CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – DECEMBER 2018

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Trust Board paper D

Executive Summary

Context

The Chief Executive's monthly update report to the Trust Board for December 2018 is attached. It includes:-

(a) the Quality and Performance Dashboard for October 2018 attached at appendix 1 (the full month 7 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to our Strategic Objectives and Annual Priorities

Questions

1. Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

1. The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the Board's input regarding content of this month's report to the Board.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register [Not applicable]

If YES please give details of risk ID, risk title and current / target risk ratings.

Datix Risk ID	Operational Risk Title(s) – add new line for each operational risk	Current Rating	Target Rating	CMG
XXXX	There is a risk …			XX

If NO, why not? Eg. Current Risk Rating is LOW

b. Board Assurance Framework [Not applicable]

If YES please give details of risk No., risk title and current / target risk ratings.

Principal Risk	Principal Risk Title	Current Rating	Target Rating
No.	There is a risk …		

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

4. Results of any **Equality Impact Assessment**, relating to this matter: [N/A]

5. Scheduled date for the **next paper** on this topic: [January 2019 Trust Board]

6. Executive Summaries should not exceed **12pages**. [My paper does comply]

7. Papers should not exceed **7 pages.** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **6 DECEMBER 2018**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – DECEMBER 2018**

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1 Introduction

1.1 My monthly update report this month focuses on:-

(a) the Board Quality and Performance Dashboard attached at **appendix 1**;

(b) the Board Assurance Framework (BAF) and Organisational Risk Register;

(c) key issues relating to our Annual Priorities, and

(d) a range of other issues which I think it is important to highlight to the Trust Board.

1.2 I would welcome feedback on this report which will be taken into account in preparing further such reports for future meetings of the Trust Board.

2 Quality and Performance Dashboard – October 2018

2.1 The Quality and Performance Dashboard for October 2018 is appended to this report **at appendix 1**.

2.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

2.3 The more comprehensive monthly Quality and Performance report continues to be reviewed in depth at a joint meeting of the People, Process and Performance Committee and Quality and Outcomes Committee. The month 7 quality and performance report is published on the Trust's website.

Good News:

2.4 **Mortality** – the latest published SHMI (period April 2017 to March 2018) has reduced to 95 and is within the threshold, but now very close to "below expected", for the first time. **Diagnostic 6 week wait –** standard achieved for 2 consecutive months. **52+ weeks wait –** has been compliant for 4 consecutive months. **Cancer Two Week Wait** was 95.2% in September. **Referral to Treatment –** our performance was below national standard however we achieved NHSI trajectory with the overall waiting list size (which is the key performance measure for 18/19) 0.7%

above plan. **Delayed transfers of care** - remain within the tolerance. However, there are a range of other delays that do not appear in the count. **12 hour trolley wait** was 0 in October. **MRSA –** 0 cases reported this month. **Pressure Ulcers** - 0 **Grade 4** reported during October. **Grade 3 and Grade 2** were also 0 for the month. **CAS alerts** – we remain compliant. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **Fractured NOF** – was 83.6% in October. **Annual Appraisal** is at 92.1% (rising trend).

Bad News:

2.5 **UHL ED 4 hour performance** – was 78.3% for October, system performance (including LLR UCCs) was 83.7%. **C DIFF –** 6 reported this month. **Single Sex Accommodation Breaches** – 9 breaches in October. **Cancer 31 day** and **62 day treatment** was not achieved in September. **Cancelled operations** and **Patients rebooked within 28 days** – continues to be non-compliant. **Moderate harms and above** – September (reported 1 month in arrears) was above threshold. **Ambulance Handover 60+ minutes (CAD+)** – performance at 2%. **TIA (high risk patients)** – 38.6% reported in October. **Statutory and Mandatory Training** reported from HELM is at 88%.

3 Board Assurance Framework (BAF) and Organisational Risk Register

3.1 The Board Assurance Framework (BAF) and organisational risk register have been kept under review during October 2018 and a detailed BAF and an extract from the risk register are included in the integrated risk and assurance paper featuring elsewhere on today's Board agenda.

Board Assurance Framework

3.2 The BAF remains a dynamic document and all principal risks have been updated by the lead Directors (to report performance for October 2018) and reviewed by the relevant Executive Boards during November 2018, where they have been scrutinised ahead of the final version to the Board today.

3.3 The three highest rated principal risks on the BAF are in relation to staffing levels, the emergency care pathway and delivery of the financial control total.

Organisational Risk Register

3.4 The Trust's risk register has been kept under review by the Executive Performance Board and across all CMGs during the reporting period and displays 226 risks, including 76 rated as high (i.e. with a current risk score of 15 and above), 143 rated moderate and seven rated low.

3.5 Thematic analysis of the organisational risk register shows the two most common risk causation themes are workforce shortages and imbalance between service demand and capacity. Managing financial pressures is also recognised on the risk register as an enabler to support the delivery of the Trust's objectives. These thematic findings from the risk register are reflective of our highest rated principal risks captured on our BAF.

4 Emergency Care

4.1 Our performance against the four hour standard for October 2018 was 78.3% and 83.7% for Leicester, Leicestershire and Rutland as a whole.

4.2 Under the leadership of the Chief Operating Officer, working through the Urgent Care Board, we continue to implement our action plan to improve performance. Progress on implementing the plan is being made but we are not yet seeing a positive impact on performance due to a growing number of attendances and an increasing proportion of patients arriving by ambulance, which has put pressure on our ambulance assessment and 'majors' areas.

4.3 The number of patients conveyed by ambulance to the hospital in October 2018 was 9% higher than the same period last year. With resource diverted to deal with the acutely unwell ambulance arrivals, we have experienced occasions of longer waits in the areas of injuries and primary care, impacting on our ability to improve performance against the 4 hour wait standard.

4.4 We are continuing to implement the following initiatives to address these pressures:-

- co-horting policy implemented at 20 minutes,
- additional administrative staff deployed at peak ambulance arrival times to support the booking-in process,
- routine use of the 'majors sub-wait area' both during daytime and overnight in order to support patient flow,
- working with the East Midlands Ambulance Service to reduce the conveyance of patients from care homes, where clinically appropriate.

4.5 A number of other key initiatives aimed at improving process flow are listed below:

- ED Floor managers now fully recruited to cover to 2AM 7 days a week,
- Ambulatory stream utilising majors sub-wait now consistently staffed,
- Improving the function of the flow team and bed co-ordinators under the leadership of the Head of Patient Flow,
- Development of a new assessment model in adult walk in assessment to reduce the time patients spend in this area before transfer,
- Improved clinical leadership of nurse practitioners to improve efficiency and consistency,
- Recruitment to uplifted Junior Trust Grade positions to better match the inflow of patients,
- Radiographer-led discharge directly from Small Parts X-Ray to streamline the patient journey and reduce duplication,
- Rapid cycle testing of new model in Majors to support rapid decision-making and turnover of patients in Majors,
- Substantively recruit to ED Consultant gaps to reduce reliance on locums and improve leadership.

4.6 Details of the Trust's emergency care performance continue to be the subject of report by the Chief Operating Officer monthly to the People, Process and Performance Committee.

4.7 Details of the Leicester, Leicestershire and Rutland Winter Plan 2018/19 are attached at **appendix 2.** Further details of the UHL Winter Plan 2018/19 are also the subject of a report by the Chief Operating Officer to the November 2018 meeting of the People, Process and Performance Committee. That Committee continues to review our emergency care performance and plans for improvement at each of its meetings, and details of the Committee's most recent consideration of the position are set out in the summary of that meeting which features elsewhere on this Board agenda.

5. Financial Position 2018/19

5.1 As previously agreed by the Trust Board, taking into account the cessation of our plans to establish a Facilities Management subsidiary, we are forecasting a deficit of £51.8M in 2018/19.

5.2 The Trust's 2018/19 financial position was discussed in detail at the recent quarterly review meeting held with NHS Improvement on 23rd November 2018. Further discussions are taking place with NHS Improvement about the position.

5.3 We are working hard to identify additional ways of saving money whilst ensuring that we maintain clinical quality for our patients.

5.4 Further information is set out in the Chief Financial Officer's report which features elsewhere on this Board agenda.

6. Collaborative Working with the University of Leicester

6.1 A paper features elsewhere on this Board agenda on a proposal to formalise partnership working between the Trust, University of Leicester and Leicestershire Partnership NHS Trust, but I thought it would be helpful to make note of a good example of collaborative working between the Trust and the University in respect of genetics laboratories.

6.2 Leicester Molecular Diagnostics (LMD) of the University of Leicester and the Leicester Genetics Laboratory (LGL) of the Trust are situated on the Leicester Royal Infirmary site. Both departments provide molecular diagnostic services for research and, additionally, the LGL provides specialised clinical diagnostic genetic testing which is accredited to ISO 15189. The LGL is also part of the East Midlands East of England Genomic Laboratory hub led by Cambridge University Hospitals.

6.3 Partnership working with the University of Leicester is core to delivering our 5 year strategy. Collaboration between the LMD and LGL has the potential to improve productivity, allow sharing of space, expertise and equipment, accelerate translation of research, and increase access to clinical and commercial trials.

6.4 Against this backdrop, at its meeting on 13th November 2018 the Executive Strategy Board agreed to formalise the collaborative working between LMD and LGL under a Memorandum of Understanding to be entered into formally by the two organisations.

7. Conclusion

7.1 The Trust Board is invited to consider and comment upon this report and the attached appendices.

John Adler
Chief Executive
30th November 2018

Quality & Performance

		YTD Plan	YTD Actual	Oct-18 Plan	Oct-18 Actual	Trend*	Compliant by?
Safe	S1: Reduction for moderate harm and above (1 month in arrears)	142	136	<=12	19	●	
	S2: Serious Incidents	<37	22	3	1	●	
	S10: Never events	0	5	0	1	●	
	S11: Clostridium Difficile	61	40	5	6	●	
	S12 MRSA - Unavoidable or Assigned to 3rd party	0	0	0	0	●	
	S13: MRSA (Avoidable)	0	1	0	0	●	
	S14: MRSA (All)	0	1	0	0	●	
	S23: Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<5.6	6.4	<5.6	6.1	●	
	S24: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●	
	S25: Avoidable Pressure Ulcers Grade 3	<27	3	<=3	0	●	
	S26: Avoidable Pressure Ulcers Grade 2	<84	36	<=7	0	●	
Caring	C3: Inpatient and Day Case friends & family - % positive	97%	97%	97%	97%	●	
	C6: A&E friends and family - % positive	97%	95%	97%	95%	●	
	C10: Single Sex Accommodation Breaches (patients affected)	0	41	0	9	●	
Well Led	W13: % of Staff with Annual Appraisal	95%	92.1%	95%	92.1%	●	
	W14: Statutory and Mandatory Training	95%	88%	95%	88%	●	
	W16 BME % - Leadership (8A – Including Medical Consultants) - Qtr 2	28%	29.0%	28%	29.0%	●	
	W17: BME % - Leadership (8A – Excluding Medical Consultants) - Qtr 2	28%	15%	28%	15%	●	
Effective	E1: 30 day readmissions (1 month in arrears)	<8.5%	9.1%	<8.5%	8.8%	●	
	E2: Mortality Published SHMI (Apr 17 - Mar 18)	99	95	99	95	●	
	E6: # Neck Femurs operated on 0-35hrs	72%	70.4%	72%	83.6%	●	
	E7: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	84.5%	80%	82.8%	●	
Responsive	**R1: ED 4hr Waits UHL**	95%	79.6%	95%	78.3%	●	See Note 1
	R2: ED 4 Hour Waits UHL + LLR UCC (Type 3)	95%	85.1%	95%	83.7%	●	See Note 1
	R4: RTT waiting Times - Incompletes (UHL+Alliance)	92%	86.0%	92%	86.0%	●	See Note 1
	R6: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	0.9%	<1%	0.9%	●	
	R12: Operations cancelled (UHL + Alliance)	0.8%	1.1%	0.8%	1.2%	●	
	R14: Delayed transfers of care	3.5%	1.4%	3.5%	1.6%	●	
	R15: % Ambulance Handover >60 Mins (CAD+)	TBC	2%	TBC	2%	●	
	R16: % Ambulance handover >30mins & <60mins (CAD+)	TBC	6%	TBC	8%	●	
	RC9: Cancer waiting 104+ days	0	13	0	13	●	

