Milton Keynes University Hospital NHS Foundation Trust

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Winter Planning at MKUH

Name of Scrutiny Committee	**Health and Adult Social Care**
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Executive summary

Winter planning is an annual challenge in the NHS as the shape of healthcare demand varies seasonally, on the background of continuous growth. In 2020/21, there are very specific challenges given that we are in the throes of the COVID-19 pandemic. As well as the direct impact of this disease on the people of Milton Keynes, we need to mitigate the potential harm being done to people through impaired access to other forms of healthcare. Given the backlogs which have built up in the health system, we need to avoid further reductions in routine activity where feasible.

The paper describes: the background to winter pressures in the NHS (driven by impaired patient flow to a greater extent than activity numbers); some of the important contextual factors relating to COVID-19; and, the current 'backlog' position at MKUH (based on figures as at July 2020). Finally, it articulates some of the key strands of ongoing work to prepare for winter.

This paper is written from the MKUH perspective, but we recognise that we work as part of a wider system, and that collaboration will be vital for the second part of 2020/21, as it has been over the first 6 months. If members have detailed questions arising from this paper, please do feel free to email the author in advance such that data can be reviewed, and accurate answers provided at committee.

*Several terms used in this paper (indicated by an asterisk *) are described in the glossary table.*

Background

Winter is always a challenging time for acute hospitals with particular pressure on capacity in terms of the bed base and staffing. The number of patients presenting to the Emergency Department does not necessarily increase over winter but the acuity (level of sickness) of patients tends to rise, as does the need for admission (as opposed to assessment and same day discharge). The length of time that patients then spend in a hospital bed may increase in winter both on account of acuity and pressures on other services downstream – for example community support and placements. Challenges in winter – whilst they may manifest as crowded Emergency Departments and queues in corridors – typically reflect problems with the *flow* of patients through and out of the hospital, rather than sheer numbers.

Winter pressures are typically a consequence of adults being admitted to hospital on an unplanned basis under medical specialties. Unplanned surgery and obstetrics tend to have relatively constant activity levels across the year. An exception can be trauma surgery where – in ordinary times – ice and snow can lead to a significant increase in some injuries, most notably hip fracture. There are peaks in paediatric activity (sometimes associated with return to school following breaks in the autumn and winter) but these peaks are usually contained within paediatrics rather than impacting upon the operation of the wider hospital.

The hospital routinely monitors a range of metrics which can be helpful when considering winter pressures. These include: the number of Emergency Department attendances; the number of emergency admissions; average length of stay; the number of 'stranded' patients (length of stay over 7 days); and, the number of 'super-stranded' patients (length of stay over 21 days). There are also various process measures reflecting activity in the Emergency Department which can be relevant: proportion of patients attending who are seen and admitted or discharged within 4 hours; and, delays in ambulance handovers.

In order to manage winter pressures, the hospital often needs to open additional beds. This leads to challenges both in relation to physical assets and staffing.

Context for Winter 2020/21

As we head towards Winter 2020/21, there are clearly several variables which arise on account of the COVID-19 pandemic and its management. It is extremely difficult to predict the impact of each of these variables in isolation, and even more so collectively. These variables – compared to 'normal years' – include:

1. The actual level of COVID-19 in the community over the months ahead and the specific groups of people that it impacts.
2. The availability of timely testing in order to ensure that we have an accurate understanding of the actual level of COVID-19 (symptomatic and asymptomatic) in the hospital and the wider community.

3. The impact of influenza and other infectious diseases (for example, norovirus) which routinely peak in winter months – there is always variability here due to viral strains, the weather and other factors but this year, the impact of wider measures reducing personal contact may be significant.
4. The psychological impact of COVID-19 on the population appears to have been significant. At the extreme end, we seem to be seeing more presentations through our Emergency Department of self-harm and acute psychiatric disturbance. Such cases lead to a real management challenge for MKUH, CNWL and MK Council staff, and have a disproportionate impact in terms of resource usage.
5. Staff availability. Our staff have had a challenging year and, in many cases, will not have had the opportunity to 'rest and recharge'. Our staff often have children for whom routine educational and childcare provision has become less reliable. They may also have other dependants and carer responsibilities. The impact of this over winter, and in particular school holidays, is difficult to predict.
6. Other resources – which we usually take for granted – may become critical limiting factors for our capacity this winter compared with others. These include, for example, supplies of PPE and piped oxygen.

