Agenda Item 8

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

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LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 5 MARCH 2021

SYSTEM UPDATE: WINTER PRESSURES REVIEW AND NHS 111 FIRST

REPORT OF THE DIRECTOR OF TRANSFORMATION AND INTEGRATION

Purpose of the report

1. The purpose of this report is to inform the Committee of how the NHS system has managed COVID and winter pressures over winter 2020/2021. The report also provides an update on the development of the NHS 111 service and pathways into urgent care.

Winter Pressures Review

2. The LLR health and care system has faced unprecedented challenges over the last twelve months, not least the challenge of planning for winter pressures during the time of the COVID pandemic. In normal times, the health and care system prepares for winter with a multi-agency winter plan, which aims to enable the maintenance of key services and delivery of safe, timely care during what is traditionally the busiest period of the year in relation to unplanned care services; emergency department attendances, ambulances, medical inpatient

admissions and the need for rapid social care and community support to people in crisis so that they can remain at home.

3. Winter planning for 2020/21 brought with it added complexities and demands, due to:

    - the likelihood of further outbreaks of COVID-19, which indeed materialised in a significant third wave during December and January;
    - the anticipated COVID-19 vaccination programme adding to pressures on workforce and organisational capacity over winter;
    - an expected increase in non-elective activity pressures due to seasonal illness;
    - reduced capacity in health and care services as a result of COVID cohorting and infection prevention and control requirements, which essentially require health care settings to operate two separate areas for COVID and non-covid patients with separation of staff, as well as requiring additional time for cleaning and changing PPE; and
    - the need, as far as possible, to restore elective activity and deal with a growing back log of routine and planned care.

4. NHS England requested that systems develop a single plan for ‘phase 3’ of COVID in this period and therefore we brought together routine annual planning for winter pressures with our planning for the use of system capacity to deliver elective and cancer care, developing a single integrated winter and COVID plan for the period November 2020 to March 2021.

5. The winter pressures plan was led by the Urgent and Emergency Care Group, which has senior lead representation from all health organisations in LLR, including East Midlands Ambulance Services (EMAS) and all three local authority social care leads.

6. The key objectives of the winter plan were to:

    - Ensure the continued delivery of high quality, safe care to patients by the whole system;
    - Reduce demand for unnecessary presentation at primary care, Emergency Departments (ED) and other emergency pathways through providing alternatives including the use of NHS 111 First and self-care;
    - Enable demand to be managed within defined, existing bed capacity and other capacity, setting out available core and surge capacity, minimising the risk of cancellations of planned care;
    - Mitigate and manage situations whereby care provided in corridors occurs ensuring risk and harm is avoided/mitigated;

- Mitigate the risk that pressures within ED impact on ambulance handover, minimising lost time and avoiding unseen risk to people needing a response in the community;
- Operate clear organisational and system-wide surge and escalation management protocols, with the management of system escalation levels led by the CCG UEC team;
- Provide assurance that all services have and maintain priority actions and resilience plans including setting out how UHL's ED is prepared to meet expected demand;
- Support the primary care and community flu vaccination programme and increase health and social care staff take up;
- Build relationships across the system for providers to manage pressures effectively in collaboration;
- Ensure that patient flow is optimised to free up maximum bed capacity to cope with anticipated bed pressures;
- Describe plans for out of hospital services to increase capacity and/or manage demand to prevent admission/discharge step down;
- Describe any additional plans required in response to COVID, in relation to IPC, surge and escalation;
- Improve patient experience by removing unnecessary delays in care and delivering care with a 'right first time' approach;
- Support primary care to remain resilient and sustainable.

7. The LLR system was operating within COVID-19 pandemic resilience arrangements throughout the winter period 2020/2021. These are overseen by the Local Resilience Forum arrangements, working alongside the Health Economy Strategic Co-ordinating Group and supporting sub-groups. The LLR Urgent Care Group is one of these supporting groups and continued to meet weekly throughout the winter period to provide oversight of system pressures, manage the escalation and emergency response arrangements and agree any actions required in the system to respond to changing pressures or challenging areas of system performance.

8. The key elements of the winter plan for 2020/2021 are described below:

- A review of the surge and escalation plans for all organisations, including social care, to include specific actions in response to anticipated COVID pressures. Primary care escalation actions and weekly escalation reporting were included for the first time.
- Increasing capacity for urgent telephone and face to face contacts in urgent care services across LLR to restore the opening hours and range of service locations previously in place before COVID. During the emergency response to COVID in March and April, a number of sites

were temporarily closed in response to the dramatic reduction in face to face activity. This equated to expanding the available clinical capacity for appointments by 31%.

