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:	**21 September 2016**
Subject:	**Urgent Care update**

Summary:

The purpose of this item is to update the Health Scrutiny Committee on urgent care in Lincolnshire.

Actions Required:

To consider and comment as necessary on the current position with regard to urgent care.

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).

The target was originally introduced in 2004 and set at 98% when nationally the number of A&E attendances rose by almost 18% to 16.5 million. The increase in numbers reflects a decision at the time to incorporate data relating to Walk in Centres and Minor Injuries Units; the introduction of which was intended to improve patient access to primary care, modernise the NHS and be more responsive to patients' lifestyles.

More recently all types of department have seen the number of attendances increase however for many hospitals the number of people who show up at A&E is not primarily the problem affecting performance and the four hour standard is only a

rudimentary measure of how well the urgent care system performs in delivering care to patients.

1.1 National context

In 2015/16 attendances were slightly down nationally whilst overall performance worsened, although attendances tend to be higher in summer than winter; performance is worse in winter. *(NHS Digital 2016).*

Impacting on winter performance is the increase in older patients attending A&E who then need to be admitted in an emergency. Older people and those waiting for admission tend to wait longer in A&E than other patients, increasing the chance of the four hour target being breached. These are usually people with complex needs and multiple illnesses who need specialist assessment or to be admitted into hospital.

The real challenge in A&E is the flow of patients into and out of the hospital. More than two thirds of all hospital beds are occupied by people admitted in an emergency. When wards are full people who need to be admitted to hospital end up waiting in A&E; once people are admitted, they can sometimes get stuck in hospital when they are fit to leave. This is sometimes because the social care they need cannot be put in place quickly enough or there is often a shortage of care home beds and limited home care services in some areas however, two-thirds of patients waiting to go home are stuck because of delays within the hospital and between NHS services. For example patients may need tests or scans which might not be available late at night or at weekends.

If patients do not get the NHS and social care support they need in the community, they may have an avoidable health crisis and a cycle of emergency readmissions occurs.

1.2 Local context

A&E attendances and performance

In Lincolnshire, performance against the four hour A&E standard has been falling since the winter of 2014/15. At the end of 2015/16 the overall performance delivered 86.0% compared with 90.2% in 2014/15.

As part of the 2016/17 planning and contracting round, local systems were expected by regulators (NHS England and NHS Improvement) to agree sensible trajectories to move from the then current level of performance to the agreed Q4 performance at year end (March 2017). This regulatory decision reflected the number of systems failing to meet the 95% target across the country.

The trajectories were built into contracts and trusts were advised to document the capacity and growth assumptions upon which the trajectory was based.

In Lincolnshire the agreed Q4 position for 2016/17 is 89.0%. To put this in context, of the nine systems within the Central Midlands locality, three have a trajectory which delivers 95%. Regulators are satisfied 89% represents a sustainable position within the local system despite being 6% below the constitutional standard. Underpinning

the recovery trajectory is a Recovery Plan based on the recommendations made by ECIP [Emergency Care Improvement Programme] in March 2016.

The agreed trajectory is outlined below and demonstrates the target was achieved overall in Q1.

	Q1 80% Actual 81.8%			Q2 84%			Q3 85%			Q4 89%		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Planned	76.6%	82%	82%	84%	84%	84%	85%	85%	85%	89%	89%	89%
Actual	80.5%	83.5%	81.2%									

National performance for July and August is yet to be published however local (un-validated) data suggests a decline in performance during July.

The table below provides a comparison against both the regional and national performance.

Four Hour Standard 95%	April	May	June
England	90.0%	90.2%	90.5%
Midlands and East Region	88.7%	88.9%	88.8%
Peterborough and Stamford Hospitals NHS Foundation Trust	76.1%	79.2%	83.5%

In order to give context for this performance, the following table gives the number of people who used A&E services during the month of June 2016 and the numbers of people who were admitted.

In first three months of the 2016/17, compared to first three months of 2015/15 Q1 attendances have grown by 4.9% (1,800) which is 20 patients a day.

