Agenda Item 10

NHS
West Leicestershire
Clinical Commissioning Group

HEALTH AND WELLBEING BOARD: 17 NOVEMBER 2016

REPORT OF LEICESTER, LEICESTERSHIRE AND RUTLAND CCGS

URGENT CARE: DEVELOPMENT OF INTEGRATED URGENT CARE AND WINTER PLANNING

Purpose of report

1. The purpose of this report is to brief the Board on the winter planning process for winter 2016/2017 and to provide an update on progress within the Leicester, Leicestershire and Rutland (LLR) Urgent Care Vanguard, particularly to inform the Board about urgent care services being procured for 2017/2018.

Link to the local Health and Care System

2. Winter planning is the responsibility of the LLR Accident and Emergency Delivery Board (AEDB), which is chaired by John Adler, Chief Executive of University Hospitals of Leicester and has replaced the System Resilience Group as the Executive oversight group for Urgent Care, in line with national guidance.

3. The LLR Urgent Care Vanguard is taking forward work to improve urgent care across the health and care system.

Recommendation

4. The Health and Wellbeing Board is recommended to note the contents of this report.

Policy Framework and Previous Decisions

5. The Vanguard work takes forward the implementation of the Keogh Review of Urgent and Emergency Care.

Winter planning and preparedness 2016/2017

6. The LLR Winter Plan was submitted to NHS England on 3rd October 2016. The Winter Plan is a system-wide plan that outlines how the constituent organisations that make up the local urgent care system will individually and collectively respond to seasonal pressures and ensure that urgent care services run safely and effectively.

7. There has been no additional funding for winter made available in 2016/2017 other than what exists in provider baselines, therefore the LLR winter plan relies on what organisations can do within existing resources. The winter plan is in addition to the Surge and Escalation plan, which details how each organisation in the urgent care

system will respond to differing escalation levels, or trigger points relating to demand pressures or unexpected events. The winter plan clearly describes how the health and care system will manage pressures in the system and use its collective resources to meet demand and cope with adverse events including harsh weather and outbreaks of seasonal illnesses including influenza and respiratory illnesses.

8. Key aspects of the winter plan are:
   - An additional 28 beds to be opened within University Hospitals Leicester (UHL) to cope with demand for emergency medical admissions;
   - UHL has continued to operate a Discharge Response Team funded from winter pressures in 2015.2016;
   - A clear protocol for opening escalation beds in Leicestershire Partnership NHS Trust (LPT). There are 14 additional beds in community hospitals that will be opened flexibly when there are patients waiting for transfer from UHL or in the community;
   - A communications and engagement plan, including promotion of the flu jab and an online campaign showing how a group of real local families are keeping well and accessing services;
   - Detailed planning for the Christmas and New Year period to ensure adequate capacity and responsiveness over peak periods and holiday periods.

9. Despite the lack of specific additional funding, there are a number of changes that have been made to urgent care services, or that are about to be implemented which will help to manage pressure on emergency services this winter. These include:

   - The new social care support service, Help to Live at Home, which will provide domiciliary care support for County patients being discharged from hospital, from 7th November;
   - A Mental Health Triage Car operated by EMAS which has been successful so far in reducing the numbers of patients needing to be taken to Leicester Royal Infirmary Emergency Department (ED);
   - Extended acute visiting services – longer hours in West Leicestershire and a pilot covering two localities in East Leicestershire. This service provides capacity for rapid home visits to patients at high risk of admission, including care homes;
   - From the end of October, the introduction of clinical navigation linked to NHS 111 providing greater levels of clinical triage, assessment and advice to patients, aiming to avoid ED attendances and ambulance dispatch

Learning from winter 2015/2016

10. Performance at UHL was very challenged over last winter, and performance dipped to 65.66% at its lowest point. Overall there was a 6% increase in activity and admissions were up 4.6%. UHL showed the predictable trend of big increases in the run up to Christmas then the activity levels dropped, with cessation of elective activity and a push on discharging patients, so that there were approximately 300 empty beds over the festive period. Emergency activity then picked up from Boxing Day through to the New Year and into January. Attendances averaged 426 per day during January 2016.

