LLR Urgent and Emergency Care Resilience Planning for Winter 2018/19

Title of the report:	**LLR Urgent and Emergency Care Resilience Planning For Winter 2018/19**
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Purpose

1. This paper provides an overview of the ongoing work to prepare for the 2018/19 winter period across the Leicester City, Leicestershire and Rutland (LLR) Urgent and Emergency Care system. The paper includes a reflection of performance last winter, what was learnt, plus the actions being taken and the expected impact to ensure we have more resilient health and social care services this coming winter.

System Performance Winter 2017/18

2. The winter of 2017/18 saw the local urgent and emergency care (UEC) system under intense pressure, resulting in poor patient experience and weak performance against national targets. A&E performance is known to drop in December, January and February each year. However, last winter this deterioration started in November and continued through to March; it was particularly intense from February to April.

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

Major Causes of Pressure

4. Not surprisingly, in such a complex system, there were several factors that contributed to the pressures.

    - Pressure was felt across all parts of the system – in GP practices, GP Primary Care Hubs, Urgent Care Centres, 111 calls, Clinical Navigation Services, Ambulances Services, ED and within the hospitals. Although hospital activity levels overall and emergency admissions were not as high as in past years, there were changes to the *type* of patient, and how poorly they were, with very high numbers of cardio-respiratory cases in particular. In summary, the pressures were not caused only by the number of admitted patients, but by how poorly they were and how long they needed to stay in hospital. Many of these were older or frail patients. In Leicester City, older people make up approximately 20% of the population, yet at the height of the pressures, 80% of hospital beds were occupied by this group of patients.

    - There was a mismatch between the number of patients coming into the hospital and the ability to discharge them quickly and efficiently, causing delayed flow of patients through the hospital.

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

    - Bed occupancy was high throughout much of the winter period. This means a lack of free beds, which has a knock-on effect on internal patient flow from admissions areas, often resulting in long trolley waits. Many working days started with patients waiting for beds to become free (often termed “negative bed capacity”).

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

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

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

    - There was a higher number of elective (i.e. planned care) cancellations last winter in comparison with 2016/2017 following a national instruction to all

acute Trusts, as well as exceptional levels of cancellations of urgent and cancer operations.

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

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

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

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

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

- Processes vary across providers and there are benefits to more standardisation.

Lessons Learnt – National

5. As well as reflecting on the lessons that the local system learnt, our actions for the future are also informed by national learning on improved ED performance. One such example is the “Patient Flow Standards” which were issued nationally and against which the system compliance is tested by the regulators. These are shown at Appendix A.

Lessons Learnt – Local

6. A number of lessons were learned locally from our experiences last year. These include:

    - Effective communication across the system often began to break down as pressure was building, resulting in increased “silo” working as partners tried to sort out the problems in their own areas.

    - Joint forward planning / forecasting of the likely activity levels and responses to them was not undertaken.

    - Skills in forecasting were not shared across the system.

- More could have been done to protect beds for emergency activity by having a stronger plan on how to deliver elective and emergency activity across the year.

- Workforce and staffing challenges were seen across several of the organisations, due to scheduling issues and staff sickness such as flu.

- There was an inability to maintain flow across the system once pressure built.

- Patients were still presenting at ED with conditions that could have been treated in primary care or via self-care, despite there being slots available in Hubs and urgent care centres.

Actions and Steps to avoid similar issues in Future

7. The Leicester City, Leicestershire, and Rutland (LLR) Urgent and Emergency Care Resilience Plan 2018/19 is currently under development in collaboration with key stakeholders across the city and county, and is due to be published during September/October 2018 following simulation exercises. This plan sets out the features / signs of increasing levels of pressure for each organisation and what the response from themselves and other partners will be as a consequence. An effective plan is key to ensuring we all take the right steps to manage the pressure but also ensures that the system can recover quickly ("bounce back") once pressure begins to decrease. The plan will be tested through simulation exercises that involve all partners, so that we are clear how the actions interact and to test whether everything has been considered. This improved communication and collaboration will be a main contributing factor to improved performance.

8. The second part of the ED development at UHL is now open, which provides improved patient assessment areas. This allows more investigations to be carried out to reach an early diagnosis, give rapid treatment and ideally prevent the need for admission to a ward.

9. When agreeing the contracts for 2018/19, the CCGs and UHL have worked together as a first step to forecast in detail how much emergency capacity is required. We have then agreed how and when the elective (planned) activity will be delivered through the year, including how many operations may need to be delivered by other providers, so that we can protect and maximise the number of emergency beds.

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

11. New and improved protocols have been agreed between UHL and EMAS to manage better the handover of emergency patients when they arrive at hospital via ambulance. This helps to decrease the ambulance delays and the number of "lost hours".

12. Improved communication systems developed between consultants and GPs to give advice and guidance about patients' care and whether or not they need to be admitted.

13. We are working with Public Health and NHS England to deliver a proactive response to seasonal flu. There will be a publicity campaign raise awareness and encourage uptake of flu vaccines with the public, and a campaign to encourage uptake of the vaccine within eligible groups and frontline staff.

14. We are introducing a "Red Bag scheme" for care homes, which has been shown to work elsewhere. The bag will be used to keep all the patient's essential items together including medication, personal items etc. and which can be transported with the patient if they are admitted. The scheme also helps to smooth the discharge process.

