JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Date:	**Monday, 26 November 2018**	Time	**10.00am**
Venue	**Meeting Point House, Southwater Square, Telford, TF3 4HS**		

Enquiries Regarding this Agenda:		
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Committee Membership:	**Telford & Wrekin**	**Shropshire**
	Councillor Andy Burford (TWC Health Scrutiny Chair)	Councillor Karen Calder (SC Health Scrutiny Chair)
	Councillor Stephen Burrell	Councillor Heather Kidd
	Councillor Rob Sloan	Councillor Madge Shineton
	Mrs Hilary Knight (Co-optee)	Mr David Beechey (Co-optee)
	Ms Carolyn Henniker (Co-optee)	Mr Ian Hulme (Co-optee)
	Mr Dag Saunders (Co-optee)	Mr Paul Cronin (Co-optee)

AGENDA

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes** — Appendix **A**
   To confirm the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 19 September 2018.

4. **Overnight Closure of the Emergency Department at the Princess Royal Hospital**

5. **Proposals to Mitigate the Effect of Winter Pressures on NHS Services** — Appendix **B**

6. **Shrewsbury and Telford Hospital NHS Trust - Enforcement Action Taken by CQC and response taken by SaTH – Maternity Services**

7. **Shrewsbury and Telford Hospital NHS Trust - Enforcement Action Taken by CQC and response taken by SaTH – A & E**

8. **Proposed Next Steps for Joint Health Overview and Scrutiny Committee**

9. **Co- Chairs' Update**

A

SHROPSHIRE COUNCIL,TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on Wednesday 19 September 2018 2.00 pm – 5.10 pm in the Shrewsbury Room, Shirehall, Shrewsbury

Members Present:

Shropshire Councillors: Karen Calder (Co-Chair), Heather Kidd, Madge Shineton
Telford and Wrekin Councillors: Andy Burford, Rob Sloan
Shropshire Co-optee: Ian Hulme
Telford and Wrekin Co-optees: Carolyn Henniker, Hilary Knight, Dag Saunders

Others Present:

David Evans, Senior Responsible Officer - Future Fit and Chief Officer Telford and Wrekin CCG
Deirdre Fowler, Director Nursing and Midwifery, Shrewsbury and Telford Hospital Trust
Simon Freeman, Senior Responsible Officer - Future Fit and Accountable Officer Shropshire CCG
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Julian Povey, Chair - Shropshire CCG
Rod Thomson, Director of Public Health, Shropshire Council
Stacey Worthington, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council
Simon Wright, Chief Executive Shrewsbury and Telford Hospital Trust

1. Apologies for Absence

Apologies were received from David Beechey, Shropshire Co-optee.

The Chair reported that Shropshire Co-optee Mandy Thorn had resigned her membership and said the Committee had benefited enormously from her knowledge experience and expertise in social care and health and had been extremely grateful to her for giving her time to attend meetings. A new co-optee would be appointed by Shropshire's Health and Adult Social Care Overview and Scrutiny Committee on 24 September 2018.

2. Disposable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matters in which they have a disclosable pecuniary interest and should leave the room prior to the commencement of the debate. Madge Shineton declared a connection with the Health Concern Group Wyre Forest.

3. Minutes of the last Meeting

The minutes of the meeting held on 15 August 2018 were confirmed as a correct record.

4. Shrewsbury and Telford Hospital NHS Trust (SaTH) – Enforcement Action Taken by CQC

The Chair thanked NHS representatives for making time to attend the meeting, acknowledging the pressures they were under. She had asked for a timeline to be provided to the Committee in order that it could understand the events leading up to the recent CQC findings and enforcement action. She said that the Committee understood the issues in the workforce, particularly in Accident and Emergency, and also that repeated calls for assistance that had been made. Members were concerned that many NHS organisations had been aware of the problems, but as set out in the Laming Report or Francis Report, no one had taken responsibility and taken measures to provide support.

Simon Wright, Chief Executive, Shrewsbury and Telford Hospital Trust (SaTH), outlined the workforce shortages and the inability to attract substantive staff to accident and emergency for a number of years and the resultant pressures on staff and the service. He also outlined events and subsequent actions taken by SATH and the CCGs which had resulted in a Regional Risk Review, and Risk and Quality summits as recently as 13 September 2018.

CQC Visit

Deidre Fowler, Director of Nursing and Quality reported that in August 2018, the CQC had made a formal unannounced visit and had raised concerns around safety of patients in the Princess Royal Hospital Emergency Department patients, and the practice of boarding. The CQC had notified conditions in relation to those activities in accordance with section 31 of the Health and Social Care Act.

Boarding was a process which should have been used only in exceptional circumstances or surges of demand but had become normal practice. The SaTH Board had taken immediate decisive action to cease boarding and there had been zero tolerance since 24 August 2018. Additional Health Care Support workers had been put on night duty and there had been an increase in overview by senior personnel.

There was now an increased audit of patient observations and records at 10.00 am and 10.00 pm, two hourly sweeps of the department to ensure safety and sepsis bundle compliance, outcomes of which were shared with CCGs and NHS England on a daily basis. The Trust had felt that what was observed by the CQC was the result of a very fragile work force with high reliance on locum staff.

Staffing

Members asked about the Regional Risk Summit that had taken place, which organisations had attended and what more could have been asked of them and in particular, what requests had been made of Health Education England.

Mr Wright explained that the Trust had made requests through its Medical Director and through the offices of the STP in October 2017, asking for additional doctors to be put onto the rotation in February to support middle grade doctors. In August, the number of doctors had been slightly better than last year, but more middle grade doctors were needed to stabilise the team. The clinical professionals were carrying a great level of strain in terms of volume of patients because of the pressures related to number of nurses and doctors of middle grade.

In July 2018, the Trust Board had talked about having to establish an end point to these circumstances, as too much was being expected in terms of discretionary effort in those teams, especially of nurses. The Trust had informed external agencies that a line was required at which point support was needed, otherwise appropriate action would need to be taken. This had brought the Trust to the position it was currently in.

The Chair asked if Health Education England had any powers to direct staff into fragile services and heard that there had been occasions where staff had been directed, and that this action had been requested by SATH. However with the current pressure on all systems, feedback to SaTH had been that trying to direct them into the Trust would not be successful.

Members also asked about the powers of the CCGs in relation to workforce issues. Mr Evans, Chief Office, Telford and Wrekin CCG, reported that both CCGs had been proactive and had supported the Trust throughout all of its meetings with NHS England and others, especially when it came to requesting middle range doctors.

In subsequent discussion members also asked about turnover and heard that it was 9%, an average rate for the NHS. The Trust would have liked it be lower but there were benefits to turnover and concern was focused in A&E and Acute Medicine. Since the capital decision had been made in relation to Future Fit, three consultants had been appointed to A&E and 60 nurses had signed ‘golden tickets’. Another 30 were to be recruited this year and these were significant strides in the right direction but immediate pressures would not go away. Work extending nurse skill sets was underway. Nurses were coming into the Trust, but not enough into areas of concern such as A&E.

There was also a national problem related to ageing profile of nurses and the demanding work involved, particularly with numbers of elderly patients and those suffering from dementia. He expressed gratitude to the 1000 plus volunteers throughout the organisation and stated that this was one of the largest number of volunteers of any hospital in the NHS.

Boarding

Members asked how it had been possible once the CQC letter had been received to stop the practice of boarding and increase supervision and why this had not been

done before. Mr Wright explained that legacy issues in relation to fire safety and the need to secure a fire certificate in what was an old building had led to the requirement to take some capacity out. 24 hours after this work had been completed, the ability to use that space had become available.

There had also been significant improvement through work with system partners on stranded patients with numbers dropping from 120 to around 40 and this had helped provide the capacity to make the decision to end boarding. Large numbers of ambulances were arriving at small A&E departments, resulting in delays and the balance between the risk of discharging a low risk patient awaiting a short period of care to enable space to be freed up for someone who was acutely unwell was a conflicting tension and had led to the environment where boarding had been required.

The Co-Chair commented that it had been fortunate that this release of space had been possible, but there remained a question around sustainable staffing and whether the measures in place were going to be sufficient to avoid the issues identified during the CQC inspection. Mr Wright explained that checks and balances were a daily issue and safeguards were in place to establish if measures taken were adequate. The hard reality for all was that this would be a particularly challenging winter for the NHS.

Winter Capacity

Members asked what would happen if demand were to exceed capacity during the winter. Mr Wright reported that the Trust had successfully bid for an additional £2.5m funding to create a new urgent care environment at the front of PRH A&E and this would be opening in November. It had also been successful in securing £3.1m to upgrade an existing ward at RSH to create more medical capacity for winter. However, it was not just about creating capacity, a workforce was needed to service and care for patients in that environment. The Trust had established training for Advanced Nurse Practitioners and had developed a series of alternative ways to recruit, train and spread the nurse skills mix with 120 Associate Nurses due to join the Trust.

As the winter approached, additional ways of balancing risk across the wider community were needed to minimise the risk of hospital attendance, eg through use of technology. He reiterated that the hard reality was that there was a fixed amount of capacity, and that if capacity was reached there was not any other means to provide for patients successfully.

Health Service Journal Article / Conditions Set out In CQC Letter

Members asked about the Health Service Journal article and whether this was a fair reflection of the content of the CQC letter as this had stated there were four concerns but only two were referred to in the report before the Committee.

The Director of Nursing and Quality explained that the report in the Health Service Journal had stemmed from an initial CQC letter which was a letter of intent providing the Trust with an opportunity to respond. As a direct result of the response made,

some concerns had been removed. The report before members outlined the issues the CQC were still expecting weekly reports on. It was also confirmed that the advice to the Trust regarding legal advice in the letter was standard CQC advice. Mr Wright added that the Trust always referred to its legal team if it needed to and that it fully accepted its responsibility to address the issues highlighted. It was confirmed that the suggestion that patients had been detained unlawfully had been dropped by the CQC.

Staff Morale

Members asked what was being done to address public perception and staff morale after a sustained period of criticism.

The Director of Nursing and Quality said that SaTH staff had integrity, compassion and needed job satisfaction. On a daily basis she heard staff stories relating to frustrations, and disappointment that they could not fulfil duties in the way they came into the profession to do so. It was very difficult but one of the ways to deal with this was to be visible, listen and be honest that there was not a magic solution. Mitigating actions included a 9am matrons meeting to consider the nursing workforce and risks for that day and to move nurses as necessary, although it was acknowledged that nurses wished to provide continuity of care for their patients. Nurses agreed to move as it was understood that this was the safest thing to do but there was only so long that such good will could last. The Trust had to scale its capacity to suit the workforce but it could not scale the workforce to suit capacity, a system approach was needed to solve this problem.

Mr Wright added that whatever the Future Fit decision, once made it would be possible to address difficult legacy issues, create a more attractive environment for staff, and have less demanding rotas. Since the capital decision had been made there had been a two fold increase in consultants joining the Trust.

Discharge

Mr Wright referred to the attempts of the system as a whole to reduce hospital attendance and frequency particularly with the frail elderly group. The Trust was working very closely with both Shropshire and Telford and Wrekin Councils, there was already a good length of stay against national parameters but further improvement was needed to help avoid patients attending a hospital setting. The frailty service available at RSH was currently being explored for PRH. and currently prevented 15 admissions every week.

The discharge process still needed improvement and a protocol led discharge that nurses could use was under consideration. There were 4.00 pm ward meetings held to discuss who might be able to go home the following day and to ensure that discharge summaries and medications would be ready. More work was needed in this area.

Night Closure of an Emergency Department

A Member asked about the options provided to the Trust Board regarding night time closure, it appeared that there was no doubt that the PRH Emergency Department

would be closed and she asked if this would be a permanent arrangement, as it would be a long time before the outcome of Future Fit became a reality. The Chief Executive stated that any decision would be taken with safety as the focus, and that any decision would result in a curtailment of service. There was not the workforce available to continue the 24/7 model of care without additional staff, this had been requested and would need to be confirmed before the Board meeting on 27 September 2018. A Fellowship Programme was being explored with Wolverhampton University, based at the Telford campus and work was underway on a model that would provide a greater number of doctors. An additional £250,000 had been spent on additional training facilities to provide an attractive location for place for people to come and learn. The development of different roles was underway and included physician associates, advanced nurse practitioners, and pathways to middle grade doctor roles but there were long lead times involved.

The Board would take all these factors into consideration and decide on what would constitute a safe level of staffing. Mr Wright emphasised that none of the Trust Board, Commissioners or Partners wanted to see a curtailment of services. Future Fit provided a strategic solution but it was not a short term one and services must be safe. Workforce was a challenge for every other hospital in the region too and they could not be expected to act heroically to provide indefinite support.

Dr Freeman, Accountable Officer, Shropshire CCG, added that the overriding issue for CCGs was 'is there a safe A&E service'. This was not just about numbers of substantive staff – but also about the large proportion of locum staff operating on shifts. Unless there was a significant increase of staff from elsewhere, any decision taken regarding business continuity was not likely to be short term.

The Co-Chair said that closing one of the Emergency Departments, albeit temporarily, would not address the staffing or capacity problems. He acknowledged that it might make them easier to organise and manage but it was not a solution. Fundamental time and investment in community and primary services was needed, but there was no evidence that resources were there to make that change. He said the bulk of the paper on the continuity plan did not provide enough emphasis on how to get people out of hospital. Mr Evans said that investment into primary and community services was happening but not as much or as quickly as would be liked. Both CCGs were very committed to changing the model of care for patients. This was not just about discharge, it was about making the population healthier in the short, medium and long term.

Dr Freeman pointed out that the business continuity plan would go through a rigorous assurance process with NHSI and NHSE, interdependencies and clinical pathways between sites would be properly considered and understood. There was no predetermined view on that process which would establish the most clinically safe solution for patients to be treated safely, there was no other agenda. It was confirmed that the SaTH Trust Board would make the final decision. CCGs had been asked to input into continuity plans and understand implications for West Midlands Ambulance Service, Wolverhampton's capacity, repatriation issues and social care for patients in other hospitals.

The Chair referred to the appointment of four new non-executives joining the Trust Board and asked if they would be fully informed before taking the decision. Members heard that there had been a formal process of induction and of the activity undertaken to bring them up to speed.

Mr Wright confirmed that no changes were planned to any other service. Had spoken to six other organisations which had experienced similar circumstances regarding closures and the majority of patients had tended to come in the following day with low risk injuries.

It was also reiterated that recommendations in the paper to the Board had been produced alongside Councils, CCGs, partner organisations, regulators, doctors, therapists, stakeholders.

Agency staff – Tablet/Paper observations

The Chair asked whether the high dependency on agency staff in A&E was why the tablet triaging system was currently not in use, and whether training of agency staff was an issue. The Director of Nursing and Quality explained that pausing the use of electronic tablet observations had been due to the high levels of agency staff, usually around 50% of nurses and also because the national standard was changing to another system. Paper and pen systems were in use and there were two hourly sweeps to ensure compliance.

Members asked if tablet systems would be reintroduced once the new national system was in place. The Director explained that the professional expectation at the point of registration was for all nurses to take observations. Although processes differed from hospital to hospital, standard competencies remained the same. Fail safes had been added such as an induction check list, nurses not known to the Trust undertaking a risk assessment and Trust and Agency Nurses signing to say that they were competent.

Care challenge/Rurality

A Member referred to a previous comment by the Director of Nursing and Quality that patient needs had to fit staff rather than the other way round and she referred to schemes to prevent hospital admissions. There were a large number of these but getting these established over a huge geographical area would not happen overnight, especially with an increasingly elderly population, and there would always be a gap between numbers of patients and staffing. Mr Wright acknowledged that discharge and obtaining care in rural areas combined with a diminishing workforce resulted in real challenge. Work underway with the Community Health Trust included intermediate stoke rehabilitation which would free capacity in hospital. It was hoped to get this in place before Winter. In response to a comment about the length of time to get measures in place, Dr Freeman referred to the effect of delays on the Future Fit process. Mr Evans referred to a significant amount of work underway to ensure sufficient capacity in acute and primary care for the winter. This would be signed off at Delivery Board next week.

In terms of the community element, Dr Freeman said that Shropshire and Telford and Wrekin patients made relatively low use of hospital and emergency services, particularly Shropshire. Mr Wright said the CQC looked at use of resources and there was a relatively low length of stay and admission rate.

Mr Evans also drew attention to differential referral rates from GPs to A&E and the higher than regional average of calls to 111 made by Telford and Wrekin population. There was more information to gather about the reasons for this.

Keeping Committee informed

A member asked about the action plan developed since the CQC visit and if reports made to CQC could be shared with scrutiny. Dr Freeman was of the view that the JHOSC should ensure an action plan was in place and complied with, but that it should not receive the detail, as assurance was provided to CQC and there was no need to duplicate this. Mr Wright said he thought it would be possible but expressed reservations as much material had already been inappropriately leaked to the media which without context had created anxiety for the public. SaTH met with commissioners every day and the CQC every week.

The Co-Chair said the Committee wanted information on a regular basis so that it could ensure the action plan was progressing and being taken seriously. He said that this was a matter of public assurance that would allow the Committee to undertake its responsibilities seriously, rather than being surprised by information that had been leaked to the media.

The Chair referred again to the Francis Report and to the expectations placed upon the Joint HOSC and reiterated the importance of keeping the committee informed. Members would like to see a clear line of information as the CQC action plan was addressed. Mr Wright said the Trust was committed to transparency, but it was still within an inspection period with CQC about to undertake scheduled well led interviews with senior leadership. The final report was expected in about 12 weeks and as with the last CQC inspection, SaTH would be happy to attend the Joint HOSC and address the findings. The Chair said that Committee Members would be more than willing to talk to CQC inspectors and Mr Wright said he would pass that message on to them.

Mr Wright reported that the CQC had never previously been aware of a leak of correspondence between it and a hospital Trust at this stage of an inspection and staff had felt the brunt of this. To provide some balance he said that the problems identified related to two parts of a provision which offered over 400 services.

The Chair thanked NHS colleagues for addressing these issues and asked to be kept informed of the next sequence of events.

5. Maternity Services

The Committee had requested a report on the investigations into maternity care, related legal processes and any interim findings. The Chair acknowledged that discussions would be limited because of the ongoing investigations but emphasised that the Committee wished to understand the scope and process.

The paper set out the background to the establishment of the Legacy Resolution Group following the Secretary of State's request to NHS Improvement to undertake an independent review into historic cases in April 2017. It outlined current activity and numbers of current legacy cases and also the subsequent enquiries following media coverage of maternity services in June 2018 and August 2018.

In summary, the paper stated that a total 15 of the 31 legacy families had contacted the Care Group in response to letters received, and following media coverage in June and August 2018 a further 20 families had contacted the Care Group with queries regarding the Secretary of State's Review, Legacy Case Review and with questions regarding their care.

In response to questions from the Committee, it was confirmed that the 20 families who had made contact following the media coverage would be invited to meetings to discuss their care and the same process would be followed if further learning was identified.

Members stated that it was important to know whether concerns of families who had made contact following the media coverage were historical as if they were recent this would be extremely serious. The Director of Nursing and Quality said that it was not possible to pre-empt those cases but that internal governance assurances, external assurance, and other assessment had shown evidence of significant learning in the Care Group.

The Chair queried whether the statement in the report 'Following the media coverage in August 2018; a further 14 families have contacted the care group outside the legacy review terms of reference' was included in the total figure stated and was informed that it was.

Members asked if consideration would be given to other cases which had not resulted in deaths and trauma but had been near misses. The Director said that a pillar of good governance was a supportive culture based on reporting of low harm and near misses as learning through these would help prevent moderate or severe harm. She referred to work with Virginia Mason Hospital on a patient safety value system. The Maternity service was participating in a national safety maternity collaborative and utilising learning from the last 18 months.

The Director of Nursing and Quality was thanked for the report and Members asked that a report on all learning be presented to the Committee following the conclusion of the reviews.

6. Chair's Update

The Chairs reported that there that there had been over 17,000 responses to the Future Fit consultation which had now come to a conclusion. They had asked to see the raw data and had been informed this would be too difficult due to the need for confidentiality, they had nevertheless felt that some indication of the type of responses submitted, unfiltered by Participate, would be useful for the Committee.

They had been given reassurance that resources were in place to analyse the results but an extension of the six week period for this purpose was likely. All were mindful of the Telford and Wrekin election purdah period in 2019.

The meeting concluded at 5.10 pm

Shropshire, Telford and Wrekin and Powys A&E Delivery Board

Winter Plan 2018-19

Version	Date	Update
1.1	10/08/2018	First iteration
1.2	18/08/2018	First system updates
1.4	19/08/2018	Demand and Capacity modelling added
1.5	28/08/2018	Post A&E Delivery Group- revised system updates
1.6	29/08/2018	Post meeting with accountable officers
1.7	02/11/2018	Layout and formatting review.
1.8	20/11/2018	Minor accuracy updates and appendices linked

Contents

1. Glossary:

Abbreviation	In Full
A&E	Accident and Emergency
AHP	Allied Health Professional
AMU	Assessment Medical Unit
CAD	Computer-aided Despatch
CCG	Clinical Commissioning Group
CDU	Clinical Decision Unit
CHC	Continuing Healthcare
CQUIN	Commissioning for Quality and Innovation
D2A*	Discharge to Assess* - *see additional information in table below*
DAART	Diagnostics Assessment Access to Rehabilitation Treatment
DH	Department of Health
DToC	Delayed Transfers of Care
DVT	Deep Vein Thrombosis
ECIP	Emergency Care Improvement Programme
ECIST	Emergency Care Improvement Support Team
ED	Emergency Department
EDD	Expected Discharge Date
EL	Elective
EMI	Elderly Mentally Ill
EMS	Escalation Management System
EOC	Emergency Operating Centre
EPRR	Emergency Preparedness Resilience and Response
FFA	Fit for Assessment
FFT	Fit for Transfer
FIT	Frailty Intervention Team
HALO	Hospital Ambulance Liaison Officer
HWB	Health and Wellbeing Boards
KPIs	Key Performance Indicators
LHE	Local Health Economy
LoS	Length of Stay
MADEs	Multi Agency Discharge Events
MDT	Multi-Disciplinary Team
MFFD	Medically Fit for Discharge
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MPFT	Midlands Partnership Foundation Trust *(formerly SSSFT)*
MSFT	Medically Safe for Transfer
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEL	Non-Elective
NHSE	National Health Service England
NHSI	National Health Service Improvement
NICE	National Institute for Clinical Excellence
OD	Organisational Development

OOH	Out of Hospital
PbR	Payment by Results
PE	Pulmonary Emboli
PHE	Public Health England
PMO	Programme Management Office
PRH	Princess Royal Hospital
RAID	Rapid Assessment Intervention and Discharge
R2G	Red to Green
RCMT	Regional Capacity Management Team
RSH	Royal Shrewsbury Hospital
SAED	System-Wide Accident and Emergency Delivery
SAFER	**S**=Senior Review; **A**=All Patients; **F**=Flow; **E**=Early Discharge; **R**=Review
SaTH	Shrewsbury and Telford Hospitals
SAU	Surgical Assessment Unit
SCHT	Shropshire Community Health Trust
SitRep	Situation Reporting
SSSFT	South Staffordshire and Shropshire Foundation Trust *(now MPFT)*
STP	Sustainability Transformation Partnership
SUS	Secondary Uses Data
T&O	Trauma and Orthopaedic
UCC	Urgent Care Centre
UEC	Urgent and Emergency Care
WDPs	Winter Delivery Priorities
WMAS	West Midlands Ambulance Service
WTE	Whole Time Equivalent

*__Discharge to Assess:__ *Patients are discharged from hospital via 3 pathways for care and rehabilitation support for up to six weeks*	
Pathway 1	To intermediate care and reablement services provided in their own homes
Pathway 2	To residential care within the independent and community sector
Pathway 3	To nursing care within the independent sector

2. Introduction

The Shropshire, Telford and Wrekin urgent care system has faced challenges for a number of years, consistently failing to deliver the 4-hour target.

Winter 2017-18 has been recognised as one of the worst on record for the system, resulting in poor experiences and outcomes for patients.

The system employed an urgent care director in December 2017 and has built on previous improvements to focus on working together to deliver six high impact changes:

- An improvement in ED systems and processes
- Implement SAFER and Red2Green across the system
- Reducing Long Lengths of Stay (Stranded Patient Metric)
- Improve the Frailty pathway across the system
- Develop the integrated discharge pathway
- Develop a demand and capacity plan

The UEC system has acknowledged the need to work on the six high impact changes together and by doing so has developed excellent system-wide operational and leadership behaviours which have resulted in a system ownership of issues and support for achievement.

To date, improvement in the flow out of the hospital has been exceptional with our main Local Authorities placing up to 88% of complex patients within 48 hours, resulting in a reduction in the number of patients who are medically safe for transfer waiting in acute beds. The reduction in the stranded patient metric from 362 to below 250 (aim 180) and in super-stranded patients from 90 to 50 has resulted in us being among the top ten of all systems for the reduction in long lengths of stay.

We have a front door frailty service in Shropshire, to be mirrored in Telford, and the SAFER patient flow bundle and Red2Green are being revitalised through value streams in the acute trust and also in our community hospitals.

As a result of a drive for Home First, many of our Pathway 2 beds in the community are now not being utilised and plans are in place to use them more flexibly this winter to maximise utilisation.

This document builds on the high impact change around the development of a demand and capacity plan which builds the capacity to meet demand all year around. It sets out the Winter Plan (the Plan) for Shropshire, Telford and Wrekin and Powys based populations, and describes how partners in the health and social care economy are planning to ensure that our services can best meet the anticipated emergency demands.

The success of this plan builds on the whole system approach and effective partnership working.

It is crucial that all partners understand their role in supporting and delivering this plan. This year the planning has started earlier and is led through the A&E Delivery Group on behalf of the A&E Delivery Board and more emphasis has been placed on a whole system planning process rather than individual organisations undertaking planning in isolation.

3. Background

It is an expectation of all partners and regulators that an effective plan is constructed and tested for the winter period 2018-19. The Shropshire, Telford and Wrekin and Powys Accident and Emergency Delivery Board (SAED) must be assured that all commissioner and provider plans evidence individual organisational and system wide resilience and congruence.

The Winter Plan (the Plan) has been formed via the employment of best practice and lessons learned from recent winter periods. Delegates from all key stakeholders have been engaged in the formation of the Plan and compliance will be the responsibility of all SAED members, in collaboration with their respective organisation.

We have tested the plan with EMS partners since September 2018 and for the escalation process, we have rewritten action cards as a result. We had planned to implement the EMS+ system in December, but training and testing has resulted in a further development in the system being necessary before we go live, so we are hoping that we start using this process from Mid-December. Until then, our existing escalation management process will continue. We are also testing the action cards with clinicians on the 4th of December to ensure that actions taken in escalation are owned by senior clinicians in the system.

4. Shropshire, Telford and Wrekin and Powys Local Context & Review

The 2018-19 Winter Plan has been developed to ensure the following areas are addressed as a priority. Safety and improved outcomes for patients will be achieved during the winter by: -

- An improvement in ED systems and processes
- Reduction in Ambulance conveyance to the Emergency Department (ED) by crews using the Care Co-ordination Centre pre-conveyance.
- Tangible improvement (up to national average) in the number of patients streamed to primary care by ensuring we have permanent ED streaming staff, streaming to an effective primary care service with appropriately trained staff.
- 98% of non-admitted patients seen within the 4 hour quality standard by ensuring that trained ENPs see patients in a timely manner and refer for any diagnostics necessary in a timely manner.
- The reduction in the number of patients who receive corridor care by using the rapid access to treatment model (Pit-stop), two hourly ED Board rounds, and the use of internal professional standards.
- Reduction in the ambulance handovers exceeding 30 minutes by the use of Hospital Ambulance Liaison Officers (HALOs) and dedicated handover nurses.

- Further embed SAFER and Red2Green across the system
  - Embedding Red2Green (R2G) across acute and community;
  - Embedding the SAFER patient flow bundle across acute and community care

Reduction in long lengths of stay:

- Reduction in all long lengths of stay (aim 180) & extended long lengths of stay (over 20days- aim of<50 to be maintained) in the acute trust; This has previously been described in our system as stranded and super stranded patients.
- Reduce the length of stay in all community beds to the national average.

- Improve the Frailty pathway across the system
  - Implement Frailty front door service at Princess Royal Hospital (PRH)

- Develop the integrated discharge pathway
  - Reduction in the length of time patients are on the Medically Safe for Transfer (MSFT) list;
  - Improvement in numbers of patients discharged before lunch to the national average.
  - Improving the Home First deployment and timeliness of transfer to community services provision including domiciliary care;

- Develop a demand and capacity plan
  - Clear and tangible plans to close anticipated bed deficit (escalation);
  - Implementation of an effective real-time demand and capacity management system.

5. Plan Interdependencies

The Plan has a number of interdependencies and should be read in conjunction with:

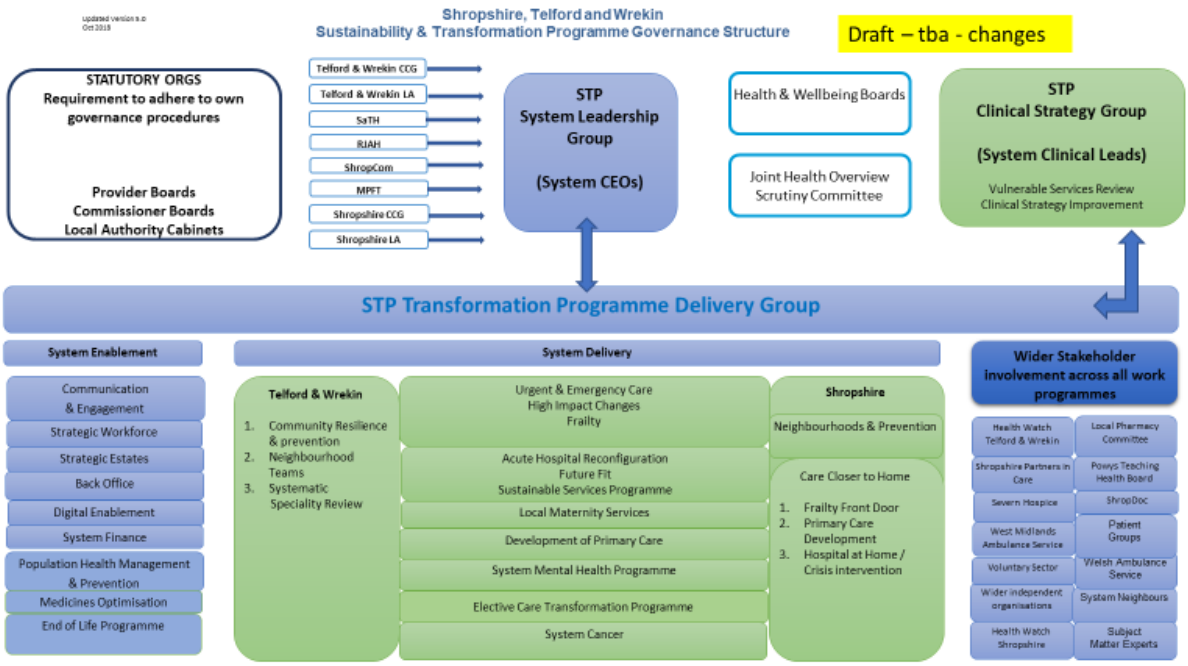
- The Shropshire, Telford and Wrekin and Powys Escalation Plan,
- The Local Heath Resilience Partnership Influenza Plan,
- Powys Integrated Winter Resilience Plan 2018/19
- National adverse weather plans,
- The plans for the six High Impact Changes
- Individual organisational winter plans (e.g. Business continuity, incident response, infection prevention etc.).
- WMAS winter plan

6. Outcomes of the Plan

The Winter Plan is complimentary to the main objectives for achievement in the STP. Our outcome for this plan is to ensure that patients are safe and have improved outcomes over the winter period. Metrics for measurement are detailed throughout the plan.

7. Governance

Winter planning is a sub-work-stream within the STP Urgent and Emergency Care (UEC) Governance structure.



Operationally, planning for winter is enacted through the System-Wide A&E Delivery Group and agreed for recommendation to individual boards through the A&E Delivery Board. The A&E Delivery Board does not have delegated authority to commit individual CCG resources, it can only make recommendations to CCGs and provider boards.

8. Programme Management Office (PMO) & Monitoring

To co-ordinate and monitor the winter period, the CCGs have dedicated an officer, supported by administration, to report on a twice daily basis to the system and to NHSI/E. Support will be provided by the system urgent care director and the STP PMO office.

The system will be using the support functions of the Regional Capacity Management Team (RCMT) Escalation Management System (EMS) to monitor pressure in the system and are revising triggers and actions to support our plan.

9. Winter Plan Key Performance Indicators

The programme has identified a set of key metrics which will enable the success of the winter plan to be monitored. These metrics include:

- % of non-admitted and admitted A&E 4-hour breaches
- Number of patients with a Length of Stay (LoS) >7 days
- Number of patients LoS >21 days
- Bed occupancy rate (acute and community)
- Number of patients on the Medically Fit for Discharge (MFFD) daily list
- Number of patients discharged to Pathway 1 (home with support) within 48 hours of LA receipt of the referral (FFA)
- Number of simple and complex discharges per week

- Delayed Transfers of Care (DTOC) rate (3.5%)

These are set out in the tables below including trigger points for AMBER and RED performance (RAG) rating to enable the system to take early pre-emptive action to avoid deterioration in performance. The triggers for the majority of the metrics are based on a calculation of 1 and 2 standard deviations from the baseline.

Winter Plan Metrics V6

SHROPSHIRE STP WINTER PLAN 2018-19 TABLE OF KEY PERFORMANCE METRICS	Baseline	Baseline period	Local winter performance target	RAG rating of performance against target		National performance target if different to local
				AMBER	RED	
% Non Admitted Breaches						
SATH	79%	Dec17 - Mar 18	90%	87.3%	83.3%	
PRH	77%	Dec17 - Mar 18	90%	87.3%	83.3%	
RSH	82%	Dec17 - Mar 18	90%	87.3%	83.3%	
% Admitted Breaches						
SATH	29%	Dec17 - Mar 18	30%	24%	21%	
PRH	44%	Dec17 - Mar 18	45%	36%	32%	
RSH	12%	Dec17 - Mar 18	12%	10%	8%	
% Bed Occupancy						
SATH	98%	Oct 17- Mar 18	98%	99.0%	100.0%	
Shropcom	93%	Dec17 - Mar 18	95%	90.3%	88.4%	
Stranded (no. pts >7days LoS)						
SATH	247	Aug 18 - Oct 18	250	260	275	
PRH	122	Aug 18 - Oct 18	117	122	129	
RSH	125	Aug 18 - Oct 18	133	138	146	
Super Stranded (no. pts>21 days Los)						
SATH	58	Aug 18 - Oct 18	50	52	55	
PRH	33	Aug 18 - Oct 18	23	24	26	
RSH	25	Aug 18 - Oct 18	27	28	30	
Discharges before 12 midday (*)						
SATH	13.6%	Dec17 - Mar 18	25%	22.3%	19.8%	
PRH	14.3%	Dec17 - Mar 18	25%	22.3%	19.8%	
RSH	13%	Dec17 - Mar 18	25%	22.3%	19.8%	
PW1 Discharges within 48 hours of receipt of FFA						
Shropshire LA	70%	Dec17 - Mar 18	90%	80.1%	71.1%	
Telford LA	65%	Dec17 - Mar 18	90%	80.1%	71.1%	
DToC						
SATH	3%	Dec17 - Mar 18	2.5%	3.1%	3.8%	
Shropcom	7%	Dec17 - Mar 18	3.5%	4.0%	4.5%	
RJAH	4%	Apr 18 - Aug 18	3.5%	4.0%	4.5%	

Average weekly number of simple discharges (by hospital site)

	SaTH			PRH			RSH		
Baseline	880	Av weekly	Oct 17 - Mar 18	381	Av weekly	Oct 17 - Mar 18	499	Av weekly	Oct 17 - Mar 18
Av Weekly Target	Target	Amber	Red	Target	Amber	Red	Target	Amber	Red
Oct	943	905	867	419	390	365	524	497	476
Nov	917	880	843	396	368	345	521	495	474
Dec	955	917	879	414	385	360	541	514	493
Jan	925	888	851	396	369	345	529	503	481
Feb	891	856	820	383	356	333	508	483	462
Mar	904	867	831	386	359	336	518	492	471

Average weekly number of complex discharges (by commissioner)

Complex Discharges	Weekly Target	Shrops Council				Target	T&W Council				Target	Powys				Target	Other		Target	SaTH Total			
		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement			Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement
Oct	53	45	50	57	61	25	21	24	27	29	11	9	10	12	13	2	3		91	77	85	95	105
Nov	59	50	56	63	68	28	24	27	30	32	15	13	14	16	17	2	3		104	88	97	109	120
Dec	60	51	57	64	69	23	20	22	25	26	11	9	10	12	13	2	3		96	81	89	101	111
Jan	69	59	66	74	79	34	29	32	36	39	12	10	11	13	14	2	3		117	99	109	123	135
Feb	73	62	69	78	84	31	26	29	33	36	11	9	10	12	13	2	3		117	99	109	123	135
Mar	60	51	57	64	69	27	23	26	29	31	11	9	10	12	13	2	3		100	84	93	105	116

Average weekly number of Fact Finding Assessments (FFAs) required to achieve the complex discharge targets above (by commissioner)

FFAs Required	Weekly Target	Shrops Council				Target	T&W Council				Target	Powys				Target	SaTH Total			
		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement
Oct	71	60	67	76	82	33	28	31	35	38	14	12	13	15	16	118	100	112	126	136
Nov	78	66	74	83	90	37	31	35	40	43	20	17	19	21	23	135	115	128	144	155
Dec	79	67	75	85	91	31	26	29	33	36	15	13	14	16	17	125	106	119	134	144
Jan	92	78	87	98	106	45	38	43	48	52	16	14	15	17	18	153	130	145	164	176
Feb	98	83	93	105	113	41	35	39	44	47	14	12	13	15	16	153	130	145	164	176
Mar	80	68	76	86	92	36	31	34	39	41	15	13	14	16	17	131	111	124	140	151

Average daily number of patients on the Medically Fit For Discharge list (by commissioner)

MFFDs	Weekly Target	Shrops Council				Target	T&W Council				Target	Powys				Target	SaTH Total			
		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement
Oct	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Nov	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Dec	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Jan	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Feb	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Mar	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85

If required, during winter, the baseline and associated trigger points can be recalibrated to reflect improved performance.

