University Hospitals of Leicester NHS
NHS Trust

Meeting title:	Trust Board public				**Paper Q**	
Date of the meeting:	6th October 2022					
Title:	Winter Plan Update for 2022/2023					
Report presented by:	Jon Melbourne, Chief Operating Officer					
Report written by:	Sarah Taylor, Deputy Chief Operating Officer					
Action – this paper is for:	Decision/Approval	x	Assurance	x	Update	
Where this report has been discussed previously	This report has been developed with the CMG Heads of Operations and Clinical Directors and discussed at the Operational Management Group on 8th September 2022, Executive Finance and Performance Group on 27th September 2022 and Operational Performance Committee 28th September 2022					

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

Impact assessment
• Identifies the UHL bed gap using the UHL developed bed model and system scenario plan. • Identifies actions being undertaken by each of the Clinical Management Groups. • Defines new schemes to address ambulance handovers and next steps required

Acronyms used:
Clinical Management Group (CMG), Virtual Ward (VW), Urgency and Emergency Care (UEC), Unscheduled Care Coordination Hub (UCCH), East Midlands Ambulance Service (EMAS), Clinical Navigation Hub (CNH).

Purpose of the Report

The UHL Winter Plan provides updates and assurances on actions that are being taken in relation to winter planning and pressures. This report will give an update on: -

- UHL projected 'Bed Gap' based on 3 scenarios, and actions to address the bed gap
- System schemes to address the gap
- Update on discharge plans and infection prevention guidance for winter
- Risks
- Escalation process

Recommendation

The Trust Board is asked to:

- Be assured that there is a clear plan to support through winter pressures
- Discuss the plan and agree the interventions
- Note and understand the risks which remain, and the next steps suggested
- Agree to receive updates on the winter plan process through the UEC governance structure

1.0 Introduction

Winter planning 2022/23 brings complexity and challenge due to the possibility of:

- Increased COVID-19 admissions and the high potential for new variants
- Increased admission for both Flu A and B. Combined with the above this will make cohorting of patients challenging
- Further pressure on resource if activity exceeds the CMG plans
- Uncertainty in the anticipated demand

This paper will update on the potential 2022/23 Winter bed gap and actions being taken to mitigate the gap, both within UHL and the system (including the potential risks to the delivery of these actions). This paper will also review the predicted impact of infection prevention requirements on Winter 2022/23 demand and capacity. Finally, this paper will highlight the escalation process contained within our whole hospital policy.

2.0 UHL Capacity Gap

Following modelling of demand and capacity, the following table details the 3 scenarios being considered across the system:

	Bed Demand and ED Waits	Beds Available	Bed Gap
Scenario 1 (Best Case)	1925	1793	-132
Scenario 2	2056	1793	-263
Scenario 3 (Worst Case)	2085	1737	-348

National advice is to plan for scenario 3 – and this paper works to this. The following table details where the gap is expected be felt across the bed holding CMGs.

CMG	Scenario 2	Scenario 3
CHUGGS	-27	-21
ESM	-141	-191
MSS	+17	+18
RRCV	-58	-94

While there is of course risk and are many variables in the bed modelling, it is clear that we need to ensure that we have appropriate capacity through our system to manage our pressures this winter.

3.0 Reviews

UHL have undertaken several reviews over the last few months and these have been incorporated into our winter plans. These include:

- Ian Sturgess Review of urgent and emergency care flow across the system
- NHS England /Improvement review of our emergency care, particularly ED
- ECIST review at the Glenfield
- West Midlands Clinical Senate review of Cardio-Respiratory services

4.0 System Action Plan

Working in partnership with system colleagues we have identified 20 priority actions for winter 2022. These are not the only actions we are pursuing, but represent those we believe can have the most impact:

