Winter Resilience Plan 19/20
University Lewisham Hospital (UHL)

1. Introduction

1.1 The purpose of this paper is to outline the winter resilience plans for the Lewisham and Greenwich NHS Trust, on the UHL site, working in partnership with Lewisham Clinical Commissioning Groups (CCG) and the respective social care economy in order to ensure the provision of consistently high quality urgent and emergency care services throughout the winter period of 2019/20.

1.2 Each constituent organisation represented has made a commitment to deliver consistent and timely support to enable all parts of the system to work collaboratively together to continue to improve patient safety, experience and outcomes.

1.3 To reflect a locality/system approach, a Lewisham University Hospital (UHL) plan has been prepared and will partner with Lewisham CCG, the London Borough of Lewisham and South London and the Maudsley NHS Trust (SLaM).

2. Background

2.1 Winter 2018/19 saw an increase in emergency activity at UHL with extended stays in acute beds attributed to poor flow through our hospitals and overstretched social care and out of hospital capacity to support patients in the community. Dependency of patients increased over the winter period, particularly amongst the elderly, with a high number admitted with underlying chronic conditions such as heart failure, asthma and Chronic Obstructive Pulmonary Disease, compounded by seasonal influenza. Together with an increased demand for Urgent Care for younger adults and children, the Emergency Department (ED) experienced delays and overcrowding owing to high volumes of attenders and insufficient inpatient beds. Ambulance handover times were therefore extended, with crews unable to clear the hospitals within the target of 15<30 minutes.

2.2 Alongside this, there were also system challenges in discharging patients from hospital in a timely manner, especially those who needed a Nursing or Care Home placement or patients who were assessed as frail and could have been discharged home with support or transferred to an appropriate step-down facility.

2.3 Over the past year, UHL has undertaken an improvement programme aimed at improving flow through ED and in-patient beds; there have also been a number of initiatives introduced to improve discharge planning to release beds earlier in the day to meet demand for emergency admission and support weekend discharge. This work will continue over the winter months, augmented by additional winter capacity and resilience.

2.4 Each locality/system has considered their winter resilience and capacity plan. This paper outlines the plan for winter 2019/20, building upon the lessons learnt from 2018/19 and continuing to work towards the national targets related to minor breach reduction, reducing patients with Long Length of Stay (LLoS), achieving Ambulance handover targets, reducing ambulance conveyancing to ED and increasing healthcare workers flu vaccination uptake.

2.5 The emphasis of Winter Planning (2019/20) has been to ensure safe, patient-focussed care across our system with a strong focus on reducing delays; ensuring patients receive the right care, at the right time, at the right place.

2.6 A capacity and demand bed model has been developed, building upon the 2018/19 model and has been previously presented to the Trust Finance and Performance Committee and the system A&E Delivery Board (AEDB).

2.7 The acute demand and capacity model allowed partners to appreciate where their intervention would have the most impact (in meeting the needs of patients) if they were enhanced/improved by investment or new ways of working over the winter period. This has included commissioning of additional out of hospital capacity, developing targeted investment of the Better Care Funds (BCF), incentives to address excess bed days, investment in both assertive in-reach and discharge support structures, commissioning support from 3rd sector partners alongside the prioritisation of services to support frail and elderly patients, including those residents within local Nursing and Care Homes.

3. Emergency Care Improvement Plans

3.1 The Trust AEDB has been working with system partners to support the delivery of key urgent and emergency care improvement targets, namely:

- 4 hour access target
- Ambulance handover targets
- Reduction in the number of patients with Long Length of Stay.

Revised trajectories have been agreed with commissioners and are summarised in the November Performance Report.

3.2 UHL have localised Emergency Care Improvement Groups (ECIG) chaired by a Trust Executive Director. These groups are charged with delivery of the improvement plans to achieve the U&EC targets and leading discussion with their local partners in CCGs, Primary and Community Care and the Local Authority.

3.3 Commissioners established an Unplanned Care Board in 2018/19 which supports the delivery of safe and effective urgent and emergency care by investing in attendance avoidance e.g. supporting local people living at home with a long term condition and addressing frequent ED attenders. This year they have introduced initiatives to reduce demand upon emergency services which have included working with LAS to reduce conveyances to hospital, supporting Care Homes to access NHS 111 *6 services which provides care home staff with urgent clinical advice and providing in-reach into care homes to support residents with fall prevention, regular assessment and medication reviews.

