LEEDS SYSTEM RESILIENCE PLAN 2019-20

Leeds System Resilience Plan 2018/19

Document Name:	**Leeds System Resilience Plan 2019-20**
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Control

This a controlled document maintained by the Unplanned Care Team within Leeds Clinical Commissioning Group (CCG) on behalf of the Leeds System Resilience Assurance Board.

Distribution

An electronic version of this plan is distributed to all members of the Leeds System Resilience Assurance Board and partners across associated organisations.

Organisations involved in developing the plan

The contribution by members of the Leeds health and Care system:

Leeds Clinical Commissioning Group [CCG]

Leeds Teaching Hospital Trust [LTHT]

Leeds City Council - Adult Social Care [ASC]

Leeds Community Healthcare Trust [LCH]

Leeds and York Partnership Foundation Trust [LYPFT]

Yorkshire Ambulance Service [YAS] – 111 and 999

Local Care Direct [LCD]

One Primary Care (OPC)

Leeds Confederation

Leeds City Council – Emergency Planning

Leeds City Council – Public Health

NHS England – Area Team

Third Sector Providers

Health watch

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1 Executive Summary

To ensure we continue to deliver quality, safe and responsive services the Leeds system needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances. It also requires us to develop a strategy to transform our system for the future and deliver The NHS Long Term Plan.

As stated in the long term plan 2019/20 is seen as a transitional year giving us time to work in partnership to begin to shape our local implementation of the long term plan for our population. Our approach to develop an overarching system resilience plan will support us navigate the complexities of the unplanned health and care landscape and demonstrate how the system will continue to meet the needs of the population from operational and strategic perspectives.

The plan describes the collective system vision, aims, objectives and priorities to achieve improved services and outcomes for our population and highlights the importance of their alignment in delivering real change.

The Leeds System Resilience Plan (LSRP) has three components listed below which describe the elements of a well-functioning system which balances strategic ambition with effective operational delivery.

- Planning and priorities 2019/20
- Escalation and incident management
- Transformational plans

Within the plan our narrative to describe these components in detail is through a set of collective actions, initiatives and or projects based on the outcomes of our winter evaluation, system diagnostic exercises and our response the NHS long Term plan. We acknowledge that this can only be achieved by working as a system with strong leadership, commitment to support changes in culture and behaviour and an adopting an integrated approach to service delivery with clear jointly owned governance processes. The Governance refresh supports a more focused approach and clarifies the roles and responsibilities of system leaders across our system with clear lines of accountability and an overall system commitment to work in an integrated way to deliver care and maximise resources.

In conclusion our plan seeks to provide a high level of assurance that there is agreed system wide initiatives in place that address both the short and long term priorities within the unplanned health and care services across Leeds. In addition the plan demonstrates that we have with clear escalation processes in place for the management of surges and incidents that place additional pressure on our system and the resilience of services.

1 Introduction

1.1 Introduction - Leeds System Resilience Plan 2019/20

Urgent and emergency health and care services continue to be at the forefront of the NHS priorities due to the fall in national performance of the 4 hour Emergency Care Standard (ECS) and the demands of an ageing population.

To ensure we continue to deliver quality, safe and responsive services the Leeds system needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances. It also requires us to develop a strategy to transform our system for the future and deliver The NHS Long Term Plan.

As stated in the long term plan 2019/20 is seen as a transitional year giving us time to work in partnership to begin to shape our local implementation of the long term plan for our population. Our approach to develop an overarching system resilience plan will support us navigate the complexities of the unplanned health and care landscape and demonstrate how the system will continue to meet the needs of the population from operational and strategic perspectives.

Over the next five years, the need for non-elective acute hospital beds will determined by continuing pressures from an ageing population balanced against achieving a left shift in the provision of care. We will achieve the left shift through implementing a proactive care approach, embedding the 'Home First' philosophy; developing community capacity and ensuring process are in place to achieve effective discharge from hospital.

It is vital that we continue to learn from our operational behaviour and activities to develop our longer term vision and inform our strategic decision making. Leeds has been fortunate to undertake a number of reviews and diagnostics (MADE, CQC and Newton Europe) across our system to support our strategic thinking and identify opportunities for improvement over the next 12-18 months. We have used the outcomes from these exercises and the winter 2018/19 evaluation to refresh the Leeds System Resilience Plan (LSRP) for 2019/20.

Through this plan we will demonstrate:

- Alignment with the Long Term Plan
- Collective accountability for the challenges faced by our system in relation to urgent and emergency care services
- Delivery of quality care and effective care across our system
- Robust management of predicted and unpredicted surges in demand through normal variation or as a result of an incident.
- Continuing to deliver improvement throughout 2019/20 building on our learning of operational and behavioural changes
- Commitment of clear and agreed vision for the further transformation of the Unplanned Health and Care landscape in Leeds

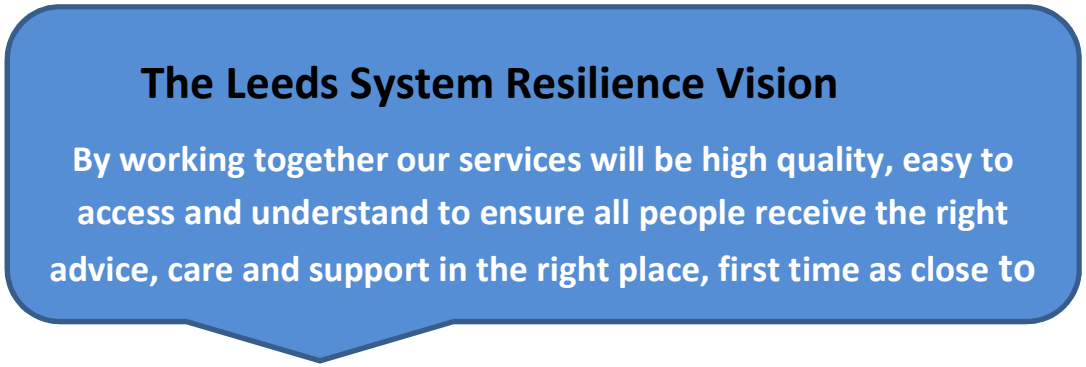
The Leeds System Resilience Plan (LSRP) has three components listed below which describe the elements of a well-functioning system which balances strategic ambition with effective operational delivery.

- Planning and priorities 2019/20
- Escalation and incident management
- Transformational plans

The plan acknowledges that Britain's planned exit from the EU poses additional challenges for the NHS and comes at a time of historical pressure 13 October as the system enters winter. Section 4.6 provides an overview of how the system lead by NHS England is preparing for Britain's exit.

1.2 System Resilience Vision

The Leeds System Assurance Board (SRAB) understands the importance of a vision to inspire individuals and organisations to commit action. SRAB will use their vision a practical guide for agreeing priorities, setting objectives making decisions, creating plans, and coordinating and evaluating the work streams and projects.



The vision will support integration across organisations keeping groups focused, especially with complex projects and in challenging times.

To ensure that we deliver our visions it was important to agree set of aims to achieve our vision along with a set of aligned relevant and measurable objectives.

1.3 Leeds System Resilience Aims

- We will provide an equitable and fully integrated urgent and emergency care service for people with physical, mental health or social care needs, across Leeds.
- At every point in the persons journey we will consider ‘home first’.
- We will harness technology so that the people of Leeds only tell their story once and get the best outcome for them.
- We will remove steps that do not add value to the patient or people of Leeds.

1.4 Leeds System Resilience Objectives - a measurable result that a group aims to achieve

The following objectives are based on national performance measures for the Leeds health and care economy. It is the aim of the Leeds System Resilience Assurance Board to ensure that all of the winter, operational and strategic intiaitves governed through the governance; detailed in section 2 will contribute to these measures to improve the overall system position supporting improve outcomes for the population.

- Model the opportunity and impact of a left shift in the provision of care and support by **March 2020**
- Implement Leeds Clinical Advice/Assessment Service (CAS)
    - Increase the percentage of people triaged by NHS 111 that are booked into a face-to-face appointment, where this is needed, to greater than **40% by 31st March 2020.**
    - Maintain a **50%+** proportion of NHS 111 calls receiving clinical assessment
- Deliver the Leeds System Emergency Care Standard – **93.3% by March 2020**
- Reduce Non-Elective Admissions by ?
    - From Care Homes
    - Increasing same day emergency care
- Reduce the length of stay for those admitted to an acute hospital bed
    - Reduce people in an acute bed more than 21 days to **319 by March 2020**
    - Reduce people in an acute bed more than 7 days to ?
- Reduce Mental Health out of area placements **to zero by 2021**
- Reduce Delayed Transfer of Care
    - LTHT
    - LYPFT
- Increase number of people receiving reablement?
- Reduce the number of people entering into long term care?

The specific trajectories and timescales for each of the system metrics will be worked through by the System Resilience Partnership Group (SRPG). The SRPG will be accountable for ensuring that all initiatives/projects that support the delivery the identified priorities, below, contribute to the overall performance.

In addition as the details of work plan are developed the SPRG will focus on collectively creating outcomes measures for the priorities that demonstrate measurable improved population outcomes to show what will different for people using our services and to ensure alignment with the future direction of commissioning.

1.5 System Resilience Priorities 2019-2021

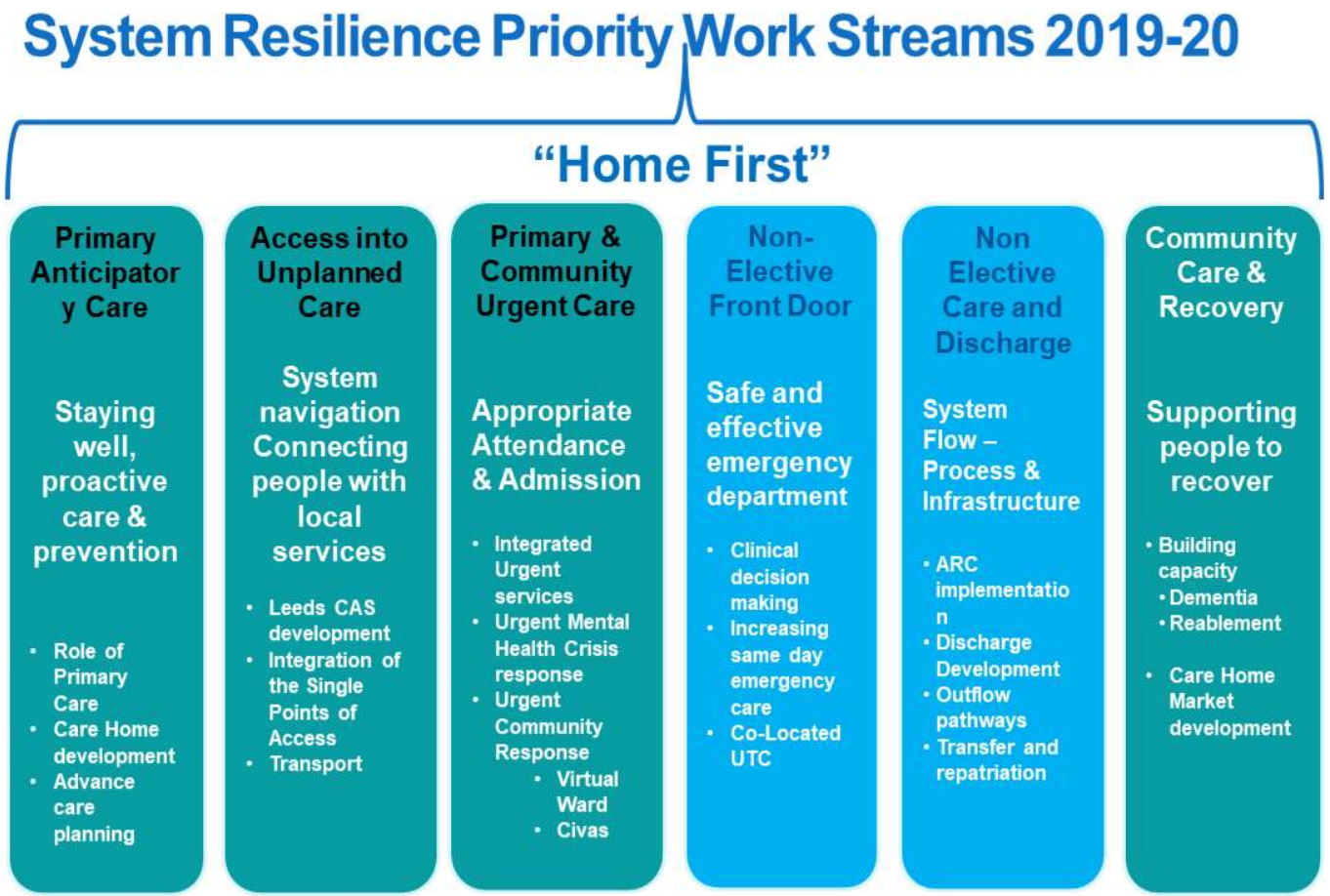
- Role of Primary Care in the Urgent Care System
- Connecting people quickly with local services
- Appropriate Attendance /Admission across the system
- Mental Health Crisis response and Dementia care
- Safe and effective Emergency Department
- System Flow – Process, Infrastructure and capacity

Enablers

- System modelling – predictive
- Surge & Escalation
- Technology
- Workforce

With a new focused approach the SRAB will be responsible for setting the strategic direction and seeking assurance from the SRPG on the effectiveness and pace of their work to address the agreed priorities. The SRPG will be accountable for the delivery of the actions, initiatives and or projects within the priorities as shown in Diagram 1, ensuring that they balance both the strategic ambitions and daily operational delivery across the health and care system retaining a focus on pressured times such as winter.

