing Director/ On-Call Director: plan formed and being acted upon to enable de-escalation. Co-ordination of action plans led by CCG.

Commencing on the 1st December and continuing through the winter period, a daily escalation call is held system wide support, with the focus on swiftly de-escalating specific parts of the system in times of high pressure.

The call is undertaken where rapid system engagement is required in response to individual or LLR pressures, to collectively take action and plan for recovery. Examples of escalation issues rectified on the call include:

- The agreement of funding and operational provision of additional ambulance crews, to support flow.
- The utilisation

The aim of the call is to:

- To establish an operational escalation position for each organisation in order to understand the wider risks across the health and social care.
- Identify the risks within individual organisations and collectively the implications to the wider system.
- Agree actions to mitigate risk individually and collectively and identify who is leading on progressing the action.
- To update on actions taken on previous calls and if appropriate agree further actions required.
- Agree timeframes and feedback
- Plan for recovery

The teleconferences will be held in response to:

- declaration of a level 3/4 escalation within the LLR Health Economy
- as a proactive measure to prevent declaration of level 3/4 escalation
- commissioner initiated to escalate, communicate and plan a response to the management of urgent care system pressures (for example during periods of expected peak activity – BH, winter)

Any organisation can trigger a T/C based on deteriorating escalation status by conversation with the CCG - On-call Director or Urgent Care Lead.

In addition, an online escalation tool is used, providing all service providers with partner updates and identified issues that may lead to increased escalation levels within the respective organisations. This tool is updated twice daily (10am and 4pm) and is utilised to enact proactive solutions prior to increases in escalation levels; and moves the system away from reactive modelling.

UHL provide daily capacity updates to the system, outlining gaps in capacity against specific specialties across the 3 hospital sites. This report is used as an indicative measure to alert the wider system of building pressures within the hospitals. LLR wide Surge and Escalation protocols are in the process of being reviewed, including how we escalate actions in response to raised occupancy rates in hospitals. A particular issue identified by our review of winter and the work of the AEIG, has been the need to improve discharge processes from UHL to LPT and a workshop was held on this over the summer, leading to revisions to operational processes and the escalation protocols. This should result in more balanced actions to support flow in both UHL and LPT to avoid bottlenecks in community hospitals and support more consistent discharges from UHL to community hospitals. The

proposed plan outlines available system support from each service provider to the wider system, specifically in times of high escalation.

To support effective management of escalation protocols, the LLR Urgent and Emergency care team provide in hours support to the system, with an Out of Hours on call rota in place. As mentioned above, we have undertaken Director on Call training for CCGs**,** and plan to undertake further joint training with LPT and UHL Director on Call teams, to improve understanding of the surge and escalation plan and improve organisational response.

4.2 On-Call Arrangements:

We are in the process of reviewing the LLR system surge and escalation protocols, this forms part of the work plan of the A&E Improvement Group and will be commenced at the next group meeting on 13th September, with a further workshop to be held to agree and align actions.

Following on from the lesson's learnt last winter and throughout the year, we identified that a weakness across the system, was the inconsistent training for on-call directors in regards to managing significant escalating issues. With this in mind, we have undertaken Director on Call (DoC) training for CCGs, and plan to undertake further joint training with LPT and UHL DoC teams to improve understanding of the surge and escalation plan; and improve organisational response to pre-empt increasing escalation levels by ensuring that the agreed actions are taken forward at relevant points.

To support UHL further, in times of increasing pressure and escalation, the UHL and CCG Directors on call (DOC) work collaboratively, the UHL DoC will update the CCG DoC after each gold command meeting or calls, which are held twice daily as required. The outlined support and required system actions will be discussed and the CCG DoC will convene further system wide escalation calls throughout the day as required.

5. Communication Plan

Increasing the number of eligible patients who need the flu jab

- Raising awareness of the flu jab amongst target groups and the potential risk associated with not getting it
- Supporting GPs to deliver more jabs through support for booking appointments

Supporting patients to seek help earlier before their condition becomes acute

- Raising awareness of the benefit of early intervention with some of the most common conditions seen in ED which cover the early warning signs of each condition and how people can seek help early.

Supporting patients to understand the services available to them over the winter period

- Early communications of service opening times and repeat prescriptions ordering
- Raising awareness of the options when services are closed over Christmas

Improving internal communications on ED pressures to practices and care home partners

- Improving communications to primary care, avoiding messages that can be seen as blaming any part of the system for inappropriate behaviour and alerting them to new initiatives which can help, including hot clinics
- Improving communications channels to care homes to ensure that we can effectively distribute the messages that they need
- Working with the care homes sub group to understand what care homes need and how they want to be communicated with.

Ensuring as far as possible messages are co-ordinated and do not overwhelm the system

- Identifying and recording all campaigns being run by our partners particularly around self care
- Identifying where possible potential areas where we will need to issue reactive communications, such as upcoming icy weather and preparing messages and materials in advance.
- Agreeing which organisations lead and who speaks on each area so that we can react quickly to more unexpected pressures
- Capitalising on joint working opportunities across LLR whilst avoiding silo working.

Raising awareness of the benefits of NHS 111 and clinical navigation hub

- Communicating areas where the clinical navigation hub makes a difference, such as booking appointments
- Raising awareness of services for both physical and mental health needs to ensure parity of esteem.

Improving the perception of NHS111 and the clinical navigation hub

- Increasing trust and countering myths around NHS 111

Improve the understanding of discharge process and benefits with patients

- Raising awareness of the patient benefits of speedy discharge with both patients and family members.
- Supporting patients to choose appropriate settings

The full communications plan to support winter 2017/2018, is included in Appendix G

6. Flu Planning:

Following on from our Flu planning and vaccination success from last winter, we want to build on this further this coming winter, to have a system wide vaccination uptake of 75%. Our plans have been informed following exercise CYGNUS in October 2016 and July 2017.

System wide, Flu immunisation is offered by all NHS organisations in LLR to all employees directly involved in delivering care.

The guidance of vaccination against flu is included in all organisations policies for the protection of transmission of flu to protect patients, staff and visitors and is an integral part of the infection prevention policies and protocols.

