Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Lincolnshire East Clinical Commissioning Group

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**18 November 2015**
Subject:	**Urgent Care – Constitutional Standards Recovery and Winter Resilience**

Summary:

The purpose of this item is to provide the Health Scrutiny Committee for Lincolnshire with information on the Constitutional Standards recovery plan for urgent care and the winter plans.

Actions Required:

(1) To consider and comment on the Constitutional Standards recovery plan for urgent care.

(2) To note the winter plans.

(3) In the light of any impact on patients, to determine whether the Committee would wish to receive further reports on the delivery of the A&E four hour standards during the course of the year.

1. Background

The NHS constitution sets out that a minimum of 95% of patients attending an A&E department in England must be seen, treated and admitted or discharged in under four hours (the four hour A&E standard).

However patient experience is the most important driver for the need for improvements. Recent evidence describes that there is an increased risk of harm to patients if the four hour A&E standard is below 90%.

Also, a study by Richardson* found a 43% increase in mortality at 10 days after admission through a crowded A&E.

**Richardson DB (2006) Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust2006:184:213-6*

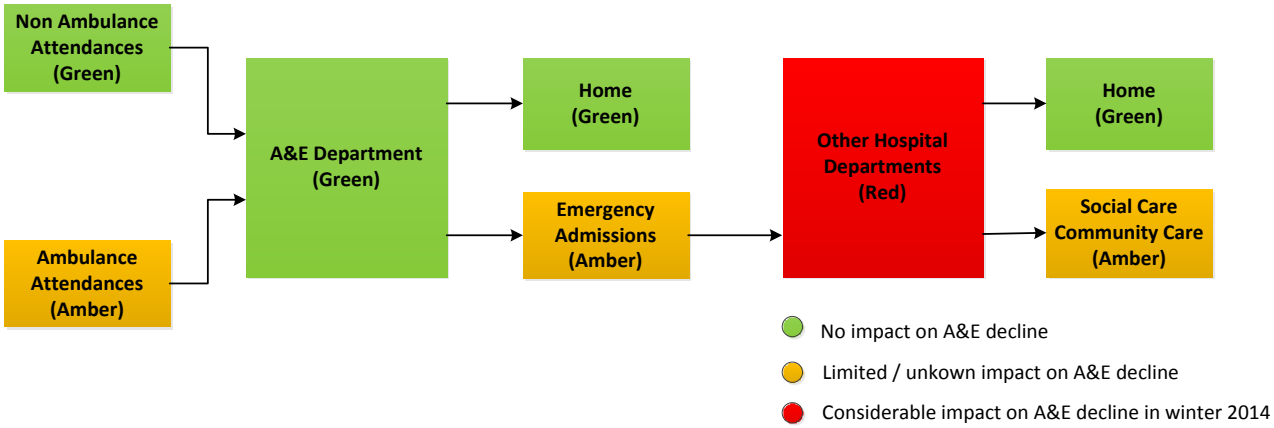
1.1 National Context

During Q3 2014/15 (winter 2014) the four hour A&E standard declined lower than at the end of the same period the previous year, to its lowest level for more than 10 years. This sharp decline was seen nationally. Since winter 2014 work has taken place to identify the factors driving the sudden decline in A&E performance in order to take action and stop it from happening again this winter.

Monitor published a report in September 2015 called *A&E delays: Why did patients wait longer last winter?* that analysed national data, the response to acute trust information request, interviews with experts and observations from acute trust visits.

Their analysis indicates that half of the decline in A&E performance against the four hour target in winter 2014 could be explained by national systemic challenges. The most important national cause was hospitals' inability to accommodate the increase in admissions from A&E departments generated by the increase in A&E attendances. This inability was a result of hospitals running at very high occupancy rates of 90% or above. Other factors such as blockages at other stages in the patient pathway had either a minor or an unquantifiable impact on A&E delays (See Figure 1). Their findings advocate that measures taken by hospitals and urgent care systems to improve patient flow through hospital departments other than A&E and back into the community may be highly effective in avoiding another sharp decline in A&E performance against the four-hour target this winter.

Figure 1: Drivers of the decline in A&E performance against the four-hour target in Q3 2014/15



Monitor found that the other half of the decline is likely to be explained by local drivers of A&E performance, which analysis at the national level were unable to capture, and potentially other drivers for which data is not yet available, in particular expenditure on social care.

