| Lincolnshire COUNTY COUNCIL Working for a better future | | THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE | |
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Open Report on behalf of Lincolnshire East Clinical Commissioning Group

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| Report to: | **Health Scrutiny Committee for Lincolnshire** |
| Date: | **16 May 2018** |
| Subject: | **Winter Resilience Review 2017/18** |

**Summary:**

The purpose of this item is to update the Health Scrutiny Committee on system resilience during Winter 2017/18.

**Actions Required:**

Members of the Health Overview and Scrutiny Committee are asked to consider the approach taken to prepare for Winter pressures as set out in the report and to offer their comments.

## 1. Background

The NHS frontline is always under considerable pressure over the winter period as demand for services tends to increase significantly with the onset of cold weather and flu. In response, our urgent and emergency care system places a particular focus on winter to ensure there is enough bed and staff capacity to meet patients' needs. Patients are usually more unwell over winter, for example, because of flu and respiratory conditions, and because of slips and falls in the cold weather. This adds to the complexity of the task, as does establishing additional capacity when the service is already running at full stretch.

Throughout the year and in particular during winter, contingency plans were in place to manage these risks and protect patient safety. At a national level and locally, the NHS was better prepared this year than in previous years, nevertheless, it is unavoidable that resilience in one organisation very much depends on the resilience of the rest of the local health and social care system.

## 1.1 National Context

Nationally this winter, pressures increased week by week, with a noticeable surge in demand for NHS care at the start of January 2018. NHS trusts reported particular challenges with regard to bed occupancy levels, A&E performance, demand for ambulance services and handover, pressures on bed and out of hospital capacity, together with increasing levels of flu, respiratory conditions and norovirus. The challenges were system-wide, with mental health and community trusts also experiencing severe pressures. This is in spite of careful planning undertaken by the NHS to prepare for winter, with higher than expected demand combined with an underlying lack of bed and staff capacity, as well as on-going pressures in primary and social care.

## 1.2 Local Context

The Lincolnshire Urgent and Emergency Care (UEC) system took a proportionate and realistic approach in response to the level of winter pressures both predicted and real.

It was clear before winter that the health and care system was already under pressure, with performance against the 4-hour A&E standard having been 75.54% in quarter 3 of 2017 (lower than the expected 90% target for November), and delayed transfers of care (DTOC) performance for December rose to 5.4% well above the government target of 3.5%. At the start of winter reporting, it was an immediate concern that general and acute bed occupancy was already at 98.58% (31 October). The level peaked at 104.67% on 13 December. To put this in context, half of acute trusts nationally were reporting occupancy of over 95%, despite an additional 800 beds being opened. The data on ambulance arrivals and delays indicates a particular surge in pressures. The acute trust received 21,084 ambulance arrivals between November and March, the equivalent being an ambulance arriving every 10.31 minutes, 24 hours a day. The A&E departments have been overwhelmed by this level of demand and the number of ambulance handover delays (the wait between an ambulance arriving and the patient being transferred to the A&E department), high admissions, increased length of stay, high bed occupancy and additional delays increased during the winter.

## 1.3 What is Behind the Pressures

The first week of January 2018 saw extensive reports of growing NHS pressures. We understand locally the severity of the pressure was due to a combination of long and short term factors. Over the long term, there is the known trend of increasing demand and acuity (i.e. sicker and frailer patients), as well as limited capacity (across the ambulance, mental health, community and acute sectors, all of which contribute to urgent and emergency care performance), workforce shortages (particularly in the emergency department), and on-going capacity challenges in primary and social care.

In Lincolnshire we have seen a trend similar to the national picture of higher levels of respiratory illness than expected; higher levels of flu than expected, with more people hospitalised and admitted above the respective baselines from last year and loss of bed capacity due to norovirus.

### 1.4 Local and National Responses to Increased Pressure

By mid-September 2017 the Winter Plan for Lincolnshire's health and care system had been signed off. Partners across the system worked hard to prepare for extra winter pressures and minimise the risks for patients.