Although we are aware that the uptake of the vaccination is on a voluntary basis, all services across LLR are providing easily accessible and alternative methods for immunisation to staff to increase the uptake and to minimise the risk of infection. As in previous years, the roll-out of immunisation primary school-aged children will continue, against the new PHE guidelines and we are aiming to increase vaccine uptake rates, particularly among those who are most vulnerable to the effects of flu.

All services are commencing their flu campaigns and clinics from the beginning of October. The details of each organisations plan is outlined in their individual winter plans in section 2.3.

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7. LLR UEC Service Provider Winter Plans

University Hospitals of Leicester Winter Plan 2017/2018	
Assurance	
Identified service lead for winter planning:	Chief operating officer Tim-Lynch
Reporting and Escalation process:	Three times Daily operational command meetings Silver Command On call cover 24/7 Daily LLR escalation calls Director on call level
Identified risks and mitigating actions:	**Risk: Bed Capacity** **Mitigation** utilisation of SAU. Opening of additional capacity on EDU (x 6 beds) /AMU (x 4 beds) /Ward 21 Spec Med (x 28 beds) R2G/safer officially launched over Spec Med / RRCV Opening of escalation paediatric capacity Front door admission avoidance schemes Early opening of GPAU/Ambulatory (November 2017) **Risk: Workforce** **Mitigation**: Corporate/specialist nursing to support inpatient nursing Continued recruitment in all areas Utilisation of support staff i.e. trainee assistance practitioners to relieve trained nurse **Risk: Not funded for 7 day service in all areas** **Mitigation**: bespoke additional shifts agreed at peak times of pressure.

System Capacity
Additional capacity planned in comparison to winter 16/17:
Additional paediatric capacity planned to cope with winter pressure (CSSU x 5 beds 24/7) Early opening (November) of GPAU Flexible capacity in EDU (x 6 beds) and SAU (x 6 beds)
Capability to Flex above planned capacity:
Utilisation of EDU/EFU capacity Utilisation of AMU escalation area Flexible use of SAU (LRI site only) Opening of discharge lounge area as overnight capacity (LRI only) Ambulatory Surgical Unit (ASU) should be considered when the organisation is on an

internal critical incident Opel 4+ but balanced against cancellation of elective activity.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Safer/red to green implemented in January 2017 to focus on reduction in stranded patient (focussed on Speciality Medicine wards at LRI and RRCV at the GGH site)
To act on all patients in excess of seven days length of stay
There is further role out planned for Gastro and Orthopaedics
Integrated discharge team to extend services to all wards within UHL to focus on DTOC and MFFD

Impact of planned bed or service reductions on winter planning:

No planned bed reductions
Possible impact of planned elective surgical reduction may release capacity during peak months i.e. December/January
GGH site had 28 additional beds opened in 16/17 to absorb respiratory/cardiology emergency patients. This ward has now been handed to Vascular surgery. There is currently no solution to increasing bed capacity at the GGH site.

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Flu staff campaign in place and starts in October 2017
Management against all IP policies and procedures
Planned to maintain system capacity during an outbreak will follow success of previous years utilising cohorting within wards/bays.
Increased cleaning presence and focus on prevention of spread

Planning for Peaks in Demand

Outline of current demand management processes:

Senior clinical presence at all front doors
Hot clinics for appropriate surgical and medical specialities
Utilisation of ambulatory medical assessment units (GPAU)
Senior clinician in all ambulance assessment areas
Possible utilisation of GP in cars visiting nursing homes etc.
Primary care co-ordinators at front door

What additional demand management schemes are in place or planned in comparison of winter 16/17

plans in place to support demand surges are outlined in section, namely:
Increased GPAU capacity from November 2017 and Specialities at front door (such as GI

Surgery).
What additional resource (service and staffing) has been planned to meet this demand?
Additional paediatric medical shift (ST4 or above) between 1800 to 0300hrs Additional adult medical shift (ST4 or above) between 1800hrs to 0600hrs All senior nursing teams matron & above are booked into clinical sessions to support the teams Duty management team has been doubled up to enable one DM to be based in ED and the other to support the wards. Additional bed coordinator shifts have been requested as overtime. Requested 1 additional ambulance crew per day between 1600hrs to 12midnight via CCG GPAU staffed until midnight with senior consultant presence Additional surgical registrar on both sites 0800-2000 hours
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
Workforce gaps both at middle grade and nursing levels to maintain consistent flow and management of escalation areas.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
Increased early frailty unit's capacity and frailty at front door DCC presence within the emergency department including therapies Increased utilisation of GP's within primary care scheme and assessment zone Increased utilisation of hot clinics
Predicted service impact:
Reduced medical take onto the assessment units Reduction in non-admitted breaches Increased ambulatory throughput to avoid admission onto a base ward Improved patient experience

Leicestershire Partnership NHS Trust (LPT)	
Assurance	
Identified service lead for winter planning:	• Pete Cross: Director of Finance Business, Estates and Facilities (**Accountable Emergency Officer**) • Rachel Bilsborough: Director for Community Health Services, with support from Pat Upsall, Clinical & Operational Lead, IM&T, Data Quality and Information Governance CHS • Helen Thompson: Director for Adult Mental Health with support from Samantha Wood • Helen Thompson: Director for Families, Young People and Children's Services with support from Julia Bolton • Bernadette Keavney: Head of Trust Health and Safety Compliance **(Overall lead for winter planning)** • Michael Ryan: Resilience and Security Manager **(EPRR Manager)** • Vicky Hill: IM&T Business Continuity Lead
Reporting and Escalation process:	• Operational Escalation Tool • Whole System Conference Call • Community Services Daily Bed State –submitted at 0830
Identified risks and mitigating actions:	• Surge in Operational Pressure – **Mitigating documents** • LPT Winter Arrangements 2017/18 • Leicestershire and Rutland 4x4 Policy (To Support Community Service Delivery) • Flexible Bed Management Policy • Seasonal Flu Campaign 2017/18 • IPC Policy • SAM Policy

System Capacity
Additional capacity planned in comparison to winter 16/17:
CHS - Flexible Bed Management agreement in operation for Community Hospital physical health beds AMHLD – A further 6 bedded female PICU ward opening in Oct 2017
Capability to Flex above planned capacity:
Yes – As per the agreed timelines set out in the LPT Flexible Bed Management agreement.