A number of these metrics will be monitored nationally on a daily basis by NHS England as part of their winter monitoring arrangements. This data is published weekly, which will enable almost real-time monitoring to take place.

Two additional key metrics will also be monitored. These are: -

- Uptake of the additional capacity for Community IV antibiotics in Shrewsbury, Bridgnorth and Ludlow
- Utilisation of SATH2Home

For those metrics not available on a weekly basis, the system will set up information flows to be able to source as near to real time data as is available.

10. Escalation Planning

The Shropshire, Telford and Wrekin and Powys A&E Delivery Board wholly recognises that the system will experience fluctuations in demand across the winter period and partners have constructed models to forecast demand and plans to support response.

A programme of very senior leadership has been working across the system to facilitate the best possible planning prior to peak periods of demand that includes: appropriate staffing levels and senior level command and control across the system at peak times and in surge.

The Shropshire, Telford and Wrekin and Powys partners have surge and escalation plans which within Shropshire link to the Escalation Management System triggers that allows health system partners to gain situational awareness of capacity pressure. Organisational plans and procedures coordinated across the LHE manage day to day variations in demand as well as the procedures for managing significant surges by having a clear escalation and de-escalation plan based on 4 levels. Winter Escalation Action cards (Appendix 3) set out the pre-agreed key actions each organisation will implement against specific objectives to increase capacity and flow.

With the advent of the new EMS+ product, we have revised all action cards and plan to use the new model to manage our escalation calls. We believe that this will coordinate with the Winter Room process so that they can have real-time updates of our system automatically, reducing the need for extra calls. We are undertaking a programme of training for Our on-call managers and all managers and clinicians involved in escalation calls. We have already developed an agenda template for calls, however the ability to automatically pull reports into the EMS system from site sitreps has still to be developed so the EMS team are working on this before we can test and go-live. In the meantime, our escalation calls continue on a twice daily basis as usual.

10.1 SaTH Emergency Department Plans

SaTH RSH Emergency Department (ED) is a Trauma Unit which supports the regional Trauma Centre service. The Emergency Department, and the PRH Emergency Department will be supported by the emergency floor Rapid Assessment and Treatment model (here called Pit-Stop), which will be improved as part of our high impact changes from October 2018 to expedite flow from the ED into assessment functions.

The two EDs regularly manage a range of attendances per day of 350-420 at seasonal peaks.

The Trust is in surge when ambulance attendances rise to more than 6 (RSH), 8 (PRH) per hour over a 3-hour period and the departments have in excess of 20 major patients.

SaTH are reviewing escalation trigger pathways for Non-Elective attendances arriving at ED in order to get improved pace and response to hourly surge activity into the department together with ‘next day’ risk management and follow on actions for expedited return to Level 1. This will include specialty in reach to support front door ‘Pit-Stop’ (Rapid Assessment and Treatment) and expansion of the ED floor to support flow, for example, the use of head and neck theatres and recovery adjacent to RSH ED and the new front door extension to ED in PRH.

Other hospital flow enablers in place to support contained escalation include:

- Adherence to Internal Professional Standards by receiving specialities, accepting and transferring patients within 30 minutes following referral. We are working with our mental health colleagues to enhance the response rate from Consultant Psychiatrists also.
- Individual tracking using a check, chase and challenge model for patients to ensure timely transfer

11. Surge Plan

As part of business continuity and contingency planning the system has to plan for expected and un-expected surges in demand. Part of the surge plan will focus on the bank holiday periods :

- Christmas
- New Year
- Easter

The system is revising action cards to ensure that risk is shared throughout the system focusing on patient safety.

Escalation calls in periods of escalation, using the EMS system triggers, will continue to be held twice a day through winter with all organisations supporting through senior CCG leadership input, with calls coordinated through SaTH. If the system experiences significant/sustained pressure, issues will be escalated to the senior leaders and regulators.

Providers have included their own specific actions to respond to surge in their winter plans.

12. System On-Call Arrangements

The system has a long-established mechanism for on call across all key partners, which is further complemented by the Escalation Management System (EMS) and Shropshire, Telford and Wrekin and Powys Escalation Plan (Appendix 3). The response element (Action Cards) of the plan is determined by the EMS level and is refreshed bi-annually.

In the event that the system experiences significant/sustained pressure issues, at least twice daily conference calls will be undertaken to identify and respond to the pressures in the system when agreed triggers are reached. During the winter period, we have agreed to have at least two calls at 10.30am and 2pm each day. The calls will be chaired by the system Urgent Care Director or CCG Commissioning Lead or deputy and will eventually use the EMS+ system to both arrange the call and also to record the actions on the call. Each meeting will have an agreed agenda, and partners will all populate the EMS capacity system so that it is visible to all.

The system has an established combination of senior management and executive level on-call rotas which will support the management of escalation.

SaTH will continue to manage flow. Community Trust, RJAH, WMAS, Non-Emergency Patient Transport, Complex Discharge, Social Care and Mental Health Operational Leads are invited to attend to support a single site view of flow and actions required to next Sit Rep.

Each provider has detailed their internal on call arrangements within their plans to ensure there is coverage.

The teleconference template module within EMS is planned to be utilised with effect from 14 December 2018 (if the module is ready and tested), in accordance with the conference call SOP, (in development) to assist with the organisation, reporting and recording of conferences calls relating to escalation.

13. Adverse Weather Plans

All key partners across the health and social care economy have organisation specific adverse weather plans which focus on the maintenance of service delivery and the safety of staff. These plans are fully tested, and the NHS plans are assured via the EPRR Core Standards Assessment Process.

All plans fully reflect the Cold Weather Plan for England, are invoked via the command and control structures and encompass specific communication arrangements. This ensures that a consistent approach is applied across the economy. The Cold Weather Plan for England specifies the levels as:

- Level 0: “Year-round planning” and the Making the Case companion document may be more of relevance to public health professionals, Health and Wellbeing Boards (HWB), local authority chief executives and elected members;
- Level 1: “Winter preparedness and action” and the Making the Case companion document will be of relevance to all professional groups, particularly front-line health and social care professionals;
- Levels: 2-4 “Severe winter weather is forecast through to national emergency” are more reactive in nature and include snow and ice as well as severe cold weather and may be particularly relevant to emergency planners and responders.

Via the EPRR route, partners receive weather warnings from the Meteorological Office and in the event of weather related incident affecting business continuity, a health cell (membership from the Local Health Resilience Partnership) will be established to coordinate the response).

At a local level, plans detail proactive communications (internal and external), staff briefings to ensure services are coordinated, flexible working, mutual aid, the use of the voluntary sector and specialised transport arrangements.

14. Influenza Strategy

The National Influenza Plan is a key prevention item for the winter and sets out a coordinated and evidence-based approach to planning for and responding to the demands across England, taken from the lessons learnt during previous Influenza episodes. It provides the public and

healthcare professionals with an overview of the coordination and the preparation for the Influenza season and signposting to further guidance and information.

The National Influenza Plan encompasses the responsibilities for NHS England, Public Health England, Local Authorities, providers, CCGs, General Practitioners and enacts the National Influenza Vaccination programme.

The Local Flu Plan supports the coordinated and evidence-based approach to planning and responding to the demands of flu across Shropshire, Telford and Wrekin and Powys supported with a Commissioning for Quality and Innovation (CQUIN). A Shropshire, Telford and Wrekin and Powys Influenza Memorandum of Understanding (MOU) is in place to ensure partnership working to support all aspects of the local health economy for example if there was a flu outbreak in a care home they would receive support from Public Health and MPFT with assessment and vaccination.

In 2018-19 the plan aims to ensure that:

- Vaccination is actively offered to 100% of all those eligible groups;
- Vaccination of at least 75% of those aged 65 years and over;
- Vaccination of at least 75% of healthcare workers with direct patient contact;
- Improving uptake for those in clinical risk groups, particularly for those who are at the highest risk of mortality from flu but have the lowest rates of vaccine uptake, such as those with long-term liver and neurological disease, including people with learning disabilities or children, a minimum uptake of 40% has been shown to be achievable in pilots conducted to date. As a minimum uptake levels between 40% and 60% to be attained and uptake levels should be consistent across all localities and sectors of the population;
- Providing direct protection to children by extending the annual flu immunisation programme and also cutting the transmission of flu across the population;
- Monitoring flu activity, severity of the disease, vaccine uptake and impact on the NHS;
- Prescribing of antiviral medicines in primary care for patients in at-risk groups and other eligible patients under NHS regulations and in line with NICE guidance;
- Providing public health information to prevent and protect against flu;
- Managing and implementing the public health response to incidents and outbreaks;
- Ensuring the NHS and PHE are well prepared and has appropriate surge and resilience arrangements in place during the flu season.
- All Shropshire, Telford and Wrekin and Powys providers attained the 75% level in 2017/18 for flu vaccination.

In addition, each provider has reviewed their flu plans and included additional actions within their own organisations plans:

Fig. 6: Additional actions within organisational flu plans

Organisation	Additional Actions
SaTH	• Monthly Flu Steering Group in order to plan, deliver and review flu programme • Embedding of a “check and prompt” process to help protect

	patients with LoS greater than 30 days • SaTH will focus on proactive communications (internal and external), staff briefings to ensure services are coordinated, flexible working, mutual aid, the use of the voluntary sector and specialised transport arrangements.
Shropdoc	• Reviewing option to deliver their own internal flu vaccination clinics
Shropcom	• Will encourage staff to have flu vaccinations with drop-in clinics, communications, increasing number of vaccinators • Work with primary care to vaccinate housebound patients • All in patients and new admissions through winter at community hospitals will be offered vaccination
Shropshire Council	• Communication re precautionary measures and symptoms of flu to care providers and direct payment advisory services
Telford and Wrekin Council	• Target care homes to all residents are offered flu vaccination • Encourage care homes to enable and promote flu vaccinations • Council Staff Flu Immunisation Programme offering free immunisation all Council Staff, in clinics held in a range of venues to maximise uptake. A total of 129 Enablement Workers, provide direct social care, these staff are being offered bespoke workplace clinics. Programme of awareness raising and promotion, including myth busting.
Powys THB and LA	• As per the integrated plan (Appendix 2)
WMAS	• Deliver flu vaccinations at various locations • Train paramedics to administer the vaccination • Aiming 80% uptake by 31st December 2018 • Trust engagement vehicle mobilised to locations not served by paramedics to ensure mobile flu clinics are available.
RJAH	• Delivering flu vaccinations in fixed areas and walkabouts to cover both clinical and non-clinical areas, with additional input from Team Prevent • Programme being advertised in daily bulletins, with Comms team supporting with staff story's • Banners, posters, intranet, with links to videos, and screen-saver messaging • Staff incentives inc vouchers for sandwich & piece of fruit. • Local businesses approached to provide prizes to be drawn each month

15. Outbreak Plans

All provider organisations have robust plans for the prevention and management of outbreaks, predominantly led by Infection Prevention Teams. The plans have been tested, applied to respond to live issues and supported by clinical teams with on-site presence and on call availability.

Outbreaks have the potential to significantly preclude system flow and whilst the system does have effective plans and a degree of side room capacity, this remains a significant risk.

All relevant staff are comprehensively trained in infection prevention and in the event of staff sickness having a material effect on a service; a clinical prioritisation process will be applied, supported with mutual aid agreements.

16. Communication

The Winter Communications Campaign on behalf of all CCGs is aligned to the National Stay Well campaign and the STP Communications Plan. The strategy includes:

- Focus on social & digital;
- Pan Shropshire, Telford and Wrekin and Powys coordinated approach including all commissioners and providers;
- Utilising Patient Participation Groups to share information within their local communities.

Providers have organisation-specific communication plans which complement the system-wide plan. All existing communication channels will be used to target the groups most vulnerable over winter to ensure that people who are most at-risk of preventable emergency admission to hospital are aware of and, where possible, are motivated to take actions that may avoid admission this winter.

The campaign will ensure that:

- There is a consistent identity to promote the range of services available to patients/service users (focussing on clinically appropriate alternatives to 999 and ED);
- Patients/service users are made aware that 999 and ED are for life-threatening/serious issues only;
- Patients/service users are made aware that NHS 111 is the most effective service for non-life threatening/serious issues;
- Self-care and prevention is fully promoted.

A communications escalation card has been developed and will be included in the set of escalation cards for the first time this year.

16.1 Cascading Advanced Warnings and Focus on High Risk Groups

In addition, the communication arrangements across the system, partners have specific plans in place to communicate to those patents/service users identified as at a heightened level of risk, due to the winter period. Activities include work with rural communities, high volume users, vulnerable patients/service users, patients/service users with long term conditions and sourcing support from the voluntary sector.

System partners also receive alert information from a number of agencies (e.g. Civil Contingencies Unit, Police, Meteorological Office etc.), which are used to proactively plan and effectively respond via the EPRR arrangements.

17. Demand and Capacity Modelling

17.1 Regional Requirement

Regional Winter Planning 2018/19 Guidance was issued on 22nd March 2018. The key requirements within the guidance included: -

- There will be no additional winter funding in 2018/19
- Winter plans to include phasing profiles to reflect seasonal changes in demand
- Winter plans to demonstrate a system-wide approach that aligns key assumptions between providers and commissioners which are credible in the round.
- Final Winter Plan to be submitted to NHS England by 31st October 2018.
- All plans and schemes in place and operational by end of November 2018 unless phased differently in the plan.in readiness for the start of winter.

As one of the system high impact changes, a system-wide demand and capacity model has been developed, with the planning for winter as an integral part of this model.

17.2 Local System Winter Planning Approach

The Plan has been developed through robust engagement of all key system partners overseen by the A&E Delivery Group. System stakeholders have also attended a NHSE workshop in April and 2 local planning workshops in July.

In parallel, system demand and capacity modelling has been undertaken to determine predicted winter demand and required acute bed capacity to inform the bed bridge calculations.

All Providers were asked to demonstrate an understanding of their demand and capacity over the winter months and provide an organisational winter plan which includes:

- Additionally, and phasing of escalation
- A workforce model to support 7-day working, senior decision making and escalation capacity
- 7-day working
- Christmas, New Year and Easter period
- Options for further surge capacity if required

17.3 Demand Analysis and Bed Bridge Calculation

SaTH experienced significant emergency pressures over the winter period 2017/18. These pressures were fuelled not only by an increasing volume of demand but by the increased acuity of patients, resulting in longer lengths of stay. These factors have been reflected in the activity and winter plan for 2018/19.

SaTH have agreed to a performance improvement trajectory for the 4-hour A&E national standard of 80% by December 2018 and 90% by March 2019. Progression to 95% going forward will be dependent upon sufficient workforce capacity being available and community services and local authorities ensuring continued timely patient transfer/discharge through the

winter. SaTH are drafting a set of internal performance measures designed to support end to end visibility of hospital flow, linked to the three high impact changes they lead on which are: -
1) ED systems and processes,
2) the reduction in the stranded patient metric (reduction in long length of stay patients) and
3) embedding the SAFER patient flow bundle and Red2Green.

Ultimately the analysis of predicted demand over the winter period is to determine the additional number of acute beds that will be required above the current core acute bed stock to meet predicted winter demand (the Bed Bridge).

The Trust's growth figures are based on a detailed bottom-up analysis of local demographics and morbidity, recent experience and known capacity constraints. Detailed demand and capacity analysis has been undertaken to inform this plan through a workstream of the A&E Delivery Group involving all key system stakeholders utilising agreed and validated data sources. Demand analysis has been undertaken at both a SATH and individual acute hospital site level. This is important to ensure that the system is fully sighted on any differentials in demand to ensure that interventions can be appropriately targeted at a hospital site level.

The outcome of this analysis is described in the following sections. The forecast method used is to plot the regression trend through actual weekly SUS data for SaTH catchment activity. Seasonality adjustments by average variances across the last 2 years from regression trend have been applied. This gives flexing of forecast to match the pattern of the last 2 years.

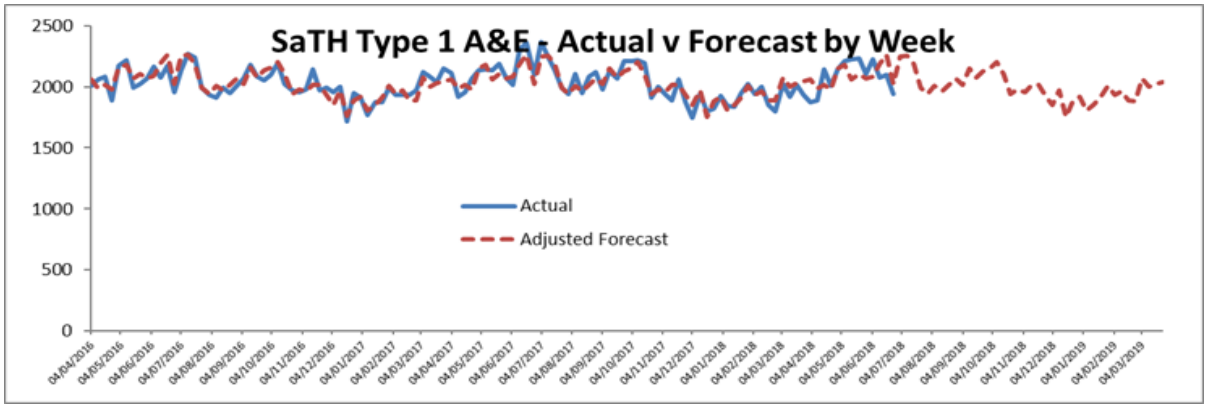
17.4 Demand – Historic Trend and Forecast

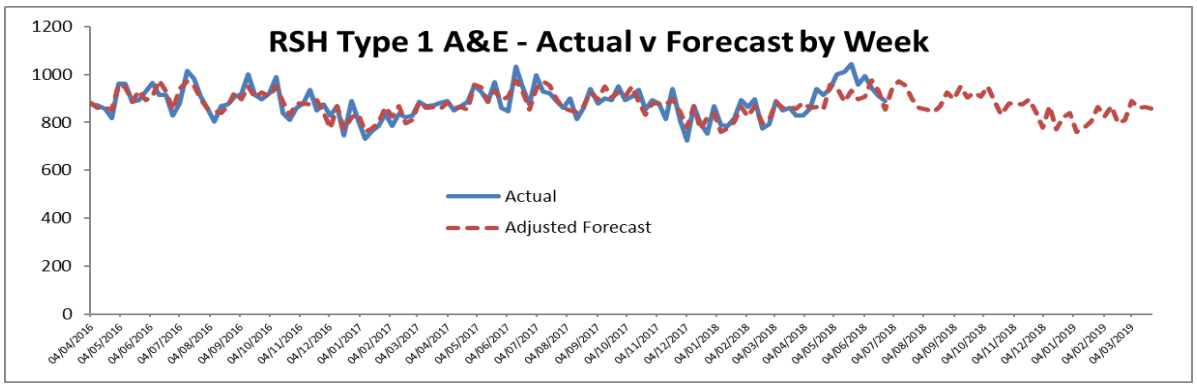
17.4.1 A&E Type 1

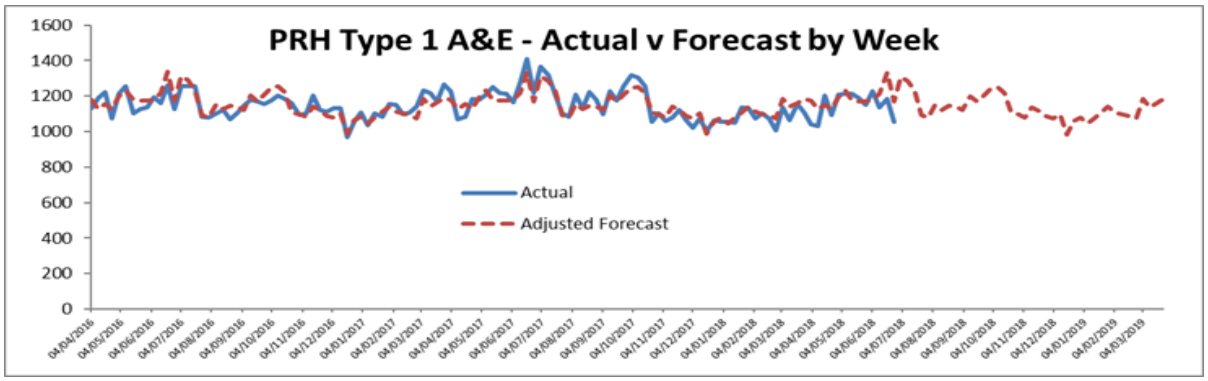
For Type 1 A&E activity the historic trend line is generally a flat trend with summer peak activity and winter troughs. The overall % growth predicted by site is shown in the table below.

SATH	RSH	PRH
1%	0.2%	1.5%

The activity trend lines by site are shown in the graphs below.







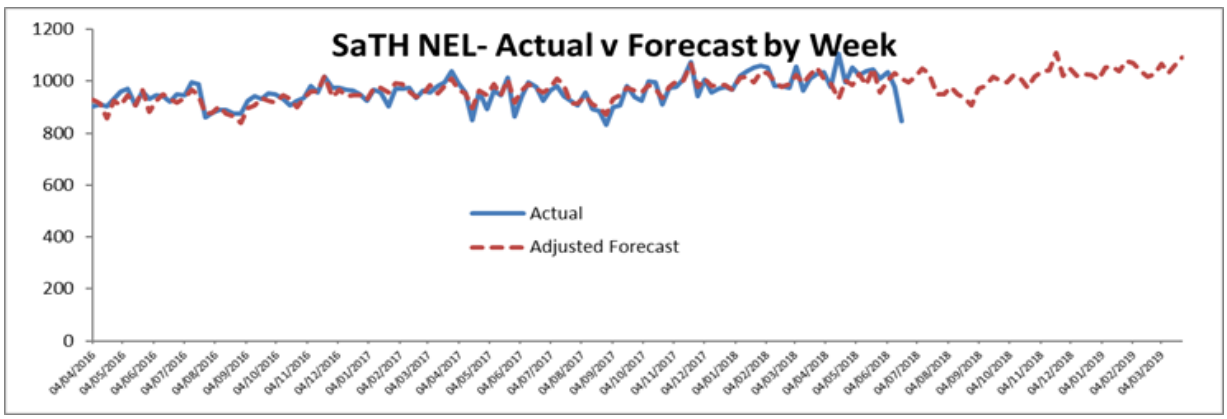
17.4.2 Non-Elective

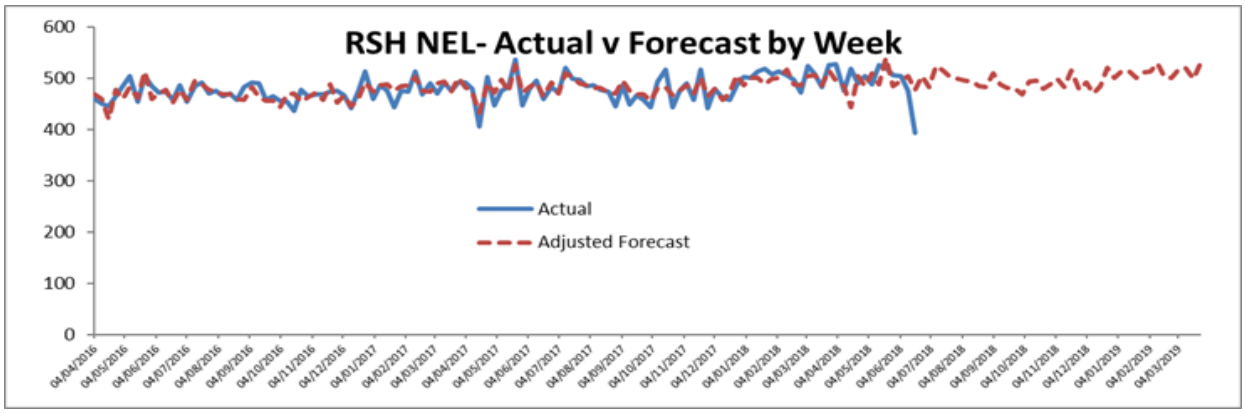
Non-elective activity shows a rising trend line although this growth is more rapid at PRH. Emergency growth is concentrated in the zero-day LOS (Apr – Jun 2017 = 28.4% compared to 33.6% in same period 2018).

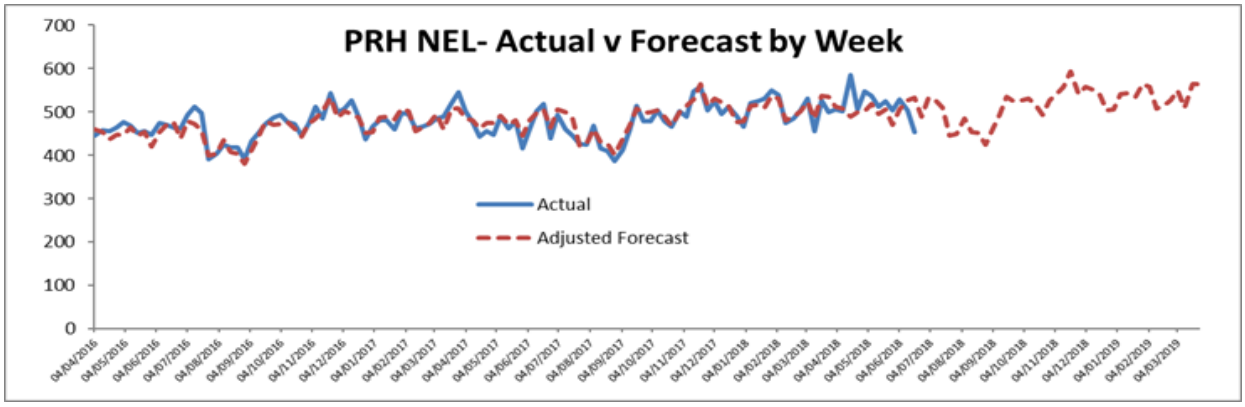
The growth in 0 LOS was higher at PRH (32.6% (2017) to 39.5% (2018). Further analysis confirmed that this growth in activity was attributable to the opening of Clinical Decision Unit (CDU) at PRH and that for RSH the growth (24.3% to 27.3%) had no material impact on required winter bed capacity numbers for that site. Adjustments have been made to the activity calculations to ensure zero LOS is accurately reflected in the bed gap calculations.

SATH	RSH	PRH
2.9%	2.4%	3.4%

The activity trend lines by site are shown in the graphs below.



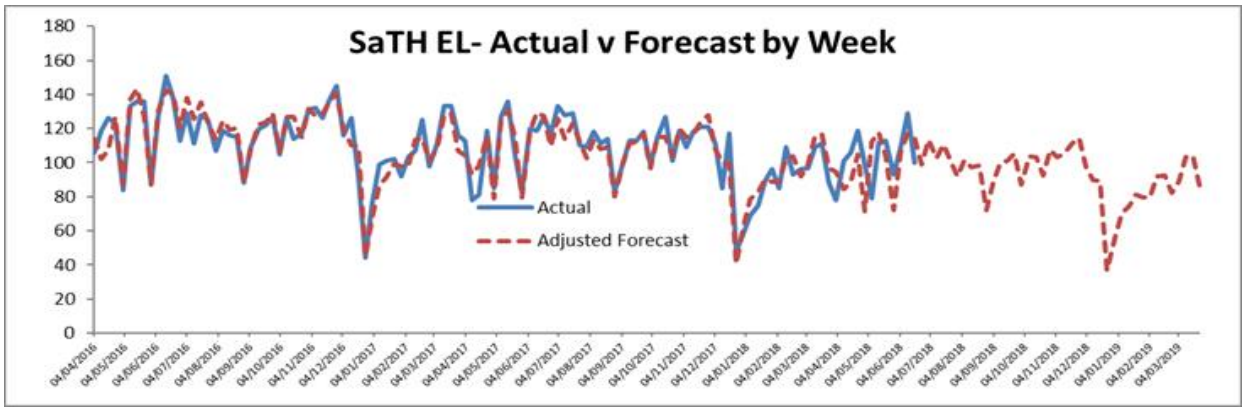


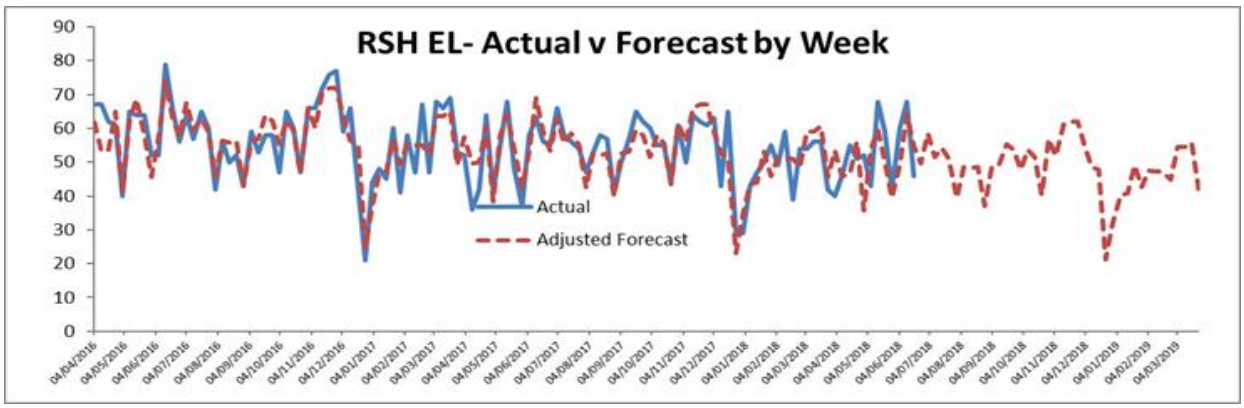


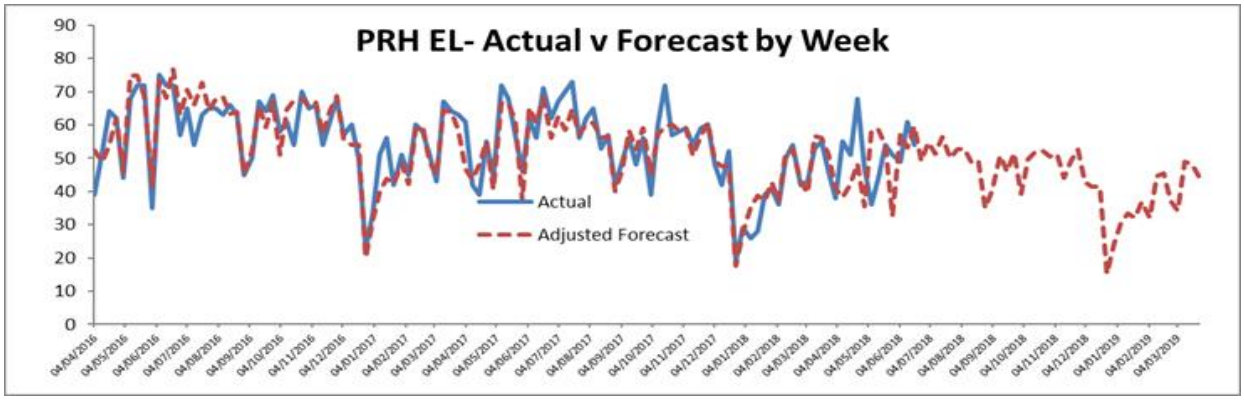
17.4.3 Elective

Analysis of elective activity shows a decreasing trend at both sites.

SATH	RSH	PRH
-7.7%	-6.3%	-9.3%







The tables below provide a more detailed breakdown comparison of the baseline 2017/18 activity and forecast demand in 2018/19 per month. As can be seen from the tables, for SATH, all in-patient activity is projecting a 2% growth. The national prediction of growth is 4% for non-elective. The system has planned for a 5% increase in non-elective activity, a net total inpatient activity increase of 3.9%. This together with the increase in 0-day length of stay in the last 12 months produces an overall 2% increase in the number of beds required as described in section 16.5.

SATH total

	Oct	Nov	Dec	Jan	Feb	Mar	Total	Growth
A&E Type 1								
Baseline 17/18	9,321	8,315	8,091	8,486	7,583	8,735	50,532	
Demand Forecast	9,185	8,477	8,303	8,381	7,670	9,006	51,022	1.0%
Contract	9,020	8,514	8,416	8,646	8,229	9,169	51,994	
Non-Elective								
Baseline 17/18	4,255	4,289	4,330	4,547	3,991	4,487	25,899	
Demand Forecast	5191	4167	5227	4196	4208	4221	27210	5%
Contract (all comm)	4,121	4,247	4,284	4,347	4,095	4,435	25,530	
Original Submission	4,189	4,269	4,491	4,399	4,157	4,589	26,094	
Elective								
Baseline 17/18	497	503	359	343	383	448	2,533	
Demand Forecast	438	465	327	338	346	424	2,338	-7.7%
Contract (all comm)	422	405	368	307	337	380	2,219	
All Inpatient								
Baseline 17/18	4,752	4,791	4,689	4,890	4,374	4,936	28,432	
Demand Forecast	5629	4632	5554	4534	4554	4645	29549	3.9%
Contract (all comm)	4,544	4,652	4,652	4,654	4,432	4,814	27,749	

RSH

	Oct	Nov	Dec	Jan	Feb	Mar	Total	Growth
A&E Type 1								
Baseline 17/18	3,973	3,684	3,480	3,678	3,326	3,794	21,935	
Demand Forecast	3,947	3,739	3,611	3,547	3,300	3,842	21,986	0.2%
Non-Elective								
Baseline 17/18	2,102	2,041	2,088	2,251	1,988	2,259	12,729	
Demand Forecast	2562	2056	2578	2069	2074	2080	13418	5.4%
Elective								
Baseline 17/18	244	254	221	198	201	230	1,349	
Demand Forecast	222	254	181	191	187	229	1,264	-6.3%
All Inpatient								
Baseline 17/18	2,345	2,295	2,310	2,450	2,189	2,489	14,078	
Demand Forecast	2,784	2,310	2,759	2,260	2,261	2,309	14,683	4.3%

PRH

	Oct	Nov	Dec	Jan	Feb	Mar	Total	Growth
A&E Type 1								
Baseline 17/18	5,348	4,632	4,611	4,808	4,257	4,941	28,597	
Demand Forecast	5,238	4,738	4,692	4,835	4,370	5,164	29,036	1.5%
Non-Elective								
Baseline 17/18	2,153	2,248	2,242	2,296	2,003	2,229	13,170	
Demand Forecast	2630	2112	2649	2127	2134	2141	13792	4.7%
Elective								
Baseline 17/18	253	249	138	144	182	218	1,184	
Demand Forecast	216	211	146	147	159	194	1,074	-9.3%
All Inpatient								
Baseline 17/18	2,406	2,496	2,380	2,440	2,185	2,447	14,355	
Demand Forecast	2,846	2,323	2,795	2,274	2,293	2,335	14,866	3.6%

In summary, the predicted growth in activity is shown in the table below.

Predicted % Growth in Demand compared to 17/18 baseline			
	SATH	PRH	RSH
A&E Type1	1.0%	1.5%	0.2%
Non -Elective	5.0%	4.7%	5.4%
Elective	-7.7%	-9.3%	-6.3%
All Inpatient	3.9%	3.6%	4.3%

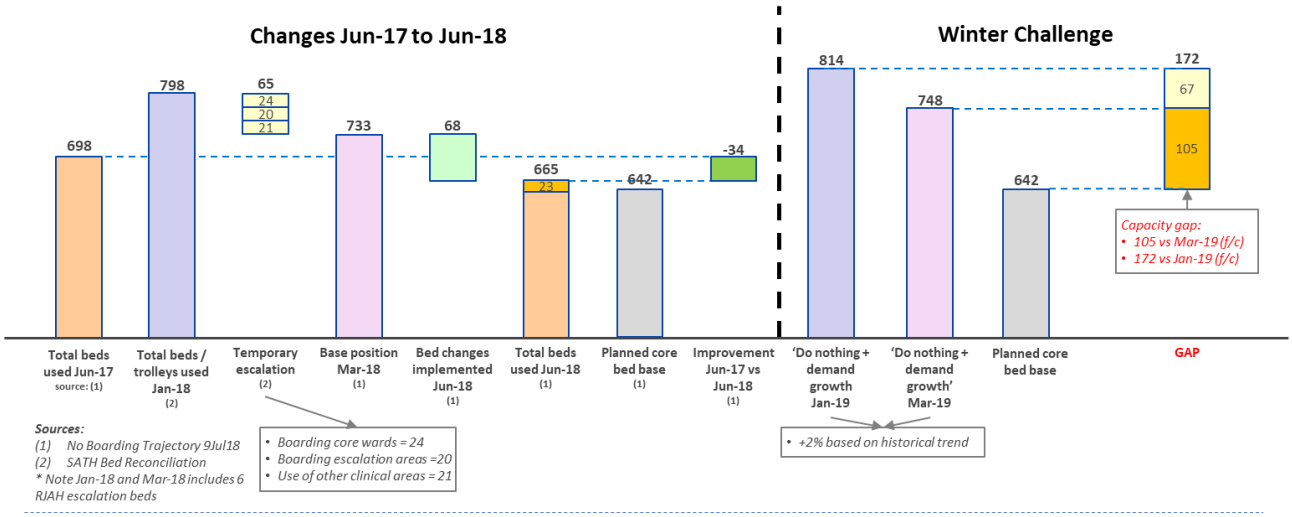
17.5 Capacity – historic capacity used and the 'do nothing' forecast

An analysis of historic bed capacity in use at key points in the year has been undertaken which identifies the trend in bed capacity utilisation, including the peak in January and the start

position this June over and above the acute core bed stock of 642 (this number excludes maternity, paediatrics and critical care). This analysis is shown diagrammatically on the left section of the diagrams below.

