South West Hampshire Operational Resilience Group

Winter 2017/18 Report

Introduction

1. This paper captures lessons identified by South West Hants Operational Resilience Group (ORG) during the planning for winter 2017/18, and the execution of those plans. This will contribute to planning for next winter.

2. South West Hampshire Operational Resilience Group is a sub-group of the Accident & Emergency Delivery Board, responsible for planning and responding to periods of pressure in the local health and social care system. The area covered is Southampton City and the New Forest, as well as the area immediately surrounding Southampton to the North and East.

3. The following organisations send representatives to ORG:

    a) University Hospital Southampton NHS Foundation Trust (UHS)
    b) South Central Ambulance Service (SCAS)
    c) Southampton Minor Injuries Unit (MIU)
    d) SCAS Patient Transport Service
    e) Partnering Health Ltd (PHL) – GP Out of Hours service
    f) Southampton City Council (SCC) – Adult social care
    g) Hampshire County Council (HCC) – Adult social care
    h) Solent NHS Trust
    i) Southern Health NHS Foundation Trust (SHFT)
    j) Southampton Primary Care Ltd (SPCL)
    k) West Hampshire CCG
    l) Southampton City CCG

4. This paper will cover the below:

    a) Planning
    b) Execution
        - Bank Holiday period
        - Jan – Mar 18
    c) A summary of lessons identified and actions required

Planning

5. ORG started planning for winter in September 2017, using the below principles:

    - Use data to drive planning and decision making. Detailed activity data from 2014 was available on the ORG Planning Dashboard, and SHREWD[1] data from 2016/17 was used to identify trends.
    - Learning from previous years – what works well, what could have been done better

[1] Single Health Resilience Early Warning Database is a system that gives real-time information on pressure in the healthcare system

- Organisational plans were shared with system partners so that the whole system was aware of each other's actions. All partners were specifically asked what support they expected from other providers, and what support they could give during escalation.
- "Mini Perfect Week" exercises to identify best practice and improve patient flow were run throughout the year
- Monthly face-to-face ORG meetings kept the focus on planning for winter.
- Patient communication co-ordinated across the system, and a consistent message given out to call 111, try pharmacy first, and to raise awareness of primary care hubs.

6. Winter money was made available to systems following the Budget on 22nd November 2017. Acute hospitals were asked to bid for funds in conjunction with CCGs. The money was later split into streams covering mental health, primary care and general acute care. Bids were submitted in December 2017 and schemes totalling just under £3m were funded. All of the schemes were focussed on the period between January and March; a full list is at Annex A.

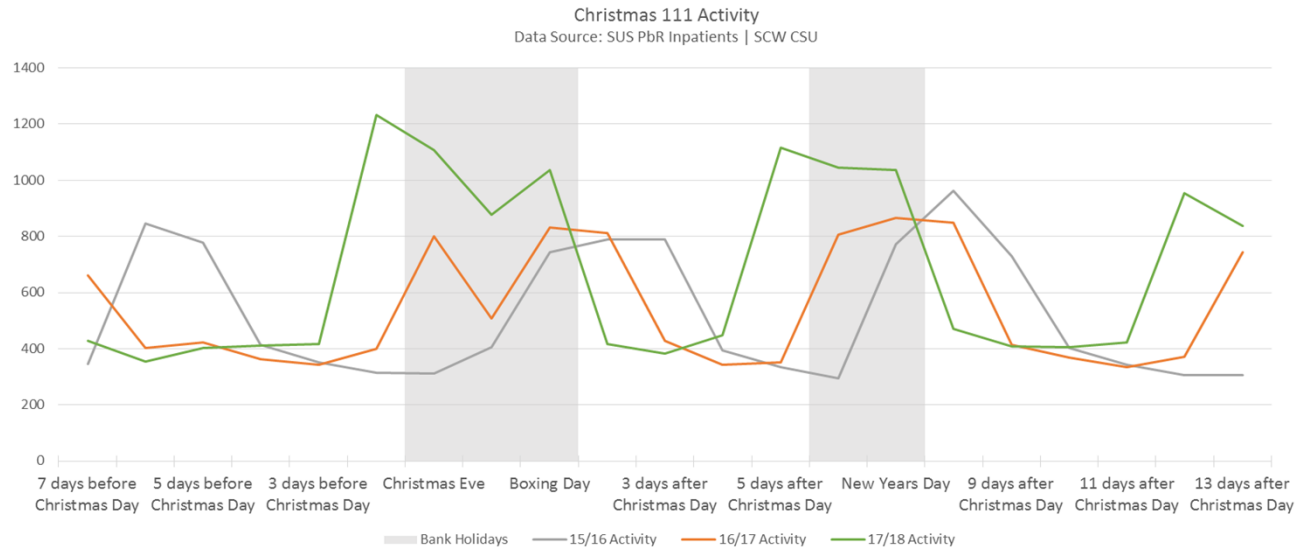
Execution

7. **Bank Holiday period**. Over the period between Monday 18th December 2017 and Sunday 7th January 2018, the system saw:

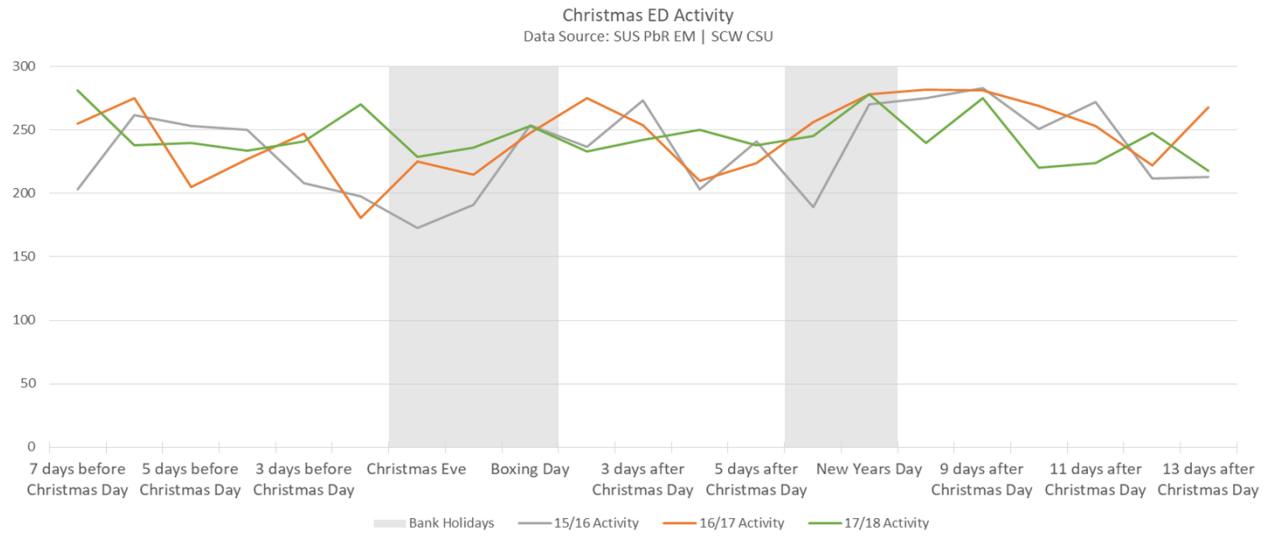
    a) 4,441 ambulance conveyances to A&E; 14.4% higher than in 2015/16 and 3.4% higher than 2016/17
    b) 14,216 calls to NHS111; 29.9% higher than in 2015/16 and 24.4% higher than 2016/17
    c) 2,757 non-elective admissions to UHS; 8.5% higher than in 2015/16 and 4.7% lower than in 2016/17
    d) 5,133 A&E attendances; 4.5% higher than in 2015/16 and 0.3% lower than in 2016/17
    e) 3,655 MIU attendances; 79.6% higher than in 2015/16 and 49.2% higher than in 2016/17
    f) An average of 82 delayed transfers of care (DTOCs) per day; 30% lower than in 2016/17
    g) UHS bed deficit (which gives an indication of patient flow across the trust) was at an average of 11; 35.5% better than in 2016/17.

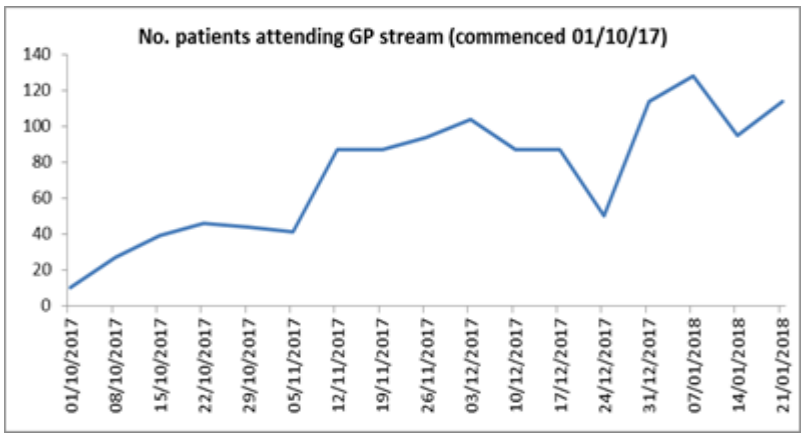
8. The large increase in MIU attendances can be attributed to increased awareness among the public.

9. Calls to 111 were higher than in previous years. The peaks in demand were more pronounced, making planning more difficult, as shown below. Call handler staffing provision was a significant risk to system resilience over this period, however due to good planning by 111 and system mitigating actions, high demand did not have a negative impact on the rest of the system.



