Meeting title:	Public Trust Board **Public Trust Board paper F**					
Date of the meeting:	12 October 2023					
Title:	**2023/2024 Winter Plan**					
Report presented by:	Jon Melbourne, Chief Operating Officer					
Report written by:	Jon Melbourne, Chief Operating Officer Rachael Briggs, Associate Director of Operations					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	x
Where this report has been discussed previously	Trust Leadership Team – 10/10/23 Operational and Performance Committee – 27/09/23					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The UHL Winter Plan provides updates on assurance and actions that are being taken in relation to winter planning and pressures.

Impact assessment
The plan will identify actions being undertaken by each of the Clinical Management Groups and new schemes to maintain ambulance handovers and to improve 4-and-12-hour performance.

Acronyms used
Urgent and Emergency Care (UEC) Children and Young People (CYP)

1. Purpose of the Report

This document provides an update on the Urgent and Emergency Care (UEC) Recovery Plan which was approved by the Board as part of the 23/24 Operational Planning process in March 2023.

The document describes the national approach to planning for this winter, an update against the 23/24 Operational Plan for UEC and the scale of the expected deficit in capacity and provides a detailed update on the actions that are being taken in the lead up to, and throughout winter. Whilst this update focuses on UEC, plans are also included for Planned Care and Children and Young People.

This paper is supported by the Leicester, Leicestershire and Rutland Delivery Plan for Recovering Urgent and Emergency Care Services which went to the Integrated Care Board in August 2023 (Appendix 1).

2. Recommendation

The Board is asked to

- Note the capacity challenges which are being faced
- Note the actions that are being taken to mitigate deficit
- Support the governance process to receive updates via UEC Steering Group, and escalations to the Trust Leadership Team as required.

3. Main Report

3.1 Introduction

The process of planning for Winter 23/24 has been led by the Clinical Management Groups, with Trust-wide oversight for areas of interdependencies - and clinical leadership in all aspects of planning. The actions focus on mitigating the most significant clinical, operational and workforce risks. The plan models the expectation of increased admissions for Flu A, B and COVID and plans for some closure of capacity due to infection prevention measures. The winter plan has been fully aligned with colleagues across the Trust, including ensuring the financial implications of any initiatives are fully planned for. This plan aligns with the 23/24 UEC plan published to colleagues across the Trust in March 2023, highlighting the advance planning in place for this winter.

3.2 Delivering operational resilience across the NHS this winter

In July 2023, NHS England issued a letter setting out the national approach to 2023/24 winter planning and the key steps we must collectively take across all parts of the system to meet the challenges. This letter reinforced the messages set out in January 2023's 'Delivery Plan for Recovering Urgent and Emergency Care Services'. The letter confirmed this was to support the two key ambitions for UEC recovery of,

- 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

The letter sets out four key areas of focus, described below. LLR and UHL's response to these focus areas are defined in this plan.

1. Continue to deliver on the UEC Recovery Plan by ensuring 10 high-impact interventions are in place
2. Completing operational and surge planning to prepare for different winter scenarios
3. ICBs should ensure effective system working across all parts of the system, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the Voluntary, Community and Social Enterprise sector
4. Supporting our workforce to deliver over winter

In addition, the letter launched an incentive scheme for those providers with a Type 1 A&E department to overachieve on their planned performance in return for receiving a share of a £150 million capital fund in 2024/25. The ask was for providers to meet two thresholds to secure a share of this money,

- Achieving an average of 80% A&E 4-hour performance over Q4 of 2023/24.
- Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

As part of the return to the national team, the UEC Partnership Group have agreed a revised trajectory to deliver 80% A&E 4-hour performance in March 2024, which is driven by additional capacity coming online in that month. There is risk to this trajectory both in UHL and LLR, and our plan is created to maximise the potential for us to achieve this.

The document also describes 10 high impact interventions, which are detailed in Appendix 2. Leaders in the UEC pathway from across LLR have developed and agreed 20 priority actions in support of the interventions, which form part of the 23/24 Winter Programme Plan.