Diagram 1



Section 3.3.2 provides further details of the some of the work streams

We acknowledge that this can only be achieved by working as a system with strong leadership, commitment to support changes in culture and behaviour and an adopting an integrated approach to service delivery with clear jointly owned governance processes.

2 Governance and Leadership

2. Governance and leadership

A resilient health and care system is equally reliant on all partner organisations being able to deliver their care elements safely. Each organisation has individual strategic, winter and service development plans, along with business continuity and major incident plans monitored through their own boards and contracts.

2.1 Governance

The governance of the essential cross organisational, development, communication and collaboration is harder to define. The governance relating to the unplanned health and care system has developed over the last 5years and has seen a number of reiterations due to continued pressures, system reviews and national guidance. Due to the publication of the NHS Long Term Plan and the Leeds Plan refresh it was felt that it was an excellent opportunity for Leeds to review governance and priorities related to ensure our system is resilient and we are committed to transform the unplanned health and care landscape.

A survey gathered the views of representatives across the various groups currently aligned to the SRAB. Key finding and recommendations below

Key findings:

- There was duplication across the various groups
- A stronger focus on the priorities would result by reducing the number of meetings
- Strong recognition that both a strategic and operational focus is required but that this could me more clearly defined within the Terms of Reference (TOR)
- Representation within the groups needs to be clearer with organisational commitment and accountability.

- The new structure, TOR and priorities need to reflect the whole system pathway

Recommendations were presented to the SRAB for consideration, these included:

- Review the TOR across all groups including purpose, aims, objectives and outputs
- Define clear structure of accountability
- Gain representation commitment from all organisations
- Create a smaller more focussed group for SRAB
- Ensure priorities reflect system inclusivity and focus on the whole pathway
- Agree new processes for managing the work plan priorities for updating on work streams instead of highlight reports
- Propose new governance structure –July 2019
- Agree system priorities August/September 2019

A revised governance structure was agreed by SRAB August 2019.

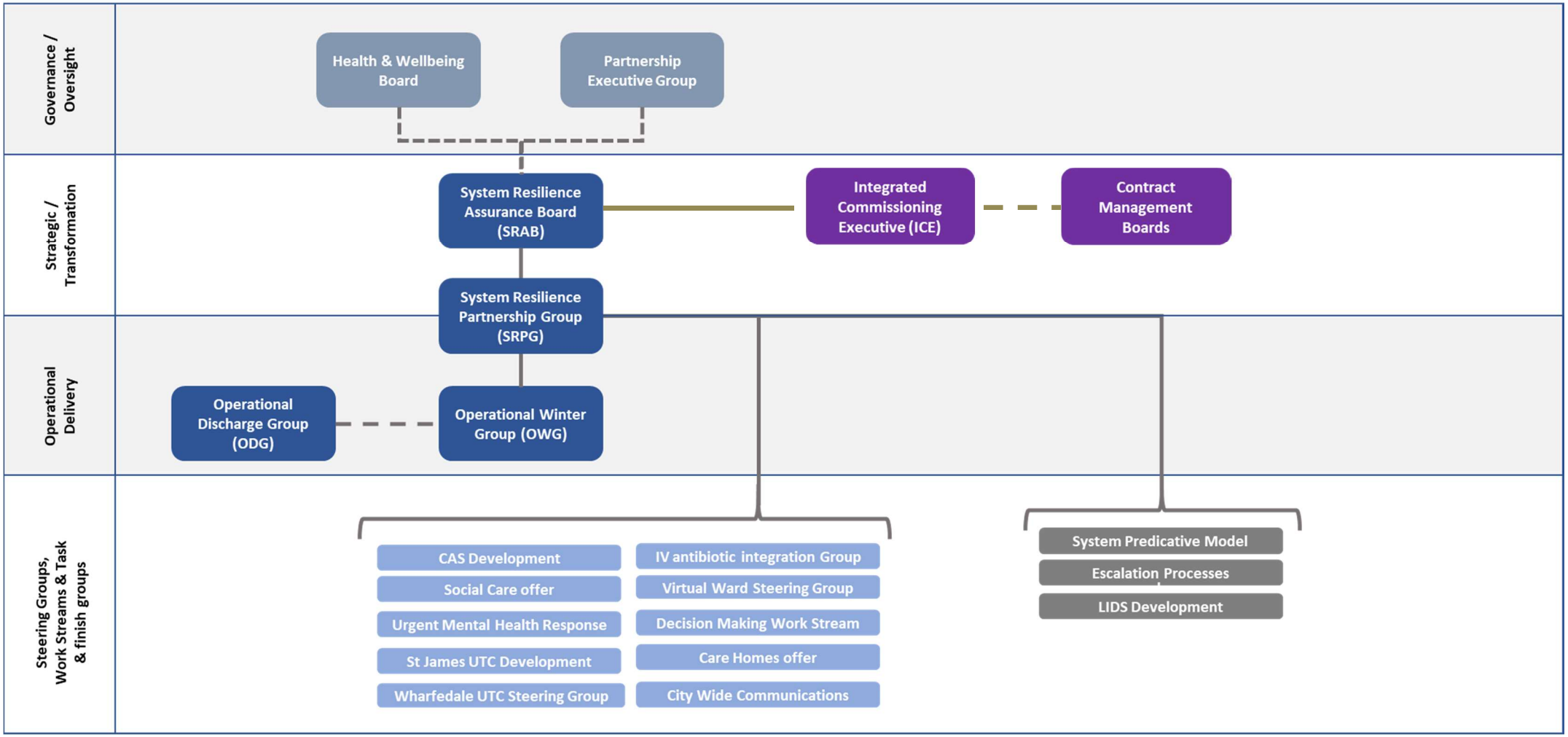
Full revised Terms of Reference for the three main groups; SRAB, System Resilience Partnership Board (SRPB) and Operational Winter Group (OWG) are within Appendix 1.

2.2 Project Management and reporting

The SRPG will be accountable in maintaining the overview of the operational and strategic system delivery via a robust reporting structure.

To ensure a consistent approach all of the identified projects leads will be required to complete the terms of reference template (Appendix 1) which will act as a Project Initiation Document defines the purpose, actives, outputs, scope and membership of the group. All projects will be required to report to the SRPG on a bi-monthly though the highlight report template.

Diagram 2. Leeds System Resilience Governance Structure



2.3 Leeds System Winter Plan Time line

Table 1 set out the key activities the Leeds system has conducted and the various groups, boards and forums who have been engaged with in developing and approving the LSRP

Table 1

Date	Activities	Comments
09/05/2019	Organisational winter Evaluation	Priorities identified for development summer 2019
16/05/2019	Newton Europe diagnostic – Discharge Re Audit/Front door diagnostic	Work commenced
20/06/2019	Review of SRAB Governance & winter findings	Survey and report completed recommendations to SRAB
11/07/2019	Newton Europe summit	Well attended by system
11/07/2019	Board to Board winter presentation	Joint presentation LTHT/CCG
18/07/2019	SRAB reflection on Newton Europe findings	Emerging priorities
15/08/2019	SRAB sign off Governance	Governance agreed
05/09/2019	North of England EU Exit Workshop	
12/09/2019	SRAB sign off priorities and comments for draft System Resilience Plan	Amendments made
03/10/2019	Operational Winter Group commences weekly meetings	
21/10/2019	National EU Exit reporting commences	
17/10/2018	SRAB Meeting-sign off Leeds System Winter Plan – including EPRR compliance statements	
30/10/2019	Winter plan scenario testing	
22/11/2019	Scrutiny Board – winter plans	

13/11/2019	Leeds System Resilience Plan to Quality and Performance committee – including EPRR	
27/11/2019	Leeds System Resilience Plan to CCG Governing Body - including EPRR	

2.4 Leeds Cross-System Winter Operations Team

Table 2 below identifies the members the Leeds system winter leads. All those nominated hold senior positions, have the authority to commit resources and make immediate decisions that impact on the resilience and effectiveness of our system.

Table 2 Winter Operational Leads

Organisation	Lead	Title	Deputy	Title
Leeds Teaching Hospital Trust	Clare Smith	Chief Operating Officer	Sajid Azeb	Interim Director of Operations
NHS Leeds CCG	Sue Robins	Director of Operational Delivery	Debra Taylor-Tate	Head of Unplanned Care
Leeds City Council	Shona McFarlane	Deputy Director Social Work and Social Care services	Nigel Parr	Head of Safeguarding and Quality
Leeds Community Healthcare Trust	Sam Prince	Executive Director of Operations	Megan Rowlands	General Manager – Adult Business Unit
Leeds and York Partnership Foundation Trust	Joanna Forster-Adams	Chief Operating Officer	Andy Weir	Deputy Chief Operating Officer
Leeds GP Con-Federation	Gaynor Connor	Director of Transformation	Wendy Pearson	Director of delivery
Yorkshire Ambulance Service	Catherine Bange	Regional General Manager	John McSorley	Divisional Commander

Local Care Direct	Andrew Nutter	Chief Operating Officer	Wendy Pearson	Director of Delivery
One Primary Care	Shaun Major-Preece	Assoc. Director of Operations and Performance	Rebecca Chege	Clinical Lead
Age UK	Iain Anderson	Chief Executive	Jess Inglis	Operations Director

Winter Leads will also be required to participate in co-ordinated system wide Sitrep calls over the winter period when the system is experiencing significant pressure. In addition all lead on major work streams within our recovery plan.

3 Planning and priorities

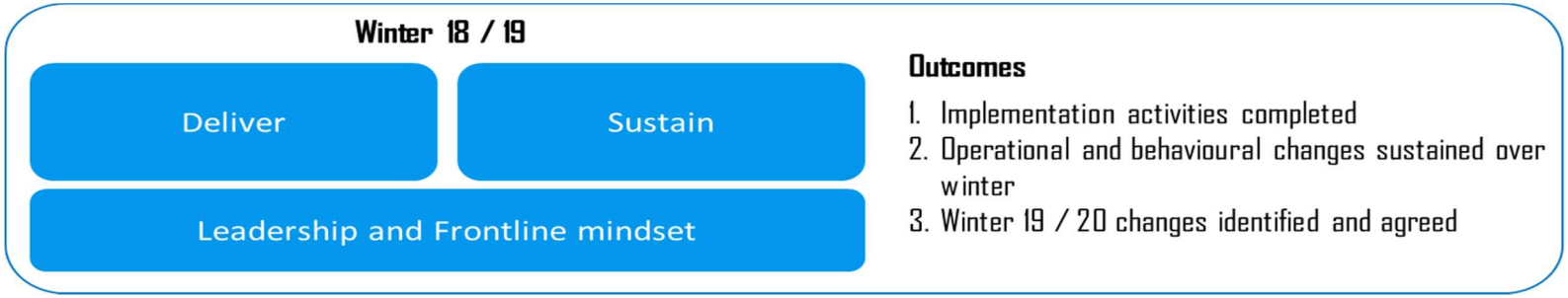
In preparation for winter 2018/19 Leeds had a comprehensive action plan based the opportunity identified through the Perfect Week (Oct 17) and Multi Agency Discharge Event (MADE Feb 18) and the Newton Europe diagnostic June 2018.

The action plan demonstrated the systems commitment to continuous improvement through agreed work streams to improve people's outcomes and experience and achieve national performance standards. The central tenant of the plan remained 'home first' as a consideration for every patient to keep people in their own homes, promote self-care and independence. Work streams included:

- Discharge decision making
- Stroke pathway- integration acute and community services
- Social work assessments
- Mental health continuing care funding
- Care Home trusted assessors
- Mental health support for care homes

It was agree by SRAB that we needed to keep focused on the outcomes as identified in diagram 1 to improve our position over winter 2018/19 and realise the opportunities presented by Newton Europe.

Diagram 1



3.1 Winter 2018/19 evaluation

To support the action plan the system also committed to make changes in the operational management of winter, introducing a weekly winter operational group to manage he day to day pressures in the system

A full report of winter 2018/19 can be found in Appendix 2. This report covers:

- System winter planning 2018/19
- Performance
- Evaluation process and outcomes

Key findings include:

- Overall the system agreed that we had a much improved winter in 2018/19 compared to 2017/18 with milder weather and low levels of flu presentations.
- ECS in April 2019 was 4.7% higher when compared to April 2018 despite a 6.4% average increase in attendances.
- Planned cancellation of all electives resulted in more elective activity overall.
- At times of pressure high patient acuity especially respiratory illness was a considerable factor
- Community investment and pathway improvements will support both attendances avoidance and reduce non-elective admissions improving outcomes and experience.
- Discharge processes and outcomes have seen an improvement but these can be further developed starting with a review of the LIDS team.
- Our approach to planning, managing pressure and working together supported positive behaviours building on existing relationships across the system. The OWG was a key vehicle in enabling this and in promoting the benefits of system co-operation.