4.1. Primary Care Collaborative

Ref	Key Deliverable	Actions (high level)	Estimated potential impact	Lead / Collaborative	Clinical accountable lead	Timescale
W1	Targeted COVID and Flu vaccination programme	Increase uptake of flu and COVID vaccinations to > 70%, with a targeted focus on equity and high risk groups	(0 to prevent double count with admission avoidance)	LLR Vaccination Board / Primary Care Collaborative	Caroline Trevithick	Jan 31st 2023
W2	Robust risk management of high risk respiratory patients	Risk stratify, identify and case manage respiratory patients most at risk of acute admission, linking to community RSV clinic and virtual ward pathway	(0 to prevent double count with admission avoidance)	Primary Care Collaborative	Dr Louise Ryan	Dec 31st 2023
W14	Efficient and effective GP > acute referral pathway	Implement GP to consultant telephone discussions for all but immediate life threatening referrals as per Sturgess recommendations	10 beds	Primary Care Collaborative	Dr Sulaxni Nainani	Dec 31st 2022
W15	Right size UTC walk in capacity	Assess and implement increase in UTC walk in capacity at Merlyn Vaz and Westcotes / assess impact of increasing Loughborough	volume of appts and walk-in % tbc	Primary Care Collaborative	Dr Nick Glover	Oct 31st 2022

4.2 Acute Care Collaborative

Ref	Key Deliverable	Actions (high level)	Estimated potential impact	Lead / Collaborative	Clinical accountable lead	Timescale
W5	UHL capacity	Design and implement pathway and model of care for UHL@Ashton Open additional capacity at LGH Discharge lounge at GGH	24 beds + 16 beds + discharge lounge spaces	Acute Care Collaborative		Ashton – complete Aug 22 LGH – complete 14/09
W11	Pre-transfer Unit	Design and implement model of care for the pre-transfer unit at the LRI	10 beds in ED	Acute Care Collaborative		Expected December 22 (12 week lead time)
W12	Implement rapid push model from ED	Assess and implement the North Bristol Model of care across UHL LRI and CDU	---	Acute Care Collaborative		Late Sept 22 (parts implemented early September)
W13	Efficient and effective ED/SDEC pathways	Implement ED/SDEC improvement plan	~10 beds	Acute Care Collaborative		Dec 31st 2022
W16	Right size UTC walk in capacity	Extend MIAMI opening hours to midnight and increase utilisation to 125-150	---	Acute Care Collaborative		Oct 31st 2022
W18	100 day discharge challenge	Implement an efficient and effective discharge process within providers to enable simple discharges by 5pm and 85% of complex discharges same day	5-10 beds	Acute Care Collaborative		Oct 31st 2022

4.3 Home First Collaborative

Ref	Key Deliverable	Actions (high level)	Estimated potential impact	Lead / Collaborative	Clinical accountable lead	Timescale
W6	LPT step down capacity	Open one ward at LPT	18-24 beds	Home First Collaborative	Dr Sudip Ghosh	Sept 9th 2022
W7	Pathway 1 capacity increase	Understand gap in workforce, identify funding & agree recruitment timescales	24-50 beds	Home First Collaborative		100% of staff in post by Dec 31st 2022
W8	Utilise all Pathway 2 capacity	Assess utilisation and unblock usage of spot purchasing	10 - 30 beds	Home First Collaborative		Sept 30th 2022
W17	Efficient and effective admission avoidance service	Expand Unscheduled Care Hub to encompass all admission avoidance for non-life threatening cat 2+ calls	20 beds	Home First Collaborative	Dr Gurnak Dosanj	
W20	Efficient and effective admission avoidance service	Mobilise and increase utilisation of > 200 virtual ward beds in key specialties	68-95 beds	Home First Collaborative		Specialty specific plans through 2022/23

4.4 Other initiatives

Ref	Key Deliverable	Actions (high level)	Estimated potential impact	Lead / Collaborative	Clinical accountable lead	Timescale
W3	Robust IPC / risk management across the system	Design and implement an IPC risk management strategy across health and care to enable the spread of risk across the system whilst maintaining safety for patients	---	Chief Nurse Forum / HETCG		31st Oct 2023
W4	Safeguard high risk patients from respiratory exacerbation due to fuel poverty	Implement fuel poverty plan in areas of high deprivation	(0 to prevent double count with admission avoidance)	Health Inequalities Board / Primary Care Collaborative		Dec 31st 2023
W9	Increase in 999 call handling capacity	Increased call handling establishment by 70 WTE, increasing to establishment of 210	+70WTE	EMAS lead commissioner		210 WTE by Dec 31st 2022
W10	Increase in 111 call handling capacity	Increased call handling establishment by XX WTE, increasing to establishment of XXX	+XXWTE	DHU lead commissioner		XXX WTE by Dec 31st 2022
W19	Efficient and effective discharge process for mental health pathway	TBC		Mental Health Collaborative		Oct 31st 2022

The actions presented are not a comprehensive list of actions taking place this winter, and appendix 1 has a broader list of capacity initiatives taking place at UHL.