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

16. There are improved discharge pathways which aim to get patients out of hospital and either back home or into a suitable care setting for assessment of their future needs. Evidence shows that this is really important for maximising recovery.

Focusing on Frail Patients

17. Over the past few years, BCF funding has supported the development of services that focus upon particular groups of patients for whom an increased level of support can prevent hospital admission. As time has gone on, we have learnt more about where this focus has the greatest impact. Moving on from this work, we are now collaborating system-wide to design a new pathway for frail patients, based upon local needs and national standards. There are 16 high impact actions that we are focusing on, prior to winter 18/19. The points below summarise the frailty work that is in progress:-

    - Patient (and Risk) Identification -
        - Better understanding of patients through data analysis has highlighted patients who would be deemed a medium to high risk of a fall or health need, and likely need hospitalisation if not managed in primary care.
        - Improving community support for complex/frail/multi-morbid patients - CCG's are adopting a population health management approach to identify the cohort of patients who will be most amenable to the range of interventions as part of the frailty programme

    - Care Plans -

    - Design and implement a system to enable each part of the system to access and enact a “care plan” through IT systems. The care plan sets out the key information about the patient, their condition, their care, their wishes and what to do if the condition worsens.
    - Establish a feedback loop whereby the quality of care plans can improve through better communication between doctors and patients
    - Working to establish a single, GP-led care plan

- Patient Discharge –
    - Revise discharge letters to identify specific actions which can prevent readmissions through better communication of patient needs in the community and primary care (and ambulance services).

- Frailty Checklist in Practice
    - Design and implement a standardised checklist of interventions (the “frailty checklist”) which each provider can access and use consistently.

- New Ambulatory Care Pathway –
    - Implement ‘diagnose to admit’ model (as opposed to “admit to diagnose”) and pilot and assess a care home module – New ambulatory care pathways could reduce the number of bed-based admissions into the Trust if a ‘diagnose to admit’ model was implemented.

- Frailty Evaluation/Scoring
    - Embed the use of the Rockwood Clinical Frailty Score in A&E and the emergency floor to identify patients who are likely to require support

- Coordinated discharge from hospital (with monitoring)
    - Ensure patients have the full range of health and social care response on discharge and also to reduce the risk of readmission. The current Integrated Discharge Team function started this process;

- Implement standardised daily interventions in all clinical areas for frail patients
    - Improving flow and decreasing the numbers of patients who stay too long within acute and non-acute beds will be vital for winter, and is a major national initiative. Although UHL is one of the better Trusts in the country in this area, standardising processes and the actions expected across LLR to enable flow is a key action pre-winter.

- Hospital Readmissions -
    - Implementation of a new system of reviewing readmissions that happen within 30 and 90 days of discharge, to understand what could be improved.

Assessment of Readiness for 2018/19

18. Planning winter preparedness across dozens of stakeholder organisations is challenging, technical and complex. The plan is being developed with input from the Clinical Commissioning Group, Leicester City Council, University Hospitals of Leicester (UHL), Primary Care, Community and Mental Health Care Providers,

Independent Sector Providers, patients and carers, Healthwatch, NHS England and NHS Improvement, as well as members of the local Leicester Resilience Forum, including the police, fire service, Public Health England, Health Protection, Health Education, utility companies, and several voluntary and charitable organisations. The plan will be approved by the LLR A&E Delivery Board which comprises of senior leaders across Leicestershire and Rutland.

19. Steady progress is being made to produce the plan by the end of September 2018, for submission to the regulators. Individual health and social care organisations have each been asked to review and submit their plans which will be shared and consolidated into one. They will also incorporate demand and capacity plans, business continuity plans, flu and infection control preparedness and adverse weather protocols. This will be checked and practiced via simulation exercises to ensure the system is clear on arrangements, contingencies, and to test for any gaps that exist ahead of winter.

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

APPENDIX A

Patient Flow Standards

These core principles will have specific measures to demonstrate progress and where rapid improvement can be targeted during periods of increased demand, and include:

- Patients arriving by ambulance enjoy a seamless handover to the Emergency Department (ED) without delay, supported by the transfer of patient information from the ambulance service to the hospital;

- Patients attending Emergency Departments with conditions more suited to assessment and treatment in Primary Care are streamed to co-located Primary Care services;

- All patients to receive timely assessment and clinically appropriate, high quality care in the Emergency Department;

- Patients presenting to EDs or on inpatient wards with mental health and related physical conditions receive compassionate care from all staff;

- Patients who can be discharged following a short period of observation, investigation or treatment are managed in appropriate short stay areas outside ED;

- Patients being considered for emergency admissions are rapidly assessed and where appropriate are streamed to Ambulatory Emergency Care;

- Patients with acute medical conditions are assessed and their treatment begun by a multi professional acute medical team. Patients are referred from the ED or Primary Care;

- Acute medical, surgical and speciality assessment;

- Frail patients are identified as they present to the ED or directly to assessment services and are discharged without delay when acute care is complete;

- Patients are discharged as soon as they no longer benefit from acute hospital care.

Source: National priorities for acute hospitals 2017 Good practice guide: Focus on improving Patient flow; NHS Improvement, 13 July 2017.