The outputs from the evaluation have been used to inform the system priorities for 2019/20 forming part of the LSRP 2019/20

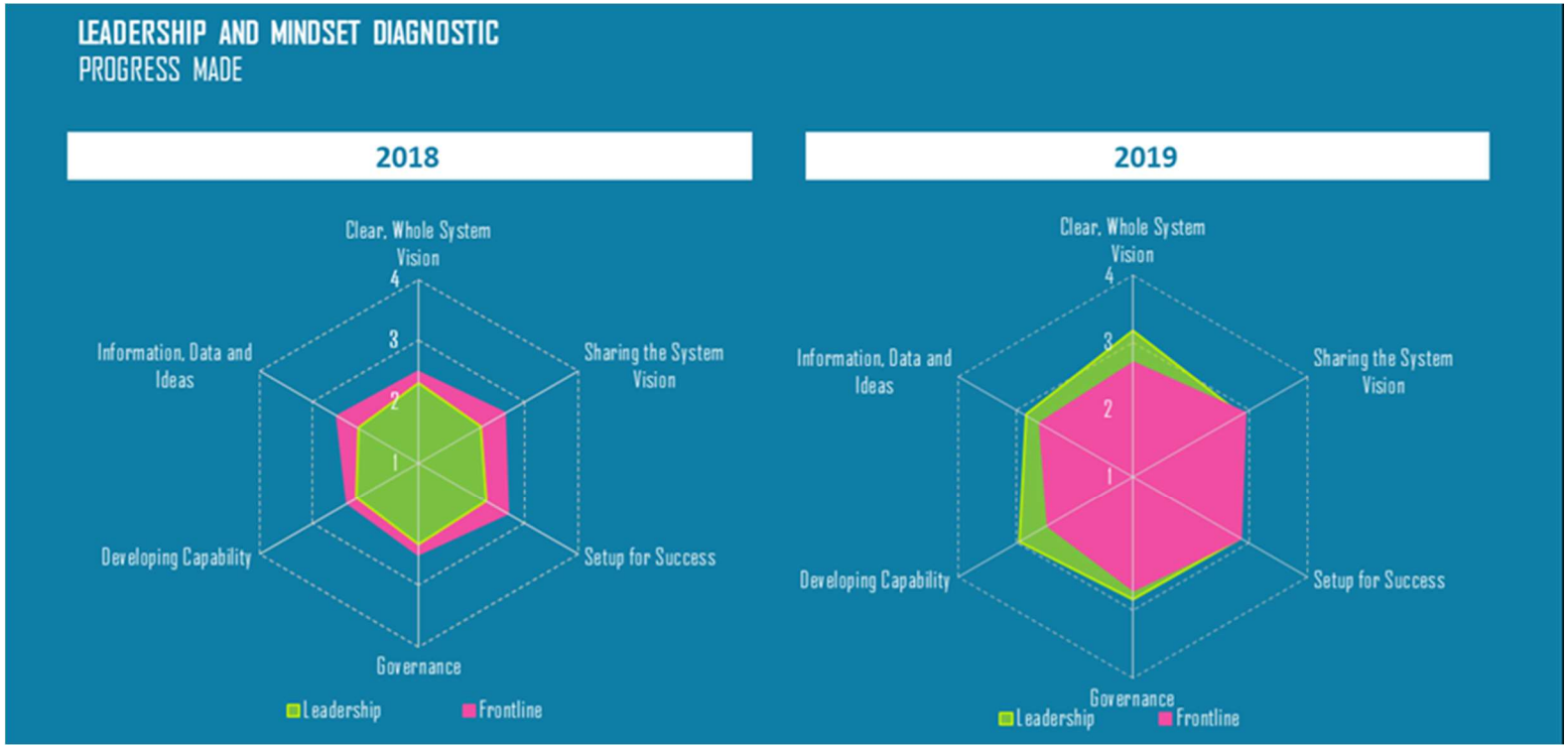
3.2 Newton Europe diagnostics 2019

It was evident from our collective winter position that we were making progress in a number areas of opportunity identified in the 2018 Newton Europe diagnostic.

- Average length of stay for those on the Stroke Pathway reduced by 45% from 34 days to 18 days
- No longer any patients waiting for a decision on Mental Health Funding
- 25% increase in the number of patients discharged before 4pm on pilot acute wards
- Increased pace of social work assessments, with 1.5 fewer days spent on referral and allocation processes

In addition we have seen progress within the system leadership and mind-set, diagram 2. From a lower starting position our leadership has seen more growth across all of the domains and demonstrates the system commitment to the vision. For 2019/20 we aim to translate this through to our frontline staff where we need to develop capability and improve our set up if we are to progress further.

Diagram 2

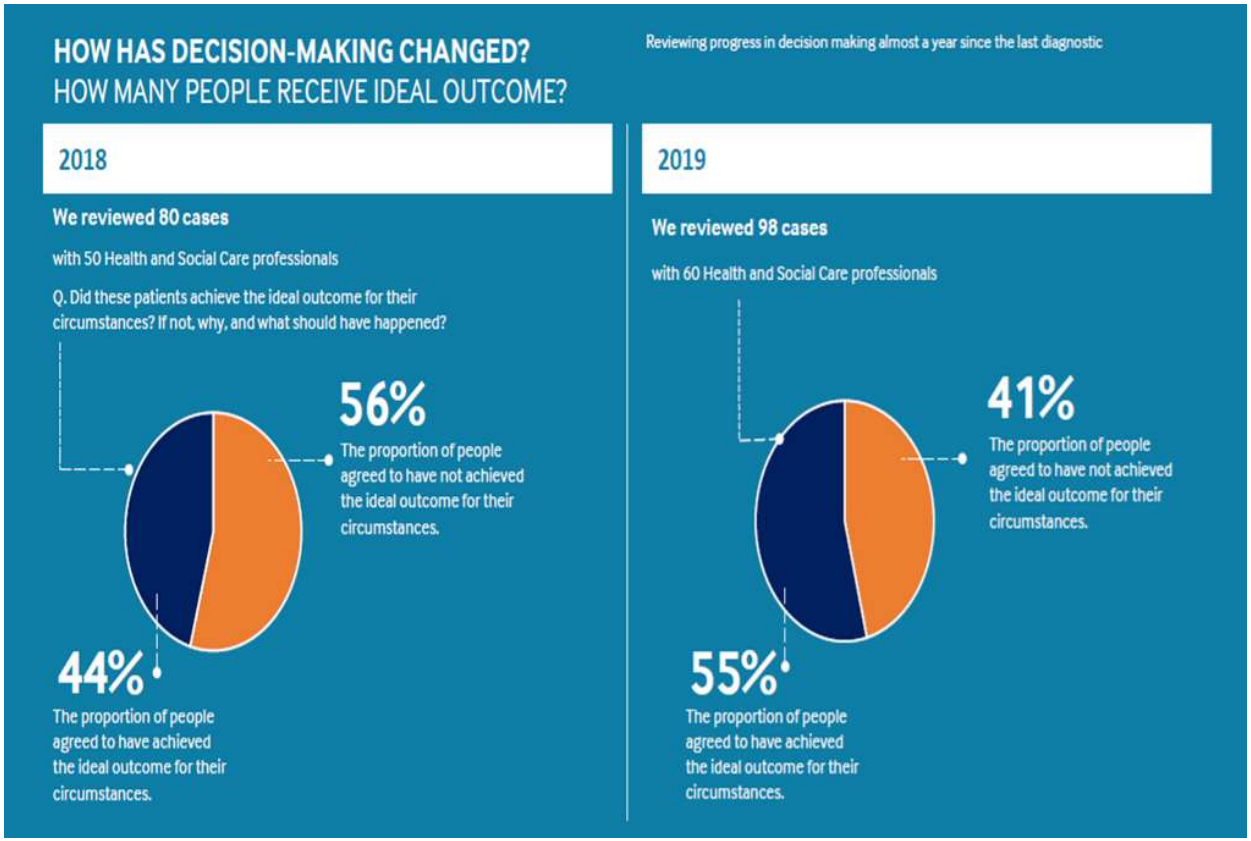


3.2.1 Newton Europe back door re-audit

To ensure we understand our progress and identify further opportunities Newton Europe agreed to re-audit the discharge decision making across our system. As the key areas for improving discharge, ensuring the optimal outcome for people and supporting effective outflow from the hospital this was a priority for the system.

The audit showed that we had made a slight progress in achieving the ideal outcome for people on discharge by 15%, diagram 2. Though there is further scope to reduce the variation in decision making. This will ensure that at discharge the best decisions to maximise peoples independence are consistently made and the opportunities for the system are realised during 2019-20.

Diagram 3



3.2.2 Newton Europe front door diagnostic

Newton Europe provided the SRAB with a version of the truth regarding the issues associated with discharge across the system. It was decided that conduct a similar diagnostic at the front door of LTHT would once again provide valuable insight into our system.

Newton Europe seeks to answer the following questions:

> ***How can we better utilise primary, urgent & community services to avoid unnecessary A&E attendance & acute ward admission?***

Outcomes of the exercise indicated:

Admissions

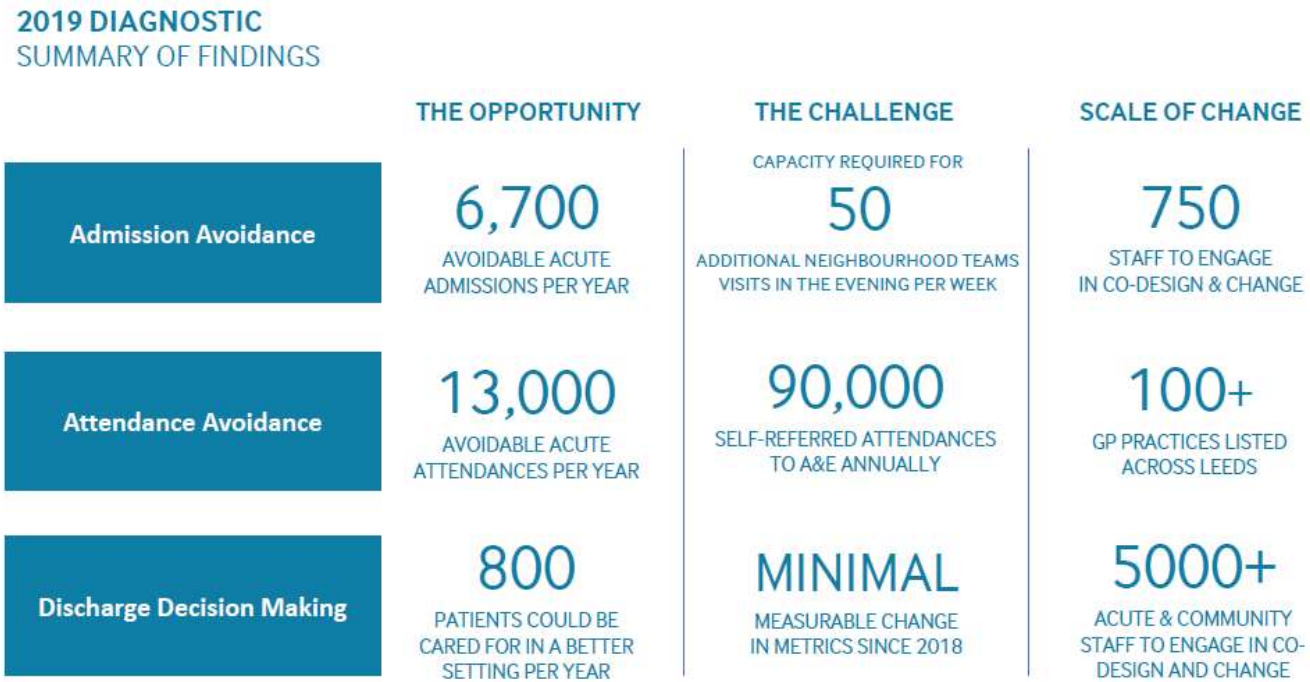
- 28% of admissions were avoidable with services **currently** in the Leeds System
- Average length of stay for the avoidable admissions was 4.5 days
- Key reasons for the admissions
    - Clinical decision making
    - None or perceived no access into alternative services e.g. variation in referrals to neighbourhood teams
    - Knowledge of alternative services perceived criteria/capacity of services e.g. Community IV antibiotic service

A&E Attendances

- 42% of people could have used an alternate pathway instead of attending the A&E
    - 14% of the 42% attended on the advice of a professional
        - 65% referred by a GP – 60% of these could have gone via PCAL negating the need to attend A&E
        - 20% referred by 111
        - 10% referred by a UTC
    - 28% of the 42% was patient choice
        - 55% of those who chose A&E could have been treated in an UTC or Walk-in-centre
        - 40% of those who chose A&E were treated in the GP stream and there could have attended a GP surgery

Diagram 4 shows a summary of the opportunity identified by the Newton Europe re-audit and the front diagnostic.

Diagram 4



It is evident from the findings above that there are significant opportunities for improvement across all aspects of our unplanned care system. Realising these opportunities would support the left shift in the provision of care and improve outcomes for the population.