17.5.1 SATH Bed Capacity Requirements Winter 2018/19

At the peak of demand in January, SATH reported a total of 798 acute beds in operation, 65 of these beds were escalation expansion into other clinical areas and boarding patients in escalation and ward areas.



In June 2018, the total number of acute beds in use in SATH was 665 which is 23 beds more than the core bed stock level of 642. However, this represents 34 fewer than were in use in the comparable period in 2017. A significant proportion of this bed reduction is attributable to the successful work programme to reduce the number of stranded patients (>7-day LoS) and to reduce the number of patients on the Medically Fit for Discharge list (MFFD).

The forecast of predicted winter bed capacity requirements above the core bed stock is described diagrammatically on the right of the diagrams utilising 2 scenarios: -

1. At Jan Peak - Do Nothing* + 2% growth in bed requirement (resulting from the 5% expected growth in activity quoted above in the predicted growth table in 16.4)

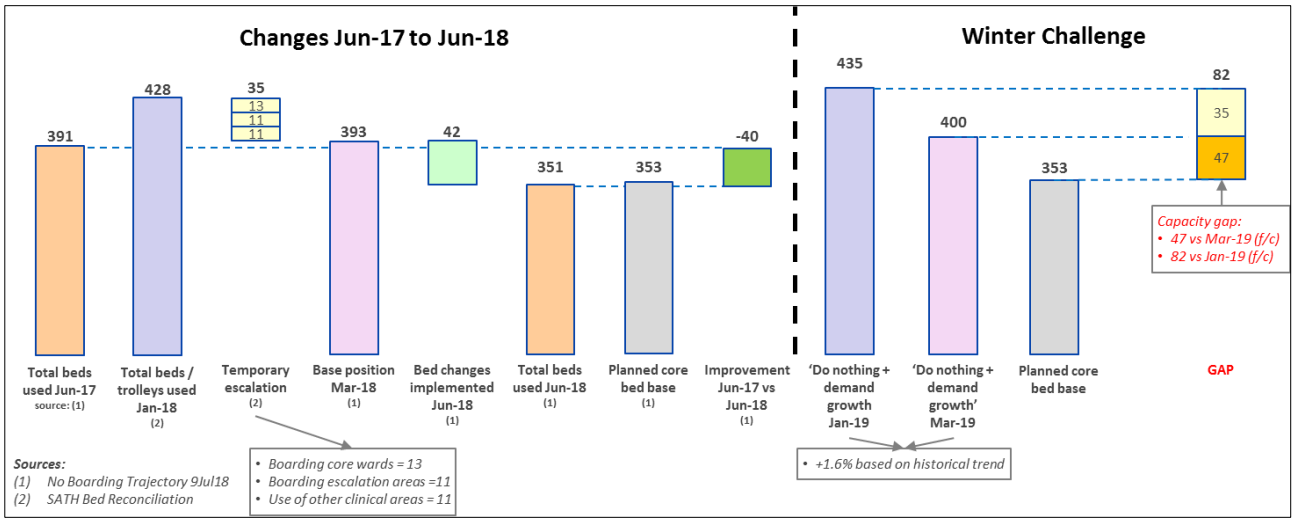
2. At March demand - Do Nothing + 2% growth in bed requirement (resulting from the 5% expected growth in activity quoted above in the predicted growth table in 16.4)

*(*Do nothing means predicted volume of demand recorded in the same period in 2017 with no mitigating interventions)*

For SATH as a whole to meet the predicted peak January demand for acute beds requires an additional 172 beds/mitigation interventions above the 642-core bed stock. To meet the predicted demand in March requires an additional 105 beds/mitigations.

However, as represented in the diagrams below, when analysed at a hospital site level the winter capacity requirements are significantly different. For the most part this is due to the majority of bed reduction benefit from the stranded and FFT programmes being realised at the Royal Shrewsbury Hospital (-40 beds). The Princess Royal Hospital is showing 7 more beds in use this June compared to June 2017.

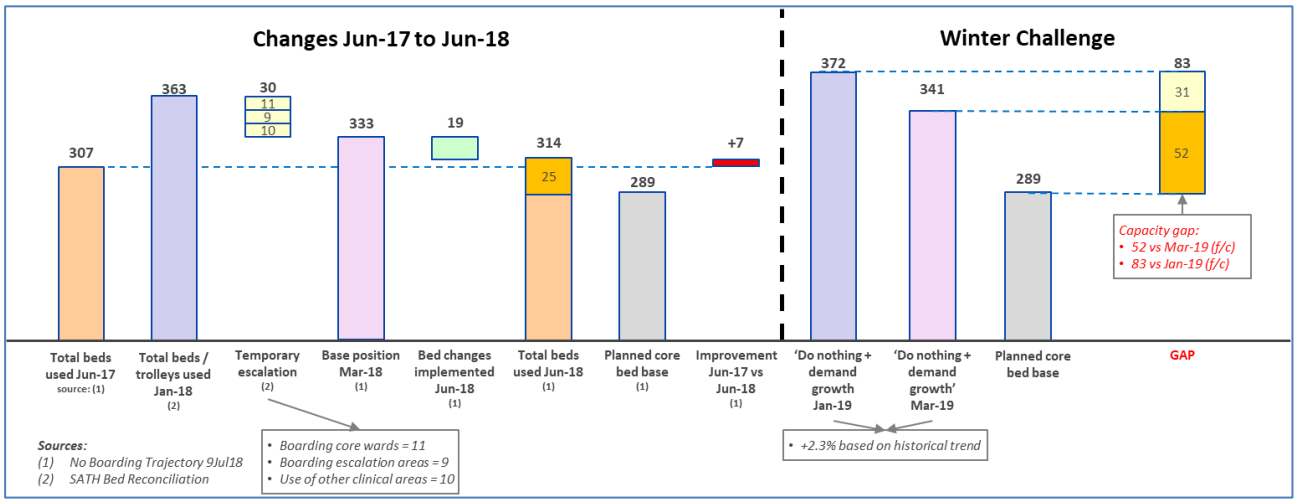
17.5.2 RSH Bed Capacity Requirements Winter 2018/19



The winter 2018/19 bed capacity forecast for RSH shows:

- To meet the January peak of 435 requires an additional 82 beds / mitigations (vs 353 core beds)
- To meet the 'March' demand of 400 requires an additional 47 beds / mitigations (vs 353 core beds)

17.5.3 PRH Bed Capacity Requirements Winter 2018/19



The winter 2018/19 bed capacity forecast for PRH shows:

- To meet the January peak of 382 requires an additional 83 beds / mitigations (vs 289 core beds)
- To meet the 'March' demand of 350 requires an additional 52 beds / mitigations (vs 289 core beds)

17.6 The impact of the PRH ED Closure overnight

At the end of September SATH Board took the decision, due to unsustainable workforce issues and the consequent risks to patient safety, that the PRH ED should be closed temporarily overnight. As a result, the demand and capacity analysis described in the previous section was revised to reflect the impact assumptions on patient flows that the closure is predicted to have.

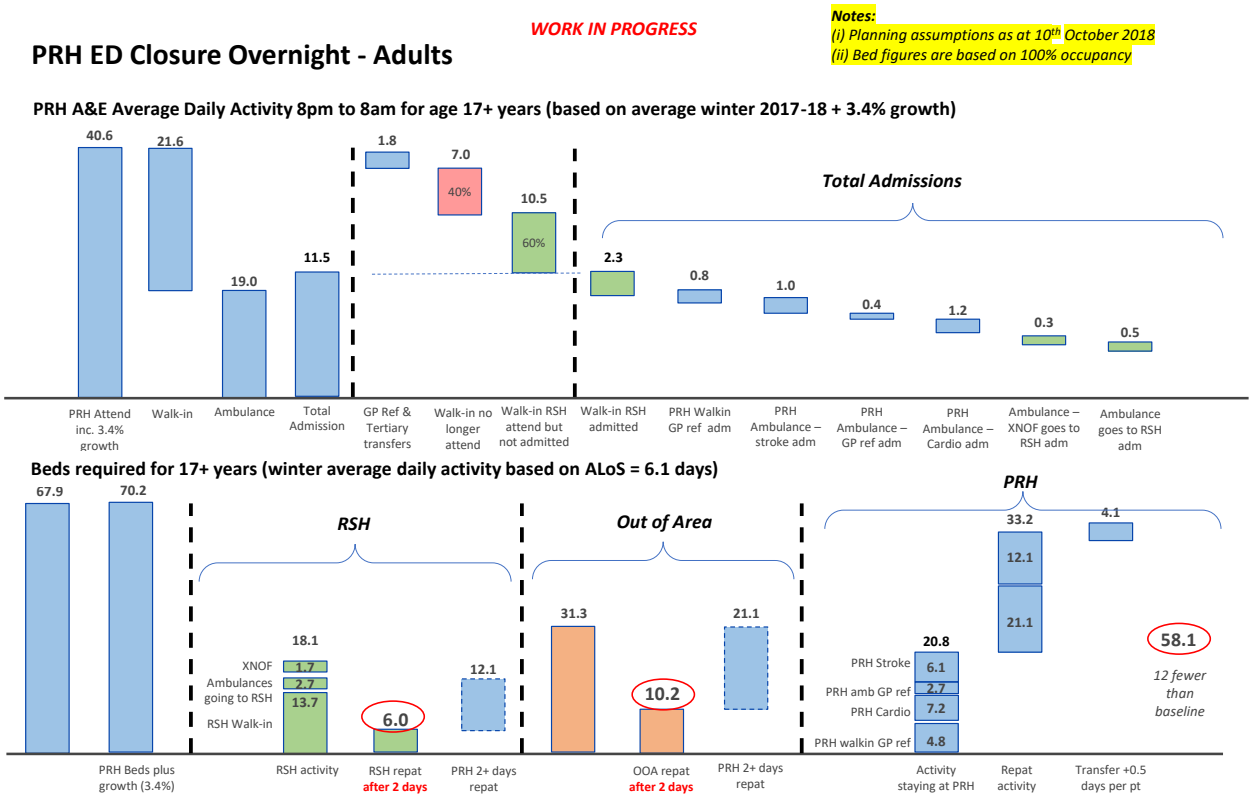
This revised analysis is shown in the diagrams below. The assumptions used in the calculations are: -

For the adult related PRH activity based on the impact experienced with overnight closure elsewhere, the following assumptions have been made:

- An estimated 40% of walk ins will no longer attend
- There are a proportion of admissions (3) that will go to RSH and a number (3) that can still be admitted to PRH overnight based on the agreed clinical pathways.
- The balance will go out of county

This is modelled in the top activity bridge diagram below.

Impact on Adult bed position:



The resulting impact on beds is shown in the bed bridge above. Key points to note are:-

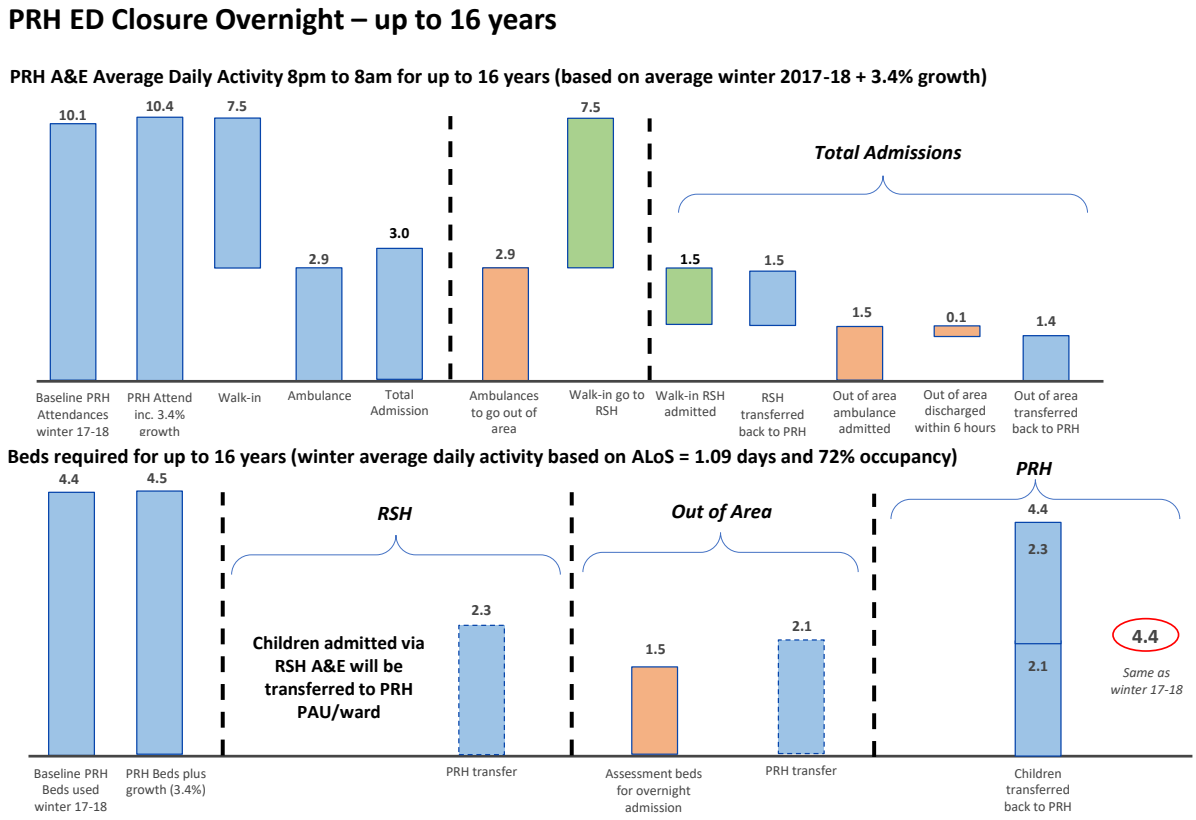
- An additional 18.1 beds are initially required at RSH but post repatriation the net increase is 6 beds. The net impact on out of county providers post repatriation is 10.2 beds.
- The total impact for PRH has been based on the sum of the activity remaining at PRH plus that being repatriated plus an expected increase in LoS of 0.5 days per patient due to the transfer.
- This equated to a total bed requirement of 58 beds which is 12 less than the baseline requirement of 70.2 including growth for 18/19.
- This is based on a planned closure of 8pm. This is currently still under discussion as the Trust has been asked to source additional staff to minimise the hours closed to 10pm – 8am. If this is successful the bed modelling will need to be refreshed for one final iteration.

In summary, this results in a lower demand for beds at PRH of -12, which is the 70.2 original demand minus the new demand of 58.1. The resulting impact for RSH is a net increase in demand of +6 beds. There is also an out of county demand of 10.2 beds.

The planned closure has a specific impact on paediatric demand as the county's Women and Children's services are consolidated on the PRH site. The assumption within the current closure plan is that all this activity will intially need to go out of county and then be repatriated back to PRH. However, the predicted impact on beds is neglible (see diagram below) with only a slight reduction expected due to a small number of children who would be taken out of area but then discharged before repatriation can take place the next day.

Impact on Paediatric Bed Position

WORK IN PROGRESS



In summary, the resulting impact on beds from the paediatric shift is negligible, a new demand of 4.4 beds versus the demand of 4.5 under the original plan where PRH ED remained open.

17.7 Winter Capacity Plan

17.7.1 Overview of the Plan

Planning work to inform the Winter Plan has involved facilitated workshops. Stakeholder partners have also submitted proposals for winter capacity schemes as part of this planning work.

In their winter capacity proposals, partners were asked to submit: -

- details of the scheme

- costs (including whether the cost is to be met from new non-recurrent investment or from existing identified funding streams)
- the anticipated impact on acute beds
- confidence level in successful operational delivery to timescales and ongoing maintenance

All the above information was collated into a long list of approximately 60 schemes. The A&E Delivery Group has undertaken an iterative review process of the long list at its bi-weekly meetings to formulate a shortlist which constitutes the final Winter Capacity Plan.

17.7.2 Summary Winter Capacity Plan Bed Impact

The table below provides a summary position of the capacity that system partners have committed to bring on line to mitigate the anticipated gap throughout the winter period by hospital site. The numbers represent the expected contribution the interventions will make to bridge the predicted bed gap this winter compared with the acute core bed stock of 642 for the peak January period.

	PRH	RSH	By When
Bed Gap			
Bed bridge gap at peak winter demand	-83	-82	Jan/Feb 2019
Bed impact of temporary closure of PRH ED overnight (+ve means reduction in beds needed)	12	-6	5th December 2018
Bed gap	-71	-88	
SATH Mitigations – Low Risk			
MFFD maintained at c70/Stranded patient improvement	24	43	1st October 2018
Extended operating hours in MAU/SAU	3	3	TBA
Phase 1 - Planned escalation bed capacity (Wards 21 and 8)	14	16	Phased from 1.10.18 as necessary, fully operational by 1.12.18
Phase 2 – Planned escalation bed capacity (Ward 19)		30	24th December 2018
Total low risk mitigation bed capacity	41	92	
Net bed gap	-30	4	
Additional system mitigations – Low Risk			
Improved utilisation of community hospital beds	10		1.10.18 criteria flexed. Discussions ongoing with acute about speciality cover allowing further sub-acute admissions
Additional LA D2A beds	7	5	1st October 2018
Expansion of SATH2Home capacity	8	2	TBA
Total additional system mitigations bed capacity	25	7	
Net bed gap	-5	11	
Additional system mitigations – High Risk			
Improved weekend discharges	5	5	Requires detailed delivery plan
Reduction in Powys LA delays	1	1	Requires agreement from Powys
Total	6	6	
Final position (+ve = surplus) net bed gap	1	17	
If required, short term time limited SATH surge contingency bed capacity			
Planned time limited contingency escalation beds	24		PRH DSU eg February for 3-4 weeks

Additional system mitigations to support the maintenance/improvement in acute flow (no direct bed capacity impact)			
Community IV antibiotics			1.10.18
Discharge lounge on both sites			
Frailty Front Door/Admission Avoidance services			RSH in place. PRH tbc
T&W Care Home MDT			Operational
Carers in a Car			Operational
x8 Shrewsbury Pathway 2 care home beds			Operational
x4 Pathway 3 Dementia beds (Redwoods)			1.11.18
Additional social work and brokerage capacity			To support weekend discharge
Rapid Response / WMAS Car scheme in Telford			Operational since 5th Nov – impact to be quantified

Assumptions applied to this plan are:

- There is no variation in the calculated bed gap throughout the winter period;
- Maintenance of the reduction in long lengths of stay at 250 (over 7 days) including 50 (over 20 days).

A more detailed description of the planned mitigations/interventions which support the Winter Capacity Plan is set out in the following section.

As previously indicated, unscheduled care demand in the Winter Plan is profiled above 17/18 activity. If the service is unable to return to seasonally expected unscheduled care activity levels, further compensatory provision will need to be made to the capacity modelling for winter.

This will be kept under review by the system wide stakeholders.

17.8 Acute Bed Gap Mitigating Interventions Winter 2018/19

17.8.1 Admission Avoidance

Frailty Front Door RSH

The integrated acute and community Frailty Intervention Team (FIT) was introduced in A&E at RSH last winter. The team have continued an on-going process of developing, embedding and improving working relationships and pathways to optimise the team's ability to support same day discharge from ED wherever possible for frail older patients. The introduction of this team has been a significant contributory factor in the ED conversion rate to admission for >75s being 6% lower between April – June 2018 than the same period last year. The improvement cycle will continue, and the team is exploring opportunities to work in partnership with the ambulance service to identify appropriate patients for direct access to the caseload by the ambulance crews to reduce demand on ED this winter.

Frailty Front Door at PRH is planned, but the commissioners and providers feel that the staffing situation going into winter will inhibit the development of this service until the next financial year. They are, however, committed to the development as soon as staffing levels allow, and are also providing admission avoidance schemes to try to prevent patients being conveyed and admitted.

Improving streaming at the front door:

The permanent provision of a streaming function at both PRH and RSH remains variable due to both staffing and confirmation of permanent funding. SaTH, with the CCGs, continue to focus on

an interim and permanent solution to ensure the service is provided during winter, as well as planned for FY 19/20

Carers in a Car

In Telford and Wrekin, Integrated Discharge Teams (IDT) highlight night needs e.g. toileting and wound/ pressure area care as a rationale for Pathway 2. The provision being commissioned will enable night time support as an alternative to Pathway 2. This will be an adjunct to domiciliary care calls where identified.

Shropshire Council have a new service to meet the needs of service users at night called “Two carers in a car.” This project came from the question, “Do all the people going into residential care or having night sit services actually need that level of care?”

The Council found that sometimes where 24-hour residential care, or a full night’s domiciliary care support had been commissioned, only short periods of assistance were actually needed through the night due to occasional falls, anxiety, or emergency support being required in the night once or twice. In addition, night time packages and residential care can take a long time to source so a solution was required to support people to come out of hospital more quickly and in some cases to prevent them from going in.

The Council have created a unique service that can support people to stay at home longer, support better hospital discharges, support people in their choices based on their confidence, comfort and dignity, making sure people are safe. They have commissioned 5 contracts which deliver a service which operates a 7 night a week service and provides two carers 10 pm – 7am on a block contract – each contract covers a specific area as follows:

Oswestry and surrounding area (Approximately 5-mile radius)
Market Drayton and surrounding area (Approximately 5-mile radius)
Bridgnorth and surrounding area (Approximately 5-mile radius)
Ludlow and surrounding area (Approximately 5-mile radius)
Shrewsbury and surrounding area (Approximately 5-mile radius)

Referrals come from the social work and EDT teams, but they can also come in from hospitals, A&E, Out of Hours Doctors, district nurses, GP’s, alarm call centre etc. The carer team are able to take referrals directly via smart phone during the night and during the days calls are picked up by their office. Carers can therefore allocate their own work and make judgements about what is needed.

The service started in Shrewsbury in July 2017 for a pilot which was so successful it has been expanded to the 5 market towns in the table above.

Telford & Wrekin Care Home MDT

The Care Home MDT is embedded within the Telford & Wrekin Rapid Response team to deliver admission avoidance and preventative interventions. They are focusing on the top six high admitting care homes in Telford and Wrekin initially. Rapid Response team take calls from the targeted care homes, rather than the homes dialling 999 initially. The dedicated Care Home MDT provide additional support after identifying training and development needs; focusing on prevention and proactive working, specific to the needs of the home and residents.

The Team are rolling out “Emergency Passports” for the residents in the six targeted homes; already successfully used by WMAS in the Walsall area, delivering a reduction in conveyances to hospital. They are also working with SaTH and the Dementia Team to develop the nationally

recommended “Red Bag Scheme” in care homes. In addition, falls prevention awareness “I-Stumble” protocol has been implemented in the six homes by the team, which is a tool aimed at care homes for use in assessing falls and includes guidance for staff on what to do during and after a fall, including when it is appropriate to call 999.

Shropshire CCG and LA are working in partnership to implement the ‘Emergency Passport’ and ‘Red Bag Scheme’ this winter in a targeted number of care homes.

Use of Community Hospitals for Step Up

Historically, 80% of community hospital admissions are from planned acute hospital discharges. The average utilisation of available community hospital beds during winter 2017/18 was 89.7%. ShropCom has committed to promote the use of community hospital beds for the avoidance of acute admission as a ‘step up’ approach, in circumstances where a ‘Home First’ approach is not appropriate. It is anticipated that 5 beds across all sites would be available for admission avoidance to maintain occupancy at 95%. Planned actions to facilitate this are;

- Introduction of the Clinical Capacity Manager from October 2018
- Flexibility of Community Hospital admission criteria
- Improved access to community hospital beds for admission avoidance

The key performance metrics will be used by the A&E Delivery Board to monitor performance.

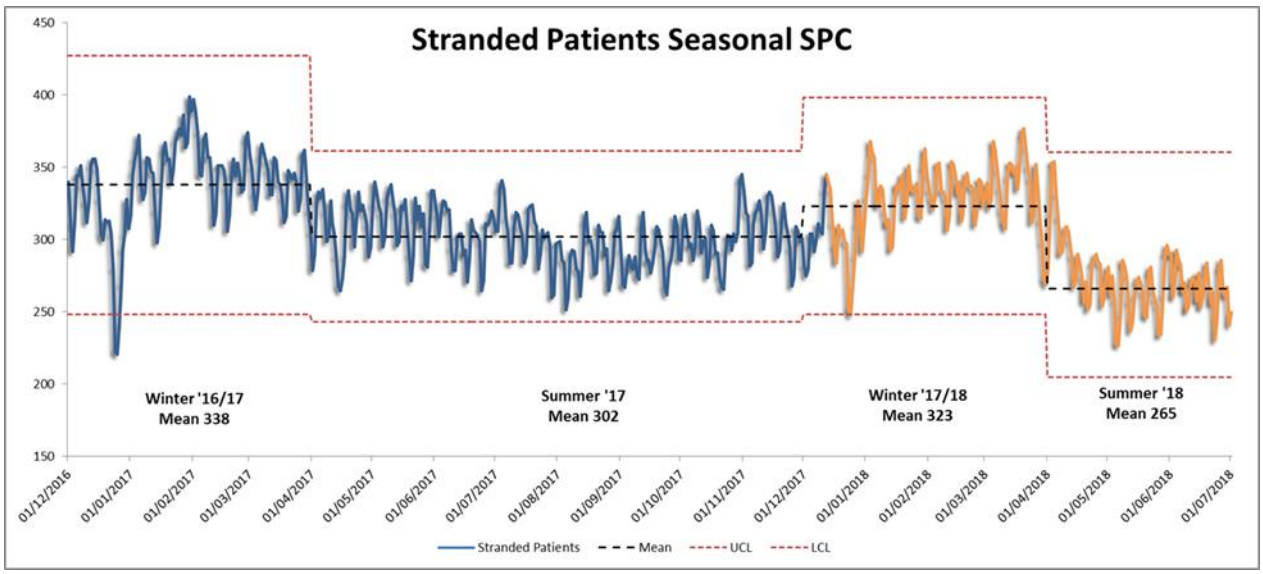
17.8.2 Improving/Maintaining Acute Hospital Flow

A number of key initiatives are planned to support internal acute flow this winter. Many are funded as part of the winter funding initiatives, however there are some schemes that require funding over and above the CCG Winter funding given. These are marked in this plan and will be subject to further negotiation with commissioners/NHSI/NHSE.

The Trust are planning to achieve 90% A&E performance by March 2019 by redesigning flow through majors to allow greater in-reach, which will be dependent on maintaining sufficient capacity at SaTH and in community services to ensure flow. The A&E internal plan includes:

- Review of A&E 4-hour breaches and reasons with a view of targeting specific pathways;
- Review Emergency Department floor template to maximise flow for admitted pathways;
- Speciality doctors ingress into A&E to ensure greater in-reach from bed-based specialities;
- Plan to achieve 95% target in both minors and paediatrics at SaTH by the end of December 2018 to achieve the overall target, this will then be sustained (Rapid Improvement Week with ECIST national programme leads-10th December 2018);
- The Trust have decided that this winter plan will be their winter plan for 18/19

A key factor in delivering the winter capacity plan is maintaining the improvement in the number of long length of stay patients (>7-day LoS) through delivery of the ‘Stranded Patient trajectory’. The graph below shows the step change in performance which has been achieved in summer 2018 delivering a 25% reduction in bed days associated with long stay patients which equates to the equivalent reduction of 22 acute medical beds (RSH) plus 14 acute medical beds (PRH site).



- Orange indicates when SaTH began looking at the stranded patient metric (patients over 7 days in hospital).
- It shows that the work prevented the worst of the winter spike
- It shows sharp improvement out of the worst of winter
- Summer 2017 Mean (302) vs Summer 2018 mean (265) = 37 improvement

Sustaining the improvement made with long stay patients will be achieved through continuation of the daily Check, Chase, Challenge process and the weekly Long Stay Patient escalation review meetings. The CCGs, Councils and ShropCom are working closely to support the Trust. ECIST are helping the system to refine all relevant processes and checking against all the advice in the "Reducing Long Stays in Hospital" guidance.

SaTH have defined 'super stranded' patients as those in a bed for more than 21 days. The following actions will be taken by the Trust:

- Daily board rounds;
- Weekly MDTs in escalation beds;
- Daily Check, Chase and Challenge meetings;
- Executive-led weekly review of long stay patients;
- Daily conference calls across community and bed-based services;
- Planned MADEs across services commencing at the end of November and early January and an enhancement of the daily Check, Chase and Challenge to incorporate Long Stay Wednesday as advised by the National Long Stay Toolkit.

SaTH have set themselves an internal aim of a reduction in long stay patients (above 6 nights) of 180 (from 362 in January 2017) they are at an average of 250 in August 2018. Further actions are now focussing on targeting PRH and medical engagement. The stranded metric reduction high impact change has the executive leadership of SaTH's Medical Director.

The provision of a Discharge Lounge on both sites will support pre-midday discharge.

The extension of the operating hours in the assessment areas of AMU and SAU will support increased same day discharge which is predicted to translate into the equivalent contribution of 3 additional acute beds on each acute site.

SaTH and ShropCom therapies are undertaking a review as part of the NHSI improvement cohort with Allied Health Professionals (AHPs) to strengthen the current provision. There are currently different models in place across services in relation to therapies. To ensure effective flow and improved outcomes for patients, the current vacancies in the services will be filled as soon as possible.

Projects are being undertaken as part of the NHSI AHP Collaborative involving a partnership between SaTH and ShropCom therapy services. This nationally led project is aimed at reducing length of stay across patient pathways. The first pathway to be reviewed by SaTH and SCHT therapists is trauma & orthopaedics from ward 22 T&O at RSH to Whitchurch Hospital. The aim is, through integrated working, LoS will be reduced by 1 day at RSH and 1 day at Whitchurch over the next 3 months. Following this, further pathways will be reviewed from a therapy integration perspective including stroke, neuro-rehab and frailty. The intended outcome of this work is seamless goal planning and transfer of care across organisations to avoid duplication so maximising the opportunities for patients to receive the therapy interventions they require in the right environment to meet their needs.

Currently, community based IV therapy is not robustly available within Shropshire / Telford and therefore, to increase the amount of IV antibiotic therapy delivered within the community as an alternative to acute based care, the system has adopted a phased approach, commencing October 2018. Phase 1 will be a pilot for an initial 12 months as part of the Winter Plan consisting of a 'Chair based' IV Antibiotic therapy for bronchiectasis, cellulitis, diabetic foot and urinary tract infection (UTI) – using existing community staff resources within Bridgnorth, Ludlow and Shrewsbury DAART/MIU (for mobile patients). Referrals to this service are monitored on a daily basis via the escalation calls to ensure it is fully utilised.

New twilight shifts will be added in ambulatory care in RSH and PRH. The Ambulatory clinics will remain open until 11pm which will enable patients to be treated and discharged, thus preventing an admission.

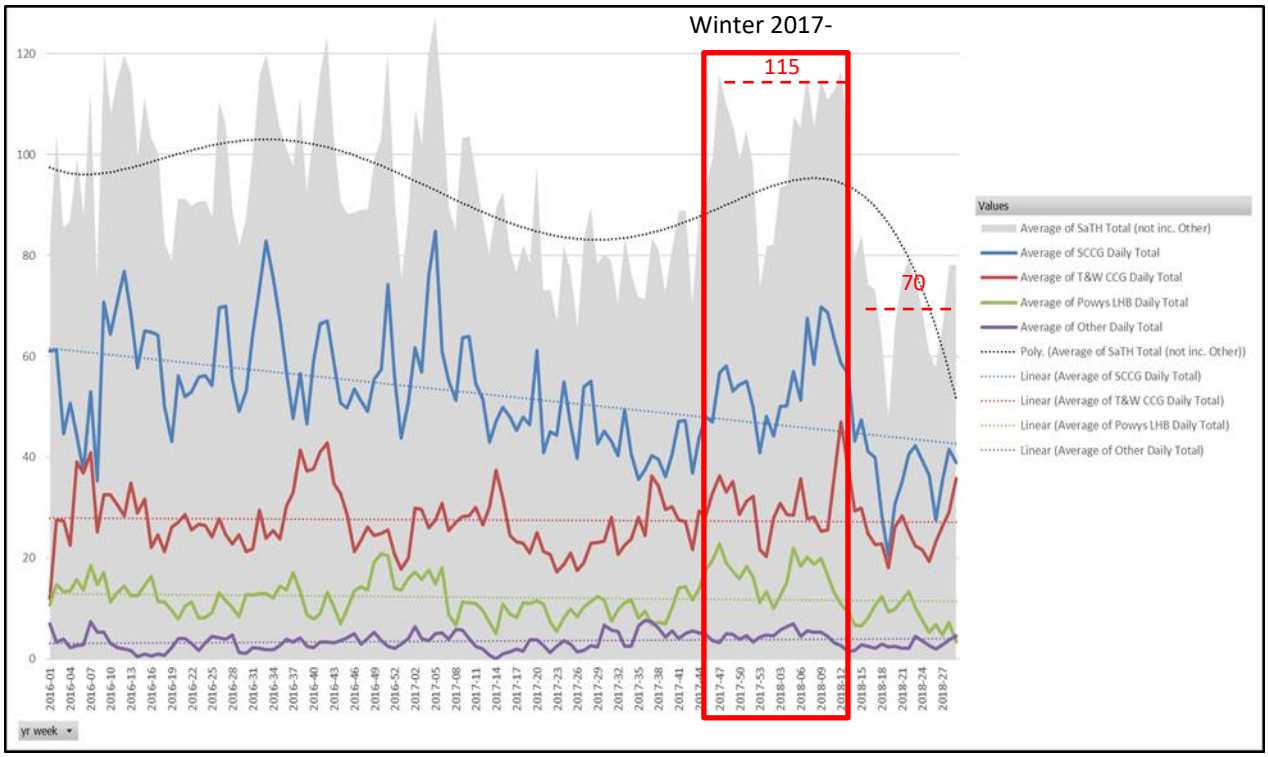
Other System-wide Acute Flow Enablers in place to support escalation between October 2018 and April 2019 are:

- Three high impact changes: Improvement in ED systems and processes, embedding SAFER patient flow bundle and Red2Green across acute and community
- Review of NCEPOD capacity – improve NEL surgery access and reduce LoS, ring fence elective capacity;
- SaTH & WMAS: Tactical Admission Avoidance through non-conveyance
- System-wide Choice policy application – refresh to include Patient Welcome Cards
- Value Stream Mapping respiratory and cardiology pathways: multi stakeholder teams. High Intensity user admission avoidance with out of hospital pathway

The key performance metrics will be used by the A&E Delivery Group to monitor performance of this section.

17.8.3 Managing Complex Discharges – to avoid growth in the 'Medically Fit for Discharge (MFFD)' List

The graph below shows the significant reduction in the number of patients who are reported daily as being on SATH's Medically Fit for Discharge (MFFD) list. Last winter the number of patients on the list peaked in October and March at 115. The number reported on the MFFD list in the first quarter of 2018/19 has reduced to, and is being maintained at, c70.



Key planned interventions which will contribute to maintaining the MFFD at c70 patients per day are: -

- Increasing NHS commissioned community rehabilitation bed capacity in Shrewsbury (compared to the same period last year)
- Increasing LA commissioned discharge to assess bed capacity (compared to the same period last year) in both LA areas.
- Increasing bed occupancy rates in Shropshire Community Health NHS Trust community hospital beds through optimisation of usage against the current eligibility criteria and agreed flex criteria
- Reducing the length of stay in NHS commissioned independent sector and Robert Jones and Agnes Hunt rehabilitation beds.
- Increasing the EMI discharge to assess bed capacity through the use of spare capacity in the Redwoods Dementia Unit and general nursing discharge to assess independent sector beds to EMI. Additional nursing home beds will be purchased to support dementia flow as temporary placements when permanent care becomes restricted.
- Releasing domiciliary capacity to support increased acute discharges to Pathway 1 (home with support)
- Additional social worker capacity at the weekends
- Addressing the supply of home care in the hardest to serve areas of the county;
- Ensure sufficient brokerage capacity to manage increases in discharge numbers.

The key performance metric will be used by the A&E Delivery Board to monitor performance of this section.

17.9 Additional Acute Hospital Beds

Phase 1 – 1st October 2018

Up to 16 escalation beds will be opened at RSH and up to 14 escalation beds at PRH with a fully dedicated Multi-Disciplinary Team (MDT) available, including Social Worker support, to ensure continuity of care and flow.

Multi-Agency Discharge Events (MADE) will be undertaken at the end of November (24th and 25th) and in early January 2019 and the daily Check, Chase and Challenge will be enhanced to include 'Long Stay Wednesday' as recommended by ECIST and the National Long Stay Toolkit.

At times of escalation senior presence will support the ward to ensure flow is maintained to free up capacity. Clear escalation processes will be in place to ensure patients who become delayed are expedited.

There will be a concentration from the system on weekend discharges. Our actions are:

External system

- Increased community therapy and nursing input to support discharge home at the weekend.
- Integrated discharge hub to run at the weekend
- Additional social work capacity being funded from additional national winter monies
- Work with the Fire Service to explore transport for patients' options and checking of safety for patients on discharge.

SATH

- Discharge liaison nurse capacity at the weekend
- Pharmacy cover for discharge at the weekend
- Therapy-cover at the weekend
- Additional substantive consultant ward round at the weekend.

Phase 2 - 24th December 2018

Opening Ward 19 RSH - 30 beds

Weekly Multi-Agency Discharge Events will be undertaken throughout January 2019 and the daily Check, Chase and Challenge will be enhanced to include 'Long Stay Wednesday' as recommended by ECIST and the National Long Stay Toolkit.

The key performance metrics will be used by the A&E Delivery Board to monitor performance.

17.10 RJAH - Acute Hand Trauma

Hand trauma provision will be provided by the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, following a pathway agreed by SaTH and the CCG's. Expected numbers are, however, small; predicted 2 per day.