- Maintaining changes to access arrangements at ED and other walk in sites put in place in response to COVID with COVID screening (including via calls to NHS 111) before patients are seen face to face.
- Continuing to deliver separate 'hot' clinics for patients who have either confirmed or suspected COVID and need to be seen urgently face to face, in addition to the existing urgent care sites across LLR.
- Strengthening the service delivered through NHS 111 to make sure that patients are seen in the right place at the right time, aiming to reduce unnecessary attendance and crowding in emergency departments and other site. More information on the NHS 111 first initiative is provided in a later section in this report
- A new service providing support for care homes and East Midlands Ambulance Service crews responding to patients in care homes, with on call specialist consultant advice to agree the right approach to care and to keep patients in their place of residence wherever possible.
- Investment to increase capacity in the Home First service, to recruit additional community nurses, therapists and social care staff to work in partnership with primary care.
- Increasing bed capacity in University Hospitals of Leicester by 75 beds to care for the expected numbers of additional admissions over winter.
- Availability of 36 'surge' beds in Leicestershire Partnership Trust which could be opened in case of a significant second COVID surge, or unmanageable winter pressures.
- Work with the three Universities in LLR to communicate the right access routes to healthcare to students including access to testing, encouraging GP registration and promoting wellbeing and mental health.
- Enhanced plans for flu vaccinations as part of our Flu Plan
- A strengthened system workforce plan in response to COVID-19 which includes mutual aid between organisations and effective monitoring of the workforce situation across health and social care, including care homes.
- Changes to the referrals routes to mental health services to provide a single, direct crisis access point for users and referrers.
- Improved and increased general signposting to the public through a communications plan and social media campaign.
- A specific plan for the Christmas and New Year period including enhanced senior cover and staffing, and additional discharge support services in place.

9. Despite the COVID pandemic and the significant increase in COVID infections and hospitalisations, which began in November and continued through to January, the LLR system has managed relatively well throughout the winter period. The following sections summarise the picture in relation to the demand faced by services and how well the urgent care and wider care system managed through the winter period.

10. Presentations to Emergency Departments, both at the Leicester Royal Infirmary and by LLR patients to other sites outside the LLR footprint, have been significantly lower than in previous years. From January 2020 we saw a marked decrease in attendances at ED, as a result of people's concern about the risk to attending health care premises during the pandemic. Although attendances have increased since the early days of the pandemic and the low point in April 2020, they remain consistently at 75% or lower than pre COVID levels. This is in part attributable to the work we have done to strengthen alternatives to emergency care both pre and during COVID, including the switch to virtual consultations and navigation through 111.