June 2016	Total A&E Attendances	Admissions via A&E	Other Emergency Admissions
England	1,950,754	350,960	129,250
United Lincolnshire Hospitals NHS Trust	13,704	3,539	1,246
Peterborough and Stamford Hospitals NHS Foundation Trust	8,931	2,215	778

Emergency admissions

Admissions via A&E at ULHT have increased by 959 compared to the same period in 2015/16.

Bed Occupancy

Bed occupancy rates for hospitals are context-dependent and vary between organisations, but the National Audit Office has suggested that hospitals with bed occupancy levels above 85% have regular bed shortages, periodic bed crisis and the risk of health care acquired infections increases.

In recent years there has been a national increase in the intensity with which beds are being used (measured by bed occupancy). Occupancy rates for acute beds have increased from 87.7% in 2010/11 to 89.5% in 2015/16. Year to date United Lincolnshire Hospital NHS Trust bed occupancy rate is 91.7% compared with 92.5%. During 2015/16, however, the number of weekly acute beds open is falling from 1,005 in 2015/16 to a current average of 994 which demonstrates an improving position overall.

Delayed Transfers of Care (DTOC)

Delayed transfers of care, occur when a patient is ready to depart from care and is still occupying a bed. According to NHS England, a patient is ready to depart when:

a. A clinical decision has been made that patient is ready for transfer
   AND
b. A multi-disciplinary team decision has been made that patient is ready for transfer
   AND
c. The patient is safe to discharge/transfer.

Longer stays in hospital can have a negative impact on older patients' health, as they quickly lose mobility and the ability to do everyday tasks. Keeping older people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the NHS and local government. NHS guidance is that patients are moved out of acute hospital as soon as it is clinically safe to do so. It is important to achieve the correct balance between minimising delays and not discharging a patient from hospital before they are clinically ready.

Caring for older people who no longer need to be in hospital in more appropriate settings at home or in their community instead could result in additional annual costs of around £180 million for other parts of the health and social care system.

According to the National Audit Office, this would reduce the potential savings of £820 million arising from discharging patients earlier from hospitals. Over the past two years the official data shows there has been an increase of 270,000 (31%) in days in acute hospitals when beds have been occupied by patients who have had their discharge delayed unnecessarily, to the current figure of 1.15 million days.

Within Lincolnshire DTOC rates have fallen over the first quarter of 2016/17 with performance in June delivering 3.6% of bed days lost. The system is on track to achieve the target of 3.2% by the required date of October 2016.

	Number of Available Bed Days Lost Due to Delays				% of Delays, i.e. Number of Available Bed Days Lost Due to Delays			
July 2016	NHS	Social Care	Both NHS & Social Care	**Total Bed Days Lost**	NHS	Social Care	Both NHS & Social Care	**Total % of Delays**
Midlands and East Region	36,787	18,782	4,160	59,819	61.5%	31.5%	7.0%	5.6%
United Lincolnshire Hospitals NHS Trust	919	101	149	1,243	80.0%	8.8%	11.2%	3.6%
Peterborough and Stamford Hospitals NHS Foundation Trust	1,311	33	0	1,344	97.5%	2.5%	0	7.9%

Lincolnshire Community Health Services (LCHS) NHS Trust has experienced significant DToCs reported through the first quarter of 2016/17. Historical DToC reports have been consistently below 4%. The main outliers influencing the increase are improved reporting by Rehabilitation Services of patients, requiring onward placements appropriate to their needs, and increased demand upon Older Adult Division, where the primary reasons for delay are "awaiting residential or nursing home placement or availability". The average demand for residential care is 65% of total DToC.

Across the Older Adult inpatient areas eleven patients are DToC over 90+ days and four at 60+ days, prime pathology specific to dementia.

The notable increase in Adult Acute Inpatient area DToC is for ward 12a at Pilgrim Hospital, with three patients for May and June attributing to 14% of the total increase. Within Connolly Ward, at Lincoln County, the male acute ward, there has been a consistent DToC across the period with two patients at 90+ days and three patients at 60+ days with prime delay due to housing.

NHS 111 performance

Over the past 12 months 154,998 calls were made to Lincolnshire 111. During the first quarter of 2016/17 37,895 calls were received. The majority (63%) of calls result in patients being signposted to attend a primary or community care facility and 10% of calls result in no recommendation for service provision.