1.2 Local Context

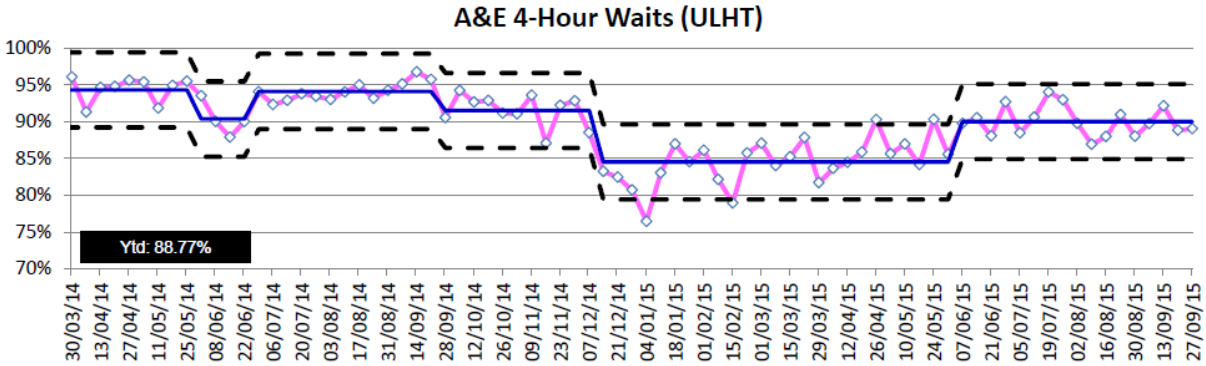
Whereas nationally there has been an improvement in the four hour A&E standard since winter 2014, Lincolnshire has not recovered to the same extent.

As a benchmark, the four hour standard is as follows in September 2015

- England 94.32%
- East Midlands 94.70%
- Lincolnshire 89.9%

The graph below shows current performance at United Lincolnshire NHS Hospitals Trust (ULHT). The impact of winter 2014 can be seen in declined performance from the beginning of December 2014 with some recovery of performance in June 2015.

Graph 1: ULHT A&E four hour standard



Key to graph – dashed line is confidence interval, solid line is trend, line with diamonds is actual performance

Lincolnshire recognises the findings in the Monitor report published in September 2015. Local analysis of data has identified two areas that have contributed to a decline in performance; bed occupancy and delayed transfers of care (DTOC). To give context, bed occupancy at ULHT is as follows.

Table 1: ULHT bed occupancy between June and September 2015

Beds	14-Jun	21-Jun	28-Jun	05-Jul	12-Jul	19-Jul	26-Jul	02-Aug	09-Aug	16-Aug	23-Aug	30-Aug	06-Sep	13-Sep	20-Sep	27-Sep
Grantham Hospital	84%	80%	94%	93%	89%	96%	89%	79%	70%	93%	92%	90%	88%	81%	85%	87%
Lincoln County Hospital	99%	95%	96%	95%	90%	85%	94%	92%	83%	91%	91%	89%	94%	90%	94%	93%
Louth County Hospital (Fotherby Ward)	25%	25%	25%	33%	33%	42%	17%	25%	42%	25%	25%	8%	0%	33%	17%	25%
Pilgrim Hospital	97%	97%	94%	97%	95%	95%	98%	99%	99%	97%	97%	95%	97%	97%	99%	97%
Trust Total	**93%**	**89%**	**96%**	**94%**	**92%**	**95%**	**94%**	**92%**	**96%**	**95%**	**93%**	**94%**	**93%**	**91%**	**94%**	**93%**

It should be noted that Pilgrim Hospital is running with a considerably higher bed occupancy than the other sites. And, it is well understood that medical beds have a higher bed occupancy than surgical beds. Week ending 1st November 2015 is a good example; ULHT bed occupancy for surgical beds was 85.25% and for medical beds was 95.71%. The majority of emergency admissions require a medical bed which exacerbates the delays for patients waiting in A&E to be admitted.

It should also be noted that in excess of 100 acute care beds were closed in ULHT during 2013/14 and in the first six months of 2014/15; discussed in a previous report to the Committee. These beds were closed for multiple reasons but predominantly so ULHT could achieve safe staffing levels and as system wide strategic decision to achieve a sustainable service.

DTOCs are a significant issue in the county with three main delays; completion of assessment, further non acute NHS care and care packages in own home.