Chart 1: Presentations to UHL ED Jan 20 – Jan 21

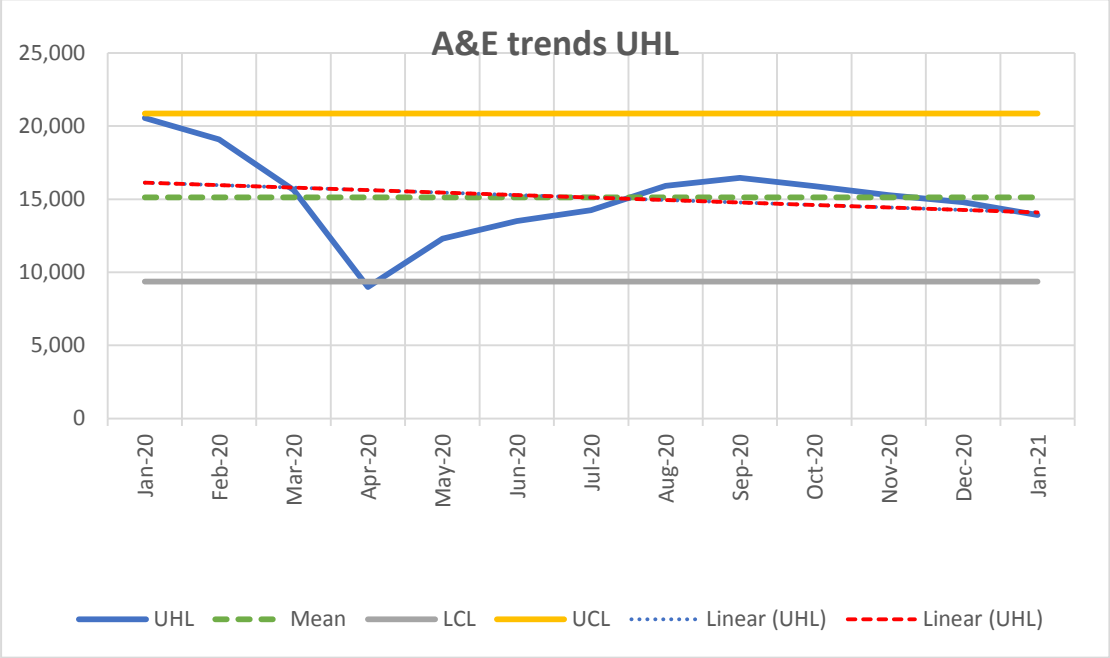
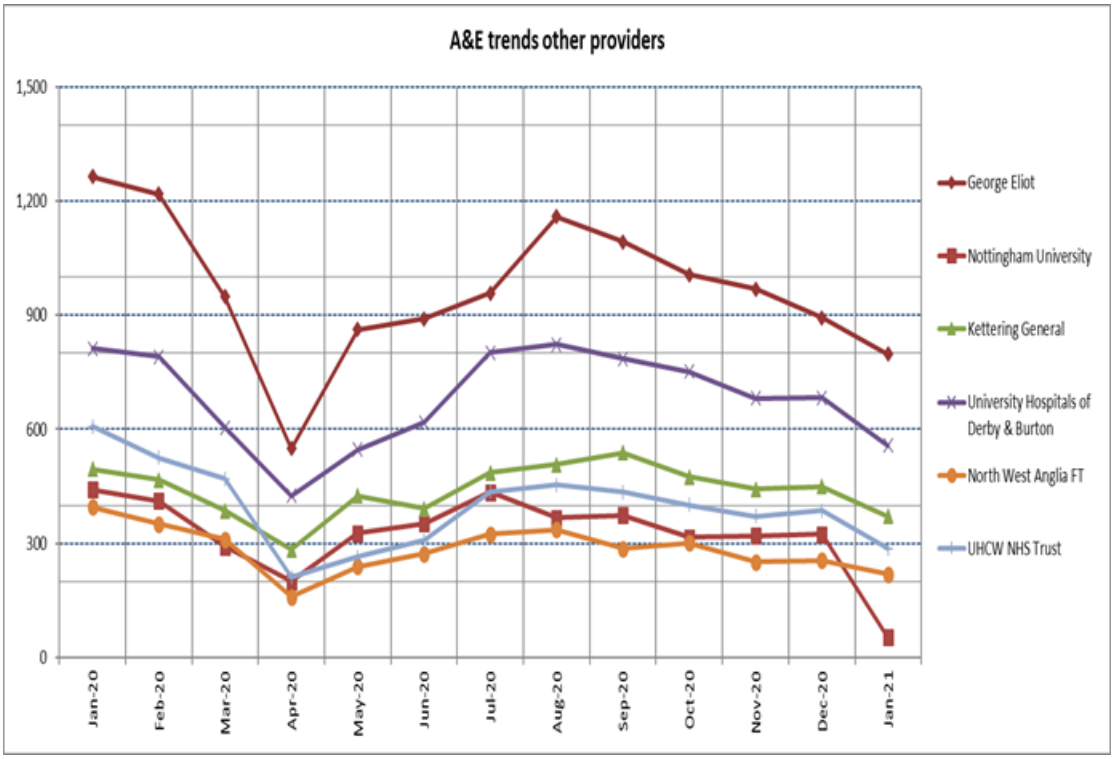
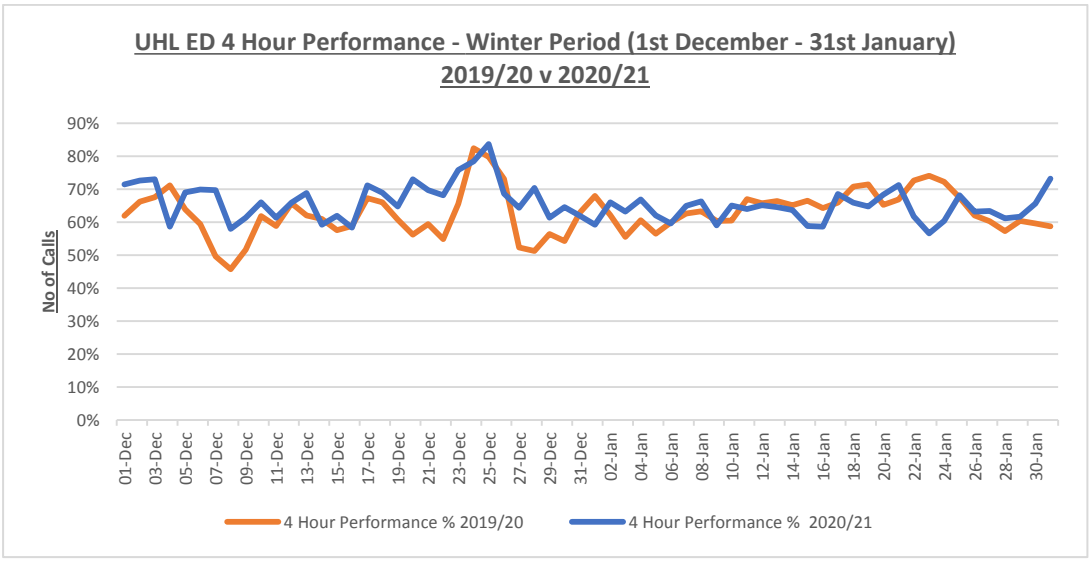


