NHS

Devon, Plymouth and Torbay

Report on Winter Pressures 2011-12

NHS Devon
Public Health Directorate
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Contents

Report on Winter Pressures 2011-12

1. Introduction

1.1 This report sets out the approach taken by NHS Devon, Plymouth and Torbay cluster (the cluster) in managing the capacity pressures for the winter period 2011-12. Included within the report is feedback from the winter debrief event held on 17th April 2012, in addition to a review of the actions from 2010-11 and recommendations to improve the position for 2012-13.

2. Background

2.1 Capacity pressures exist throughout the year but it is generally recognised that there are additional demand for health services during the winter period. For planning purposes, the winter period covers the period from 1st November until 31st March.

2.2 Contributory factors that contribute to putting the health system under additional pressure during the winter period include seasonal influenza and respiratory infections, outbreaks of infectious disease (particularly Norovirus), severe cold and icy weather and holiday periods.

2.3 As in 2010-11, planning focused on:

- a 'capacity pressures plan' rather than a 'winter plan', as it has become evident that pressures occur throughout the year and therefore processes to manage these pressures are relevant the whole time
- a locality focus to the tactical response to organisational escalation, to enable immediate action to be taken locally to manage pressures
- a focus on assurance that organisations have appropriate plans in place

3. Winter 2011-12

3.1 The NHS Devon Capacity Pressures Plan was submitted to the Strategic Health Authority (SHA) on 21st October 2011 who approved it following a face to face assurance review on 9th November 2011.

3.2 The plan was tested and validated during the table top Exercise PASCAL 2011 on 10th October 2011.

3.3 In 2011-12 plan reflected the structural changes within the NHS, notably the cluster arrangements for NHS Devon, Plymouth and Torbay. One cluster plan was developed and Dr Virginia Pearson was the nominated executive lead for capacity pressures preparedness for the cluster.

3.4 An assurance process was undertaken, based on the assurances required by the South West Strategic Health Authority, and incorporating actions identified

in the de-brief of the 2010-11 plan. Each provider organisation across the cluster was asked to respond to a relevant subset of the Strategic Health Authority assurance questions and to assess their preparedness against the criteria. Any self-assessment scores that equated to an amber or red RAG, (red, amber green) rating required time-limited actions to be identified to improve the organisation's preparedness towards green. All providers took part in the assurance process, as did the four localities. When the plan was submitted it had a green status of being 'very well prepared.'

3.5 Assurance was sought from all organisations at regular intervals with progress against action plans monitored. For the purposes of assessing the overall cluster preparedness, the lowest RAG rating against each criterion was used as the cluster assurance score.

Data Collection

3.6 The 2010-11 debrief event had highlighted some duplication and inconsistency with data capture. A revised data sheet that monitored activity and pressures within the system was agreed with the providers and used throughout the 2011-12 winter period.

3.7 These data were collated and sent to all localities daily. There was an increase in consistency with the data returns for the winter period, with more providers regularly providing completed timely data.

Assurance

3.8 As in 2010-11 tactical meetings between the localities and local providers were held by teleconference as required. These meetings promoted local solutions to capacity pressures.

3.9 Cluster wide community capacity pressures strategy group teleconferences were also convened as required and chaired by Dr Virginia Pearson. These meetings were attended by representatives of wider healthcare providers and looked to solutions across the cluster geography.

3.10 The Strategic Health Authority required weekly exception reports from the cluster.

4. How Winter Unfolded

4.1 At the beginning of winter only NDDH reported a green status, Plymouth reported amber and both South Devon and RD&E reported red.

4.2 All acutes recorded a black status during the winter period.

4.3 RD&E reported its first black only a couple of weeks into winter on 17th November 2011. They remained red and black for prolonged periods, culminating in a very black status on 5th January 2012 when a major incident was called. They remained on black from 29th December 2011 until the official last day of winter on 31st March 2012 when they were still at black status.

4.4 Northern Devon Healthcare Trust recorded its first black status on 14th December 2011. They showed pressure throughout the winter period and ended with an amber status.

4.5 South Devon Healthcare Trust recorded its first black status on 29th February 2012. Of all of the acutes, South Devon recorded the most days with a green status and were green at the end of winter.

4.6 Plymouth recorded its first black status on 4th January 2012. They showed some pressures during January and February and ended winter with an amber status.

4.7 The winter of 2011-12 was much milder than the previous winters with a mean temperature of 4.5 degree C with no significant periods of cold weather, snow or ice across the south west.

4.8 There was no significant seasonal influenza throughout the winter. Weekly recordings showed that influenza did not ever exceed the expected seasonal rates.

Capacity Pressures 5th January 2012

4.9 On the 5th January, The Royal Devon and Exeter Hospital became under extreme pressure and felt unable to accept the current level of emergency admissions. A strategic meeting chaired by Dr Virginia Pearson was called and it was agreed that SWAST would flex the catchment areas for Plymouth, South Devon and North Devon and divert patients to other providers were it was practical and safe to do so. This led to a number of patients being diverted to other hospitals. Plymouth had to withdraw from accepting patients once they too experienced extreme pressures later that day. The divert was stood down at 1000hrs on the 6th January 2012. An independent multi-agency investigation has been conducted in relation to this incident.