11. The last winter was not a particularly harsh one, and there were no major flu outbreaks or spikes in seasonal illness. However, there were notable challenges relating to ambulance handover times and assessment times at Leicester Royal Infirmary ED. Ambulance handover delays peaked in November 2016 with 2204 hours lost at Leicester Royal Infirmary during the month. As a result of pressures at UHL and delays in assessment, UHL were the subject of a Care Quality Commission warning notice. Actions taken to improve handover times by EMAS and UHL were effective in reducing these delays from January, and delays have dropped by about a third from the peak; these actions included a cohorting protocol in the ED and Standard Operating Procedures for assessing and streaming ambulance patients.

12. The winter plan for 2015/2016 included investment totalling £1.8m, plus £50k for Winter Communications which was overseen by the Urgent Care Board. Funding was used to support a range of schemes which provided additional capacity in health and social care services, including 7 day social work cover, additional discharge transport capacity, and funding for smartphone access to the directory of services for ambulance crews. Within the total, we also allocated some additional funding of £75K for delivering the communications and media plan.

13. The A and E Improvement Group and its predecessor group the Operational Resilience Group has undertaken a review of services funded within the 2015/2016 winter plan. Some services have been continued/picked up with internal resources, such as the Discharge Response Team in UHL, although the majority of services were stepped down at the end of March 2016.

14. The A and E Improvement Group is currently in the process of reviewing the learning from last year, and prioritising schemes which were shown to be effective in managing pressures. This is in order to have an agreed list of high priority schemes which would restart at short notice if funding does become available over the winter period. Additional social work capacity and inreach to hospital to support discharge are two areas which the Group would like to fund if there is any additional money in the system.

15. Communications Plan: despite a detailed communications plan in 2015/2016 including a number of media campaigns, there was no evidence that messages to the public about avoiding using Emergency Department services had any impact and, as mentioned above, there were sharp increases in activity over the last year. There is growing evidence both nationally and locally that media messages about Emergency services have the effect of increasing presentations at the ED rather than keeping people away. The learning from this has been reflected in this year's communications plan which places less emphasis on trying to tell people not to use ED services.

Developing Integrated Urgent Care in LLR

16. Work has been progressing within the LLR Vanguard to improve urgent care services, and significant progress has been made on developing a model of integrated urgent care, which the Vanguard Team is now in the process of implementing/contracting for.

    The Vanguard service model responds to the Keogh review and is based on the following principles:

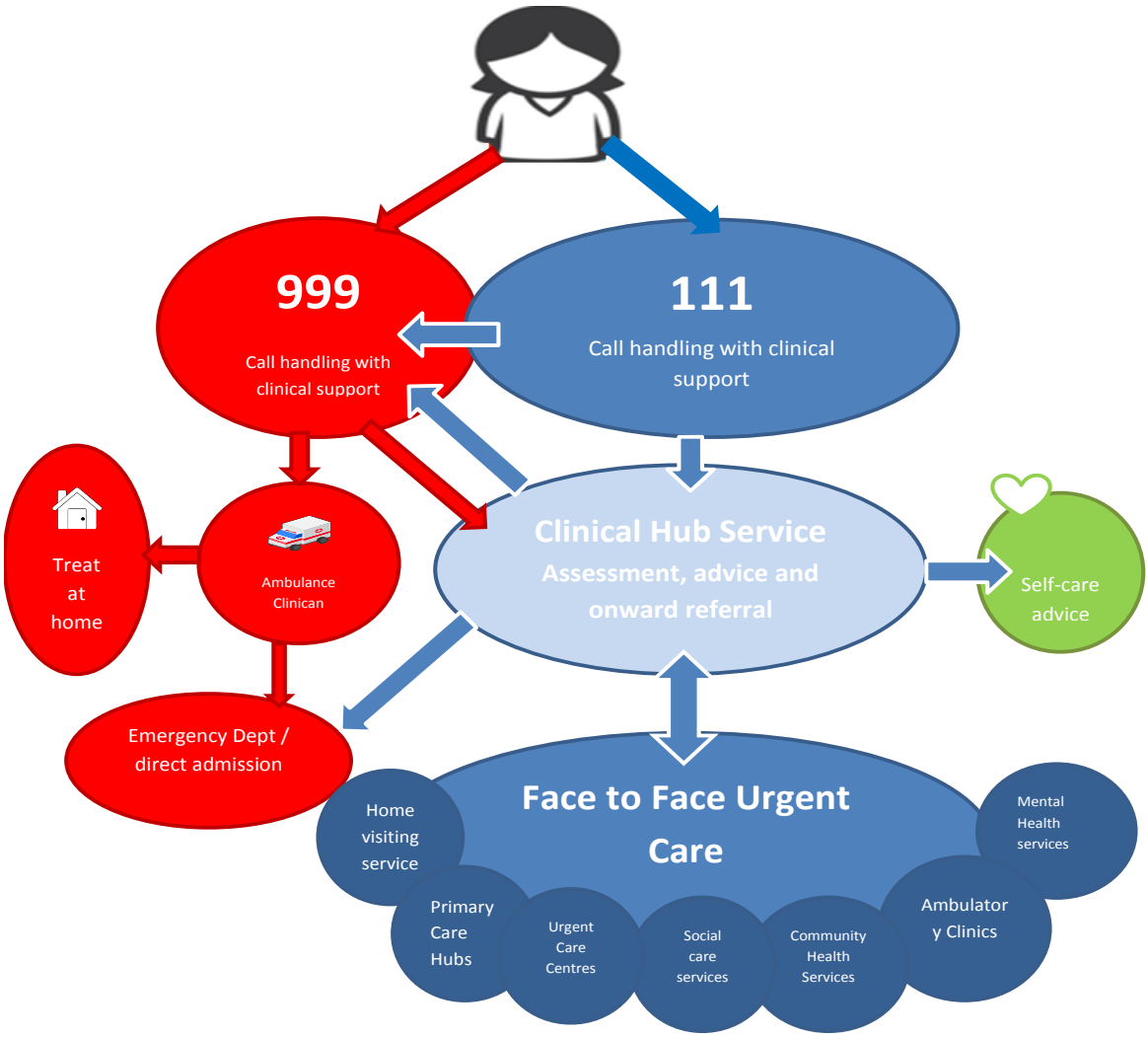
- Providing better support for people and their families to self-care or care for their dependants.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
- Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and a good recovery.
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