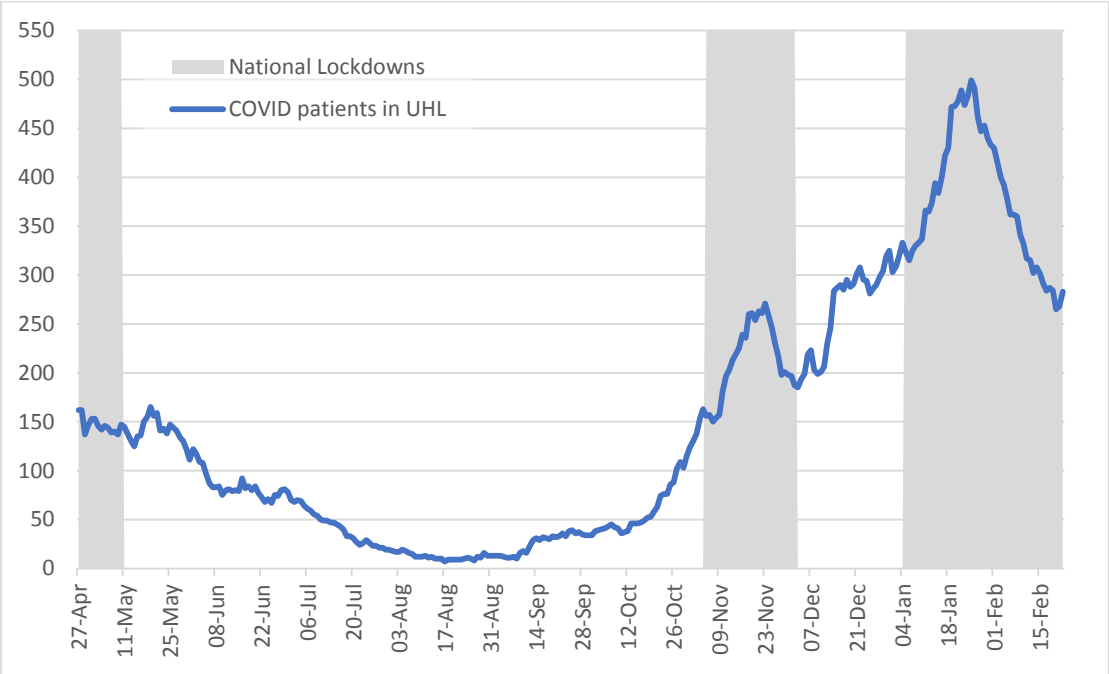
Chart 2: LLR attendances at other EDs





11. Overall waiting times in LRI ED were slightly better over December and January in 2020/2021 than 2019/2020 (66% compared to 63%) but performance has remained challenging, despite the decrease in the number of attendances. This is partly attributable to the operational impact of separating ED staffing over COVID and non COVID ED areas, as well as being a reflection of the increasing pressures on bed capacity within UHL slowing admissions within the four hour national target timeframe, for those patients who cannot be discharged home. During December and January, the number of patients with COVID requiring admission to hospital increased rapidly, as the chart below shows, regrettably coinciding with the peak winter months.

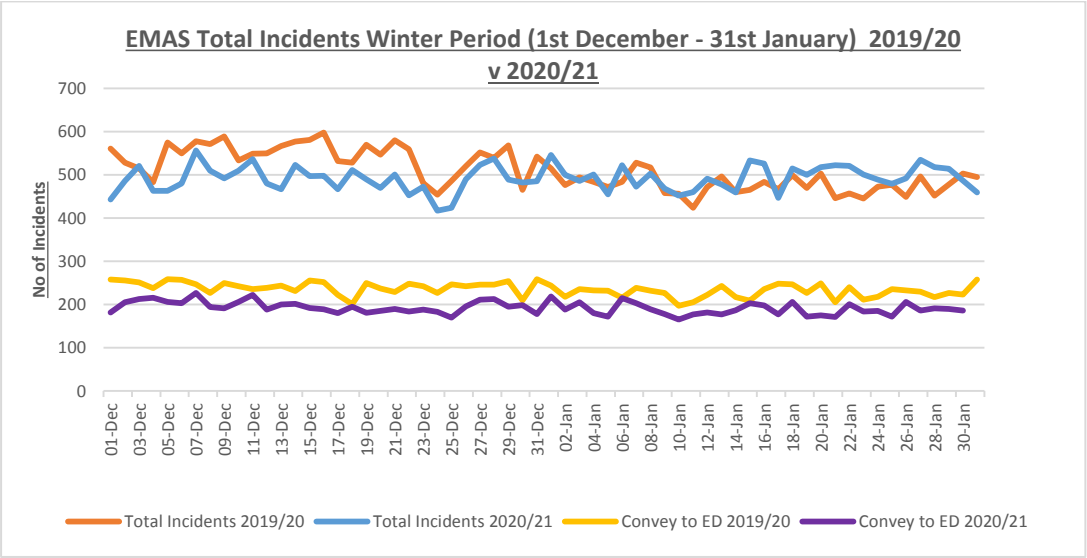
Chart 4: COVID admissions at UHL



12. From the second half of December 2020, the LLR system was operating at its highest level of COVID response, due to the significant increase in COVID infections and numbers of patients requiring hospital admission and ventilation, and this co-ordinated response has continued through to February 2021. The system response has included the full enactment of our COVID surge plans, and the need to redeploy significant clinical space and staffing away from routine and urgent planned care to manage the needs of patients with COVID. Theatre staff, theatre operating spaces and intensive care recovery beds (ITU) were all deployed to manage the response to the COVID wave during the peak winter months of December and January. Other actions taken included opening additional community hospital beds (at the highest point 67 COVID beds were created in community hospitals), and redeploying social care staff from non-urgent cases to provide crisis response both to keep people from being admitted and to enable patients to go home quickly, releasing hospital capacity to take new admissions.