3.3 Leeds System priorities

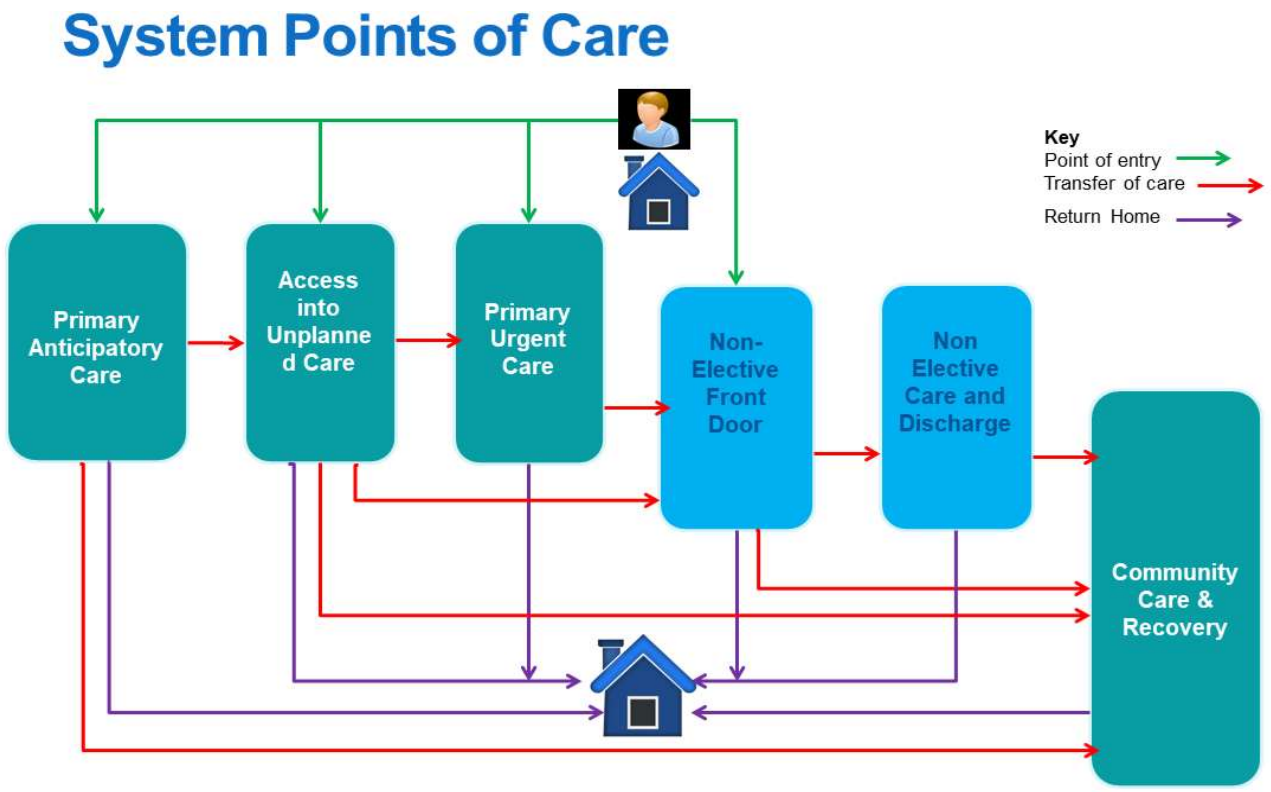
Following the outputs from both Newton Europe diagnostics, the winter review and the NHS Long Term Plan, SRAB has reviewed the priority work streams for 2019/20.

Feedback form the governance review highlighted the need for to focus across the whole pathway of unplanned care. The system points of care diagram 5 form the 6 key areas of the pathway across the system. The priority work streams span all points of care to ensure our plans reflect the full scope of the opportunities available to achieve the left shift and deliver the aims of the long term plan.

3.3.1 System pathway

Diagram 5, illustrates the points of care and the complexities across the unplanned care system.

Diagram 5

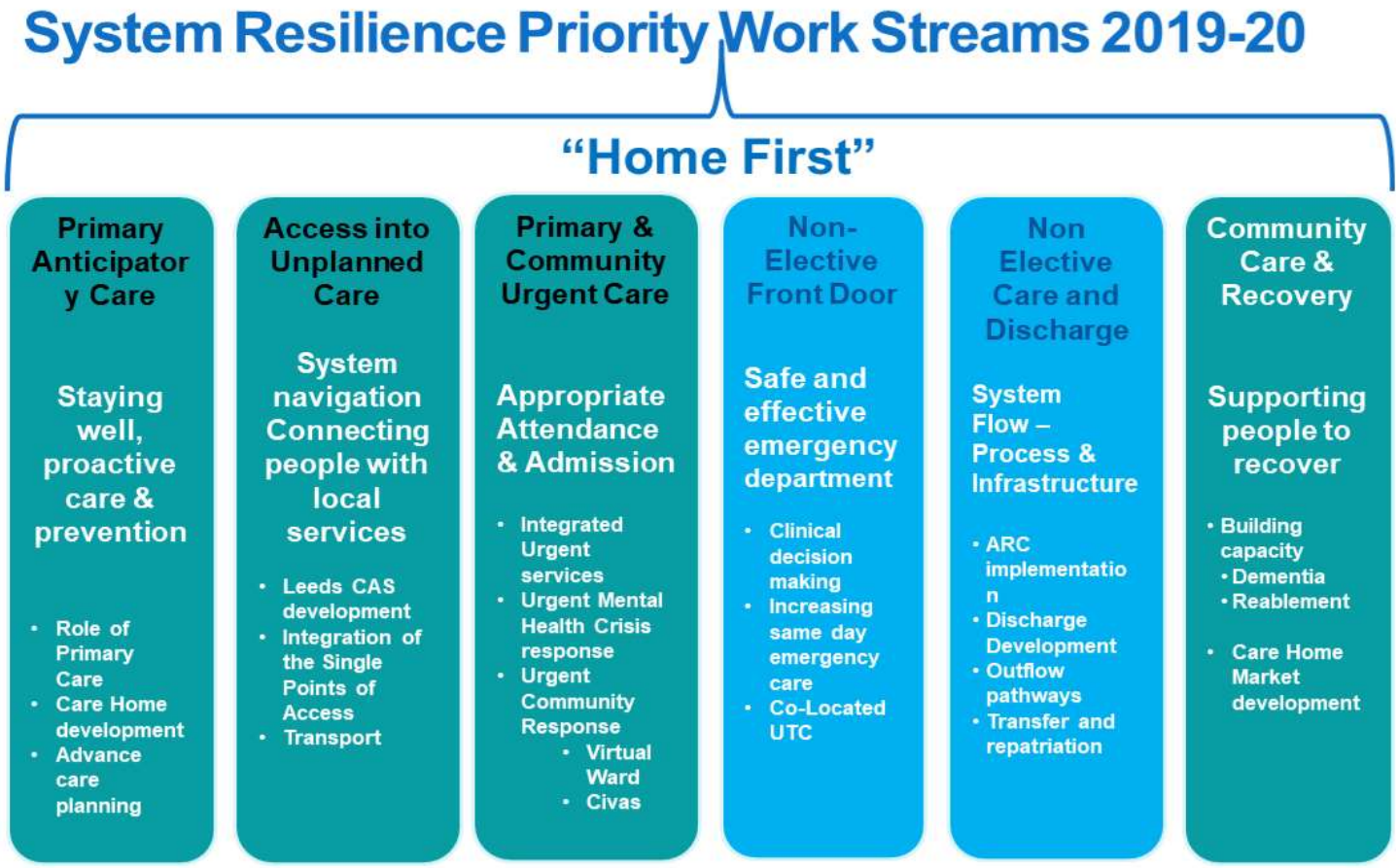


3.3.2 System priority work streams

The work streams identified in diagram 6 support the delivery of the priorities for 2019/21. Many of the work streams are established and are clear regarding their aims and governance. Pulling these work streams into the SRAB governance will ensure pace, a renewed focus holding system partners accountable for delivery.

Key to our success will be monitoring progress to understand the impact of the work streams and the collective impact on the system and performance. Each work stream will be required to demonstrate how their project maps to the vision and aims supports overall system performance and the left shift .

Diagram 6



The next section describes a number of the work stream in more detail.

Primary Anticipatory Care – staying well, proactive care and prevention

- **Care Home developments**

The quality and the sustainability of older people's care home provision remain key issues both nationally and locally, and the Council and the CCG have a key role to play in supporting care homes to continuously improve the quality of care delivered and to remain viable to ensure there is sufficient capacity to meet needs. The governance of the various projects and work streams have been brought together though the establishment of the Integrated Care Homes Oversight Board.

The main aim of the plan through various initiatives and programmes is to support the reduction of avoidable hospital attendances and admissions and ensure processes are in place to support effective timely discharges. There is a continued focus on people with complex needs and/or challenging behaviours relating to their dementia delayed in wards at LTHT and at The Mount at LYPFT and who are experiencing excessive lengths of stay because they are awaiting a suitable care home placement.

To address we have extended LYPFT Care Homes Liaison support to provide additional clinical input, including access to out of hour's psychiatric services to care homes where they were willing and able to offer a placement to a person exhibiting challenging behaviours relating to their dementia. Also there has been additional funding available for transitional payments to care homes for up to 6 weeks for additional staffing when a person with complex needs/challenging behaviours are admitted to their care home.

Our highest group of DTOCS in Leeds is for dementia patients, many of whom present with challenging behaviour. In discussion with Leeds city council we are in the planning stages for the re conversion of a number of community care beds along with other facilities to provide an intermediate tier offer for these patients. These would not be a step down facility but a medium term units where patients can be fully assessed and supported towards long term care options. This could be up to 30 beds which would start to free up capacity in both LTPFT and LTHT and improve outcomes for this population.

Other initiatives include:

- The 'Red Bag' initiative
- Telemedicine scheme - trialled in 14 care homes, now extended to 30 homes
- React to Red Skin campaign
- Enhanced care home scheme – Aging Well Model (Long Term Plan)

- Care home capacity tracker
- Enhanced Surveillance tool and joint protocol for addressing safeguarding and risk escalation
- 'Delivering Effective Social Care with LGBT People' RIPFA (Research In Practice for Adults
- Dementia mapping
- The Living Lab Project – initiative led by the Leeds Care Association – a collaboration between care homes and the Universities of Leeds and Maastricht, to improve quality and to nurture and support learning cultures in care homes
- Digital connectivity - enhancing the use of technology in care homes to improve service provision including:
  - the Social Care Digital Innovation Programme
  - support to care homes to complete the Data Security and Protection toolkit
  - support to care homes to access the Leeds Care Record and an NHS.net email address
- Workforce
  - registered managers network, activities co-ordinators network
  - a joint health and care annual awards ceremony for care home staff
  - supporting the nursing workforce in nursing homes/Leeds Teaching Care Homes

During 2019/20 we will continue to work in partnership with care home providers/registered managers to raise the standards of care and to achieve a 'Good' CQC rating throughout our care homes in Leeds. In addition we know we need to secure further capacity for nursing care and particularly for high quality specialist dementia care home provision through market facilitation and development.

System navigation- connecting people to local services

To support people to navigate the system and access the optimal service by embedding multidisciplinary Clinical Assessment Services (CAS) that will integrate with NHS 111, mental health, ambulance dispatch, acute, community and primary care services and social care. Section 5.2.2 provide more detail regarding our long term plans to develop a Leeds CAS

There are 4 main areas for development within this work stream during In 2019/21:

- Continue testing the integration with 111 and a local Leeds CAS
- Expansion of pathway development within the Primary Care Advice line (PCAL), within LTHT)
- Integrating the Single points of access across the city

- National Pilot site - Clinical Assessment Services Supported Discharge
- Accelerator site for Urgent Community Response

➢ **Leeds Local CAS**

Due to the size of the city, it was felt that Leeds would benefit from developing its own local CAS. The local CAS will supplement the Core CAS function. It will offer clinical advice from a varied health and care clinical skill mix to the population. This will support the move towards increasing the volume of clinical advice given to people by health and care professionals over the telephone, reducing the volume of activity going into face to face appointments. For those individuals who do require a face to face appointment, the CAS will direct book an appointment the individual into the right service, within the right timescales depending upon the clinical need of the individual support the national targets within the Long term plan and our system objectives.

The proof of concept of implementing a local CAS has been tested; with the pilot successfully evidencing clinical advice was the outcome for 50% of the calls coming in to the CAS. 30% of calls requiring a face to face appointment were seen in the GP Out of Hours service, and the remaining 20% of calls requiring a face to face appointment had appointments booked back at their own registered general practice. The data from the testing the proof of concept supports:

- The ability to give clinical advice, supporting the national ambition;
- A reduction of face to face appointments within the system;
- Direct booking in service for onward care/assessment
- The left shift model of service delivery;
- Positive collaboration and system working between providers and commissioners;

The ambition is to utilise a phased approach to gradually build up and test new elements within the local CAS function. The development will be based on the findings from continuous learning and formal evaluation. This development will continue over the upcoming 5 year period. This supports the NHS 10 Year Plan as by 2023 the local CAS will have been developed to include the function of discharge.