AMHLD have a set bed stock that is open 24/7 – This is managed by the AMHLD Bed Management Team and report on 3 x daily.

Going forward the LPT daily capacity will be reported on the operational escalation tool

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Limited evidence of impact on delayed transfers at this stage of roll out however evidence suggests a reduction in LoS and therefore increased capacity for admissions

Impact of planned bed or service reductions on winter planning:

Nil

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

- Isolation Beds opened to support operational delivery
- IPC Policy offers guidance and support in managing these situations.
- Seasonal Flu Vaccine available from October to support the campaign to protect frontline staff from seasonal flu
- SAM Policy sets out direction for managing staff during infectious outbreak. Bank staff would be rostered in to cover gaps or off framework agency would be used to provide staff.
- If a Business Critical Incident was declared, a priority of work would be agreed and staff would be moved to deliver the trust priorities.

Planning for Peaks in Demand

Outline of current demand management processes:

LPT Winter Arrangements 2017/18 are aligned to the Operational Escalation Level Framework, and provide direction on actions to be carried out as operational triggers are met.

AMHLD Bed management team to manage, out of area placements, demand and capacity reviewed 3 times daily by bed management.

What additional demand management schemes are in place in comparison of winter 16/17

What additional resource (service and staffing) has been planned to meet this demand?

Reviewed Winter Arrangements Plan 2017/18
Bed management team capacity can manage this with existing resources.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Therapy and ANP working 5 days. Mitigation in place which supports nurse led discharge on physical health wards to support discharges at the weekend.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

AMHLD - Crisis House.
Crisis team gatekeeping.
Home treatment via the crisis team.
Move on accommodation coming online in October to help with patient flow to enable capacity.

Predicted service impact:

No predicted impacts at this stage – LPT are able to deliver a safe level of service going into winter 2017/18

East Leicestershire and Rutland Urgent Care Centres

Assurance

Identified service lead for winter planning:	Rachel Taylor
Reporting and Escalation process:	• Senior team leader on call during weekend at peak times • Operations Manager on call 24/7 • Clinical Manager on call 24/7 • Chief Executive on call 24/7 • Daily Handover reports • Conference calls during peak times (internal and external with partners as per LLR requirements)
Identified risks and mitigating actions:	• Surge over and above predicted contracted activity – internal escalation process and mutual aid from within Vocare group. • Weather restrictions – severe weather, deployment of 4x4 staff transport as required. • Reliance on Agency and Locum staffing has significantly reduced following successful recruitment campaigns • Operational winter Plan in place

System Capacity

Additional capacity planned in comparison to winter 16/17:
Currently running with full staffing levels, standard appointment slots in place as per weekend and bank holiday plans.
Capability to Flex above planned capacity:
Bank holidays will be fully operational at all sites
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak

e.g. D&V/Norovirus/Flu
All frontline staff within Vocare will be offered vaccination. Planned vaccinations planned to commence October/November supply dependant. The plan is for all staff to take up the offer of vaccination, however our current target is 75%

Planning for Peaks in Demand

Outline of current demand management processes:
Swift export of additional staffing from other areas if support required. Continue to use agency staff to help support existing team
What additional demand management schemes are in place in comparison of winter 16/17
Annual Leave Embargo is in place for peak times. List of clinicians available who will support the service at short notice is in place. Additional nurse to be deployed on all BH to manage festive period surge in demand.
What additional resource (service and staffing) has been planned to meet this demand?
Recruitment underway for more bank staff to ensure that peak times (weekends and bank holidays) are well staffed.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
Limited to number of staff able to work at any one time due to space restrictions in the centres.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
NA
Predicted service impact:
NA

Loughborough Urgent Care Centre	
Assurance	
Identified service lead for winter planning:	Rob Haines
Reporting and Escalation process:	Standard Daily to Organisation Monthly to Commissioners Enhanced Organisation and escalated to Commissioners
Identified risks and mitigating actions:	Space may be a contributing factor for enhanced treatments and reviews.(limited space) Unexpected referrals out from the LUCC may have prolonged wait from other Emergency services (EMAS) if under pressure. Potential unstable patients not being transferred as LUCC seen as place of safety..

System Capacity

Additional capacity planned in comparison to winter 16/17:

The service has been recommissioned since winter 2016/2017. Additional activity has been purchased through the contract at LUCC to reflect the new service model. In addition, primary care hub 'spokes' at Hinckley and Bosworth provide bookable appointments via 111 and clinical navigation in evenings and weekends (Hinkley) and Saturday mornings (Coalville). These new services provide a net increase in appointment capacity of 13,500 appointments, 4,400 of which are in the new primary care spokes.

Capability to Flex above planned capacity:

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

NA

Impact of planned bed or service reductions on winter planning:

NA

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g D&V/Norovirus/Flu

Vaccinations will be available through local Occupational Health. There will also be the opportunity for staff to attend the drop in clinic provided by DHU on site. It is hoped all staff will take up the opportunity in receiving this treatment.

Planning for Peaks in Demand

Outline of current demand management processes:

Swift export of additional staffing from other areas if support required.
Continue to use agency staff to help support existing team

What additional demand management schemes are in place in comparison of winter 16/17

Practices in WLCCG can e-refer patients to LUCC for ambulatory assessment and diagnostics as an alternative to ED referral, this has an admission avoidance impact.

In addition, we are running a 'Test bed' with Charnwood practices to provide a direct referral to LUCC from GP practices in hours for 'acute' primary care patients. This provides additional resource to same day access and supports the UTC model at LUCC.

Annual Leave Embargo is in place for peak times.
List of clinicians available who will support the service at short notice is in place.
Additional nurse to be deployed on all BH to manage festive period surge in demand.

What additional resource (service and staffing) has been planned to meet this demand?