Accident and Emergency Target Breaches

4.10 One of the targets for Accident and Emergency departments is the time that patients wait between arrival and being discharged, admitted or transferred. It is expected that 95% of patients receive this care within four hours. All of the acute providers performed below the 95% target at times during the winter period, although South Devon appeared to have breached on fewer occasions than the other acute hospitals.

Figure 1: RD& E Accident and Emergency Four Hour Performance

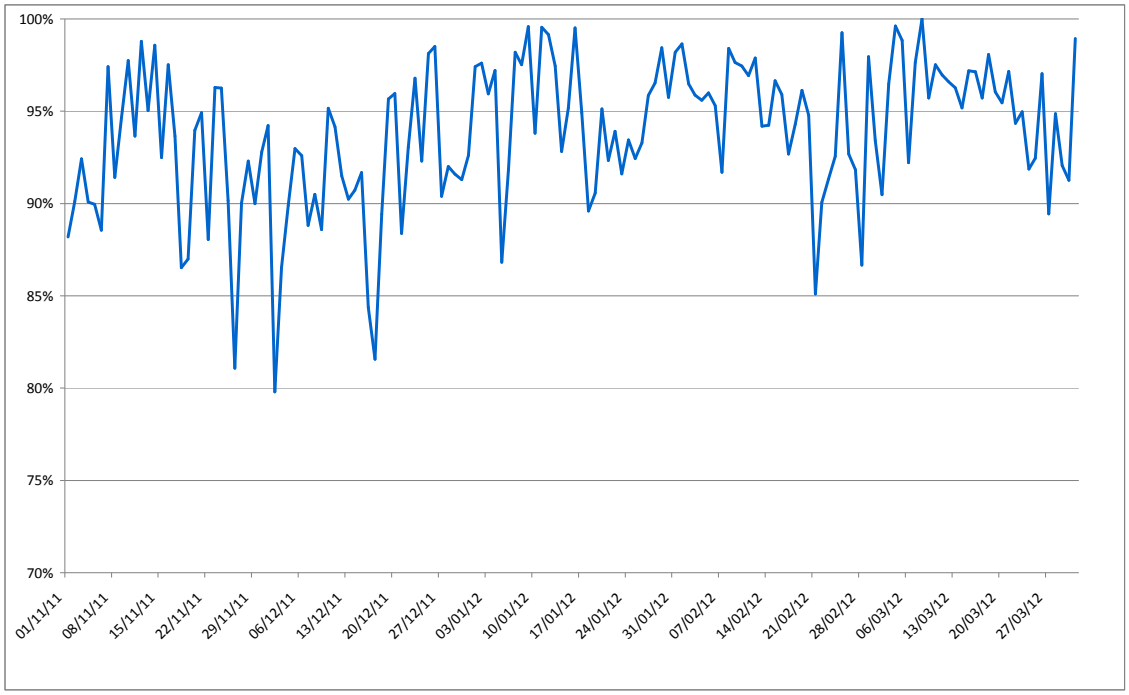


Figure 2: NDDH Accident and Emergency Four Hour Performance

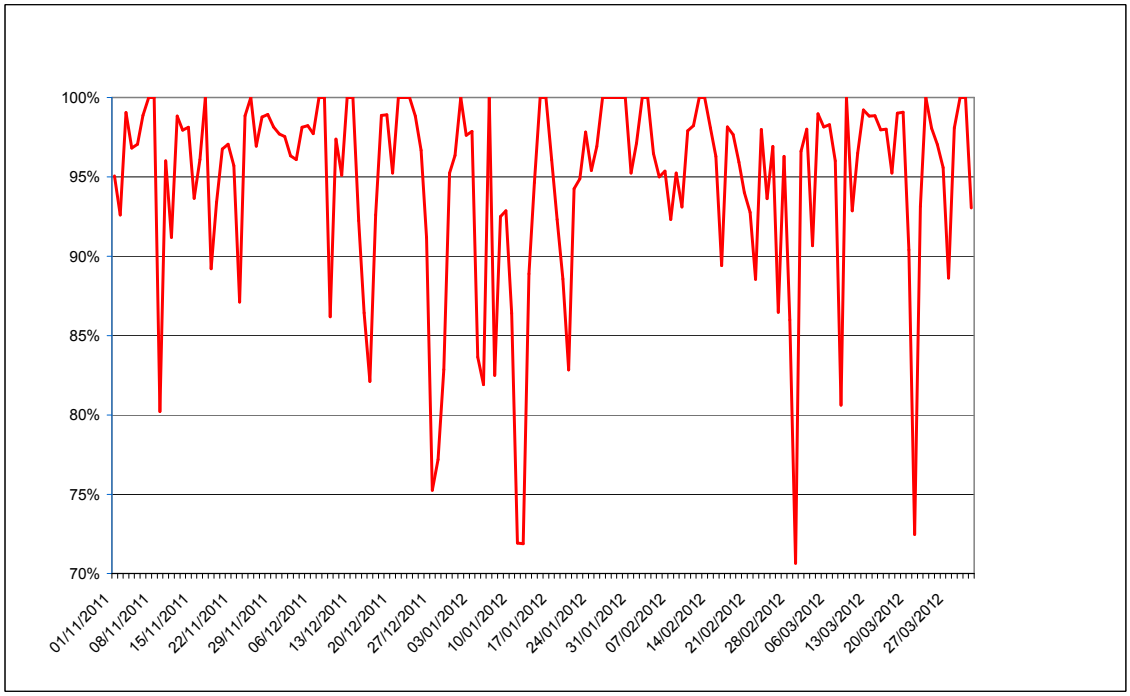


Figure 3: SDHCT Accident and Emergency Four Hour Performance

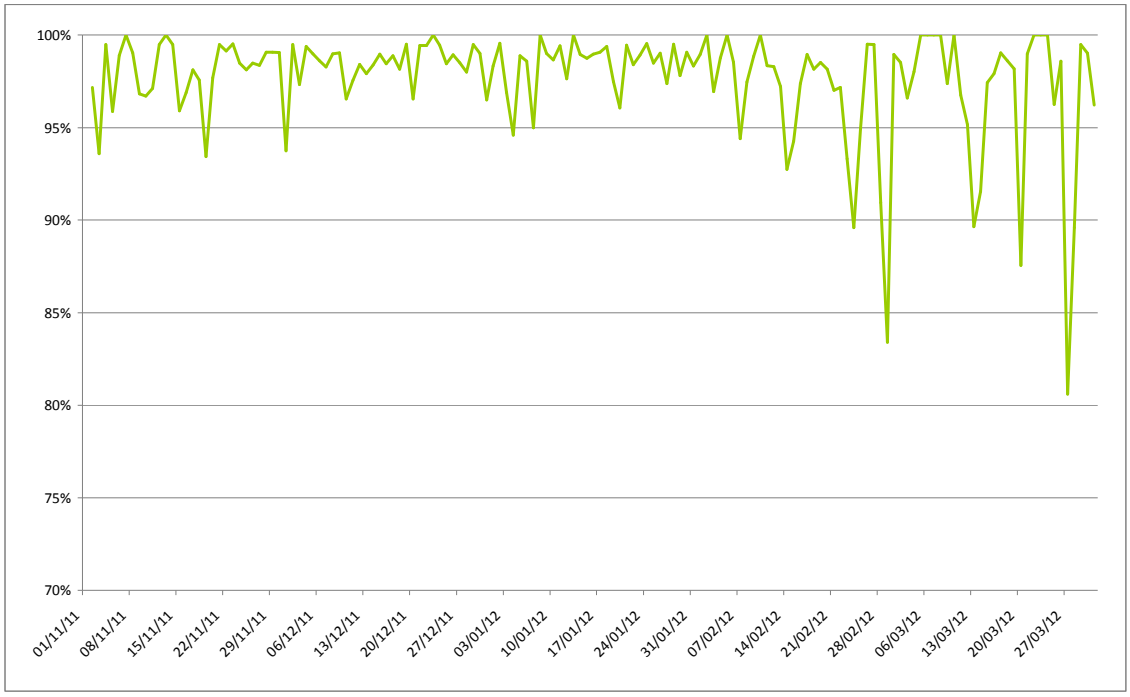
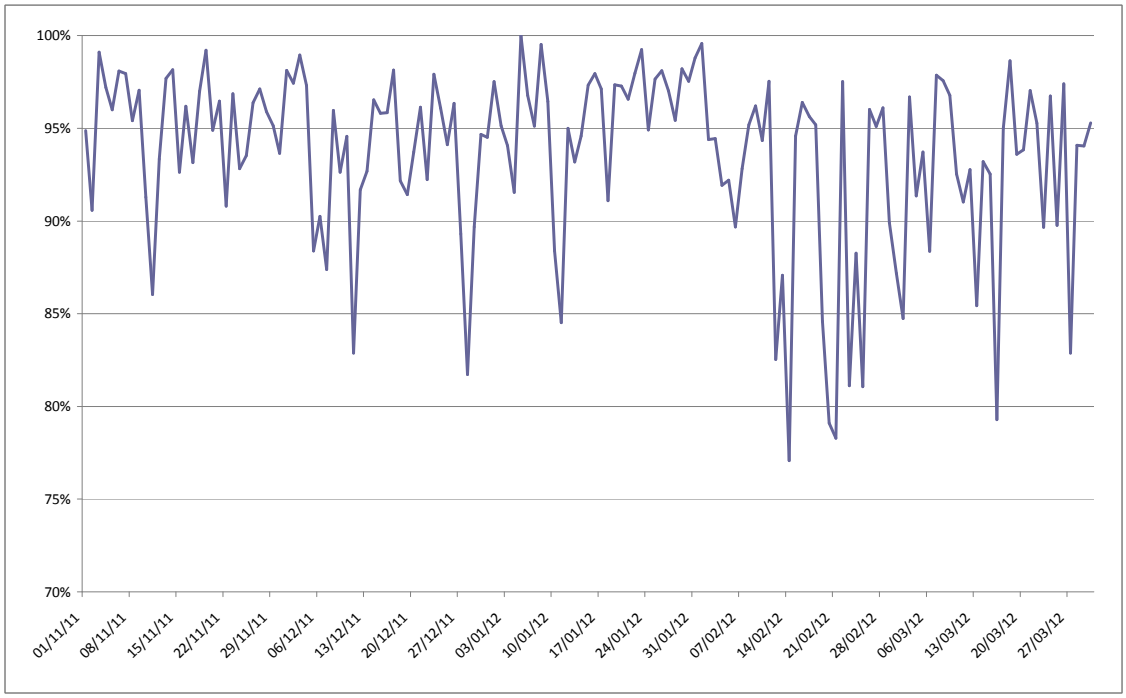