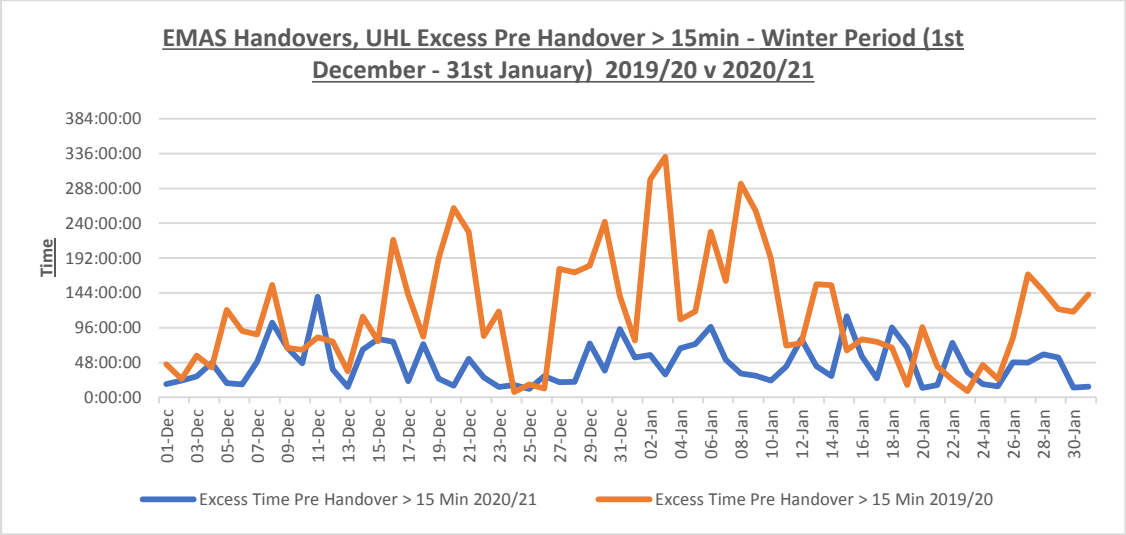
13. We have worked very effectively with EMAS and other urgent care services to reduce the proportion of calls to EMAS that result in a person needing to be taken by ambulance to the Emergency Department. LLR consistently has the lowest 'conveyance' rate of any of the East Midlands systems, as a result of the initiatives we have put in place to support EMAS to access clinical advice and alternative care pathways, so that fewer than 50% of patients seen by EMAS end up going to hospital. The chart below shows that although total EMAS demand has not decreased from last year and indeed was higher on average in January, the number of patients taken to ED has been lower.

Chart 5: EMAS activity and ED conveyance rates 19/20 and 20/21



As a result of the above, and the strong partnership working between EMAS and staff at the LRI, ambulance handover times at the LRI ED have been improved. The chart below shows that the number of ambulances waiting for more than the national target of 15 minutes to transfer a patient into the ED has been reduced compared to the previous year.

Chart 3: EMAS handover delays at LRI ED 19/20 and 20/21



14. Despite the improved handover performance in general, on some days of high pressure, particularly when there are problems with staffing capacity in ED or with medical inpatient bed capacity, ambulance handovers have built up to unacceptably high levels. These instances are much less frequent than in 2019/2020 and operational performance generally recovers much more swiftly to get waiting times down than before. This has been achieved despite the

challenges posed by in effect running two emergency departments, one for suspected or known COVID patients. As a system we now tend to 'de-escalate' and recover acceptable performance more quickly than in pre-COVID days which is a testament to operational processes and how resilient the overall system is.

15. The pressures caused by winter and the number of COVID patients in hospital has had an inevitable detrimental impact on the provision of routine and planned or 'elective' care for LLR patients. During the level 5 COVID incident during December and January, UHL hospitals were only able to complete planned surgical procedures for the highest priority (P1) urgent care and cancer patients, with the vast majority of other elective cases deferred or not booked for procedures during the incident response. This has led to an understandable but very significant number of patients who have not received care, including patients who have been on waiting lists for more than 52 weeks. Reviews to assess and avoid any patient harm are being undertaken in all clinical specialties and UHL is actively reviewing the backlog patient lists and scheduling care in order of clinical priority.