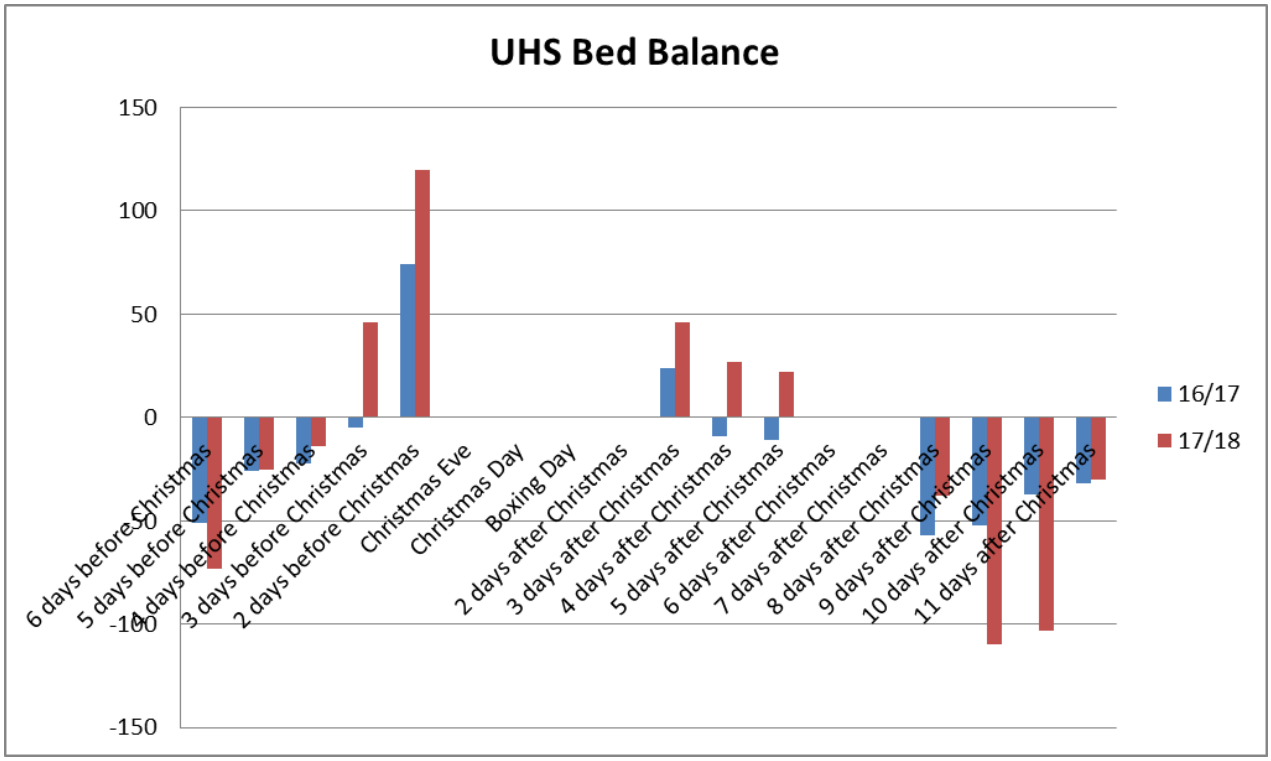
10. A&E attendances were marginally higher than last year, with a peak on 1st Jan 2018 of 366 attendances. This was the first winter that GP streaming[2] was in place at UHS A&E (see below), which worked very well in seeing, treating and discharging patients quickly, and supported the A&E department's ability to maintain patient flow.



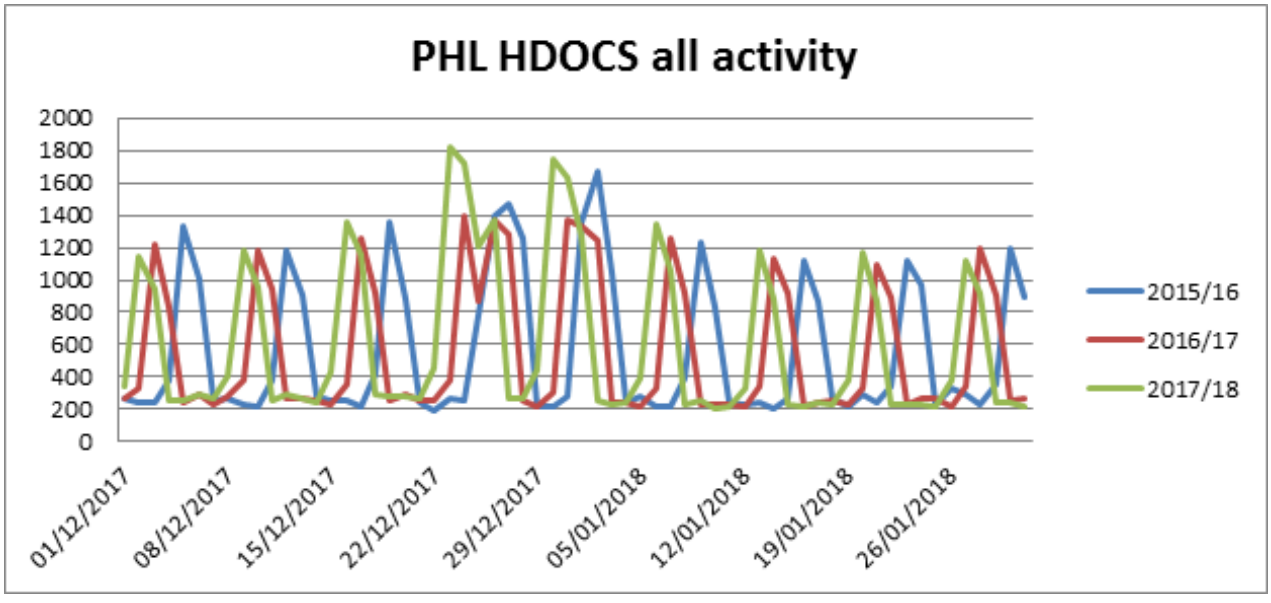


[2] GP streaming: a GP located at A&E to see and treat patients without the need for admission or taking up A&E resources.