		YTD Plan	YTD Actual	Sep-18 Plan	Sep-18 Actual	Trend*	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	93.7%	93%	95.2%	●	
	RC3: 31 day target - All Cancers	96%	95.9%	96%	95.4%	●	
	RC7: 62 day target - All Cancers	85%	75.0%	85%	71.7%	●	Dec-18

Enablers

		YTD Plan	YTD Actual	Qtr2 18/19 Plan	Qtr2 18/19 Actual
People	W7: Staff recommend as a place to work (from Pulse Check)		61.1%		61.9%
	C10: Staff recommend as a place for treatment (from Pulse Check)		72.8%		75.2%

		YTD Plan	YTD Actual	Oct-18 Plan	Oct-18 Actual	Trend*
Finance	Surplus/(deficit) £m	(11.5)	(42.7)	5.7	(2.7)	●
	Cashflow balance (as a measure of liquidity) £m	1.0	7.0	1.0	4.1	●
	CIP £m	18.7	17.1	4.4	3.2	●
	Capex £m	18.4	10.0	2.3	2.1	●

		YTD Plan	YTD Actual	Oct-18 Plan	Oct-18 Actual	Trend*
Estates & facility mgt.	Average cleanliness audit score - very high risk areas	98%	96%	98%	97%	●
	Average cleanliness audit score -high risk areas	95%	93%	95%	94%	●
	Average cleanliness audit score - significant risk areas	85%	**93%**	85%	**94%**	●

* Trend is green or red depending on whether this month's actual is better or worse than the average of the prior 6 months

Please note: Quality Commitment Indicators are highlighted in bold. The above metrics represent the Trust's current priorities and the code preceding many refers to the metrics place in the Trust's Quality & Performance dashboards. Please see these Q&P dashboards for the Trust's full set of key metrics.

Note 1 - **'Compliant by?'** for these metrics a are dependent on the Trust rebalancing demand and capacity.

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Leicester City, Leicestershire, and Rutland (LLR)

Health and Social Care System

Resilience Winter Plan 2018/19:

Summary

(Excluding Embedded Provider-Specific Plans)

Name of document:	LLR System Resilience Plan 2018/19 Executive Summary
Version:	V15
Status:	Summary
Owner:	AEDB
File location/Filename:	Resilience/Winter 201819/PlanV14-Final
Management:	Mike Ryan, Director of Urgent and Emergency Care; LLR Urgent and Emergency Care (UEC) Team
Engagement and Consultation undertaken:	Priorities and key messages: • AEDB member organisations • System Integrated Urgent and Emergency Care Group • Health and Wellbeing Board (Leicester City) • Overview and Scrutiny (Leicester City) • Overview and Scrutiny (Leicestershire County and Joint) • LLR Prepared and Resilience Partnership • Leicestershire Fire and Rescue • Leicestershire Police • Healthwatch Leicestershire • NHSE England • NHS Improvement • CCG Governing Body
Equality and Diversity Impact Assessment:	N/A
Approved by:	AEDB 21/11/18

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Purpose and Introduction

The purpose of this paper is to summarise the LLR winter resilience plan, and outline additionality and identified risks for the winter period 2018/19.

There remain a number of key areas for AEDB to remain focused upon as part of urgent and emergency care (UEC) priorities within Inflow, Flow, and Outflow. The plan has been continually tested and adjusted throughout its development to reflect the increased pressure and volume of demand since July. It is however clear that in most areas demand has continued to grow since then and the taking action early this year has enabled better management of demand both inside and outside of hospital to ensure patients receive safe and effective care from a well-coordinated local health and social care system. The overall effectiveness of the plan is to ensure system partners work together to identify and manage the inevitable peaks in the most appropriate way; with the most effective use of professionals and minimising attendance and admission to hospital where possible.

Last winter was extremely challenging nationally and locally for LLR, and in particular pressures felt at UHL reflected in their daily Operational Pressure Escalation Level (OPEL) declarations with 90% of days at OPEL 3 or 4. For short periods of time some services were overwhelmed in various parts of the system. Front line staff showed fantastic commitment and professionalism in response to growing pressures, but the situation was known to be relentless and unsustainable. Since new OPEL processes this summer LLR / UHL has rarely been above OPEL 2 demonstrating improved process and effective action with 13% days above OPEL 2 - although demand mirrors last year's winter demand levels. This demonstrates the importance of establishing the discipline of defined BAU, escalation thresholds and triggers, and corresponding actions.

Significant progress has been made the past six months to embed recommendations and improvement needs identified from learnt lessons from 2017/18 into UEC priorities that were endorsed by the LLR AEDB in July 2018. Further additionality is identified with additional national and regional funding identified to support specific areas for improvement, and thus the winter resilience plan will serve as a dynamic plan. Overall readiness has been assessed as:

- Improved position going into winter – 'on the front foot.'
- Lessons learnt recommendations embedded within UEC priorities May/June 2018.
- Different approach taken this year to align with wider public services and five key system priorities.
- Plan alignment to national, regional, local expectations.
- Anticipate challenging winter period, including acuity of frail patients. Risk via A&E Delivery Board (AEDB).
- Increased demand year round – services continue to demonstrate improved resilience.
- Review processes built in for continuous improvement and monitoring dashboard.
- Assurance checks to date to test plans:
    - NHS England 'Pulse Check' submission
    - Winter Assurance Visit 22nd November - Verbal feedback highly positive and improved position ahead of expected pressure.

Summary

The purpose of the winter resilience plan is to enable a coordinated approach to managing the expected rise in demand across all health and care services, and provide assurance to patients and the public that there are plans in place which connect public services and demonstrate how LLR will prevent escalation when times are challenging as well as how LLR will de-escalate when surge in demand stretches staff and services above normal levels.

Planning for winter and general surge in demand is a complex process due to number of variables involved. All local A&E delivery boards (AEDBs) are required to submit comprehensive winter plans covering from 01 December up to the Easter holidays. This includes preparation across the wider system as well as hospital A&E or 'front door' services, internal hospital flow processes and multi-organisation discharge processes, upgrading business continuity arrangements, as well as demand and capacity planning to ensure sufficient capacity is available to meet expected demand.

The LLR winter plan bridges multiple public service plans to support proactive and reactive preparation and actions which will create a more visible resilience for patients in times of surge and increased demand for services, and better value for money to the public purse. With the need for a longer-term, sustainable approach to urgent and emergency care, the winter planning approach across LLR has specifically focused upon building and sustaining resilience that is visible and in place at all times to:

- Maintain critical and essential services;
- Maximise the utilisation of resources by working in partnership both systematically and effectively;
- Maintain business as usual and minimise risk to patients during periods of pressure or surge; and
- Promote personal resilience to maximise safety amongst the public, including enabling both patients and staff to choose the right services through communication campaigns and engagement.

In addition, a winter performance dashboard and storyboard have been created to ensure monitoring of key data on a daily basis to inform where pressure is building and how to respond accordingly. This includes connecting key activity data with performance achievement inside and outside hospital, and will be reviewed daily by the LLR urgent and emergency care (UEC) team, and shared and reviewed collaboratively on a weekly basis to support continuous learning and improvement.

Aims

A whole system approach has been undertaken to ensure visibility of individual provider priority actions and system management, with measures to address the demand for services from an individual's home through to acute hospital care.

The overarching aim of the winter plan is to ensure that all services across health and social care will have refreshed and updated resilience plans, and that staff are drilled and aware of these plans. Summary Aims:

- Reduce overcrowding in ED through alternatives and increasing non conveyance rates;
- Work within the footprint of defined, existing bed capacity;
- Visibility and partnership working with public services outside of health and social care in aligning plans; practical aspects of winter – keep warm, every contact counts;
- Avoid situations whereby care provided in corridors occurs and risks can be mitigated;
- Clear organisational and system-wide surge and escalation management protocols, with the management of system escalation levels led by the WLCCG UEC team;
- Ensure a regimented and disciplined approach to maintain consistent process;
- Assurance all services have and maintain priority actions and resilience plans;
- Community flu vaccination and increase health and social care staff take up;
- Direct communications to at risk patients; care plans and self-care, etc;
- Building the relationships across the system for providers to manage pressures effectively;
- Multi-agency Discharge Events pre and post the Christmas and New Year period, to accelerate discharge flows and free up maximum bed capacity to cope with anticipated bed pressures;
- Clear understanding of how UHL's ED is prepared to meet expected demand;
- Confirmation of UHL bed capacity gaps and System Partner priority actions.
- Use of additional escalation bed capacity in both UHL and LPT when required in response to admission rates and occupancy levels;
- Multi-agency on call training in relation to escalation protocols;
- Demand forecasting by individual organisations, informing rota planning with additional capacity over key days.
- Assurance of outside hospital service activities, including increasing urgent care system capacity and primary care out of hours services;
- Additional social care capacity in-reach to hospitals over the winter period (subject to funding);
- Additional capacity in designated GP practices, primary care hubs and Urgent Treatment Centres from December onwards (subject to funding);
- System flu plan

Governance

The LLR A&E Delivery Board (AEDB) has overall responsibility for leading system resilience, winter planning, and response to escalation to ensure proactive planning for expected increase in demand throughout the winter period.

To effectively manage system pressures, the AEDB acknowledge that performance is dependent upon maintaining strong multi-agency collaboration, particularly to support patient flow within hospital and outside hospital.

Plan Interdependencies and Integrated Emergency Management (IEM) Principles

This winter plan should be read in conjunction with the following cross-organisation documents outlined as appendices:

- Individual organisation winter operating plans, business continuity plans, and infection prevention and control policies as appropriate.
- Leicestershire Resilience and Major Incident Response Plan
- Regional and National directives (numerous)
- System flu plan
- Multi-Agency LLR Adverse Weather Plan and National Cold Weather Plan
- Local 4 x 4 transport plan

LLR recognises the expectations of members of the public, as well as NHS England and NHS Improvement, and has submitted its assurance plans for consideration. Known as a 'pulse check' it is designed to draw attention to the different variables involved in health and social care to identify any areas for improvement to ensure LLR is appropriately prepared. This particularly relates to:

- Forecast demand to capacity alignment;
- Preparing and testing operational readiness;
- Joint working between health and social care;
- Provision of critical and emergency care services;
- Preventative measures captured via multiple communication campaigns including immunisation programmes for patients and staff;
- Reducing long stay patients in hospital;
- Working with ambulance services to enable effective patient handover and transporting patients for care to the right place, first time;
- Delivery of out of hours services; and

- Consistent and robust communication system across networks

In addition, the plan applies the fundamental principles of integrated emergency management (IEM) to ensure continuity of management and system escalation processes:

- **Anticipate -** Be aware of new hazards and threats facing the health economy.
- **Assess -** The hazards and threats for likelihood of occurrence and their impact
- **Prevent -** The range of actions taken to limit the likelihood of occurrence, and the effects or impact of any threats.
- **Prepare -** Appropriate planning arrangements and management structures
- **Respond -** Management of immediate consequences of an incident or emergency.
- **Recover -** Plans and actions to return to normal activity following an interruption.