3.3 Delivery of the 23/24 Operational Plan

As part of the 23/24 Operational Plan, the combined efforts of UHL and partners committed to reducing the bed deficit from 350 to 42, with significant investment across various initiatives – some new and some existing. This was to support the delivery of 92% bed occupancy and UEC access standards.

For 2023/24, the approach to demand and capacity modelling has been enhanced to include a non-acute bed model for Leicestershire Partnership Trust (LPT) and directly commissioned beds by the Integrated Care Board, as well as the acute bed model. One of the key drivers for this was to strengthen the joint oversight of UHL and non-UHL mitigations. Colleagues from across the system have been involved in the development and agreement of the underpinning assumptions as well as the mitigations.

The four key areas to reduce our capacity gap are:

- The schemes funded in 22/23 across LLR (open but not recurrently funded) to remain open - reduce the deficit to 248. This includes additional UHL, and community capacity opened in 22/23.
- New schemes to increase capacity at UHL; including all three Glenfield Wards - reduce the deficit to 120
- Additional capacity and productivity outside of UHL - reduce the deficit to 77
- UHL schemes focussed on processes and productivity - reduce the deficit to 42

Whilst most aspects of our UEC plan for 23/24 remain on track, one risk which has been realised is the delay to two of the additional wards at the Glenfield site, which will not be completed in time for winter 2023/24 due to challenges with the programme timescale. This capacity (56 beds) has been removed from the below numbers.

3.4 Internal (acute) Actions

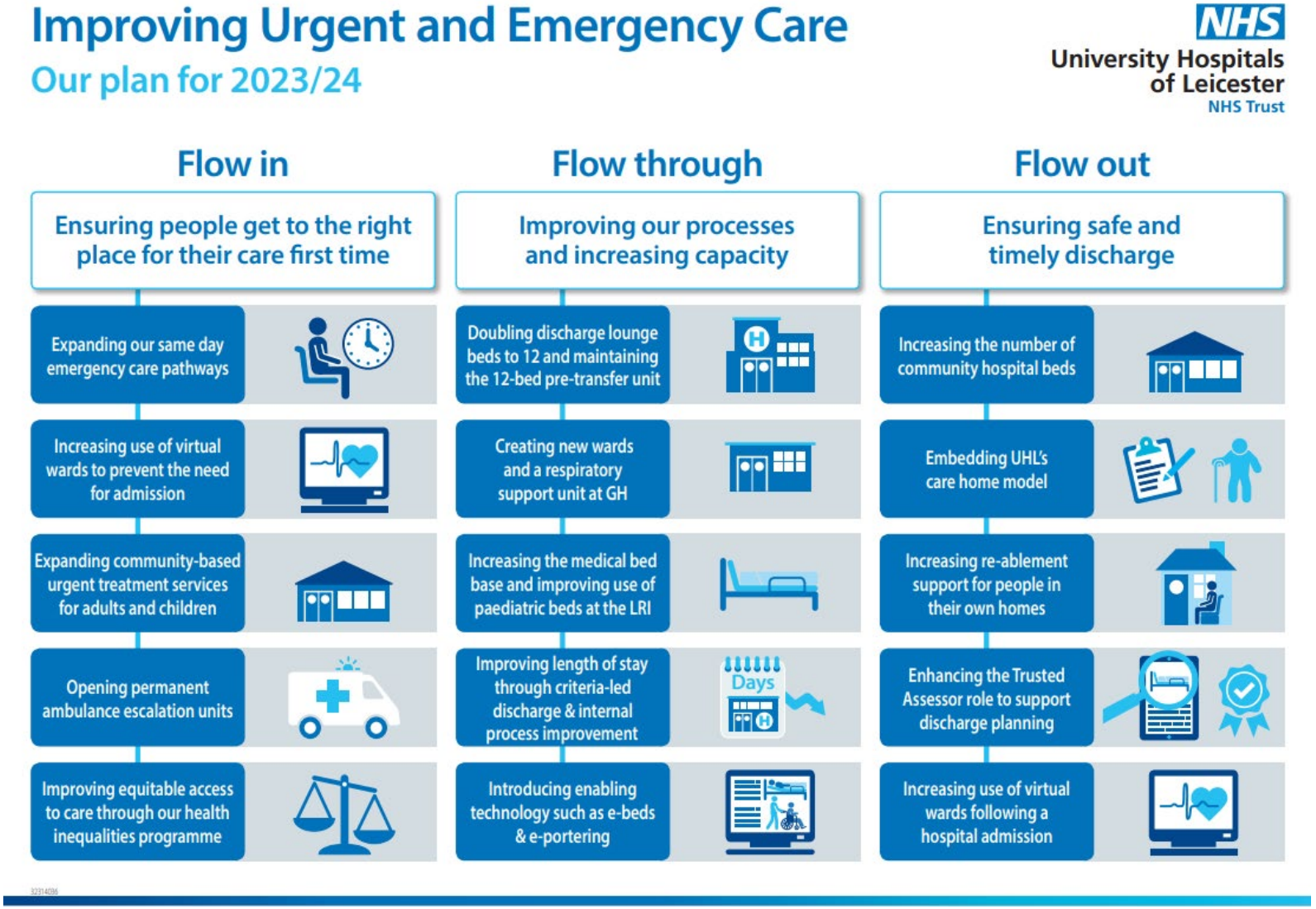
The table below summarises the list of schemes to mitigate the bed deficit; this is not exhaustive but covers the key interventions.