3.4 Over 2019/20 to-date there has been continued challenges in both hospitals with meeting the mental health needs of patients presenting to ED. SLaM are working towards improving the care and flow of patients in ED, building local solutions in-line with those highlighted in the London Mental Health Compact.

3.5 Investment in the workforce has been on-going throughout 2019/20, with improved staffing levels as compared to last winter. Additional winter capacity is dependent upon the availability of clinical and support staff to treat and discharge patients in a safe and timely manner. Temporary staffing will be deployed to support wards and departments with increased demand, with access to short term contracted agency staff required for specialist roles, particularly therapists.

3.6 Maintaining low sickness levels over winter is critical. All frontline health care workers have been offered the seasonal influenza vaccination, with a target to vaccinate 75% of staff. Currently, as of November 1st, 49% of trust staff are vaccinated.

3.6 Notwithstanding all of the improvements made over the past 12 months, the trust needs to have a proactive plan for winter to provide services at a time when there may be increased demand. Each locality/system has therefore been required to develop a Winter Resilience Plan to ensure patient safety, accelerate improvement and address opportunities to increase capacity (where possible) to ensure optimum patient flow.

4. Lewisham Locality/System Winter Resilience Plan

4.1 Priorities for the Lewisham System for winter 2019/20 have been reviewed with system partners and the following additional focus/investment is already agreed/funded:

Priority Area	Proposed intervention	Impact *Safety/Quality/Performance*	Source	Risk
Ensuring all patients are rapidly accessed and referred to the appropriate Urgent & Emergency Care pathway for treatment KPIs – compliance with the 4 hr access target and Ambulance handover times	Nurse in Charge to be rostered in UCC |(in addition to the Nurse in Charge in Majors), to ensure patients are directed to the correct pathway upon arrival and that plans are delivered within target time	Performance: Increase number of patients treated in UCC and Ambulatory Care; actively manage non-admitted flow to reduce ED congestion	Existing Run Rate	Staff availability Risk (L)
	Increase capacity within the GP Extended Access service at times of peak demand, with further increased number of GP slots weekends/evenings to address demand	Demand management: Patients redirected to reduce congestion in ED; better patient experience	CCG	CCG ability to deploy staff: Risk (M)
	Pilot *Social Prescribing* at point of streaming	Demand Management: support social care needs and redirect patients away from ED e.g. to local pharmacy	CCG	Limited impact upon ED demand: Risk(M)
Optimise in-patient flow KPI – Bed Occupancy	Open 16 acute beds on Chestnut Ward	Capacity: Additional beds to admit emergency short stay patients	Existing Run Rate	Staffing: Risk (M)
Safe and timely discharge from hospital KPIs – LLoS target and >30% of ward discharges achieved	Enhanced support from the integrated Lewisham Patient Flow Centre	Performance: Patients discharged plans are in place to support 7 day discharge profile	CCG	Staffing: Risk (M)
	Additional support for CHC team to ensure no delays are incurred awaiting checklist or DST assessment	Performance: Fewer delayed patient discharges	CCG	Staffing: Risk (M)
	Lewisham Senior Social Service staff available at weekends with brokerage schemes agreed	Performance: Patients discharged when medically fit – no delays due to packages	LA	Staffing: Risk (L)
	Additional care tenancy agreements for patients ready to leave hospital but are in need of housing support	Performance: Fewer delayed discharges	LA	Limited impact: Risk (M)
	Community Manual Handling with additional Occupational Therapy Support	Performance: Reduced LoS attributed to equipment delays and earlier agreement of double handed care packages; Reduce readmission to UHL	System Transform-ation funds (in run rate)	Limited impact upon performance: Risk (M)
	Discharge team support from additional Complex Case Manager and Social Worker	Performance: Focus upon LLoS patients with additional case management where needed	CCG/LA	Impact limited due to shortfall in Nursing and Care Home

by 1pm				capacity: Risk (H)
	Support from 3rd sector Hospital Support and Discharge Service	Safety: Transport home or step-down facility with escort for vulnerable patients	CCG	Provider availability; Risk (M)
	Additional non-acute capacity commissioned in Lewisham, including Respite, Step-down and Domiciliary Care	Performance: Fewer patients remain in acute beds once medically fit for discharge	LA	Impact upon performance Risk (L)