Table 2: ULHT Delayed Transfers of Care

DTOC - ULHT	Aug-14		Sep-14		Oct-14		Nov-14		Dec-14		Jan-15		Feb-15		Mar-15		Apr-15		May-15		Jun-15		Jul-15	
Reason For Delay	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days	Patients	Days
A) Completion of assessment	11	370	13	457	21	492	17	470	17	564	15	346	13	331	26	457	19	489	21	563	15	448	22	494
B) Public Funding	4	93	0	48	4	50	0	69	0	19	4	70	1	52	0	20	1	32	0	17	0	16	0	18
C) Further non acute NHS care (including intermediate care, rehabilitation etc)	10	253	9	272	8	187	6	320	26	419	21	494	24	414	12	592	20	365	16	487	20	385	16	421
Di) Awaiting Residential Care Home Placement	1	55	0	28	1	7	0	33	3	24	1	44	1	34	1	43	0	0	0	0	0	15	0	9
Dii) Awaiting Nursing Home Placement	0	0	0	0	1	5	0	5	0	0	0	0	1	9	0	2	0	0	0	0	0	0	0	3
E) Care package in own home	2	60	4	56	4	68	5	148	4	99	1	80	7	155	8	239	3	172	8	97	5	131	5	125
F) Community Equipment/adaptions	3	62	1	13	0	20	4	35	1	21	0	23	1	41	2	75	0	60	1	47	4	40	0	36
G) Patient or family choice	9	245	7	272	10	214	8	196	5	204	5	204	6	128	7	222	6	230	3	92	4	132	5	125
H) Disputes	2	64	1	53	2	65	1	38	1	37	1	31	1	28	1	31	1	49	1	31	1	51	3	41
I) Housing - patients not covered by NHS and Community Care Act	0	41	0	7	0	1	0	23	1	3	2	23	1	25	0	6	1	44	1	18	1	17	0	19
Total	**42**	**1243**	**35**	**1206**	**51**	**1109**	**41**	**1337**	**58**	**1390**	**50**	**1315**	**56**	**1217**	**57**	**1687**	**51**	**1441**	**51**	**1352**	**50**	**1235**	**51**	**1291**

To give context, July 2015 had 1291 lost beds days in ULHT due to delayed transfers of care. This is equivalent to approx. 42 beds at 95% bed occupancy; a rate of 4.1%. NHS England wanted this rate to be reduced to 2.5% by the end of September 2015 which would release 17 beds. Whilst September's data is not available, the author suggests that this target will not have been achieved in September.

1.3 Lincolnshire's Constitutional Standards Recovery Plan

In June, the Trust Development Agency (TDA) and NHS England put the Lincolnshire health system into a recovery programme. A Constitutional Standards Recovery Plan was developed which has been monitored through a new governance structure called the Lincolnshire Recovery Programme Board, chaired by NHSE and the TDA, meeting monthly. The Constitutional Standards Recovery Plan covers not only urgent care but cancer and referral to treatment (RTT) standards as well.

In addition to the Constitutional Standards Recovery Plan led through the SRG, the Lincolnshire Recovery Programme Board also has three other groups that are addressing recovery in the following areas; system finances, quality plus leadership and organisation development (OD). This paper does not address workforce issues but it would be remiss not to mention the impact of low staffing levels on Lincolnshire's ability to deliver sustainable services. The Lincolnshire workforce has contracted since last year; there are fewer staff in post and leavers continue to outweigh starters. The critical areas for vacancies are ULHT nursing and therapies and in some medical specialities (emergency care consultants) and also therapy vacancies in LCHS. In addition, LCC are reporting closures in Nursing Homes due to a lack of registered nursing staff. These workforce issues are being addressed through the LHAC Workforce and OD Board on 9 November 2015 and have been raised with the Lincolnshire Recovery Programme Board, Leadership and OD group.

The urgent care element of the Constitutional Standards Recovery Plan is split into the following critical projects;

(1) pre hospital
(2) Emergency departments
(3) Length of Stay (The Patient Flow Bundle - SAFER)
(4) Out of Hospital Care (Complex discharges and community capacity)

The details of these projects are in Appendix A.

It should be noted that the procurement of domiciliary care and reablement has, and continues to have, a significant negative impact on delayed transfers of care.

October 2015 was the agreed recovery trajectory for the four hour A&E standard. This was not achieved; the October performance was 85.47% at ULHT. Additional actions / projects are currently being finalised and will be going to the next Lincolnshire Recovery Programme Board on 20 November 2015.

In the meantime, the Emergency Care Improvement Programme (ECIP) is in Lincolnshire for the next three months. ECIP is helping 28 urgent and emergency care systems across England that are under the most pressure. It is a national clinically led programme that offers intensive practical help and support to urgent and emergency care systems that are failing to recover.

1.4 Lincolnshire's Winter Plan

Lincolnshire health and care agencies have developed a winter plan which is going to the System Resilience Group (SRG) on 10 November for ratification. This plan builds on the Recovery Plan. In addition, it is covers the following key areas;

(1) **Anticipat**e that includes Adverse Weather conditions, seasonally related illness

(2) **Assess** that identifies risks this winter

(3) **Prevent** that includes Public communication campaigns, Flu Prevention, Business Continuity and maximising the role of Neighbourhood Teams with the Voluntary and Community Sector

(4) **Prepare** which maximises capacity in services and how to maximise availability of staff through reducing sickness. This section also identifies responses in case of Industrial Action and different ways of working, e.g. integrating therapies.