- **Primary Care Advice line**

Set up over 10 years ago PCAL has support General Practice in the management of people requiring acute assessment/care negating the need for them to go to A&E. The service has developed over the years and is now a fundamental part of managing acute flow into LTH. The Newton Europe diagnostic highlighted the need for the service to be expanded in terms of capacity and pathways to maximise its potential in reducing A&E attendances, avoidable admissions and improving peoples experience and outcomes. Funding to support the required capacity has been identified within the Leeds winter ICS allocation.

Priorities for the PCAL service during 2-019/20 include:

- Balance demand and capacity
- Embed the Ambulance pathway to ensure people are taken directly to an appropriate assessment unit where appropriate
- Consultation with geriatrician to direct people to the frailty unit and the virtual wards as they develop
- Re launch PCAL across the system
- Integration with Single Point of Urgent Referral (SPUR)PCAL to direct people to Neighbourhood Teams and Community Care beds

- **Integrating Single Points of Access**

Leeds, there exist multiple single points of access. Some of which are available to the public, some to health and care professionals, and some which are available to both. Evidence suggests people and professionals use the single points of access that they are most familiar with, and perhaps are not aware off other offers, which may better suit the presenting needs.

There is an opportunity to converge all the single points of access to generate a truly single, multi-disciplinary clinical skill mix offer, to both the public and professionals, to give clinical advice and when necessary to book people into the right service within the unplanned care system. Scoping of the opportunity is completed and full work plan is in development.

- **Clinical Assessment Services Supported Discharge**

By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care. Leeds has expressed an interest in becoming a pilot site for supported discharge with a focus on acute care alongside establishing good practice within the acute setting for when discharge support is started. This will support the development of the CAS function as well as the Non elective care and discharge -decision-making works stream. We are waiting to hear form NHS England as to whether or not we have been successful.

Primary and community urgent care – appropriate attendance and admissions

- **Urgent Mental Health response**

The Independent Mental Health Taskforce Five Year Forward View (February 2016) made it clear that improving access to high-quality mental health care must become a national priority. Locally it is also recognised that there is a growing need for urgent mental healthcare services in Leeds to support people to access care.

A mental health crisis is defined as a situation that the person or anyone else believes requires immediate support, assistance and care from an urgent and emergency mental health service.

Improving access, pathways and care for people in crisis will involve all partners including the third sector and service users to work in collaboration. We will work to improve blue light and community based crisis response, ensure Children's and Adolescent Mental Health services (CAMHS) services are developed. This will include development of pathways e.g. street triage that provide an alternative to the Emergency Department (ED) and provide a more appropriate care for patients seven days a week.

Key commitments during 2019/20 aligned to the long term plan:

1. Ensure that anyone experiencing mental health crisis can call NHS 111 and access 24/,7 age-appropriate mental health community support.
2. Continue ambition to ensure that all adult and older adult community crisis resolution and home treatment services are resourced and operating with high fidelity by 20/21

3. Ensure that by 2023/24, 70% of Mental Health Liaison services in acute hospitals meet the ‘core 24’ standard for adults and older adults, working towards 100% coverage thereafter.
4. All children and young people will have access to 24/7 crisis, liaison and home treatment services by 2023/24
5. Increase provision of non-medical alternatives to A&E such as crisis cafes and sanctuaries that can better meet needs for many people experiencing crisis.
6. Increase alternatives to inpatient admission in acute mental health pathways, such as crisis houses and acute day services.
7. Improve ambulance response to mental health crisis by introducing mental health transport vehicles (subject to future capital funding settlement), introducing mental health professionals in 111/999 control rooms; and building the mental health competency of ambulance staff.
8. Specific waiting time’s targets for emergency mental health services will for the first time take effect from 2020 (Part of wider clinical review of Standards)
9. Improve the therapeutic offer on inpatient wards, e.g. more psychologists and occupational therapy

A new group is being established to oversee this work to ensure links with both the Mental Health and Children and Adolescence strategies.

Urgent Community Response

- **Neighbourhood teams**

Across Leeds there are 13 Neighbourhood teams delivering health and care services to their communities. The Newton Europe diagnostic showed that 17% of admissions could have avoided by referring to the NT as an alternative. All identified patients were over 65 years old and 75% were admitted between 18:00 & 23:00.

Diagram's 7 and 8

Diagram 7, shows neighbourhood teams referral pattern vs A&E admissions. Following an in depth study with 3 Community Matrons 45% of evening (6pm-12am) acute admissions could have been discharged home with Neighbourhood Team support. This has the potential to effect 2,700 people per year by returning home with support requiring an additional 50 NT visits per week.

To understand the full scope of the opportunity to maximise NT we also looked at how many people could have been supported during the day. It showed that 14% of admissions between 8am-6pm could have been discharged with support. 600 people a year.

The total opportunity equates to 3.300 people avoiding admission to an acute bed receiving care in their own home.

Understanding the variation across the NT along with developing a 27/4 model that would increase the capacity of the teams to start to realise the left shift in care is be a priority for LCH as they develop their response to the national implementation of the Aging Well Model. This will see Community Rapid response service responding within 2 hours and the reablement offer (Leeds City Council) within 4 hours.

- **Virtual Wards**

The development of a city wide Virtual Ward across multiple specialities including respiratory and frailty is key in the development of Neighbourhood Teams in increasing the community rapid response offer and supporting the left shift.

The ambition within Leeds is to develop a multidisciplinary Virtual Ward which will be a collaborative service between LTHT and LCH and the Confederation to provide coordinated rapid care to people in their home who are experiencing an acute medical episode. This rapid care involves providing responsive specialist assessment (including medication review), monitoring, investigations, treatment, support and education for people and their carers by the most appropriate specialised team.

It will ensure people's needs are safely met within the community without requiring a hospital attendance/admission where appropriate. A phased implementation has been agreed which sees avoiding hospital based care as the initial focus with the service supporting earlier discharge in phase 2 expected in Q1 of 2020/21.

The virtual ward projects have been funded through system transformation monies.

- **The Community IV Antibiotics Scheme**

Newton Europe diagnostic showed that 7% of admissions for those 65 and over could be been avoided though using the Community IV Antibiotics Scheme (CIVAS).. CIVAS is a community based service that is delivered jointly by Leeds Community Healthcare (LCH) and LTHT. The aim of the service is to support discharge from hospital; Emergency Department (ED) and inpatient wards at the earliest possible opportunity by providing IV antibiotic therapy in a community/outpatient setting to prevent either and admission or extended length of stay. The service is delivered in both people's homes and community hub clinics by a multi-disciplinary team consisting of staff and senior nurses, LTHT clinical nurse specialists, pharmacists, and Infectious Diseases Specialists.

By developing the service and increasing the capacity to manage up to 75 cases at any one time there is the opportunity is to avoid 1,500 admissions. Priorities for the service in 2019/20 include:

- integration of the service across LCH and LTHT
- provision of IV Diuretics, and Line Care
- Implement Cellulitis Pathway
- Rebranding of the service - CIVAS as this implies only IV Antibiotics can be provided as is therefore misleading to referring clinicians.

Safe and effective emergency departments

- **A&E decision making/triage**

Clinical decision making within and ED can vary due to a number of factors, Newton Europe identified an opportunity for the Leeds system to avoid up to 2,700 admissions though education of ED staff of alternative services in the community. The system is currently working though how this can best be achieved through a number of initiatives including:

- Focus on developing/improving mind-set and behaviours of front line staff
- Shadowing of staff across roles/teams ie. neighbourhood team/community to gain more knowledge about the services
- Education to improve confidence and knowledge of the services to support decision making
- Key educational massages for the system
- Maximise technology to support decision making- CAILTEC, DOS
- Improved data sharing to inform decisions and understand behaviour
- Tools to support care navigation - local DOS

- **CAILTEC**

Leeds is currently working with partners CAILTEC is an innovative technology solution to harness digital power to transform to transforming and integrate high quality patient care. It looks to find a way to accelerate education and skills retention of clinicians by studying opportunities to create technical integrations between systems to increase the quality of data across the emergency care's patient journey.

- **Co-located Urgent Treatment Centres**

In 2019/20 we will confirm the plans for the development of our first co-located UTC within the LTHT footprint. There will be a single entry point for all people who walk-into the hospital with an urgent need. All people will be triaged and then streamed to the most appropriate services for their presenting needs, these include:

- UTC
- Champion for signposting/booking into alternative more appropriate services
- Assessment area/unit
- Emergency Department

This will enable the right skills and capabilities in the right place ensuring those with the most life threatening conditions have the best chance of survival.

Non Elective Care and Discharge - System Flow, Process & Infrastructure

The Decision making work stream has been established for a year now and has been making progress in the decisions for people leaving the acute trust who require further care or support. Though it is acknowledged that there is still scope for improvement to ensure people receive the ideal outcome for their circumstances. The group is in the process of reviewing progress and scoping further opportunities.

Three further areas of development have been proposed for 2019/20:

- Achieving Reliable Care (ARC) to reduce LOS and bring about real behavioural and cultural change on our wards.
- Implement the outputs of the Leeds Integrated Discharge Service
- Implement the Discharge to Assess pathway for community care beds

All of these initiatives will be supported through winter monies to ensure resources are available to progress further and impact the system this winter.

Community Care & Recovery- Supporting people to recover

A fundamental aspect to effective discharge from hospital is to ensure that community services have sufficient capacity and support to ensure people return as quickly as possible to the most appropriate place for their care.

Within section Primary and community care urgent response, we refer to work within the NT, including social care and the wider Local Care Partnerships that will support attendance and admission avoidance which also support people discharges from hospital.

In discussions with Leeds City Council we are scoping the options to expand the reablement service in response to the Aging Well Model supporting attendance and admission avoidance. These discussions will also focus on maximising the service to facilitate discharge and support keeping peoples them in their own home retaining their independent and reducing the system long term placements in response to the Newton Europe findings.

We will continue to ensure the reablement services has sufficient capacity by ensuring it:

- Recruits to establishment
- Maximise time with service users
- Ensure service users spend the right amount of time receiving the service

Addressing all three points will continue to see increased numbers of weekly starts to meet the extra demand and support a shift towards recovery and independence services

System Resilience Communications

Data shows that the ‘winter pressures’ experienced by urgent and emergency care services is a year round issue with various in demand experienced throughout the year, however the media tends to highlight activity during the winter period.

Evidence suggests that some of the pressure on the system could be reduced by patients making appropriate use of all services available to them should they fall ill or get injured. “While A&E is the right place for many of these patients, estimates quantifying the size of non-urgent A&E demand (patients who could be better treated elsewhere) vary from 20% to 40% of all attendances”, (source: Department of Health).

Evidence shows (BMJ, 2016 and RCN, 2016) the A&E 'superbrand' continues to attract patients who could potentially be treated elsewhere. Furthermore evidence shows that when faced with a range of options, patients are confused and default to A&E (NHS England, 2017). More recently the British Social Attitudes Survey (2019) reinforces this and highlights the perception people have that it's difficult to get GP appointments as well as increased trust in hospital-based doctors over other clinicians.

Our communications activities are year round designed to provide a consistent set of messages that highlight alternative support available as well as placing an onus on self-care and prevention, where appropriate.

In Leeds we are now working together to see how all system partners can support communication activity that encourages people to self-care where appropriate, use alternatives to A&E and look out for vulnerable neighbours. We are following the principles of the national 'Help us help you' campaign with communication messages and activities based around preparedness, prevention and performance and the idea of developing a reciprocal relationship with people.

- **Our focus**

Throughout this year and as we head into winter we have concentrated our communications effort on the following.

- Ensuring people are aware of the alternatives to A&E for non-emergency care. We've particularly focused on developing the 'Talk before you walk' concept to encourage people to call NHS 111 when they're feeling unwell but it's not an emergency.
- In line with national campaigns we have also highlighted the support people have available from pharmacies including a concerted effort to demonstrate that they are skilled healthcare professionals.
- We know that not everyone is aware that GP practices are open on evenings and weekends, this is something we've continued to promote so that every available appointment is taken up.
- Providing year round seasonal advice such as a summer health campaign, with a particular push on ensuring people stay hydrated.
- Strong internal communications so that system partners are aware of the work we're doing in Leeds.
- Linked to the above we ran the Big Thank You campaign that encouraged people in Leeds to say a message of thanks to anyone who helps them through winter (and beyond) which supported positive messaging for internal colleagues.

- We've played a key role in developing the first every regional campaign by the West Yorkshire and Harrogate Health and Care Partnership. 'looking out for our neighbours' was launched in March and has recently been evaluated, with results showing a positive impact among those who had seen the campaign.