Testing the Plan

Following the 2017/18 winter period, a review was carried out to learn lessons and ensure the LLR system improves patient experience and performance. Priority initiatives and projects for the year were agreed in May/June 2018 to build improved capacity and capability within the urgent and emergency care system that meets patient needs and expectations, and thus the winter plan priorities began earlier this year. Throughout the year to date, the system has experienced significant increases in demand for services and as a result continually tested these system improvements over the course of the year and led to adjustments.

The Integrated Urgent and Emergency Delivery Group is a multi-agency operational group reporting into the AEDB which has acted to embed the plan as the operational resilience group for continuously improving LLR response and resilience throughout the winter period. Members have further contributed to the review and refinement of processes and defined escalation plans.

LLR Operational Pressure Escalation Level (OPEL) Protocols Revised

Escalation protocols known as operational pressure escalation levels (OPEL) protocols and corresponding actions were updated over a period of months and agreed in October 2018 to ensure that health and care partners across LLR are coordinated to respond quickly and appropriately to all/any increased service demands or patient needs experienced within an area which in turn places heightened pressure on the system.

It is acknowledged across LLR that demand and capacity fluctuations are no longer purely a 'winter' phenomenon, and are material issues throughout the year requiring a systematic and consistent response to managing general increase in demand. In addition, various mechanisms

have existed historically to manage these issues depending on the level of escalation or pressure which in turn have been updated.

Revised OPEL protocols describe how LLR:

- Responds to periods of high demand caused by multiple variables which may include local public events, seasonal illness, flu, infection control, or adverse weather – ensuring that there is a well-coordinated and planned response to create the necessary capacity to meet additional need;
- Proactively makes decisions to act upon predicted surges of demand as well as managing future demand – this includes preventing escalation and mobilising actions to de-escalate quickly; and
- Declares appropriate OPEL level using updated escalation triggers to ensure an integrated and shared process between primary, community, secondary, and social care providers.

OPEL 1 (BAU / signs of early pressure)	**OPEL2** (moderate pressure / number of providers reporting issues)	**OPEL 3** (severe or prolonged pressure across providers, prolonged recovery)	**OPEL 4** (multiple/ confirmed pressure, unsustainable increase in demand)

LLR On Call Directors are responsible during out of hours for both the proactive and reactive management of capacity issues (general escalation or winter surge), and therefore will be involved in the management of critical and/or major incidents, taking a lead role where these incidents affect health and social care patients. The system Emergency Preparedness Resilience and Responsiveness (EPRR) policy and protocols have been updated to link EPRR and OPEL processes and enable clear roles and responsibilities.

The LLR UEC team has worked closely with providers to define normal business as usual and baseline everyday operations to differentiate between routine actions related to internal pressure and more impactful triggers for escalation, e.g. emergency departments are generally very busy any time of the year, but there is natural variation to which the hospital has little control over and thus escalating actions are likely to have little impact. LLR has further established a local escalation tool whereby providers submit situational reports twice daily, and an email automatically circulates key information to key stakeholders to highlight areas of escalation and inform immediate actions. There are defined fields of information to determine when system-wide teleconference calls are required, and provides an effective benchmark for determining what actions an individual organisation can take or has already taken before

escalating for wider system support. This process and tool is assessed and overseen by the UEC Team, and forms an important enabler for ensuring the system continuously monitors and improves during the winter period.

Reflection - 2017/18 Winter Period

The winter period of 2017/18 was a particularly difficult for all both locally and nationally with an extended period of relentless demand felt by all services from November through to April/May. Throughout the winter period, the high acuity of patients coming into and staying within the acute Trust often compromised patient flow and triggered the need for full capacity plans to be activated. Furthermore, the high number of influenza, norovirus and D&V challenged the system.

As part of the review, a number of lessons were learnt and embedded into UEC priorities for the year with actions therefore underway since May 2018 in preparation for the upcoming winter period. These include key areas for improvement and included the need to:

- reduce occupancy rates and address bed capacity across the Trust;
- embed rapid flow processes and reduce avoidable process delays;
- address staffing issues within both ED and wards to improve flow;
- continue to develop community alternatives to admission and to support rapid discharge; and
- bridge other public service plans for winter to better work together for the public and patients.

Themes and recommended actions were collated and shared with the AEDB in May and June 2018. The following table highlights those recommended actions, and what LLR has done to address them:

No.	17/18 Winter Review	18/19 Response and Winter Assurance
1	Additional medical ward capacity at both LRI and GGH	UHL capacity transitioned to accommodate 4% growth.
2	Strengthened medical capacity within ED and paediatric ED, including overnight	Medical staffing rotas reviewed and strengthened.
3	Embed the ED flow manager role	Flow management function clarified with focus on non-admitted breaches across all areas. All posts are recruited and cover from 8.30am until 01.00am. 7 day service from 31/12/18. Rapid flow function established.

4	EMAS urgent dedicated crews to reduce late PM ambulance presentations	General management review of peak demand to align crew capacity. Prediction tool refined and shared to AEDB.
5	Improvements to UHL and LPT length of stay to reduce bed occupancy.	Red to Green is in practice at both UHL and LPT, with improved discharge processes through the enhanced IDT.
6	Additional specialist discharge nursing capacity within UHL	Integrated discharge team (multi-agency) capacity increased.
7	Improvements to the transport booking and interface process at UHL	Closer working and planning of patient transport service capacity.
8	Review of UHL internal escalation protocols and plans in a number of areas, including handover protocols, rapid flow, etc.	Protocols reviewed and updated alongside refinement of OPEL level definitions and corresponding actions.
9	Review of discharge to assess with improved pathways in place before winter 2018.	Discharge to assess pathways reviewed and enhanced. Pathway 3 procurement framework established to enable more discharging capacity as/when needed.
10	Redesign of the ICS to develop integrated home based rapid response/reablement support.	ICS services reviewed. Subject to funding, enhance reablement / ICRS capacity to bridge packages of care over the winter period.
11	Improve patient flow into Community hospitals from UHL, including review of referral criteria and bed allocation processes	LPT and UHL collaboration to ensure referral criteria reflect patient needs and system capacity availability.
12	Strengthened domiciliary care capacity, particularly in areas of Leicestershire to improve the availability of packages of care	Subject to additional resource, actions to maintain and enhance the number of dom care hours to ensure timely discharge and improve DTOC
13	Risk sharing arrangement between CCGs and Local Authorities to accelerate discharges following CHC assessments.	Agreed and in place summer 2018.
14	Risk sharing agreement between CCGs and UHL to support discharge to assess.	Agreed and in place summer 2018.
15	Review of IPC protocols including changes to discharge policies linked to OPEL levels, and strategies for admission avoidance of patients with norovirus/D&V who could be managed without admission.	IPC protocols updated and captured within both new Integrated Discharge Team (IDT) function, and OPEL level actions for increased visibility. Actions include assessment and multiple considerations to inform decisions.
16	New Emergency Floor 2 model aiming to reduce ward admissions	Emergency Floor phase 2 implemented in June. Audit of activity to take place December/January to evidence areas for improvement.

2018/19 Structured Priorities

The 2018/19 plan builds on the existing urgent and emergency care priorities and plans which incorporate lessons learnt from previous years across Inflow, Flow, and Outflow, as well as new initiatives from across the system specifically to support this winter.

The scope of the plan is designed to cover 1st November 2018 to 30th April 2019 to ensure realistic application to expected surge in demand and pressure on services. It incorporates all areas in which the LLR population will encounter during the course of winter and aims to ensure clarity of plans to enable the management of increases in demand and minimise disruption to services. The system has not to date received any additional, specific funding to support winter plans for 2018/19 as opposed to 2017/18.

LLR has focused upon five key system structured priorities to enable stability of performance, and quality and safety:

1. **Connectivity for Operational Grip;**

    a. OPEL Processes ,Thresholds, Reporting
    b. Actions,
    c. Practical aspects of winter,
    d. Monitoring performance, and quality and safety
    e. Communication Campaigns

2. **Hospital Flow, Capacity Planning, and Functionality**

3. **Demand Management Initiatives,** as well as support triaging patients (acute and mental health) away from A&E departments and admitted pathways.

4. **Ambulance Handover Management**

5. **Discharge;** IDT plus and Reducing Long Stay Patients by 25%

Additionality – What's New for 2018/19 and will make a difference?

Work is ongoing to align and agree the most appropriate measures to demonstrate the impact of each intervention and use of resource, to ensure they are monitored to establish effectiveness and enable continuous improvement over the course of winter as well as ensuring a consistent baseline to support post winter review. This includes an initial stock take and evaluation of perceived gaps at local provider levels that may benefit from additional funding, recurrent or non-recurrent, and will enable continuous improvement throughout the winter period and inform 2019/20 UEC system priorities.

The following represent the additional activities undertaken in preparation for winter 2018/19 across the LLR system outlining the general, demand management, processes, hospital capacity and flow, patient cohort specific, primary care, and targeted communications:

- **General:**
  - New approach to winter resilience planning; connectivity across all services and alignment to practical aspects of winter and wider engagement with key stakeholders.
  - Lessons learnt embedded in UEC Priorities since May18.
  - Identification and understanding of expectation through listening to what people care about.
  - Overarching plans reviewed individually and collectively.
  - Detailed Cold/Severe weather planning.
  - Targeting of specific patient groups (frailty, respiratory, vulnerable).

- **Demand Management Initiatives to help avoid hospital attendance and admission:**
  - Focused projects with Care Homes (telemedicine, red bag scheme, Pathway 3 procurement).
  - Clinical Navigation Service and connecting clinicians; improved communication systems developed between consultants and GPs.
  - Ambulance conveyance to urgent treatment centres for specific, category 3 conditions as alternative to LRI ED.
  - Maintenance of Consultant Connect Advice Line. Further expansion planned.
  - Enabling increased professional capacity for MH crisis and response to reduce and prevent ED attendances (subject to resource allocation).
  - Mobilisation of a Digital Minor Illness Referral Service; NHS 111 direct patient referral into Community Pharmacies for minor ailments, with 75 pharmacies live and taking referrals from early December.
  - Connecting urgent care services - Enabling full utilisation of urgent care services across UEC pathways, 111 and the home visiting service; Clinical triage in the clinical navigation hub, including green ambulance triage within NHS 111.

- **Processes and People Behaviour:**
  - Focussed review and revision of the system Escalation Processes.
  - Improved access to IT systems so clinicians are able to see the patient's clinical record.
  - New, improved protocols are agreed between UHL and EMAS to manage handovers.
  - Communications clearer to prevent escalation proactively v s reactive actions

- **Hospitals Capacity and Flow:**
    - The second part of the A&E development ED Phase 2 at UHL opened in June, with the creation of the full emergency floor, which provides improved patient assessment areas.
    - ED floor managers to oversee patient flow.
    - UHL has re-aligned their bed capacity overall and created additional ward capacity to meet the expected increase in medical patient demand. Equivalent to 3 to 4 wards.
    - Further embedding of the Safer Care Bundle and Red2Green practice on wards with staff education/training programme.
    - Development of ambulatory care pathways within hospital to support flow.
    - We have forecast in detail how much emergency capacity is required at 92% occupancy.
    - Reducing long stay patients by 25% (from 200 to 150).
    - Improved discharge pathways which aim to get patients out of hospital and either back home or into a suitable care setting for assessment of their future needs.
    - Working with LPT to evaluate and clarify criteria for discharge to enable clear communication during periods of pressure.
    - Ambulance handover management
    - Additional patient transport capacity planned to ensure that transport enables patient flow and does not contribute to delayed discharges.
    - Additional hospital imaging capacity at weekends to maintain patient flow;
    - Pharmacy support;
    - Revised referral processes and criteria between UHL and LPT to enable access to community hospital capacity as/when appropriate.