16. In summary, despite an unprecedented period of pressure as a result of the COVID pandemic, combined with expected seasonal pressures over winter, the LLR system has been remarkably resilient in maintaining service provision and performance relative to the previous year. Health and care plans and joint working arrangements across system partners stood up well to the challenge, managing to deliver the most essential services and maintain operational delivery of life saving care in a timely way for our population while coping with the third wave of COVID over winter. Staff in all our services have worked immensely hard in the face of extreme pressures and deserve all our thanks. Looking ahead, restoring pre-COVID levels of planned care and recovering from the impact of the pandemic presents a perhaps even greater challenge.

NHS 111 First Update

17. NHS 111 First is a national programme to extend the use of the NHS 111 service to support the principle of offering people the right care in the right setting at the right time and avoiding unnecessary use of emergency healthcare services. This is important so that emergency service capacity is available to meet the needs of people with serious clinical emergencies.

18. The learning from the early period of COVID demonstrated that people with urgent care needs could be offered advice, support and care in different ways without needing to attend Emergency Departments. There was a big shift

towards telephone consultations and the provision of virtual care in LLR, mirroring the national experience. These factors, combined with the desire to avoid infection and associated harm risks to patients and staff of people attending clinical settings unnecessarily, have been the driving force behind the further development of the NHS 111 model.

19. LLR has always had a strong model of clinical triage and navigation in its urgent care services, and was one of the first systems in England to introduce clinical navigation to support NHS 111 in 2017, as an Urgent Care Vanguard. In addition, LLR has a good range of urgent care services outside of hospital, with urgent care centres and extended primary care hubs in multiple locations which offer an alternative to Emergency Department care. We have continued to build on this in subsequent years, and have relatively low rates of usage of ED compared to the national average.

20. The key deliverables of the 111 First programme were to:
    - Aim for 20% of 'unheralded*' attendances at ED or urgent care centres to be re-directed elsewhere, either through calling 111 or by triage at the front door of the ED;
    - Increase the number of alternative pathways available directly through NHS 111, such as ambulatory care and 'hot' clinics at hospital;
    - Enable direct booking from 111 into timed slots in ED;
    - Develop a clear communication & engagement strategy, with local and national media;
    - Carry out a structured evaluation of outcomes, and provide data into a national reporting system;

    '* unheralded' means that people have not been referred to or advised to attend ED after contact with a clinical service.

21. LLR was asked to be one of the first systems nationally to go live with an expanded 111 offer, with a short timeframe to meet the national deliverables requiring rapid development and implementation of a project plan. We progressed to mobilisation of key changes, including booking into ED services at the end of September 2020, a mere eight weeks after project inception.

22. The key partners in this work have been Derbyshire Health United (DHU), who provide the East Midlands 111 service as well as the LLR Clinical navigation hub and run a number of LLR urgent care/treatment services; East Midlands Ambulance Service (EMAS); primary care and University Hospitals of Leicester (UHL).

23. Having successfully introduced a number of changes to the 111 First and ED service in LLR, we have undertaken an initial evaluation of the impact of the changes, which is summarised in this report.

What changes have been made?

24. By the end of September 2020, achieving our target date, 111 began to book patients who required care in an Emergency Department into booked time slots in the Leicester Royal Infirmary ED. This was enabled despite the lack of a national IT solution, building on work we had already done with UHL and DHU. The benefit to patients has been that they can attend at a specified time, were expected by the ED team and would not have to wait in communal waiting areas. This is more convenient for people as well as reducing the risk of infection from people in busy waiting areas. LLR was the first area in the East Midlands to do this, but most other EDs in the region are now also accepting direct bookings from 111 and LLR patients can be booked into a range of other hospitals as well as UHL, depending on where they live and their choice of location.

25. Building on the existing model of clinical navigation via NHS 111, we have reviewed the types of clinical problems that are mapped to different services. There has been an increase in the number of patients that go to clinical navigation for further assessment before advice is given to the patient on the most appropriate care, and this has reduced ED referrals further.

26. Changes have been made to the Directory of Services that supports 111 and enables patients to be referred into alternative pathways. This will continue to be an ongoing piece of work, adjusting for the learning and initial evaluation findings.

27. Improvements have been made to direct booking pathways, in particular to resolve IT issues that were preventing patients being booked into appointments with their own GP practice.

28. Significant changes have been made to ambulatory care pathways at UHL to enable EMAS, the clinical navigation hub and GP practices to refer and book patients directly into specialist and emergency clinical assessment pathways without patients having to go first to an Emergency Department, where they have to wait to be seen before getting to the right clinical service. This change means patients are now going straight to assessment units for medicine, surgery and gynaecology who previously were being seen first in the UHL ED.

This has improved patient experience, reduced waiting times and reduced pressures on ED.

29. The above changes have been supported by a range of communication activities. From October 2020, once the initial changes had been tested, we ran a range of communications, using social media and local radio. A large scale national TV campaign promoting the use of NHS 111 ran during November and December 2020. The key messages of our local campaign have been to stress that people can get help in identifying the most appropriate and convenient service for them by calling NHS 111.