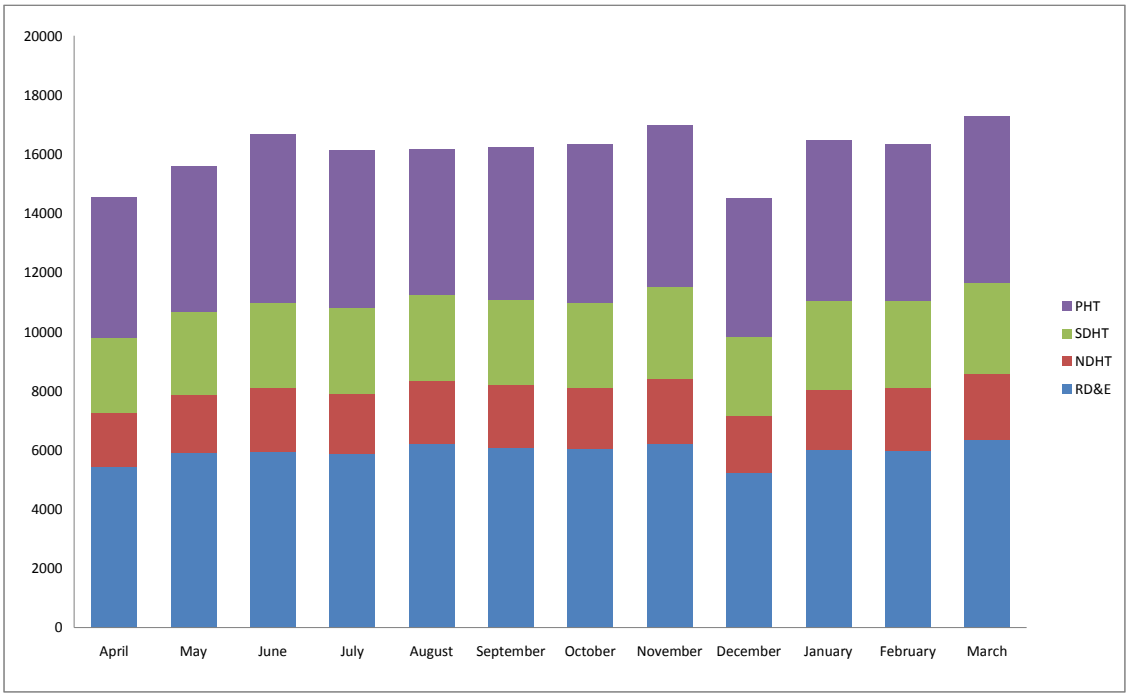
Figure 4: Plymouth Accident & Emergency Four Hour Performance



Elective Admissions

4.11 Elective activity refers to activity that is planned rather than emergency treatment. One way of helping to reduce capacity pressure is to manage the flow of elective activity, reducing planned activity at known busy periods. Elective activity peaked during March 2012 with the lowest monthly figure being in December 2011. Figure 5 shows the elective admissions by month.