- **Patient Cohort Specific**
    - Self-Care - We are supporting more patients with self-care to understand and manage their conditions, with respiratory and cardiorespiratory patients a major focus.
        - Hand hygiene
        - Respiratory/inhaler use
        - Norovirus and gastro
        - Sports injuries
        - Winter buddy factsheet
        - Self-care booklet
        - Interactive digital medicine box
    - Frailty Programme - Collaborating system-wide to design a new pathway for frail patients based upon local needs and national standards, alongside other

interventions to help battle 'isolation' and engage carers and voluntary organisations.
  - Respiratory Programme - Collaborating system-wide new pathways for respiratory patients (Impact Jan19)

- **Primary Care**
  - Extended Access with increased pre bookable and same day appointment availability.
  - City Hub capacity
  - Development of additional schemes (subject to funding)

- **Communications – proactive, planned, preventative messages**
  - National messages
  - Flu
  - NHS 111
  - Antibiotics
  - Self Care
  - Stay Well
  - GP Extended Access
  - Pharmacy

Identified Areas of Risk and Mitigation

The following are identified as identified variable risks to an effective management of winter pressures:

No	Category	Risk	Origin	Ongoing Actions and Mitigations	Expected Impact
1	Acute Bed Capacity	Hospital Bed Capacity Gap of circa 40-50 beds remains after internal UHL mitigation, impacting January 2019 at planned 92% occupancy. Primary risk without quantified mitigation of gap	Sep-18	Additional 'tip ins' identified as system priority enablers but impact is subject to monitoring. Existing schemes anticipate conversion impact of circa 15-20 beds. Close monitoring through OPEL to enable visibility of risks and initiate	Bed gap mitigated through system efficiencies.

		via system.		additional capacity options (ICS, Pathway 3, etc.)	
2	Workforce	All provider organisations maintain gaps in workforce.	Sep-18	Individual provider plans to mitigate risks and ensure continuity of care.	Close monitoring through sitrep to ensure key indicator and OPEL link to action to minimise risk.
3	Demand	Volume of patients into ED is significantly higher than anticipated (note change of paediatric pathway yielding 25-30 additional attendances).	Oct-18	Activity profiling to target specific sources of demand. Demand management analysis and initiatives, including target communications.	Increase demand outside of hospital to offset ED demand. Target key patient groups. Monitor through daily sitrep.
4	Demand	Ambulance activity is higher than predicted, with 15% 25-30 conveyances typically category 3 urgent which could be seen elsewhere.	Sep-18	Demand management initiatives. EMAS and DHU ongoing mobilisation to establish alternatives and use of Clinical navigation hub to avoid hospital conveyance where possible.	Conveyance of appropriate Category 3 to LUCC increased.
5	Demand	Communication campaigns causing natural demand – whereby patient expectations have risen.	Sep-18	Targeted communications. Education messages to support access to right care, first place, first time.	Patients access appropriate services first time. Monitor through data sharing and tracker.
6	Resource	Uncertainty of winter funding for Adult Social care contribution.	Nov-18	Allocation determination agreement.	Discharge flow and reducing long stay patients.
7	Resource	Lack of additional funding to purchase additional capacity from GPs / primary care.	Oct-18	Preparation of plans in primary care developing in the event of funding allocation.	Increased capacity into primary care.
8	Resource	Insufficient 24/7 service capacity to meet mental health needs for crisis	Oct-18	Risk remains and escalated. Plans proposed to access funding to mitigate.	Responsiveness to expected increase in mental health needs and attendance

		response.			avoidance.
9	Demand	Paediatric demand outstripping capacity; low levels of qualified workforce capacity impacting on critical care capacity.	Nov-18	Raised with critical care network and NHSE. Consideration of regional and national picture.	Plan for critical care network to ensure paediatric capacity meets forecast demand and continuity of care.
10	Capacity	Potential impact of redesigned capacity via new model for managing stroke capacity via wrap around services from Nov18.	Sep18	Wrap around services designed for home first support. Alignment to demand and forecast future demand. New model of care as part of agreed pathway redesign.	Continuous monitoring of demand/capacity.
11	Capacity	Mismatch of ICS capacity across x 3 CCGs to meet surge in demand. New process for utilisation of ICS beds to ensure capacity	Oct18	CCG patient origin process and checkpoint for monitoring occupancy (via daily escalation reporting and protocol tba).	Capacity unaffected but utilisation allocated to appropriate budgets.

University Hospitals of Leicester (UHL)

Last winter was very challenging at UHL, particularly the high level of patient acuity and the number of frail patients placing significant pressure within the hospital and the wider LLR system. More generally this fundamentally increased the pressure and impact on hospital flow, occupancy rates, patient length of stay, staffing, and the inability to utilise and flex bed capacity across sites as in previous years, and also had a detrimental effect upon performance and quality of service. A system-wide collaborative Frailty Programme Task and Finish Group was established earlier this year, with the Chief Executive chairing collaboratively tackle long-standing challenges with this patient group identified as medium-to-high risk for likely access to hospital/multiple admissions based on multiple morbidities and healthcare needs.

UHL has throughout the year taken considerable action to improve care and hospital flow, and implemented significant internal, operational improvements (process and workforce) in planning

capacity in response to anticipated demand. Both the internal Urgent Care Board and external A&E Delivery Board are assured that UHL is in a significantly better and stronger position in advance of the upcoming winter period 2018/19.

The UHL winter plan centres on:

- Ensuring Safe Care;
- Maximising the efficiency of existing bed capacity, and decreasing occupancy as much as possible - Activity and Capacity modelling, including identification of 'gaps' and mitigations;
- Ensuring efficient discharge including transfer processes from health to social care;
- Increasing bed/ward capacity by creating additional beds with robust staffing plans to ensure they can be utilised at times of need;
- Elective phasing (protection of ITU capacity) / switch off over winter;
- Robust intelligence on availability of urgent care alternative pathways (UCC, Pharmacy);
- Robust workforce planning for nursing, medical and support staff including overnight workforce planning in ED, GPAU and CDU;
- Description of efficiencies in place to address predicted challenges; and
- Monitoring and control/governance arrangements.

Summary Actions include:

- Trust investment in building greater resilience estimated to be £4million.
- Continued focus on embedding the SAFER care bundle and practice of Red to green.
- System action plan to decreasing long-stay patients and reducing length of stay by up to 25%.
- System-wide, multi-agency admissions avoidance events.
- Enhanced leadership over the festive and holiday period.
- An enhanced discharge lounge and protocol to ensure increased utilisation earlier in the day and throughout the day.
- Increased flow managers on the medical and surgical (CHUGGS) wards as a proof of concept funded through winter monies.
- Increased social services input as an expansion to the Integrated Discharge Team (IDT) funded through UEC transformation funds.

- Recognising the peak demand forecast in January, actions to enable the cancelation of non-urgent internal meetings in January
- Operational teams are supplemented by relevant expertise from corporate Nursing and corporate medical.

In addition, UHL has outlined specific behaviours and practice that will support routine monitoring and control of hospital operations, including:

- Lead Executive allocated and working on each site for all of January.
- Safety walk-arounds across acute admission areas.
- Daily focus on transferring patients from trolleys to beds when indicated.
- Safe nurse staffing checks led by silver nurse and overseen by Chief Nurse / Deputy.
- Silver / director quality checklist.
- Focus on maintaining Emergency ITU bed on each site.
- Medical Director and Chief Nurse focus on quality and safety in ED at weekly clinical review.
- If at OPEL level 4 - co-ordinated leadership by Medical Director, Chief Nurse and COO.
- Over each winter Bank Holiday there will be a Clinical / Operational Director on site.
- Rapid flow to admission areas where base ward beds are identified.
- Clear escalation areas and protocols for managing a 'full' hospital.
- Clear protocols agreed with both EMAS and LPT for managing inflow and outflow.
- Utilisation, embedding, and training of newly refined OPEL thresholds and processes that align internal hospital escalation response with external, system escalation response across all partners/providers.

Acute Hospital Bed Capacity Gap – Forecast at 92% Occupancy

UHL have made significant strides to forecast expected levels of bed capacity at 85% and 92% respectively, and throughout the year have taken action to mitigate risks of any mismatch between bed capacity and forecast demand. However, a bed gap overall was estimated to be approximately 40-50 beds in total as worse-case scenario during the busiest month of January

and largely across acute medicine and medical specialities. AEDB colleagues have identified a series of initiatives as enablers as further mitigation, with work ongoing to fully quantify the impact.

In light of the forecast bed modelling capacity gap at UHL, the following table outlines the series of LLR priority initiatives and enablers ('tip ins') to help mitigate this forecast gap:

No.	Priority (NEW 18/19)	Initiative/s	Benefit/Impact	Additionality
1	Reducing Long Stay patients over 21 days by 23% (46/200 patients) (NEW)	Integrated Discharge Team (IDT) plus to support avoiding admission at the front door and ensuring effective discharge.	Reduce long stay patients (c200) up to 25% (50 patients). Improved patient experience. Patient flow enabler. Improved processes.	Y Monthly Submissions
2	Discharge To Assess / Pathway 3 (NEW)	Procurement to establish additional capacity for reablement.	14 + 20 + new additional capacity as/when needed.	Y In Place
3	Referral and response co-ordination (NEW)	Co-coordinators for County HF service integrated ASC/Health offer	Extra resource taking referrals from all hospitals to avoid delayed discharge. Patient flow and patient experience	Y Ongoing Development
4	Presence in pre-admission areas (NEW)	Increase resource (currently have 1 x CSW to support pre-admission)	Admission Avoidance. Reduction in 4 hour breaches and reduction in admission to ED and base wards	Y In Place
5	Readmissions avoidance pilot (NEW)	Hinkley ILT Pilot;	Reduce avoidable readmissions in at risk cohorts with an emphasis on frailty checklist	Y Ongoing Development
6	Readmissions avoidance (NEW)	Extend access to HTLAH Health pathways	Reduced admissions and early discharge. Free up beds faster.	Y Ongoing Development
7	City D2A Home Pilot (NEW)	Pilot for 12 weeks with the intention of making this business as usual	Free up beds. Patient experience and outcomes. Flow. Ensure patients exit Hospitals on the correct pathway	Y Ongoing Development