The above interventions can create up to 215-299 beds of capacity, however there is risk within many of these schemes, including workforce.

5.0 Additional interventions

We recognise that further interventions are required with options being explored including: -

- Moving services to free up capacity
- Implementation of MRSA Screening to support outlying and a review of IP guidance
- Cardio / Respiratory support for LRI
- A review of all 3 sites for locations where additional capacity can be created
- Expanding out of hospital capacity such as care homes

6.0 UHL Discharge Schemes

As a result of the national pandemic the horizon for hospital discharge changed in March 2020 and many new practices and processes have been agreed across Leicester, Leicestershire, and Rutland (LLR) as a consequence. The LLR system advocates a discharge to assess (D2A) model of care with the intention to support more people to be discharged to their own home with rehabilitation, reablement or recovery.

The plans detailed below are the actions that will help support the way in which the CMG efficiencies will be delivered:

Urgent and emergency care improvement ambitions have been reset to provide focus for: Board rounds (10 wards in speciality medicine and 2 wards in RRCV during June to October).

- Long length of stay reduction work
- Pre–noon and pre 5pm discharge and
- Minimising delays by ensuring patients are prepared for discharge in terms of swabs, TTO's and Transport' to prevent delays to discharges.
- Working with clinical teams to develop and embed criteria led discharge.

- Work is in place to improve the functionality and ease of completion of the NerveCentre Home first' form that provides the electronic referral route into the LLR Discharge Coordination Hub.
- Evaluation for LLR Patient Transport Services procurement.
- Embed the new processes for brokerage and case management of patients requiring 'high dependency residential care'.
- Promotion of Integrated discharge team working within the Discharge coordination hubs across the Trust and attendance of adult social care at board rounds/ named wards.
- Embedding the Discharge Specialist Nurses to the management of the Clinical Management groups to fully embed and foster the ownership of supported discharges within the CMG.
- Providing ward based and classroom education and training for clinical teams on 'discharge principles and practice'
- Undertaking work in preparation for the opening of 24 UHL led residential care home beds at the Ashton Care Home in Hinckley to ensure timely discharge.
- Working with system partners to procure and mobilise contracts for July 2023 for discharge to recover, reable and assess Pathway 2 model.

- Holding improvement events with LPT community hospitals to understand the constraints to transfer and reduce delays.

7.0 Infection Prevention

The COVID pandemic has highlighted weaknesses in the UHL estate which directly contribute to acquisition of Healthcare Associated Infection.

Compared with other acute trusts, UHL has one of the lowest proportions of single occupancy rooms with ensuite facilities (11.7% in UHL versus the England average of 20.7% figure 2), which makes it difficult to place infectious patients in source isolation. Of note, the Clinical Decision Unit in Glenfield Hospital, the receiving area for patients with acute respiratory infection, has no mechanical ventilation to dilute and remove air that is contaminated with respiratory pathogens.