Figure 5: Elective Admissions by Month, 2011-12

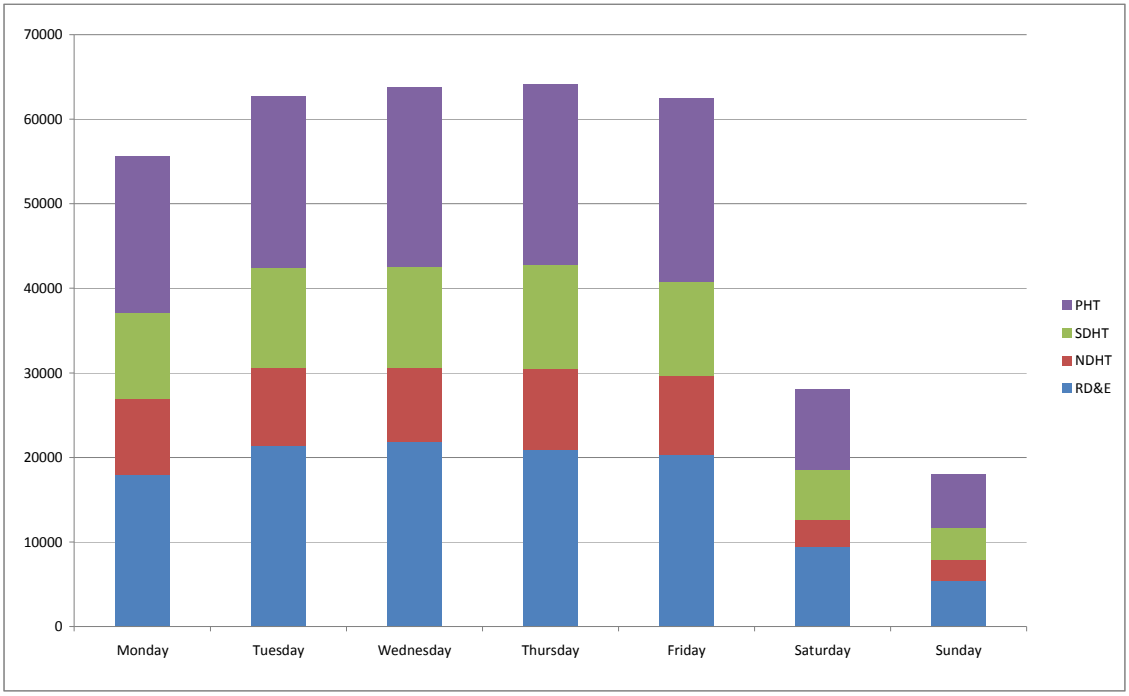


4.12 Further analysis of the elective data at in-patient and day case level shows a move towards non bed based interventions over the Christmas period and winter months in general The months vary by a maximum of 30% with December being the lowest, but April/May are also relatively low and this may reflect where holidays fall. Overall, whilst there is some evidence of profiling of type of elective activity, there is minimal difference between the half of year which includes winter and the half which does not. Cancellations peaked in January, which has consistently been the peak month for cancellations in the last three years.

Discharges by Day of the Week

4.13 The winter reports of 2009-10 and 2010-11 highlighted a pattern of discharges across Devon, and this pattern has been repeated during the winter of 2011-12. The number of discharges that happen during the week are fairly consistent from Tuesday to Friday inclusive. At the weekend, much lower numbers of discharges are seen with Sunday being the lowest day for number of discharges. Some providers acknowledged this and put in place processes to increase the number of discharges occurring at the weekend.

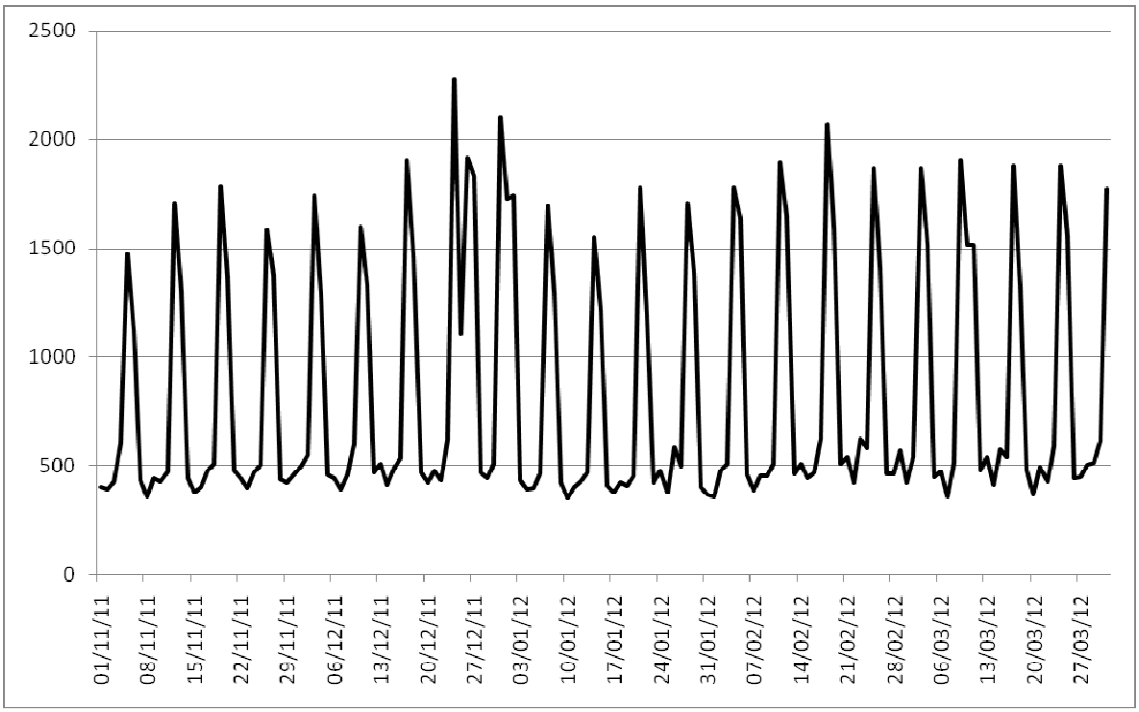
Figure 6: Average Number of Discharges by Day of Week, 2011-12 by Acute Provider.



Devon Doctors Ltd Activity

4.14 The Primary Care Out of Hours service is provided by Devon Doctors Ltd. Information is provided by them and an expected pattern is that there is a peak in demand coinciding with the closure of GP practices at weekends. There is a lower and steady number of calls during the week. Figure 7 shows this pattern but also highlights the additional demand over public holidays. The peak over Christmas was significantly lower than it had been in 2010-11.

Figure 7: Primary Care Out of Hours Calls



4.15 During capacity pressures when there are limited beds available it becomes necessary to cancel elective surgery. This is not ideal for the patients and adds pressure to the referral to treatment targets. During high levels of pressures at times all but lifesaving and urgent cancer surgery were cancelled in some parts of the cluster. It was also reported that some patients who had been rescheduled were having a second cancellation.