8	Development of single point of access to City Home First services.	System-wide impact to improve patient flow.	More coordinated response from City Home First partners. Improved use of community resources. Significant benefits to Health and Social care practitioners; Enhanced partnership work; Improvement in patient experience; Ease of transfer of patients across disciplines	Y Ongoing Development
9	Development of step up and step down Home First	Enhanced offer at first contact for new referrals whether step up or step down.	System wide impact and improved patient flow. Ease of transfer of patients across disciplines	Y Ongoing Development
10	Development of Trusted Assessor Model (NEW)	Link with UHL for the development of Exemplar ward(s). Maintain rapid response to pre-admission wards – AFU and EFU.	Free up beds and increase flow. Prevent admission to base wards. Positive patient experience and outcomes and patients discharge on correct pathway. Early alerts and response and developing more flexible services	Y Ongoing Development
11	Demand Management and alternative conveyance activity. (NEW)	EMAS Conveyance to LUCC for non-complicated fractures, simple wound closures, COPD patients.	Reduced ED conveyance. Utilisation of resources	Y Ongoing Development
12	Integrated respiratory pathway (NEW)	Demand Management and containment given increased exacerbations in cold weather, including a large, holistic action plan.	Reduce zero length of stay emergency admissions. Reduce unwarranted variation across Primary Care in the management of respiratory patients, through consistent	Y

			delivery of best practice	
13	Frailty (NEW)	16 impact changes/initiatives. Patients managed outside hospital.	Admission Avoidance. Right care. Improved patient experience.	Y
14	Extended Access (NEW)	Increase in primary care appointment capacity.	Increased access to primary care appointments.	Y
15	First Contact Plus – LRF (NEW)	County Council Prevention. Enable every contact counts and sharing of information in targeting identified, vulnerable people.	Co-ordination of messages. Joint/co-ordinated approach with other public and voluntary agencies to enable practical approach making every contact count.	Y
16	Communication Campaigns (NEW)	Self Care, NHS 111, Universities, Target areas, Flu and Immunisation, Healthwatch, RTVF and media,	Information for public - measured	Y
17	Care/Nursing Home patients (NEW)	Red Bag Scheme	Reduced LOS and improved patient experience.	Y
18	Care/Nursing Home - Access to clinical advice (NEW)	Telemedicine and Clinical Navigation Scheme. Increase to the pilot and clinical capacity (transformation funds).	Access to GP/specialist advice to avoid ambulance where appropriate.	Y
19	Care/Nursing Home – enhanced care home bed state tracker (NEW)	Enhanced bed state tracker for care homes increasing visibility of capacity to support discharge efficiencies.	Reduce DTOC and therefore LOS across UHL and LPT allowing LLR to meet DTOC national trajectories and Reducing Long Stay ambition. Also providing key capacity in hospital over the winter period. Live care home bed state tracker is to be mandated by NHSE soon. Reduces calls to	Y

			care homes and admin time chasing freeing up staff time to care for patients/residents.	
20	Redirection protocol at UHL front door (NEW)	Enable redirection to be enhanced at front door where clinically appropriate. Build into OPEL level actions.	Reduced attendances. Reinforce education and communication messages. Reduce footfall into ED for minors that can go to other places.	Y
21	MH provision in ED. (NEW)	Enhance capacity and associated responsiveness of mental health provision in ED, through development of an offer consistent with the national Core 24 model	Improved MH responsiveness for patients in ED.	Y
22	Crisis team development - discharge initiative and reduction of out of area placements. (NEW)	Business case developed to enhance the adult Crisis Resolution Home Treatment Team to meet the nationally recognised Core Fidelity Standards; including service users self-referral and adequate Home Treatment to enable earlier discharge and increased flow - thus reducing Out of Area Placements and admission delays	Reduction of Out of Area placements.	Y
23	Mobilisation of Digital Minor Illness Referral Service; Community Pharmacy (NEW)	Project mobilised with 75 pharmacies live across LLR. UEC team liaison with chair of	Reduce minor illness ED attendances. Alternative NHS referral pathway via 111 to attendance and utilisation of system capacity.	Y 75 pharmacies live and available for NHS111 referrals with DoS update w/c 3rd Dec.

Outflow from Hospital and Discharge

The system maintains very strong performance related to delayed transfers of care (DTOC), and an integrated discharge team (IDT), with further work ongoing to improve logistical planning and communication for the overall discharge process to support patient flow. This year significant work and investment is further strengthening the IDT to function across both the outflow discharge processes but also the front door/A&E to help prevent unnecessary admissions and navigate patients to more appropriate settings.

An established Discharge Working Group reports into the A&E Delivery Board and enables a multi-agency focus with discharge capacity modelled to meet demand and variation (workforce, beds, equipment, funding). The group manages a collaborative action plan across health and social care, including:

- Continued focus on implementation of the Eight High Impact Changes for Managing Transfers of Care:
    - Early discharge planning
    - Systems to monitor patient flow
    - MDT/MAT discharge teams
    - Home First/Discharge to Assess
    - Seven day Services
    - Trusted Assessors
    - Focus on Choice
    - Enhancing health in care homes
- Additional home-care packages commissioned to support discharge to assess, with the Pathway 3 procurement framework for an additional minimum 20 beds available if required at periods of surge.
- Less than 15% of assessments in an acute setting and a refined CHC End to End Process in line with the new CHC framework published in October 2018.
- Placement without prejudice process for continuing health care needs with risk share agreement in place since summer 2018.
- Escalation triggered ICS Capacity Management Operational Protocol.
- Implementation of consistent Choice Policy – this is currently being audited on use
- Consolidation of the Discharge to Assess pathways – Home and Bed based
- Delivery of Trusted Assessment principles to support case management across the IDT – health and social care. Current care home initiatives support the building of this ‘trust.’
- Development of out of county D2A offer.

Connecting Public Service Operations

The winter resilience planning process has enabled the opportunity to better engage and connect public services for patients and members of the public. Further work is ongoing to shape LLR urgent and emergency care priorities to increase this connectivity for shared learning, improved services, and better value for money.

Local Authorities (City and County)

Local Authorities have been preparing to tackle the winter season since earlier this summer to minimise potential disruption from cold weather. Ensuring effective road maintenance services during cold weather and the winter period is essential to for public safety and also for the national and local economy in maintaining the movement of traffic and pedestrians.

Councils are responsible as/with the Highway Authority for the Winter Service including precautionary salting, provision of salt bins and snow clearance of all adopted public highways. There is a statutory duty to clear snow and ice from the highway in times of significant snowfall so far as is reasonably practicable, to ensure that safe passage along the highway is not endangered by snow or ice. Councils monitor the weather constantly and if freezing temperatures are forecast fleets of gritters treat major roads and key routes; gritter drivers are on standby every night and spread salt whenever there is a likelihood of frost, ice or snow affecting roads. This does not mean that all roads and footways are treated as soon as ice forms or snow falls, and there are a multitude of factors which enable effective treatment of roads. Roads are prioritised into categories for traffic networking, and it is estimated that 36% of Leicester City roads are targeted as main distributor roads, and Leicestershire County roads is 48%.

With the majority of individual slips, trips, and falls due to ice most often occurring in/at private residences or businesses, in addition to gritters, there are snow wardens based in communities who further grit local paths as well as a small network of local farmers who utilise tractors to plough roads and local areas. Further, the councils provide advice and information to local residents including how to clear snow and ice most effectively, as well as preparing for the cold season with keep warm messages and encouraging people to get seasonal flu vaccination. These messages are now consistently reinforced by the Leicestershire Resilience Forum with representatives from all providers of public services across Leicestershire.

Leicestershire Fire and Rescue Service

Many of the most vulnerable patients are known to more than one public service, but those public services often do not work together for the benefit of the population due to lack of connectivity, communication, and/or data sharing restrictions. The UEC team has begun working more closely with the Leicestershire Fire and Rescue Service to better connect services,

specifically for the more vulnerable person. Many of the most vulnerable people are also known to both health and social care, and through

The Leicestershire Fire and Rescue Service has for the past several years focused upon fire prevention services and safety checks to better protect vulnerable people, and have moved away from chasing demand management to greater focus on prevention. Health and social care services are facing similar challenges to the fire service. Further, there are financial benefits in that it is estimated that every £1 invested in fire prevention the benefit to health and social care can be £2.50 and

Community Pharmacy Services

Community pharmacy services are well-positioned to help keep hospital admission and readmission rates down, and ease the burden on both acute and primary care services. LLR continues to work with commissioners to ensure patients can access community pharmacies for minor ailments and medicines where appropriate.

Severe Weather

The northern and more rural parts of Leicestershire can be affected by snow and ice which through the disruption to transport can impact on the delivery of community services and in-patient services.

There is also a clear link between periods of cold weather and increased presentation to the health community through respiratory and heart conditions and falls. This may require community providers to provide mutual aid to partner agencies under the Leicestershire, Leicester and Rutland (LLR) Urgent Care Surge and Escalation Plan.

Providers will ensure inpatients and service users in the community are supported during periods of cold weather as required under the Department of Health Cold Weather Plan. The Cold Weather Plan for England was published 31st October 2018 and is supported by the Met Office Cold Weather Alert Service. It gives advice to help prevent the major avoidable effects on health and social care during periods of cold weather across England. It is a framework intended to protect the population from harm to health from cold weather, and aims to prevent the major avoidable effects by alerting people to the negative health effects of cold weather to enable them to prepare and respond appropriately.

LLR maintains a locally adapted LLR Cold Weather Plan as well as a policy and protocol for the use of 4x4 vehicles to support the transportation of patients and/or staff during severe weather. These plans and policies have been refreshed, approved, and distributed to key stakeholders through the Local Resilience Forum and emergency preparedness resilience and response (EPRR) network.

Flu / Infection Control and Seasonally-Related Illness

Each year there is an increase in seasonally-related illness, principally gastrointestinal or respiratory illness) as weather changes between November and March. LLR maintains an outbreak plan which details processes for managing seasonally-related illness linked to business continuity and EPRR plans as required. The LLR Quality Assurance Group maintains oversight of the infection control plan with all key stakeholders engaged. These plans have been tested and updated more recently over the summer in managing local infection control.

Nationally, a Flu Vaccination Programme was launched with guidance provided 1st August: https://www.england.nhs.uk/wp-content/uploads/2018/08/flu-programme-delivery-guidance-2018-19.pdf. System leaders have worked with Public Health and NHS England to deliver a proactive response to seasonal flu and linked these to specific campaigns across Primary Care, Public health and community pharmacy.

In addition, health and social care staff are encouraged to obtain flu vaccination to ensure all front-line clinicians receive flu jabs as per national instruction. The vaccine is offered to frontline healthcare workers every year to reduce risk of contracting and spreading virus. Staff are encouraged to have a flu jab, but it is not mandatory, and at UHL for example the aim is to increase staff take up above 75% this year.

As well as protecting against the flu, the NHS Stay Well This Winter campaign strongly encourages people over 65 or those with long-term health conditions such as circulatory or heart disease, respiratory illness, diabetes, and stroke to prepare for cold weather with advice on how to protect themselves from common illnesses.

The NHS Help Us Help You / Stay Well This Winter campaign includes:

- General Advice and Guidance
- Keep yourself warm – heat your home to at least 18C / 65F if possible.
- Get your flu jab
- If you start to feel unwell, even if it is just a cough or cold, then get help from your pharmacist quickly before it gets more serious.
- Make sure you get your prescription medicines before pharmacies close on Christmas Eve.
- Look out for other people who may need a bit of extra help over winter
- Always take your prescribed medicines as directed.

Public health services throughout winter will routinely circulate epidemiological information on disease outbreaks to system-wide Lead nurses and Chief Nurses to ensure the system can

monitor the seasonal illness position across LLR, and NHS England monitor regional infection control on a daily basis to ensure appropriate response.

Public Information and Communications

Information to the public regarding services and accessibility is essential to ensure that we are able to more effectively manage demand throughout winter. LLR CCGs agreed to apply the winter communications campaign (Help Us Help You / Stay Well This Winter) in order to support members of the public to make good lifestyle choices and to be proactive in keeping healthy. The UEC communication network developed an overarching and extensive plan in August and September, with communication messages were tailored to various audiences and public communications focused on promoting and responding to the appropriate use of services, particularly urgent care. Specific co-ordinated campaigns include:

- Help Us Help You / Stay Well This Winter
- Weather alerts and actions
- Message Board and Live Waiting Times across Providers
- Multiple Proactive action and messages
- Get the Flu jab
- Keep warm
- Look out for vulnerable
- Better Understanding of Services and Access (members of the public AND healthcare provider staff); 111 and primary care; health hubs on your doorstep,
- Self Care – Ask your GP AND Pharmacist

Analysis of winter activity in subsequent years has highlighted core groups across the population that would benefit from targeted communication, including young people and voluntary services. The campaigns have focused on both members of the public, as well as staff across health and social care for consistent messaging. The range of stakeholders interventions to date with specific targeted have included, but is not limited to:

- X 3 Universities – Attendance at Freshers Fairs.
- Information distributed to LPT to forward onto school staff nurses.
- Health and Social Care staff engagement events.
- Distribution of materials to voluntary and community sector via partners.
- Social media activities with regular ‘tweets’ and messaging.
- Digital display of winter health messages at Diwali lights switch on and at Fireworks at Abbey Park.