Recruitment underway for more bank staff to ensure that peak times (weekends and bank holidays) are well staffed.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Limited to number of staff able to work at any one time due to space restrictions in the centres.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

NA

Predicted service impact:

NA

TASL PTS (contract does not commence until October 2017)

Assurance

Identified service lead for winter planning:	Stewart Briggs – Operational
Reporting and Escalation process:	Lee Barham – Chief Operating Officer
Identified risks and mitigating actions:	• Seasonal Flu – Encourage Flu Vaccine take up by key staff • Severe weather – Implement Resource Escalation Action Plan – Prioritise patients' activity – Conference Calls with CCG & Health Care Partners – 4 x 4 vehicles mobilised • Disruption to base – key staff to use laptops – scheduling still possible via pda – request support from alternative bases – relocate operational support to nearby base if required – organise overtime, ready bank staff and review rotas • Staff unable to get to work – available staff to work additional hours to cover absence and service demand – request operational support vehicles/staff from other bases – liaise with CCG/Providers to prioritise transport priorities if service disruption to be severe • Regular communications with staff – Conference calls at appropriate frequency with Operational and Senior Staff to provide overview of situation, escalating in frequency if the situation deteriorates.

System Capacity

Additional capacity planned in comparison to winter 16/17:

Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
Staff are encouraged to obtain the seasonal flu vaccine and TASL has, where possible, all linked into local provider arrangements for staff to attend their OH sessions.

City Social Care	
Assurance	
Identified service lead for winter planning:	Mat Wise
Reporting and Escalation process:	Ruth Lake
Identified risks and mitigating actions:	Most obvious risk is that resources have been diverted from Hospital Discharge Teams to support the Integrated Discharge Team. Should this appear to be creating problems, the Service Lead will discuss with the IDT Systems Lead and escalate if appropriate.

System Capacity
Additional capacity planned in comparison to winter 16/17:
No plans to increase capacity vs. 16/17 as there were no issues with delays last winter. Locality Teams not who are responsible for a very small percentage of discharges will be advised to prioritise these to maintain flow.
Capability to Flex above planned capacity:
Currently in discussion with ASC Strategic Commissioners as to whether additional Assessment Beds can be purchased from current contracted residential homes over the winter period. In addition, hospital discharge is a relatively small part of ASC activity and there is scope, should it be needed, to utilise community facing staff to increase assessment capacity.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
Acute DtoCs attributable to City ASC are practically zero so we do not foresee a problem. We are trying to increase the number of discharges before formal assessment notices are received.
Impact of planned bed or service reductions on winter planning:
We have no plans for service reduction prior to winter 17/18. We will continue to provide services in accordance with statutory requirements as a minimum but will always look to work in a multi-agency, integrated way, in order to assist partner organisations where we can.
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
Corporate Business Continuity and Incident Response Plan 2017/18 in place and more specific Health Transfers Business Continuity Plan 2017/18 also signed off.

Planning for Peaks in Demand

Outline of current demand management processes:
As above, there are additional community facing staff that can be called upon in the event of increased demand for assessments. Reablement provider service can also exclusively support discharges if demand peaks.
What additional demand management schemes are in place in comparison of winter 16/17
None
What additional resource (service and staffing) has been planned to meet this demand?
Current talks to temporarily expand number of assessment beds over the winter period.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
None. We have presence 6 days a week with ICRS taking over on Sundays and any bank holidays not covered by the Hospital Discharge Teams.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
No change in avoidance admission vs winter 16/17. ICRS continue to respond to referrals from pre-admission wards to facilitate return to the community.
Predicted service impact:
N/A

County Social Care	
Assurance	
Identified service lead for winter planning:	Jackie L Wright
Reporting and Escalation process:	Surge and Escalation Plan
Identified risks and mitigating actions:	

System Capacity

Additional capacity planned in comparison to winter 16/17:

HTLAH Domiciliary providers:

- More stability within live HTLAH lots with greater security and sustainability for providers in the market
- Re-procurement of 3 vacant HTLAH lots nearing completion. Transition stabilisation measures will be put in place for new providers
- Work ongoing with Providers in closed Lots to enable these to be opened prior to the winter.
- Working with providers to increase capacity across all lots
- Domiciliary care 'await care' data is improving
- Monitoring and liaising with providers regarding time to pick up packages
- Evidence that reablement packages are reducing numbers of service users requiring maintenance packages

Residential/Nursing Care

- There is confidence that there will sufficient capacity to support

HART (Leicestershire County Council in House Reablement Service)

- Reduced demand on HART for maintenance packages, with improved stability of reablement throughput;
- Maintenance of existing staff resources, no reductions during 2017/18;
- Average weekly contracted hours for care staff is 20-25 hours, therefore there is some ability to increase these on a short term basis without impacting on working time directive;
- Effective use of Crisis Response Service (CRS), which currently operates 7.00am – 10.30pm;
- Development of 24/7 CRS – implementation due in November 2017.

Leicestershire County Council – Occupational Therapy Service

- Single Handed Care project – review of double-up care packages to ascertain if single handed equipment reduces the need for two carers, releasing capacity into the domiciliary sector.

Operational - Social Work Capacity /functions

- Increased number of staff at UHL in the IDT/ hospital social care team and A&E over 7 days (subject to funding)
- Continuation of NWB pathway to include residential and domiciliary services (subject to funding)
- Continuation of the Pathway 3 (Peaker Park) initiative (subject to funding)
- Daily communication with health and ASC staff with appropriate levels of skill and authority. The triggers for these are described in the LLR Surge and Resilience Plan

Integrated working at UHL

3 July saw the start of the Integrated Discharge Team – the overall aim is to reduce duplication of assessments; IDT members linked to busy medical wards; more effective throughput of patients; ensuring patients are identified for the correct discharge pathway thus reducing readmissions.

I**ntegrated working between ASC and CCHS/Integrated Locality Leadership**

Joint working is established and continued to develop in in four main areas:

-Joint approach to community hospital discharge and a monthly joint discharge MDT meeting

- Joint 'early intervention' monthly community MDT meeting for our shared complex community caseload

- Building a local published contact directory to make contact with each other easier

- Establishing a joint locality monthly management oversight meeting to drive and build upon the above activities, bringing teams closer together.-

Each locality has a timetable for bringing these mechanisms to life, being led by Service Managers and CCHS Operational Leads.

Integrated Locality Leadership Meetings are in place/developing to review our shared caseload and the opportunity to improve outcomes for patients/service users and staff. Implementation is led by the CCG's.