➢ **Priorities for this winter**

We will continue to work in partnership to run health awareness, signposting and direct action campaigns as below:

- We will engage with local citizens and health and care professionals to develop a significant behaviour and culture change programme. The current working title is 'Home First'. Home First is about educating and supporting people to leave hospital as soon as they are medically fit to do so as well as proactively supporting people so they get well at home rather than getting admitted to hospital. We'll also, where appropriate, support NHS England and NHS Improvement's 'Where Best Next' campaign targeting acute settings in an effort to reduce long stays
- The 'Looking out for our neighbours' campaign will be running again over winter to get people to look out for those around them (www.ourneighbours.org.uk)
- With over 1600 messages received last winter and regular positive media coverage we'll be running the Big Thank you campaign again (www.bigthankyouleeds.co.uk).
- We have a number of campaigns running that help further and higher education students make the right healthcare choices. This includes No Regrets that promotes safer drinking (www.noregretsleeds.co.uk) and Feel Better that encourages use of pharmacies and NHS 111 (www.feelbetterleeds.org.uk).
- We're currently considering options for a mass mailout to promote NHS 111, pharmacies and extended GP opening hours as well as actions that support the 'left shift' approach.

➢ **Activity and resources**

Our proactive approach includes the below:

- A year round social media calendar with messages adapted to meet seasonal needs eg flu vaccine, summer health advice etc

- Planning ahead for bank holidays with advice issued on social media, through local media and internal communication channels
- Regular reprint of fridge magnets with advice for parents and carers of children aged 0-5, distributed to health and care settings
- Promotion of national Help Us Help You campaign
- Reprint of information leaflets and social media advertising targeting members of the Eastern European community backed up by a dedicated website www.healthinleeds.org.uk
- Proactive messaging ahead of extreme weather to help people plan ahead, this is often supported by paid for social media advertising
- Providing communication resources and advice for GP practices this includes a web portal with information resources https://www.leedsccg.nhs.uk/help-us-help-you-comms-resources/

➢ **Communications plan**

The communications plan for this winter will broadly follow the same approach as the one for 2018-2019 (appendix 3).

The current plan is being discussed by the citywide communications group and will be signed off by SRAB

Assess the opportunity of the left shift- capacity and demand

It is vital that as we start to develop work streams and projects to achieve the left shift in the provision of care by increasing primary care and community capacity, that we start to understand the potential shift of activity and associated financial flows that will be required.

In response to the Long Term Plan Implementation Framework we are required to submit a strategic planning tool to NHS England in September 2019. This submission will show our long term acute activity assumptions and strategic financial investments by sector across our system, supported by our workforce assumptions. The plan will be signed off by both the CCG and providers. It is

important to mention that this brings potentially £27m into the West Yorkshire system. We are awaiting confirmation of Leeds allocation and guidance on how this will be spent.

This will be the start of developing a detailed model which includes but is not limited to:

- Population Health Management
- Newton Europe outputs and opportunities
- Current contracts
- Development of Primary Care Networks
- Financial investment plans

3.3 Investment

Realising the opportunities identified within the plan will require a shift in investment over the next 2-5 years. The systems response to the long term plan implementation framework will start to provide an overview both commissioners and providers investment strategies. The development of one version of the truth regarding the future system demand, capacity and the left shift opportunity by March 2020 will be key in further informing the investments and detailing plans, business cases and financial risks.

- **Winter 2019/20 investment**

Though the West Yorkshire Integrated Care System (ICS), Leeds will be has been allocated £775.000 to invest in winter initiatives. Priority Project has been agreed by SRAB August 2019 and in turn by the ICS Urgent and Emergency Care Board. We are now in the process of working with the projects leads to identify the required resources including workforce.

Leeds proposed projects are:

- Social Workers to support the Discharge 2 Assess pathway
- Development of the CIVS service
- Expansion of the PCAL function within LTHT
- Community Dementia capacity

Though the ICS allocation will support a number of 2019/20 priority projects the resilience of our system especially at times of pressure depends on our commitment to work in an integrated way. There will be a continued focus on new ways of working across organisations to maximise existing investment, capacity and ensure resources are used effectively and efficiently to support the delivery of quality services for our population.

Due to the Aligned Incentive Contract (AIC) the CCG and LTHT have agreed a financial envelope through the based on previous years costs with CCG setting aside a budget for winter pressures. In the event of activity and/or demand significantly above expected levels the System will take joint responsibility and develop mitigation plans within agreed cost envelopes. The CCG and LTHT will monitor demand levels within the unplanned working group and System Resilience Assurance Board. The CCG has plans protecting LTHT against the loss of elective capacity from increased non-elective demand especially with the intent to suspend some elective activity in January 2019.

3.4 Risks

The high level risks and mitigating actions to support the delivery of a resilient health and care system in 2018/19 are identified within 2 areas:

- Variable risks are those which we cannot predict but where we can put mitigating plans in place, 9 high level risks have been identified.
- Impact risks are those we have assessed and highlighted the probabilities and consequences of the risk, 8 high level risks have been identified

The high level risks have been RAG rated pre and post the agreed mitigating actions, the full risk register for the LSRP are included in Appendix 4.

3.5 Public Health - Leeds City Council

The Leeds Local Authority Public Health contribution focuses on preventative and preparedness health measures and is informed by the PHE Cold Weather and Heatwave plans for England (2018). LCC Public Health are leading a number of key programmes to ensure vulnerable people are protected from the adverse effects of cold and hot temperatures. Public health are working to optimise the role of the Council to address priorities including promoting key messages through Council services, working with commissioned services to prioritise programmes with service users, and ensuring that Elected members are briefed on key messages and issues.

Public Health priorities:

- Infection prevention and control; improving flu vaccine uptake in target groups, increasing community staff skills, knowledge and competencies through the delivery of infection prevention training; outbreak planning and management across the community
- Mitigate the impact of the negative effects of cold and heat on vulnerable people; commissioning of winter warmth services including winter friends programme, providing vulnerable people with high impact interventions to keep people well during cold and hot periods, delivery of small grants schemes for community groups and others.
- Living with Frailty; delivery of programmes, including the commissioning of the Home Plus, to support people living with frailty focusing on falls, malnutrition and support for independent living

4 Escalation and Incident Management

Variation in the demands across a health and care economy is normal and occurs throughout the year though experience informs us that winter months pose significant challenges. To ensure we continue to deliver quality, safe and responsive services Leeds needs to be equipped, prepared and coordinated to respond quickly and appropriately to any change in demand or circumstances as well as develop a strategy to transform our system for the future.

4.1 Escalation and Mutual Aid

Operational Pressures Escalation Levels (OPEL) NHS England Mandated framework for all NHS health organisations aims to provide consistency in the reporting and managing escalating situation across system both locally and nationally.

It was evident during the winter of 2017/18 at times of extreme pressure the system veered away from agreed processes and our mutual aid was not sufficiently defined to support de-escalation and recovery. With clear processes, robust mutual aid agreements; including the Decision Management tool (Appendix X) and the establishment of the weekly OWG we entered winter 2018/19 in an improved position. All partners were clear on their roles and responsibilities and there was the assurance that these were aligned to organisational on call procedures and national reporting requirements. With only the need for 3 Sitrep call over the 2018/19 winter we will be building on the foundations of this success as we plan for 2019/20.

All organisations in 17/18 developed a Decision Management Tool which provided a risk assessed model to identify contingency actions that we would need to take if our system reached OPEL 4. The tool focuses predominately what services could be suspended and resources re-deployed.to manage the incident and support recovery. This was further developed in 2018/19 and will be reviewed as part of the 2019/20 LOPEL refresh.

We are in the process of refreshing the Leeds Operational Pressures Escalation Levels (LOPEL) for 2019/20 to ensure it is reflective of operational activities and behaviours. The refresh will focus on the agreed objectives carried forward from last winter below:

- Confirm governance arrangements for winter – winter room, patient level operational groups
- Mutual understanding of the parameters of the OPEL Levels and how they work within Leeds to ensure they reflect and meet local changing needs
- Review and align organisational triggers to OPEL to ensure consistency in the interpretation
- Internal actions to be taken to ensure/support de-escalation
- Joint planning to support the prediction of flow issues and delays
- Complete an analysis of mutual aid across the system to identify develop and agree tangible and realistic actions based on the Leeds system principles
- Agree daily the reporting format, analysis and sharing information including primary care
- Refine our approach to the timely management of the system; command and control to address operational challenges and promoting a recovering system (SiTRep calls, winter room)
- Agreeing our approach, processes and escalation to executive level command
- Review of organisational decision management tool to inform system management and actions at OPEL 4/critical, major incident
- Review all On call arrangements and ensure alignment and communication is clear and understood, including exception reporting process during winter, further on –call training
- Desk top exercise to test process and mutual aid in an escalating scenario, to include adverse weather and flu
- Align predictive and responsive communications to OPEL levels to develop consistent and targeted messages to staff and the public
- Implement a structured approach which drives and supports assurance of organisational compliance with the 2019/20 Emergency, Preparedness, Resilience and Response

4.2 Leeds Escalation principles

Clinical quality and safety are the top priority in the delivery all health and care services. During the periods of intense pressure in Leeds we have maintained zero twelve hour trolley breaches and people in non-designated bed areas since May 2018.

The principles below where agreed in 2018/19 and will be carried forward for this year's plan. These principles underpin our plans and ensure we have a shared approach to deliver quality and safety for our population with clear outcomes.

- The Leeds health and care system provides consistently high quality and safe care, across all seven days of the week
- Zero tolerance of 12 hour trolley breaches
- Non patient cared for in a non-designated hospital areas
- No cancellation of elective surgery within 48 hours
- Services have a set of standard response times and categories for prioritisation
- Clinical standards are clear and articulated through assessment, intervention and discharge pathways
- Patients will not wait longer than 15 minutes in ambulances before handover at ED
- Clear infection control protocols are in place including the transfer of people on to or returning to alternative services
- Capacity is managed within organisations and as a coordinated system across the health and social care economy.
- No action that would undermine the ability of any other part of the system to manage their core business will be taken by one constituent part of the system without prior discussion.
- Should an organisation take action which results in unintended consequences for another/others they will, as soon as if practical and practicable, rectify that action
- As far as possible, the clinical priority of patients, across all care groups and categories of service (i.e. between emergencies and electives) will be the key determinant of when and where patients are treated and cared for. E.g. this may mean that some patients who have self-referred as an urgent are given lower clinical priority than urgent elective patients.

- No action will undermine or question the clinical judgement of practitioners but will however aim to decrease escalation by sign posting patients to less congested services where acceptable clinical alternatives are available.
- Managing patients at a time of increased escalation will require accepting and managing additional risk across organisations, as individual decisions on patient's care are taken, and competing pressures/targets are prioritised.
- Services should be maintained for as long as is practicable in times of increased escalation and organisations will work to recovering suspended services as soon as possible.
- Decision-making and actions in response to escalation alert will be within appropriate timescales.
- De-escalation will be agreed by all partners.

All of our developments need to be flexible to allow an effective response to a whole spectrum of incidents and events that may create a surge in demand or disrupt the normal delivery/flow of services for health and care services, irrespective of situation, duration, scale and type.

4.3 Provider clinical escalation plans

All providers annually review their internal clinical escalation plans which outline their organisational response to managing clinical safety and quality during times of escalation. These are tailored to reflect organisations key priorities, scale of business and are based on continuous learning to provide insight to target interventions when they face further quality, safety and performance challenges

The plans include; but are not exclusive how organisations will manage:

- daily operational process including
    - management of OPEL triggers and action plans
    - weekly quality meetings
    - weekly executive meeting chaired by the CEO
    - escalation process in place for workforce shortfalls

    - cessation of non-essential training and development
    - re-deployment of staff to manage pressure areas
    - transfer of clinical staff in non-clinical roles to support patient areas.
    - daily duty response to care homes
- operational silver command response
- approach to Joint Decision Making (JDM)
- implementation of Full Capacity Protocols
    - trolley wait escalation
    - organisational balancing of clinical risk
    - the use of use of flexible labour
    - agreed process of workforce mutual aid across our internal teams
    - elective care activity and the cancellation of routine elective requiring inpatient stay
    - staff flu vaccination programme
    - comprised capacity and flow due to infection and the management of outbreaks
    - prioritisation of services to manage risk and redeploy resources through Decision Management Tools
    - response to increasing demand
- additional winter / flex beds
- conversion of 5 day wards in to 7 day capacity
- additional evening / weekend cover secured via on-call Psychiatry
- medically supervised bays for ambulance conveyances
- additional workforce at times of key pressure to support operational flow
    - implementation of robust audit processes to assure plan effectiveness and identify further opportunities

4.4 NHS England Exception Reporting

To ensure a national view of performance regional winter rooms have been in operation 7 days a week to gather information from systems. The Leeds system has robust processes in place to ensure that we comply with the requirements of exception reporting 7 days a week during the reporting periods. Reporting consists of the following elements:

1. NHS England's weekly call for systems to report their performance, pressures and recovery/supporting actions, CCGs represent their system. To ensure we are able to provide timely information, the Operational Winter Group discusses each week the local pressures and actions taken to provide an overview which is further informed by a call immediately prior to the NHS call between LTHT and the CCG, with other partners included by exception.
2. Relates to assurance reporting to NHSE by way of a daily assurance return, should one of five trigger criteria be met. On days when a specific trigger is met, ongoing actions within the acute hospital are shared by the A/DOP for escalations (that day) or the on call general manager (weekends and bank holidays). The CCG is responsible for collating and submitting the assurance return detailing the steps taken both short and long term by the system to recover the position and support performance improvement and recovery, either via the unplanned Care Team or the CCG on call manager (weekends and bank holidays).