17.11 Mental Health – MPFT

As part of the capacity and demand review, the mental health review from the liaison nurses within 1 hour in the ED was seen as appropriate for need. The review on the wards within 24 hours was also appropriate for need. There were two areas that required review:

1. Assessment and Care of the young person- particularly for Powys young people

To rectify this, the mental health team have conducted a rapid improvement event to establish a clear pathway between the young people's crisis team and the RAID assessment team, establishing a clear pathway to specialist opinion 24/7. Outcomes will be reported to the A&E Delivery Group as part of the 30/60/90-day review process.

2. Complex discharge of patients with confusion and dementia

To rectify this, Shropshire LA will vary the current discharge to assess contract and will continue to spot purchase nursing dementia beds as required.

Shropshire LA are discharging more complex patients back to their home with confusion and dementia. This has been supported by schemes like 2 carers in a car, in reach support from the dementia home treatment team, carer's advice and support in reaching into the acute trusts and targeted reablement support has resulted in an increased number of individuals at home 91 days following discharge.

Telford and Wrekin will continue to work closely with the RAID team and have 2 block purchased specialist EMI Nursing beds available for Complex confusion and dementia Discharges on Pathway 2. For those on Pathway 3 they will spot purchase residential or Nursing EMI beds. There is a specialist Mental Health Social worker within the team who links closely with the West Midlands Partnership Team.

Support for all people and their carers leaving hospital including those with dementia and confusion has been established. There is a link carer's supporter who works with those with complex needs, their family and carers. The Assistive technology team is based in the Team and there are individual packages available to support with discharge. British Red Cross provides Discharge Support for an extended period on discharge.

17.12 West Midlands Ambulance Service (WMAS) Capacity

WMAS have a robust winter delivery plan that details all the actions that will be taken to ensure a safe and robust service over the winter and festive periods. WMAS have provided detail of their expected demand within their plan (Appendix 1). Typically, there is 4.5% increase year and year with a 10% growth in December and January. The Trust has developed a strategic plan with early investment for robust plans in place to ensure that during winter there is the maximum number of staff available and they can meet the demand expected.

WMAS has a strong Command and Control structure to ensure resource is managed effectively. An additional Duty Senior Commander will be based in headquarters as it has been proven in the previous two years that it is beneficial to have extra senior leadership on site.

WMAS will meet this additional demand through recruitment of more staff, ensuring timely replacement of vehicles to enable a temporary increase in the fleet for the busiest months, increased call takers and Vehicle Preparation Operatives.

17.13 Powys

Powys Local Authority are experiencing delays in discharging complex patients within 48 hours of being MFFD. All commissioners are required to seek alternatives to a delayed placement if this results in the patient being MFFD over 48 hours in an acute bed. For Powys LA, the system is seeking an agreement that Shropshire Council will place patients over 48 hours in Shropshire beds and that Powys will reimburse the cost to Shropshire Council. This will commence as soon as agreement can be reached with Powys LA.

For Powys LHTB, when patients are over 48 hours MFFD, permission will be sought for an alternative placement for example into a Shropshire Community Hospital bed where available.

Powys' Winter Plan (Appendix 2) sets out how Powys will deliver the 5 winter delivery priorities (WDPs) set out by Welsh Government:

WDP 1: **Optimising clinical engagement and partnerships** to deliver timely and high-quality access to services

WDP 2: Explicit focus on **better management of demand in the community**

WDP 3: **Enhanced operational grip and clinically focussed hospital management** to mitigate peaks in pressure and manage risk effectively

WDP 4: **Focus on the significant opportunities to enable people to return home (or as close to home as possible) when ready from a hospital bed**

WDP 5: Wherever possible, people should be supported to return from acute hospital sites to their home for assessment (**implementing a discharge to assess model)**

The Powys Integrated Winter Preparedness and Resilience plan has been developed jointly by partner organisations to respond to the assessed risks associated with winter. They are based upon a structured review of 2017/18 and learning from previous winters. The plans are described to mitigate risks and are expected to provide adequate assurance that all reasonable actions are being taken in preparation, recognising there are constraints on each of the partner organisations and not all eventualities can be accounted for.

17.14 111 (Care UK) Capacity

We are awaiting final version of the plan from Rachael Ellis the Regional Commissioner

17.15 Shropshire Doctors on Call (Shropdoc) Capacity

Shropdoc will continue to monitor demand and performance weekly, combining this with system partners to identify and/ or predict any upsurge in demand as quickly as possible. They use the prevalence of respiratory illness as an indicative clinical marker for expected increased activity.

Where increases in demand are identified they have the ability to put on additional GP resource at weekends, the 'Shropshire Relief car' which can undertake home visits, community hospital visits and base visits depending on where the demand is greatest.

17.16 Primary Care Capacity

Extended Access will be in place from 1st September 2018 and this will result in the following:

- Shropshire CCG – 600 x 15-minute appointments per week across an extended day;
- Telford and Wrekin CCG – 500 x 15-minute appointments across an extended day per week.

Shropshire

This will improve access for the population by providing time slots across evenings and weekends. It should be noted that these appointments are intended for routine, pre-bookable (non-urgent) clinical appointments and will have limited impact on urgent care resilience.

In addition, however, the CCG has approved funding for additional same day urgent appointments and expressions of interest from practices are currently being obtained. The likely start date for this additional primary care capacity is 1st December.

Telford and Wrekin

There is no national funding this year for winter pressure for practices – T&W executive/PCCC have approved the spend at £2.24 per patient.

Practices are submitting their plans at neighbourhood level to encourage closer collaborative working – plans will be based on previous successful winter pressure campaigns and plans. T&W primary care clinical lead has also suggested some win-win approaches which should also make significant impact on the wider system:

The CCG is suggesting a model structure that they think could be delivered, and that would be focused on addressing some of the areas of need/structural weaknesses in existing urgent care structures, as well as helping to develop neighbourhood working

That structure for each neighbourhood could include some or all of: -

1) Additional afternoon urgent care clinic 3pm -7pm, available to 111 plus

2) Additional morning urgent care clinic 8am -10am, available to 111

3) Neighbourhood-based afternoon home visiting service

4) Neighbourhood based early in season flu vaccination of the housebound

5) Enhanced influenza vaccination targets

T&W priority is the enhanced urgent care access for patients contacting services later in the day, as they already see a peak of demand in ED late afternoon that extends in to the evening, that we need to address. The morning appointments would allow appropriate diversion of patients away from ED overnight when the streaming service is not available.

Practices and neighbourhoods are invited to adopt parts or all of the model structure, or to submit alternatives if they cannot deliver the model, or feel they have a better proposal. Any alternative proposals would clearly have to deliver equivalent benefit.

17.17 Falck Capacity (Patient Transport)

Shropshire FALCK Capacity is detailed within (Appendix 8)

17.18 HALO

The safety of patients when they enter the Emergency Department is currently enhanced by the presence of specific handover nurses at both ED's. There is a HALO at RSH ED (an additional will be provided at PRH subject to final sign-off of winter funding schemes), who provides a West Midlands Ambulance Officer on-site presence providing the Strategic Operations Commander within West Midlands Ambulance Service Emergency Operations Centre local intelligence regarding capacity (current and anticipated), operational issues identified across the

healthcare care system that could affect optimisation of ensuring flow out of the ED resulting in ambulance handover delays. The HALO will attend site safety meeting and monitor the CAD and EPR for appropriateness of conveyance to hospital, challenge as require conveyances that could potentially be referred to other providers other than ED, these may be community-based services or directly to speciality within the Acute.

The HALO will endorse and actively promote the use of alternative providers other than EDs across Shropshire and the Care Co-ordination Centre escalating to the West Mercia Directory of Services Lead any issues with access that may need resolution, participate in retrospectively reviewing same day conveyed discharges for trends and potential deficits in service provision other than ED's. Monitoring the CAD and subsequent escalation to the capacity teams within the Acute to advise of potential surges in ambulance conveyances will be undertaken whilst the HALO is on duty so mitigating actions can be taken to minimise any potential ambulance handover delays by creating sufficient flow out of the ED or supporting with additional clinical staff.

A key role of the HALO is to optimise ambulance resource availability once the clinical handover has been undertaken and the patient is on an ED trolley. The HALO will undertake actions as required to ensure ambulance resource is available in a timely manner without any un-necessary delays and escalate any issues internally within WMAS. The HALO role is not designed to accept handover from the ambulance crews unless the ED is operating to extremis levels. In the event of extremis, the HALO where appropriate will cohort patients escalating any clinical concerns to the ED staff and identify such patients to the hospital desk by requesting a cohort call sign is assigned the WMAS incident number.

18. Workforce Planning

18.1 SaTH Workforce Planning

Recruitment remains challenging around medical, therapy and nursing posts given the competition from other NHS organisations and private providers. The Trust continues to work with the external recruitment provider to expedite the selection process for those successful applicants going through the employment checks process.

Rolling adverts are being utilised to aid a speedier recruitment and selection process, and recruiting managers are requested to review/interview candidates as and when applications are made rather than waiting for specific closing dates and pre-scheduled interview programmes.

The Trust will be visiting a number of Job Fairs at Universities over the coming months in order to seek to attract newly qualified nursing staff to work at the Trust.

The Trust will also look to increase the availability of flexible workers through an internal recruitment campaign whilst being mindful of the European Working Time Directive and the health and well-being of staff already employed in a full-time role within the Trust.

The Trust will be tapping in to the national nursing recruitment campaign launched on the 4th July 2018 to celebrate the 70th Birthday of the NHS and using the Careers social media accounts and the expertise of the Trust's Communication Team to point candidates towards the employment opportunities within the Trust.

In addition to the above, opportunities for employment within the Trust are being promoted through leisure centres radio across the County, and we are looking to use the information screens in doctor's surgeries to enable us to target the areas with most need.

The learning and development programme is being reviewed and revised, including the time allocated for shadowing in some areas where this is appearing to be lengthier, to ensure that the workers are available at the earliest opportunity, whilst having the correct skills to undertake their duties safely.

Retention has been identified as an issue within the workforce one of the main reasons cited is the shift patterns, these are being re-visited by the E-Rostering Team, operational managers to see if there is a more efficient and effective roster that can be implemented that better supports the work life balance of the workers and therefore aids retention of their skills, whilst recognising the needs of the service.

Information is collated on a weekly basis and vacancies monitored through the STP Programme Board, a specific Workforce Workstream, reporting in to the STP Programme Board to support the recruitment, development and retention of this workforce and more closely monitor progress towards a full establishment.

From October 2018 a new structure of weekend working for discharge doctors will commence. The weekend discharge team is being scoped with a senior medical lead, physiotherapists, occupational therapists and pharmacists to prevent delays for those patients who are medically fit for discharge.

The discharge team will be reviewing patients to ensure decision for discharge has been determined and all the actions required to enable the patient to be discharged will be put in place. Additional rotas will be in place to manage the additional escalation wards across both acute sites.

The importance of EDD setting and the use of clinical criteria for discharge cannot be underestimated in the achievement of success for this team.

18.2 ShropCom Workforce Planning

Recruitment remains challenging for nursing posts given the rural nature of Shropshire and competition from other NHS organisations and private providers. The Trust continues to work with the external recruitment provider to expedite the selection process for those successful applicants going through the employment checks process. The areas judged most vulnerable to staff shortages and additional pressures are Community Hospital Inpatient wards, Minor Injuries Units and Stoke Heath Prison.

To provide a secure and flexible workforce the trust is;

- Increasing the numbers of available staff and give these, and other services, a greater degree of resilience, Shropshire Community Health is undertaking targeted recruitment campaigns and a general drive to increase the size and availability of its internal staff bank.
- Has revised the staffing model for Community Hospitals in recognition of the long-standing vacancy rates for qualified nurses in Inpatient Wards, and now features a

higher proportion of Healthcare Assistants. Recruitment to the new model is under way and overall vacancies have reduced.

- Recruitment of Apprentice Assistant Practitioners and developing plans for future cohorts of Nursing Associates.

18.3 MPFT Workforce Planning

To provide 7 days working for services over winter will require a change in service provision. Before any consultation commences the Joint Staff Partnership need to be notified, this is too late for July and there is no JSP in August, so a separate meeting has been convened. There is also a need to complete a comprehensive Equality Impact Assessment on the staff groups affected.

Below was a timescale based upon a start date of 1st October for 7 days working. SaTH have now confirmed that this will go live on the 1st of December as the consultation period for staff was extended to the 26th of November.

This will be for AHP and Social Work roles:

Date	Activity
w/c 23th July 2018	Commence consultation with affected staff and Trade Unions
27th August 2018	Close consultation on proposed seven days working.
w/c 27th August 2018	Consider representations and queries. Response to the Consultation and issue any changes.
30th August 2018	Issue letters advising changes to contract
1st October 2018	Seven day working pattern commences
1st of December	Revised start date based on consultation

Recruitment remains challenging around the Home First service and nursing posts given the competition from other NHS organisations and private providers. The Trust continues to work with the external recruitment provider to expedite the selection process for those successful applicants going through the employment checks process. Rolling adverts are being utilised to aid a speedier recruitment and selection process, recruiting managers are requested to review/interview candidates as and when applications are made rather than waiting for specific closing dates and pre-scheduled interview programmes.

The Trust will be visiting a number of Job Fairs at Universities over the coming months in order to seek to attract newly qualified nursing staff to work at the Trust. The service does not currently utilise bank staff in the Home First workforce and options around this are being explored within the Care Groups. The pool of flexible workers, both qualified and unqualified registered at the former SSSFT Trust will increase the availability of workers to the service going forwards to cover any sickness absence, this is not something that has previously been available.

The Trust will also look to increase the availability of flexible workers through an internal recruitment campaign whilst being mindful of the working time directive and the health and wellbeing of staff already employed in a full-time role within the Trust. An advert for flexible Health Care Support workers is currently live on NHS Jobs and there are plans to expand the number of adverts across all professional groups in order to address agency spend.

The Trust will be tapping in to the national nursing recruitment campaign launched on the 4th July to celebrate the 70th Birthday of the NHS and using the Careers social media accounts and the expertise of the Trust's Communication Team to point candidates towards the employment opportunities within the Trust. In addition to the above opportunities for employment within the Home First service are being promoted through leisure centres radio across the County, and we

are looking to use the information screens in doctors' surgeries, that will enable us to target the areas with most need.

The learning and development programme is being reviewed and revised, including the time allocated for shadowing in some areas where this is appearing to be lengthier, to ensure that the workers are available at the earliest opportunity, whilst having the correct skills to undertake their duties safely. We are in discussions with an NHSI approved care agency and exploring opportunities for them to be able to provide domiciliary workers to the Trust under a master vend arrangement, these discussions are also part of a wider remit to expand the existing master vend arrangement for all clinical roles across the new Trust ensuring we engage workers at the most competitive rates wherever possible.

Retention has been identified as an issue within the Home First workforce one of the main reasons cited is the shift patterns, these are being re-visited by the E-Rostering Team, together with Meridian and operational managers to see if there is a more efficient and effective roster that can be implemented that better supports the work life balance of the workers and therefore aids retention of their skills whilst recognising the needs of the service. Exit data and Listening-Into Action data will be examined over the next few months, to establish any other areas of dissatisfaction, and an OD plan developed based on the results.

The contract with the outsourced recruitment provider SBS ends in October, moving the recruitment and selection process to an in-house service will give greater control and flexibility over the recruitment process and allow for team resources to be flexed to meet demands in recruitment to posts.

Information is collated on a weekly basis and vacancies monitored through the Programme Board, a specific workforce workstream, reporting in to the Programme Board is being established to support the recruitment, development and retention of this workforce and more closely monitor progress towards a full establishment.

Key risks & mitigation to delivery

Risk	**Mitigation**
Market forces impact on Recruitment	Identifying high risk areas where demand could outreach capacity, alternative solutions are being identified and internal actions are currently being explored to reduce the risk.
Inability to flow patients through Home First	Additional recruitment, working with partners to monitor and report the situation, daily escalation via CCGs
Retention issues with AHPs and Social Care staff as it may be that staff leave rather than accept 7 days working. The therapy services are already identified as "hard to recruit" posts.	Good communication and consultation with staff could reduce the risk.
Moving to a 7-day working pattern without further investment in staffing levels would clearly not in itself improve capacity	additional funding would be required to increase staffing
Market forces impact on availability of temporary staff	Identifying high risk clinical areas where demand could outreach capacity, which could impact on safer staffing levels, alternative solutions are

	being identified and internal actions are currently being explored to reduce the risk

Mental Health Liaison operates 24/7 at RSH for adults and older people, and at PRH from 8am to 8pm, with a core hours service for children and young people under the age of 16.

18.4 Shropshire Council Workforce Planning

Shropshire Council will monitor the on-going demand and are committed to being flexible to meet the requirements of this and continue to explore the viability of seven day working across assessment capacity and supporting teams.

The Commissioning staff will communicate with providers over the coming weeks to ensure that a full list is formulated of providers who will work seven days and what the working patterns will be over winter.

This will be shared with Social Work colleagues to improve speed of placements and keep referrals targeted to then aid egress from hospital for residents or users of domiciliary care. This list will be modified throughout winter and we will also monitor referral rates at weekend and over the bank holidays to not only ensure that we know where referrals can effectively made, but also in order to shape our response to seven days working internally.

Shropshire Council will be able to see the availability of staff over Christmas and New Year, and any existing capacity on rotas will be able to be utilised.

18.5 Telford and Wrekin Council Workforce Planning

While the Council will promote seven-day assessments and discharges across all care homes with which it contracts, due to the nature of many providers and the balance of supply and demand, the winter plan is not premised on achieving equal flow into all care homes on each day of the week.

The Trusted Assessor model is focused on those care homes that are most frequently used to support hospital discharge (due to their capacity, price and other elements of market position).

Similarly, in terms of seven-day access into home care, the contractual requirements to support restarts of packages can be triggered seven days a week. For new referrals, the Council's approach is to prioritise flow seven days a week into its key strategic home care partners.

Our Social Care and Brokerage Teams will continue to work closely, alongside all key partners to ensure availability over the Christmas and New Year periods.

18.6 WMAS Workforce Planning

WMAS have no vacancies (including paramedics). They have a low utilisation of bank staff and the lowest level of sickness in the country. The Trust is completing early recruitment of new staff to ensure training is complete and they are operational for the festive period.

To maximise capacity there will be no non-urgent/non-mission critical meeting in headquarters between December 14th and January 9th.

All officers must book on duty with the EOC so that they are able to respond to incidents with the closest vehicle, all managers with a blue lighted care will make themselves available throughout winter. The Trust has agreed key dates where all operationally qualified managers make themselves available:

- December 2018 – 14, 15, 16, 17, 21, 22, 23, 24, 26, 27, 28, 31,
- January 2019 – 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15

18.7 Shropdoc Workforce Planning

Shropdoc are currently recruiting for all clinical and operational roles in line with their winter staffing requirements. The training programme will be completed in autumn to ensure all staff are available to work frontline across the winter period.

19. Closure of Winter Capacity

Similarly, to the phasing of the opening of the escalation beds moving into the winter period, a similar exercise is required to decant those same beds post-Easter. This will ensure these beds do not become part of standard usage and are available again as escalation beds as part of winter planning in 2019/20, if required.

A system approach will be used to ensure that bed closures do not negatively impact upon any system partner.

19.1 Risks to the Shropshire, Telford & Wrekin and Powys Winter Plan

The plan takes into account the review from previous year's winter planning and where possible has mitigated aginst the key identified risks.

The following are key risks identified across the health economy. There are plans being executed to mitigate the risks going into winter:

- Workforce availablity (including sickness increase);
- Activity exceeding planned capacity;
- Unprecedented impact from Flu;
- Higher levels of infection resulting in closed wards
- Unexpected domicilary agency closures
- Adverse Weather

20. Finance

The financial model to support the implementation of the Winter Plan is built on a number of funding streams, as follows:-

a) CCG winter money funding of £2.9m
b) Allocation of iBCF monies
c) Additional tariff income from additional bed capacity in SATH
d) Existing resources

In developing the Winter Plan, system stakeholders submitted winter capacity scheme proposals which described the scheme, source of funding (new or existing), impact on acute beds and confidence level in operational delivery.

These proposals were consolidated into a long list of approximately 60 schemes. This long list was reviewed by the A&E Delivery Group at meetings in July/August to form a shortlist.
SATH are receiving £2.3m of the £2.9m CCG winter money to fund their winter capacity schemes as set out in the table in section 16.7.2. This funding also includes ambulance handover nurses on both sites. The remaining £600k was pre-committed following approval from the System A&E Delivery Board.

21. Appendix Listing (enclosures):

All in location /NHSE-templates/UEC/Shared Documents/WinterPlan18-19 Appendices

Appendix 1	WMAS Plan	WMAS WINTER PLAN Version 3.0 2018.pdf	Appendix 1-WMAS-WINTER PLAN V3.0 2018.pdf
Appendix 2	Powys Plan	Powys Integrated Winter Resilience Plan 2018 / 2019 DRAFT	Appendix 2 -POWYS INTEGRATED WINTER RESILIENCE PLAN 2018.docx
Appendix 3	The Shropshire, Telford and Wrekin and Powys Escalation Action cards	Further updating currently in progress from workshop on 17/9/18 & clinical risk workshop to test amended cards 04/12/18	Appendix3-Draft-Winter Escalation Action Cards
Appendix 4	T&W Primary Care Plans	ShropCom Winter 2018 2019 escalation plan DRAFT	Appendix 4-Shropcom Winter 2018 2019 escalation plan DRAFT.docx
	SaTH winter plan	SaTH have decided that the system winter plan is their plan	
Appendix 6	MPFT winter plan	MPFT Winter Plan Draft V4.1	MPFT Winter plan Draft V4.1
Appendix 7	Shortlist of Winter Capacity Financial Schemes	Shortlist of Capacity Schemes	Appendix 7-Shortlist of Winter Capacity Schemes-29Aug18
Appendix 8	FALCK Shropshire		FALCK_SHROP-WINTER_PRESENTATION_2018-19.pdf

West Midlands Ambulance Service NHS
NHS Foundation Trust

2018/19

Winter Plan

Version	3
Ratified by	Operational Management Team
Date ratified	April 2018
Author	Strategic Operations Director
Intended audience	WMAS Staff NHS England Area Teams Ambulance CCG Commissioning Lead Local A&E Delivery Boards
Related Plans	WMAS Major Incident Plan WMAS Adverse Weather Plan WMAS Process for patient handover and turnaround at Acute Trust's Mutual Aid Plan Resourcing Escalatory Action Plan (REAP) Surge Demand Management Plan

Trust us to care.

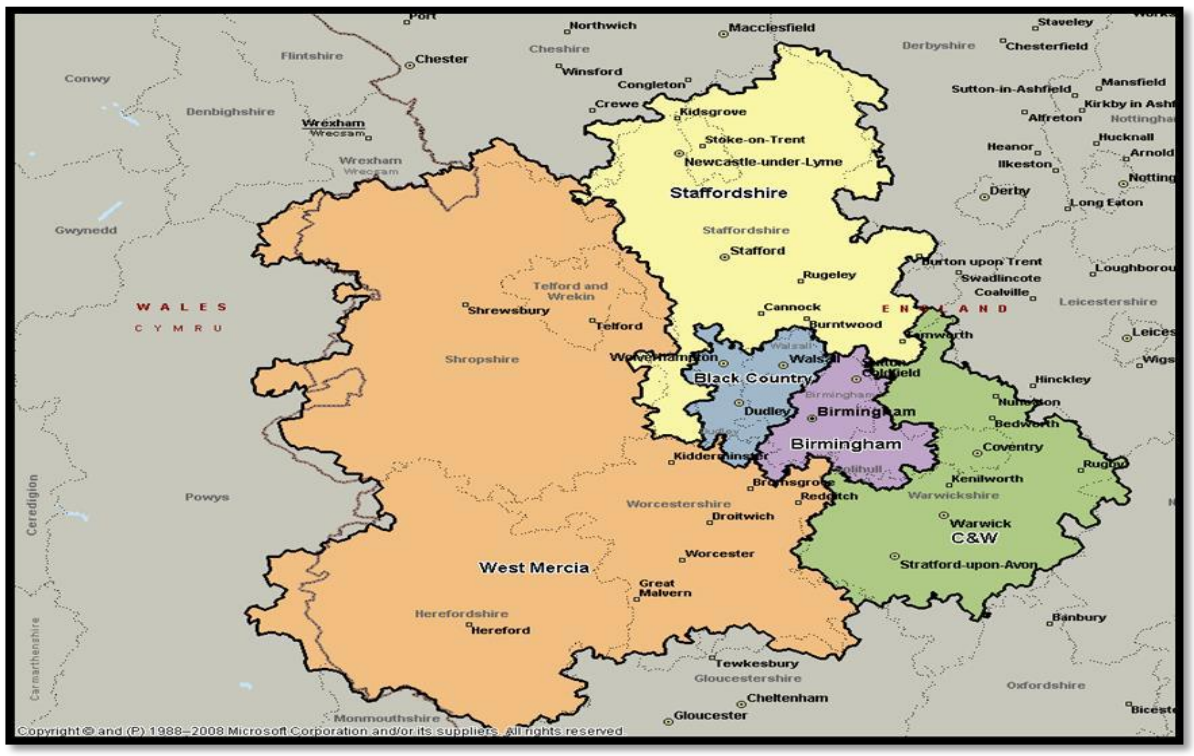
Version Control

Version	Date of issue	Updated by	Change log
1.0	14/04/18	N Henry	Strategic Commanders review
2.0	18/04/18	N Henry	Following review of 2017/18 winter review plan
3.0	27/04/2018	N Henry	Reviewed Strategic Operations Director Craig Cooke

Disclaimer

This plan may require dynamic management during operational delivery due to the nature of the work undertaken, which can result in last minute changes. The author will inform colleagues of any required changes and log all decisions accordingly. This plan and any associated documents must not be circulated beyond the plans distribution list.

The Map below shows the geographical areas of the West Midlands Region. The Trust provides all the Emergency Ambulance Service provision and currently provides Patient Transport Services in 5 of the sub areas.



Distribution

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Commissioning CCG

Local A&E Delivery Boards

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EOC Management	Region Wide
EOC Duty Managers	Region Wide
Incident Command Desk	RCC
On Call Teams	Teams 1 to 4
Martin Minard	Logistics Manager Emergency Services
SOC Commanders	Regional Coordination Centre
EP Team	Emergency Preparedness Managers

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1.0 Background to WMAS

West Midlands Ambulance Service NHS Foundation Trust is located in the heart of England; it serves a population of over 5.6 million people, who live in the areas of Shropshire, Herefordshire, Worcestershire, Warwickshire, Staffordshire and the Birmingham, Solihull, Coventry and the Black Country conurbation. This covers a region of 5000 square miles of which 80% is rural landscape and also well known for some of the most remote and beautiful countryside in the country that includes the Welsh Marches on the Shropshire / Welsh borders and the Staffordshire Moorlands.

The West Midlands is an area of contrasts and diversity. It includes the second largest urban area in the country, covering Birmingham, Solihull and the Black Country where in the region of 45% of the population live. Birmingham is England's second largest city and the main population centre in the West Midlands, second only to the capital in terms of its ethnic diversity. It also sees an annual influx of people of all age groups who attend particular events such as nightlife; Christmas markets; football matches; marches; cricket; live shows at the Barclaycard Arena, NEC or travelling to and from Birmingham airport

The Trust has a strong set of underpinning structures to ensure the very best services are provided to the patients and public which we serve, whilst ensure continuous improvement and efficiency is enabled for long term sustainably.

WMAS is a high performing urgent and emergency ambulance service that has a significant track record of delivering successful services over many years. The Service is also experienced in managing significantly sustained incidents (such as pandemic flu) and continuous high demand periods (such as heatwave and severe winter weather), and has successfully led the response to such incidents.

The winter of 2017/2018 was the most difficult 5 months for the NHS since the pandemic Flu outbreak and demand was consistently above the winter where pandemic Flu outbreaks were experienced. WMAS was able to meet the operational standards over the winter of 2017/18 despite very high demands and significant hospital delays. The learning from 2017/18 will be utilised to further improve the plan for winter 2018/19.

1.1 WMAS Firmographics

- Established in July 2006 merging with Staffordshire in October 2007
- 5.6 million population (Circa 10.5% of the English population)
- Over 5,000 square miles, 80% rural
- Approaching 3000 *999* calls per day
- Over 532,000 emergency journeys annually
- £250 million budget
- Fleet of over 515 vehicles including:
    - 450 Emergency Ambulances
    - 15 4x4 Wheel Drive Double Crew Emergency Ambulances
    - 50 Rapid Response Ambulance Cars
    - 4 x Helicopters
    - Specialist Vehicles including:

        Polaris Ranger 6x6 Off Road Ambulance

        Mass Casualty Vehicles

        Mobile Command Vehicle
- 4,500 Staff and 1,000 Volunteers
- 582 defibrillators per million population (2nd highest number in the country)

1.2 Infographics

- Only Ambulance Trust with Outstanding CQC rating

- No Vacancies, including Paramedic (nationally there are 2,500 Paramedic vacancies)
- Over 99% of all front-line ambulances have a Paramedic on board (highest skill mix in the country)
- Best fleet in the country, no vehicles more than 5 years old
- Only Outstanding Ambulance Trust in segmentation 1 of the SOF
- Zero spend on agency staff and Private and Voluntary Ambulance Services
- Low Bank Staff use (<1%)
- Leading member of the Ambulance Response Programme - achievement of all new targets following implementation

- Over 300 more Student Paramedics will begin training this year
- Achieved the mandated flu target at 77.75%
- Lowest level of staff sickness in the country (3.55%)
- Highest achievement of PDR completion and mandatory refresher training (99% and 99% complete 2017/18)
- 2018/19 Operational 2 day Training is planned to complete by end November 2018
- Activity continues above contract
- High non-conveyance rate (45%)
- 100% roll-out of the electronic patient record (EPR)
- Over 95% of all incidents recorded on the EPR
- Very high performing in terms of response times – highest performing ambulance service in the country
- High level of preparedness for the eventuality of a Marauding Terror Firearms Attack (MTFA) or other terrorist activity, enhanced equipment on all vehicles
- Financial Key Metrics (EBITDA, CIPs, Capital, Cash) target achieved for 2017/18

2.0 Introduction

The winter/festive period is an extremely busy time for WMAS and presents significant challenges in terms of increased 999 and 111 activity. In reviewing the 2017/18 winter period, the pressure began to increase in October and ran through until mid- March. In reviewing the winter months profile, it demonstrates that the Trust experiences an average increase in incidents of 7% through the period compared to the rest of year average. Other factors such as increased sickness, delays at acute hospitals and reduced services in the wider health economy, will further affect our ability to respond to patients quickly.

The primary focus of this Winter Plan is to review and outline the service's plans and preparation in readiness to provide sufficient resources, in all areas, to achieve a safe service for the delivery of patient care and maintain performance over the Winter. Within this period, the Trust will experience payday weekends, school holidays, various festive events, Christmas and New Year parties and increased congestion on the roads. In addition, it is well documented that the overall NHS system becomes challenged during this period with high demand which is often sustained and creates considerable capacity issues. During this time, there are also long periods where other health and care services either close or reduce in capacity.

This Winter Plan has been developed to cover the arrangements for the Trust and so encapsulates all 15 local A&E Delivery Boards that operate within the WMAS regional boundaries.

A separate and detailed operational plan will be published to ensure the Festive period (pre-Christmas, Christmas, New Year and post New Year) are managed effectively, this will be known as the Festive Plan (FP), and will contain very detailed operational resourcing plans.

2.1 Strategic Planning

The Trust has developed its strategic plan with early investment for robust plans to be in place to ensure that during the Winter/Festive period, that it has the maximum number of available staff to better manage the increases in call volumes and the ability to respond to patients at the busiest period of the year. This to include early recruitment of new staff so that their training is complete, so they are operational for the festive period, reduced abstractions for the festive period, timely fleet replacement program in place to be enable a temporary increase in fleet for the busiest months, increased call takers and Ambulance Fleet Assistance's (AFA's).

In planning for 2018/19, the Trust has made available resources to increase both the operational workforce and fleet, to ensure high demand can be fully serviced, and the stability of operational deliver can be maintained in the winter of 2018/19.

All additional staffing and resource will be available and ready to be deployed into frontline operations ahead of the festive period. The annual training of operational staff (mandatory training) will also be complete before December. Therefore, the Trust will have the maximum workforce available to frontline duties between early December 2018 and March 2019 continuously.

The purpose of this plan is to maximise resourcing to meet high demand. The Emergency Operations Centre (EOC), each of the 9 Operational Sectors, Emergency Preparedness, Fleet, Logistics and Business Continuity support are all reviewed and explicitly addressed in plans, any local issues and risks that were experienced during previous Christmas/New Year, Easter, May and coming August 2018 Bank Holiday weekend.

Plans should illustrate how those same risks will be mitigated during the period, including those actions that have been taken to address any potential gaps. All departments must provide their working hours and how they can support Operations over the winter period. Officers with blue light cars will be asked to provide additional Operational support.

All Trust Business Continuity Plans (BCP) are up to date and have been tested.

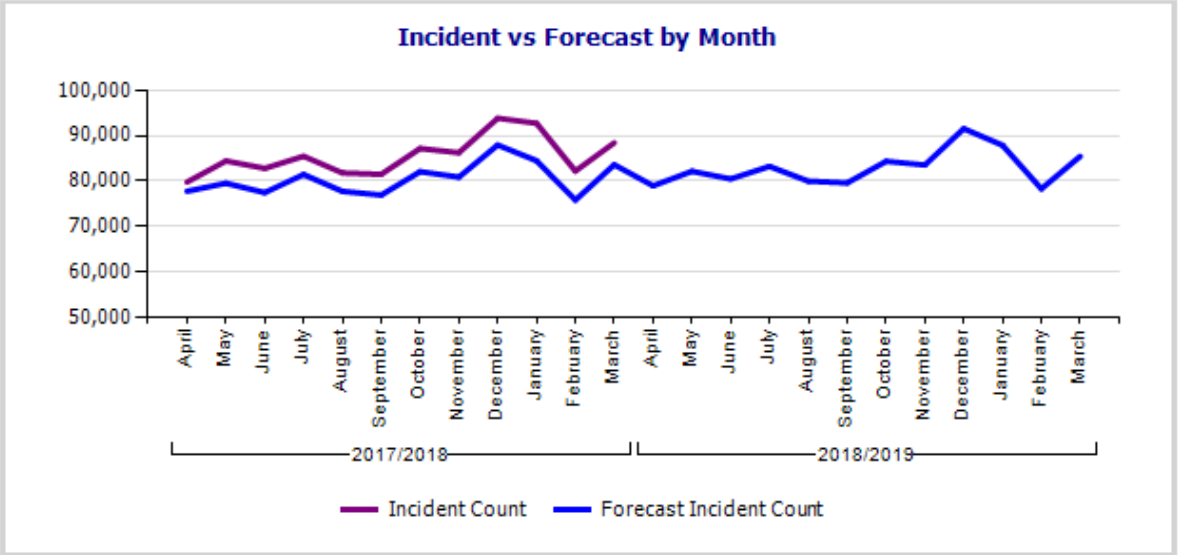
In order to maximise patient safety over the critical festive period there will be no non-urgent / non-mission critical meetings in Headquarters between Friday 14th December and Wednesday 9th January inclusive.

All operational effort is to be focused on responding to patients including all union reps, clinical managers, etc. from 7th December 2017 -15th January 2018.

In addtion to the strategic planning for winter and the agreed operational plans for winter, the CEO has delegated authority of the Board to implement further operational options to increase capability, as the winter demands prevail. This will ensure that patient safety can be maintained at all times. A number of contingency options for additional resourcing will be developed prior to the winter to support unforeseen circumstances arising.

2.2 Winter Demand

There is typically a 4.5% demand increase year on year, although through the winter period the Trust experiences a typically 10% growth for the months of December and January, compared to the mean average of non-winter months and can also see spikes of 15% at times. The below graph shows the expected increase in demand to assist in the planning of resources.



Demand is also affected by the timing of the festive period. For 2018/19 the Christmas period falls on a Tuesday (Christmas Day) and Wednesday (Boxing Day), so gives a slight break from the weekend on the Monday 24th which will see reduced services available, before the festive Bank Holidays begin. Two 'normal operating' days occur before another weekend followed by a 'normal operating' Monday, going into a Tuesday Public Holiday (New Year's Day). This cluster of public holiday days with single day breaks from weekends, creates an added pressure on health care services that provide a 24/7/365 service.

2.3 Resilience and Specialist Operations

The winter months present some specific challenges for the Trust in relation to Resilience and Specialist Operations.

The potential for operational challenges encountered through inclement weather often increase throughout the winter period. Such occurrences are covered through the enactment of the Trusts "Adverse Weather Plan" Local and Regional forward and real-time forecasting is maintained by the Resilience Departments close links with the "Met Office" and the Environment Agency to allow sufficient time for any actions required.

Winter also says the potential for increased cases of outbreaks and flu type episodes. The Trust has robust plans in place to ensure any increase in seasonal outbreaks are managed appropriately.

Although more prevalent in the weeks preceding the festive period, many areas across the region will see a significant rise in footfall through major towns and cities leading to "crowded place" scenarios. These scenarios are potential subjects for the increased possibility of terrorist attacks given the recent change in tactics seen across the globe in recent years. The Trust has a significant capability both in terms of planning, response and links with local agencies in such matters.

3.0 Commissioning

WMAS is commissioned by 20 CCGs across the West Midlands, with Sandwell and West Birmingham CCG being the Lead Commissioner.