17. The service model developed by the Vanguard has been developed in response to National guidance and the Five Year Forward View, as well as reflecting the needs of the LLR population and the diversity of population and geography. The principle of a core, consistent offer across LLR, with local flexibility has been followed.

18. The overall service model design for LLR is an integrated, coherent and intelligible urgent care system, with patients supported to access the right service via enhanced clinical navigation linked to NHS 111. Community urgent care services will be available 24/7, 7 days a week with reduced duplication as a result of functional integration, as part of an integrated network. There will be improved information sharing and signposting between providers.

19. The model of care at the LRI ED Front Door will be consistent with and reflect the integrated community urgent care model, with senior primary care clinicians at the Front Door streaming patients to an urgent care stream, ED majors or assessment units and base wards as appropriate to their clinical need. Where clinically appropriate, patients will receive rapid treatment and advice from the streaming service or be redirected to alternative primary and community based services.

Figure 1: How clinical navigation works within the LLR urgent care pathway



20. Achieving this vision will depend upon improved collaboration between providers, with a joint clinical governance framework supporting front line staff. In order to achieve this, LLR CCG Governing Bodies have agreed to develop an Alliance agreement, bringing together the providers of the individual service components along with commissioners to oversee the operation of the urgent care system, with shared outcomes and performance standards.

21. The new service model will comprise of four core service components.

Component 1: Integrated primary and community urgent care services

This is to be procured in 3 CCG sub-lots:

a. West Leicestershire CCG for 1st April 2017
b. Leicester City CCG for 1st April 2017
c. East Leicestershire and Rutland CCG for 1st October 2017.

Component 2: Leicester Royal Infirmary New Front Door & Urgent Care Service

This procurement is to be led by UHL with the close involvement of the CCGs and the Urgent and Emergency Care team) for 1st April 2017.