11. UHS bed balance is a high level measure of flow in the hospital. A bed **deficit –** indicated by a negative number – means that there are more admissions expected than discharges planned. A bed **surplus** means that there are more than enough beds to cope with expected admissions. Whilst the average for this period in 2017/18 suggests that flow was better this winter, the graph below shows that the variation this year was more pronounced. The large bed surplus before Christmas Eve shows that large numbers were discharged prior to the bank holidays, and that flow was maintained very well between Christmas and New Year. The peaks after New Year's Eve (NYE) were during the period of extreme pressure over that weekend, and the immediate recovery.



12. PHL (GP Out of Hours service) also saw significant spikes in activity compared to previous years (the below data is across all of the PHL footprint).



13. In summary, during this period, urgent care demand was at a high level throughout; however this did not lead to a lack of patient flow as it has in previous years. Patient flow was maintained very well due to Delayed Transfers of Care (DTOCs) being low, simple discharges being maintained and good system working, especially between UHS and community providers regarding rehab/reablement care and admission avoidance.

14. **New Year's Weekend Pressure**. The system came under severe pressure, with urgent care demand at very high levels. Although patient flow had been maintained very well, consistently high A&E attendances and ambulance conveyances, which peaked on New Year's Day, put significant strain on all healthcare providers. A brief timeline of events is in the table below.

Date	Issue
Sunday 3 December 2017 onwards	Very high acuity and volume of UHS A&E presentations, sustained over several weeks. Acuity in resus particularly high in lead up to NYE
Friday 29 December 2017	Portsmouth system escalated to OPEL 4[3], criteria agreed for "soft" diverts from Portsmouth Hospitals Trust (PHT). NHS England task Portsmouth system with leading co-ordination across Wessex
Saturday 30 December 2017	UHS escalated to OPEL 4. Divert agreed from PHT for certain specialties only; in total 65 patients were diverted to UHS
Sunday 1 January 2018	Busiest day at UHS A&E (366 attendances). All acute hospitals in SW Hants and Portsmouth report no bed capacity and full A&E
1 – 7 January 2018	Continued high demand at UHS A&E. No more diverts requested. Complete lack of patient flow as all hospitals in SW Hants system at capacity, very little social care capacity. 17 patients from divert remained inpatients at UHS until 7th Jan, affecting their ability to see SW Hants patients

15. More detail, and lessons learned from this specific period of pressure can be found at Annex B. In summary, this was a period of intense pressure, where surrounding systems coming under pressure had a huge impact on South West Hants. Internal escalation was followed and worked well, however the extreme nature of the demand was exceptional. Planning for next winter will take this into account.

16. **Jan – Mar 18**. Detailed data is not yet available for this period. After the immediate recovery from NYE weekend, urgent care demand has remained at expected levels, with one significant peak on 12 and 13 March 2018, where high A&E attendances caused UHS to escalate to OPEL 4.

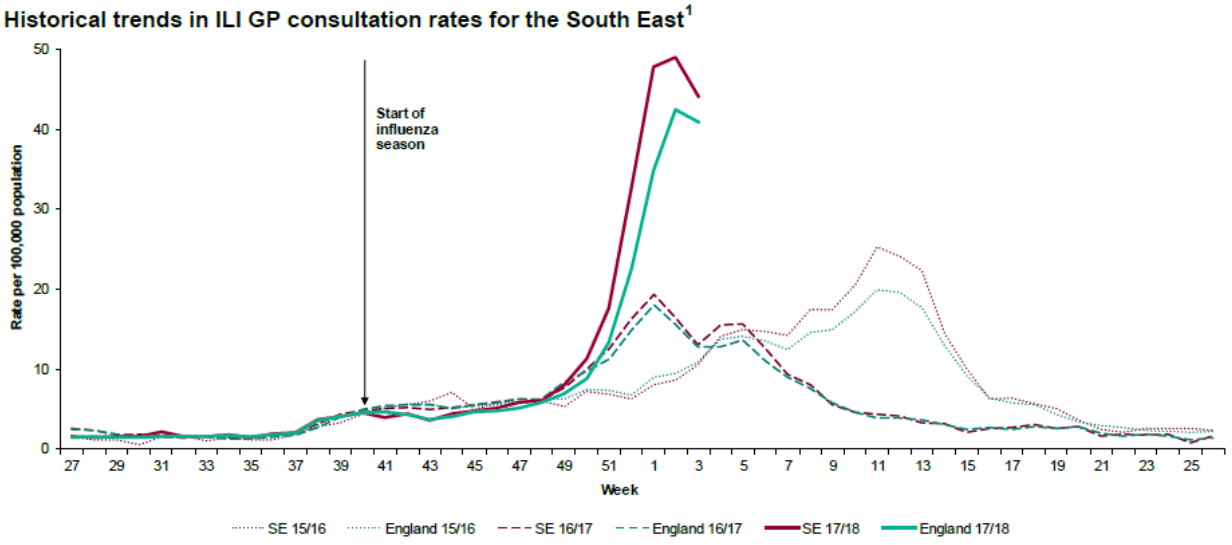
17. Winter money has funded several schemes that have been focussed on relieving pressure in the system during this period:

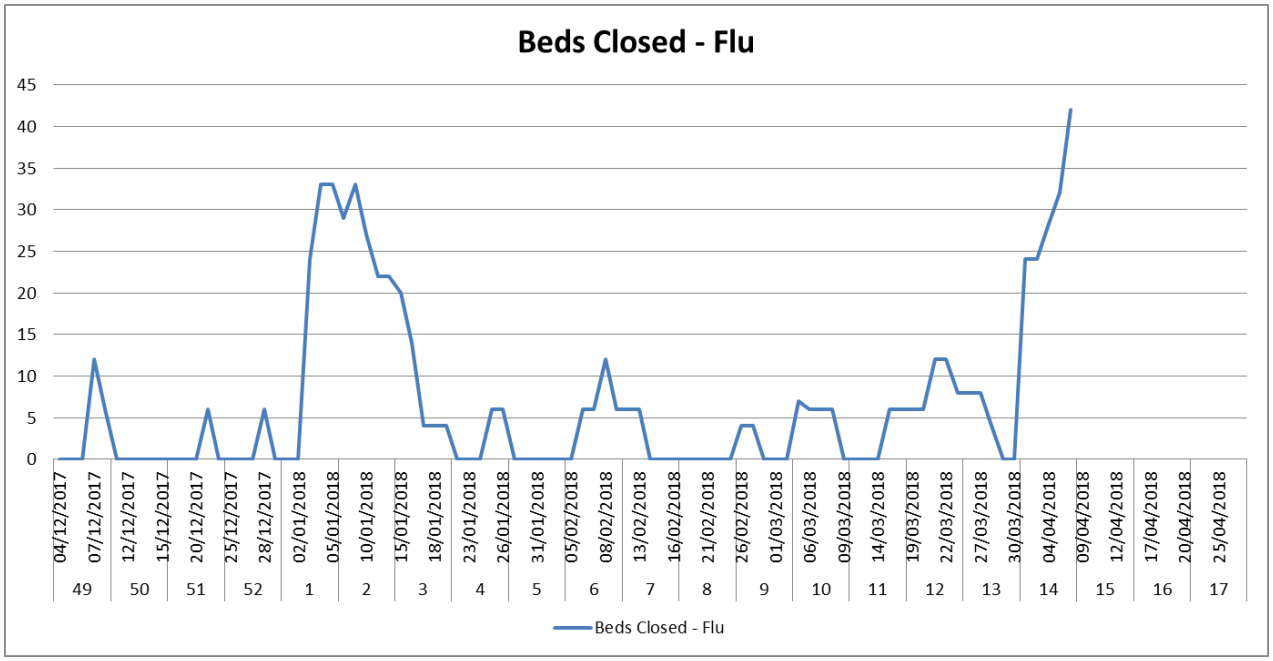
    a) Additional primary care capacity in Southampton, both during the day and evenings/weekends
    b) GP streaming in A&E – extended hours
    c) Additional mental health support to UHS A&E
    d) Additional staff in UHS A&E at evenings and weekend
    e) Clinicians in 111 call centre

[3] OPEL 4 is the highest level of alert, equivalent to what used to be called 'Black Alert'.

18. Seasonal flu was worse this year than in previous years, however it did not reach levels seen in 2010. ORG focussed on operational planning for increased pressure caused by flu. As can be seen below, UHS saw periods where significant numbers of beds were closed due to flu, most pronounced during the first week in January 2018.

19. ORG planned for a second, smaller peak in flu admissions in February, based on the trend from 2015/16, however this did not materialise.





Lessons Identified

20. A full list of lessons identified and actions can be found at Annex B. Highlights and themes are:

    a) SHREWD was helpful in giving an up-to-date picture of system capacity, and enabling de-escalation actions to be taken earlier than would otherwise be the case.
    b) System working within South West Hants; all providers reported mature relationships and productive system calls that had a positive impact on patient flow.
    c) Flexibility of SPCL meant that GP streaming capacity, and hub capacity (primary care), could be released at very short notice, benefiting the whole system.
    d) GP streaming in A&E was a useful resource, which worked best when GPs were proactive in seeing less complex patients and ambulance arrivals.
    e) Inappropriate referrals from 111 to A&E were reported by several providers. Work is required on the Directory of Service to ensure alternatives are appropriately signposted. The most effective measure would be clinicians in the 111 call centre.
    f) Large volume of assurance information requested from NHS England and NHS Improvement, often different departments requesting the same information.
    g) Pressure from external systems had a real impact on South West Hants, particularly UHS.