There are triggers in place that necessitate exception reporting each day from October to March and on all bank holidays:

- A&E standard at or below 80% or a deterioration of more than 10% from the previous day,
- Any 12 hour trolley breaches,
- More than 5 Ambulance delays greater than 60 minutes,
- Increase in beds closed due to D&V by 20 beds from one day to the next,
- Other significant event e.g. disruption due to a catastrophic event or loss of infrastructure where the flow of ED is disrupted, major patient safety issues, developing situations where national briefing and preparedness would be of help to the system

4.5 Emergency, Preparedness Resilience and Response

All NHS organisations have a statutory responsibility to ensure they are properly prepared to deal with an incident or emergency. There are well-defined core standards for Emergency Preparedness, Resilience and Response (EPRR) across NHS organisations. All NHS organisations are responsible for the achievement, maintenance and monitoring of the standards, and are accountable to NHS England through the Local Health Resilience Partnership Board (LHRP).

4.5.1 Emergency, Preparedness Resilience and Response standards

The EPRR standards are used to inform and direct our approach to escalation management along with the OPEL framework. The detailed standards seek assurance on all levels of planning, guidance and preparedness on information sharing, command and control arrangements, responsibilities and mutual aid arrangements to enable prompt recovery from disruptions. Business continuity plans are a key part of EPRR planning including the regular testing.

Emergency Preparedness Resilience and Response – Responder Categories
The Civil Contingencies Act (2004) specifies that responders will be either:

- Category 1 (primary responders), or
- Category 2 responders (supporting agencies).

Category 1 responders for health are those organisations at the core of emergency response:

- Department of Health on behalf of Secretary of State for Health
- Public Health England
- NHS England
- Local authorities (inc. Directors of Public Health)
- Acute service providers
- Ambulance service providers

Category 2, responders are critical players in emergency preparedness, resilience and response and will work closely with other category 1 and category 2 responders. The following are considered to be category 2 responders for health:

- Clinical Commissioning Groups (CCGs)
- NHS Property Services.

All NHS providers will complete a self-assessment across a number of domains. The standards are reviewed and updated annually as lessons are identified following incidents or testing, or changes made to legislation or guidance. The 2019/20 standards remain the same as 2018/19; 68 individual standards under 10 domains below which range from command and control to evacuation.

Organisations will be assessed as either Full, substantial, partial or noncompliance based on their response to the standards that their organisation is required to assess against. As Category 2 Responders CCGs are required to self-assess against 43 individual standards, these sit within the 10 domains. By comparison acute providers have to assess against 64 individual standards.

The ten domains are:

- Governance
- Duty to Risk Assess
- Duty to Maintain Plans
- Command and Control
- Training and Exercising
- Response
- Warning and Informing
- Cooperation
- Business Continuity
- CBRN

The submission date is 31st October; SRAB will receive provider's assessment outcomes and develop an approach to address any areas for development especially where themes are evident.

4.5.2 2019/20 EPRR Assurance Deep Dive

Each year NHS England uses the core standards assurance process to undertake a 'deep dive' look at a specific topic relating to EPRR. Previous deep dive topics include Command and Control, Pandemic Influenza, Business Continuity and Governance. Deep dive results are not included in the overall organisational compliance rating and are therefore reported separately. In 2019/20 the

deep dive topic is Severe Weather and Climate Adaptation. Severe Weather would clearly have a system impact, and quickly invoke escalation management processes. Climate Adaptation and Sustainability are city priorities and for these reasons there was support to review this deep dive area in partnership with health providers and the local authority.

4.6 EU Exit Preparations

The Department of Health and Social Care (DHSC) is leading the response to EU Exit across the health and care sector. The application of national guidance is mandatory including all communication, planning and the assessment of risk. Professor Keith Willetts is leading NHS England response to the exit from the EU which focuses on the following key areas as identified by DHSC:

- Interruption to the supply of medicines and vaccines;
- Interruption to the supply of medical devices and clinical consumables;
- Interruption to the supply of non-clinical consumables, goods and services;
- Availability of workforce;
- Changes to reciprocal healthcare arrangements;
- Continuation of research and clinical trials; and
- Interruption to data sharing, processing and access.

Nationally we are being told to expect to begin assuring local preparations in September. This assurance process will cover similar ground as previous exercises, including your plans, systems and contingency arrangements for key areas such as operational readiness, communication, continuity of supply, workforce, clinical trials, data, finance and health demand. Further clarification will be provided at the national workshop for the north of England September 5.

The NHS in Leeds and Leeds City Council are working together on citywide plans to prepare, plan and respond to any impact related to EU Exit. A city wide steering group chaired by Dr Ian Cameron; Director of Public Health was established to ensure a collective and consistent response across the city. It was agreed that the remit of the group was to:

- gain assurance of individual organisations plans.
- focus on themes that effective all organisations, identified as

    - Medicine and equipment
    - Staff
    - Fuel disruption
    - Communication
- collective test our continuity plans at a system level

Table 3 shows the Senior Responsible Officers across the Leeds NHS organisations.

Table 3

Organisation	Lead	Title
Leeds Teaching Hospital Trust	Clare Smith	Chief Operating Officer
NHS Leeds CCG	Sue Robins	Director of Operational Delivery
Leeds City Council	Ian Cameron	Director of Public Health
Leeds Community Healthcare Trust	Sam Prince	Executive Director of Operations
Leeds and York Partnership Foundation Trust	Sara Munro	CEO
Leeds GP Con-Federation	Jim Barwick	Chief Executive
Yorkshire Ambulance Service	Steve Page	Deputy Chief Executive & Executive Director of Quality,
Local Care Direct	Andrew Nutter	Chief Operating Officer

In addition Leeds City Council has an EU Exit 'no deal' Strategic City Recovery Plan that demonstrates strong links with partner organisations across the city. The plan focuses on the following key areas:

- Infrastructure and Supplies impact
- Business and Economic impact
- Community impact
- Council impact
- Media, Communications and Public Affairs

As the new exit date of October 31 approaches all groups have been re-established to assess the current status and progress planning. National guidance asks all organisations progress the following mandated actions in preparation for national messages expected early in September.

Nationally mandated actions August 2019

- Complete the mitigation of any issues identified in the previous assurance processes
- Make sure your EU Exit team is in place. This should include, Advising your Board that the EU exit response is being stood up for leaving the EU on 31 October
- Having an EU Exit SRO in place, with supporting EU Exit team, and full management and oversight of the organisation's Single Point Of Contact (SPOC) email for EU exit communications
- Having relevant subject matter experts available for critical areas including supply/ procurement, pharmacy, logistics, estates and facilities, workforce, data
- Reinstating on-call arrangements, and ensuring on-call directors understand what is required of them and the escalation routes for problems
- Ensure your business continuity plans are up-to-date and tested, including winter and flu plans
- Make sure you are engaged with local system preparations around EU exit through Local Health Resilience Partnerships and Local Resilience Forums, and have agreed to link with partner agencies including local authority, CCG and provider colleagues to collaboratively manage and address issues.

- Re-familiarise your teams with details of the EU exit operational guidance from 21 December 2018 bearing in mind some aspects of this may have been supplemented or may be updated in the coming weeks
- Register to attend the regional EU Exit workshops in September, where you will be updated on the operational guidance and planning context, including the key changes since April.
- Revisit your organisation's contract and supplier assurance process including 'walk the floor' checks, to include smaller and/or niche local suppliers not covered by national assurance exercises (this applies to both CCGs and providers)
- Ensure you communicate with healthcare professionals and patients using the available information on the GOV.UK, NHS England and Improvement websites and NHS Choices.

We are informed that we should expect regular situation reporting to start from 21 October. All organisations in Leeds have plans in place for completing the reporting as required.

5 Transformation Plans

5.1 Transforming Leeds Unplanned Health and Care System

The NHS Long Term Plan details the strategic direction for the NHS over the next ten years. The plan highlights the challenges facing the NHS including staff shortages, growing demand and an aging population. With a focus on changing the way we do things to tackle these challenges the plan aims to give people more control over their own health and care whilst preventing illness and tackling health inequalities.

With emphasis on integrated care the long term plan is a framework not a blueprint giving local systems the flexibility to develop their response to meet the local needs and priorities of their populations. Through Integrated Care Systems (ICS) Leeds commissioners will make shared decisions with providers on population health, service redesign and implementation of the Long Term Plan.

The Long Term Plan sets out actions to ensure patients get the care they need, fast, and to relieve pressure on emergency departments. This will be achieved by developing and investing in primary and community services such as urgent treatment centres. For people requiring hospital care there is a drive for these to be treated through ‘same day emergency care’ without need for an overnight stay where appropriate. It is hoped that by implementing this model that the proportion of acute admissions typically discharged on day of attendance from a fifth to a third. Building on previous successes in improving outcomes for major trauma, stroke and other critical illnesses conditions, new clinical standards will ensure patients with the most serious emergencies get the best possible care. And though our continued partnership with local council’s further action to support people to return home and retain their independence where possible will support reducing delayed hospital discharges.

5.2 The system pathway of care

The six areas referred to in section 3 also support the development of our strategic transformational plans.

5.2.1 Anticipatory Primary care

The development of Primary Care Networks and Local Care Partnerships are key in delivering efficient and effective urgent and emergency care services. Primary care networks build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. As they develop we will work with them to ensure links to all urgent and emergency services and maximise any opportunities to integrate services.

The UTC's are a great example of how can deliver the national mandate and support local people through the integration of services. We will build on this as we develop further services across the system.

5.2.2 Access into Unplanned Health and Care Services

Nationally and locally, it is recognised that there are too many entry points into the unplanned care system. This makes it confusing for people to know where to go when they feel they have an unplanned care need. The vast majority of unplanned care services offer walk in options. People therefore tend to present to the service they are most familiar with, as opposed to presenting at the service that may best meet the person's health and care needs. Health and care professionals equally report understanding the unplanned care landscape is difficult and complex to navigate.

In Leeds, multiple single points of access exist. Some of which are available to the public, some to health and care professionals, and some which are available to both. There is an opportunity to converge all the single points of access to generate a truly single, multi-disciplinary clinical skill mix offer, to both the public and professionals, to give clinical advice and when necessary to book people into the right service within the unplanned care system. This will allow unplanned care to move back into planned care at the earliest opportunity.

The newly commissioned NHS 111 Integrated Urgent Care (IUC) service allows for greater synergies between the urgent (NHS 111) and emergency (999) services which supports the aim of the access work stream as regards to making access to urgent and emergency care more seamless.

Planned and unplanned (emergency 999) Patient Transport Services (PTS) is recognised as a key enabler for the delivery of the access work stream ensuring the needs of patients can be met within various healthcare settings. Robust planned and unplanned transport services will ensure that people are able to access emergency care, present at urgent unplanned appointments and attend planned appointments anywhere within the health and care system.

The development of transport services programme will seek to improve the National Ambulance Response Programme (ARP) targets, create a hybrid service model between emergency and planned transport and improve access and integration between health and care transportation.

5.2.3 Primary and Community Urgent Care

A clear driver in the establishment of UTC's is to standardise the offer the public can expect from unplanned care services including for primary urgent care. People tell us, locally and nationally that there is a confusing mix of services for urgent care. These include walk-in centres, minor injuries units, urgent care centres and A&E's. In addition, numerous General Practices offer differing appointment systems and varied offers of core and extended services.

The recent publication of the *NHS Long Term Plan* (2019)[1] and the NHS Operational Planning and Contracting Guidance 2019/20 (2019)[2] specifies that commissioners should continue to redesign urgent care services outside of A&E, aiming to designate the majority of UTCs by December 2019. The guidance states UTCs should meet the previously published standards and ensure that they operate effectively as part of a network of services including primary care, integrated urgent care, ambulance services and A&E.

The aim of delivering standardised UTC's are to:

- simplify the system and access to services that meet people's needs, making the right choice the easiest choice
- improve people's experience of health and care services
- integrate services across the health and care system
- reduce attendance within Emergency Departments

[1] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2018/12/nhs-operational-planning-and-contracting-guidance.pdf

- reduce conveyance to Emergency Departments
- support effective system flow,
- ensure Emergency Departments have the dedicated resources for higher acuity and specialised services
- support the improvement of the Emergency Care Standard
- achieve a left shift in the delivery of care closer to home
- increase access to diagnostics in the community

A fundamental requirement to achieve a network approach for the UTC's is for the providers to work in strong collaboration with one another at each UTC location, with services to be integrated where required. This strong, positive collaboration approach was implemented at the St Georges Centre UTC development and was a critical factor in the success of the UTC achieving designation status.

Opportunities are presented within the UTC mandate to support the development of 24/7 urgent primary care and ensuring that people receive care as close to their place of residence as possible. This will include the review of how we commission GP Out of Hours service in the future, either at place or ICS level. The review will explore the different elements of the current contract to maximise the future opportunities and economies of scale. These elements are:

- Infrastructure to manage the calls across the 111 regional, sub-regional and local levels
- Delivery of GP Out of Hours service

The review of GP Out of Hours will explore what rapid response may be required to support keeping people at their own home, and by what skill mix of health and care professionals. Both the UTC and GP Out of Hours offer will be further supported and complemented by the evolution of Primary Care Networks and Local Care Partnerships.