The baseline assumption – given the variable menu of societal restrictions now available and evolving systems for test, track and trace – is that second and subsequent waves of hospitalisation due to COVID-19 will be 'less tall but more prolonged' than the first wave experienced in March to June.

It is important to note that the NHS has been through an extraordinary six months: whilst the focus has been on the pandemic itself and the direct harm done by COVID-19, there has been a profound impact upon the provision of 'routine care' over this period. Even whilst the actual level of COVID-19 is low in the community, infection control precautions (PPE and social distancing) and a testing regime which is not as agile as we might wish conspire to reduce efficiency and throughput. Reduced efficiency and throughput would be a concern in normal times, doubly so when there is a significant backlog of unmet need.

The NHS is rightly under pressure to maintain and increase the provision of routine services (for example outpatient appointments and diagnostics) and planned care (for example, operations), whilst simultaneously managing winter peaks in emergency demand.

The Current Position

As we move towards winter, it is helpful to understand our current position in relation to several key aspects:

1. Cancer Care
2. Elective (Planned Care) Performance
3. Physical Capacity
4. Staffing Capacity

Cancer Care

It is important to note that the hospital only becomes aware of a patient with possible cancer when the patient is referred to us with symptoms by their GP or identified through a cancer screening programme. Cancer screening programmes were stood down during the height of COVID-19 (we were early to reinstate them in MK), and GP attendances and referrals fell dramatically. Once referred or identified, some of the diagnostic tests and treatments which we might ordinarily use were not available (for example, non-emergency endoscopic examination) or were judged inappropriate due to COVID related risks (for example, undergoing a major operation or commencing some types of chemotherapy).

Throughout the peak of the pandemic, we clinically reviewed all potential cancer referrals that we received in order that markers of higher risk could be identified, and care prioritised accordingly. Key performance metrics deteriorated a little as per the table below:

Metric	**Target**	**2019/20**	**Apr – Jun**
2WW*	93%	92.1%	86.4%
62 day*	85%	82.2%	74.4%

At the time of writing, there are 39 patients waiting over 62 days from referral to their first cancer treatment. Some of these patients are 'shared' with tertiary centres. We hope to reduce this number to zero by the end of November.

Elective (Planned Care) Performance

Due to a significant reduction in our ability to carry out planned activity (for example outpatients and diagnostics), performance metrics declined despite reduced referrals into our services. Changes were made where appropriate, such as a switch to radiology-based investigations and away from endoscopy for the evaluation of some serious gastrointestinal symptoms.

All areas have seen substantial recovery in activity over the summer although improvement in performance metrics often lags behind an upturn in activity, particularly in the presence of a growing waiting list. Key performance metrics deteriorated markedly as per the table below:

Metric	Target	2019/20	July	Comment
GP Referrals	n/a	Circa 6,500 pcm	3,689	Trough of 1,500
RTT*	92%	83.9%	42%	
52WW*	0	0 at March 2020	175	
Diagnostics < weeks	99%		83.3%	Trough of 53%
Planned admissions	n/a	Circa 2,700 pcm	1,236	Trough below 500

These changes reflect national trends: 2 million people have waited over 18 weeks for admission to hospital for a procedure, and 83,000 people in England have been waiting for over a year. There are national expectations around the pace and extent of recovery in relation to activity – outpatients, diagnostics and procedures – typically looking to activity levels at 90-100% of last year's baseline by November. Plans are in place across all services to achieve this level of recovery in activity levels. However, performance in terms of RTT and long waits will take a much longer period to recover.

Physical Capacity

We are in the fortunate position of having some vacant physical capacity at the hospital at present. This is largely due to the opening of the cancer centre as the COVID pandemic began. In addition, a marked reduction in the number of super-stranded patients occurred in the Spring in large part thanks to the efforts of families and partner organisations (MKC, CNWL and the care home sector) in providing suitable alternative environments for patients to free up capacity in hospital.