21. In summary, this winter saw higher urgent care demand than previous years, however patient flow was well maintained, with the exception of several periods of significant pressure. The system planned well, and worked well to de-escalate promptly and support the provider under the most pressure.

Annex A

Winter Funding 2018/19 – allocated schemes

Bid	Scheme	Summary Details	Organisation	Amount Requested	Amount Funded	Date
Finances	Tranche 1 funding to UHS	Improvement in UHS's M7 forecast position and A&E improvement by maintaining current performance level of 90.13% YTD throughout Q4 2017/18	UHS	£1,832,000	1,832,000	15 December 2017
Mental Health Bid	Children's Mental Health psychiatric liaison in ED - UHS, PHFT, HHFT	Extension funding of a children's MH nurse at UHS ED to extend the hours of availability to match peak demand - current Band 7 nurse to be supported by Band 8a nurse to provide leadership and extra capacity	UHS	£130,000	£93,860	15 December 2017
Mental Health Bid	Psychiatric liaison - dual diagnosis - UHS	1 WTE additional care coordinator to work within Commissioned Community Substance Misuse Services to provide bespoke care coordiantion and recovery planning to ensure effective engagement of people identified by University Hospital Southampton Alcohol Care Team and supported into Community Services by In Reach provision.	UHS	£35,000	£25,270	15 December 2017
System Bid	CHC - Implement Discharge to Assess Model	12 x Pathway Three 'Discharge to Assess' beds. Reduction in Acute and Non-acute DTOCs	WHCCG	£300,000	£300,000	13 December 2017
System Bid	Acute Visiting Service	Additional capacity, ANP, paramedics, GPs Prevent admission Visit early in the day so that other services can be mobilised	SPCL	£60,000	£60,000	15 December 2017
System Bid	Further enhance clincian capacity within the ED, and alternative hospital assessment facilities	ED, Acute Medical Unit - evenings & weekends, Ambulatory Emergency Care, Clinical Decisions Unit, Mgt/Matron rota to strength flow management and problem resolution out of hours.	UHS	£300,000	£300,000	15 December 2017

Bid	Scheme	Summary Details	Organisation	Amount Requested	Amount Funded	Date
System Bid	Supplementing co-located GP Service	Supplementing exisiting GP service, adding GP shifts working within the ED also focused on assessment and discharge of frail/complex medical patients.	UHS	£130,000	£130,000	15 December 2017
System Bid	Clinicians in 111 call centre	Additional clinicians in 111 call centre to support triage and review of ED and Green calls. Additional capacity will be shared across Hampshire CCGs. Also provide additional funding for pharmacist in call centre at peak periods	Porstmouth CCG on behalf of Hampshire CCGs	£50,000	£50,000	15 December 2017
System Bid	Mental Health Navigation Service	Mental Health Navigators in 111/OOH GP service. MH nurses with knowledge and experience of navigating the mental healthcare system	SCAS/PHL	£110,000	£110,000	15 December 2017
System Bid	WHCCG Extended Access	Medicines Management in practices and increased capacity for extended access hubs	WHCCG	£63,000	£63,000	
SCCCG Primary Care Bid	Acute Visiting Service GP Extended Access Hubs	TBC - our bid originally said we wanted £500k to enhance capacity within existing hub services during Q4, and pump prime the IUC pilot. The email allocating us the money said it was for AHVS and GP Extended Access Hubs	SPCL		£32,048	15 December 2017

Annex B

Winter 2017/18 Lessons –Lessons Log for ORG

No.	Lesson Identified – Description	Impact and Solutions	Action Required
1.	Winter funding: • Very short deadline from NHSE • Several different streams, which became confusing: NHSE, then mental health, then primary care • Ongoing requirement for feedback every 2 weeks	• Should be managed through AEDB • Decide at AEDB what the focus and principles` should be, then disseminate for completion • Use money to bolster existing work, focussed on admission avoidance and discharge, rather than start new work • Especially avoid anything that requires recruitment – it takes too long	Feed back to NHSE To accommodate the potential for a short notice request, principles for spending should be agreed up-front as part of the winter planning process
2.	Planning at ORG • Start early • NHSE asked systems for very detailed assurance of plans • Planning early at ORG reminds everyone to start their own planning • Early identification of gaps/interfaces between providers that require additional action	• Send out template in July/August • Ensure data from last year(s) is shared, discussed and actions agreed • Table-top exercise of escalation framework, using scenarios from previous year • Table-top exercise with PSEH system	Planning for winter 18/19