Capability to Flex above planned capacity:

- Continued work to support HTLAH providers with regard to expectations, and multi-agency working through a HTLAH joint management group
- Contingency HTLAH providers adding extra capacity where required
- Residential/Nursing care provision – option to contract with additional providers
- Business Contingency Plans specify minimum staffing levels at times of predicted surge in demand and also actions in the event of unplanned staff loss to protect critical business functions.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Impact of planned bed or service reductions on winter planning:

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Internal frontline staff

- Subject to Corporate Management sign off (which we do not expect to be a problem) the County Council will be expanding the arrangements regarding the seasonal flu vaccination of internal front line staff and other key personnel, such as those in our Customer Service Centre.
- Based on an evaluation on last year's scheme, we will be offering surgeries across the county, vouchers and re-imbursement options to identified staff groups.
- Staff get individual emails (or for those not on the email system information through their line manager) about booking into a surgery, ordering a voucher or information on how to get reimbursed for a vaccination purchased in a local pharmacy etc. It will also encourage those eligible for a free vaccination from their GP to do so.
- A communication plan will support the roll out and which will also include how to stay safe and well over the winter, infection control - pertinent to flu and other outbreaks (hand hygiene, respiratory etiquette) etc. This information is also available on our intranet.
- The authority is considering possible incentives – but no decision has been made regarding this matter.
- The scheme is cross authority and includes all departments and is endorsed by unions.
-

Examples of eligible staff groups

- Adult and Children's social work staff
- Quality & Contracts staff visiting providers
- HART (in-house home care)
- Visiting Finance and Benefits Officers
- Passenger Transport Driver Attendant Loaders and Escorts for adults and children
- Staff working in adults and children's day services
- Staff working with vulnerable adults in Adult Learning

External Providers (Residential and Domiciliary Care)

- We do not reimburse our providers for the seasonal flu vaccinations that their staff may have; but we do encourage them to do this and provide information in line with that produced internally regarding those who might be eligible for a free vaccination through their GP, potential to reduce sickness rates and minimising risk to their vulnerable service users and infection control. We also send a letter to them from the Director of Adult & Communities (Adult Social Care) Director Children and Families Services and Director of Public Health to support seasonal vaccinations.
- The Infection Prevention Team (IPT) and Quality Improvement team and Contracts Officers support this initiative each year. The Infection Prevention Champions in each home receive information and the IPT undertakes training.

Planning for Peaks in Demand

Outline of current demand management processes:

What additional demand management schemes are in place in comparison of winter 16/17

What additional resource (service and staffing) has been planned to meet this demand?

Service resource – HTLAH

- More stability once final three lots awarded
- Assisting providers with recruitment and retention plans

See also Additional Capacity Section

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

- 3 HTLAH lots vacant; however, re-procurement is underway and there are contingency arrangements in place for vacant lots
- Operational staff (Social Work) are not contracted to work over 7 days but we will mitigate for this by negotiation with staff and commissioning of additional staff/agency over the winter period (subject to funding)

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

Admission Avoidance

- Increased staffing levels in ED to avoid admission where needs are social care, not clinical.
- Crisis Response Service will aim to avoid admissions by providing urgent support to people in the community.
- CRS/HART will take referrals and broker support until 10.00 p.m. and over weekends and bank holidays.

Predicted service impact:

EMAS Winter Plan

Assurance

Identified service lead for winter planning:	Dave Whiting Chief Operating Officer - EMAS
Reporting and Escalation process:	Ben Holdaway Deputy Director of Operations - EMAS
Identified risks and mitigating actions:	• Severe Weather - 4x4 Activation Plan / EMAS Winter Operational Plan • Increase in Demand and Key Dates – REAP / CMP Action Plans / Local Surge & Escalation Action Cards / Review of available Resources for known key dates. • Hand over delays at LRI due to increase demand at front door & reduced patient flow through the Acute Trust. Halo / Conference Calls with CCG & Health Care Partners / Opel actions. • Seasonal Flu – Flu Vaccine program for EMAS Staff & Community Responders / EMAS Pandemic Influenza Plan

System Capacity

Additional capacity planned in comparison to Winter 16/17:

Additional A&E Resource for identified key dates being planned to help manage the predicted increase in demand.

Multi Treatment Centre Unit will be deployed in the city centre for Key dates building up to and over the Christmas & New Year Period to help reduce attendance at LRI A&E department.

POLAMB vehicles will be deployed on a Friday & Saturday Night in Leicester City & Loughborough to help manage the night time economy.

Capability to Flex above planned capacity:

- Reap Action Plan
- Capacity Management Plan
- Proactive Halo cover for LRI acute unit to manage Clinical coordination and to support Ambulance hand over and turn around activity, when capacity / flow issues are being experienced within the local A&E department.
- A senior EMAS manager will also be available to discuss options with LRI management team re EMAS hand over delays and look at working with the LRI management to formulate & implement solutions to help reduce extended hand

over delays.
- Review Predicted activity on key dates for possible increase in demand over & above expected activity

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

Impact of planned bed or service reductions on winter planning:

Increase in Ambulance Turn Around Times at A&E due to poor flow at front door will lead to Impact on ability to reach 999 calls / patients in the community leading to impact on Ambulance Service delivery and Performance.

Plan to maintain system capacity (Staffing & Service) in the occurrence of an Outbreak e.g. D&V/ Norovirus/Flu

EMAS Trust IPC Policy & Procedures
EMAS Trust Business Continuity Plan
EMAS Trust Influenza Plan

EMAS Vaccination Plan
EMAS brings together a team of 'flu fighters' from across the Trust to plan and implement the flu campaign, the team is drawn from each of the divisions, Emergency Operations Centre (EOC) and enabling services ensuring the planning approach is Trust wide, including input and flu vaccine delivery by our occupational health provider.

- Each year drop in clinics are held across all of our divisions within the region with specified dates and times. EMAS also use a mobile vehicle to reach staff that is not able to attend any of the available clinics.
- An e-learning package has been created to train/refresh paramedics and nurses in the flu vaccination procedures
- Influenza vaccination available to all EMAS staff

The clinics usually begin in October running through until the end January

We aim to reach the national target of 100%, but some staff refuse to have the vaccine for personal reasons. Last year we achieved a 60.5% across EMAS NHS Trust.