4.16 One of the main onward destinations following an acute hospital spell, particularly for the elderly, is to a community hospital. There have been many initiatives aimed at improving the flow of patients across the acute and community hospital interface. One of the recurring themes is the availability of beds in the nearest community hospital, with patients often having to be accommodated at an 'out of area' hospital. This is likely to have a detrimental effect on discharge planning and is not ideal for the family and visitors who are very often elderly themselves.

4.17 There was higher demand compared to availability in specific hospitals, including Whipton and Crediton and there was spare availability in some of the other hospitals.

4.18 Devon Partnership Trust provided liaison to the community hospitals which had been highlighted as a need over the previous winters. Although at times there were extreme pressures on bed capacity, particularly in the Exeter area, there was only one five day period at the beginning of February when there were no beds available.

SWAST

4.18 One of the indicators collected throughout the winter period is the number of ambulance handover delays. There were some spikes in delayed handovers when the acute hospitals unable to receive the incoming patients. This was

most notable at South Devon Healthcare Trust who had several spikes of delayed handovers of more than 30 minutes.

5. Predictable Winter Pressures

Seasonal Influenza

5.1 Across England there is a peak in the number of people infected with seasonal influenza that usually occurs between December and March each year. The rates of seasonal influenza are recorded weekly by the Health Protection Agency. Once the rates rise above the background level of 30 consultations per 100,000 there is typically a wave pattern of a rise and return to normal levels over a period of approximately 16 weeks.

5.2 The GP influenza-like illness consultation rates for 2011-12 were the lowest on record in England and Wales. Levels did not reach early warning thresholds throughout the winter season. There were some outbreaks of respiratory infections, mainly among the young and elderly contributing pressures to both primary and secondary care but the general picture was of a flu free winter.

5.3 The seasonal influenza vaccination campaign 2011-12 included the component for influenza A (H3N2) and A(H1N1)pdm09. In addition to the clinical groups and people over the age of 65, pregnant women were again included in the identified cohort. There was a small increase in the percentage of over 65s who received the seasonal influenza immunisation, but there was a decrease in the percentage of pregnant women who received the seasonal influenza immunisation, with the largest decrease being in the group of pregnant women who were not already in a clinical 'at risk' group. Leaflets and posters were distributed to encourage the uptake among pregnant women, which had been below target in 2010-11. Despite including the importance of vaccine uptake among pregnant women in the annual uptake and linking with the maternity providers the uptake of vaccine in this group was relatively low.

5.4 Vaccine supply was consistent with many patients getting their vaccination early in the season. There was good accurate data available back from the practices on the vaccine uptake rates.

5.5 The dominant subtype of influenza was A(H3N2) with some B virus also circulating. Few A(H1N1)pdm09 were detected.

5.6 There are currently changes in the circulating lineage of B viruses and some of the A(H3N2) strains to those previously detected and incorporated in the northern hemisphere vaccine. The vaccine being made available for 2012-13 will be adapted as a response to this.

Figure 8: Uptake of Seasonal Influenza Immunisation by Practice in Devon, Over 65 years, 2011-12