Actions included:

- Creating extra capacity through opening temporary (escalation) beds; providing additional staffing to respond to increased demand
- Steps to ensure the seamless flow of patients through to discharge
- Increased trusted assessor capacity to expedite discharges
- Developing local resilience plans with partner organisations such as social care
- Improved communications
- Support to ensure people with mental health needs were treated in the right place
- Increased availability of community beds
- Discharge surge events
- Urgent care streaming in emergency departments to ensure patients are treated in the right setting

Significant steps were also taken at a national level to improve NHS resilience, which included:

- A more joined-up approach, including a National Director responsible for winter planning and establishing the National Emergency Pressures Panel (NEPP)
- Contingency plans to support trusts at greatest risk of having difficulties this winter
- An extra £335 million in the 2017 Budget to help the NHS cope with winter

While preparations for winter have never been more meticulous and thorough, there remained a number of continuing difficulties and pressures jeopardising the system's ability to cope:

- Flu – this year's strain has already placed health systems in Australia and New Zealand under severe pressure.
- Funding pressures – the additional NHS funding for winter in the Budget was welcome but has come very late to be used to maximum effect. To make the most of every pound, the system needed to see this in the summer, so that additional beds, services and staff could have been put in place.
- Lack of beds – in late autumn ULHT was already over the recommended safe bed occupancy level of 92%. This means there was very little give in the system. Too many patients still faced delays in being discharged after they were ready to move on.
- Workforce pressures –shortages of key staff groups including paramedics, GPs and A&E consultants and nurses.
- Underlying performance pressures – capacity was already stretched, as evidenced by all four key NHS performance targets being missed last year, for the first time ever, even though productivity gains have been much greater than the whole economy average.

### 1.5 Patient Impact

With the acute trust seeing more people, in both worse and more frail conditions, it is right that the system focuses first on those patients who need help. With this in mind, the National Emergency Planning Panel recommended to all acute trusts that non urgent operations be cancelled during January. Whilst this was enacted in Lincolnshire it was regularly reviewed and not all operations were cancelled. Along with risking patient safety and quality when cancelling operations and outpatient appointments, cancelling operations results in less income for NHS trusts, which is an additional challenge for our system which is already under significant pressure to deliver savings; recover financial targets and assure their sustainability.

### 1.6 The Wider Context

The NHS is in the middle of the longest and deepest financial squeeze in NHS history. Costs and demand are growing by 5% a year, but we are in the midst of a twelve year period where funding increases have not matched this. Three independent health think tanks estimate, based on projections from the Office for Budget Responsibility (OBR), that health spending would need to rise to approximately £153 billion (from £123.8 billion in 2017/18) by 2022/23 to maintain standards of care and meet rising demand.

There are severe workforce shortages, with recruitment and retention problems. Many staff say they cannot provide the safe, high quality care that patients deserve, even though they are routinely working longer than recommended or paid hours. The pressure on NHS performance can be seen throughout the year. Despite best efforts, in 2016 all four key NHS hospital performance targets were missed; and waiting lists for routine surgeries are the longest they have been for a decade.

## 2. Lincolnshire Performance

### 2.1 System Performance

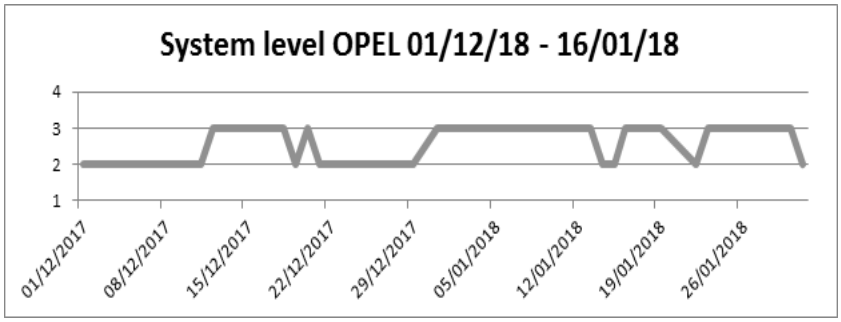
The Operational Pressures Escalation Level (OPEL) is utilised throughout winter to identify daily system performance, capacity and risk. Daily reporting takes place via the CCG Urgent Care Team to NHS England to provide a system perspective to regional and national directors.

The OPEL reports are comprised of organisation OPEL levels which are reviewed and fed into a system wide level. The levels vary from level 1 to 4, one being the lowest level of pressure to OPEL 4 being critical. The report is generated following a 9am teleconference where system partners discuss current OPEL levels and provide feedback on high priority issues and signed off by the Urgent Care Programme Director.