No.	Lesson Identified – Description	Impact and Solutions	Action Required
3.	List of NHSE requests for written assurance or plans: • 9th October : 1st draft of winter plans, including assurance template, cover letter and key winter contacts • 30th October – 31st March: escalation/de-escalation reporting • November – regular GPFV submission on primary care access. This duplicates a lot of information in the winter templates • 17th November – 2nd draft of winter plans, following feedback from Wessex LAT • 17th November – Winter assurance collection (staffing and capacity over bank holiday period) • 20th November – Clinical Escalation Actions (acute trusts) • 20th November – Primary Care collection (access over bank holiday period) • 30th November – NHS111 assurance • 6th December – reconfirm access to primary care over bank holiday period • 19th January – primary care evaluation; in depth data on capacity over Christmas/NYE • 2nd March – assurance requested every Friday in March, and 6th April, for weekend on-call arrangements and patient flow	• Takes resource away from planning and operational management, especially when deadlines are very tight, which is often the case • Several requests asked for the same assurance from different parts of NHSE e.g. primary care and delivery team assurance on impact of winter funding	Feed back to NHSE
4.	External systems escalating before SW Hants • Whatever the reasons, Portsmouth system and North & Mid Hants come under pressure earlier than SW Hants • This led to requests for diverts, which increased pressure on UHS and lengthened recovery period	• In planning for next winter, assume that other systems will come under pressure early, and will ask for help • When considering requests for external support, especially diverts from PHT, consider impact it may have in 2 days' time as pressure likely to increase in our system	Planning for winter 18/19

No.	Lesson Identified – Description	Impact and Solutions	Action Required
5.	Key lead indicators for pressure: • Outlying patients were a lead indicator for pressure • Stranded patient numbers increase (threshold?) • Lower discharges than planned in lead up to Christmas • Other systems escalating to OPEL 4	• Put stranded patients indicator onto SHREWD • When these indicators start to move from Amber to Red, ensure all providers are aware and start de-escalation actions	SHREWD strategic direction meeting on 8th Feb 2018
6.	Complex discharges • Don't slow down between Christmas and NY • Feedback from IDB manager at NYE review	• Ensure IDB staffed appropriately between Christmas and NY • Ensure external parties also have staff in during this period e.g. CHC, Fast Track • Additional push on complex discharge in preparation for January pressures	Planning for winter 18/19 Taken forward by IDB Leaders
7.	NHSE decision not to open ICC over NYE weekend, and instead tasking PSEH run inter-system response	• An early decision to set up an ICC would have given systems much-needed centralised command and control across HIOW for decisions such as diverts and critical care capacity • Led to Portsmouth focus of all actions e.g. HCC reablement resources being redirected to supporting QAH bed flow, to the detriment of UHS and others	
8.	Assurance calls over NYE bank holiday • Conference calls every 2 hours, requiring presence of senior clinical and operational managers	• This diverted decision makers away from front line, which is where they needed to be • Lack of clear direction – confusion created by not declaring major incident, and not taking control	Feed back to NHSE/PSEH
9.	SW Hants ORG calls work well and add value when the right people are on them, and they are run in a calm and controlled manner.	• Be clear on the aim of TCs: to give everyone an up-to-date situation report and put actions in place to enable system de-escalation. • Do not routinely conduct calls more than once a week; schedule ad-hoc calls when required • Over a weekend: calls on a Friday and Monday are helpful, not during the weekend as the right people won't be on them	Planning for winter 18/19

No.	Lesson Identified – Description	Impact and Solutions	Action Required
10.	Escalation framework: • Table top exercise raised that framework doesn't closely reflect what happens when pressure hits the system • Useful as a check list of what organisations should do in response to pressure, but all will follow internal escalation processes rather than this one	• Replace/supplement with set of action cards for various scenarios of pressure increasing • Align closely to SHREWD thresholds • This will make it easier to implement SHREWD Escalation	Propose at ORG
11.	GP streaming in ED • More patients seen over busy weekends • Proactive GP going into minors/majors and pulling patients works best • GP in pitstop during busiest periods worked well	• Alleviate pressure on ED	Being taken forward by UHS ED colleagues, CCGs and SPCL
12.	SPCL support to wider system • Short notice flexibility and increased capacity in ED, hubs, support to practices and AVS has helped prevent admissions and improve ED performance • Involvement in ORG calls has helped de-escalation actions and admission avoidance at weekends	• Continued involvement with ORG • Include in planning for winter 18/19 and other periods of pressure • Consider as priority for winter funding bids – AVS	Feed back to SPCL Planning for winter 18/19
13.	There is potential for more to be done at 111 to prevent patients presenting to ED unnecessarily	• Get patients to the right place first time: clinicians in 111 call centre • PHL will be trialling one-hour GP re-triage of patients with an ED disposition	• Investigate – 111 to provide evidence • Clinicians in 111 call centre
14.	Minor Injuries Unit – extending evening opening hours does not result in easing pressure at UHS front door • Opened until midnight on 8th December 2017; this has also been trialled twice previously in 2017 • No patients seen between 2200 and midnight on any of the occasions	• Not a viable system de-escalation action • Better to focus on re-direction of patients from ED to MIU in-hours, before they arrive at ED • Screen in ED with current MIU waiting time displayed	• Raised with ED/MIU to take forward • ?18/19 SDIP