The national standard for NHS 111 is that 95% of all calls will be answered within 60 seconds. The table below gives the performance of NHS 111 so a comparison can be made.

NHS 111	April 2016	May 2016	June 2016
England	87.1%	88.2%	90.6%
Midlands and East Region	90.3%	90.0%	91.4%
Lincolnshire NHS 111	88.7%	94.0%	95.2%
Cambridgeshire and Peterborough NHS 111	96.5%	96.4%	97.9%

1.3 Lincolnshire's Constitutional Standards Recovery Plan

Since last reporting to the Committee, the urgent care recovery plan has now been focused on two distinct areas: a 30 day rolling programme of actions for Pilgrim Hospital; and five priority areas agreed with the Emergency Care Improvement Programme (ECIP). In February, a concordat was agreed by leaders from each part of the Lincolnshire system and the regional tripartite to demonstrate the overall commitment to the five priorities which are:

1. Emergency Care Flow
   - Development of "front door" services and early Comprehensive Geriatric Assessment
   - Early senior assessment in the Emergency Department
   - Review of pathways/criteria specifically short stay
   - Development of default to ambulatory care
   - Development of surgical ambulatory processes
   - Access to rapid access clinics

2. Safer Care Bundle & 'No Waits' process implemented on 5 wards per month (including community)
   - Senior Review
   - All patients have a Predicted Date of Discharge
   - Flow
   - Early discharge before 10am

3. Therapy Review/ Improvement
   - Assessment of current provision/ skills/ competencies
   - Review safe thresholds for transfer to non-acute environments/ home
   - Further development Early Supported Discharge

4. Amalgamation of existing discharge portals into a home first/ Discharge to Assess model (Transitional Care)
   - Ensure pathways developed and widely communicated with thresholds that accept patients
   - Ensure enablement resources are packaged around the patient
   - Patients must be managed actively through pathways

- Goals set and managed
- Ensure mental health support available

5. Perfect Week Programme
    - Ensure whole system engagement and response
    - Ensure metrics are clear from beginning
    - Staff engagement a priority encouraged by social movement approach
    - Executive Leadership and visibility required

Delivery of the trajectory and Recovery and Improvement Action Plan is managed via several multi-agency stakeholder groups, which include:

- Within ULHT, there is an Urgent Care Delivery Group meeting weekly, reporting into a fortnightly Operations Group chaired by Mark Brassington (Chief Operating Officer).
- Within LCHS, there is an Operational Delivery Group delivering internal transformation change chaired by Craig McLean (Deputy Director of Operations).

These meetings manage the specific Acute and Community Trust trajectory projects.

- The Lincolnshire Urgent Care Working Group was established in May is chaired by Ruth Cumbers (Urgent Care Programme Director). This group meets fortnightly to agree four to six week actions that support the recovery of the four hour emergency department standard and tracks recovery of the overarching Recovery and Improvement Plan. The Chairman reports directly into the A&E Delivery Board chaired by Jan Sobieraj (ULHT Chief Executive) which is attended by Executive Directors from across the system responsible for urgent care including local authority counterparts.

The introduction of A&E Delivery Boards was made by NHS England, NHS Improvement and ADASS (Association of Directors of Adult Social Services) in August 2016. The Boards replace local System Resilience Groups and are designed to focus primarily on A&E.

Alongside local system improvement, the Board is mandated to oversee five improvement initiatives. These initiatives are based on actions which the best health systems have already implemented and include a focus on outcomes and processes:

1. **Streaming at the front door to ambulatory and primary care**. This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.

2. **NHS 111 – increasing clinical call handler capacity in advance of winter.** This will decrease call transfers to ambulance services and reduce A&E attendances.

3. **Ambulances – Dispatch on Disposition and code review pilots.** This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance

and an increase In ‘Hear and Treat’ and ‘See and Treat' to divert patients away from the Emergency Department.

4. **Improved flow – "must do’s" that each Trust should implement to enhance patient flow.** This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the Safer bundle will facilitate clinicians working collaboratively in the best interests of patients.

5. **Discharge – mandating ‘discharge to assess’ and ‘trusted assessor’ type models.** All systems moving to a ‘Discharge to Assess’ model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system.