Planning for Peaks in Demand

Outline of Current demand Management Process:

Ambulance Response Programme (ARP)

- ARP has been introduced into EMAS from the 19th July 2017 to identify life

threatening conditions quicker and to ensure the most appropriate response is provided for each patient first time.

Resource Management Centre now operating at divisional HQ at Birstall in Leicester - responsible for planning of Divisional operational A&E work force.

Local review of predictive demand & forecasting activity, and management of resource to enable planning of resources to meet divisional activity & demand.

Christmas and New Year arrangements

- Suspend all annual leave from 18th December 2017 to 7th January 2018
- Focus on Christmas & New Years staffing with dynamic deployment of Relief / Flexible Working / Bank staff over this two week period.

What Additional demand management schemes are in place in comparison of Winter 16/17:

- Review use of VAS/PAS
- Manage Increase in supplies of essentials (Medicines / Blankets / Vehicles & Winter Vehicle Supplies)
- Review of Current Alternative Care Pathways available to EMAS with local CCG & Health Care Partners
- Monitor & proactively manage peaks in demand, use REAP and Capacity Management Plan to manage available resources to meet demand and maintain regular updates to local Stake Holders.
- Monitor illness trends/ patterns in local community that may effect specific patient cohorts, escalate to local Stake Holders re increase of trends / patterns of certain illness currently being seen / managed by EMAS within the local community.
- Encourage use of alternative care pathways (Hear & Treat & See & Treat) with staff following Pathfinder / NEWS guidance.
- Proactively Manage Booking On & Mobilisation Times, review extended on scene times.
- Proactively Manage Turn Around times at the Acute Hospital with Acute Trust Partners
- Proactively Manage Sickness with early referrals to Occupational health

What Additional Resource (Service & Staffing) has been planned to meet this demand:

Multi Treatment Centre Unit will be deployed in the city centre for key dates building up to and over the Christmas & New Year Period to help reduce attendance at LRI A&E.

POLAMB vehicles will be deployed on a Friday & Saturday Night in Leicester City & Loughborough to help manage the night time economy.

Additional A&E Resource on identified key dates to help manage the predicted increase in demand.

Increase in management cover within the division and 24/7 on call Strategic & Tactical management cover.

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

Alternative Care Pathways available to EMAS are available via the SPA these include:

Cellulitis Pathway
Acute Urinary Retention
Falls Pathway
Community Hospital Bed
Rapid Intervention Team (City only)
Intermediate Care Team (County & Rural)
Hypoglycaemic Pathway
OOH GP
Urgent Care centre LRI
Overnight Nursing Assessment Unit
Integrated Crisis Response Service
Loughborough Urgent Care Centre

Predicted Service Impact:

East Leicestershire and Rutland CCG	
Assurance	
Identified service lead for winter planning:	Paula Vaughan, Deputy Chief Operating Officer ELR CCG
Reporting and Escalation process:	In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system. The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required. The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service. Situation Reports (SITREP) and Winter Reporting In order to manage the day to day activity, daily SITREPs will commence in December. In the event of significant issues being reported, NHS England will also be notified at the same time as the SITREP is submitted.
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity

Additional capacity planned in comparison to winter 16/17:

This is based on a number of assumptions and will require ratifying.

2016/17 the CCG provided 643 additional appointments per week for an 8 week period, we anticipate being able to increase this by 50%, however, there is a dependency on mobilisation taking place earlier than in 2016/17.

Currently ELR CCG is working closely with our GP federation to develop a plan to integrate the evening and weekend services provided by the out of hours provider, GP extended hours and the service provided in the 4 urgent care centres to have a single GP led service that includes both walk in, pre-bookable appointments.

Capability to Flex above planned capacity:
We are currently exploring appetite with member practices and Federation for additional shifts during the Christmas and New Year period, however, the CCG is committed to ensuring services are funded that offer value for money.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NHS England and NHS improvement asses that providers should aim to operate at a bed occupancy level of 92% or below to support patient flow. Therefore it is vital that UHL ensure patients are being placed in the most appropriate setting or word. This will be reviewed and assessed by the CCG and the Integrated Care Co-ordinators via the daily 11am and 2pm.
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
All East CCG staff will be offered vaccination from Sept 2017 and appointments are currently being arranged, this is supported across all member practices. Both CCG and member practice Business Continuity Plans have been reviewed and where necessary, recommended changes to pathways have been implemented.

Planning for Peaks in Demand

Outline of current demand management processes:
The CCG monitors peaks in demand such illness patterns in the local community and weather changes that may affect specific patient cohorts. A dedicated demand management lead has been identified within the CCG, and they report to the CCG Executive Committee. The ELR Out of Hospital Care Board also reviews and considers performance in areas such as A&E attendances, availability if community beds/step down, DTOC etc.
What additional demand management schemes are in place in comparison of winter 16/17
The CCG has specifically commissioned a Demand Management Community Based Service which all its member practices are signed up to deliver via the GP SIP scheme. This scheme includes regularly reviewing
What additional resource (service and staffing) has been planned to meet this demand?
ELR federation are supporting its 31 member practices, full details are being finalised at the moment, but this includes resourcing of additional staff and premises at short notice to

meet surge in demand.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
Funding release

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
Effective care planning is integral to delivery. Revisions have been made to the Integrated Care Planning template to support GPs and Nurses in active sign posting, discussions around staying well over winter etc. Each of the CCG localities are committed and support the Integrated locality Team model and a number of Test Beds are currently underway.
Predicted service impact:
At the moment we predicate a reduction in attendances circa 10,000 over the winter period.

West Leicestershire CCG	
Assurance	
Identified service lead for winter planning:	Ian Potter
Reporting and Escalation process:	In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system. The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required. The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service. **Situation Reports (SITREP) and Winter Reporting** In order to manage the day to day activity, daily SITREPs and system escalation calls will commence in December. In the event of significant issues being reported, NHS England will also be notified.
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity
Additional capacity planned in comparison to winter 16/17:
Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
GP Practices are planning now (August) for the Flu Campaign (commencing September) to ensure that patients in the 65+ and At Risk cohort are able to receive a flu vaccination in a timely way ahead of the winter period. Public Health England monitor flu vaccination uptake rates and the CCG is a stakeholder on the regular Flu

planning meeting.