4.2. In addition to these existing plans, the following additional unfunded schemes are proposed for improving winter resilience:

Priority Area	Proposed intervention	Impact *Safety/Quality/Performance*	Source	Risk
Ensuring all patients are rapidly accessed and referred to the appropriate Urgent & Emergency Care pathway for treatment KPIs – compliance with the 4 hr access target and Ambulance handover times	Pilot Mental Health Triage Pathway - Psychiatric Liaison Nurses (PLN) working alongside triage nurses in ED	Performance: Significantly reduced time spent in ED for non-admitted Mental Health patients	Cost pressure – cost to be shared with SLAM	Criteria limits impact to ED flow: Risk (H)
	GP referrals and SDEC patients redirected from ED to ACU and Surgical Assessment Unit	Demand management: Fewer patients attend ED. Increased quality of care.	Cost Pressure	Compliance: Risk (L)
	Hospital@Home team to pilot Paediatric Admission Avoidance focused upon respiratory conditions	Demand management: Fewer children attend ED, those that do present stay shorter period in ED.	Cost Pressure	Ability to establish pathways with Primary Care: Risk (M)
Optimise in-patient flow KPI – Bed Occupancy	Open 14 Frailty Beds on Sapphire Ward	Capacity: Additional beds to access and prescribe interventions for frail elders.	Cost Pressure	Staffing: Risk (M)
	Improved diagnostic turnaround times to optimise patient flow and reduce length of stay	Performance: Fewer delays to care	Cost Pressure	Staffing: Risk (M)
	Additional Speech & Language support at weekends	Safety: Fewer discharge delays attributed to awaiting a swallowing assessment	Cost Pressure	Staffing: Risk (L)
Safe and timely discharge from hospital KPIs – LLoS target and >30% of ward discharges achieved by 1pm	Extra weekend pharmacy availability to support discharge	Performance: Fewer delayed discharges attributed to waiting for medication to be dispensed	Cost Pressure	Staffing: Risk (M)

4.3. The above plans are supported by one proposed minor capital scheme:

Optimise in-patient flow	Provide access to ring-fenced beds on Linden over the winter period without compromising elective flow	Capacity: Provide access to 8 acute surgical beds	CAPITAL	Not on Capital Programme

4.4 Commissioners have indicated that winter funding may be available to support the opening of additional acute capacity and options for opening of Sapphire Ward are being actively pursued.

4.5 Exit plans for winter schemes will be developed with a phased closure of the additional capacity created to address the predicted winter demand. There may be opportunity to continue LA and CCG funded schemes but LGT schemes are intended to end in April 2020. Primary financial risk going into 2020/21 may be the trusts' inability to close the escalation beds opened on Chestnut and Sapphire Wards.

6. Flow and Escalation Policy

6.1 The Flow and Escalation Policy (FEP) outlines the action required as different Operational Pressures Escalation Levels (OPEL) which are agreed with system partners and co-ordinated by the Surge Hub. It also provides clarity in terms of management of incidents and the control of risks including Infection Control and Prevention.

6.2 Both hospitals have experienced days when there is a surge in demand when more than anticipated patients attend ED. In the short term, this which can cause congestion in ED which extends treatment times and impacts adversely upon performance. Congestion can also occur even when demand is as predicted i.e. when patients are detained in ED awaiting assessment and/or formal admission. This further compounds congestion in the ED and increases risks to patients.

6.3 To reduce the risk to patients a Full Capacity Protocol (FCP) has been refined which is triggered at times of extremis to reduce congestion in ED. Actions include:

- ***Your Next Patient*** - Transfer of patients to wards pending a discharge from that ward;
- ***Fit to Sit*** implemented in ED and Chestnut Ward to maintain flow through ED;
- Use of alternative areas for in-patients (outlined in the Escalation and Flow Policy/FCP);
- Increased seniority of clinicians to support discharge planning, enabled by reduced OP activity and cancellation of SPA activity;
- Additional senior nurse and managerial support for ED & wards – non essential meetings cancelled and staff redeployed from non-clinical activities;
- Escalation of urgent diagnostic and pharmacy requests that could expedite discharges;
- Speciality teams in-reach to ED and AMU, with additional ward rounds to expedite flow;
- Extend opening of the discharge lounge;

6.4 Supporting enhanced early discharge (e.g. 30% of discharges completed by wards before 1pm) and addressing the causes of delayed discharge are critical to the winter capacity plan. The Lewisham Flow Centre and QEH Transfer of Care Collaborative will need to support the hospitals across the 7-day week to maintain flow and escalate causes of delayed discharge so that they can be addressed; The Discharge Patient Tracker List (DPTL) will be a shared resource to support teams address delays.