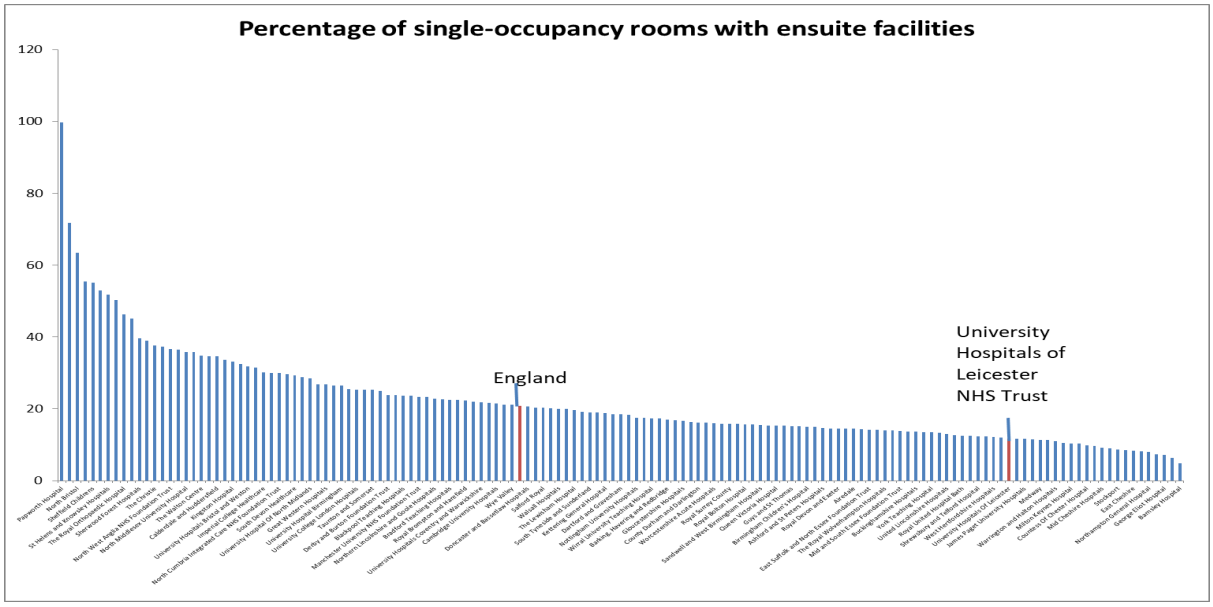

Figure 2. Percentage of single rooms with ensuite facilities within NHS Acute Trusts, 2019-2020. *Data source: PHE Fingertips (https://fingertips.phe.org.uk/search/ensuite#page/3/gid/1/pat/15/par/E92000001/ati/118/are/RCF/iid/92151/age/-1/sex/-1/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1)*

Given the negative impact that poor estate has on healthcare infections in patients and staff, along with a workload that has steadily increased over several years, the Trust is faced with the challenge of finding more beds set in an environment better able to cope with the challenge of respiratory infections.

Without this there is little that can be introduced that will have a positive effect on managing/reducing Infection Prevention winter bed pressures.

It should also be noted that respiratory viruses cannot be nursed together and require physical separation which means COVID, RSV and Influenza cannot be nursed in the same ward unless there are bays which have both doors and separate shower and toilet facilities within. Also, of note Influenza A&B also require nursing separately.

It is highly likely that Influenza A&B and RSV will once again be circulating viruses this winter. During the last two years we have not seen Influenza and very little adult RSV

An average year would see 65 plus Influenza patients as in patients at a peak, with the potential for over ten ITU and ECMO patients per week.

Whilst the Medical speciality plan is to use some ward space at the LGH, it should be noted that the LGH has multiple Nightingale wards and wards where the environment is likely to support the spread of viral infections. These wards therefore are likely to be closed for large parts of the winter as they are highly likely to be restricted due to outbreaks of infection.

The risk of healthcare infections may be mitigated by a range of measures. These include structural and engineering approaches, administrative measures, and personal protective equipment (PPE). Structural approaches include isolation of infectious patients in either single-occupancy rooms or in cohort bays. Engineering supportive measures include frequent air change to remove and dilute airborne pathogens. The use of PPE, such as face masks, is a well-established approach to reducing cross-infection of respiratory pathogens. The efficacy of these measures varies. Structural and engineering interventions are most effective, while PPE is the least effective.

Recommendations being implemented:

- Ensure '4 panel Cephid' admission screening for all patients with respiratory symptoms to ensure immediate appropriate ward placement can be made. 4 panel Cephid screening identifies COVID, RSV, Flu A&B.
- Support the increased bed space cleaning team proposal and mealtime service separated from the daily ward cleaning duties of E&F ward based domestic staff.
- Retro-fitting mechanical ventilation into existing clinical areas throughout the Trust, especially in Glenfield
- Improving passive ventilation through increasing window opening while maintaining patient safety using other devices to prevent falls.

We have reviewed installing modular units at the Glenfield similar to wards 43 and 44 at Leicester Royal Infirmary, however due to timescales and costs we do not recommend pursuing this for winter 22/23.

8.0 Risks

Workforce and the ability to staff the additional capacity areas is the single biggest risk to the plan alongside: -

- Staff Wellbeing / Morale leading to increased sickness levels
- Capacity in the UEC and system teams to delivery change at pace
- Supplier shortages / delays for capital projects
- Funding should any overspends occur and Funding for capital requirements
- Residual capacity gap post actions
- Glenfield Hospital – physical capacity
- Demand increases

In addition, there remains significant risk of UEC challenges in 22/23 given the demand being seen across LLR and the NHS currently.