(5) **Respond** - Lincolnshire's Escalation and Surge Plan has been refreshed this autumn. It details the arrangements and procedures that SRG partners in Lincolnshire will utilise in the event of surge and capacity issues, irrespective of cause, affecting one or more partner in order to sustain the provision of high quality responsive care. Within this plan, escalation trigger levels, actions and responsibilities are clearly defined and shared amongst key stakeholders.

(6) **Recover** – the Escalation and Surge Plan also sets out de-escalation levels that will support system recovery. A formal post-winter debrief session is planned in April 2016.

1.5 Fines and Penalties

Through the contractual mechanism, health commissioners have two types of fines that can be applied to non achieving organisations;

- financial penalty for not achieving an operational standard and a national quality requirement. These penalties are calculated on a monthly basis. Members of the SRG have previously agreed that all urgent care related contractual fines and penalties be aggregated and made available for application by the SRG as appropriate in-year.
- a Contract Performance Notice (CPN) that withholds 2% of income until the standard has been achieved.

If a CPN is issued, commissioners meet with the receiving provider and a Recovery Action Plan (RAP) is agreed. When this is achieved, the 2% funds that have been withheld are returned. In effect, the 2% will have already been committed by the provider as part of the totality of their annual budget so will be spent based on this pre-commitment.
If the RAP is not delivered the commissioners have choices on how to reinvest the 2%.

2. Conclusion

Urgent care is a complex adaptive system that is dynamic in terms of its interactions and relationships between professionals, services and organisations.

Put simply, increased demand is not driving the Lincolnshire urgent care system so it has to be these interactions. These interactions are non-linear meaning small changes in inputs, physical interactions or stimuli can cause large effects or very significant changes in outputs / performance.

In Lincolnshire, there is now a shared understanding that these interactions are detrimental to flow through the acute hospitals, exacerbated by a reduced number of beds and high occupancy, and high numbers of delayed transfers of care, exacerbated by reduced capacity in domiciliary care and reablement services. The Recovery Plan is focused on improving these interactions and the Winter Plan is focused on the wider system actions that will impact on system resilience.

3. Consultation

This is not a direct consultation item.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	High level details of the urgent care projects within the Constitutional Standards Recovery Plan

5. Background Papers

The following background papers was used in the preparation of this report:

Report to the Health Scrutiny Committee for Lincolnshire, 17 December 2014 – Winter Pressures 2014-15.

This report was written by Sarah Furley, who can be contacted on 01522 513355 ext. 5424 or sarah.furley@lincolnshireeastccg.nhs.uk

Appendix A

The Urgent Care Element of the Constitutional Standards Recovery Plan

The following are critical projects;

(1) pre hospital – implement a Clinical Assessment Service (CAS). The Lincolnshire CAS went "live" on 1st November 2015 and aims to reduce variation in assessment and outcome for patients making sure that they receive the right care first time. It will make it simpler for patients and the general public to understand how to access urgent care services when they need medical help fast, but the situation is not life-threatening. It will reduce ambulance conveyances, A&E attendances and emergency admissions.

(2) Emergency departments – this project has multiple parts and includes;

a. improving flow through the A&E departments including leadership, room utilisation, how the Rapid Assessment and intervention Team operates, how the Ambulatory Emergency Care Team operates
b. improving the use of data to inform decision making including live data capture as well as analysis
c. escalation processes

(3) Length of Stay (The Patient Flow Bundle - SAFER)
This project is multi-faceted and predominantly focuses on simple discharges;

a. S - Senior Review. All patients will have a Consultant Review before midday.
b. A - All patients will have an Expected Discharge Date (that patients are made aware of) based on the medically suitable for discharge status agreed by clinical teams.
c. F - Flow of patients will commence at the earlier opportunity (by 10am) from assessment units to inpatient wards. Wards (that routinely have patients transferred from assessment units) are expected to 'pull' the first (and correct) patient to their ward before 10am.
d. E – Early discharge, 33% of our patients will be discharged from base inpatient wards before midday. TTO's (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so.
e. R – Review, a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge. This will be led by clinical leaders supported by operational managers who will help remove constraints that lead to unnecessary patient delays.

(4) Out of Hospital Care (Complex discharges and community capacity)
This project includes the implementation of Transitional Care (intermediate care), the impact of the LCC procurement for domiciliary care and reablement services. These services are completely interdependent and will improve patient experience and reduce hospital length of stay and DTOCs.