The organisations that provide an individual sitrep and OPEL level who contribute to this report are:

- ULHT – Daily updates
- LCHS – Daily updates
- LPFT – Daily updates

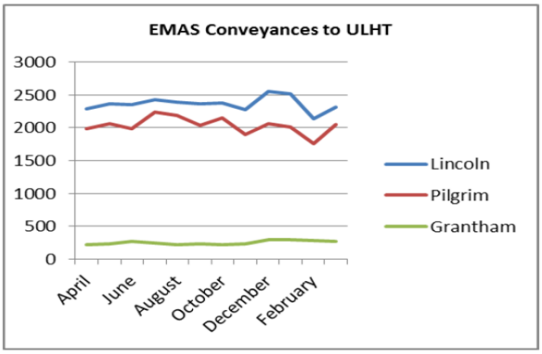
- EMAS – Daily updates
- ASC – Weekly updates (adhoc as requested)
- NHS 111 – Daily Updates

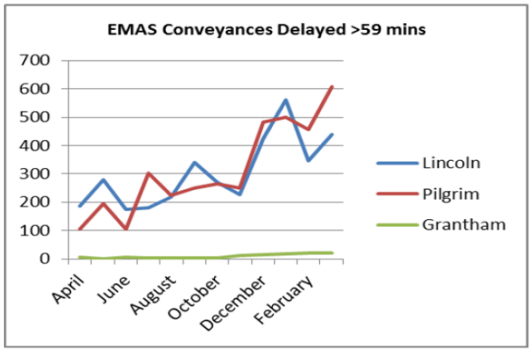



Normal operating for the Lincolnshire system is OPEL level 2; this reflects a system that is able to de-escalate quickly from surges in demand. The chart above shows Lincolnshire was above average and operating at OPEL 3 for the duration of December and January. In contrast, we have reported OPEL level 2 for 20 of the past 21 days during April. Level 4 was reported on only 2 occasions (days) this winter during severe weather.

OPEL levels are built from current performance and pressures. These are therefore a good indication of how well a system and organisation is able to deal with the demand on its services.

## 2.2 Ambulance Handover




Ambulances conveyances on all sites remained consistent during winter. The new RAT area at Lincoln has had a positive impact, whilst at Pilgrim hospital there have been issues with process and staffing. This was picked up by the CQC and is a key focus area for improvement with external help from NHSI and the trust has brought in SSG to assist with an improvement programme across the trust "ADPRAC" to help in ACP training at PHB. Early indications for April are positive.

United Lincolnshire Hospitals NHS Trust was among the top five poorest performers nationally for % of ambulances delayed over the 30-minute arrival to clear target, in December 2017. The impact of this is far reaching by stretching already thin resources. EMAS and ULHT are being supported in improve process and system improvement by NHS Improvement and SSG Health. To date, additional changes have been made to the patient cohorting process – including plans for the pre-handover practitioner to be able to take a cohort of up to 3 patients and speed up handovers. SSG facilitators are coaching

staff with a focus on internally-led immediate and practical interventions and to ensure new working habits stick; and medium term change interventions remain on track. Since the work commenced, the system is tracking a 35% improvement in handover delays.

### 2.3 Urgent Care Streaming

The Urgent Care Streaming Service (UCS) is in place at the front door of the Accident and Emergency Departments at Lincoln and Pilgrim Hospitals, enabling patients presenting with a perceived A&E need (which is actually on assessment a Primary Care need) to be streamed in to a Primary Care Service within the hospital.

UCS has been in place at Lincoln and Pilgrim since mid-October 2017. The impact of UCS can vary per day; ranging from approximately 8% to 20% of patients treated in the emergency department. The table below shows UCS performance by month from October 2017 – April 2018.

| Month | ULHT A&E Attendances (All Types) | Streaming Activity | Streaming as % of A&E |
|---|---|---|---|
| Oct-17 | 13,351 | 1,286 | 9.6% |
| Nov-17 | 12,746 | 1,609 | 12.6% |
| Dec-17 | 13,023 | 1,332 | 10.2% |
| Jan-18 | 12,849 | 1,298 | 10.1% |
| Feb-18 | 11,635 | 1,126 | 9.7% |
| Mar-18 | 13,551 | 1,358 | 10.0% |
| Apr-18 | - | 1,332 | - |

A CCG led monthly Clinical Governance Group monitors quality of the service and performance is managed via an Operational Group with system wide representation to ensure the development of an integrated and effective service. There are basically two elements to the Urgent Care Streaming Service; these are the initial streaming process and then behind this the supporting Primary Care Service.

The Urgent Care Streaming Service has already been building referral capability straight to specialties or other services such as social care and mental health liaison.

The existing pathways through UCS are for patients amenable to traditional Primary Care provision, was extended with enhanced diagnostic and treatment capabilities e.g. Near Patient Blood Testing, X-ray accessibility, staff training from 01 May. This will enable more patients to be seen and treated within the Urgent Care Streaming Service e.g. some Minor Injuries such as: small wounds needing suturing, patients with suspected DVT, Frail Elderly etc.