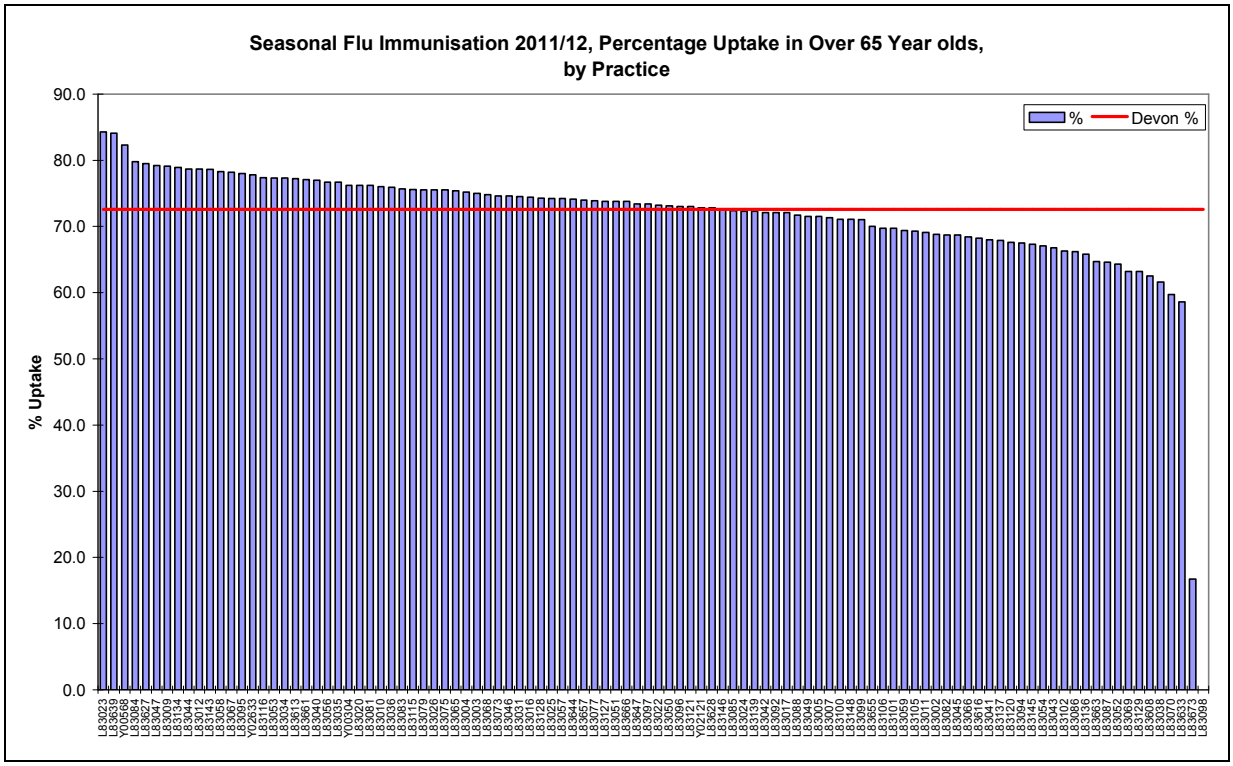
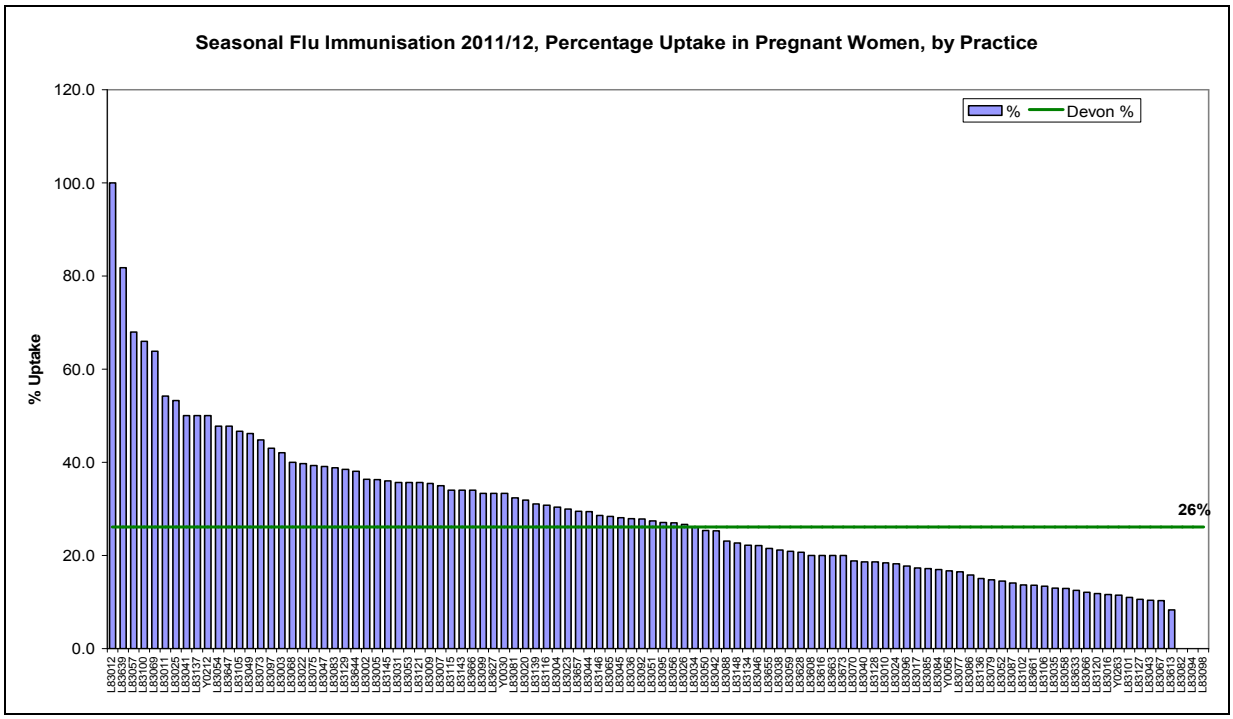


Figure 9: Uptake of Seasonal Influenza Immunisation by Practice in Devon, Pregnant Women, 2010-11



5.7 There was some variation across the South West in the proportion of employed staff having had an influenza immunisation. For the third year

running this was heavily promoted as part of staff responsibility to keep themselves well and thus prevent sickness absence during the time of most intense pressure for the NHS (Table 1). The uptake for 2011-12 was higher than previous years.

Table 1: Health Care Workers Seasonal Influenza Vaccination Rates for 2011-12

Employer Trust	%
NHS Devon	35.1
Royal Devon and Exeter	32.4
North Devon Healthcare	35.1
Devon Partnership Trust	20.6
Torbay Care Trust	45.6
South Devon Healthcare Trust	49.6
NHS Plymouth	28.2
Plymouth Hospitals Trust	40.3

Weather

5.8 Although considered a predictable event there was no significant periods of snow and ice across the south west. The winter of 2011-12 was much milder than the three previous winters. There was one short period of cold weather at the end of January but there was below average rainfall throughout the winter and the mild weather lasted until the end of the winter period.