3.1 Lead Commissioners

The Lead CCG Commissioner can be contacted for a variety of reasons such as

- Act as a communication point between WMAS and CCGs
- Highlight specific issues that need Commissioner input
- Keep appraised of issues that are ongoing

WMAS have a named Commissioning Executive Director who will be the point of contact for all commissioning matters, specifically:

- Additional winter resources
- Attendance at 15 A&E Delivery Boards
- Lead for the STP's
- Alerting to additional system resilience requirements
- Escalating system pressures relevant to CCG's (e.g. Ambulance Turnaround delays)

3.2 Potential Risks

- The Ambulance Response Programme (ARP) spring review being completed for implementation of amendments prior to September 2018. These changes will need to be understood and embedded going into the second winter of ARP.
- Commissioners are looking to WMAS to support delivery of the local healthcare system
- High demand (significant growth due to sudden severe adverse weather or increased illness in patients)
- Hospital Turnaround delays at Emergency Departments is a likely key risk which face will impact the operational delivery of the Emergency Service
- System risks are managed via A&E Delivery Boards, Chief Executives of providers, and Local Authority representation
- Substantial incident or outbreak

The following should be focused on to assist in managing the identified risks and workload:

- Increased cover on Bank holidays, weekends and other key dates
- Sustained conveyance to hospital rates
- Reduced handover times and reducing excessive long delays
- Continued use of the Clinical Support Desk
- Use of alternative Pathways of patient care

3.3 111

111 is provided across the region by Care UK and Vocare (Staffordshire only), WMAS are dependent on the 111 services delivering a high level of performance, and it is known that if the public don't get a responsive service they may default to calling 999.

There is an increase in the use of 111 during the winter period and it is important that robust arrangements are in place to ensure that this does not impact on WMAS, through increased call transfer rates.

There needs to be awareness of the impact of the 111 services on the WMAS service and be aware of:

- A greater call volume coming into EOC if the 111 call answering times routinely goes above 60 secs.
- Patients also defaulting to calling 999 if they are not satisfied with the service that 111 has delivered.
- Ensuring the Directory of Services (DoS) is up to date

4.0 Command and Control

The Trust has a strong track record in delivering effective services through a command structure. This consists of a) Executive Director of On-Call 24/7 (normally the CEO), b) the Strategic (Gold) Commander team who provide 24/7, 365 day strategic leadership and management through an on-call provision. At times of extreme demand these arrangements will be boosted to provide a live working Strategic on-duty at Headquarters. The on-call system also provides Tactical level management for each geographical area and functional operational department.

In the winter period (2018/19) the Trust will provide a) an Executive Director of On-Call 24/7 (normally the CEO), b) an On-Call Strategic Gold Commander 24/7, c) an additional Duty Senior Commander based in Headquarters (Millennium Point EOC), this has been proven through the last two winters to be very beneficial to have this senior leadership on site (dealing with matters live and support staff). This position will be provided through a mixture of On-Call Strategic Commanders working live and covering additional hours of special cover. This will be completed within a formalised rota from 5th November through until at least the end of January 2019.

There are 9 sectors within the Operational arena of WMAS:

Sectors				
Coventry & Warwick		Hereford & Worcester		Stafford
Dudley		Hollymoor & Bromsgrove		Stoke
Erdington & Lichfield		Shrewsbury & Donnington		Willenhall & Sandwell

Sectors are led by a Senior Operations Managers (SOM's) that have a combination of Hub/s and Community Ambulance Stations where staff book on and off duty. The SOM leads the Hub/s and larger Hubs have an Assistant Senior Operations Manager (ASOM's) for support; each hub has a team of Operations Managers (OM's) who work 24/7 and are responsible for the day-to-day welfare of staff. In addition, they respond and manage serious incidents.

The SOM's planning arrangements will be integrated within an overall Regional Festive Plan (RFP) that will be published on the 27th November 2018, for submission to commissioners as required.

4.1 Officers Booking On and Off Duty

All Officers MUST book on duty with EOC via ARP and MUST inform EOC when moving location or returning home. Officers must be prepared to respond to incidents if they are the nearest vehicle to a 999 call.

4.2 Duty Strategic Commander

Given the experience of the last few winters, the Trust has implemented an arrangement to provide an additional trained and experienced senior commander based at Trust Headquarters, in the Regional Coordination Centre (RCC). This position is primarily looking at live operational issues and taking senior decisions to resolve problems within the WMAS operation or escalating matters which other providers need to take urgent and robust action, in-order to ensure WMAS operations are not compromised.

This function will be undertaken by a mixture of the Assistant Chief Ambulance Officer's (ACAO) and trained senior managers providing additional, extended weekday shifts. The function will be based at Millennium Point EOC and will work typically a late shift.

This will ensure that the risk to patients is minimized in periods of high demand or situations where WMAS resource is being affected by other providers (such as Hospital Turnaround delays). The arrangements will be continually reviewed for effectiveness in the winter period and adapted as required.

4.3 Key Operational Requirements

A number of key principles have been agreed as an operational team to ensure focus and consistency is applied in the winter months. This will help all managers to apply a consistent approach and provide some priorities also:

- Ensure all incidents types are allocated without delay
- Reduce downtime to the minimum and ensure Hospital turnaround is tightly managed and escalated
- Maintain low sickness levels through robust and effective and timely management of all sickness
- Ensure an effective Flu Vaccination plan is being delivered
- Maximise Ambulance resource cover, ensure strong cover is in place for peak periods such as weekends, Mondays and key dates
- Maintain the minimum RRV resource levels and additional resource support planned to Ambulance cover in all Divisions
- Focus on delivering a Paramedic on every vehicle
- Plan ahead for all staff coming from training in readiness for the Festive period
- AFA cover to be maximized and recruitment plan to be prioritised
- Operational manager posts will be backfilled at all times for Annual Leave etc
- There is no planned use of external VAS support
- Mandatory training will be complete by the end of November 2018

4.4 Additional Manager Cover

All managers with a blue lighted car will make themselves available throughout the winter period by booking on with the EOC, when on duty at all times.

The Trust has agreed a number of key dates where it requires all operationally qualified managers who are not delivering frontline services or priority training, to make themselves operational available to EOC, either through booking on with their blue lighted car or arranging to work as part of an additional Ambulance crew. Those dates are as follows:

December 2018:

14th, 15th, 16th, 17th

21st, 22nd ,23rd, 24th

26th, 27th ,28th, 31st

January 2018:

1st, 2nd, 3rd, 4th

7th, 8th, 9th, 10th

11th, 12th, 13th, 14th, 15th

There is a requirement for all operationally trained staff to be available to respond to patients through this period. Given that there will be reduced meetings over the dates stated above, this will increase availability of regional staff to operations.

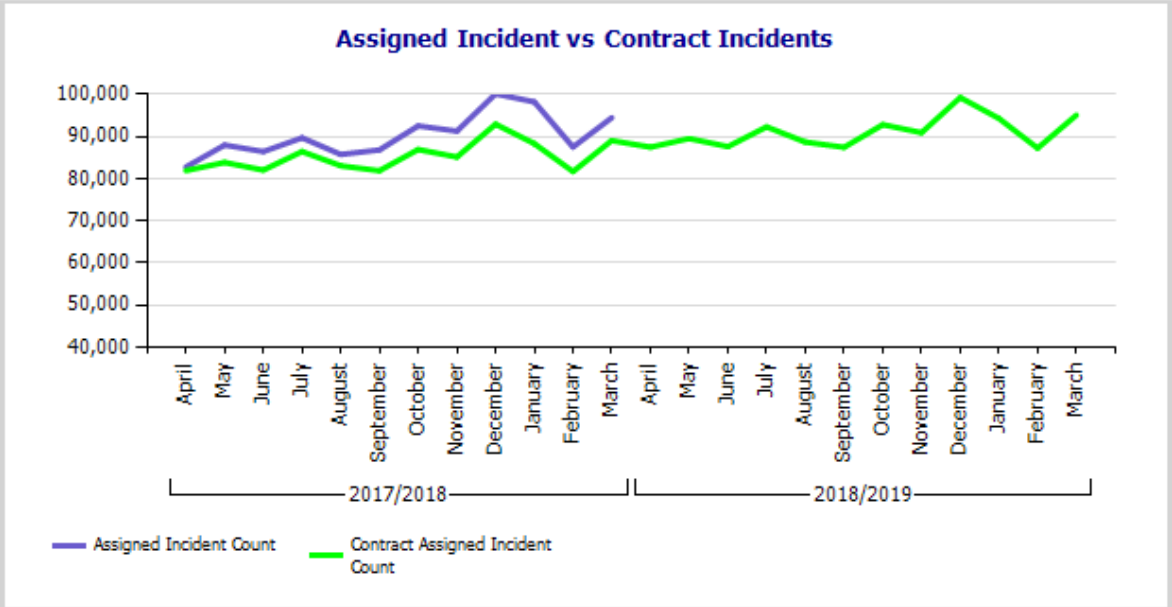
4.5 Tactical Cell

Tactical Cell is based at Stafford Hub and will be utilised to support the region in Command and Control situation, as required. The cell will function under the direction of the Strategic Commander and provide resilience to the region.

5.0 Activity / Contract / Resourcing Forecasts

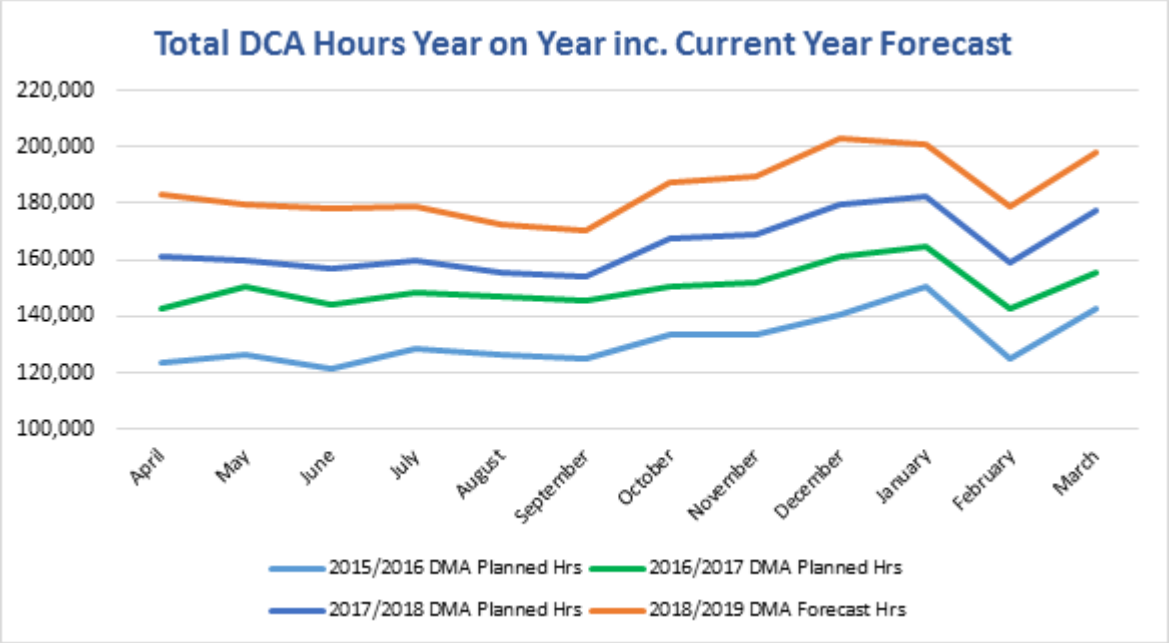
5.1 Activity vs Contract

The chart below depicts the assigned incident count against the contracted incident count.



5.2 Resource Hours Comparison

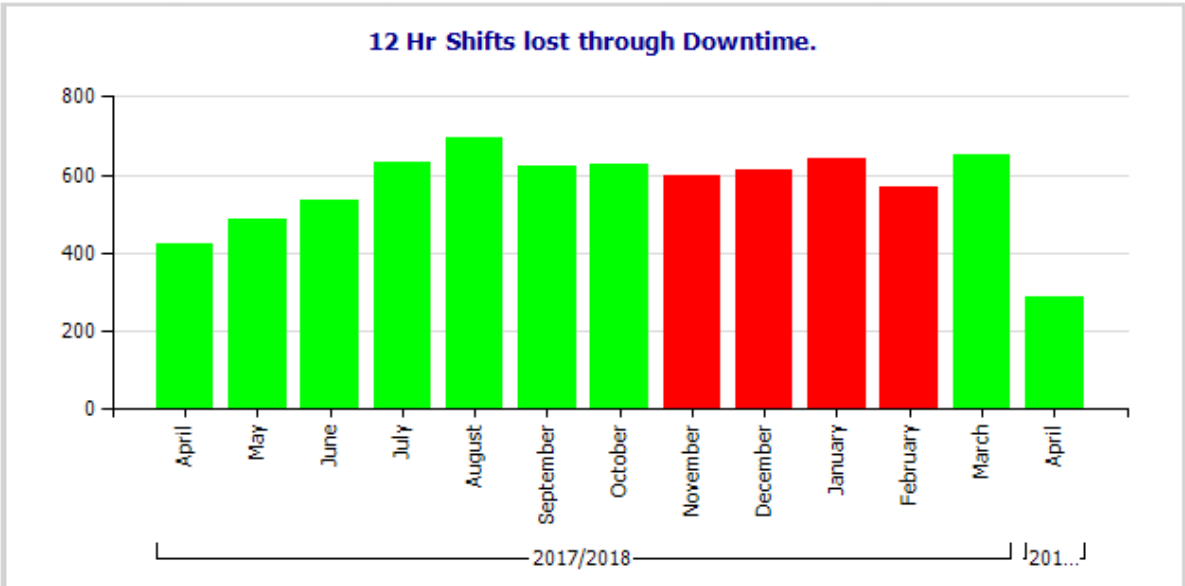
The below chart shows the number of resources hours for the last 4 financial years compared to this years forecasted requirement. October to March are core rotas and Festive cover will not be completed until October



The changes and reduction in hours seen this year relate to the changed operating model with reduced RRV resource levels and increased DCA's.

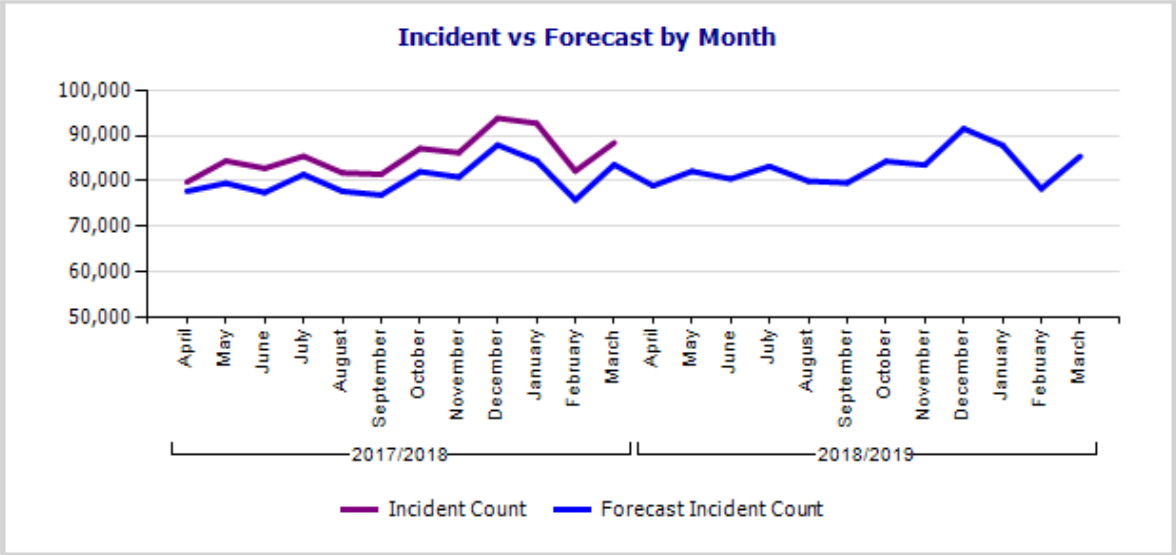
5.2.1 Resource Lost Hours

The below chart represents the number of extra 12 hour shifts that would need to be scheduled in order to account for the lost hours that result from resource downtime. Red bars indicate winter months.



5.3 Winter Incident v forecast

The below chart represents demand. It is the incident count against the forecast incident count.



6.0 Management of Hospital Escalation and Ambulance Turnaround

The escalation and management of ambulance resource during patient handover and turnaround delays will be coordinated consistently with the use of the Trust's Management process for patient handover at Acute Trust's. This gives a standard approach across the region, outlining the use of Strategic Operations Cell, Hospital Desk and HALO/Managers.

6.1 Strategic Operations Cell (SOC)

The SOC is located within the Regional Coordination Centre (RCC) of the Emergency Operations Centre at Millennium Point and is staffed by a dedicated team of experienced Tactical Commanders, providing 24/7 cover. The SOC Commanders provide Tactical level leadership to manage the strategic overview position with regards hospital turnaround and escalation between WMAS and the acute hospital management teams.

In conjunction with the Duty WMAS Strategic Commander, the SOC provides escalatory intelligence and support to the WMAS On-Call Tactical teams and EOC Duty Managers across both Emergency Operation Centres. On behalf of NHS England's Area teams, SOC are the "operational facilitators" with regards to the management of hospital escalation and mitigation of hospital turnaround delay, in response to operational demand and increased EMS Level(s). Additional hours will be deployed to the SOC and HT Desk in the winters to ensure the demands placed upon this facility are fully resourced in the periods of high demand. The Trust will also develop some new logging tools to assist with the accurate recording of the Hospital Delays and Escalation actions being undertaken.

The Duty SOC Commander will operate in conjunction with the Hospital Ambulance Liaison Officers (HALOs) and Hospital Turnaround Desk Supervisors (HTDesk). The HTDesk will coordinate all escalation, intelligent conveying and requests for diversion/deflection of activity across the region and beyond. SOC Commanders will also provide key strategic support and tactical advice within the Regional Coordination Centre.

During normal operation, the SOC Commander will attend conference calls in regard to escalation of Acute, during peak times local operational management will assist in joining these calls where there is high level escalation or when multiple acute's are escalating and call may overlap.

6.2 Hospital Desk (HTDesk)

The HTDesk works under the strategic leadership of, and in collaboration with the Duty SOC Commander. The HTDesk Team comprises experienced supervisor level personnel and they cover 24hrs a day, 7 days a week with additional hours available for cover (abstractions permitting) through relief. The function has a fundamental role in ensuring crews are released from receiving units and departments in a timely manner, to be available for the next tasking. Their main responsibilities include:

- Being the single point of contact for escalation to and from an acute receiving unit's inside and outside the region
- Escalating potential and actual turnaround delays to the SOC Commander and EOC Duty Managers in the EOCs

6.3 WMAS Trigger for the RCMT Escalation Management System (EMS)

The Regional Capacity Management Team (RCMT) administers the West Midlands region-wide "Escalation Management System" (EMS). EMS is essentially a web-based viewer that displays the levels of pressure being declared by partner agencies against a defined set of triggers for each of the 4 levels.

These levels consist of defined triggers that cover front door information, plus areas such as elective surgery, medical outliers and use of planned additional capacity – effectively focusing on the complete patient pathway.

For the Acutes, these levels are based around ambulance waiting times, bed capacity and 4hr breaches. WMAS in reality base our declared EMS levels allied to our current REAP Status.

Each trigger is weighted so Acutes simply input all the relevant data into the reporting matrix and the system calculates the most appropriate EMS Level, which will ensure that the EMS level declared is wholly reflective of the overall pressures being seen within each Acute. The information is only useful and accurate at the time the level is declared – and organisations are only required to update their declared levels before 0930hrs every morning and before 1500hrs in the afternoon.

6.4 Officer Deployment to Acute Sites

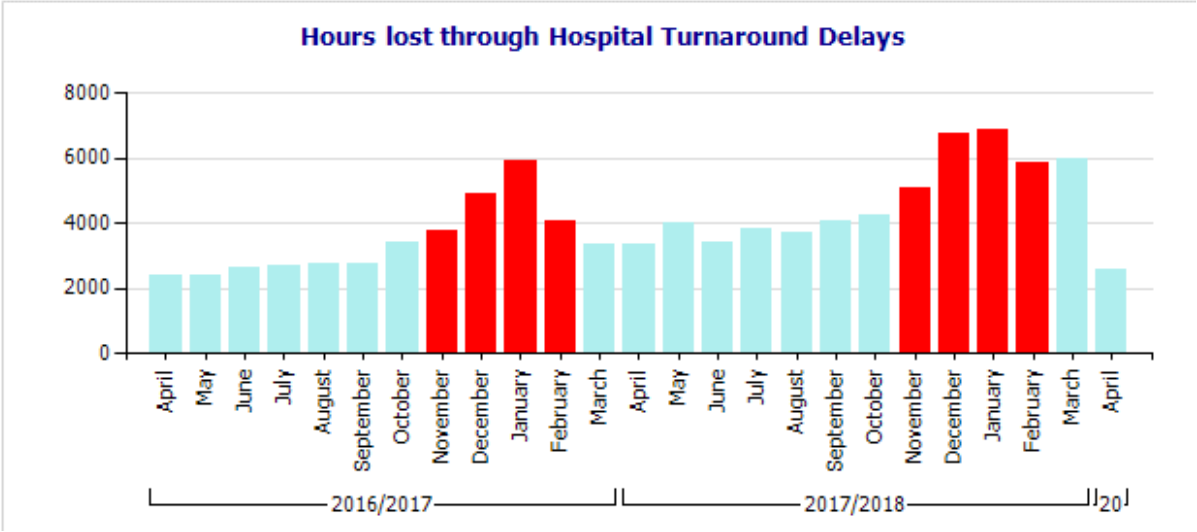
Hospital Ambulance Liaison Officers (HALO) are commissioned by individual CCG's – which must be clearly defined and financially accounted for in each sector. HALO's have an assigned acute hospital that they work within.

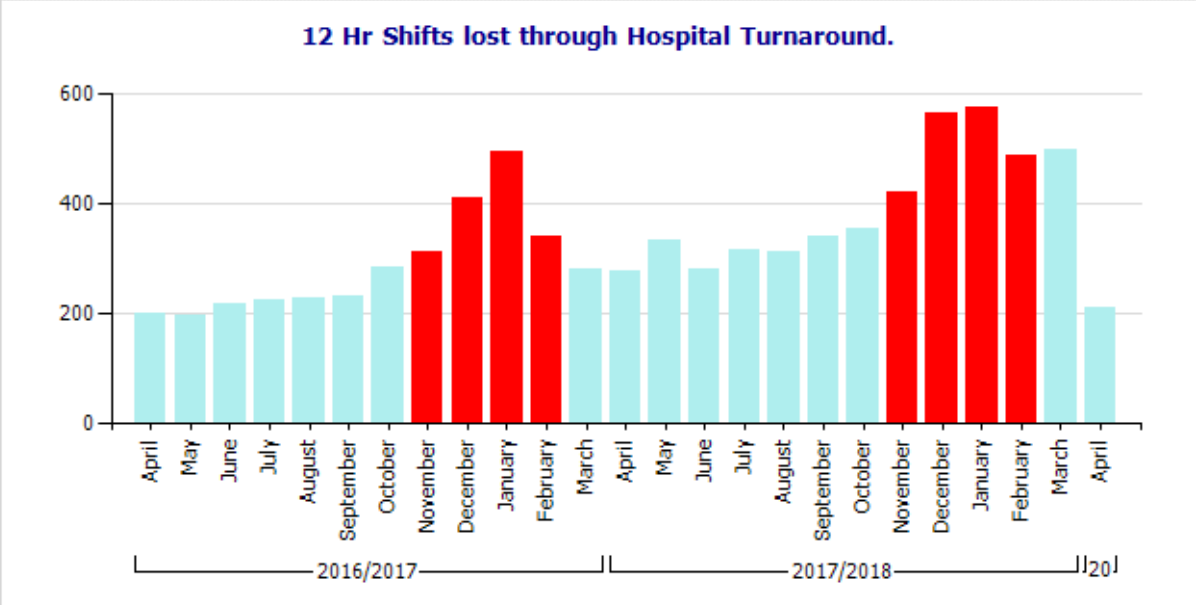
HALO's are line-managed by the Senior Operations Manager in the local sector, however during their hours of duty are required to book on with the Hospital Desk or SOC, who will provide tasking, guidance and direction based on the overall picture of operational pressures. HALO rosters are held on GRS, collated centrally by the HTDesk and can be viewed by all Tactical Commanders.

During the Winter months the Trust provides additional HALO support across the region to ensure additional support is provided throughout the challenged period.

6.5 Lost Hospital Hours – Turnaround

The below chart depicts the number of hours that WMAS loose when an ambulance takes longer than 30 minutes to turnaround at hospital. The first chart represents these in total lost hours; the second represents the number of 12-hour shifts that are lost. These charts clearly demonstrate the need for robust management of hospital turnaround and the impact it has on WMAS's ability to respond to sick patients in the community. The Red columns are winter months.





7.0 Commercial Services

Regional Coverage

WMAS holds 10 Non-Emergency Patient Transport Services (NEPTS) contracts across the West Midlands region and Cheshire.

Accounting for 65% of the regional NEPTS services, the service encompasses routine Patient Transport Services, Renal Dialysis, Mental Health, and High Dependency Services.

Activity Patient transport activity is in excess of 1 million journeys per annum, and is serviced by a workforce of 800 staff, 334 vehicles and 5 control centres providing 24/7/365 service provision.

During winter periods, activity generally remains constant within NEPTS and does not suffer from increased activity or significant variances; notwithstanding this, pressure upon timely discharges do present as winter pressures exhibit across the wider health economy.

In forecasting terms, activity is planned for one to two days in advance of the operating day and responds to the actual activity known and presented; the planning takes into account patient mobilities and vehicle variant requirements. Based upon this, staffing and vehicle allocations are flexed from the full and part-time employed staff pool, as well as bank staff and overtime allocation. Annual leave is managed and controlled during this period to ensure that adequate staff availability is maintained.

To service 'On the Day' activity, such as late notice bookings, discharges and transfers (usually 10-15% of overall activity), additional and unplanned crews are designated in order to service the demand as presented; the unplanned crews are increased during the winter periods in order to meet the growing winter pressure for timely and prompt discharges.

Each contract has a Senior Operations manager who is overall responsible for the operational delivery which is supported by a designated operations manager and supervisors.

The contracts are as follows:

- Cheshire
- Staffordshire
- Pan Birmingham
- Coventry & Warwickshire
- Worcester
- Dudley & Wolverhampton
- Health Care Logistics

There are five control rooms across the region at the following locations:

Frankley – covers PAN Birmingham, Dudley and Wolverhampton

Bodmin (Coventry) – covers Coventry & Warwickshire and Worcester

Tollgate – covers Walsall, Black Country partnership and Out of Hours

Warrington – covers Cheshire

As part of plans for managing winter pressures NEPTS will:

- Continue to work with Commissioners and Acute Trusts aim to ensure discharges are arranged earlier in the day. Timely discharges will contribute to patient flow and support "keeping the front door clear"
- Provide additional Regional discharge crews between – 1400 and 0000 (Mon- Fri)

In order to ensure adequate staffing levels for the winter period and to service the presented activity and maintain a normal service provision, annual leave is managed within control levels; Bank staff are utilised as required, and overtime offered.

A 24/7/365 NEPTS Tactical on call team operates, to deal with issues on both an in hours and out of hour's basis.

'Snow Socks' are carried on all NEPTS in order to ensure continuity of service during adverse weather conditions.

NEPTS will assist the Emergency and Urgent Services with resources as requested and required throughout the winter period, subject to operational availability. In the event of a Major Incident, NEPTS will provide support as outlined in the WMAS Major Incident Plan

8.0 Mass Vaccination Plan (Flu)

WMAS has implemented a managed programme for 100% of all eligible staff to participate in the Frontline Staff Flu Mass Vaccination Programme. The WMAS Influenza Mass Vaccination Plan 2018/19 will detail the programme in full. In 2017/2018 and 2018/2019 the flu vaccination programs are joined and supported with a Commissioning for Quality and Innovation (CQUIN).

Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season- a much higher incidence than expected in the general population.

Influenza is also a highly transmissible infection. The patient population found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected.

Influenza is a serious health threat, especially for vulnerable populations like older adults and people living with and caring for frail, disabled and/or aging persons, including those who work in long term care.

Health Care Professionals who are not vaccinated against influenza may:

• become infected with influenza through contact with infected patients

• become infected with influenza through contact with other infected professionals

• spread influenza to patients and other Heat Care Professionals.

Potential exists for WMAS frontline staff to carry the virus and unknowingly infect patients and colleagues – causing illness or even death. Without the vaccine, staff are more likely to infect each other as well as patients, families, and their colleagues. The vaccine will prevent increased pressures on the workforce through sickness and absence.

The Trust will train Paramedics to administer the Flu Vaccine to eligible staff at their base Hub locations. There is a significant programme in place to deliver Flu Vaccine to sites and maintain the cold storage chain. All staff will be approached positively to encourage the uptake of Flu Vaccine administration, with an incentive scheme in place to further promote the uptake of vaccine for at least 80% of the eligible workforce before December 31. In locations which aren't served by Paramedic staff the Trust Engagement Vehicle will be mobilized to ensure mobile Flu Vaccine clinics are available to all eligible staff.

9.0 Community First Responder Schemes (CFR)

Key to supporting the communities of the West Midlands region are the Community First Responder's (CFR). CFR's contribute towards patient care and operate within the vicinity of where they live, (5 miles or 10 minutes). They are contacted if they are booked on duty with EOC. Their utilisation is reliant upon dispatching from both EOC's and are monitored by the local Community Response Manager for each historic divisional area.

9.1 Communicating with CFR's

Community Response Managers inform CFR schemes when there is a predicted increase in demand, such as winter and the weekends leading up to the Christmas & New Year and request the schemes to book on duty. This is with the clear focus that it is in addition to their usual targeted hours per month.

10.0 Fleet

Double Crewed Ambulances (DCA) 465 and Rapid Response Vehicle (RRV) 50 are the new fleet stock for 2018/19. This represents a considerable uplift in the fleet numbers to fully support the operational requirements. All vehicles will be less than 5years and no fleet will be swopped over in the winter of 2018/19, which will allow the operational teams and fleet teams to focus solely on the daily delivery of frontline operations.

10.1 Fleet Replacement Programme

Deliveries of new DCA's will complete in Quarter 1. On completion of the delivery programme the DCA fleet will total 465.

10.2 Fleet Opening Hours Daily

Vehicle availability and cover during the winter months, Christmas and New Year period is paramount. Opening hours of the workshops and mechanic availability both in and out of hours through on-call can be viewed in the charts below. These times may change as the Trust moves closer to the holiday/festive periods and will be reflected in the separate operational holiday/festive plan for this period

During periods of adverse weather, mechanics availability for evenings and weekends will be scaled up as appropriate, i.e. early starts and late finishes. A standing agenda item for winter

10.3 Work Plan at Service Delivery/Operations

Work Plan at Service Delivery/Operations Management Team Meetings will take place; to include fleet availability and workshops cover.

As well as having internal cover (cover supplied by WMAS workshop staff) additional cover has been arranged with our recovery agents, Mansfield Group. A Mansfield Group mechanic will be made available to attend WMAS sites or vehicles broken down with repairable defects, on a nightly or weekend basis, as and when required, throughout the winter months.

Vehicle recovery will be available through our vehicle recovery agents, Mansfield recovery, 24/7 (as normal) inclusive of the Christmas / New Year festive period.

Contact number for Mansfield recovery is 0870 6003444

10.4 Fuel Stocks

During the winter period, all Trust fuel bunkers at each hub will have increased deliveries to ensure better resilience given the increase in demand and reduce the impact should inclement weather impact roads networks/ infrastructure.

11.0 Logistics and Regional Make Ready Recruitment

The Logistics Manager will remain focused on AFA recruitment, AFA training and process control. This regional function will also manage the stocking of new vehicles as they arrive within the Trust, working closely with the fleet department.

The Trust are providing additional AFA's to hubs across the region to ensure the provision of vehicles being Made Ready is maintained through the winter, these staff will be recruited and trained by the AFA trainer.

In line with normal Trust winter arrangements, the regionally controlled winter ambulance load list will be rolled into the Make Ready process at each hub in October to ensure each Emergency vehicle has an ice scrapper, de-icer, a snow shovel and snow socks load on every RRV and Ambulance vehicle, with adequate spares held on each hub. Hubs will ensure that adequate stock of protective windscreen covers, ice scrapers and de-icer is in place on hubs and CAS sites as required.

The Trust has in place a contract to grit the Operational Hubs and EOC sites. This is provided by an external contractor who monitor temperatures daily and set thresholds to grit based upon Met Office information (daily). A report is circulated each day showing which sites will be gritted that night. The contractor then visits the highlighted sites that evening and spreads grit around the carpark and walkway areas. This provision occurs every day when the threshold is met. This service is managed and facilitated by the estates department, any problems are reported through the Estates Help Desk. In addition, the Trust provides a small stock of grit to supplement certain areas (smaller locations).

This year there will be no additional local over stocking of consumables on hubs to ensure management of stock is maintained and reduce available space at the hub. If adverse weather forecasts emerge, then the On Call Strategic Commander will determine if additional stock needs to be mobilised from central stores to each hub in good time.

12.0 Operational Sector Readiness

The Trust is covered by 9 Sectors:

- Coventry and Warwickshire
- Erdington and Lichfield
- Hollymoor and Bromsgrove
- Willenhall and Sandwell
- Shrewsbury and Donnington
- Dudley
- Worcester and Hereford
- Stoke
- Stafford

This plan covers the essentials in ensuring that all sectors are in a state of readiness to cope with the demands placed on service delivery for the winter period. This will include additional hours AFA's, OM's and HALO's throughout the period,

The Winter, Christmas and New Year period traditionally and historically has presented operational delivery challenges to the Trust, with a sustained period of increased demand concentrated in both urban and rural areas.

It is therefore prudent that during anticipated period of increased demand that we harness our available resource capacity to maximum effect.

• Maximised WMAS staff outputs to forecasted workloads (patient facing & AFA)

• Maximised fleet/workshops availability

• Ensure sites are in a state of winter preparedness

Abstractions rate across all sectors will be kept to a minimum to maximize available resources to enable us to respond to the demands placed upon the Trust.

12.1 Hospital Turnaround

The 15-minute clinical handover and 30 minute turnaround will be enforced through the period to ensure crew availability for response. This will be managed through by the HALOs, OMs, ASOM's, SOM's and Tactical on Call out of hours with support from the 24/7 SOC and Hospital Desk.

12.2 Fleet/Vehicle supplies for vehicles

Supplies:

- Snow socks for all vehicles have been checked with orders placed for missing items
- De-icier stocks have been checked for all sites and orders placed as required
- Fuel delivery arrangements have been confirmed with the Fleet Department and all fuel cards are current. Where applicable Fuel bunkers have sufficient stocks to manage the festive period Bank Holiday break

Vehicles:

Each HUB has a specialist 4x4 ambulance capability with trained staff, these vehicles will be deployed 24/7 operationally when poor weather is forecast, in addition to supporting the overall Ambulance Fleet to meet peak outputs.

13.0 Emergency Operations Centre (EOC)

13.1 Duty Manager

A Duty Manager will be present at both Tollgate and Millennium Point EOC for each and every shift taking responsibility for the day to day running of the duty EOC team. Additional support and management will be supplied by an EOC Commander during normal working hours across both EOC's and the EOC Tactical on call during the out of hour's periods.

13.2 EOC Tactical Cover

EOC Tactical arrangements are in place and cover increased in order to provide additional support during periods of high activity and pressure.

13.3 Dispatch

Every effort is made to ensure that dispatch teams are fully staffed and that any additional requirements, such as TMIU controllers are identified and sought in advance.

13.4 Incident Command Arrangements

An ICD supervisor will be on duty on each and every shift providing 24/7 cover to manage and deploy resources to any large scale or specialist incidents in line with current ICD protocols. This is a regional desk where specialist incidents are managed by the ICD from any location within the areas covered by WMAS. In addition, each of the dispatch teams have identified and trained a dispatcher that is capable of providing additional support or cover should the need arise.

13.5 Call Taking

During each shift call taking at both MP and Tollgate EOC's will be managed by a call taking supervisor and a call taking supervisor assistant. Additional Call Taking staff have been employed to meet the high demand period, this has been the number of 2min BT delays reduce to very low levels. This recruitment will be sustained to ensure the winter 2018/19 demands can be fully met. They will provide support and line management responsibilities for the call taking function. Call taking numbers are dynamic in line with the predicted call taking demand to produce circa 28 call assessors on duty during the busiest period of a normal day (outside of NYE).

The number of staff on duty at any one time is varied in order to provide the right level of cover to meet call demand. A separate staffing assumption has been made regarding Christmas and NYE and will be contained within the Festive plan. Protocols changes and staff notices will be kept to an absolute minimum during the winter period so that the dispatch and call assessor teams are not distracted by adhoc changes.

13.6 The Clinical Support Desk Team, (CSD) incorporating the Clinical Hub

The Clinical Support Desk Teams are located within both EOC's and provide 24 /7 cover it is manned by 25 experienced Clinicians. The staffing of the team varies throughout the hours of operation to match the activity presented. The Clinical Support team have primary roles;

- The triaging of lower category calls (Category 4 calls) where an ambulance response is not required, utilising alternate pathways primarily via the Directory of services (DOS), additional to this at busy periods CSD will carry out a welfare check for all other categories of calls which may have a delay in response, this may result in the clinician down grading the call if the response is deemed inappropriate.

- Identify alternative treatment routes available for the patient outside of hospital, utilising the DOS.

- To update the patient's own GP with information or a case note

- Make a referral to a community based service
- Get advice while on scene with a patient with complex needs, utilising the clinical website and other databases available to the team.
- CSD provide support for the EOC team, primarily for call assessors, who may benefit from clinical knowledge during complex 999 triage.

13.7 Directory of Service Leads (DOS Leads)

The NHS Directory of Services (DoS) has a key part in managing patient flow throughout the health economy. During the winter period, there is increased demand for the Area DoS Leads to support local commissioners and providers by capturing winter initiatives and ensuring referral pathways are in place for key providers such as WMAS, NHS111 and Acute Trusts. Winter is also a time when utmost accuracy is required for existing services, pathways and technical links. The DoS leads will provide DoS and operational support to both EOCs, NHS111 and Operations on key dates as required.