Planning for Peaks in Demand

Outline of current demand management processes:

Following the cessation of support from Arden GEM CSU, all 48 practices have had the opportunity to download risk stratification data allowing them to plan appropriately for patients most at risk of hospital admission, and those where risk factors increase in the winter months. This risk stratification will continue locally at practice level until the completion of a new risk stratification tool being developed in partnership with Midlands and Lancashire CSU.

Practices are already producing care plans for their at risk and frailty patients as part of core contractual requirements. These care plans are developed in collaboration with patient and their carers, including nursing and residential homes patients, and are refreshed at least annually and / or post a hospital attendance / admission and subsequent discharge.

Practices are expected to plan for any surge in demand as a result of exacerbations in patients with Long Term Conditions; this links with effective care planning and supporting patients to self-manage. This includes maintaining links with the home visiting service as part of the integrated urgent care offer and supporting patients to access services appropriately.

Practices are also expected to ensure that they have a robust business continuity plan in place, and that this is refreshed such that it is reflective of current circumstances and arrangements that can be quickly effected to mitigate potential service disruption as a result of adverse weather conditions e.g. flash flooding, snow drifts, or in the event of staff illness e.g. flu, norovirus. Wherever possible, these plans should demonstrate contingency arrangements and often depict a 'buddying' arrangement with other practices locally to ensure continuity for patients. Practices are encouraged to alert the CCG where there are specific issues in order that they can be supported to address these.

WLCCG write out to all 48 practices confirming the expected contracting arrangements for the Christmas and New Year period. This approach will be in alignment with Leicester City CCG and East Leicestershire & Rutland CCG, ensuring appropriate cover arrangements are in place for all patients and allowing ample time for practices to plan and confirm capacity arrangements to the CCG accordingly.

Offer of the Emergency Repeat prescription service from a community pharmacy without the need to access OOHs and reduce the risk of patients attending ED as a result of running out of their medication.

What additional demand management schemes are in place in comparison of winter 16/17

Practices will be reminded of the importance of updating any current Special Patient Notes and ensuring that these are shared appropriately with DHU to enable visibility of care plan details to out-of-hours clinicians.

Practices currently routinely closed on a Thursday afternoon will be requested to open on Thursday 21st December ahead of the four day closure from Friday evening at 6.30pm through to Wednesday morning at 8.00am. This will include a request to:

- Provide clinical sessions across the entire day and not just the morning
- Telephone lines to be manned throughout the day
- Practice buildings to be open for patients from 08.00 – 18.30 to manage any queries from patients

- The rationale for asking practices to open on the 21 December 2016 is to:
- Support the overall surge for Christmas and New Year period.

Provide additional access to patients during an already stretched time of year

What additional resource (service and staffing) has been planned to meet this demand?

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

UHL Admission Avoidance Pathways

Please refer to attached UHL Directory of Services which details all ambulatory admission avoidance pathways, which includes hot clinics and rapid access clinics. This includes how to access bed bureau and SPA. Admission avoidance pathways are also available to practices through PRISM.

Electronic Referrals

Please refer to attached list of specialities covered through the E-Referral Service. The E-Referral Service offers specialist advice and guidance to GPs, there is also an opportunity to discuss cases with consultants through Consultant Connect.

CDU Ambulatory Pathway

Direct referral to CDU for respiratory and cardiac problems.

Loughborough Urgent Care Centre Ambulatory Care Pathways

A number of ambulatory care pathways have been commissioned through the Loughborough Urgent Care Centre;
Asthma, Diabetes, Gastroenteritis, Heart Failure, Hyperkalaemia, Pneumo/Chest Infection and Sepsis.

Integrated Urgent Care Offer - NHS 111 Clinical Navigation Hub

Patients clinically triaged through NHS111 are referred to the most appropriate care setting through the clinical navigation hub.

Predicted service impact:

Leicester City CCG	
Assurance	
Identified service lead for winter planning:	Rachana Vyas
Reporting and Escalation process:	In line with NHS England requirements, the LLR CCGs will be involved in multi-agency conference calls and meetings facilitated by the NHS England, to discuss the operational position across the whole LLR health and social care system. The CCGs will direct any appropriate communications to primary care providers highlighting operational issues as required. The 3 CCGs have a leadership role to ensure that the health and social care systems across the LLR system are co-ordinated to respond to the increased needs and/or service demands throughout the winter period, particularly where there is increased activity exceeding the seasonal norm and where response and recovery is beyond the internal capabilities and escalation procedures of an individual NHS commissioned service. **Situation Reports (SITREP) and Winter Reporting** In order to manage the day to day activity, daily SITREPs and system escalation calls will commence in December. In the event of significant issues being reported, NHS England will also be notified.
Identified risks and mitigating actions:	All risks and actions will be taken via the A&E Delivery Board and A&E Improvement Group

System Capacity
Additional capacity planned in comparison to winter 16/17:
All urgent care centres are open 12 hours a day seven days a week and are fully integrated with local urgent care services. All appointments are bookable through 111 as well as GP referral.
Capability to Flex above planned capacity:
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
NA
Impact of planned bed or service reductions on winter planning:
NA
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Flu clinics have been arranged and all LC CCG staff will be offered flu vaccinations.