This extended capability will enable more patients to be streamed away from the main A&E footfall. With Near Patient Testing and X-ray capability more patients will be able to be discharged without need for day case/short stay < 1day admission/observation. Further training in Minor Injuries care, so all UCS clinical staff have these competencies will also

reduce footfall on the main Emergency Department by enabling treatment within UCS of some of what were previously Minors patients.

Currently there is marked variation between the numbers through UCS at Pilgrim compared to Lincoln, with Lincoln having a higher rate as a percentage of total A&E attendees. LCHS Urgent Care Medical Lead is currently reviewing the reasons for this and spending time at both sites to establish whether there is a difference in presentations to the A&E Departments or ways of working of UCS that would account for this difference.

Within Lincolnshire we have the Lincolnshire Clinical Assessment Service that has been established fully since April 2017. This service, an alliance between, LCHS & EMAS provides Clinical Triage to 111 calls both in and out of hours, this service already prevents significant footfall to our GPs in and out of hours, to A&E and to Urgent Care Centres.

This and other admission/attendance avoidance initiatives may be the reasons why we are not hitting the initially predicted targets (25 -30%) for patients presenting to A&E amenable to a Primary Care Service via UCS.

However the number of patients being seen by UCS at Pilgrim has been at low levels on some days which given high overall attendances to the A&E Department at Pilgrim, would not have been expected, so it is clear there is a need to fully understand this variation and take action to improve the service if this is indicated from the review.

### 2.4 Four Hour Standard

The figures for A&E attendances and emergency admissions up to March 2018 demonstrate a system under significant pressure; although there is no simple correlation between A&E performance data and risk to patient safety, A&E pressures are closely tracked and can give a broad indication of the health of the wider system. The four-hour standard is a proxy for safe patient care, and every breach of the standard can therefore be regarded as a potentially elevated risk.

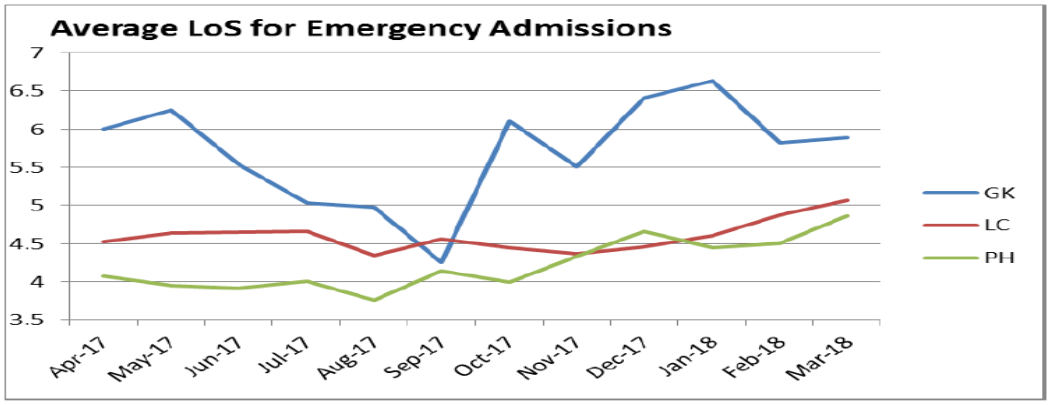
Acute Trust performance for Type 1 attendances plus streaming was 65.21% in March against a target of 95%. Month on month the trust falls short of the target, with the addition of community based Type 3 performance (97.33%) the system achieved 76.33% in March.

A realistic improvement trajectory for 18/19 has been developed and agreed across the urgent and emergency care system. The plan is dependent on a number of system wide actions to improve hospital flow and reduce DTOC, enabling the emergency department to move patients through the system quickly.

| Lincolnshire 4 Hour Standard Trajectory 2018/19 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr 18 | May 18 | Jun 18 | Jul 18 | Aug 18 | Sep 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 | Mar 19 |
| ULHT Type I | 69.69% | 72.03% | 74.38% | 76.72% | 79.07% | 81.41% | 82.22% | 83.02% | 79.07% | 76.72% | 77.53% | 86.24% |
| ULHT + Streaming | 72.04% | 74.33% | 76.63% | 78.92% | 81.22% | 83.51% | 84.39% | 85.26% | 81.22% | 78.92% | 79.79% | 88.74% |
| ULHT + Streaming & Type 3 | 82.07% | 83.68% | 85.30% | 86.91% | 88.52% | 90.13% | 90.94% | 91.75% | 88.52% | 86.91% | 87.72% | 95.00% |