Metric	Late 2019/20	July
Super-stranded*	Circa 115	30
DTOC*	Circa 40	8

In the Emergency Department, attendances are now approximately 10-15% down on usual levels, and the ED 4-hour performance has been excellent (>98% in recent months).

Staffing Capacity

The Trust's overall staff vacancy rate is below 10%. Expenditure on agency staff in recent months has been less than half of that a year ago. Both of these elements are positive but must be balanced against a degree of uncertainty caused by COVID (workplace absence, childcare and availability of agency staff).

Key Elements of MKUH's Winter Plan

There are a number of key strands to the hospital's winter plan as described in the following section.

Planned care

- Maintenance of elective capacity wherever possible – effective 'zoning' of the hospital for patients who have had a negative COVID test and are having planned procedures ('green' pathway).
- A particular focus on maintaining dedicated capacity for inpatient orthopaedic procedures and day surgery.
- Collaboration with local independent providers around additional planned care capacity under NHS contract.
- Continuation of virtual contact (as opposed to face-to-face) where feasible and appropriate.

Infection Prevention and Control

- Flu vaccination – 100% of frontline staff and signposting / facilitation of vaccination for high risk patient groups.
- COVID vaccination – readiness to vaccinate frontline staff as soon as a vaccine is licenced and available.
- Focus on infection precautions (universal and COVID-specific), including PPE, modified visiting and social distancing.
- Prioritised access for hospital staff to COVID testing (to maintain the workforce and minimise potential for transmission in the hospital).
- Further improvements in the TAT (turnaround time) for COVID tests.
- Improvements to the intensive care environment (completion November 2020).

Urgent and Emergency Care

- Clear pathways for patients considered likely to have COVID infection and those who do not (pending the results of routine COVID test on admission).

- Structural modifications to the Emergency Department and selected ward areas such that these pathways can be flexed in size as the community prevalence of COVID (and illnesses which mimic COVID) varies.
- Escalation capacity (beds) including appropriate staffing plan: agreed prioritised list of where additional capacity can be accommodated (revised from previous versions in light of COVID). Identification of off-site storage facilities in order to facilitate clinical use of this physical space.
- Revision and agreement of protocols for use in the event of full capacity / corridor care, such that these can be implemented (as a last resort) with a sharp focus upon patient safety.
- Optimisation of 'same day emergency care' and alternatives to hospital admission for medical and surgical patients.
- Adoption of national programmes including '111-first' such that unscheduled attendances at the Emergency Department are minimised and demand can be managed (facilitating social distancing in an otherwise busy environment).
- Specific escalation plan for paediatrics to ensure capacity and maintain a separate pathway for planned care.
- Ongoing work with partner organisations to ensure that flow from the hospital continues and to identify additional capacity in community and care home settings.

<u>Other</u>

- Monitoring of various key metrics including COVID rates (hospital and community), PPE stock, staff absence and oxygen usage.
- Incorporation of COVID-related prompts / reminders / care plans into our electronic patient record.
- Maintenance of appropriate incident management structure (gold and silver command)

Dr Ian Reckless

17 September 2020

Glossary

Several terms used in this paper (indicated by an asterisk *) are described in the table below.

Term	Description
2WW	A patient should be seen by a specialist within two weeks of referral from a GP with suspected cancer.
62 day wait	A patient should begin their first treatment for cancer within 62 days of referral with suspected cancer.
RTT	'Referral to treatment' – patients should have commenced a first definitive treatment (or been discharged from the hospital service) within 18 weeks of referral.
52WW	No patient should wait for over 52 weeks to commence a first definitive treatment (or be discharged from the hospital service) following referral.
Super-stranded	An adult patient in an acute hospital bed for over 21 days (irrespective of clinical circumstances).
DTOC	An adult patient remains in an NHS-funded acute bed when ready to go home or to move to a non-acute setting. An individual DTOC is attributed to health or social care.