- Patient Participation Groups (PPGs) to raise awareness of winter messages via three CCG's and primary care team.
- Self care – hand washing video developed by UHL, interactive medicine box available for all to use on there website.
- Presented at Leicestershire Pharmacy Committee to get local pharmacy to support and raise awareness of our campaigns.
- Respiratory / Norovirus Question and Answer (Q&A) developed and shared.
- Tool kits for all campaigns shared to enable others to spread messages as 'champions.'
- Stand at Loughborough Market raising awareness of self care, antibiotics and NHS 111
- University of Leicester conducted NHS 111 awareness projects across campus and presented findings

Definitions

Business Continuity	The capability of an organisation to continue to delivery services at acceptable predefined levels following a disruptive incident.
Emergency / Major Incident	Under Section 1 of the CCA 2004 an "emergency" means "(a) *an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;* *(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;* *(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom*". Major Incident means: *An event or situation, with a range of serious consequences, which requires special arrangements to be implemented by one or more emergency responder agencies.* (Revised Jul 2016 Cabinet Office)
Emergency Preparedness, **Resilience and Response (EPRR)**	The collective term utilised by the NHS to cover business continuity planning and preparing for emergencies.
Major Incident Plan / Emergency Plan	Clearly identified procedures to be used at the time of an incident, (external or internal) to implement an effective and co-ordinated response.
OPEL	Operational Pressures Escalation Levels (OPEL)
Business Continuity Plan	Documented procedures that guide organisations to respond, recover, resume and restore service delivery to a pre-defined level of operation following a disruption.
Severe Winter / Inclement Weather	Winter weather such as heavy snow and ice and inclement weather such as flooding, strong winds which disrupt the road network and public transport affecting the ability of staff to travel to work or see patients in the community.
Seasonal Flu	A highly contagious acute viral infection that affects people of all ages.

System Partner / Provider Winter Resilience Plans and Reference Documents

Organisation	Reference / Supporting Document
University Hospitals of Leicester	1. Winter Plan 2. Capacity Modelling 3. Business Continuity Plan 4. Stranded Patient Action Plan 5. NET Stranded Patient Ambition 6. Safer Patient Flow Bundle 7. Reducing Long Stays Action Plan 8. Inter-professional Standards 9. Capacity Flow and Escalation Policy 10. Whole Hospital Response to Emergency Care Demand 11. Flu Planning 2018/19 12. Escalation for Potential Elective Operation Cancellations Policy 13. Trauma Unit Policy 14. Transport of the Critically Ill-Adult guidelines 15. Discharge Planning Good Practice guidelines 16. Inter-speciality Professional Standards 17. Hospitals daily capacity bed state 18. EPRR core standards review
Leicestershire Partnership Trust	19. Winter Plan/Arrangements 20. Business Continuity Plan 21. EPRR core standards review 22. Flexible Bed Management Policy 23. IPC Policy 24. Self-Administration of Medicines (SAM) Policy 25. Community Services Daily Bed State
Derbyshire Health United	26. Winter Plan 27. Business Continuity Plan 28. Out of Hours and NHS 111 Predicted Outcomes
East Midlands Ambulance Services	29. Winter Plan 30. CoNOPS 31. Business Continuity Plan
Vocare	32. Winter Plan 33. Business Continuity Plan
Leicester City Council	34. Winter Services Operational Plan 2018/19
Leicestershire County Council	35. Winter Services Operational Plan 2018/19
Rutland County Council	36. Winter Services Operational Plan 2018/19
TASL	37. Winter Plan 38. Business Continuity Plan 39. EPRR core standards review
System Specific	40. Winter Lessons Learnt 2017/18 Report 41. Primary care business continuity plans 42. OPEL Protocols 43. 4x4 Policy 44. Cold weather plan 45. LLR-wide Winter Communications and Engagement Plan/Campaigns 46. Provider workforce coverage plans 47. EMAS Predictions 2018/19

	48. Winter funding proposals 49. EPPR Policy 50. EPRR Core Standards Review x 3 CCGs 51. Frailty Programme Plan 52. Primary Care Festive period capacity plans/opening hours
Regional	53. NHSE Cold Weather Plan 54. Winter Reporting Expectation 55. East Midlands Public Health England Communicable Disease Outbreak Management Plan 56. Public Health Annual Flu Programme Information
National Reference	57. Reducing Long Stay Patients by 25% 58. Ambulance Handover and ARP standards 59. Good Practice in Hospital Flow 60. Care Home Capacity Tracker 61. Adult Social Care Winter Funding 62. Winter pressures and mental health contribution – national letter

Operational Pressure Escalation Level (OPEL) Protocol and Triggers

LLR Operational Pressures Escalation Levels (OPEL) – Process, People, Performance

Introduction

To support system wide escalation status, declaration and reporting during winter 2018/19, the LLR Urgent Care Team are required to report a system-wide overall status on a daily basis. This will be based upon individual provider updates so it is essential that **all** providers continue to provide a daily escalation status through existing reporting and escalation conference calls.

Process

The Urgent and Emergency Care Team (or CCG Director on-call during out of hours periods) will refer to the guidance below to inform them of a system-wide status. For the purpose of an overall system-wide status declaration, the following key providers are required to submit twice daily written status updates:

- UHL
- LPT (Inc. Community and Mental Health)
- EMAS
- TASL
- City Adult Social Care
- County Adult Social Care
- DHU/111
- DHU/OOH

***Where the system declares OPEL 3 status based on information situational reports, all system partners will be alerted to join a teleconference at 1030AM.**

Table 1: Definition of Escalation Statuses

NHS England Operational Pressures Escalation Levels (OPEL)
OPEL 1: The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2: The local health and social care system is starting to show signs of pressure. The local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3:The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National teams will also be informed by DCO/sub-regional teams through internal reporting mechanisms.
OPEL 4: Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

SERIOUS INCIDENT	**Serious Incident Requiring Investigation (SIRI)**Following a divert or declaration of system OPEL 4 the CCG to which assistance was given must raise a Serious Incident Requiring Investigation (SIRI) and undertake a full investigation, root cause analysis and lessons learnt exercise **Further information is available in Appendix 4. SIRI Summary Information**

Escalation level	Acute Trust (s)
OPEL One	• Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. No staffing issues identified • No technological difficulties impacting on patient care • Use of specialist units/beds/wards have capacity • Good patient flow through ED and other access points. Pressure on maintaining ED 4 hour target • Infection control issues monitored and deemed within normal parameters
OPEL Two	• Anticipated pressure in facilitating ambulance handovers within 60 minutes • Insufficient discharges to create capacity for the expected elective and emergency activity • Opening of escalation beds likely (in addition to those already in use) • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services • Lack of beds across the Trust • ED patients with DTAs and no action plan • Capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO)
OPEL Three	• Actions at OPEL 2 failed to deliver capacity • Significant deterioration in performance against the ED 4 hour target (e.g. a drop of 10% or more in the space of 24 hours) • Patients awaiting handover from ambulance service within 60 minutes significantly compromised • Patient flow significantly compromised • Unable to meet transfer from Acute Hospitals within 48 hour timeframe • Awaiting equipment causing delays for a number of other patients • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Serious capacity pressures escalation beds and on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 2 hours
OPEL Four	• Actions at OPEL 3 failed to deliver capacity • No capacity across the Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 120 minutes • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO) • Infectious illness, Norovirus, Severe weather, and other pressures in Acute Trusts (including A&E handover breaches) • Problems reported with Support Services (IT, Transport, Facilities Pathology etc) that can't be rectified within 4 hours

	Measure	OPEL 1 (within expected levels of pressure / signs of early pressure)	OPEL2 (moderate pressure / number of providers reporting issues)	OPEL 3 (severe or prolonged pressure across providers, prolonged recovery)	OPEL 4 (multiple/confirmed pressure, unsustainable increase in demand)
		Indicators	Indicators	Indicators	Indicators
Pre hospital	Ambulance and Ambulance handover delays	• Activitys within forecasted levels. • Abstractions within EMAS are within normal seasonal levels. • Abstractions within Control are less than 5% over normal seasonal levels. • No reported supply chain difficulties. • No severe events are a threat to activity. • No hospital delays over 15 minutes. • No critical infrastructure issues. • No Large events planned	• Abstractions within EMAS have increased by 5 - 10% over normal seasonal levels. • Reap 2 • Abstractions within Control have increased by 15% over normal seasonal levels. • Call abandoned rate at 10%. • 90% calls answered within 5 seconds. • Supply chain difficulties are short lived. • Events are having a limited local impact on activity. • Hospital delays are being experienced at a single site. • Critical infrastructure issues have been experienced for a period of 6 hours and are not expected to reoccur. • High Vehicle off Road numbers potentially effecting service delivery. • Severe Weather Warning (LLR) • Up to two performance trajectories not meeting contracted level by less than 10%. • Hospital delays of greater than 15 minutes but less than 60 minutes are being experienced on a single site.	• All 4 performance trajectories are not achieving contracted level. • Reap 3 • One or two trajectories are greater than 10% under expected level. • Severe staffing pressures. 10 % to 15% above normal abstraction numbers. • Higher than anticipated levels of demand. • Off loading delays at 1 hour or more at acute hospital with no plans to resolve. • Severe Weather • Major incident declared in neighbouring Trust • Activations between 5%-10% above norm. • Abstractions within Control have increased by 15% over normal seasonal levels. • Call abandoned rate >15%. • 80% calls answered within 5 seconds. • Hospital delays are being experienced at multiple sites & severe delays 60 minutes plus. • Critical infrastructure issues have been experienced for a period of 12 hours and are expected to continue for a specified time of no more than 6 hours. • High Vehicle Off Road numbers effecting service delivery	• Failure to meet all four trajectories by greater than 10% • Reap 4 • Activations more than 10% above norm. • Abstractions within EMAS have increased by 15% over normal seasonal levels. • Abstractions within Control have increased by 15% over normal seasonal levels. • Call abandoned rate 20%. • 70% calls answered within 5 seconds. • Hospital delays are being experienced at multiple sites no evidence of reduction or single site – severe delays + 90 minutes • Major critical infrastructure issues have been experienced for a period of up to 24hours and are expected to continue for a specified time of no more than 24 hours.
ED	ED performance %	85% +	80 to 85%	75-80%	<75%
	Number of potential breaches	Risk of one or more patients breaching 4 hours in ED within the next hour.(exception clinical need)	Risk of one or more patients breaching 8 hours waiting for a bed in ED within the next hour.(exception clinical need)	Risk of one or more patients breaching 10 hours waiting for a bed in ED within the next hour.(exception clinical need)	Risk of one or more patients breaching 12 hours waiting for a bed in ED within the next hour.(exception clinical need)
	Number of patients in ED	<120	<140	140 - 160	>160
	Majors in ED	• Majors Occupancy <24 • WTBS <60minutes	• Majors occupancy <=32 • WTBS 60-90 minutes	• All cubicles in Majors are full Majors sub wait is open • WTBS 90-180 minutes	• All cubicles in Majors are full and the corridor escalation protocol has been enacted. • Majors sub wait is full. • Enacted the Full Hospital Response. • WTBS >180 minutes
	Injuries in ED	• Injuries occupancy <20 • WTBS <60 minutes	• Injuries occupancy <25 • WTBS 60-90 minutes	• Injuries occupancy <30 • WTBS 90-180 minutes	• Injuries occupancy >30 • WTBS >180 minutes+ • Enact Full Hospital Response
	Resus	• > 1 resuscitation bay available for immediate use	• 1 resuscitation bay available for immediate use	• No resuscitation bay available for immediate use • Plan to deescalate	• No resuscitation bay available in ED for next hour • No plan to deescalate.