No.	Lesson Identified – Description	Impact and Solutions	Action Required
15.	Flu worse than previous years • More patients hospitalised • Decision point in Feb – based on 15/16 data	• ORG needs to plan for additional pressure this places on the system • Use ILI data and profile – local data from previous years	• Planning for winter 18/19
16.	Home Care 7 day working – formally extending the assessment approach in Home care to include weekends • Pilot of 7 day working opened 2 weeks before Christmas and will extend to 31st of March 2018. • Development of new pathway with HDT to promote this approach still progressing. • Expanded hours available within pilot agreed in January 2018.	Early results would suggest that there is value in this approach rather than purely investing in front line Home Care capacity • Would be a key element to develop further over busy periods in 2018/19 ahead of the new framework in April 2019 • Investing in infrastructure support in Home Care supports the wider development of capacity.	• Lessons learnt to be shared with system groups i.e. Better Care Southampton (at end of pilot) • Planning for winter 18/19
17.	Patient comms. An early aspiration of ORG was for all patient communications from all providers to send a similar message. CCG comms team worked up key messages which were shared with ORG, however seemed to have little impact, or wasn't used.	• Focus on one key message e.g. hub availability to keep it extra simple • If we want to do some real, impactful comms (buses, radio, TV etc) then we need money, and to plan from August at the latest	• Comms team planner
18.	Adverse Weather 26th Feb to 4th March • Had a big impact on all health services • EPRR leads took over • This was a business continuity issue however ORG should plan for the peak in demand after snow • 111 and OOH demand was very high	• Believe the weather forecasts and plan for aftermath once roads are clear • Mutual aid and comms between providers	• Put in a table top exercise as part of winter prep

Annex C

New Year's Day Bank Holiday Weekend – After Action Review

At ORG on 11th January 2018 the group conducted a review of the winter bank holiday period, which was one of very high demand across the UK, particularly for urgent and emergency care.

Themes Identified. Full answers are in the table below.

1. When and where did pressure first start to build up?

    - From 3rd Dec: very high volume and acuity of urgent and emergency care presentations
    - Number of stranded patients at UHS increased
    - Surrounding trusts began struggling

2. What went well?

    - System working
        - High level of trust between colleagues
        - SHREWD
        - System calls productive and supportive
    - Flexibility of urgent care providers, particularly UHS, PHL and SPCL
    - GP streaming in ED
    - Clinical engagement
        - UHS downstream wards pulling patients from ED and responding very quickly to requests
        - SHFT – good engagement in additional actions to maximise discharge and admission avoidance
        - All providers – staff going above and beyond (staying late, volunteering for extra shifts)
    - Integrated working between community health staff and social care (SCC and Solent)

3. What didn't go well?

    - Pressure from other systems affecting SW Hants

    - Diverts from multiple systems to UHS
    - Ambulances queuing at Winchester and PHT
- Divert policy changed too close to BH weekend
- Conference calls every 2 hours were not productive
- There could be more focus on DTOCs during quiet period between Christmas and New Year's Eve

4. **Wider system review**. It would be beneficial if ORG could have sight of any high level debrief that was conducted by system leaders following the NYE weekend.

No	Question	UHS	Community	Ambulance	Social Care
1.	When and where did pressure first start to build up?	• From 3rd Dec: very high acuity and volume of ED presentations, sustained over several weeks • Surrounding trusts began struggling earlier than UHS • Number of stranded patients increased dramatically • DTOCs consistently high • Acuity in resus very high	• Fewer discharges than usual from inpatient wards prior to Christmas, mainly due to acuity of patients • Slowdown in care packages	• From 29th Nov: demand and acuity increased beyond expected levels • Ambulances queuing at Winchester and PHT	• Reablement and dom care market slowed down, main issue lack of double up care
2.	What went well?	• System working – high level of trust and mature working • GP streaming – 2nd GP in ED • AEC hot clinic too patients from ED • Consultants offering to work on NYE despite not being on rota • Internal team working – staff regularly going above and beyond • Direct admissions to wards e.g. ASU input to pitstop, wards collecting from ED • Downstream wards responding very quickly to requests	• Clinical engagement with emphasis on discharge prior to Bank Holidays, and with increased demand • Quick reviews and discharges • Frailty service and admission avoidance team maximising management in own home • Additional ward rounds • System calls very productive and supportive • Integrated Urgent Response Service proved very flexible, speedy response to need	• Ambulance handovers at UHS	• System calls, SHREWD • Behaviour across the system – remaining calm • Decisions made in timely fashion

No	Question	UHS	Community	Ambulance	Social Care
3.	What didn't go well?	• Multiple diverts from other hospitals worsened lack of medical beds • ITU capacity taken up by IoW patients that would normally have gone to PHT • Conference calls every 2 hours over NYE weekend • Divert policy changed too close to BH weekend	• Suggestion: could dom care availability be put onto SHREWD?	• Ambulances queuing at PHT and Winchester – delays in other areas having a knock-on impact in SW Hants • Time on scene could have been reduced	• Within Integrated Discharge Bureau, HCC reablement resources diverted to PHT • Some partners within IDB appearing to take foot off gas between Xmas and NYE – could more have been done to move patients in between during quiet period?