6.5 LGT continues to see a high number of patients presenting in ED with an acute Mental Health need. Whilst there are improvement plans to establish safer environments for MH patients, these will not be commissioning until early 2020. Over the winter months, investment in additional support in ED has been agreed locally with system partners, SLaM, and the voluntary sector to support non-admitted patients, and sector-wide investment will continue to source additional acute MH beds.

7. Impact upon Elective and Urgent Activity

7.1 LGT is currently driving a recovery programme for RTT performance with improvement targets across all specialities which will continue over the winter months. Admitted and outpatient activity should continue as planned; only impacted if the FCP is enacted. Whilst every effort will be made to support elective admissions, patients on an admitted pathway may be adversely impacted over the winter given the anticipated bed pressures. Performance structures are in place to monitor any impact this has upon performance and work with Services to develop action plans to address issues where necessary.

7.2 A set of criteria for cancelling non-emergency activity have been set out in the FCP. The Trust has developed the FCP to only target cancellation of elective and outpatient activity where it will have a direct impact on reducing emergency pressures on the site.

7.3 Where bed capacity is significantly limited due to emergency demand, priority will be given to patients awaiting urgent surgery and those on a cancer pathway, many of whom will be treated in day/short stay facilities which should have capacity protected when in escalation; The day care beds within both hospitals remain the last to be utilised within the escalation and flow plans and therefore will only be impacted when the Trust is under the most extreme pressure.

7.4 The Trust plans to maintain ring-fenced elective orthopaedic capacity throughout the winter although at a reduced level. This will minimise the impact of winter pressures on elective orthopaedics.

8. Workforce Plans

8.1 Workforce remains the greatest risk to delivery of the overall winter plan. Staffing and vacancy levels remain a key risk for the Trust, however, over the last 12 months, there has been a significant improvement in our staffing levels and a reduction in our Trust vacancy rate from 15.79% (Sept 2018) to 11.78% (Sept 2019), which is below Trust target level and above plan for our NHSI workforce return. Our staff in post has moved from 5,902 to 6,054 from April to Sept 2019. We continue to have a positive pipeline of new starters including international recruits to improve our position.

8.2 The Trust also has a robust temporary staffing department who run an effective staff bank and source temporary staff to fill any vacancies or gaps. Our fill rate was 90% in October, of which 72% was filled by Bank staff. The team work hard to book in line with NHSI agency capped rates and breaches are based on shortage occupations and hard to fill posts.

8.3 Staffing rosters are also been reviewed to ensure these are published in good time and to minimise reliance on temporary staff over the festive period with temporary staffing controls in place.

8.4 Sickness absence remains above Trust target and will need close monitoring over the winter period. Regular meetings are place and reviewed at divisional level to ensure staff are actively supported and managed in line with the recently reviewed Managing Attendance policy

9. Governance and Management Arrangements

9.1 High level winter planning has been guided by the AEDB with detailed operational winter plans developed by both hospitals in agreement with locality partners. These are underpinned by robust escalation and planning processes that are outlined below:

- frequent updates/pro-active escalation by the Divisional Director of Operations to relevant partner senior management leads to prevent risks escalating;
- weekly winter system-wide updates (November 2019 – mid April 2020) summarising progress with delivery of the agreed winter plan, shared with all system health and social care partners:
- weekly system escalation calls, attended by executive leads from all health and care partner organisations to address delays or issues faced by the local system;
- weekly winter escalation call, hosted by NHS England/ Improvement and attended by all key decision makers;
- fortnightly progress report to Trust Management Executive via the Emergency Care Improvement Groups, and;
- 6 weekly meeting of the AEDB to oversee the performance impact of interventions aimed at reducing the impact of known winter pressures.

9.2 UHL has established improvement groups who will oversee delivery of the winter plan alongside the continued operational delivery of services to U&EC patients.