	Ambulance Handover	• No risk • >2 bays available in Ambulance Assessment • Capacity to move patients into Majors	• No risk • <2 bays in Ambulance Assessment • Capacity to move patients into Majors	• Risk of patients on the back of ambulances. > 60min • Ambulance Assessment and Majors full.	• Risk of patients >90 min on the back of ambulances • Corridor escalation protocol has been enacted
Flow	Medical beds occupied/bed capacity.	• At 13.00 actual/predicted medical capacity > 50.	• At 13.00 actual/predicted admission capacity of 40 - 50 medical beds.	• At 13.00 actual/predicted admission capacity of 25 and 40 medical beds. • Ability to use outlying capacity	• At 13.30 actual/predicted capacity of l<25 medical beds. No ability to use outlying capacity
	Critical Care	• Emergency capacity on all 3 sites • Elective admitting capacity in critical care.	Emergency capacity on all 3 sites • Potential cancellations of non-cancer elective patients.	• All critical care capacity occupied and planned overflow areas in use. • Risk of cancellation of cancer procedures	• Critical care full –network used for referrals • Cancellations of Cancer procedures.
	Number of admissions waiting	<10	< 15	<25	>25
	Super Stranded patients over 721 days	<156	–156-175	176-185	>185
	Number of ops cancelled (elective/urgent/cancer)	• Elective work proceeding as planned	• Some threat to elective work proceeding as planned • No threat to urgent and cancer work proceeding as planned	• <10 elective inpatient work cancelled on the day • Threat to urgent and cancer work proceeding as planned	• Cancellations of all elective work on the day • Cancellation of urgent and cancer work
Discharge	Number of DTOC	10	11-20	21-30	30+
	Predicted discharge	250-299	200-249	149-200	Less than 148
	Discharges before midday	33%	20%	10%	5%
Out of hospital	Community hospital bed occupancy ILT bed capacity	• Community bed availability is at or > 7% (more than 21 beds in city and county community hospitals)	• Community bed availability is < 7% (less than 21 beds in city and county community hospitals)	• Bed capacity is less than 10 beds across city and county community hospitals.	• Bed capacity below 7 beds
	Reablement capacity (at home)	• Able to accept referrals and provide on-going care	• Unable to guarantee non-urgent planned or unscheduled service response times in one locality	• Unable to guarantee non-urgent planned or unscheduled service response times in more than one locality	• Unable to guarantee urgent and non urgent unscheduled and planned service response times across the service line.
	Domiciliary care capacity	• Normal rate and volume of work including normal rate of referrals from Acute and Community Hospitals	• 20% Increase in volume of referrals from Acute and Community Hospitals	• Persistent increased demand (>50%) in volume of referrals from Acute and Community Hospitals	• Continued and significant volume of referrals from Acute and Community Hospitals > 75%

TRIGGER AND ACTION CARDS – LEVEL 2

LLR LHE OPERATIONAL BUT EXPERIENCING SOME PRESSURE TELECONFERENCE TO BE CONSIDERED

Provider	Triggers	Organisational Actions	System Wide Actions
UHL	• Risk of one or more patients breaching 4 hours in ED within the next hour.(exception clinical need) • 5 Patients waiting in excess of 1hr. to be seen by a clinician • 10 Patients waiting in excess of 180 min. for senior decision • At 13.30 admission capacity of 100 - 150 trust wide – excluding critical care and Paeds) • Patients subject to decision to admit at risk of waiting 6 hours on a trolley in the next 4 hours. • Cubicles in A&E are 80% -100% occupied • Only 1 resuscitation bay available for immediate use • No outliers	• Escalate internal delays e.g. diagnostics/therapies and action additional support to accelerate discharge e.g. consider out-patient diagnostics • Work with PTS providers to provide additional resource to accelerate discharge/transfer times • prioritize TTO's for discharge • Telephone contact with Local Authority/CCG/Duty Manager from Community Service to identify actions for specific patients via point of census and DTOC calls • Work with partners to clear DTOC by reducing lead time for official referrals • Review all out of area transfers and utilize community capacity (city/county)	**LPT** • Review patients in bed bureau to identify suitability for community ICS • Review and management of bed availability by patient need and gender to optimise bed availability **OOH** • GP support for admission avoidance **TASL** • Deploy discharge co-ordinators to expedite discharges

TRIGGER AND ACTION CARDS – LEVEL 3

LLR LHE PROLONGED PRESSURE – ORGANISATIONS TRIGGERING LEVEL 3 SHOULD NOTIFY THE URGENT CARE TEAM / CCG ONCALL DIRECTOR - LHE TELECONFERENCE NECESSARY

Provider	Triggers	Organisational Actions	System Wide Actions
UHL	• Risk of 5 or more patients breaching 4 hours in department for non-clinical reasons • Patients waiting in excess of 3 hours to be seen by a clinician (post triage) • At 13.30 between 50 and 100 beds trust wide – excluding critical care and Paeds). • 5 to 10 urgent inpatient work cancelled for the next 24 hours • Patients subject to decision to admit now waiting longer than 8 hours on a trolley. • All 26 cubicles in A&E are full and patients are waiting in planned overflow areas. • All critical care capacity occupied and planned overflow areas in use.	• Escalate to all specialties to provide input to ED i.e. critical care in resus, orthopaedics for minors/ injuries/ medicine for assessment and majors. • Additional nursing resource for ED as detailed above • Ensure additional portering staff identified to support patient movement • Liaise with radiology to provide additional support to prevent delays in x ray • Creation of additional capacity internally by opening ambulatory areas as escalation areas. Identify appropriate outliers for additional capacity • Consider Glenfield divert following cardio respiratory pathway. • Ensure all community capacity is full, Alert GP's via CCG's to ensure alternative pathways explored • Request additional PTS vehicles to expedite discharge • Escalate to other director on call to liaise Social Services/other providers to obtain increased flexibility in use of their capacity to take medically fit patients to alternative settings • Fast track radiology for patients who could go home following investigation • Consider additional sessions for diagnostics if causing delay • Consider extra sessions of cath lab if causing delay • Reiterate ED patient redirection protocol and alert system	**LPT** • Additional Board Rounds on each community ward and ICS to identify patients suitable for transfer or discharge. • SPA to support navigation of referred patients to appropriate community provision • Review and management of bed availability by patient need and gender to optimise bed availability • Discharge co-ordinators to specific identified wards to support identification **OOH** • Increase resources on a temporary basis to address service demand **NHS 111** • Redeploy staff according to demand **TASL** • Provide early transport • Potential to use emergency department crews • Crew single crewed resource and implement taxi use **SOCIAL CARE CITY** • Targeted review **SOCIAL CARE COUNTY** • Team to support in ED

			• Targeted review **EMAS** • Deploy managers to ED to manage turnaround (HALO) • Deploy Mobile Treatment Centre and POLAMB as appropriate **GP'S** • Ensure availability of GP appointments • Maximise utilisation of admission avoidance schemes **CCG'S** • Reiterate demand management initiatives as core reminder of clinical navigation • Co-ordination of Teleconference comms and media. • Discharge Multi-agency escalation call. • Access to Pathway 3 procurement framework capacity (care home additionality) • Enable appropriate patient transport capacity authorisation for additional resource.

TRIGGER AND ACTION CARDS – LEVEL 4

LRR LHE UNDER EXTREME PRESSURE, UNABLE TO SUSTAIN BUSINESS CONTINUITY

ORGANISATIONS TRIGGERING LEVEL 4 SHOULD NOTIFY THE URGENT CARE TEAM / CCG ON-CALL DIRECTOR IMMEDIATELY - LHE TELECONFERENCE ESSENTIAL

Provider	Triggers	Organisational Actions	System Wide Actions
UHL	• One or more patients waiting more than 4 hours for assessment (post triage) and unlikely to be seen for the next 4 hours. • 3 patients waiting more than 60 mins on ambulances • At 13.30 Capacity of less than 50 beds trust wide – excluding critical care and Paeds) • Cancellations of elective work on the day Patients subject to decision to admit now waiting longer than 8 hours on a trolley and at risk of waiting longer than 12 hours in the next hour. • All cubicles in A&E are full and patients In the corridor • No resuscitation bay available in A&E for next hour. • Critical care full Same sex breaches required to maintain flow	• Review next day electives and consider cancellation • Use ambulatory assessment areas as in patient space • Ensure additional senior decision makers are providing additional ward rounds • Implement whole hospital response • Capacity for 10 additional patients in the community in the next 6 hours • Inreach to identified areas • Additional transport for DC • All patients referred by GP must be seen first • External review of all DTOCS and identify alternatives	**LPT** • Review patients in bed bureau to identify suitability for community ICS • Additional Board Rounds on each community ward and ICS to identify patients suitable for transfer or discharge. • SPA to support navigation of referred patients to appropriate community provision • Review and management of bed availability by patient need and gender to optimise bed availability • Relocate PCC in reach resource to specific identified wards to support identification • To review the requirement to open flexible beds. UHL to identify patients suitable to transfer, confirm patients ready to transfer, confirm patients require a community hospital bed. Up to eight beds can be opened in a 12 – 24 hour period. A further 7 beds could be consider over a 48 – 72 hour period. **OOH** • GP support for admission avoidance • Increase resources on a temporary basis to address service demand **NHS 111** • Redeploy staff according to demand

			TASL • Provide early transport • Potential to use emergency department crews • Crew single crewed resource and implement taxi use • Deploy co-ordinator roles **SOCIAL CARE CITY** • Targeted review **SOCIAL CARE COUNTY** • Team at front door • Targeted review **EMAS** • Deploy managers to ED to manage turnaround (HALO) • Deploy Mobile Treatment Centre and POLAMB as appropriate **GP'S** • Ensure availability of GP appointments • Maximise utilisation of admission avoidance schemes **CCG'S** • Co-ordination of Teleconference comms and media

Table 1: Definition of Escalation Statuses		**LLR Application**
GREEN **OPEL 1**	**Level 1: patient flow management** - The Local Health and Social Care System capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. Commissioned levels of service will be decided locally.	No more than one key provider reporting AMBER (all other providers reporting GREEN)
AMBER **OPEL 2**	**Level 2: mitigation of escalation –** The Local Health and Social Care System starting to show signs of pressure. Focused actions are required in organisations showing pressure to mitigate further escalation. Enhanced co-ordination will alert the whole system to take action to return to green status as quickly as possible.	Two or more key providers reporting AMBER **OR** One key provider reporting RED
RED **OPEL 3**	**Level 3: whole system compromised** – Actions taken in Level 2 have failed to return the system to Level 1 and pressure is worsening. The Local Health and Social Care System is experiencing major pressures compromising patient flow. Further urgent actions are required across the system by all partners.	Two or more key providers reporting RED **OR** One key provider reporting BLACK
BLACK **OPEL 4**	**Level 4: severe pressure and failure of actions** – All actions have failed to contain service pressures and the Local Health and Social Care system is unable to deliver comprehensive emergency care. There is potential for patient care to be compromised and a serious incident is reported by the system. Decisive action must be taken to recover capacity.	Two or more key providers reporting BLACK **OR** A major incident / business continuity event that causes system wide failure