Scheme Type	Bed Number
Additional Capacity *Including new Glenfield Ward, Discharge Lounge, GP Assessment Unit expansion, Children's Hospital Bed Reconfiguration, etc.*	72
Admission Avoidance & Productivity *Including increased Same Day Emergency Care capacity, Glenfield Chest Pain Centre, improving discharge processes, etc.*	35
Total impact (beds)	**107**

All the schemes have individual clinical and operational owners identified and progress, in terms of delivery and impact, will be monitored on a weekly basis through the Urgent and Emergency Care Steering Group (see ‘governance’ below).

These schemes include many recurrent schemes which will support UHL’s plans for years to come, including an expanded discharge lounge, additional respiratory capacity, and paediatric capacity.

Urgent and Emergency Care Plan 23/24



3.5 System and Partner Actions

Colleagues across the system are working on the implementation of out-of-hospital schemes that are expected to further mitigate the bed deficit. There are 20 priority actions which are directly linked to the 10 high impact interventions; they include

- Open an additional 28 LPT beds to support intermediate care and step down from UHL and improve the utilisation of existing capacity
- Open Urgent Treatment Centre capacity to 'walk-in' patients
- Develop and implement ARI clinical pathway (Acute Same Day Access) for Respiratory
- Increase the utilisation of existing Virtual Wards and implement new pathways such as heart failure and frailty

It is likely that these actions, as well as the additional capacity described in section 3.4 will be insufficient to fully mitigate the bed deficit. To further manage this, the capacity escalation process is described in section 7.

There will be a planned increase in the workforce for the Emergency Department to mitigate patient safety risks due to crowding. Where possible, this will focus on senior decision makers and in-reach for specialist services to safely limit the number of patients being admitted, as well as additional colleagues to provide care and comfort for patients who are waiting for beds.

3.6 Planned Care

In recognition of the extensive waiting times across planned care pathways, UHL plan to continue with as much elective activity throughout winter as is safe to do so, with a significant focus on our most clinically urgent patients and those not requiring a bed, such as day case and outpatients. In winter 22/23 significant progress was made with planned care – with significantly more completed than in 21/22, and we plan to continue that progress this winter. The infographic in Appendix 3 describes the 23/24 plan for elective recovery.

The demand and capacity modelling summarised in section 3.3 is modelled to account for this, and so in periods of extreme pressure on the emergency pathway, cancellation of elective activity could be a mitigation when in surge, however this has not been planned for nor accounted in the bed bridge.

3.7 Children and Young People's Plan

In response to previous winters, the paediatric team have developed a robust programme of work which will reconfigure the bed base in the Children's Hospital. This reconfiguration will separate emergency and elective patients, creating a dedicated Children's Surgical Day Case Unit and increase emergency inpatient beds by 14 with the associated additional workforce required.