Norovirus

5.9 Norovirus is highly infectious, causing gastrointestinal symptoms including vomiting and diarrhoea. It is often known as winter vomiting disease because it is more common in the winter season. It can spread quickly and whilst it is generally mild, lasting only a couple of days, it can cause significant difficulties when an outbreak occurs in a hospital. Wards affected with norovirus remain closed to new admissions for 72 hours until the outbreak has ended and the environment has been cleaned. Patients in a ward which is affected cannot be moved to other care settings, delaying investigations, treatment and discharge.

5.10 The pattern of norovirus saw several spikes rather than long periods. This avoided long periods of bed closures that had been seen in previous years. The overall rates for 2010-11 were lower than previous years. There was a small peak in February 2012 which was later than had been seen in previous years.

5.11 There was effective communications around norovirus outbreaks with good planning and consistent infection control procedures across the acute trusts.

5.12 The incidence of norovirus within the community did not act as an early warning for the hospitals.

Table 2: Norovirus Outbreaks: Reported on the Hospital Norovirus Outbreak Reporting Tool

	NOV	DEC	JAN 2012	FEB	MARCH
North Devon	3	5	1	9	5
Plymouth	1	4	1	0	0
Royal Devon & Exeter	3	1	0	6	0
South Devon	0	0	0	0	0

Holiday Period

5.13 The Christmas period for 2012 included a four day weekend, and whilst most elective interventions are not booked for this period, there are still demands for emergency care. During this time there is also limited access to primary care including GP surgeries and pharmacies.

Adult and Community Services Funding

5.14 Localities were asked to manage additional pressures and were given access to the national 'winter' funding in Devon, which they could use to ease capacity pressures within their localities. The early reports from the acuity report indicate that there were fewer delays in the system due to awaiting funding decisions.

6. Winter Debrief and Learning Event

6.1 A winter debrief learning event was held on 17th April 2012 with presentations from:

- Royal Devon and Exeter NHS Foundation Trust
- Northern Devon Healthcare NHS Trust
- Devon Partnership NHS Trust
- Devon County Council
- Plymouth Hospitals NHS Trust
- South Devon Healthcare NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- Torbay & Southern Devon Health and Care NHS Trust
- Devon Doctors Ltd

- Plymouth Community Healthcare
- Cluster locality directors

6.2 These presentations reflected on some of the pressures experienced during the winter and shared some examples of good practice. Some common themes emerged from the presentations.

- capacity pressures were extremely high all year around. On the day of the debrief pressures remained extremely high
- the very low influenza rates and lack of adverse weather conditions was beneficial, but did not make the pressures feel any less intense
- the GPs were more involved with the capacity pressures and it was felt that they were holding more risk within the community which had helped to reduce some admissions
- there was good community resilience with localities showing benefits from reablement funding
- daily tactical meetings at locality level had worked well, with strategic co-ordination across the cluster occurring as required
- there was some good support offered by the partnership trust in relation to older people with mental health needs
- some decisions had been taken 'off plan'
- additional shifts from Devon Doctors Ltd had worked well in managing demand
- discharge planning across the localities had worked better than in previous years
- one of the main themes from the debrief event was the use of the 'black' status. Some of the acutes spent long periods with a black status and it did not seem sensitive enough to describe the pressures being felt
- all healthcare providers were pulling from the same agency/bank pool and whilst many staff worked additional shifts to cover capacity pressures this did not have robust long term resilience
- organisations working together and staff supporting one another
- staff commitment to keeping systems working
- innovation within localities to maximise capacity
- escalation beds funded and opened
- increased day surgery capacity

Update from 2011 Debrief Event

6.3 The recommendations from the debrief event were reviewed to ensure that all of the recommendations had been completed.

6.4 The recommendation to profile electives was made for 2009-10 winter. It has not yet been achieved but remains a recommendation for 2012-13.

6.5 Many of the recommendations were not truly tested due to the lack of seasonal influenza, and cold weather although progress had been made in preparedness for these events.

7. Recommendations

7.1 Whilst progress was made on many of the recommendations from last year, some are repeated again for this year to further improve capacity pressure preparedness and management, with additional recommendations coming out of the debrief event.

- To agree common criteria for alert levels and actions to be taken at the different alert levels, particularly the use of the black status so that the wider healthcare community can have a better understanding of the specific pressures, e.g. infection, capacity, staffing
- For healthcare providers to work together re bank/agency staff needs, including the use of block contracts, and to be flexible about staffing arrangements.
- To review the service provision that is available at weekends, public holidays and out of hours, in all areas of health and social care.
- To profile elective admissions to help manage capacity pressures over predictable periods of higher demand, including public holidays.
- To plan for predicable events, including Mondays, public holidays, seasonal influenza, cold weather, norovirus.
- To improve the uptake of seasonal influenza vaccination of at risk groups by Primary and community care services, and to reduce the variation between practices.
- To increase the uptake of seasonal influenza immunisation by NHS staff.
- To manage discharges more effectively over the weekends.
- To develop work with GPs and other community healthcare staff to support them managing risk in the community.
- To profile the demands by community hospital to assess whether the capacity is best placed.

8. Action Required

8.1 To receive the report.

Dr Virginia Pearson
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www.hpa.org accessed 17th July 2012