LPT - Escalation Triggers and Actions for LPT Community Health Services

Level 1 – Normal Working	Level 2 – Moderate Pressure	Level 3 – Severe Pressure	Level 4 – Extreme Pressure
Community Beds	**Community Beds**	**Community Beds**	**Community Beds**
• Bed capacity is 15 beds or more with discharges planned • No operational issues • Staffing meets demand • Availability outweighs demand. Good spread of gender and geography availability	• Bed capacity is less than 15 beds available. • Discharges are planned for same day • Availability outweighs demand and discharges planned within 24 hours. • Service area experiencing staffing issues	• Bed capacity is less than 7 beds available. • Availability less then demand with discharges planned in the next 24 hours • Service line experiencing staffing issues	• No beds available • No discharges planned in the next 24 hours • CHS experiencing staffing issues across all service lines
Community Services	**Community Services**	**Community Services**	**Community Services**
• Able to accept referrals and provide on-going care • Staff able to fully engage in community hospital board rounds and proactively identify patients to discharge into the service. • Staffing hours available match on going service need	• Unable to guarantee non-urgent planned or unscheduled service response times in one locality. • Staff unable to participate in community hospital board rounds to proactively identify patients to discharge into the service. • Service demand in a single locality outweighs the staff available.	• Unable to guarantee non-urgent planned or unscheduled service response times in more than one locality • Staff unable to participate in community hospital board rounds to proactively identify patients to discharge into the service • Service demand in more than one locality outweighs the staff available	• Unable to guarantee urgent and non urgent unscheduled and planned service response times across the service line. Cancelling routine clinic appointments to release staff. • CHS experiencing staffing issues across all service lines
MHSOP Hospital Beds and Services	**MHSOP Hospital Beds and Services**	**MHSOP Hospital Beds and Services**	**MHSOP Hospital Beds and Services**
• Community bed availability is 6 beds available) • No operational issues • Availability outweighs demand	• Community bed availability is < 7% (less than 6 beds) • Discharges are planned for same day • Availability less than demand but discharges planned within 24 hours.	• Bed capacity is less than 6 beds • Discharges planned in the next 24 hours • Availability less than demand • Service line experiencing staffing issues	• No MHSOP bed capacity • No anticipated discharges within 48 hours • CHS experiencing staffing issues across all service lines

LPT - Escalation Triggers and Actions for LPT Community Health Services

Level 1 Normal Working	Level 2 – Moderate Pressure	Level 3 – Severe Pressure	Level 4 – Extreme Pressure
Community Services	**Community Services**	**Community Services**	**Community Services**
Community Hospital Beds • SPA to support navigation of referred patients to appropriate community provision • ED Discharge set on admission for proactive discharge planning. • Daily Board rounds – MDT board rounds on each community hospital ward to identify patients suitable for transfer or discharge. Inclusion of social care and community team at least weekly. • Daily review and management of bed availability by patient need and Gender to optimise bed availability. • Bed coordination – named bed coordinator 5 days a week who is single point of contact to address and escalate any bed issues and support flow. • Weekend ward manager to support flow and address capacity and staffing concerns. • Daily bed state – issued at 8.30 am Monday – Friday identifying bed capacity and predicted discharges. • Daily census report identifying all delays and the action being taken • Daily DTOC Conference Call at 12.30 – Health and social care conference call to expedite any delays and discuss potential	As level 1 plus; **Community Hospital Beds** • Matron for beds respond to 8.30am bed state and daily census information to identify delays in discharge and escalate to relevant service manager as appropriate to support resolution • Staffing issues managed within service line • Matron for beds escalate to social care areas of pressure for packages of care or residential placements • Matron for beds escalates to senior manager UHL admission outweighing discharges to identify if move to level 3 actions required. **Community Services** • Prioritise caseloads to ensure management of essential and critical patients, rescheduling planned non-essential activity to maximise capacity. • Service managers to engage with colleagues in other teams and localities to work across boundaries to support activity. • Escalate issues relating to equipment delays to commissioners to consider action that can be taken with equipment	As level 1 & 2 plus; **Community Hospital Beds** • Delay admissions until next day • Staffing issues managed within LPT through staff relocation. Review of leave and training • Undertake afternoon board round to support identification of suitable discharge along with community and social care • Discuss bed capacity challenges with patient/family and re offer interim placements to support discharge • Request additional senior clinical review to support appropriate discharge (geriatrician) • Escalate to Head of Service to inform LPT on call director of deteriorating picture (out of hours – on call manager to call on call director) **Community Services** • Increase capacity within teams through review of use of annual leave and overtime for substantive staff. • Review staff training and cancel where clinically safe to do so to support staffing levels. • Primary care to be requested via the CCG'S to support early	As level 1, 2 and 3 plus; **Community Hospital Beds** • Director advises LLR partners level of escalation and gold command activated • Contact external organisation (partners) to request staffing support • Stop admission to community hospitals • Cohort patients to multi ward sites to maximise staffing resources • Cancel all training and consider cancellation of all annual leave. • Activate CHS plan to redeploy all clinical staff from non-essential roles across LPT **Community Services** • Primary care to be advised of capacity and only urgent essential referrals to be taken. • All visits cancelled except urgent essential care. Primary Care and patients to be advised of each cancelled visit. • Cancel all training and consider cancellation of all annual leave • Activate CHS plan to redeploy all clinical staff from non-essential roles across LPT.

resolution. • CHS Friday Conference Call – Update on pressures within CHS and potential weekend pressures to inform on call manger • On weekends on call managers provide LPT Director on call with up to date position statement re bed availability and Community pressures • On weekends LPT Director on-call participates in the 10am. LLR Executive level call to identify any system pressures and action required • Response to competing demand for community hospital bed will be managed in accordance with the level of escalation in the referring acute hospital. • Weekly staffing conference call to ensure appropriate number of staff to meet patient acuity. **Community Services** • Daily review of community caseloads to ensure management of planned and unscheduled referrals • Daily ICS bed capacity issued at 8.30 Monday – Friday • SPAS to ensure all referrals to community services identify appropriate priority level. • Weekly attendance (at least) by ICS Clinical Lead on community hospital board round • Daily review of ICS caseload to step down to planned care • Daily named community	provider. • Consider the need to utilise business continuity plans to respond to increase or persistent pressures **MHSOP Hospital Beds and Services** • Service managers to respond to 8.30 bed capacity and weekly census information to identify delays in discharge and escalate to Head of Service as appropriate to support resolution • Escalate issues relating to equipment delays to commissioners to consider action that can be taken with equipment provider. • Bed coordinator is advised by senior operational manager to ensure all referring clinicians are aware of bed pressures and are advised of alternative community services available. • Consider the need to utilize business continuity plans to respond to increase or persistent pressures	discharge from community services for identified patients. • Community nursing team administration staff to request relatives to provide transport for housebound patients to access primary Care services once appointments has been obtained. **MHSOP Hospital beds and Services** • Admissions prioritised to areas of greatest need. • Review bed availability at wards, and gender mix to optimise bed capacity. Discussion with Lead nurse and Head of service. • Increase capacity within teams through review of use of annual leave and overtime for substantive staff. • Review criteria for agency/substantive mix on wards based on risk assessment of patient safety.	**MHSOP Hospital Beds and Services** • Head of service to agree re-opening of beds on Wakerley ward. • Gwendolen and Coleman ward to provide substantive staff cover and back fill by bank and agency. • Cancel all training and consider cancellation of all annual leave Activate CHS plan to redeploy all clinical staff from non-essential roles across LPT

coordinator 7 days a week to be single point of contact for ICS capacity and staffing **Additional Winter Pressure Activity** • 10.30am LLR daily conference call to update on capacity and areas of pressures • Fortnightly and as required updates to CHS Senior Management Team. • Primary Care coordinators in working in ED and admissions unit areas to prevent acute admission into UHL. **MHSOP Hospital beds and services** • ED Discharge set on admission for proactive discharge planning. • Daily Board rounds –to identify patients suitable for transfer or discharge. • Daily review and management of bed availability by patient need and Gender to optimise bed availability. • Bed coordination – named bed coordinator 5days a week who is single point of contact to address and escalate any bed issues. At weekend and out of hours, to contact duty-coordinator. • Daily bed state – issued at 8.30 am Monday – Friday identifying bed capacity, predicted discharges and capacity. • weekly census report identifying all delays and the action being taken			

• **Additional Winter Pressure Activity** • MHSOP weekend bed information sheet sent to on call managers and director n Friday afternoon. • On weekends on call managers provide LPT Director on call with up to date position statement re bed availability and Community pressures • On weekends LPT Director on-call participates in the 10 a.m. LLR Executive level call to identify any system pressures and action required • Weekly CHS SMT updates Information to CHS senior team to ensure full engagement and understanding of potential pressures and impact on services. • Review potential for seasonal business continuity disruption and implement business continuity plans (adverse weather/flu)			

Escalation Triggers and Actions for LPT Adult Mental Health & Learning Disability Services

Level 1 – Normal Working	Level 2 – Moderate Pressure	Level 3 – Severe Pressure	Level 4 – Extreme Pressure
Adult Mental Health	**Adult Mental Health**	**Adult Mental Health**	**Adult Mental Health**
• 5 or more beds available • Availability outweighs demand. • Staffing meets demand • No operational issues Referral line managing all referrals	Minimum 2 triggers required:- • In-patient bed availability less than 5 beds. • Discharges are planned for today. • No operational issues but monitored closely • Referral line managing all referrals but assessments slots filling for next 24hrs • No pressure from admissions expected in next 24hours. • OOA beds available but use not expected. • Difficult to manage single sex accommodation compliance.	Minimum 2 triggers required:- • In-patient bed availability less than 3 beds. • Discharges are not planned for today. • Availability less than demand • OOA beds available and may be used. • Increased demand for assessments via referral line limited assessment slots • Staffing needing review to meet increased demand • Leave beds in use • Considering use of contingency capacity (PSAU) • Single sex walk through breaches	• No inpatient bed capacity • Discharges not planned to today. • Patients on waiting list and or unable to place • OOA beds not available • No patient identified for EDP • Hospital beds in use • Ward rounds completed and no additional predicted activity • Referral line taking high volumes demand exceeds capacity, impacting on capacity of Crisis to support home treatment. • Contingency capacity open (PSAU) open.

Escalation Triggers and Actions for LPT Adult Mental Health & Learning Disability Services

Adult Mental Health	Adult Mental Health	Adult Mental Health	Adult Mental Health
• Report to Service Manager and bed state issued 3 times daily • Bed state for all AMH in-patient beds available and updated 3 times daily • Weekly LOS meeting used to unblock flow and determine work plan for the next 7 days. • Review of bed state by bed management team 3 times daily with crisis team manager • Crisis meeting assessment times • Crisis staff attending wards to identify EDP patients • Daily patient reviews • No leave beds in use	As Level 1 plus • Escalate move to all ICL Service Managers AMH referral line and Bed Management Team are advised by Service Manager to ensure all referring clinicians are aware of bed pressures. • Chase up the progress of the Early Discharge Process (EDP). • Look at the option of supporting discharge via CRHT to promote discharge • Crisis meeting assessment times but closely monitored • Any additional contacts/updates risk assessed • Leave beds available and patient flow monitored Head of Service (Access) advise Divisional Director / CD Patient suitable for EDP supported leave, leave and transfer to rehab identified.	• As Levels 1 & 2 pluService Manager escalates situation to Head of Service ICL. • Priority list drawn up based on risk and need for patients waiting for beds admissions delayed wherever possible • Crisis to support delayed admissions • Check discharges for up to next 72 hours to see if any discharges can be brought forward, with support of EDP supported leave, Crisis team • Senior Management and Senior Clinicians hold emergency briefing to review situation. • Staffing increased to support demand and capacity issues Bank/Agency overtime Head of Service (Access) advise Divisional Director / CD and secure staffing for contingency capacity	As Levels1, 2 & 3 plus • Escalated to Director on Call and senior colleagues in partnership organisations(AHMP Teams & UHL) • Patients cared for at home and risk managed via ○ Increased staffing ○ Agency staff ○ Scale back from non-critical activities to free staff ○ Use of overtime • Review use of never options Place of safety bed Seclusion Side Rooms Lounges Belvoir