3.8 Governance

The delivery of the internal actions will be tracked through the UEC Steering Group on a weekly basis - chaired by the UHL Chief Operating Officer and includes the Chief Nurse, Medical Director and wider representation including the Emergency Department Head of Service. This will allow early escalation of emerging risks. Escalation from UEC Steering Group will be directly to the Trust Leadership Team.

External actions will be tracked through the UEC Programme Plan and UEC Delivery Group, with early escalations through to the UEC Partnership Board, chaired by Richard Mitchell (LLR UEC SRO).

4.0 Infection Prevention

The COVID pandemic has highlighted some challenges in the UHL estate which contribute to acquisition of Healthcare Associated Infection. It should be noted that patients with different respiratory viruses cannot be nursed together and require physical separation which means patients with COVID, RSV and Influenza cannot be nursed in the same ward unless there are bays which have both doors and separate shower and toilet facilities within. Also of note, influenza A and B are distinct viruses, so patients infected with these also require nursing separately. Planning should include preparation for Influenza A&B, RSV and Norovirus which will undoubtedly once again be circulating viruses this winter.

The 10 High Impact Interventions are welcome from an IP perspective as some of these seek to reduce the footfall of patients into the acute setting. Wherever possible the use of the Hierarchy of Controls should be employed in the order of the most effectiveness. These include structural and engineering interventions, i.e., physically removing hazards, are the most effective. The Infection Prevention Team will work with Estates & Facilities and operational colleagues to support the employment of these where possible. In the absence of adequate controls, the only option is the use of PPE (face masks), and the organisation should be prepared for the requirement for increased, if not a return to universal mask wearing across the Trust.

In addition to the risk of increased respiratory infections; a programme of estate improvements in Osborne building at the Leicester Royal Infirmary site are underway. A loss of capacity while these works take place has been accounted for the demand and capacity modelling detailed.

Mitigations in place

- Ensure '4 panel Cepheid' admission screening for all patients with respiratory symptoms to ensure immediate appropriate ward placement can be made. 4 panel Cepheid screening identifies COVID, RSV, Flu A&B.
- Fully support the increased bed space cleaning team proposal to improve flow out of and thereby improve capacity within base wards
- Support creation of a Patient Equipment Cleaning Centre at the LRI and GGH which will be utilised to improve turnaround of base ward bays where patients have been identified with infections and whole bay cleaning is required.
- Retro-fitting mechanical ventilation into existing clinical areas throughout the Trust, especially in Glenfield, wherever possible.
- Improving passive ventilation through increasing window opening to encourage fresh air circulation
- A return to universal mask wearing in clinical areas

5.0 Finance and Approvals

The interventions detailed in this paper were integrated into the UHL planning process in 23/24, meaning that they are accounted for financially. This paper is not seeking approval for any further schemes.

Any additional schemes that are identified or to mitigate new risks will need to be managed through the slippage of other schemes and taken through appropriate approval processes.

There is a requirement for the delivery of cost improvement against the UEC plan of £14m, £12.6m of which has been identified. In addition to this, there is a need to identify further efficiencies in UEC across the system of £10m.

6.0 Risks

There are several risks in the delivery of the plan which are described in the table below.