30. Communications materials have been translated using the most frequently used languages in LLR and we have used community radio stations and multi-lingual broadcasts fronted by local GPs to help get messages across to different communities in LLR, including Hindi, Polish and Somali as well as English. 5 out of 6 community stations in Leicester City are participating and playing the messages.

31. A number of webinars, communications materials and learning events have been organised to promote the 111 First work. Some of these have targeted GPs and primary care staff, while others have been open to a wider audience.

What impact have the changes had?

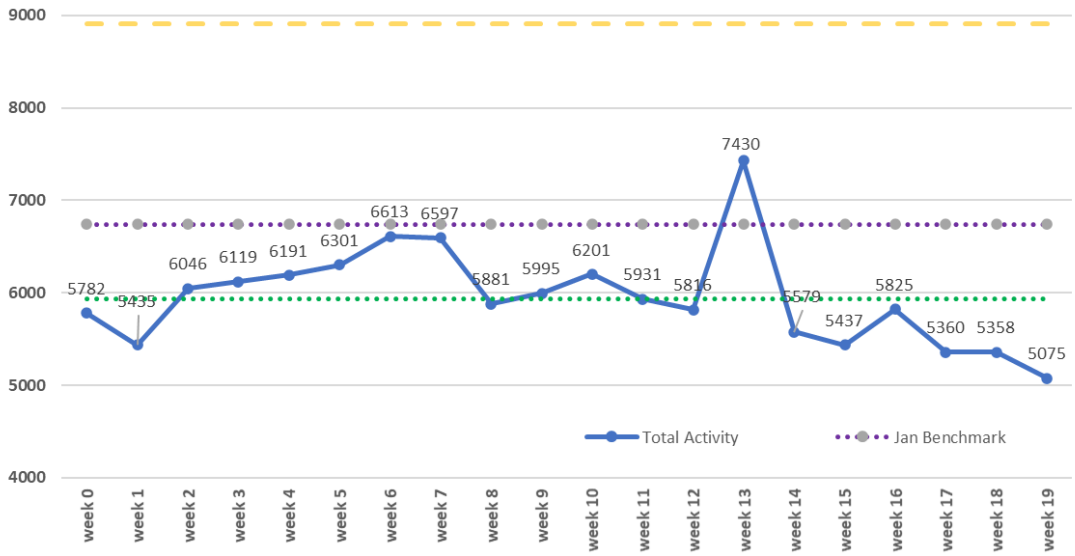
32. It has been difficult to draw definite conclusions from the initial evaluation data about the impact of 111 First for a number of reasons:

33. As well as implementing 111 First, we have made a number of changes to services and pathways through last summer, autumn and winter, which mean there is not a stable baseline or comparator and the cause of changes may not be attributable to 111.

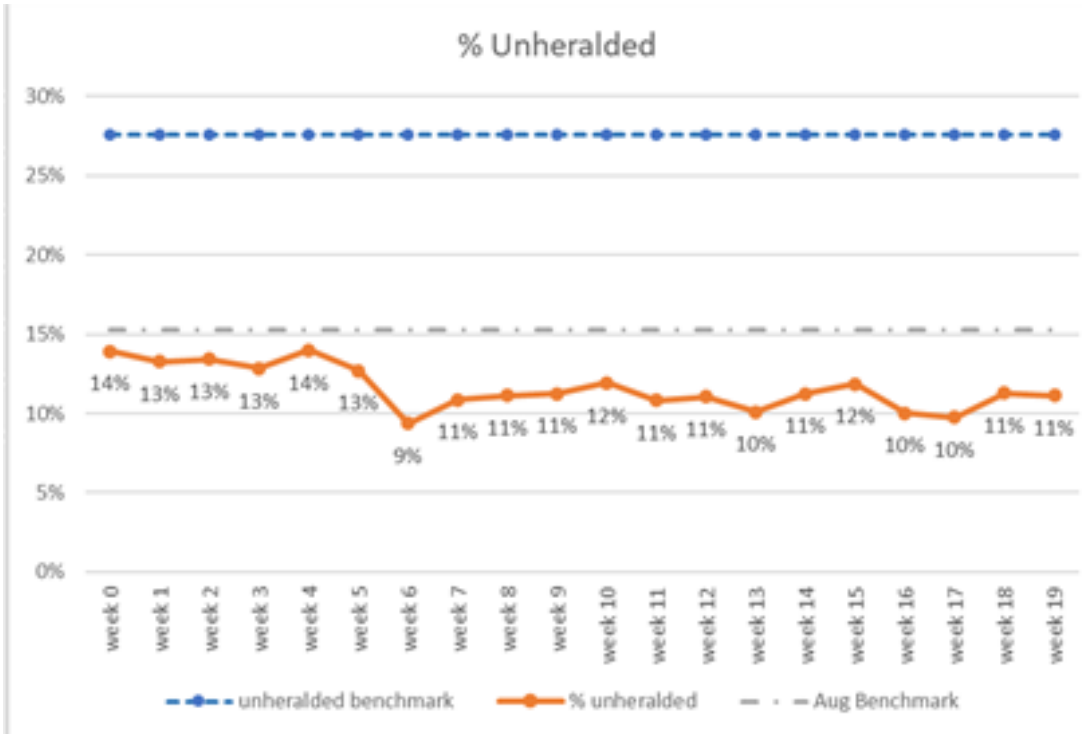
34. Since implementing 111 First, we have experienced two further COVID peaks which will have affected total demand for health care as well as the case mix. However, we can identify some clear trends from the work so far, which are summarised in the paragraphs below.