14.0 Mutual Aid

WMAS has a Mutual Aid Plan that gives clear actions that are required when the plan is enacted.

The decision to request or supply mutual aid will be the result of either a national conference call between all the United Kingdom Ambulance Services or a direct "Strategic (Gold) to Strategic (Gold)" call and will be due to one of the individual ambulance services being in a position where it is unable to provide a safe service to the public in that area. This may be due to a declared Major Incident but may also be due to other pressures existing in that area at that time.

Powys

Integrated Winter Resilience Plan 2018 / 2019

The following plan has been produced collaboratively to ensure the Health Board is prepared for the winter period and as such outcomes and experience for the people of Powys can be optimised during this challenging period. The winter period is defined as beginning in October 2018 through to the end of March 2010.

This plan also recognised the challenges faced by our neighbouring acute NHS Health Boards and Trusts both within Wales and across our border with England.

1. Governance Arrangements

In line with the guidance provided by Welsh Government and the Unscheduled Care Programme Group this plan has been written in collaboration with the Local Authority, Mental Health, Primary Care, GP OOH, Third Sector and WAST. Liaison with WAST will be required to ensure alignment of both plans. This plan will be signed off in partnership with local authority partners, through ……..

Governance Arrangements			
	Powys Teaching Health Board	Powys County Council	Welsh Ambulance Service Trust
Responsible executive officer for winter resilience planning		Alison Bulman Director of Social Services	
Winter resilience plan to be approved at Board level on:			

2. Introduction

The purpose of this plan is to provide assurance to the respective partner organisations in the Powys region that a robust Integrated Winter Preparedness Plan is in place for winter 2018/19. The development of the Integrated Plan has been led by Powys Teaching Health Board (PTHB) and produced in collaboration with key partners including the Welsh Ambulance Services NHS Trust, Powys County Council and Third Sector Partners. It aims to demonstrate how joint plans from these organisations contribute to a whole system approach to ensuring the quality and safety of services is maintained during the winter months.

The health board is predominantly a commissioning organisation, buying services on behalf of the population from a wide range of providers, including from primary care contractors, independent sector care homes, ambulance services, District General Hospitals (DGH's) and other specialist hospitals. Our partnerships with (DGH), care homes, domiciliary care providers, WAST, social care and essentially the Third Sector, means that integrated care for people continues to strengthen.

Demand for health services fluctuates seasonally, with winter typically seeing heightened demand for services combined with challenges such as adverse weather, infectious and viral outbreaks and the exacerbation of chronic medical

conditions. In response to this increased demand it is essential to develop a comprehensive plan to reduce the likelihood of winter factors impacting negatively on patients and the public.

The approach to winter planning taken by PTHB has engaged with key stakeholders in both reviewing winter 2017/18 and the development of the current Integrated Plan. The review process to understand what were the key learning points to inform the development of the 2017/18 winter plan began in March 2018.

This plan sets out how Powys will deliver the 5 winter delivery priorities (WDPs) set out by Welsh Government:

WDP 1: **Optimising clinical engagement and partnerships** to deliver timely and high-quality access to services

WDP 2: Explicit focus on **better management of demand in the community**

WDP 3: **Enhanced operational grip and clinically focussed hospital management** to mitigate peaks in pressure and manage risk effectively

WDP 4: **Focus on the significant opportunities to enable people to return home (or as close to home as possible) when ready from a hospital bed**

WDP 5: Wherever possible, people should be supported to return from acute hospital sites to their home for assessment (**implementing a discharge to assess model)**

3. Understanding the Demand

In May 2018 undertook a review the winter of 2017/2018. This addressed the following areas:

- To consider the impact of the winter pressures and demand surge between December 2017 to March 2018 across the UK on Powys.
- To provide a reflective account of actions undertaken to maintain business continuity across Community Hospitals and Community Services in Powys during the winter pressure period;
- To review of spend against additional £380k Welsh Government funding to support flow;
- To provide information on services cancelled and remedial action put in place to ensure services were delivered.

The review document can be viewed via the link below:

Understanding the demand and resilience			
Ref	**Action**	**Lead Organisation**	**Due Date**
3a	Undertake demand analysis to identify the main area for A&E admission including time and day of week	**PTHB**	**Sept 2018**
3b	Undertake demand analysis of presentation to MIU including time and day of week	**PTHB**	**Sept 2018**
3c	Undertake demand analysis of WAST calls to include reason, time and day of week	**WAST**	**Sept 2018**
3d	Understand the pattern of falls: location, time, day, age, WAST involvement, admission	**WAST**	**Sept 2018**
3e	Agree and implement the future delivery of integrated 111 and out of hours' services for Powys.	**PTHB**	**July Update**
3f	Develop a set of Performance Indicators that enable measurement of USC demand	**PTHB**	**Oct 2018**
3g	Review winter resilience 2017/2018 and identify good practice, lesson learned and changes to be implemented in preparation for 2018/19	**PTHB**	**Sept 2018**
3h	Develop a robust multi-agency winter plan for 2018/19	**PTHB**	**Sept 2018**
3i	111 Rollout - Powys are due to go live September 2018 and will require support to promote across all stakeholders	**WAST**	

4. Promote and support self-care/management

Communication to the public about the appropriate use of health services will be achieved through 'Choose Well' and Self Care. These messages will be distributed via social media. There is on-going work with the communications team to increase messages around appropriate pharmacy use specifically over the festive period, and ensure clarity around Primary Care contractors' in-hours opening times over the festive period. Information for patients will be displayed on screens in GP surgery waiting areas.

4.1 Primary Care

Primary care continues to be the corner stone of healthcare provision for the majority of people in Powys and access to high quality, responsive services is crucial to ensuring that winter pressures can be adequately met. To this end the Primary Care Department is working with all Practices, but particularly those that have capacity challenges, to ensure that appropriate alternative pathways are in place. These include the provision of Practice based Pharmacists, Physiotherapists, Urgent Care Practitioners and Physicians Associates, along with an enhanced Community Dentistry Service. These, coupled with in hours clinical triage systems and multi disciplinary/multi organisation Community Resource Teams will continue to ensure that capacity is maximised over the winter period and that patients are seen as quickly as possible by the Practice Team member most suitable for their needs.

4.2 A Community Pharmacy Common Ailment Service

We currently have 22 community pharmacies in Powys who can provide the common ailments service (CAS). This is out of 23 community pharmacies across Powys (Llanwrtyd Wells can't). Please note that for the service to run an accredited community pharmacist must be on site to deliver, which may not be possible every day.

Community pharmacies can provide advice on self-care and over the counter medicines as well as the CAS service. The CAS service offers access to free NHS advice and treatment for common ailments that cannot be managed by self-care. There is no need to make an appointment and a growing wide range of different conditions are included such as: acne, athletes foot, cold sores, dry eyes, hayfever, indigestion and reflux, in growing toenails, scabies, sore throats and tonsillitis.

Other services offered by the Community Pharmacy include offering influenza vaccination and an emergency supply of prescription only medicines, within parameters, if a patient is unable to get a prescription from the GP – but capacity may be an issue if significant volume of patients need to access this at once e.g. GP practice closure.

4.3 Seasonal Flu Campaign

The community flu vaccination programme is a key feature of planning for winter pressures. It impacts on Powys services that provide direct care and on the wider health and social care system that supports people in 'at risk' groups. The annual immunisation programme helps reduce unplanned hospital admissions to both community hospitals and our provider District General hospital emergency departments in England and Wales. By maximising the proportion of people to receive the flu vaccination helps improve public and health and reduce pressure on services.

Hospital wards can also offer vaccination to long stay inpatients in cases where this is appropriate and the patient has not already been vaccinated through other means. The vaccination status of patients will be communicated to GPs via discharge summaries and clinical portal.

PTHB has developed a flu information sharing template that provides regular updated flu seasons data which is circulated to each practice manager and a standing agenda item at cluster meetings

Practice-specific immunisation profiles are circulated quarterly and contain flu information for those aged over 65 and particularly at risk groups. Progress will be monitored throughout the winter period and uptake figures will be circulated to and discussed at cluster meetings.

4.4 Nursing Homes

As announced in the Welsh Health Circular 2018-023, nursing and social care staff working in adult care homes will be offered NHS flu vaccination at no cost to themselves or their employing organisation. All staff employed at care homes will be eligible because of the higher risk to staff and residents due to the enclosed nature of the setting. There is a 60% uptake target for health care workers providing direct patient care. These free vaccinations will be provided by community pharmacies, more than 85% of whom have signed up to offer it.

PTHB have offered to assist with these promotions to support increasing uptake of the free vaccination in the care home sector with the actions below:

- Contact nursing home managers in Powys by email to make them aware of the flu campaign 2018/19, free vaccination and resources available online
- Making your LA contacts aware who liaise with residential care home managers in your area to make them aware of the flu campaign 2018/19
- Provide postal addresses of the care homes we liaise with so we can issue flu posters (or assistance with delivery to the homes)
- Help reinforce the messages about getting immunised with use of prepared prompt sheets and templates for shift-handover meetings (e.g. flyers stapled to payslips).

4.5 Winter Preparedness pack for care homes

Public Health Wales are also making amendments to the Winter Preparedness pack for care homes which is being designed to be an electronic resource and guidance pack which is simple to use and of practical help for homes.

4.6 Immunisation

The Powys Immunisation Steering Group meeting have now commenced for 2018-19 period which will reflect the National Strategic Immunization Programme.

The development of the project plan is currently in its infancy of development but has the underlying principle of effective monitoring, prevention and treatment which will include;

- Actively offering the flu vaccine to eligible groups.
- Vaccination of healthcare workers who are in direct contact with patients and service users.
- Improve targets for those patients under 65 years for those in high risk groups.
- Vaccination of pregnant women will be facilitated by. – This is a pilot for 18/19 only in the mid it will be evaluated to hopefully roll out next year
- District Nurses will vaccinate housebound patients on their caseload.
- The Health Board will work collaboratively with Primary care and community pharmacists to increase the uptake of Powys residents

The Flu Code Standards will be adhered to which include;

- Flu vaccination is an organisational priority.
- There will be a named flu lead executive (locality service lead)
- Senior healthcare professionals lead by example
- Powys will have a structure communication plan as an integral part of the campaign.
- Flu vaccine is easily accessible for eligible individuals irrespective of their condition, mobility ethnicity or location.
- Everybody who is eligible for a flu vaccine is offered one.
- Healthcare staff actively encourage flu vaccination in eligible groups
- Knowledgeable staff are able answer questions about the flu vaccine in a timely way.
- Accurate and timely information on flu vaccines are administered is recorded and shared appropriately.
- All health and social care staff are encouraged to complete an information session on flu annually.

Powys Teaching Health Board are committed to ensuring that the local programme is adequately resourced engaging with Public Health Partners and health professionals in Primary and Community care. The overall monitoring of progress of the immunization programme will be overseen by the Powys Public Health Team.

Promote and support self-care/management			
Ref	**Action**	**Lead Organisation**	**Due Date**
4a	Roll out Invest in Your Health Community Programmes across Powys	**PTHB**	
4b	Evaluation of Invest in Your Health outcomes	**PTHB**	
4c	Undertake a deeper evaluation of Invest in Your Health to better understand impact on LoS, GP contact and admissions	**PTHB**	
4d	Develop proposals for widespread adoption of 'Choose Pharmacy'.	**PTHB**	

5. Community Care

5.1 Adult Social Care

It is essential for a robust winter reliance plan to have a prevention strategy as an element of this plan. Adult social care continues to work with the communities and third sector in terms of commissioning of preventative support which in turn prevents unnecessary hospital admissions. The information, advice and support which is available assists to sign post individuals appropriately.

Adult Social Care is a key component and partner in the development of the winter resilience plan. There are joint agreements, based on section 33 arrangements that are in place for key support services such as reablement and joint commissioning of care home beds. This is and continues to increase the joint ownership in terms of capacity management.

A review is underway in terms of improving access to the council's single point of access which in turn will stream line the system and enable customers to have access to expertise at the front end of service.

Adult social care will ensure that there are allocations and assessments for statutory care and support are not adversely delayed and will follow their in house escalation procedure should capacity increase specifically during winter months.

Adult social care acknowledged that on occasions there is a limited capacity within the domiciliary care sector. Work continues with both internal and external providers in order to address and work together on issue such as recruitment. The in house domiciliary care has now been extended to cover the north of the county and is assisting with the flow for both the community and hospital to facilitate a timely support service.

Reablement is a key support service to assist with flow within the health and social care system, in partnership with PtHB the council has been able to review the pathways both in terms of access and discharge from the reablement service. The Quality Management System which is in place, enables a consistent approach across the authority.

Adult Social Care aims to ensure that individuals are supported, wherever possible, to return home in order to ensure that individuals have the right environment in which to make informed decisions in relation to their future care. The increased use of technology is essential to enable this to take place, together with positive risk taking strategies.

Powys County Council has continuity plans for adverse weather and have agreements in place with providers of care and transport.

Telecare is used widely in Powys and ongoing and future promotion ensures that more people are enabled to stay at home.

5.2 PAVO Third Sector

PAVO Community Connectors support people aged 18+ to access support from the third sector to improve their health and wellbeing.

Community Connectors work with health colleagues across the County, in virtual wards and MDTs to support individuals to remain independent as possible in their homes, by brokering support from the third sector. Community Connectors also support the discharge of patient's home from hospital by accessing third sector services.

Community Connectors are actively engaging with discharge planning staff at PTHB to help support the discharge of Powys patients from DGHs back home where possible. This is dependent on capacity within the third sector services and may vary across the county.

Community Connectors accessed a small grant in 2017/18 to enable them to carry out several engagement sessions across the county to promote the winter Flu Campaign.

5.3 Flexing of Ward Bed Capacity

This year the Health Board undertook an analysis of the potential bed requirements associated with winter pressures.

It is typical for bed demand to begin to increase from November and through December, until dropping significantly in the days immediately preceding Christmas. From Boxing Day it increases sharply until reaching a peak in the first week of January. Early January is normally the most pressured time of year for bed capacity and this is often reflected in the unscheduled care performance measures. In general this pressure will continue through February and March before the system gradually recovers during April and May.

Last year PTHB identified a number of escalation beds across each community hospital that could be opened at times of increased pressure across Wales and with our two neighbouring DGHs SATH and WVT Trusts.

PTHB will again deploy this capacity in a tactical way, flexing bed capacity up and down when required across the whole winter period. The total additional bed capacity available to the system for winter is 6 beds (2 South, 1 Mid, 3 North).

5.4 GP Out of Hours Services

The 'out of hours' service offers great potential to alleviate demands placed on A&E and MIU departments and the ambulance service. Powys already has the highest GP shift fill rate, the lowest emergency admission rate, the lowest A&E attendance rate and the lowest ambulance transportation rate in Wales. The call handling and clinical triage service will move from Shropdoc to the all Wales 111 service provided by the Welsh Ambulance Service Trust in October 2018, with face to face services continuing to be provided by Shropdoc. Shropdoc are the only out of hours service assessed by the Care Quality Commission in England as providing "excellent" clinical services. The health board will continue to work with both WAST and Shropdoc over the winter period to ensure that service levels and performance are maintained.

Primary & Community Care			
Ref	**Action**	**Lead Organisation**	**Due Date**
5a	To improve access to community delivered respiratory services through implementation of the respiratory plan	**PTHB**	
5b	Engagement with Primary care - share data from last year HCP calls with Cluster groups to evidence demand and consider alternative options closer to home	**WAST**	
5c	Develop a directory of pathways available to all partners	**PAVO**	
5d	Trial an End of Life Pathway (aligned to the ongoing review of EOL care across PTHB).	**PTHB**	
5e	Explore and scope a Respiratory Pathway (aligned to the ongoing review of Respiratory care across PTHB).	**PTHB**	
5f	Develop a D&V pathway to keep Powys residents as home or in ring-fenced Community beds		
5g	Develop and implement the community / WAST model to respond to Falls calls ie Tele Health and WAST's iStumble project.	**WAST**	

6. Reducing our Admissions to DGHs

Whilst Powys aims to provide healthcare in or close to home wherever possible, as a highly rural area, spanning a quarter of the landmass of Wales, with no DGH, patients have to travel outside Powys to receive most secondary and tertiary treatment. Patients flow into five main neighbouring health economies – and further afield for specialised health services.

Across the border in NHS England SaTH and WVT currently provide emergency and planned services for the Powys population and their local populations.

There have been major challenges in key delivery areas during 2017/18, particularly in keeping pace with unscheduled care demand. These pressures are not unique to Powys, but experienced throughout the United Kingdom. Locally, much of this increased demand is generated by the system's inability to adequately care for the growing number of elderly frail patients. The impact on our ability to manage flow for all patients (planned, urgent and emergency care needs) across the system are significant. Some of the key areas to focus on in 2018/19 to deliver more timely access to services include:

- Reducing the number of patients being admitted to Acute Care/DGH's that could be managed via alternative pathways.
- Working with ambulance services to make sure patients are directed to the best place to meet their needs to reduce delays for ambulances at hospitals.
- Reducing the average Length of Stay in the Community Hospitals.
- Reducing non-Mental Health Delayed Transfers of Care.
- Improving care coordination and community flow, by measuring demand and capacity

6.1 Ambulance Services

PTHB will build on the collaborative work with WAST focussing on reducing avoidable call outs in cases where the patient can be safely reviewed by one of the Community Teams. Two schemes have been developed and are in trial phase to determine whether they achieve the desired outcome. A weekday pathway involving a clinician to clinician referral to District Nursing Teams for patients that can be managed in the community has commenced in Montgomeryshire, Rhayader and Llanrindod Wells.

A second trial concentrating on low acuity fallers in residential and nursing homes will commence in North Powys during the late summer/early Autumn using the iStumble algorithm.

Working collaboratively with WAST to focus on residential homes and community teams to develop pathways to reduce avoidable call outs in cases where patient can be safely reviewed by the Community Team.

A business case will be presented to EASC to support an All Wales Advanced Paramedic Practitioner Expansion programme. This plan has been developed to enhance and contribute Welsh Ambulance's role as a community based provider of care across a 5 year programme.

6.2 Virtual Ward

The virtual wards are Pan Powys working within GP populations, the emphasis of this GP enhanced service is to prevent admissions and support discharges in turn supporting flow with the introduction of the Powys to assess model this should improve the outcome comes for the patients and enable them to remain at home where possible.

Analysis of winter admissions has identified that Respiratory problems and falls are the top reasons for emergency admissions.

6.3 Emergency Pressures Escalation Procedure

The emergency pressures escalation procedure is set out below:

- Open up Health Emergency Control Centre (HECC) to co-ordinate flow and bed capacity supported by key staff – At What Level do we consider this below actions can be managed from the HUB ?
- Escalate the position to Social Care / Primary Care/ Third Sector colleagues
- Integrated Clinical Team Managers (ICTM) remain in their areas on respective sites to support flow
- Activate additional internal bed management call to inform national calls
- ICTM's support with the review of all patients to determine those that can have their discharge expedited.
- Liaise with WAST work in collaboration to divert clinically appropriate patients to MIU's avoiding DGH admission
- Consider extending opening times in services where DGH pressure points have been identified e.g. Ystradgynlais MIU with radiology support

- Identify additional bed capacity and review staffing
- Inform TSU of position and potential need for additional staff
- Care Transfer Coordinators (CTC) continue to work with neighbouring Health Boards to identify patients that can be transferred / discharged from DGH to Powys community
- District Nursing (DN) teams advised of high escalation and the need to manage patients at home and via virtual ward to avoid hospital admission
- Liaison between WAST and DN service to identify potential patients triaged to be managed at home
- Document actions taken

DGH Admission Avoidance			
Ref	**Action**	**Lead Organisation**	**Due Date**
6a	Remote monitoring of the stack to help increase H&T processes	**WAST**	
6b	DNs monitor stack remotely for opportunity to manage the call	**WAST**	
6c	MIUs to monitor stack remotely for opportunity to manage the call	**WAST**	
6g	Use paramedic pathfinder as MIU criteria to increase pathway with relevant cases	**WAST**	
6h	Develop and Implement the Flow Dashboard to better understand and improve patient flow within community hospitals and ensure Flow Boards are utilised to best affect	**PTHB**	**Provisionally March 2019**
6i	Implementation of the principles of safer patient flow, utilising Lean methodology to reduce length of stay	**PTHB**	**July 2018**
6j	Consistently embed Estimated Discharge Date (EDD) identification and planning process throughout the community hospitals, providing EDD to DGH's to secure timely transfers.	**PTHB**	**Sept 2018**
6k	Third sector transport/taxi initiative for low acuity calls	**WAST**	

7. Discharge and Reablement

7.1 Heath & Care Co-ordination Hub

When requiring secondary care, Powys patients are admitted to any one of the six other health boards in Wales or the two main NHS Trusts in England. This makes the prioritisation and coordination of repatriation complex. The Coordination Hub will ensure a more efficient way of managing the timely repatriation of Powys patients from other health board's DGH / acute hospital beds in Wales and England and manage flow in and out of Community Hospitals in collaboration with Powys County Council. It will increase our ability to ensure the length of stay in a DGH / acute care bed for Powys patients is minimised, as patients who are admitted

will be transferred to the most appropriate setting in a timely way as soon as they no longer need acute hospital care. This will support a 'home first' ethos and a 'discharge to assess' model of care.

The purpose of the Hub is to facilitate the overall coordination of flow across Powys working in partnership with our Social service and 3rd sector colleagues to improve information, communication and flow of Powys residents through our community services.

The Hub will engage daily with stakeholders monitoring the demand and capacity of our community services against predicted discharges, admissions and repatriation from our commissioned DGH's into Powys.

The Hub will hold capacity information for community services to enable people to be supported at home as a first option

The Central hub provides a communication point for our neighbouring DGH's to enable the H&C Hub Lead to assess the demand pressure points for PTHB community services and provide information to the executive on call for all Wales escalation calls. The Clinical lead provides clinical support for the CTC's when exploring discharge options.

7.2 Powys Discharge to Assess

There is on-going multiagency work aimed at expediting discharge covering a range of accommodation solutions, community based services and support to facilitate rapid discharge. At present there are several pathways which support discharge but there needs to be improve coordination and realignment to ensure that patients are assessed in the most appropriate setting. The plan is develop pathways in line with Discharge to assess models created in other NHS organisations promoting the approach of home first and rapid assessment. It is the intention this will be named Powys to Assess and will be led by the new Health and Care Hub, utilising existing services like Reablement, virtual ward specialist nurses, therapies, domiciliary care, PURSH ,Red Cross, third sector connectors and community hospitals.

The scoping over the month August will then develop a plan of implementation reviewing the potential gaps and education of shifting to the home first principles with rapid assessment and provision for short term support (6 weeks). Optimising existing services and possible additional funding from ICF.

The Powys to Assess discharge model will focus on an enhancement of the Community Teams which will provide both step up and step down care to individuals requiring support in their own home. The intention will be to provide more rapid access to community based personal care and therefore reduce length of stay.

Discharge and reablement – SAFER Discharge Principles, DToC management, Discharge to Assess			
Ref	**Action**	**Lead Organisation**	**Due Date**
7a	Implement a new joint health and care coordination hub and using utilising Lean methodology: ▪ Reduce Delayed Transfers of Care (DTOC), Improve patient repatriation time and level discharges ▪ Assess social care demand and capacity ▪ Understand the impact of Community Connectors not just on patients but on reducing LoS, GP contacts and admissions	**PTHB**	**Dec 2018**
7b	Jointly conduct a review of the reablement model and make recommendations for development	**PTHB**	**Mar 2019**
7c	Implement the actions identified in the WAO Discharge Audit	**PTHB**	**Dec 2018**
7d	Develop and implement a Powys Wide Discharge to Assess model phase 1 'Home First'	**PTHB**	**Dec 2018**
7e	Undertake DToC Validation to help embed good discharge planning into daily practice	**PTHB**	**Dec 2018**
7f	Enhance management of ED delays in the English EDs either by joining with WMAS or use of Care Transfer Co-ordinators/HCSWs	**WAST**	**October 2018**
	Develop a plan to ensure access medicines for inpatients in our community hospitals during inclement weather	**PTHB**	**October 2018**

8. Civil Contingency Severe Adverse Weather Plan

PTHB's Inclement Weather and Major Travel Disruption Policy and Procedure (HR025) has been designed to balance the service and business needs of the organisation, against the practical and personal difficulties inclement weather and major disruption to travel presents for its employees. This Workforce and Organisational Development policy, which should be read in conjunction with service level business continuity plans, aims to provide guidance, advice and support to managers and employees in the event of adverse weather conditions which cause major disruption to travel services i.e. rail or road thus severely affecting the ability of employees to travel to or from PTHB premises.

A link to the policy is available in Appendix

In addition, PTHB is undertaking further work to develop a Civil Contingency Severe Adverse Weather Plan. The Civil Contingency Severe Adverse Weather Plan will provide an overarching has been developed as a framework for to coordination of PTHB wide resources in the event of severe adverse weather conditions that impact upon the normal operational efficiency of PTHB.

The Civil Contingencies Severe Adverse Weather Plan will not be limited to heavy snowfall events as experienced during winter 17/18, the plan will cover all elements of adverse weather i.e. heavy snowfall, heatwave etc. as referenced within the Dyfed Powys Community Risk Register.

The completed plan will include guidance on the course of action to be undertaken in response to national processes i.e. The Met Office Weather Warnings and will also incorporate relevant links to the Dyfed Powys Local Resilience Forum Severe Weather Plans and procedures.

A link to this plan is available at Appendix (not completed yet)

Whilst it is noted that a link to the plan is available in Appendix.

It is designed to give guidance, advice and support to managers and employees in the event of adverse weather conditions which cause major disruption to travel services i.e. rail or road thus severely affecting the ability of employees to attend work; and /or disrupts the ability of patients and staff to travel to or from PTHB premises; and / or negatively impacts upon the stability of the procurement supply chain.

Many issues can be resolved via existing escalation processes at an operational management level (refer to Section 6 of this document), . Howeverd, dependent upon the nature, scale, severity, and predicted length of the disruption it may be necessary to implement the formal processes normally associated with a major incident.

A link to this plan is available in Appendix…...

Command, Control and Co-ordination are important concepts in the multi-agency response to emergencies. A nationally recognised three tiered structure known as Strategic (Gold), Tactical (Silver) and Operational (Bronze) has been adopted by the emergency services and most responding agencies.

The PTHB Command and Control arrangements are based upon this system. These arrangements help to ensure interoperability between responders and are set out within the PTHB Civil Contingencies Plan.

A link to this plan is available at Appendix Major Incident Plan.

9. Infection Control Outbreak Management Procedure

There is a procedure in place for managing infectious incidences and outbreaks within the Health Board. The investigation and management of clusters of infections associated with health care provision across PTHB is a key part of the work to prevent the spread of infections and disruption of services. This procedure outlines the actions required in the management of infectious incidents under investigation, outbreaks and major outbreaks.

The aim of the procedure is to ensure that all staff of the Health Board understand the implications of outbreaks of infections in health care and are able to contact

the correct personnel in order to manage or prevent an outbreak. Outbreak management is also facilitated through an outbreak control group comprised of appropriate staff.

When patients are admitted with respiratory infections, diarrhoea and or vomiting prompt isolation and segregation of patients is necessary to prevent transmission and bed closures. ICTMs will ensure that clinical areas have adequate stock levels of personal protective equipment to care for patients with infections (e.g. fluid repellent masks, FFP3 respirators, facial protection, aprons and gloves) in order to protect staff from infection.

The target for influenza vaccination uptake for health care staff is set at 60% this year. An effective communication campaign is necessary for staff to understand their responsibility regarding vaccination and to increase staff influenza vaccine uptake.

All infection prevention and control policies can be viewed via the link below:

http://nww.powysthb.wales.nhs.uk/infection-control-policies-and-guidance

10. Mental Health

Mental Health does not see seasonal fluctuations in demand to the same extent as other services although demand varies for other reasons. As a result there will be normal service provision over the winter months, with the usual liaison and out of hours cover.

11. Monitoring and Evaluation

The Oversight and implementation of plans will be monitored through the Unscheduled Care Implementation Group meeting and performance reviews and the regular delayed transfer of care meeting.

Metrics will be developed for the main schemes in addition to the routine measures already in place. A formal, multi-agency review of winter will again take place in May 2019 and reported to the Executive Committee PTHB.

12. Actions to Address Key Risks

Winter preparedness is fundamentally about the assessment and management of risk, acknowledging the consequences that insufficient preparedness can bring for the quality and safety of services provided. The list below reflects an assessment of the most significant potential risks identified for winter 2018/19:

No	Theme	Description	Winter Risk Only?	Rating
1	Workforce	Insufficient capacity within community resource teams and social services	No	
2	Workforce	Inability to recruit staff to primary care	No	
3	Capacity shortfalls	Insufficient community bed capacity leading to delays in admission or discharge from	No	

		neighbouring DGHs in Wales and across the border in England.		
4	Capacity shortfalls	ASC capacity for assessment, domiciliary care provision, residential and nursing beds	No	
5	Infection	Significant infection outbreaks	No	
6	Poor Vaccination Uptake	▪ There is a risk of influenza outbreak due to sub optimal vaccination uptake which will increase the number of admissions to hospital.	Yes	
		▪ Good staff uptake across PTHB and WAST however, uptake of Influenza vaccination may put patients at risk due to potential of contracting Influenza from staff	Yes	
		▪ Increased risk of staff sickness during the winter period adversely impacting on staffing at ward level	Yes	
7	Seasonal Increased Demand	There is a risk that the number of admissions to hospital will increase during the winter period due to exacerbations of chronic conditions, seasonal flu outbreak and increased injurious in inclement weather this will impact on available capacity within the hospital and compromised patient safety	Yes	
8	Demand	Significant ambulance turnaround delays	Yes	
9	Demand	Significant increase in demand above projections	Yes	
10	Cold Spells	There is a risk that sudden episodes of extreme cold could precipitate exacerbations in individuals with chronic chest conditions and which would increase demand on acute and community beds	Yes	
11	Severe weather warning	There is a risk that severe weather will present challenges to workforce capacity due to the inability to travel to the hospital and / or to patient's homes to provide essential care resulting in sub optimal delivery of critical patient care.	No	
12	Legislation	There is a risk that expectations to provide social care support by patients, their family / carers and health care staff exceeds that which the Local Authority is able to lawfully provide as outlined in the Social Services and Wellbeing (Wales) Act.	No	
13	Reputational	Reputational risks to partner organisations and Welsh Government	No	

13. Conclusion

A number of specific risks to the delivery of the Integrated Plan outlined above have been identified. They include:

The Powys Integrated Winter Preparedness and Resilience plan has been developed jointly by partner organisations to respond to the assessed risks associated with winter. They are based upon a structured review of 2017/18 and learning from previous winters. The plans are described to mitigate risks and are expected to provide adequate assurance that all reasonable actions are being taken in preparation, recognising there are constraints on each of the partner organisations and not all eventualities can be accounted for.

Appendix A Communications Plan – Adrian

To be confirmed

A communication plan for the winter period to help address the issue and support teams in both Primary and Community Care settings is needed.

The plan needs to bring together aligned and complimentary activity and messages for the Out of Hours GP service, pharmacy, optometry and other services, NHS Direct, WAST, PTHB Minor Injuries Unit. It will also need to include escalation plans for communications activity during periods of pressure and link with public health work such as the flu campaign, infection prevention and control and issues around the frail elderly.

Specific schemes are planned for winter are:

- Article on keeping well during cold weather - to be distributed via local media
- Article on most inappropriate uses of A&E and OOH - to be distributed via local media
- Launch of Infection Prevention and Control campaign to limit the spread of infection in hospital
- Encouraging the use of Optometrists for eye health in place of General Practice
- Delivery of Flu Campaign
- Choose well messaging in response to demand / impact on our services.

Goals

- More appropriate use of hospital and community services such as the Emergency Unit and Out of Hours GP.
- Better use of pharmacy, optometry and other services.
- Reduced inappropriate use of services.

Objectives

- Influencing Patient behaviour
- Influence Service provider behaviour:
- Raising confidence other services and professions
- Gain insight into who is using services inappropriately and why.
- Create a combined communications plan and programme of activity for in hours and out of hours unscheduled care services
- Explore opportunities for further insight to inform future campaigns

Strategic Context

The plan supports the following elements of Health and Care Strategy:

TBC

It also supports the following strategic objectives:

TBC

Approach

High level/general activity

- Campaign on general messages around appropriate use of healthcare services this winter.
- Repeat prescriptions and medication
- Unwell is not uncommon: educating the public about recognising common ailments and how to manage them
- Flu vaccination and public health messaging campaign

Focussed/insight driven activity

- Using data to identify periods for specific problems and using proactive communications appropriately
- Linking with frontline staff to develop communications escalation plan to support periods of high pressure

OOH GP/Community

- Minor ailments campaign
- Promoting eye care in the community
- Medication/repeat prescriptions
- Targeting high use areas/users of the OOH service
- Frail elderly campaign e.g. check on your neighbours, falls prevention

Internal/stakeholder communications

- Making sure pharmacies and other partners are directing the public appropriately to services
- Asking staff to help support and share these

APPENDIX III Capacity Management Directors Pack for Escalation Processes

Commented [OP1]: Udates included from T&W Council - Shrops Council

Telford and Wrekin, Shropshire, Powys Local Health Economy Capacity Management — LEVEL 1 Action Card

Actions required by Local Authority Social Care Services

T&W LA

1. Facilitate safe and timely discharges in the normal way by liaising with Discharge Liaison Teams on both SaTH sites.
2. Be in receipt of the occupancy levels in the Block purchase beds. Aware of availability of Residential, Nursing and Domiciliary Care Provision, to support safe and timely assessment and transfer from acute hospitals.
3. Conference calls and Management at this level by Team Leader or appointed deputy
4. Normal working with Brokerage, who will inform Team Leader of any issues in the system

Shropshire LA

1. Facilitate safe and timely discharges for patients requiring social care support in the normal way by liaising with hospital staff at both sites.
2. Prioritise activity relating to 'work-list' (those medically fit for transfer) and delayed transfers of care.
3. Update the DLN responsible for DTOC daily on the actions relating to those patients on the 'work-list'

Be aware of acute, and community hospitals escalation levels and address transfer issues as they arise.

Level 1: Normal Working Management & On-site Manager (No negative triggers applicable)

LEVEL 1

RCMT

1. Ensure that EMS has been updated during the mandatory times of 07:30-09:30 and 14:30-16:30
2. Request Front door attendances from the previous day if not received for the Acute Trusts
3. Monitor daily activity
4. Produce a 'Sit Rep' to provide the region with a snap shot view of escalation levels and areas of concern.
5. Contact the SOC for divert or deflect information and the SOC commander for the day
6. Provide additional sit reps if required.
7. Monitor EMS and CAD on line for activity levels and changes in the escalation level of organisations
8. Respond to calls from Health Economies, WMAS and Major incident alerts 24/7.
9. Record all actions on RCMT data base Salesforce

Actions required by CCG Commissioners

1. Be aware of the acute and community hospitals escalation levels addressing any transfer issues.
2. Commissioners are aware of the situation via twice daily EMS and daily Fit to Transfer and DTOC lists

Management – CCG Lead Commissioners

Actions required by Community Trust

a) Community hospitals

1. Continuous review of patient length of stay - CH
2. Continuous review of Delayed Transfers Of Care
3. Reviews against expected Date of discharge
4. Twice daily capacity reports; hospital & community
5. Demand matches resource for the rest of the working day

b) Community Services

1. Maximising patient numbers and acuity against resources available
2. Community Teams to review at least twice weekly patients on community hospital wards to facilitate discharge to community teams, liaising with the Discharge Liaison Nurses within each community hospital.
3. Training, Doppler and continence work being fitted in within workloads.

c) Integrated Care Services

1. Facilitate safe and timely discharges in liaison with discharge liaison teams
2. In all hospital sites.
3. Prioritise activity relating to 'work-list' (those medically fit for transfer) and delayed transfers of care

Operational responsibility Locality Managers

Actions required by Powys Health and LA

1. Normal operating as per bed management tool kit

Actions required by Acute Trust (SaTH)
Refer SaTH's Level 1 Action Card

Action Required by RJAH

1. Complete and return daily capacity report
2. Review delay transfer of care patient's

Actions Level One			
Duty Manager - Role to maintain patient through the specialty 1. Be aware of escalation levels 2. Attend bed meetings	**Diagnostics & Therapies - Role to Support patient flow** 1. Be aware of escalation levels 2. Be aware of predicted activity	**Pharmacy Role - To Support patient flow** 1. Be aware of escalation levels - communication via email to senior Operational Pharmacies at each site 2. Be aware of predicted activity	**Director On Call Role - To maintain Patient Flow through the Specialty Area.** 1. Be aware of escalation levels 2. Be aware of predicted activity
Medical Response Role - To maintain Patient Flow through the Specialty Area. 1. Be aware of escalation levels 2. Normal Working	**WMAS** 1. Monitor amount of crews at hospital 2. Check activity across all departments 3. Contact Nurse in charge if delays develop 4. Appraise Local Bronze Commander 5. Monitor subsequent hospital activity and advise Duty Officer accordingly	**A&E / MAU - SaTH Ambulance Handover within 15 minutes** 1. On arrival ambulance crews to be greeted and patient registered greeted by designated ambulance triage nurse ATN wearing red armband. 2. Standard operational reports should report no unnecessary patient delays at accident and emergency or any other receiving area in the hospital 3. Ambulance Triage Nurse to click "Pat Release" on CD Screen once a bed has been allocated to the crew and transfer is complete. 4. Communicate with CSM regularly and as necessary. 5. Ensure that all patients have a plan at 3 hours for either admission or discharge. 6. Any patients without a plan or who are expected to breach (e.g. Mental Health) to be escalated to CSM and ED Ops Mgt as soon as they come apparent	**Working with Local Authorities** 1. Be aware of SaTH escalation levels 2. Facilitate safe and timely discharges in the normal way liaising with the integrated case management teams (ICMT) on both sites and discharge liaison nurses in Community Hospitals. 3. Address any transfer issues, particularly focusing on DTOCs 4. Give accurate information twice a day to CMSs regarding bed states. Use a pull approach from the acute trust to Community Hospitals 5. Use the live database to record bed states 6. Participate in the daily conference call at 10.30am 7. Normal community hospital bed management, community services, capacity management and liaison with Acute Trusts and Social Care

Telford & Wrekin, Shropshire and Powys Local Health Economy Capacity Management **LEVEL 2 Action Card**

Actions required by Local Authority Social Care Service

T&W LA
As Level 1 plus

a. Brokerage work to discharge medically fit within 24 hours where safe to do so.
b. Identify and work to plan complex discharges, not yet identified as Medically Fit for Discharge.
c. Plan for discharges over next 3-5 days.
d. Senior Broker to highlight any capacity issues to Team Leader Procurement and Commissioning who will work to expedite resolution.
e. Team Leader to ensure flow through all admission avoidance and enablement facilities are optimized.