Risk	Description	Impact
There is a risk that capacity may not be delivered on time	Due to delays such as suppliers, planning or other competing demands, the additional capacity planned as part of the mitigations may be delayed	**Access** – bed bridge capacity will not be delivered as per the plan, and this will impact on occupancy levels and performance output for patients **Quality** – patients may still see longer waits for admission in some periods **Financial** – if the acute hospital is in surge and requires additional actions that have not been planned for, there may be a need to spend additional revenue that has not been budgeted for
There is a risk that out-of-hospital schemes are not delivered on time or have the impact	Due to delays outside of the direct influence of UHL, additional capacity and demand management schemes may be delayed	**Access** – bed bridge capacity will not be delivered as per the plan, and this will impact on occupancy levels and performance output for patients **Quality** – patients may still see longer waits for admission in some periods **Financial** – if the acute hospital is in surge and requires additional actions that have not been planned for, there may be a need to spend additional revenue that has not been budgeted for
There is a risk that there is a lack of availability of workforce	Workforce supply for the additional capacity is a significant risk, with reliance on bank and agency Increased sickness levels due to increased respiratory illnesses and other sickness	**Workforce** – increased sickness levels due to reduction in staff morale and moral injury due to exhaustion
Assumptions in the demand and capacity plan are not all realised	If demand exudes the assumptions, or more capacity closes due to a lack of workforce available of IP restrictions then access to emergency care will be further restricted	**Access** – longer waiting times for patients **Quality** – patients may still see longer waits for admission in some periods

7.0 Escalation / Surge

The Whole Hospital Response is based on an end state escalation when there is failure to deliver sufficient patient flow to meet demand. There will be times when the ED is deemed to be at full capacity and the Trust has more patients than it can potentially safely care for. This is usually demonstrated by long waits in ED for specialty or Assessment Unit beds. The Whole Hospital Response will be activated when the trust is operating at its highest escalation levels where demand significantly outweighs capacity and actions taken at OPEL Level 4 have failed to improve service pressures.

The policy requires a wider and faster range of UHL and partner activities to be enacted to rectify the situation as the Trust services can no longer be maintained within routine service arrangements, and it requires special procedures not previously employed. Proceeding to whole hospital response policy and beyond should not occur if there are any empty beds on any of the 3 sites.

The below sequence must be adhered to:

1. All empty beds must be used by outlying base wards.
2. Rapid Flow and Boarding has taken place across appropriate areas.
3. Open Discharge Lounge (escalation area) as overnight capacity
4. Cancel non-cancer/non-urgent elective inpatient surgery & consider cancelling outpatient clinics (only where it can free up medical & nursing staff to support inpatient care)
5. Cancel urgent electives (not cancer)
6. Opening additional capacity - *opening additional capacity will be agreed in UHL Tactical Bed Meetings by the Chief Operating Officer/Chief Nurse/Medical Director and/or the Director on-call (out of hours).*

8.0 Conclusion

UHL has defined its UEC plan – as well as its planned care and CYP plans – for 23/24 early this year, including sharing the UEC plan with colleagues in March 2023. This has allowed us to become more proactive in our planning for Winter 2023. Our winter plan wholly aligns with this plan.

The demand and capacity challenges which we face as a Trust are significant, yet UHL is in a better place going into winter 23/24 than it was in winter 22/23 – with continued and sustained performance improvement seen on our UEC pathways.

UHL has a clear plan and robust governance and escalation in place for winter 23/24, whilst we also acknowledge that there remains risk going into this winter given the challenges in capacity on both our elective and UEC pathways which still exist.
Board is asked to

- Note the capacity challenges which are being faced
- Note the actions that are being taken to mitigate deficit
- Support the governance process to receive updates via UEC Steering Group, and escalations to the Trust Leadership Team as required.

Appendix 1: Leicester, Leicestershire and Rutland Delivery Plan for Recovering Urgent and Emergency Care Services