35. NHS 111 activity has gone down since the introduction of the 111 First changes, despite both local and national promotion activity. This is the reverse of the expected position, which was predicted to be a 13% increase nationally. The trend in LLR patient calls to 111 is shown below (the spike at week 13 is Christmas). The decrease locally mirrors the national trend and this is thought

to have two causes, the first is that there has been less prevalence of minor colds and injuries due to lack of social contact and activities. Secondly, suspected COVID calls are managed by the national COVID 111 CAS service and are excluded from local 111 activity.



36. There has been a decrease in the number of ‘unheralded’ patients arriving at ED who have not got a booked appointment or been referred by a health professional. We have exceeded the target reduction in un-referred walk in activity, as shown in the graph below.



37. Since implementing the direct booking from NHS111 and our Clinical Navigation Hub into ED we have seen an increase in patients being booked, from an average of 15 patients per day in week 1 to 28 patients per day in week 12. This is reflected in the reduction of unheralded activity presenting at ED.

38. Compared to the pre-mobilisation baseline week in August, the proportion of patients who have been referred to ED from 111 has dropped from 5% of calls to 2% of calls, reflecting the increase to the range of conditions that now get clinical assessment via 111 and the navigation hub.

39. Work to improve IT booking pathways has led to an increase of 38% in the number of patients getting a booked GP appointment after calling 111. (Note that most of these patients would previously have been told to simply call their practice but not given a confirmed appointment.)

40. Uptake of new direct pathways into ambulatory care has been slow so far, despite publicising this to GPs, EMAS and clinical navigation.

Further work

41. We are still undertaking further evaluation to understand the impact of the changes to date. This will feed into work to improve the NHS 111 model further as well as urgent care pathways more generally.

42. Work is underway to develop an inequalities plan, including analysing the use of NHS 111 by patient from different post codes and age groups across LLR to compare this to the demographic profile of our population. This will enable us to see any groups who are under or over represented in using NHS 111 and develop plans to target these groups with relevant information, engage with them to identify the reasons why they may not use 111 and adapt our services so that we can improve access and reduce any inequalities,

43. We are gathering patient experience information in two ways; firstly from DHU by asking patients to share their feedback on using 111, secondly by undertaking engagement with UHL ED users on their experience of 111 and urgent care pathways. The results of this work will be available later in the spring.

44. A key focus of our future work is to increase the number of ambulatory and emergency care services that can be accessed as an alternative to ED, and to increase the direct referrals and direct bookings into these via 111/EMAS/DHU/GPs.

45. To conclude, we have successfully implemented a number of improvements to the NHS 111 service and met the national expectations in respect of this. This has had some positive benefits for local people in allowing more booked appointments at ED, GP practices or other services, and reducing walk in activity at ED. However, the impact to date appears to have been fairly modest. We are continuing to refine our local pathways as well as we learn from the initial evaluation and are continuing to review the equalities impact and develop further plans for improvement.

FLU

46. Uptake has increased, and the national target was met for the over 65's.There was a 10% increase in uptake for 'at risk' groups.

47. Overall vaccination rates for key 'at risk' groups were up 8.7% on last year at 67.8%.

48. For the over 65's, flu vaccine uptake rates were 81.1% (up 10% % on last year).

49. The data below is the latest available from the monthly reports provided through the IMMFORM data.

GP Practice Flu Immunisation uptake - Week 03 202		Summary of Flu Vaccine Uptake %					
CCG Code	CCG	65 and over	Total Combined - 6 months to under 65 years: At-risk % uptake	All Pregnant Women	All Aged 2	All Aged 3	50-64
03W	NHS EAST LEICESTERSHIRE AND RUTLAND CCG	83.4%	53.0%	50.6%	67.3%	68.9%	35.5%
04C	NHS LEICESTER CITY CCG	75.9%	43.6%	34.9%	44.8%	45.1%	24.8%
04V	NHS WEST LEICESTERSHIRE CCG	83.4%	51.1%	49.7%	68.5%	68.9%	37.1%
	ENGLAND	**80.7%**	**52.1%**	**43.6%**	**55.0%**	**57.6%**	**-**

50. Support to general practice and primary care networks continues to be provided by the CCG with general and specific targeted support undertaken. However efforts and work is being undertaken on the COVID vaccination programme so it is not anticipated that the flu percentage will increase much further if at all.

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