* Call staff are allowed up to an additional 120 seconds to clinically assess all calls bar the most serious (Red 1) before a resource is dispatched.

Grantham Hospital A&E

During July 2016 Lincoln and Pilgrim emergency departments expressed increasing concern as to their ability to fill their middle grade medical rotas. Due to the increasing reliance locally and demand nationally for locum doctors the fill rate of our A&E shifts was reducing leaving the departments at Lincoln and Pilgrim significantly understaffed.

Between the 31st July and the 6th August a further three middle grades at Lincoln and 0.6 at Pilgrim had left. As a result of only having 2.6 whole time equivalent (wte) middle grade doctors in Lincoln against an establishment of 11 and 4 wte middle grade doctors at Pilgrim against an establishment of 11, despite extreme mitigation and planning, the rota could not be safely staffed on a prospective basis.

The Trust Board was appraised of the situation on 2 August and the potential options. The Trust Board was in agreement that the level of additional risk to patients as indicated by; deterioration in ambulance handover times (particularly at Lincoln County Hospital), delays in first assessment (although the sickest patients are always prioritised) and a significant reduction in the number of patients assessed, treated, admitted or discharged within four hours (causing overcrowding within the emergency departments) is too great to continue without action. Approval was given to work through the possibility of a temporary service closure at Grantham in order to support staffing at Lincoln and Pilgrim A&E departments.

A significant volume of discussion and work was conducted following the Trust Board to consider the implications and impact on patients, staff and partner organisations. Throughout the intervening period the Trust Board as well as key stakeholders have been kept informed where possible.Support to proceed with the temporary change to the opening hours at Grantham was provided on the morning of the 9 August with the change taking effect on Wednesday 17 August.

The impact of these changes cannot be underestimated upon patients, stakeholders and staff. The decision to reduce the opening hours at Grantham was not taken lightly but on the grounds of patient safety due to a lack of a viable alternative option.

A monitoring process has been agreed and is in place. The early monitoring undertaken by the Trust suggests:

- Daily average attendances at Grantham are c.60. This demonstrates a reduction of 20 attendances a day on the average attendances (80) seen between 1st August and 16th August. This is less than the 25 reduction predicted. The daily peak in attendances is now being seen earlier in the afternoon suggesting a change in presenting behaviour. There has been no increase in attendances at Lincoln or Pilgrim.

- Daily average admissions at Grantham are 12 compared to a previous average admission rate of 14. This suggests a daily reduction of 2 admissions a day. This is less than the 6 predicted. There has been no increase in admissions at Lincoln or Pilgrim.

- No material change in Out of Hours presentations.

Early indications suggest that the expected impact is lower than originally thought. However this will remain under close scrutiny as the above data is only for a 13 day period and therefore needs to be viewed with caution.

During these early stages releasing staff and orientating them to the department 120 hours of middle grade support from Grantham staff have provided cover at Lincoln A&E. This equates to 16.5% (1:6) of the Lincoln middle grade rota. This is expected to increase over the coming weeks as the rotas settle.

2. Conclusion

This paper has aimed to describe the current state of the Lincolnshire urgent care system. It focuses solely on the acute hospital four hour A&E standard of 95% and thus “masks” good performance in other services and does not acknowledge the interdependencies which impact on the acute trust's ability to deliver the four hour A&E standard of 95%, e.g. DTOC.

Urgent care is a complex system that “flexes” to accommodate surges in demand as it should but this also means that it requires dynamic solutions to meet ever changing problems.

All the performance measures detailed above and national performance (as a benchmark) have been considered when identifying a recovery trajectory for the Lincolnshire acute hospital four hour A&E standard of 95%. The trajectory was achieved in quarter 1 and a significant improvement in DTOC demonstrates a whole system response to performance management is impacting positively on patient care.

It remains the aspiration of Lincolnshire clinicians and leaders to improve beyond this trajectory.

3. Consultation

This is not a direct consultation item.

4. Background Papers

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

Report to the Health Scrutiny Committee for Lincolnshire, March 2016 -
Urgent Care – Constitutional Standards Recovery and Winter Resilience

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