Shropshire LA
As Level 1 Plus:

a. With brokerage facilitate discharges today
b. Plan discharges 3-5 days in advance
c. Liaise with lead commissioner to highlight any issues with capacity or blocks to expedite resolution.

Actions for Powys

- Identify issues and constraints and take all necessary actions to prevent potential risk to patients
- Utilise predictive data/information to routinely monitor discharge and patient flow, including discharge rates against those predicted and transport delays. Take the most appropriate action. For example:
- Senior nursing: review all inpatients with the MDT
- Additional Ward Rounds
- Review staffing levels/resources and requirements (including use of over contract, agency, skill mix and staff redeployment)
- Assess Community Resource
- Open short-term surge

Level 2 Early / Prolonged Pressure (Four Triggers Applicable)

LEVEL 2

RCMT

1. Ensure that WMAS are providing crews with messages to use the alternative pathways.
2. Inform SOC of potential pressure points and actions taken
3. Participate in any conference calls when invited to do so

Actions required by CCG Commissioners

1. Be aware of the acute and community hospitals escalation levels addressing any transfer issues.
2. Consider communications to GPs if predicting escalation to level 3, to request support by the use of alternative pathways
3. Consider requests for spot purchase beds

RJAH

1. Review delay in transfers of care patients
2. Team Leaders proactive management of team resource to maintain balance of demand and staff resources

SATH

Actions require by Community Trust

a) **Community Hospitals**

1. DTOCs requiring funding escalated for a decision to CCGs and Councils. Prioritise patients for Social Care support.
2. MDT check, chase and challenge
3. Consider call in GP's to review Community Hospital in-patients for those requiring medical review to progress discharge.
4. Discharge planning to include lead times for actions

b) **Community Services**

1. Team Leaders proactive prioritisation and management of team resource to maintain balance of demand and staff resources.
2. Review in-reach resources for DAART and Elderly and Frail
3. Considered cancelling routine reviews and/or provide in a clinic setting where possible.

c) Integrated Care Service

1. Participation in Self Directed Support Brokerage
2. Identify capacity in Intermediate Care, Reablement and Independent Sector Care Providers.
3. Expedite planned discharges to same day, where safe and appropriate to do so.
4. Review PM version of 'work list when supplied. to identify any patients who are medically fit for transfer who are not allocated and allocate a worker to progress discharge planning

Operational responsibility: Deputy Director of Operations / Senior Manager On Call.

SCHT Director on call Role – To maintain Patient Flow through the Community Hospital and Community services

1. Be aware of escalation levels

▪ Appropriate local actions to be initiated / Divert internal resources to areas of greatest risk - to expedite discharge and support flow ▪ Consider purchasing additional capacity through interim beds / Consider authorising packages out of panel and hospice provision ▪ Consider authorising additional urgent domiciliary Response (PURSH) ▪ Consider authorising additional community nursing / therapy Services **WMAS** **1.** Monitor the delays to see if any impact is being had on performance. **2.** Inform Silver Commander who will liaise with Bronze and remain in contact, attending hospital if necessary (e.g. if no bronze available] **3.** Maintain resource overview **4.** Contact the on Call Silver (Ops) to keep them appraised if delays continue past the estimated time agreed **5.** Complete an SUl for all category 'A' and 'B' calls that we were unable to attend in standard due to delays at hospital **6.** Record delays in status reports 0930, 1330, 1730, 2130	1. Duty Manager liaise with external LHE Duty Managers 2. If the Trust is moving from a 2 to 3, the Heads of Capacity to advise CSM/Out of Hours Duty Manager that all actions have been undertaken and escalate any actions that have not been taken, and, request assistance with resolution 3. Diagnostics, Therapies & Pharmacy Review prioritisation of requests for services according to acuity of patient and urgency of discharge 4. Diagnostics, Therapies & Pharmacy liaise with Heads of Capacity (in hours)/CSM (out of hours) to establish actions needed 5. Clinicians who discuss and assess predicted capacity with the CSM and Doctor 6. Medics to prioritise workload for discharge tomorrow by: • Expediting investigations, discharge decision to admit patients already in the hospital • Ensure discharge medications and letters are completed • Dispense TTOs • Identify patients that can be out lied. **A&E / MAU - SaTH Ambulance Handover Between 15 and 45 minutes** 1. Breach report complete for each incident by team on duty capturing all elements of delays. 2. CSM to ensure 'Handover Escalation Plan' is followed. 3. Record length of handover duration and ensure that the number per day and week are included in any required local or national reporting. 4. Clinical Commissioners notified via weekly management process patient delays. 5. Ensure CAD Screen is updated as crews are released. 6. Ensure online EMS Escalation is accurately reported and updated regularly.	2. Be aware of patient flow through community hospitals 3. Be aware of community service/capacity pressures 4. Maintain contact with Duty Manager if Level 2 is reached **SCHT Manager on Call Role – To maintain Patient flow through the Community Hospitals and Community Services** 1. Be aware of escalation levels 2. Review actions required for patients on Community Hospital and SaTH FTT list 3. Discuss patient flow through community hospitals to facilitate discharge 4. Be aware of community service capacity/pressures and provide support 5. Consider cancellation of non-essential meetings and training to provide additional resource targeted against need 6. Monitor and provide support with workforce requests 7. Maintain contact with Duty Director if level 2 is reached

Telford & Wrekin, Shropshire and Powys Local Health Economy Capacity Management **LEVEL 3 Action Card**

Actions required by Local Authority Social Care Services As level 1 and 2 plus:

T&W

a) TICAT staffing to be utilized to the areas of high need.
b) Expedite any discharges from SaTH that can be brought forward.
c) Expedite any discharges from Block Beds that can be brought forward.
d) Commission Leads to liaise with providers to increase capacity.

Daily Conference Call at this level will be at delegated responsibility of the Team Leader. Extraordinary Conference call will be at Service Delivery Manager level

Shropshire LA

a) Brief Service Manager on status and Service Manager will attend conference call when requested to agree extraordinary actions.
b) Service Mgr. will notify Director of Adult Services.
c) Divert all social workers to discharge activity that will free up immediate capacity only.
d) Increase capacity of SW team where necessary.
e) Divert Community Social Work teams to expedite discharges wherever possible from Community Hospital settings to create capacity.

LEVEL 3

- **Capacity and/or resources not meeting current demand**
- **No flow potential or anticipated**
- **Acute Bed capacity 100%**
- **Patient care environment not optimal in many areas**
- **Clinical safety being compromised**

OBJECTIVE: Senior Managers and Consultants agree actions required to increase capacity and flow to ensure patient care environment optimal and safe.

RCMT

1. Verify trigger points if required
2. Participate in any conference calls when invited to do so
3. Be available to discuss plans with representatives of the Health economy and provide advice and assistance if required.
4. Advise of the position of neighbouring organisations and whether a deflect or divert is worth consideration – contact WMAS to see if they are in a position to assist
5. Advise WMAS (SOC) of potential level 4

Options considered by Community Trust

a) **Community Hospitals**

1. Escalate patients still requiring funding for short term care packages / care home / intermediate care to commissioners to ascertain requirements to open surge beds , additional staffing and seek commissioner agreement
2. Review options for interim placements unable to access long term placements
3. Ensure MIUs staffed to support patients out of acute care
4. Review options and resources available to staff all hospital beds and where temporary beds can be established
5. Consider cancellation of out-patient rehabilitation and redeployment of staff to bed based or community services.

b) **Community**

1. Review and re-plan routine visits
2. Enhanced in reach to SATH/Community Hospitals by ICS/Rapid Response
3. Review and prioritise all visits for urgency, for example, dressings
4. Defer routine Catheter management
5. Resourcing Palliative / EOL & diabetics
6. Work with Ambulance Service to support patients where possible in the community using ICS/IDTs and Rapid Response
7. Check chase and challenge Community service caseload and maximise capacity for urgent patients and for in reach to community hospitals and SaTH to facilitate discharge from a bed and the front door.

c) Integrated Care Service

f) Review planned discharges and consider alternative discharge plans that will expedite discharge if safe and appropriate to do so. g) Liaise with commissioning teams to identify potential additional capacity and help to identify appropriate patients to transfer **WMAS** 1. As Level 2, plus- 2. Maintain cover in affected area were possible 3. Contact oncoming & off going crews to negotiate an extension of shift 4. Divisional / Silver Commander to liaise with the Chief Operating Officer in the Acute Trust to jointly authorise escalation to Level 3 to participate in the health economy conference call 5. Confirm the call signs delayed with Bronze Commander	**RJAH** 6. Involvement at Deputy Director/assistant Director of Nursing level with teleconference 7. Review delayed discharges and possible discharges from Elderly rehabilitation ward 8. Liaise with Community services to support discharges 9. Identify numbers of beds available for transfer to elderly rehab beds 10. Consider clinical transfer of hand patients to RJAH **Actions required by CCG Commissioners** **As level 2, plus –** 1. CCG Director to participate in health economy urgent conference call, agreeing appropriate actions to assist in agreeing recovery plan (de-escalation) and action plans required to restore capacity balance, **Management**: CCG Director on call **SATH Actions**	1. Team Leader will work with Enablement Team to provide increased assessment resources to Home from Hospital Team. 2. Create capacity, where possible by transferring, if safe to do so, residents of Enablement / Interim Beds into community with Domiciliary Care Packages. 3. Review any outstanding funding decisions. 4. As level 2 with SDS + escalate to commissioning service delivery manager prioritise workload and liaise with SPIC 5. Divert all social workers to discharge activity that will free up immediate capacity only. 6. Increase capacity of SW team where necessary 7. Divert Community Social Work teams to expedite discharges wherever possible from Community Hospital settings to create capacity. 8. Review planned discharges, consider alternative discharge plans that will expedite discharge if safe and appropriate to do so. 9. Liaise with commissioning teams to identify potential additional capacity and help to identify appropriate patients to transfer **e) Organisation Wide** 1. Consider cancelling non-clinically critical and essential visits.

Actions required by Powys Health and LA 1. The following actions which MUST be considered. Non implementation will need to be justified and alternative solutions determined to address the constraints and maintain patient safety. 2. Open surge capacity 3. Identify patients where packages of care are unchanged and ensure they can be immediately reinstated. 4. Identify interim placements for medically fit (patient choice) 5. Appropriate local actions to be initiated 6. Divert internal resources to areas of greatest risk – to expedite discharge and support flow 7. Appropriate local actions to be initiated **8.** Assess & advise timeframe for recovery/de-escalation (max 24 hours)	1. Duty Manager to escalate to COO/Exec Director/on call consultants any issues with actions that remain unresolved 2. Diagnostics, Therapies and Pharmacy to attend site safety meeting 3. Out of service hours, Diagnostics, Therapies and Pharmacy staff to assess demand on service and attend site if appropriate 4. Head of Capacity to arrange an LHSE Executive Level conference call for 11am and 3pm if either site is starting the day on EMS level 3 and circulate by 9.30am via email the SITREP for each site to all system partners together with details of any specific actions that are required of external partners to support de-escalation. 5. Head of Capacity to arrange an LHSE conference call within an hour of a declared EMS level 3 after 11am. 6. On Call Director to arrange an LHSE conference call at 12:00 at weekends and Bank Holidays 7. Consultants undertake additional ward rounds in hours and out of hours 8. AMU, ED and Surgeon on call to attend site safety meetings at 08:45 and 15:45	2. Identify with acute trust what staff resources could be required to support inpatient care 3. Scope and prepare resources available if leave cancelled 4. Release available bank staff following funding agreement Director (or deputy) /on call Director and Clinical Services Manager/on-call manager, to participate in health economy urgent conference call, agreeing appropriate actions to assist in recovering the situation. Open Trust Operational Coordination Centre **Operational responsibility: Assistant Director of Operations** Locality Manager and Director on Call SCHT Director On Call Role – To maintain Patient Flow through the Community Hospitals and Community Services 1. Be aware of escalation levels 2. Be aware of patient flow through community hospitals and support on-call manager to progress actions including Director to Director escalation to agree funding arrangements. 3. Be aware of community service capacity/pressures and support Director dialogue to progress actions. 4. Maintain contact with Duty Manager it no return to level 2 **SCHT Manager On Call Role – To maintain Patient Flow through the Community Hospitals and Community Services** 1. Be aware of escalation levels 2. Review actions required for patients on SaTH and Community FTT list 3. Check, chase hase and challenge community service caseload **4.** Ensure sufficient workforce available to meet demands **5.** Maintain contact with duty director if no return to level 2

Telford & Wrekin, Shropshire and Powys Local Health Economy Capacity Management **LEVEL 4 Action Card**

LEVEL 4

- **Capacity and/or resources not meeting current demand**
- **No flow anticipated for next 24 to 48hrs**
- **System bed capacity >100%**
- **Patient's safety and clinical risk compromised in many in-patient areas areas.**

OBJECTIVE: In addition to agreed actions at level 4 Executive Directors and Medical Directors to agree extraordinary interventions and actions to increase bed capacity and review access to health care required to accommodate patients and collectively accept risks associated with those actions and interventions.

Actions required by Local Authority Social Care Service

T&W

a) Service Delivery Manager to work with Team Leader and report to Assistant Directors at this level.
b) Stop all noncritical social work, meetings and training and divert resource to Hospital discharge and admission avoidance in TICAT
c) Maximize all available beds in the community
d) Ensure full utilization of all Block beds.
e) Commission the use of other beds
f) Service Delivery Manager Procurement and Commissioning will work with Brokerage to manage market and brokerage Senior to manage team resource to cope with demand

Shropshire LA

As per level 3, plus -

a) Brief Director of ASC on status and Director will attend

RJAH

1. Executive involvement in meetings / teleconference
2. Review all possible discharges from Elderly rehab ward
3. Liaise with community services to support early discharge and address delayed discharges
4. Liaise re: appropriate transfers from SATH meeting RJAH criteria
5. Liaise re: Providing clinical support outreach
6. Arrange on site review by Senior Nurse of possible trauma/spinal disorders transfers. Review current admissions in line with 18 weeks

RCMT

1. Inform SOC of all actions and assist with co-ordination across the Region
2. Participate in any conference calls as required
3. Ensure that all organisations involved are informed of de-escalation and gain a position statement from them to ensure that they have coped with any additional activity
4. Contact Welsh Ambulance Service to advise of pressures and request communication with crews to use alternative pathways and where possible utilise Welsh acute trusts

Actions required by CCG Commissioners

1. CCG Accountable Officer / On call executive to agree extraordinary interventions actions to rapidly increase the level of support to the health economy.
2. Ensure Executive presence on LHE conference call as soon as possible with Executive Directors from Health and Social Care, Ambulance Divisional Commander and CCG Director on call where a Level 4 situation is likely to last longer than 4 hours. This group is

Operational Actions required by Community Trust

Implement Business Continuity Plan

a) Community Hospitals

1. Open all beds in this context and review safe staffing levels consider non-trust employees to perform non-clinical roles. Staff up MIUs and extend hours to support patients away from ED consider temporally housing patients in MIU
2. Interim funding for delays agreed between partners
3. Cancel outpatients to support patients at home

b) Community

1. Risk assessment complete for patients requiring non urgent care to identify review period.
2. Consider requesting insulin and tinzaparin patients be managed by carers/ GPs / Practice Nurses / Independent care sector.
3. Consider bank HCA staff for rural domiciliary care
4. Consider shared care for provision of packages of care to support admissions avoidance and discharge pathways
5. Community HCAs used to support low level POC
6. Review staffing support to take unplanned low-level activity on locality basis

c) Integrated Care Service

1. Stop all noncritical social work, into the community; divert resource to Home from Hospital Team.
2. Maximize all available beds in the community liaising with CQC over flexibility of admission process to homes
3. Ensure full utilization of all LA beds.
4. Commission the use of other beds e.g. hotels if necessary.

	responsible for taking tactical control and providing a health economy wide response to resolving the situation 3. CCG on call to notify NHS E if de-escalation is not expected within 2-3hours. 4. Debrief report is on Local Health economy basis. Management CCG Director on call NHS E Director on Call only on level	**c) Organisation wide** 1. Trust establishes an Incident Control Room to centralise resource / demand co-ordination — consider Central clinical advice line for staff. 2. Consider Risk stratification being applied throughout the system (Director/ Clinician led). 3. Consider cancellation of all routine work and deploy all staff to patients' highest critical need/priority both in the community and community hospitals. 4. Establish resource requirements for extreme Business Continuity Management measures. 5. Consider providing clinical and non -clinical support to Shropdoc for care coordination/call handling. 6. Consider cancellation of all Day cases and redeploy nurses 7. Consider cancellation all Trust outpatients 8. Re-deploy all clinically qualified staff in management positions to patient care duties. 9. Consider commissioning extra child care to extend staff resource availability. 10. Director Of Operations to work with community team managers and agree extraordinary interventions / actions to rapidly increase the level of support, e.g. community & hospitals to identify patients for discharge where no care package or community beds are available and liaise with commissioners to assist. 11. Communications to the Public and staff concerning the pressures and advise of where to seek advice on health care matters 12. Review of demands on the workforce e.g. number of hours worked, sufficient breaks/meal times **Operational responsibility: Chief Executive and Directors. Director. On call Senior Manager** **SCHT Director On call and SCHT Manager On Call Role** **To continue with Organisation wide actions**
	Actions required by Powys Health and LA ▪ Escalated to Chief Executive ▪ Divert options (if in place) to be reviewed every 2 hours ▪ Appropriate local actions to be initiated ▪ Fully consider a cross-organisation response to maximise out of area capacity ▪ Detailed action plan and risk log in place to achieve de-escalation within 12 hours and avoid the need to declare a BCI ▪ Ensure key decisions are made through effective and timely clinical engagement	

SATH Actions Level Four

Duty Manager Role – To maintain patient flow through the specialty area

1. Maintain communications with the Director on call
2. Ensure that actions by others at this level are functioning
3. Ensure that there is a clear plan to de-escalate using figure 2

Director On Call Role - To maintain patient flow through the specialty area.

1. Maintain communications with the Director of CCG/Local Authority/ Surrounding Acute Trusts as appropriate.
2. Ensure that resources are appropriately identified for the Trust to function at this level.
3. Ensure that communication from the external organisations is communicated as appropriate
4. SATH Executive on-call to request diversions with the Ambulance Service and in the process secure approval from the receiving organisation

Diagnostics & Therapies Role – To Support patient flow and the process if rapid de-escalation back to Level 3

1. Ensure level 1, 2 & 3 actions have been exhausted.
2. In hours, prioritise workload to match urgency/acuity requests. Suspend routine working.
3. Out of hours - on call therapists, diagnostics to be on site in order to action requests

A&E / MAU - SaTH Ambulance Handover over 45 minutes

1. Acute Trust Executive Lead / Breech Manager will contact ambulance executive lead and agree next steps via the Ambulance Hospital Desk, 01384 246373.
2. Seek to provide additional operational capacity escalation beds to alleviate pressure.
3. Over 45 minutes individual case by case 'local exception' reports to CCG commissioners / SHA, LAT
4. Any exceptional delays (as locally determined) to be reported personally by NHS Trust Chief Executive to the CCG Chief Executive within next working day
5. Ensure CAD Screen is updated as crews are released from the corridor.
6. Ensure online EMS Escalation is Accurately reported and updated regularly.

Working with Local Authorities

1. As Level 3, plus-
2. Director / Director On Call to brief service managers and agree extraordinary interventions actions to rapidly increase the level of support
3. Join the health economy conference call, attending meetings if required.
4. Agree and implement further actions to assist in the recovery of the situation
5. CCG Chief Executive / On call executive to agree extraordinary interventions actions to rapidly increase the level of support to the health economy.
6. Attend the Control Group meeting, agree further extraordinary actions to assist in recovering the situation or confirm that a local resolution is not possible.
7. Convene a LHE conference call as soon as possible with Operations Directors from Health and Social Care, Ambulance Divisional Commander and PCT Director on call where a Level 4 situation is likely to last longer than 4 hours. This group is responsible for taking tactical control and providing a health economy wide response to resolving the situation
8. 0n call Community Trust Director to brief community team managers and agree extraordinary interventions actions to rapidly increase the level of support, e.g. community & hospitals to identify patients for discharge where no care package or community beds available, and liaise with commissioners to assist

pharmacy Role - To Support patient flow and the process if rapid de-escalation back to Level 3

1. Ensure level 1,2 & 3 actions have been exhausted.
2. In hours, prioritise work load to match urgency/acuity of requests. Suspend routine working.

Working with Ambulance Crews

1. As Level 3, plus-
2. Maintain cover in affected area were possible
3. Confirm the call signs delayed with Bronze Commander
4. Contact oncoming 8 off going crews to negotiate an extension of shift

Medical Response Role – To maintain patient flow through speciality area

1. In hours: Medical Director, Clinical Leads and all consultants informed of capacity pressures and directed to identify any potential discharges and suitable patients who could be out lied to escalation areas if necessary.
2. Out of hours: On- Call Consultants informed of capacity pressures and asked to review potential discharges identified by medical and senior nursing team
3. Operational Senior Centre Manager, Duty Medical Consultant, Consultant Acute Physician(s) and A&E Consultant to re-assess A& E MAU demand and throughput every hour

3. Out of hours - on call pharmacists to be on site in order to action requests and call in other pharmacy staff if appropriate	5. Divisional Commander / On Call Silver to participate in the health economy conference call, provide tactical support and brief the Gold Commander. 6. Operate from Silver Cell if 2 or more sites reach Level 4	4. In association with relevant Consultants consider reducing all category B1 elective admissions for the following day. Consider discharging category B1 elective patients admitted for Surgery that day 5. On Call Consultants to lead on identifying and prioritising patients for discharge. CSMs to confirm all community beds have been utilised. 6. On call Consultants to attend and initiate additional patient discharge ward rounds

Shropshire Community Health NHS Trust – Winter 2018/19 Escalation plan

Escalation Level 1	**Business as Normal**	• **Capacity and resources meet current demand** • **Acute bed capacity <85%** • **Patient care environment optimal** • **No clinical risks**
OBJECTIVE: Health and social care system operating within normal business practice and monitoring demand and capacity flows.		
ESCALATION LEVEL 2	**Moderate pressure on Acute Beds**	• **Capacity and/or resources not meeting current demand.** • **Acute bed capacity 95%+** • **Patient care environment not optimal in some places** • **Some clinical risks**
OBJECTIVE: Managers and clinicians agree actions to Increase capacity and flow to return to normal working and prevent escalation to level 3.		
SaTH	**ShropCom**	**Shropshire Council**
•	• Maintain continuity of ED clinical presence, admission avoidance & Clinical Capacity Mangement.	•
Telford Council	**RJAH**	**Powys**
•	•	•
MPFT	**WMAS**	**CCG**
•	•	•
ESCALATION LEVEL 3	**Severe pressure on acute beds**	• **Capacity and/or resources not meeting current demand** • **No flow potential or anticipated** • **Acute Bed capacity 100%** • **Patient care environment not optimal in many areas** • **Clinical safety being compromised**
OBJECTIVE: Senior Managers and Consultants agree actions required to Increase capacity and flow to ensure patient care environment optimal and safe.		
SaTH	**ShropCom**	**Shropshire Council**

•	• Target Shropcom clinical resources against SaTH requirements. • Flex community hospital admission criteria for medically stable, pathway 3 and end of life • Provide additional resources to PRH and RSH ED • Redeploy care home assessors to assess criteria for community hospital and community based care. • Accept additional referrals from WMAS.	•
Telford Council	**RJAH**	**Powys**
•	•	•
MPFT	**WMAS**	**CCG**
•	•	•
ESCALATION LEVEL 4	**Extreme pressure on acute and community beds.** **(System Full)**	• **Capacity and/or resources not meeting current demand** • **No flow anticipated for next 24 to 48hrs** • **System bed capacity >100%** • **Patient's safety and clinical risk compromised in many in-patient areas areas.**
OBJECTIVE: Executive Directors and Medical Directors agree extraordinary interventions and actions to increase bed capacity and review access to health care required to accommodate patients and collectively accept risks associated with those actions and interventions.		
SaTH	**ShropCom**	**Shropshire Council**
•	• Release clinical staff from OP/clinics to support district nursing eg diabetes nurses. • Release IPC nurses to support Community Hospital staff. • Consider closure of MIU and redeply ANPs to EDs for admission avoidance. • Case by case review of acute simple IV patients for Community Hospital admission • Deploy Shropcom bank HCAs to support gaps in domiciliary care provision. •	•

Telford Council	RJAH	Powys
•	•	•
MPFT	**WMAS**	**CCG**
•	•	•

Midlands Partnership NHS Foundation Trust

Winter Plan 2018/19

DRAFT

SUMMARY

The purpose of this document is to describe the arrangements put in place by the Midlands Partnership NHS Foundation Trust to work collaboratively with partner organisations to support urgent and emergency care systems across Staffordshire and Shropshire, and maintain waiting times throughout the winter including the Christmas and New Year holiday period. This plan covers the main winter pressure period which will commence October2018 and continue to include Easter 2019. This plan will form part of the Staffordshire and Shropshire wide system plans and compliments key information from partner provider plans as well as whole community arrangements.

It is essential to note that this remains a live document which is subject to update and constant review and amendment throughout winter 2018/19.

INTRODUCTION AND BACKGROUND

The resilience of those working in the NHS and Social Care is especially tested throughout the winter period. Despite increased planning compared to previous years, the delivery of whole system urgent care across Staffordshire and Shropshire continues to present a significant challenge to all stakeholder organisations. Last year saw the postponement of non-urgent operations, the opening of escalation beds and an increasing focus to reduce patients with Delayed Transfers of Care (DToC). Despite these efforts, services remained full and the urgent care systems repeatedly failed to achieve the national target of seeing 95% of patients within 4 hours. The whole system plan to reform urgent care focuses on the following key programme areas:

- Demand management, admission avoidance and prevention
- Improving patient flow and processes

Clinical Commissioning Groups are responsible for ensuring that robust plans for managing winter pressures are developed, tested and coordinated with all partners within the local health community, including local authorities, general practitioners and independent sector providers.

This is the second year of a system-wide winter planning which has been developed to ensure that effective arrangements are in place to provide safe, high quality and responsive elective, urgent and emergency care over the winter period.

WINTER PLANNING PRIORITIES

The planning priorities for 2018/19 have been identified and set. This is:

1. **Reducing long stays in hospital - to reduce patient harm and bed occupancy**
   - *capacity will be created as surge*
   - *planning 7 day services*
   - *delivering 10% above baseline, and phased*
   - *reduction in stranded and super stranded patients across the system*

2. **Flu planning**

3. **National support and winter planning**

- *Demand and capacity plans*
- *Effective discharge processes*

- *Planning for peaks in demand over weekends and bank holidays*
- *Ensuring the adoption of best practice as set out in the NHS Improvement guide: Focus on Improving Patient Flow.*

In addition, the following Local Priorities have been identified:

- ***Medically Fit for Discharge (MFFD) and Green to Go (G2G) in UHNM (waiting information from Queen's Hospital)***

MFFD and G2G numbers are important measures of flow together with the length of time waiting for G2G. MFFD and G2G have improved significantly over recent months at UHNM from 220/110 respectively to an average of c130/65. The ambition of the system is to reduce MFFD/G2G to 110/50 for RSUH and 18/9 for County Hospital as it is anticipated that a sustained reduction in MFFD and G2G will allow sufficient capacity and flow. This is ambitious and will be challenging, requiring a collective effort from all system partners. MPFT are committed to supporting this ambition. MPFT will continue to participate in the review and escalation calls 3 times per day held at RSUH to support and address any areas of concern.

- ***On Call Arrangements***

MPFT has robust on call arrangement in place 24 hours a day, 365 days per year. This is

- 1 x Gold Commander
- 3 x Silver Commanders (Rotas cover North Staffordshire, South Staffordshire and Shropshire)

In addition senior operational leaders will be available to join escalation calls daily if required and command and control functions can be commenced throughout the period of winter.

PURPOSE OF THE PLAN

This plan and accompanying documents set out the MPFT proposed response for winter. The plan takes into account the current position of a newly formed organisation but acknowledges that this will be subject to review and change in line with organisation development, marketing campaigns, and flu preparation.

1. Reducing long stays in hospital - to reduce patient harm and bed occupancy

It remains a challenge to define the appropriate levels of demand for services; however historical trends suggest that an increase in 10% above baseline is required to meet the surge in winter.

MPFT aims to increase capacity in bed based, community and social care services to meet the demands of winter.

<u>Creating Capacity as Surge</u>

The additional beds opened on Scotia Ward to support the winter pressures 2017/18 will be closed by 31st July 2018; the ward will stop admitting week commencing the of 23rd July and it will close on 31st July 2018. Currently Scotia Ward has a cohort of palliative and assessment/rehabilitation patients. The palliative patients will return to Dale Hall on Chatterley Ward, along with the associated palliative care trained staff and any additional other staff will be moved across the site to support with the current vacancy factor.

The work to close the ward has commenced. A review of the patients on Scotia Ward has been completed to understand the discharge requirements and timeframes to ensure that they have a planned exit strategy for the 31st July. This review commenced week of 2nd July as part of the Community Hospitals Multi-Agency Discharge Event.

Within this review the aims are to:

- Determine the exit strategy of all patients
- Facilitate the transition of palliative patients to return to Chatterley Ward
- Manage the cohort of beds across the sites to ensure that patients are appropriately placed up until the point of Scotia Ward closing (for example utilising Scotia Ward for those patients already on the Haywood site but with a known exit date)

Escalation Capacity

The community hospital provision is a valued service and meets the needs of those individuals who are unable to return home. There are currently 102 rehabilitation beds.

Brighton House	25
Chatterley	25
Grange	32
Jackfield	20

The MPFT increased escalation capacity for winter in addition to the 102 rehabilitation beds:

Area of escalation	No of beds	Planned date of opening
Scotia In-Patient Ward	10 beds	(TBC)
Milford Ward	12 beds	3rd Dec 2018
Scotia Day Case Unit	3 beds	7th January 2019

****This will need to be agreed and funded***

This would take the total number of beds to 127 (an increase of 24%).

To increase to this number of beds additional staff from the therapies and social work teams would need to be recruited to ensure continued flow and prevent long stays in hospital. The community hospitals have 7 day medical cover (9am – 5pm) with robust OOH's arrangements via SDUC.

A discharge lounge will be operational from September 2018 – April 2019 for any patients in a community hospital bed who are being discharged back to home this will enable early

release of beds to prevent transfers of patients to community hospitals earlier in the day and aid UHNM flow.

Home First Capacity

The 'Home First' (HF) Discharge to Assess service is central to ensuring safe and timely discharge, admission avoidance and system resilience. The 7 day service, which has been implemented incrementally over the last year, focuses on patients who are clinically optimized and no longer require an acute hospital bed but may have ongoing care and support needs. Patients are discharged to their own home, where appropriate, or another community setting where assessment for longer-term care and support needs can be undertaken in the most appropriate setting and at the right time.

Jointly commissioned clinical and nursing resources, social care support and provision of nursing, residential, therapy support, reablement and domiciliary care, aim to deliver improved outcomes for patients and a more efficient use of resources across the local health and social care economy. The model aims to ensure timely discharge of patients from hospital with home being the first option for the majority of people. Home First has a fully integrated multidisciplinary discharge team (Track and Triage) which enables swifter acceptance and discharge to and from the service utilising a 'Trusted Assessor' approach.

Due to the infancy of the service and its reporting dataset, comparable data for winter is not available therefore the demand and capacity modelling is based upon the currently commissioned hours; based on this assumption MPFT will provide an additional 10% (834) HF care hours across Staffordshire.

The plan for winter is to achieve the 10% increase in hours by 1st December 2018. This will be an incremental growth, month on month to achieve the commissioned capacity.

Further detail to support the incremental increase including any financial impact is currently being developed.

The additional capacity will be delivered through the following key actions:

- continued implementation of the long-term plan to provide the required number and skill mix of staff needed both immediately and to ensure sustainability in the future
- improvements in productivity to extract as much value as possible from available spending (currently well in progress via wok with Meridian Productivity Ltd to increase staff / patient face-to-face time);
- to outsource any capacity gaps through sub-contract arrangements
- paid overtime to Home First workers once they have worked over and above their contractual hours (rather than once they have worked 37.5 hours in any one week). This proved very effective in increasing capacity, and was attractive to staff last winter. This is more cost effective than using agency staff and it provides continuity for the people using the service.

Critical to the success of the service is the identification of 'right patient, right time'. MPFT remain committed to working with system partners, as part of the continuous improvement process and STP UEC plan to create faster flow through services and improved patient experience.

Social Work Capacity

In terms of the additional capacity for social care assessment, MPFT will look to provide 7 day a week cover where discharge to assess is not embedded (ie the out of county hospitals and some additional support into Queen's), in addition to this MPFT would look at additional capacity to work on a Monday and a Friday to ensure the appropriate level of flow is maintained. There are also some additional capacity requirements around the beds; any expansion of social care assessment function, for it to be successful and provide effective 7 day flow, is dependent on LA Brokerage and care homes admitting patients 7 days a week.

Any increase in capacity, bed based or community will require additional resource to respond to demand. MPFT has a responsibility in the assessment of the social care needs of individuals at:

- UHNM (RSUH & County)
- Queens Hospital, Burton
- Good Hope
- Walsall
- Royal Wolverhampton
- Russells Hall

There are some differences in the current provision of social care. In the north there is 7 day assessment cover in the acute hospital. In the south the provision remains on a Monday-Friday basis. Over winter, the plan is to increase the Social Care presence making the service more responsive to the needs of partners (the exact requirement will be confirmed following further discussions with HR and finance. This will need to be contractually agreed and funded via Commissioners).

Therapies

MPFT are undertaking a review with AHP's to strengthen the current provision. There are currently different models in place across services in relation to therapies. To ensure effective flow and improved outcomes for patients, any increase in service provision also requires an increase in therapy resource. This will include weekend therapy provision. There is 7 day therapy support in Home First and Brighton House but currently more limited weekend therapy support at the Haywood which will need further review.

Haywood Walk-in Centre (WIC)

The WIC is able to increase its opening hours to meet expected demand in winter if required. The planned extension would be:

- To extend the opening hours until midnight
- To open at 08.00hrs Sat & Sun

This is will need to be agreed and funded

Mental Health

There are currently acute trust schemes in South Staffordshire that would need to be extended to cover the service over 7 days in both County Hospital & QHB that would be in line with the evidence base for CORE 24 staffing as endorsed by the 5 year forward view for mental health:

1. Increase Liaison Mental Health cover at QHB – Increased availability outside current weekday hours to cover 7 days for liaison mental health cover for ED and ward activity, this would include dedicated Consultant Psychiatrist input and

specialist skills and knowledge in the field of substance misuse and support for people with dementia.

2. Increased Liaison Mental Health cover at County Hospital - Increased availability outside current weekday hours to cover 7 days for liaison mental health cover for ED and ward activity, this would include specialist skills and knowledge in the field of substance misuse and support for people with dementia

3. Extended hours for the existing 7 day Liaison Mental Health cover at Princess Royal Hospital Telford – increased availability from 8pm to 2am 7 days per week

Increase availability of specialist older people's mental health services and support out of hours, including to nursing/care homes to support admission avoidance, this service is currently commissioned over weekdays and would need to be extended to cover 7 days Increased availability out of hours of specialist mental health nurses to in-reach into care homes to avoid admissions to both acute and mental health trusts. In addition it would provide and outreach service for people in care home beds with EMI needs who are placed there through D2A by ensuring care homes will receive outreach support to manage behaviours reducing re-admission rates to Acute Trusts.

Reducing stranded and super stranded across bed based services

The 'stranded patient metric' is defined as the number of beds occupied by patients who have been in hospital 7 days or more, this definition was designed for acute hospitals, therefore for community hospitals/escalation beds the stranded patient metric will be defined as any patient who has been in a community bed (community hospital or CCG escalation bed) for more than 28 days.

The vast majority of patients who require on-going bed based services following an acute stay are over 65 years of age. These older adults are at greater risk of deconditioning – losing muscle power, strength and abilities due to restricted mobility. A prolonged bed based stay can mean the difference between independence and complete dependence.

It is imperative to enable patients to leave hospital as soon as they are able by providing the support they need to continue their recovery at home and return to their previous routines and activities.

To help to reduce the number of stranded and super stranded patients in beds the following actions will be taken by MPFT:

Action	Impact
Daily board rounds on Community Hospital Wards	waits are identified and effectively managed by the team
Weekly MDTs in escalation beds	waits are identified and effectively managed by the team
Weekly reviews of stranded patients	Maintain focus and escalate challenges/barriers
Daily conference calls across community and bed based services	To review performance and identify current and potential challenges/barriers in the services
Planned monthly MADEs across services	Create a multi-disciplinary approach to support improved flow

Flu planning

The Local Flu Plan sets out a co-ordinated and evidence-based approach to planning for and responding to the demands of flu across the NHS England Shropshire and Staffordshire, taking account of lessons learnt during previous flu seasons. It will aid the development of robust and flexible operational plans by local organisations and emergency planners within the NHS and local government. It provides the public and healthcare professionals with an overview of the co-ordination and the preparation for the flu season and signposting to further national guidance and information.