As Primary Care Networks and Local Care Partnerships develop and integrate, we will need to be clear regards how they link with the UTC's to develop clear pathways and where appropriate, additional services for their respective populations. This will provide an ideal opportunity to put more formal arrangements in place around integrated urgent primary care.

One of the national ambitions for UTC's is to reduce activity at the Emergency Departments to support the achievement of the 4 hour ECS performance target across the system. It is recognised in Leeds that due to pre-existing urgent care services (MIU's Walk-in-centre) this is not Leeds prime driver for implementation. The main driver for UTC's will be to standardise the service offer to reduce confusion for the public and support the delivery of 24/7 primary care at both a place based and primary care level.

5.2.4 Non-Elective Front Door

Efficient acute hospital flow encompasses quickly, proficiently, and effectively meeting the demand for care at both the front and back ends of the hospital. It involves effective coordination of patient care, moving the patient through pathways safely, to achieve the best possible outcomes. Poorly managed patient flow at hospitals front door can lead to adverse health outcomes, including increased re-admissions, longer length of stays and adverse mortality rates.

The non-elective front door work stream is broken down into the following:

Hospital handovers

The amount of ambulance to hospital handover delays across Leeds will be reduced and the handover process will be improved. The handover of clinical information about the patient from ambulance staff to the hospital is potentially a critical point in a persons unplanned care journey. Any information that isn't passed over effectively could result in sub-optimal patient experience through effecting the actions taken once the person hits hospital.

Attendance Avoidance

- We will reduce the number of attendances at hospital through identifying and supporting schemes across the system which facilitate the shift left and lead to more patients accessing community alternatives for unplanned care episodes.

Admission Avoidance

- Avoidable admissions will be reduced through a number of schemes including:
    - improving access to PCAL for front line staff
    - Improving acute frailty services to ensure patients are assessed treated and supported by Multi-Disciplinary teams in A&E and acute receiving units with people receiving rapid assessment.

    - Concentrating on admission avoidance pathways from care homes – “Analysis suggests that over a third of hospital admissions from care homes are avoidable”. [3]
- We will also implement the recommendations of the NHS clinical standards review for those patients with the most serious illness and injury to ensure they receive the best possible care in the shortest timeframe. This includes patients who come to A&E following a:
    - Stroke,
    - Heart attack
    - Severe asthma attack
    - Major trauma
    - Sepsis.

Same Day Emergency Care (SDEC) and Ambulatory Care

Same Day Emergency Care ensures that people presenting in hospital in an unplanned car with certain conditions can be rapidly assessed, diagnosed and where appropriate and safe to do so, treated without being admitted to a ward. People are then able to go home to their place of residence on the same day. Assessment areas and ambulatory care hubs will be utilised to reduce the number of people with short stay admissions to ensure more are discharged on the same day.

More effective management of patients who attend the hospital who would have previously attended ED and been admitted will support better outcomes for people. For the system, over time, it is assumed that we will be able to reassess the capacity required for non-elective admissions and ultimately reduce non elective demand on the LTHT bed base. This will also support the achievement of ECS target through more appropriate management of patients at the front door and ultimately support the achievement of planned care targets e.g. 18 weeks.

Co-Located UTCs

These will contribute to the improved flow of the hospital ensuring that people who present with an urgent primary care need will be streamed effectively into the UTC to ensure they get the most effective care for their needs. This will mean that the Emergency Department will be freed up to care for those patients with a true emergency need.

[3] https://www.gov.uk/government/news/record-nhs-funding-to-give-patients-a-better-alternative-to-hospital

The UTC will treat most injuries or illnesses that are urgent but not life threatening e.g. sprains and strains, broken bones, minor burns and bites and stings. The co-located UTC will provide an initial assessment and treatment of patients and reduce the need for an admission.

5.2.5 Non-elective care and discharge

Hospital Discharge

The Leeds Health and Care system will work in partnership to ensure discharge is effectively planned from the day of arrival into hospital to ensure people receive the most optimal outcomes for their care. There is currently a disparity in where people are currently discharged to and where would provide the best outcome for their discharge. We aim to ensure that this is addressed with the right choice for the patient also being the easiest choice. In order to improve hospital discharge we will:

- Continue to implement initiatives which help to optimise discharge and make it timelier.
- work to ensure that people get the most efficient pathway through and out of the hospital
- increase the number of patients who are discharged to the most optimal discharge pathway for their care as described in the Newton Europe findings contributing to the left shift in patient care.
- look to improve Length of Stay (LOS), Delayed Transfer of Care (DTOC) and reduce the number of ward moves. We will also look to increase the number of people who are given an estimated date of discharge (EDD) on the day of arrival.
- look to reduce the year round reliance on the medically fit for discharge wards run by villa care ensuring alternatives in the community are identified and available
- Improving discharge processes contributes to all previously outlined system benefits.

5.2.6 Community care and recovery

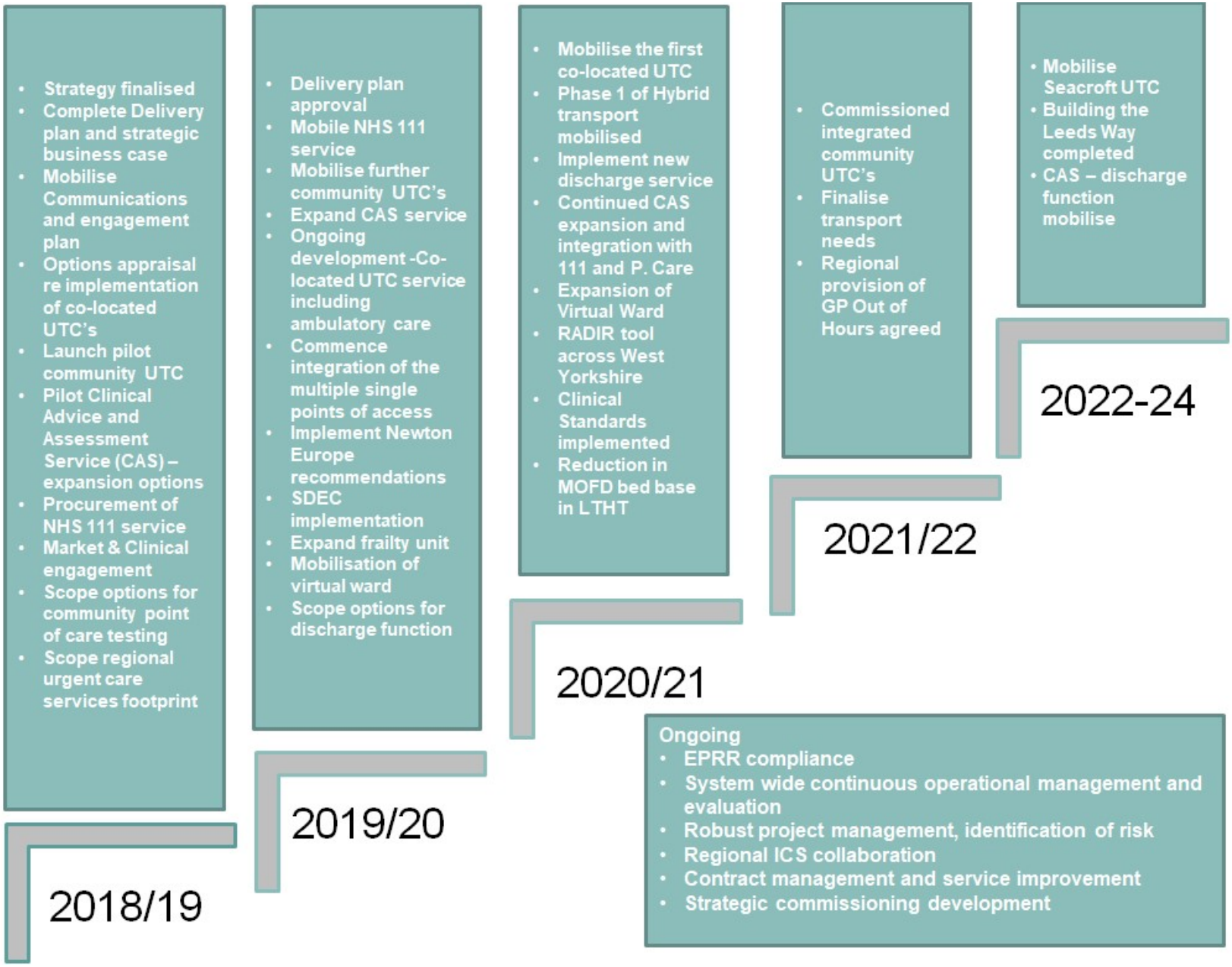
A fundamental aspect to effective discharge from hospital is to ensure that services in the community are able to efficiently support the shift left and get patients back out of hospital as quickly as possible to the most appropriate place for their care.

Discharge not only has to be planned effectively in hospital but also post discharge, to ensure that patients receive the best care and support possible. Effective care in the community can stem the flow of readmissions, decrease future care use and improve long term health outcomes for patients. In order to improve post hospital discharge we will:

- Expand and improve the range of flexible and responsive health and care services to support the left shift
- Ensure more people are being discharged to the most appropriate place for their care as measured by the Newton Europe audit.
- Engage the voluntary and third sector more in effective post hospital care and recovery
- Develop a range of care options and pathways for different levels of required support
- Increase the number of patients going home with reablement
- Use population health management to be proactive in a person's care following discharge from hospital and ensure they get appropriate reviews and follow ups.

Diagram 9 show the strategic milestones for the development and commissioning of the Urgent and Emergency care system in Leeds for the next 5 years.

Diagram 9


2018/19
Strategy finalised
Complete Delivery plan and strategic business case
Mobilise Communications and engagement plan
Options appraisal re implementation of co-located UTC's
Launch pilot community UTC
Pilot Clinical Advice and Assessment Service (CAS) – expansion options
Procurement of NHS 111 service
Market & Clinical engagement
Scope options for community point of care testing
Scope regional urgent care services footprint
2019/20
Delivery plan approval
Mobile NHS 111 service
Mobilise further community UTC's
Expand CAS service
Ongoing development -Co-located UTC service including ambulatory care
Commence integration of the multiple single points of access
Implement Newton Europe recommendations
SDEC implementation
Expand frailty unit
Mobilisation of virtual ward
Scope options for discharge function
2020/21
Mobilise the first co-located UTC
Phase 1 of Hybrid transport mobilised
Implement new discharge service
Continued CAS expansion and integration with 111 and P. Care
Expansion of Virtual Ward
RADIR tool across West Yorkshire
Clinical Standards implemented
Reduction in MOFD bed base in LTHT
2021/22
Commissioned integrated community UTC's
Finalise transport needs
Regional provision of GP Out of Hours agreed
2022-24
Mobilise Seacroft UTC
Building the Leeds Way completed
CAS – discharge function mobilise
Ongoing
EPRR compliance
System wide continuous operational management and evaluation
Robust project management, identification of risk
Regional ICS collaboration
Contract management and service improvement
Strategic commissioning development

7 Conclusion

Through the LSRP the overarching system aim is to demonstrate that we improve the outcomes for our population especially at a time of significant pressure.

As we strive to retain people's health and wellbeing and maintain their independence we know that this will require new ways of working and an aim to shift the provision of care form the acute trust into the community close to peoples home.

Leeds continues to take collaborative and proactive approach to planning for those predictable, unpredictable and longer term challenges that face our health and care system as well as out longer term strategic plans to transform our system.

Our plan seeks to provide a high level of assurance that there is agreed system wide initiatives in place that address both the short and long term priorities within the unplanned health and care services across Leeds.

There are clear lines of accountability and governance and an overall system commitment to work in an integrated way to deliver care and maximise resources.

We will ensure that we have identified measurable objectives in place to demonstrate the impact our changes are having for the people that access our services their families and carers as well as to our system and the people that work within it.

Glossary

CCG	Clinical commissioning Group
DTOC	Delayed Transfer of Care
ED	Emergency Department
ECS	Emergency Care Standard
EDAT	Emergency Duty Assessment Team
EMI	Elderly Mentally Infirm
EPRR	Emergency Preparedness Resilience & Response
HWBB	Health and Wellbeing Board
LCC	Leeds City Council
LHRP	Local Health Resilience Partnership Board
LCH	Leeds Community Healthcare
LSRP	Leeds System Recovery Plan
LSWP	Leeds System Winter Plan
LTHT	Leeds Teaching Hospitals Trust
LYPFT	Leeds & York partnership Foundation Trust
LIDS	Leeds Integrated Discharge Service
SRPG (ORG)	System Resilience Partnership Group
OPEL	Operational Resilience Escalation Level
PEG	Partnership Executive Group
STP	Sustainability and Transformation Plan
SiTREP	Situation Report
SRAB	System Resilience Assurance Board
UHCS	Unplanned Health and Care Strategy
UTC	Urgent Treatment Centre

Appendices

Appendix 1	Leeds System Resilience Governance
Appendix 2	2018/19 Review
Appendix 3	System Resilience Communications Plan
Appendix 4	System Resilience Risk Register