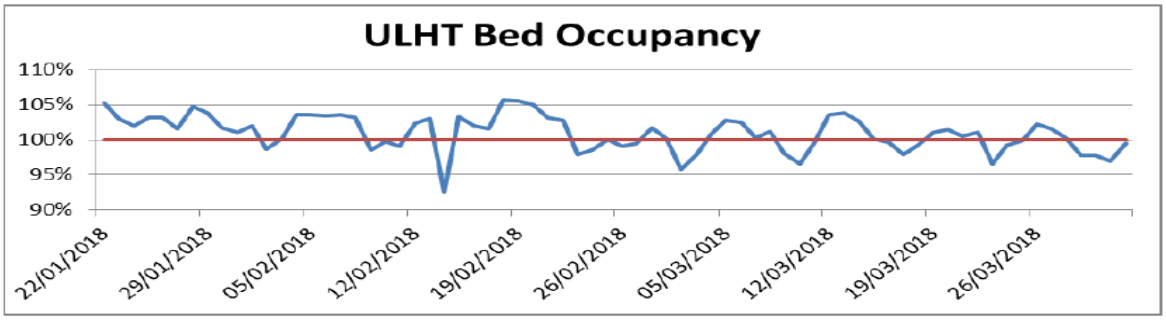
## 2.5 Admissions

Length of stay (LoS) for emergency admissions has been increasing steadily since October 2017. Grantham continues to have the highest non elective LoS but Lincoln and Pilgrim Hospitals have seen their highest average for the year in March. With an increasing LoS, bed occupancy has remained high and “exit block” persists as one of the key breach reasons during March. Occupancy across the acute trust has been consistently at or in excess of 100% throughout winter with highest occupancy on Mondays, slowly reducing through the week as a regular pattern.




## 2.6 Bed Capacity

In assessing bed capacity, it is important to look at the number of available beds and demand. In terms of demand for beds, there are year-on-year increases in demand itself and the acuity of that demand. For example, in total, A&E departments in 2016/17 saw attendances increase by 3% with 3% more patients admitted to hospital. While the data for this winter is not yet available, it is clear from the sitreps that local bed occupancy levels are higher in 2017/18 than in 2016/17, suggesting that demand and/or acuity has risen, creating real pressure on bed stock and capacity.




Within the community, bed occupancy for February is 85.1% remained within tolerance levels.

## 2.7 Delayed Transfers of Care

Like the four hour standard, Delayed Transfers of Care (DTOC) are a crude measure of the health of the urgent care system. Most importantly, delayed transfers of care have negative impacts on the people who become delayed, with significant implications for their independence. In addition, delays have an impact on wider service delivery and performance across the whole health and care system but the immediate effects manifest themselves within hospitals.

The DTOC standard is less than 3.5% of available bed days will be lost due to delays. The table below gives the local performance during the past 7 months.

| Provider perspectives (NHS acute only) | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 |
|---|---|---|---|---|---|---|---|
| United Lincolnshire Hospitals | 3.6% | 3.4% | 4.1% | 4.9% | 5.4% | 5.0% | 4.5% |

Within the community, Lincolnshire Community Health Trust has continued to the work around the tight management and escalation of all DTOC, which has enabled the Trust to successfully manage a high number of very complex cases seen across Community Hospitals and Transitional Care. Like the ULHT, LCHS engaged with two recent Discharge Surges which resulted in a huge increase of patients discharged from the acute hospital into community beds, home or to alternate care settings. This led to an increase in the number of beds spot purchased by LCHS and Adult Social Care and a decrease in beds occupied within the acute hospital by patients medically stable to transfer.

## 3. Conclusion

The focus right now needs to be on what can be done to help frontline services respond to patient need. For example, we continue to be guided by national directions through the NEPP to support our system to take action and reallocate resources to emergency care as appropriate during periods of high demand. All local partners are working to create additional care capacity to respond to surge, particularly along the east coast during the summer period when demand mirrors winter.

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

In a system working with limited resources to meet the demand, interactions can be compromised. The system works through the relationships and tolerances of each organisation. Future planning will consider the impact on performance and building positive relations between professionals and organisations to reduce the opportunities for process led organisational conflicts.

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

## 4. Consultation

This is not a direct consultation item.

## 5. Background Papers

No background papers were used within the meaning of Section 100D of the Local Government Act 1972

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