Planning for Peaks in Demand

Outline of current demand management processes:
LLR CCG's look to create capacity in both the clinical navigation hubs and home visiting services, this includes an increase in night nursing capacity and the number of slots available in community integrated urgent care services for 111 and CNH referrals.
What additional demand management schemes are in place in comparison of winter 16/17
3 x extended hour primary care centres will be in place offering a mixture of walk-in, 111 and health professional booked appointments. With support of GP/RN and ECP if required. City GP's have been sent a proforma to outline their Christmas and New Year opening plans. This has been undertaken to ensure that practices are meeting their contractual requirements and to deter patients away from utilising alternative healthcare services.
What additional resource (service and staffing) has been planned to meet this demand?
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
GP's encouraged to utilise clinical navigation hubs for variety of options (clinician to clinician conversations, hot clinics, ambulatory care pathways, home visiting service etc) to promote admission avoidance where clinically appropriate.
Predicted service impact:
NA

DHU – 24 /7 Home Visit Service	
Assurance	
Identified service lead for winter planning:	Rob Haines / Malcolm King
Reporting and Escalation process:	
Identified risks and mitigating actions:	Current volume and contract agreements

System Capacity

Additional capacity planned in comparison to winter 16/17:

Currently running the 24 hours HV service. Previously tap switched off. We will not do this. Increase in number of clinicians that have kit and can undertake home triage. Pick up at short notice.
Can increase by an additional crew car
Pharmacist support
Increase clinician numbers

Capability to Flex above planned capacity:

We have an on call service where clinicians sit in on-call shifts. These will be looked at and increased based on the discussions above.

We have communicated with clinicians that there needs to be flexibility and movement to where the demand is. Triage training is in place so that clinicians have the ability to move to triage if required.

Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:

N/A

Impact of planned bed or service reductions on winter planning:

N/A

Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu

Flu vaccinations being ordered for all staff. Current training and meticulous standards in relation to IPC.

We have a plan for extra capacity if required in relation to any outbreak

Planning for Peaks in Demand

Outline of current demand management processes:

- Review of daily and weekly volumes, linked to same period last year.
- Duty Manager presence at Fosse House, escalation to CCG and Directors on-call.
- Liaison with DHU 111 duty manager. Review in-bound call types and volumes.
- Consider mutual aid from City UCC: identify types and number of patients that may be redirected. Early liaison with UCC managers.
- Hourly monitoring/reporting and review

What additional demand management schemes are in place in comparison of winter 16/17

- Indemnity cover – increase employed workforce. People coming forward
- Senior Manager on site at Fosse House with other DHU managers mobilised (clinical bases presence)
- Senior Manager maintains liaison with DHU Director on call
- Continue to deploy additional resources available.
- Liaison with CCG in place
- Review 111 dispositions against capacity – defer patients with appropriate dispositions (e.g. “Contact practice within 24 hours” not seen within NQR of 6 hours).
- Collaborative working with City UCC and LUCC in place. Streaming of appropriate patients to agreed numbers, types and acuities. Hourly review with UCC leads.
- Public communications strategy (in conjunction with CCG) to advise and promote appropriate use of all available services.

What additional resource (service and staffing) has been planned to meet this demand?

- All off duty staff contacted, leave cancellation
- Maximise all LLR remote locations to increase capacity. Liaison with LPT Community Hospitals.
- Consider collaborative working with other DHU sites.
- Liaison with cross-border providers of OOH/UCCs/WICs. Consider diversion of patients via 111 or following clinical advice.
- Deployment of additional clinical and operational resources throughout the service to meet service demands (telephone advice, base/home visits) by locality from within DHU and engagement of locums.
- All non-essential meetings cancelled.
- Planned training reviewed and cancelled where possible.
- Consider redeployment of staff appropriate to skills (e.g. administration/management staff able to perform patient navigator/dispatcher, supervisor or HCA/driver roles, and management team with current clinical

qualification/practice skills).

What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?

- Discussions currently taking place with Commissioners
- Communicating processes regarding increased liaison with other services EMAS etc real time if trends r peaks are identified.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:

- Currently re triaging of ED disposition cases
- Looking at purchase of D Dimers for HV vehicles
- Re triage of 111 green 2 etc can be put in place if required
- Liaison with EMAS for real time trend activity if we see a spike in any area / conditions

Predicted service impact:

NHS 111	
Assurance	
Identified service lead for winter planning:	David Hurn, NHS 111 Head of Performance
Reporting and Escalation process:	
Identified risks and mitigating actions:	High absence rates. Dedicated 111 HR resource for absence management with Team Management restructure.

System Capacity
Additional capacity planned in comparison to winter 16/17:
DHU 111 have increased forecast by 3.1% for Oct17-Jan18, compared with actual demand for same 4 months last year. Forecast staffing requirement increased in line with projected demand.
Capability to Flex above planned capacity:
Reasonable capability to flex resource using internal contingency process on/off site.
Predicted SAFER & R2G impact on the reduction of DTOC and MFFD vs. winter 16/17:
N/A
Impact of planned bed or service reductions on winter planning:
N/A
Plan to maintain system capacity (staffing and service) in the occurrence of an outbreak e.g. D&V/Norovirus/Flu
Internal contingency to be invoked with relocation to be considered. Internal processes to be followed.

Planning for Peaks in Demand

Outline of current demand management processes:
Reviewed demand for same period last month, increased by 2.5%, staffing increased accordingly.
What additional demand management schemes are in place in comparison of winter 16/17
On-going recruitment to target service needs, G2 ambulance validation line, pharmacists cover.
What additional resource (service and staffing) has been planned to meet this demand?
Increased capacity with home working clinicians, review of rota patterns to meet peak requirements (Health Advisors, Clinical Advisors, Dental Nurses, Pharmacists, Shift Leads, Team Managers and Senior Management), and a review of internal processes to improve efficiency, targeted training to reduce call lengths and support needed. Continued work on 999 and ED referrals rates.
What gaps have been identified that may impact on the successful maintenance of patient flow 7 days a week?
High absence rates.

Admission Avoidance Schemes

Admission avoidance schemes in place vs. winter 16/17:
N/A
Predicted service impact:
N/A

8. Appendices:

Appendix A – Winter 2016/2017 Review

APPENDIX A 1617 winter Review.docx

Appendix B – Care Home Benchmarking Tool

APPENDIX B CH Benchmarking tool.xls

Appendix C – Care Home Support Action Plan

APPENDIX C Care Homes Support Actior

Appendix D –

APPENDIX D SAFER Patient Flow Bundle.d

Appendix E – High Impact Changes for Managing Transfers of Care

APPENDIX E - LLR 8 high impact changes f

Appendix F - DTOC Action Plan

APPENDIX F DTOC PLAN.xlsx

Appendix G – Winter Communications

APPENDIX G Winter communications and e