9.0 Escalations

The whole hospital response policy outlines the response of the whole system at times of increased demand or limited capacity. It requires a wider and faster range of activities to be enacted to rectify the situation as Trust services can no longer be maintained within routine service arrangements, and it requires special procedures not previously employed.

The policy ensures that beds across sites are used before we consider cancelling elective activity, that cancer and urgent planned care is prioritised, and that there are clear steps and escalation routes for decision making.

10.0 Governance

Internally at UHL the winter plan will be overseen by the UEC Steering Group Chaired by the Chief Operating Officer), with will report into EFPB and OPC. Within the LLR system it will be overseen by the Winter Board (chaired by the UHL Chief Executive Officer).

11.0 Conclusion

Winter will be a challenging time, with increasing pressures causing delays in care in our emergency pathways. System plans for winter pressures are being developed in conjunction and form part of a single plan for how the system will manage the continued restoration of routine activity alongside the management of winter pressures and any additional pressures arising from COVID19 and Respiratory viruses.

The plan presented is ambitious and covers the whole emergency pathway, from presentation, to flow through the hospital to discharge and ongoing care. Yet we recognise that more needs to be done to meet the demand we are seeing and to mitigate the risks stated.

Appendix 1: UHL capacity initiatives

The table below displays the list of original and funded winter schemes that will help bridge the bed gap. These schemes all have timelines for delivery along with individual clinical and operational owners identified and progress is monitored weekly/monthly through the Urgent and Emergency Care action plan

CMG	Scheme	Scheme Description	Impact on Beds	Funded
ESM	Winter & Ambulance	Open Winter Ward (Ward 22LGH)– from September	16	Yes
	Ambulance	UHL at Ashton Care Home beds	24	Yes
	Winter	ESM Priorities - ESM Medical In reach Team	3	Yes
	Winter	ESM Priorities - ESM Junior Doctor (21) Contracted Substantive basis	5	Yes
	Winter	ESM Priorities - ED Consultant Overnight	5	Yes
	Winter	Additional Winter Ambulances	0	Yes
	Winter	Additional GPAU Support (Internal Locums & Bank Nursing)	5	Yes
	Winter	PTCDA / IDT On site / Outflow team	5	Yes
	Winter	Additional ED Cover (Internal Locums)	3	Yes
	Winter	Additional Porters will support ED flow	0	Yes
	Winter & Ambulance	Extended MIAMI opening hours will help overcrowding in ED but not bed gap	0	Yes
	Ambulance	Extended use of Ward 15 at LRI	8	Yes
	Ambulance	Pre-transit Unit at LRI (12 spaces)	0	Partly
	Ambulance	Escalation areas in ED (8 spaces)	0	Partly
	Ambulance	Enhanced Reablement	0	Yes
		TOTAL	**74**	
RRCV	Winter	Junior Drs Supporting COVID/Surge/Winter Pressures - 18 Drs and JDA	4	Yes
	Winter	Increase Ward 15 to 29 beds	2	Yes
	New	Convert Ward 32 Seminar Room (capital)	2	NO
	Winter	Increase SDEC	8	Yes
	Winter	Additional Cardiology Consultants improve flow	0	Yes
	Winter	Ward Clerk - Floater and Flow Co-ordinator will help overcrowding in CDU	0	Yes
	Winter	STEMI pathway	3	Yes
	New	Additional Modular wards at Glenfield (32 – 40 beds)	0	NO
	Ambulance	Discharge lounge capacity (8 – 10 spaces)	0	Yes
		TOTAL	**19**	
CHUGGS	Winter	Ward 21 additional beds	4	Yes
	Winter	Ward 22 additional beds – continue outsourcing	4	Yes
	Winter	Triage running 8am – 8pm and weekends	4	Yes
	Winter	FY1's to support TTOs	2	Yes
		TOTAL	**16**	
MSS	Winter	Trauma Lists – Insourcing	2	Yes
	Winter	Pre-op LOS reduction through trauma lists	2	Yes
	Winter	NOF pathways – 2 ring fenced beds	2	Yes
	Winter	Ringfence 1 Spinal bed	1	Yes
	Winter	Ringfence 1 Airway bed	1	Yes
		TOTAL	**8**	
W&Cs	Winter	Open Badger Bay on Ward 11	6	NO
	Winter	Ensure all beds are open (staffing and acuity)	14	Yes
		TOTAL	**20**	
		OVERALL TOTAL	**137**	