Component 3: LLR Urgent Care Home Visiting Service

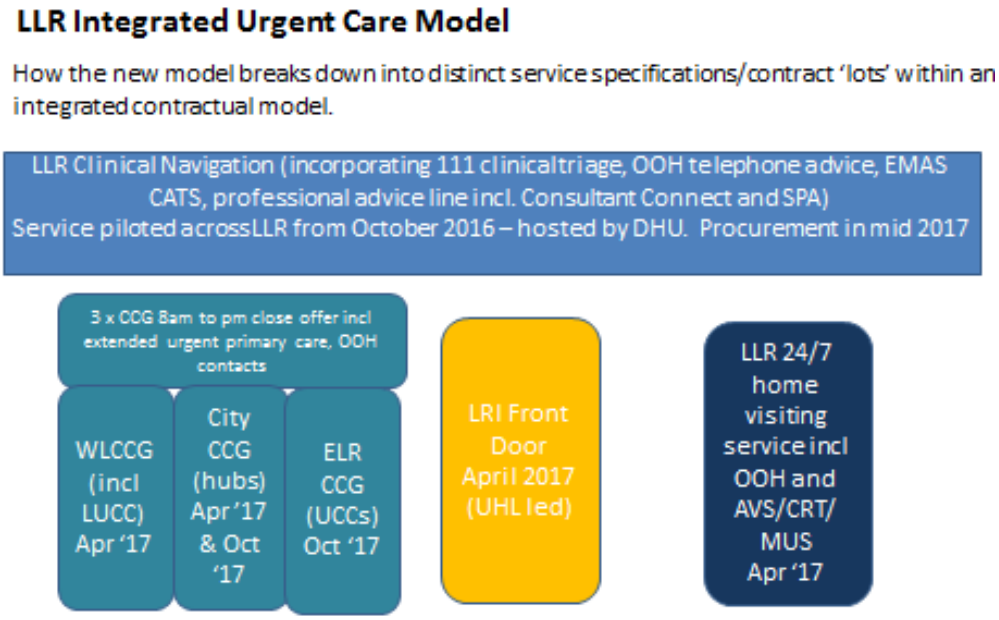
This incorporates Out of Hours (OOH) home visiting, Acute Visiting, Crisis Response Teams and Mobile Urgent Care Services for 1.04.17.

Component 4: Clinical Navigation Hub Service

This will not be procured at this point in time but will be initially piloted on a pan-LLR basis to assess the impact of the model, allowing commissioners to refine the service model and operating protocols before a formal procurement takes place. Derbyshire Health United (the current LLR provider of NHS111 and OOHs) will host this pilot, which enables the use of existing clinical staff, within clear and established information governance and clinical governance arrangements.

These service components form distinct lots for the purpose of procuring and contracting as described above and shown below.

Figure 2: The elements of the LLR Integrated Urgent Care system



Procuring the new service model

22. The three LLR CCGs have now commenced the process of procuring a number of new services as described above. Not all the new service contracts will come into place on 1st April due to the contract expiry dates for some existing services. This means that Urgent Care Centre services in ELR CCG will remain as they are until October 2017. However, changes to home visiting and clinical navigation/NHS 111 will cover all of LLR from the outset.

23. It is the CCGs' intention to construct an Urgent Care Alliance with the providers of the new service model. The Alliance will bring urgent care providers and the CCGs into a collaboration to deliver care with agreed, shared outcomes and incentives, with a shared clinical governance framework and risk/gain share.

Consultation

24. The service model has been developed in response to the feedback and views of local people, patients and carers. The CCGs have amassed an extremely rich library of the outputs of engagement exercises, analysed this output into key messages/themes and used this to inform the plans for improved services.

25. The Vanguard has carried out specific engagement activities with the three Healthwatch organisations for the region to seek people's views on integrated urgent care, and specifically to get feedback on the introduction of clinical navigation.

26. There are no major service changes in respect of sites or the level of service being provided and therefore it is the view of the CCGs that formal consultation on the changes is not required. However, using and responding to the views of local people has been at the heart of the Vanguard work.

27. Additional engagement on the planned changes to urgent care has taken place in forums such as CCG Annual General Meetings and with GPs and the Local Medical Committee.

28. Communications are planned with local people on the forthcoming changes and what they mean for them, using a 'You said, we did' approach. A stakeholder communication has been distributed and an animated video describing the changes is in production.

29. During the pilot for clinical navigation we will use the Experience Led Commissioning tool to gather people's feedback on the new pathway and use it to inform further developments to the service model.

Resource Implications

30. At the time of writing, the outcome of the procurement exercise is not known. However, the CCGs have undertaken extensive modelling and the new service model is expected to operate within the same financial resource as the current urgent care contracts. There is some scope for financial efficiencies relating to reducing duplication in both operational processes, staffing and assets. It is also expected that the service model will reduce activity in ED and ambulance services. No additional investment decisions have been made by the CCGs in order to deliver the new service model.

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Relevant Impact Assessments

Equality and Human Rights Implications

31. We have undertaken an EQIA for the new service model. Overall, there are considered to be positive benefits arising from the new service model relating to

equalities and groups of people with protected characteristics. The EQIA was shared with the CCG Governing Bodies to support their decision making in relation to the new service model.