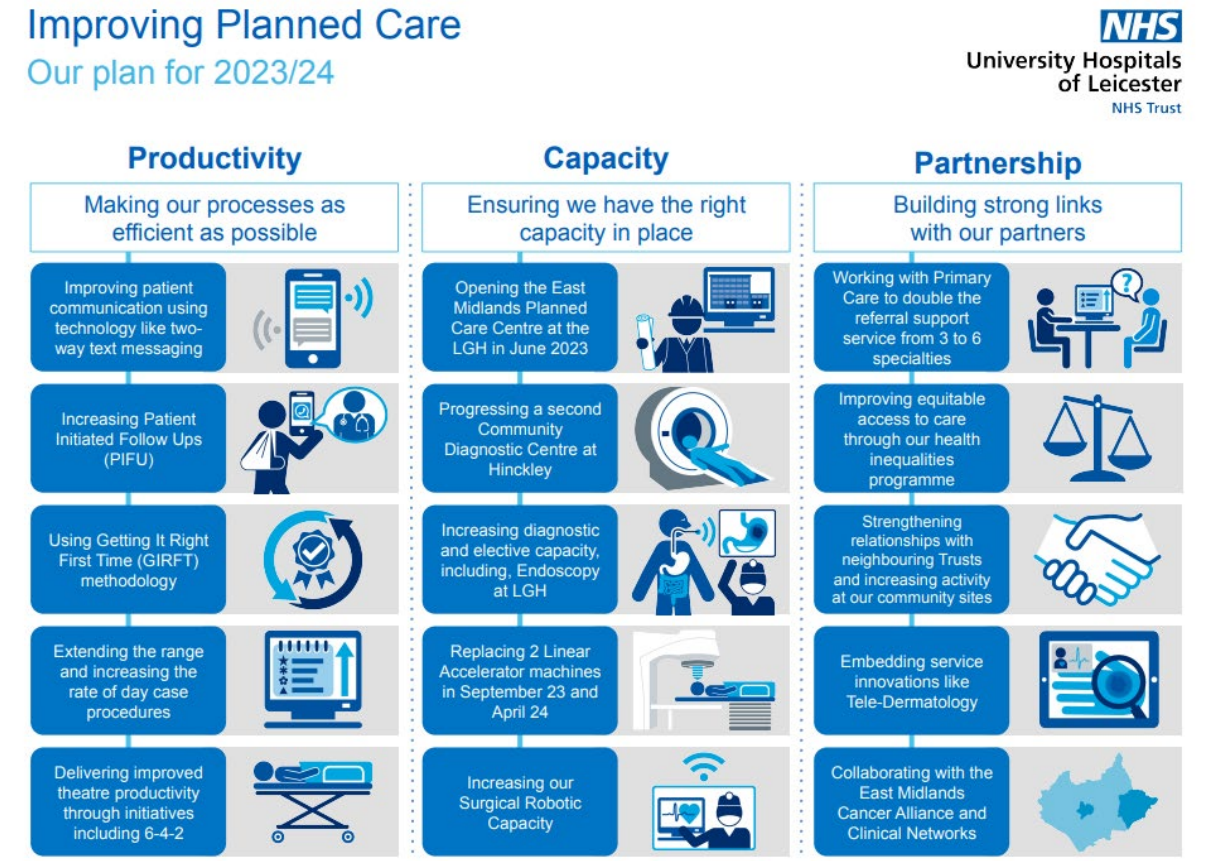
LLR – ICB Paper F Winter Plan 2023-24 (10.8.23)

Appendix 2: 10 High Impact Interventions

1.	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2.	**Frailty:** reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3.	**Inpatient flow and length of stay (acute):** reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow:** reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs:** implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity:** supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards:** standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response:** increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access:** driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, e.g. home treatment
10.	**Acute Respiratory Infection Hubs:** support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Appendix 3: Planned Care and CYP Plans 23/24

Planned Care



Children's and Young People

Improving Urgent and Emergency Care (Children & Young People)

Our plan for 2023/24

NHS University Hospitals of Leicester NHS Trust

Flow in

Ensuring children and young people get to the right place for their care first time

- Enhance Same Day Emergency Care Pathways
- Improve access and streaming to Urgent Treatment Centres
- Take part in national pilot on revised acuity and triage processes
- Reinstate Acute Respiratory Infection hubs (ARI) to support winter surge

Flow through

Improving our productivity and increasing capacity

- Developing rapid access clinics in the children's hospital
- Improving step-down from HDU for long-term ventilation patients
- Reconfiguration of bed base to increase emergency and elective bed capacity
- New antibiotic therapy service to support patients at home

Flow out

Improving safe and timely hospital discharge

- Improving access to alternative care settings e.g. Rainbows
- Expansion of virtual wards to children's hospital
- Criteria-led discharge for children's respiratory and gastroenterology
- Improving length of stay in respiratory and gastroenterology