The purpose of the local plan is to (a) provide a robust, locally coordinated and evidence based framework to planning and delivering the seasonal flu programme for 2018/19; and (b) develop a proactive action plan which seeks to improve uptake in all eligible groups.

In 2018/19 the ambition of the flu plan is to ensure that:

- Actively offering flu vaccination to 100% of all those in eligible groups (this will include offering all in-patients the flu immunisation on admission)
- vaccinating at least 75% of those aged 65 years and over
- vaccinating at least 75% of healthcare workers with direct patient contact
- improving uptake for those in clinical risk groups, particularly for those who are at the highest risk of mortality from flu but have the lowest rates of vaccine uptake, such as those with long-term liver and neurological disease, including people with learning disabilities or children, a minimum uptake of 40% has been shown to be achievable in pilots conducted to date. As a minimum uptake levels between 40% and 60% to be attained and uptake levels should be consistent across all localities and sectors of the population
- providing direct protection to children by extending the annual flu immunisation programme and also cutting the transmission of flu across the population
- monitoring flu activity, severity of the disease, vaccine uptake and impact on the NHS
- prescribing of antiviral medicines in primary care for patients in at-risk groups and other eligible patients under NHS regulations and in line with NICE guidance
- providing public health information to prevent and protect against flu
- managing and implementing the public health response to incidents and outbreaks
- ensuring the NHS and PHE are well prepared and have appropriate surge and resilience arrangements in place during the flu season.

Each provider and CCG has a flu vaccination plan in place and the CCGs have agreed a scheme in order for practices to write formally to ‘at risk’ patients, in order to maximise the Influenza vaccination uptake rates.

There is an internal campaign to encourage staff to have a flu vaccination, this includes:

- Drop in clinics

- Intranet Articles to promote uptake
- Increasing the number of vaccinators across the organisation

We need to add our response ie targeted campaign to vaccinate all staff through drop in clinics, flu champions and team based programmes. The campaign includes Infection Control and team based vaccinators and Trust wide communications to raise awareness and improve update.

In community services through working closely with colleagues in Primary Care vulnerable housebound patients will be identified and plans agreed for the vaccination of these patients.

In Community Hospitals and Brighton House long stay patients will be offered vaccination and during the flu period all new admissions meetings the criteria will be offered the vaccination to minimise the risk of further spread.

Escalation Cards

The winter plan for 2017/18 linked the escalation cards to the EMS triggers which was implemented and monitored. These are Trust wide action cards which set out the expectations of services in times of surge, increased demand or reduced capacity. These will be reviewed and updated for 2018/19 in line with organisational changes.

Weather Plans

As with all community services inclement weather can be of significant issue for staff and patients. MPFT has guidance for staff to ensure the safety and continuity of service to vulnerable patients. This includes links with the Civil Contingencies Unit and is linked with the National Cold Weather plan.

Workforce

To provide 7 day working for services over winter will require a change in service provision. Before any consultation commences the Joint Staff Partnership need to be notified, this is too late for July and there is no JSP in August, so a separate meeting will need to be convened. There would also need to be a comprehensive Equality Impact Assessment on the staff groups affected.

Below is a proposed timescale based upon a start date of 1st October for 7 day working. This will be for AHP and Social Work roles:

Date	**Activity**
w/c 23th July 2018	Commence consultation with affected staff and Trade Unions
27th August 2018	Close consultation on proposed seven day working.
w/c 27th August 2018	Consider representations and queries. Response to the Consultation and issue any changes.

30th August 2018	Issue letters advising changes to contract
1st October 2018	Seven day working pattern commences

Recruitment remains challenging around the Home First service and nursing posts given the competition from other NHS organisations and private providers. The Trust continues to work with the external recruitment provider to expedite the selection process for those successful applicants going through the employment checks process. Rolling adverts are being utilised to aid a speedier recruitment and selection process, recruiting managers are requested to review/interview candidates as and when applications are made rather than waiting for specific closing dates and pre-scheduled interview programmes.

The Trust will be visiting a number of Job Fairs at Universities over the coming months in order to seek to attract newly qualified nursing staff to work at the Trust. The service does not currently utilise bank staff in the Home First workforce and options around this are being explored within the Care Groups. The pool of flexible workers, both qualified and unqualified registered at the former SSSFT Trust will increase the availability of workers to the service going forwards to cover any sickness absence, this is not something that has previously been available.

The Trust will also look to increase the availability of flexible workers through an internal recruitment campaign whilst being mindful of the working time directive and the health and wellbeing of staff already employed in a full time role within the Trust. An advert for flexible Health Care Support workers is currently live on NHS Jobs and there are plans to expand the number of adverts across all professional groups in order to address agency spend.

The Trust will be tapping in to the national nursing recruitment campaign launched on the 4th July to celebrate the 70th Birthday of the NHS and using the Careers social media accounts and the expertise of the Trust's Communication Team to point candidates towards the employment opportunities within the Trust. In addition to the above opportunities for employment within the Home First service are being promoted through leisure centres radio across the County, and we are looking to use the information screens in doctors surgeries, that will enable us to target the areas with most need.

The learning and development programme is being reviewed and revised, including the time allocated for shadowing in some areas where this is appearing to be more lengthy, to ensure that the workers are available at the earliest opportunity, whilst having the correct skills to undertake their duties safely. We are in discussions with an NHSi approved care agency and exploring opportunities for them to be able to provide domiciliary workers to the Trust under a master vend arrangement, these discussion are also part of a wider remit to expand the existing master vend arrangement for all clinical roles across the new Trust ensuring we engage workers at the most competitive rates wherever possible.

Retention has been identified as an issue within the Home First workforce one of the main reasons cited is the shift patterns, these are being re-visited by the E-Rostering Team, together with Meridian and operational managers to see if there is a more efficient and effective roster that can be implemented that better supports the work life balance of the workers and therefore aids retention of their skills whilst recognising the needs of the service. Exit data and Listening Into Action data will be examined over the next few months to establish any other areas of dissatisfaction and an OD plan developed based on the results.

The contract with the outsourced recruitment provider SBS ends in October, moving the recruitment and selection process to an in-house service will give greater control and

flexibility over the recruitment process and allow for team resources to be flexed to meet demands in recruitment to posts.

Information is collated on a weekly basis and vacancies monitored through the Programme Board, a specific workforce workstream, reporting in to the Programme Board is being established to support the recruitment, development and retention of this workforce and more closely monitor progress towards a full establishment.

Key risks & mitigation to delivery

- **Market forces impact on Recruitment**

  Mitigation: Identifying high risk areas where demand could outreach capacity, alternative solutions are being identified and internal actions are currently being explored to reduce the risk

- **Inability to flow patients through Home First**
  Mitigation: Additional recruitment, working with partners to monitor and report the situation, daily escalation via CCGs

- **Retention issues with AHPs and Social Care staff as it may be that staff leave rather than accept 7 day working. The therapy services are already identified as "hard to recruit" posts.**

  Mitigation: Good communication and consultation with staff could reduce the risk

- **Moving to a 7 day working pattern without further investment in staffing levels would clearly not in itself improve capacity**

  Mitigation: additional funding would be required to increase staffing

- **Market forces impact on availability of temporary staff**

  Mitigation: Identifying high risk clinical areas where demand could outreach capacity, which could impact on safer staffing levels, alternative solutions are being identified and internal actions are currently being explored to reduce the risk

SHORTLIST OF SHROPSHIRE STP WINTER CAPACITY SCHEMES 2018/19 (@29.8.18)

In plan	(Multiple Items)									
Type	Orgn	Scheme short name	Confidence level in successful operational delivery (LOW/MEDIUM /HIGH)	IF LOW/MEDIUM, summary of the key risks (eg workforce, planning lead time, estates etc.)	Sum of Cost (£k)	Sum of Pre-commitment from winter monies required to year end	Sum of Pre-commitment from winter monies to 1.10.18	Sum of Remaining Funding requirement for the winter period	Sum of Impact acute beds PRH	Sum of Impact acute beds RSH
AA	SATH	Ambulatory Care - shortfall in workforce			£235	£0	£0	£0		
		Ambulatory Care GPs	Low		£133	£0	£0	£0	2.0	4.0
		GP streaming at Front Door of PRH	Medium	Increase referrals from ED to GP Streaming	£0	£0	£0	£0		
	SCCG	Frailty service at RSH	High		£0	£0	£0	£0		9.8
		Additional same day GP appointments	High		£100	£0	£0	£100		
	Shropshire Coun	2 carers in a car	High		£0	£0	£0	£0		
	TWCCG	Care Home MDT	High		£0	£0	£0	£0	2.3	
		Mental Health alternative pathways to SATH	High		£0	£0	£0	£0	0.8	
		Urgent Care referrrals to TRAQs	High		£0	£0	£0	£0	2.8	
	TWCCG/SATH/ T	Frailty Front Door of PRH	High		£321	£0	£0	£141	5.7	
AA Total					£789	£0	£0	£241	13.6	13.8
complex	SCCG	8 P2 rehab beds in Shrewsbury ind sector	High		£383	£0	£173	£210		3.0
		D2A P3 - CCG top up and medical cover	High		£106	£106	£0	£0		
		Redn in LoS in x15 P2 beds in RJAH	Medium	Requires RJAH to agree to change in model of management	£0	£0	£0	£0		1.3
	SCCG/MPFT	D2A P3 EMI - use of 3/4 spare bed capacity	High		£0	£0	£0	£0		0.9
	Shropcom	Optimising bed occupancy in community hos	High		£0	£0	£0	£0		
	Shropshire Coun	(ICS) social work at weekends	Medium	Dependent on recruitment, but this will be offset by flexible use of resource	£0	£0	£0	£0		
		2 social worker MDT Frailty team - RSH	High		£0	£0	£0	£0		
		4 extra care units in Shrewsbury	High		£0	£0	£0	£0		
		4 trusted assessors	High		£0	£0	£0	£0		
		Additional x4 Pathway 3 D2A beds	High		£0	£0	£0	£0		
		Dedicated carers lead based at RSH	High		£0	£0	£0	£0		
		Timely equipment assessment	High	Confidence in achieving ass	£0	£0	£0	£0		
	TWC	Additional Brokerage capacity	High		£0	£0	£0	£0	0.1	
		Alternatives to domiciliary care capacity	Medium	Provider developing model; workforce recruitment and training before impl	£0	£0	£0	£0	0.3	
		Assistive Technology to support early discha	High		£0	£0	£0	£0	0.0	
		Commission 'Carer in a Car'	High		£0	£0	£0	£0	0.3	
		Reduced LoS in P2 and P3 beds	Medium	Ensuring domiciliary care interventions are successful in increasing capacity	£0	£0	£0	£0	0.1	
		Releasing dom care capacity for P1 discharge	Medium	Capacity with Council to complete reviews; Invest to Save bid for additional	£0	£0	£0	£0	0.8	
		Shared Lives as alternative to P3	Low	Availablity of ground floor accomodation for identified patients	£0	£0	£0	£0	0.1	
		Trusted Assessor for Spot purchase Care Ho	Medium	Gaining agreement with all providers	£0	£0	£0	£0	1.6	
	TWC/SATH	Integrated Discharge Team	High		£0	£0	£0	£0	0.3	
	TWCCG/ TWC	Additional 7 beds for surge capacity	High		£77	£0	£0	£77	0.7	
complex Total					£566	£106	£173	£287	4.3	5.2
flow	SATH	Additional Beds and Mattresses			£25	£0	£0	£0		
		Additional CSM / DLN			£152	£0	£0	£0		
		AMU Twilight Shift Nursing - PRH			£56	£0	£0	£56	3.0	
		AMU Twilight Shift Nursing - RSH			£56	£0	£0	£56		3.0
		CDU RSH - extension of current area			£141	£0	£0	£141		4.0
		Discharge Lounge PRH			£65	£0	£0	£0		
		Discharge Lounge RSH			£91	£0	£0	£0		6.0
		SATH clinical advice to Intermediate Care Te	Medium	Identification of function within SATH eg Frailty team	£0	£0	£0	£0		
		Twilight Registrar			£83	£0	£0	£83		
		Twilight Shift in SAU			£121	£0	£0	£121		3.0
		Weekend Consultant & Junior Medic Cover			£83	£0	£0	£83		
		Stranded patient improvement	High		£0	£0	£0	£0	10.0	30.0
	SCCG	Ambulance Handover Nurses RSH	High		£264	£0	£132	£132		
		HALO (RSH)	Medium	Requires agreement with WMAS on change in job role/specification	£120	£0	£41	£79		
		Spot purchase	High		£30	£30	£0	£0		
	Shropcom	Community IV - Phase 1 unit based	Medium	Operational delivery within Shropcom high confidence to implement, howev	£145	£0	£0	£0	1.6	6.4
	TWCCG	Ambulance Handover Nurses PRH	High		£264	£0	£132	£132		
		HALO (PRH)	High		£79	£0	£0	£79		
flow Total					£1,775	£30	£305	£962	14.6	52.4
acute cap	SATH	DSU escalation at PRH - 24 beds			£394	£0	£0	£394	24.0	
		Ward 21 - 16 beds - RSH			£529	£0	£0	£529		16.0
		Ward 8 - 14 beds - PRH			£532	£0	£0	£532	14.0	
acute cap Total					£1,455	£0	£0	£1,455	38.0	16.0
Grand Total					£4,585	£136	£478	£2,945	70.5	87.4
							Bed capacity req'd -peak		83.0	82.0
							Variance from reqm't		-12.5	5.4

FALCK SHROPSHIRE NEPTS

Winter Preparedness

2018/2019

LESSON LEARNT 2017/18

- Impact of out of county journeys, especially on the day need to be managed more proactively to ensure resources remain robust locally.

- Site Manager usage at RSH, PRH and RJAH need to be optimised to gain improved communication links between hospitals and Falck dispatch and planning.

- VOR [Vehicle Off Road] days to be reduced by increasing maintenance and by promoting forward thinking in terms of servicing timetables and mileages.

- Number of available fully flexible bank staff to cover shortfalls not at levels previously thought to be satisfactory.

- Management structure and escalation processes blurred when fully called into action resulting in lost time reference decision making.

- Lack of 3rd Party Provider cover was an obstacle last year when escalations were called and hospitals fell into level 4.

RESOURCING/RECRUITMENT

- Ensure core rostered shift lines are maintained throughout the winter period taking into account the following:

  Annual Leave – mitigate with bank staff where needed – option for 3rd party

  Short Term Sickness (STS) - mitigate with relief and bank staff where needed

  Long Term Sickness (LTS) - mitigate with relief and bank staff where needed

- In order to facilitate the covering of the above Falck Shropshire will need to ensure that perm/bank staff numbers are at sufficient levels. With this in mind the following recruitment courses have been authorised to ensure appropriate recruitment:

  26-11-18 Shropshire PTS Induction/Training Course [Atcham]

  10-12-18 Shropshire PTS Induction/Training Course [Atcham]

- This will safeguard relief/bank numbers over the winter period into the new year – additional courses will be available if required.

RESOURCING/RECRUITMENT

» To ensure Falck are prepared for Winter pressures and meeting the shifting activity profile that is moving later in the day, the following roster pattern has been designed and signed off:

08 WEEK ROLLING ROTA

	NAME	BASE	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Break	Weekly Hours
01	Employee01	Atcham	1800-0400	1800-0400	1800-0400	1800-0400	1800-0400	RD	RD	1.0	45.0
02	Employee02	Atcham	RD	1200-2200	1200-2200	1200-2200	1200-2200	1100-2100	RD	1.0	45.0
03	Employee03	Atcham	1000-2000	1000-2000	1000-2000	1000-2000	1000-2000	RD	RD	1.0	45.0
04	Employee04	Atcham	1100-2100	1100-2100	1100-2100	RD	1100-2100	1100-2100	RD	1.0	45.0
05	Employee05	Atcham	1000-2000	1000-2000	1000-2000	1000-2000	1000-2000	RD	RD	1.0	45.0
06	Employee06	Atcham	1100-2100	1100-2100	1100-2100	RD	1100-2100	1100-2100	RD	1.0	45.0
07	Employee07	Atcham	1800-0400	1800-0400	1800-0400	1800-0400	1800-0400	RD	RD	1.0	45.0
08	Employee08	Atcham	RD	1200-2200	1200-2200	1200-2200	1200-2200	1100-2100	RD	1.0	45.0
										Average Hours	45

» The benefits of this roster:

- » Increased resource coverage into the evening
- » Up to four additional discharge crews available on the contract
- » Increased resilience for post midnight activity – backing up existing night crew coverage
- » Extra Saturday crews to cover increasing winter weekend activity

RESOURCING/RECRUITMENT

- To ensure Falck are recruiting and sustaining a healthy Voluntary Car Service (VCS) over the winter period, a series of avenues are being explored through online adverts, written press and local poster initiative:

  - https://www.shropshirelive.com/features/2018/11/05/father-and-son-from-telford-in-volunteer-driver-appeal/

  - http://www.loveshrewsbury.com/contrib/county-volunteer-driver-appeal

3rd Party Resilience

» To ensure Falck are able to maintain maximum resilience throughout the winter period we have identified a number of local transport providers to work in partnership with:

Cartello Ambulance

» Fully registered PTS provider located in Cannock – are able to provide Falck with flexible Ambulance availability

RapidResponse MEDICAL GROUP

» Fully registered PTS provider located in Stafford – are able to provide Falck with flexible Ambulance availability

Shrewsbury TAXIS

» Leading local provider of taxi services helping Falck with walking patients across the county and beyond

» Further 3rd Party Providers have also been approached and we are awaiting due diligence paperwork before implementing site visits

Vehicles

- Falck Shropshire have an internal garage for repairs and maintenance on vehicles that is supported by two fully trained mechanics.

- We also have third party agreements with a number of local garages to ensure we have resilience on the contract and maintain vehicle availability throughout the winter.

- Hire agreements are also in place to ensure any potential shortfall in Ambulances can be reacted to quickly, lowering the risk to the service provision.

- 4x4's winter provisions are in place in preparation for adverse weather conditions

- Hire agreements are also in place if the contract requires additional support

» Falck Shropshire staff have been communicated the following:

Winter driving can bring testing conditions for all drivers, whether it's gently falling snow, lashing rain or icy roads. Here you will find winter driving tips to prepare yourself, your vehicle and advice on driving in snow.

Atcham Site Area

Make sure you have the following items on site to deal with snow and Ice around the Atcham site:

- Bags of salt/grit - Snow shovels - De-icer to free off frozen key locks

Footwear

- Ensure you have suitable footwear to carry out your daily tasks on snow or ice

Preparing to drive in wintry conditions:

- Check the weather in advance - don't ignore police warnings about closed roads.
- Make sure you have an emergency kit so you are prepared in the event of a breakdown. This should include a torch, food for energy, water suitable footwear, gloves, hat, money and blankets.
- On longer journeys always let someone know you have set off and tell them your planned route.
- Ensure your mobile or communication device is charged up so you can make a call in an emergency.
- As well as your daily check do a proper winter check of your vehicle, check washer fluid, ice scraper, map and tyres - Ensure you have plenty of diesel or petrol
- Where Available take snow chains or snow socks and a snow shovel
- Make sure you have all your Falck contact details including breakdown recovery agent details in the vehicle.

Winter Driving - Ice or Snow:

- Double or even triple your normal stopping distance from the vehicle in front.
- If the roads are icy or covered in snow, plan your journey around busier roads – these are more likely to have grit.
- On motorways stay in the clearest lane possible. Stay away from slush and ice. Keep within the clear Tyre Tracks if you can. - Stay in a higher gear for better control.
- As conditions improve make sure your fog lights are only on if necessary – they can dazzle other drivers.
- In falling snow use dipped headlights to make you are visible to others (especially pedestrians).
- It's important to get your speed right when driving in snow: not too fast so that you risk losing control, but not so slow that you risk losing momentum when you need it – brake, steer and accelerate as smoothly as possible.
- If you get yourself into a skid the main thing to remember is to take your foot off the accelerator and steer, try to avoid braking.
- Only use Snow chains when the road is covered in snow or ice using snow chains on clear roads will damage the vehicles tyres
- Remember It is illegal to drive with snow on your vehicle glass or excessive snow on the vehicle body, always remove it before driving, an exception to this is the roof on high sided vehicles
- Some of our operations use Scooters or Cycles, these must not be ridden on snow or ice

The Shrewsbury and Telford Hospital NHS Trust

Joint HOSC
SaTH Maternity CQC Update
November 2018

Deirdre Fowler

Director of Nursing Midwifery and Quality

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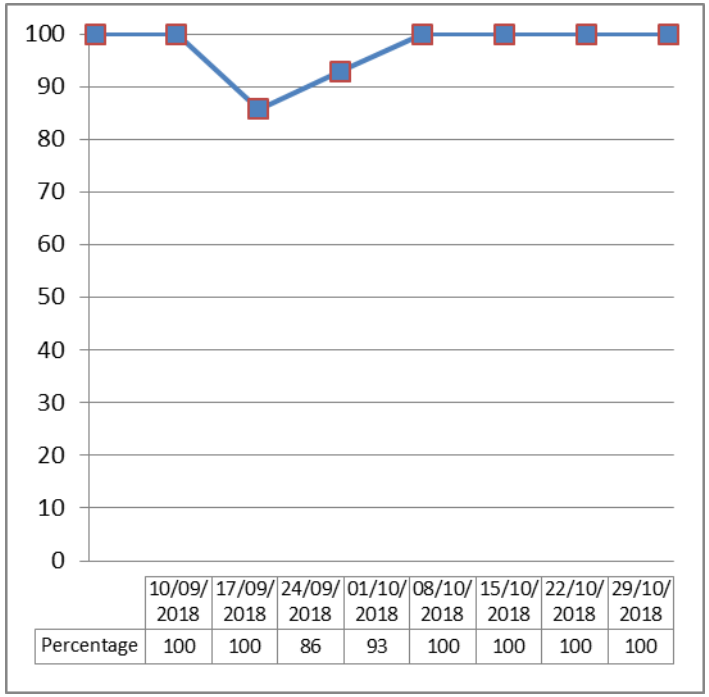
Maternity Overview – Actions to date

Actions	Completed/Updates
Review of all incidents of reduced fetal movements	Completed 05.10.18
Immediate Action: women with risk factors who have CTG for reduced fetal movements at any MLU - CTG scanned through to delivery suite or triage for immediate medical review	Completed 14.09.18
Subsequent Action: All women who report reduced fetal movements seen on Obstetric Unit Triage for CTG monitoring	Completed 21.09.18
Reduced fetal movement guideline updated and amended to further strengthen escalation and antenatal electronic fetal monitoring guideline updated	Completed 26.10.18
Review of modified early obstetric warning system (MEWS) to further strengthen escalation and timely review from medical staff	Currently benchmarking - Anticipated ratification 19.11.18
Triage standard operating procedure and triage assessment cards updated guidance to include strengthened escalation plan/timely review from medical staff	Completed 09.11.18
To understand and identify if Birmingham Symptom Specific Obstetric system (BSOTs) model is recognised	Awaiting clarification from CQC-factual accuracy
New Proforma & Obstetric Handover Process agreed and implemented Twice daily multi-disciplinary Board Round evidence supplied	Completed 05.10.18
Weekly data reporting and follow up of high risk women with reduced fetal movements who decline or are unable to attend PRH Triage in a timely manner via the Obstetric Risk Meeting	Completed 24.09.18

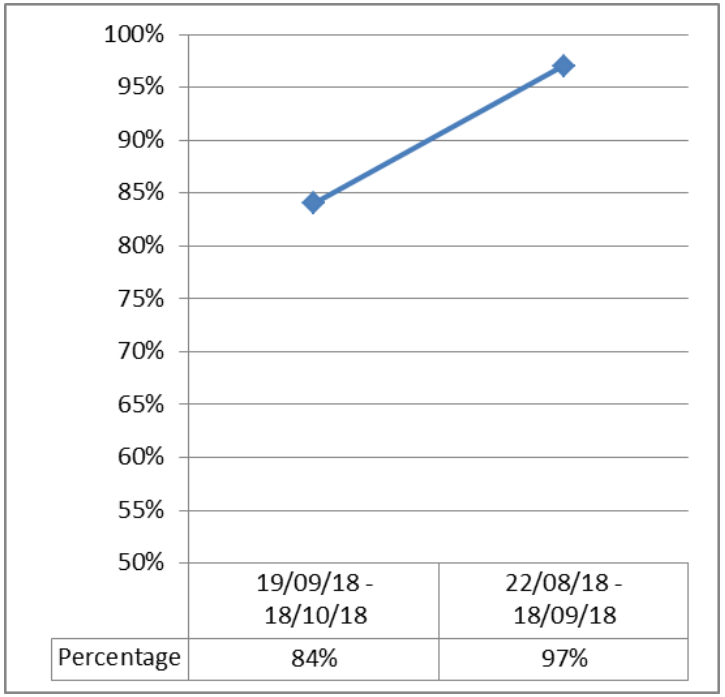
Maternity Metrics Compliance

Twice daily Delivery Suite Ward rounds and completion of proformas



	10/09/2018	17/09/2018	24/09/2018	01/10/2018	08/10/2018	15/10/2018	22/10/2018	29/10/2018
Percentage	100	100	86	93	100	100	100	100

Analysis of completion of handover proformas on a monthly basis to be reviewed at Maternity Governance



	19/09/18 - 18/10/18	22/08/18 - 18/09/18
Percentage	84%	97%

The drop in compliance is representative of a evening and morning omission , and further drive demonstrated increased awareness of its importance.

Maternity Dashboard (copies of full dashboard with papers)

Descriptor	APR	MAY	JUN	Q1	JUL	AUG	SEP	Q2	OCT	SaTH YTD	National Figure	National Data Source
Normal birth rate	69.9%	68.7%	68.4%	**68.9%**	65.1%	66.7%	71.9%	**67.9%**	64.2%	**67.8%**	**66.0%**	**NMPA**
Caesarean Section rate %	20.3%	20.4%	22.7%	**21.2%**	22.7%	20.6%	19.1%	**20.8%**	19.0%	**20.7%**	**25%**	**NMPA**
PPH 1500ml or greater	1.4%	1.7%	1.3%	**1.5%**	2.9%	1.6%	2.7%	**2.4%**	2.3%	**2.0%**	**2.7%**	**NMPA**
Babies/term Apgar score <7 at 5 mins	0.3%	0.8%	0.8%	**0.7%**	0.3%	0.6%	0.8%	**0.6%**	1.6%	**0.8%**	**3.5%**	**NMPA**
Crude stillbirth rate				**2.6/1000**				**2.6/1000**		**2.6/1000**	**3.5/1000 (2016)**	**MBRRACE**
Vaginal births with a 3rd/4th degree tear	2.2%	3.4%	3.6%	**3.1%**	1.7%	3.0%	3.3%	**2.7%**	3.4%	**3.0%**	**3.5%**	**NMPA**
Episiotomy rate overall	10.0%	14.8%	8.7%	**11.3%**	14.0%	14.1%	11.2%	**13.1%**	17.5%	**13.0%**	**22.0%**	**NMPA**
Skin to skin within 1 hour of birth	99.4%	99.3%	100.0%	**99.6%**	100.0%	99.7%	99.7%	**99.8%**	98.5%	**99.5%**	**79.8%**	**NMPA**
Overall Trust total births	355	418	396	**1169**	390	390	385	**1165**	405	**2739**	**375-425**	**Local**

The Shrewsbury and Telford Hospital NHS Trust

Joint HOSC CQC UPDATE November 2018

Deirdre Fowler

Director of Nursing Midwifery and Quality

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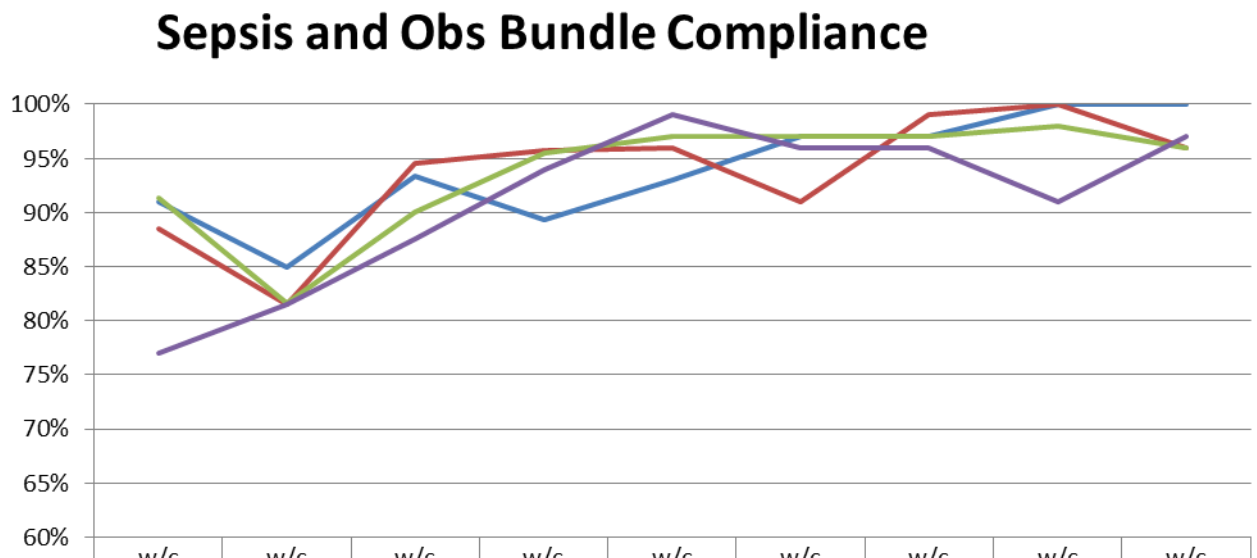
EDL Sepsis and Observations Bundle compliance



	w/c 06/09	w/c 13/09	w/c 20/09	w/c 27/09	w/c 04/10	w/c 11/10	w/c 18/10	w/c 25/10	w/c 01/11
RSH Obs %	91%	85%	93%	89%	93%	97%	97%	100%	100%
RSH Sepsis %	89%	82%	95%	96%	96%	91%	99%	100%	96%
PRH Obs %	91%	82%	90%	95%	97%	97%	97%	98%	96%
PRH Sepsis %	77%	82%	88%	94%	99%	96%	96%	91%	97%

Weekly ED Consultant audits to review
Week Commencing 19/10/– 25/10: 21 case notes reviewed, 2 cases of delay in treatment but no evidence of harm
Triangulated with complaints
No complaints re sepsis & delayed diagnosis* and delay in obs since August 2018 and no Moderate /Serious incidents

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Datix's: delayed diagnosis

*

	SI/Harm Level	Sep	Oct	Grand Total	Comment
PRH	DEATH	0	1	1	Reporting as an SI due to treatment delay as blood results not reviewed and acted upon.
	LOW	2	1	3	
	MOD	0	1	1	Patient taken into Resus at Prh and seen straight away. Following 2 x CT scans and discussion with NMUH she was transferred. *Awaiting care group to confirm that this is no longer a moderate harm incident, as no delay in being seen/diagnostics, then this is likely to be re-classified to "none".*
		4	3	7	
	PRH Total	**6**	**6**	**12**	
RSH	NONE	5	1	6	
	RSH Total	**5**	**1**	**6**	
Both	Grand Total	**11**	**7**	**18**	

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ED: Environment

		PRH					RSH				
No.	Summary	w/c 4/10	w/c 11/10	w/c 18/10	w/c 25/10	w/c 01/11	w/c 4/10	w/c 11/10	w/c 18/10	w/c 25/10	w/c 01/11
1	Are the Resus doors shut when not in use?	100%	60%	57%	71%	100%	77%	77%	78%	100%	100%
2	Resus - are all store rooms locked?	88%	80%	57%	57%	92%	100%	100%	100%	100%	100%
3	Resus - are all wall drug cupboards locked when not in use - and no medication left on work surfaces?	75%	100%	100%	100%	92%	100%	92%	100%	100%	92%
4	PRH ED Theatre Minor Injuries - is the cupboard locked?	100%	100%	100%	86%	100%	n/a	n/a	n/a	n/a	n/a
5	PRH Childrens Waiting room - is the door locked at all times?	100%	100%	100%	100%	100%	n/a	n/a	n/a	n/a	n/a
6	Ambulance Equipment required	100%	100%	71%	86%	92%	100%	100%	100%	100%	92%*
7	Is all ED Nitrous oxide stored in the Resus Storeroom (when not in use)?	88%	100%	100%	100%	100%	100%	100%	100%	100%	100%
8	Fit to Sit area - are there 4 or less patients in this area (seating for up to 4 patients only). Check SOP available for Staff.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
9	Induction of agency staff - have all new agency staff received an induction into the department?	100%	100%	100%	100%	92%	92%	100%	100%	100%	92%
10	PRH Reception - are the doors from the main corridor closed at all times?	100%	100%	100%	86%	100%	n/a	n/a	n/a	n/a	n/a
11	Clean Utility - is the door locked (door to be locked at all times)?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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- n/a = questions not applicable to RSH
- * actioned immediately = 1 non-compliance

Audit Completion % by time and audit

		w/c 06/09	w/c 13/09	w/c 20/09	w/c 27/09	w/c 04/10	w/c 11/10	w/c 18/10	w/c 25/10	w/c 01/11
RSH	% 10am Checks	100%	100%	100%	100%	86%	86%	86%	100%	86%
	% 10pm Checks	100%	100%	100%	100%	71%	71%	57%	71%	71%
	% 2 hrly sweeps	100%	100%	84%	88%	64%	80%	92%	80%	92%
PRH	% 10am Checks	100%	100%	100%	86%	100%	100%	86%	86%	71%
	% 10pm Checks	100%	100%	100%	71%	57%	71%	71%	71%	57%
	% 2 hrly sweeps	100%	93%	96%	76%	95%	96%	100%	84%	88%

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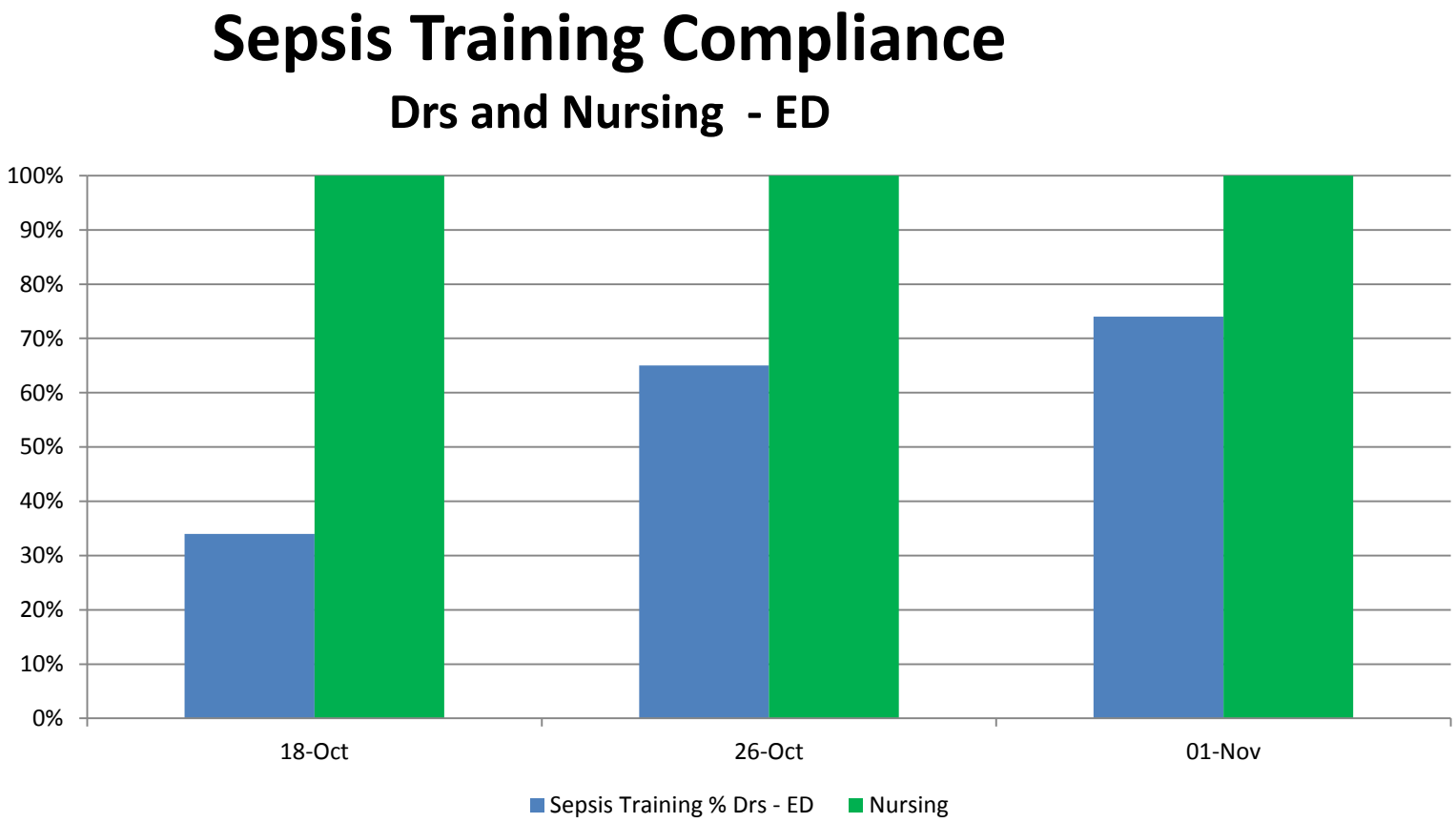
Sepsis Training Compliance – ED Nursing and Doctors



Nursing Sepsis training delivered through:

- Study Days
- Induction (new staff)
- E-Learning

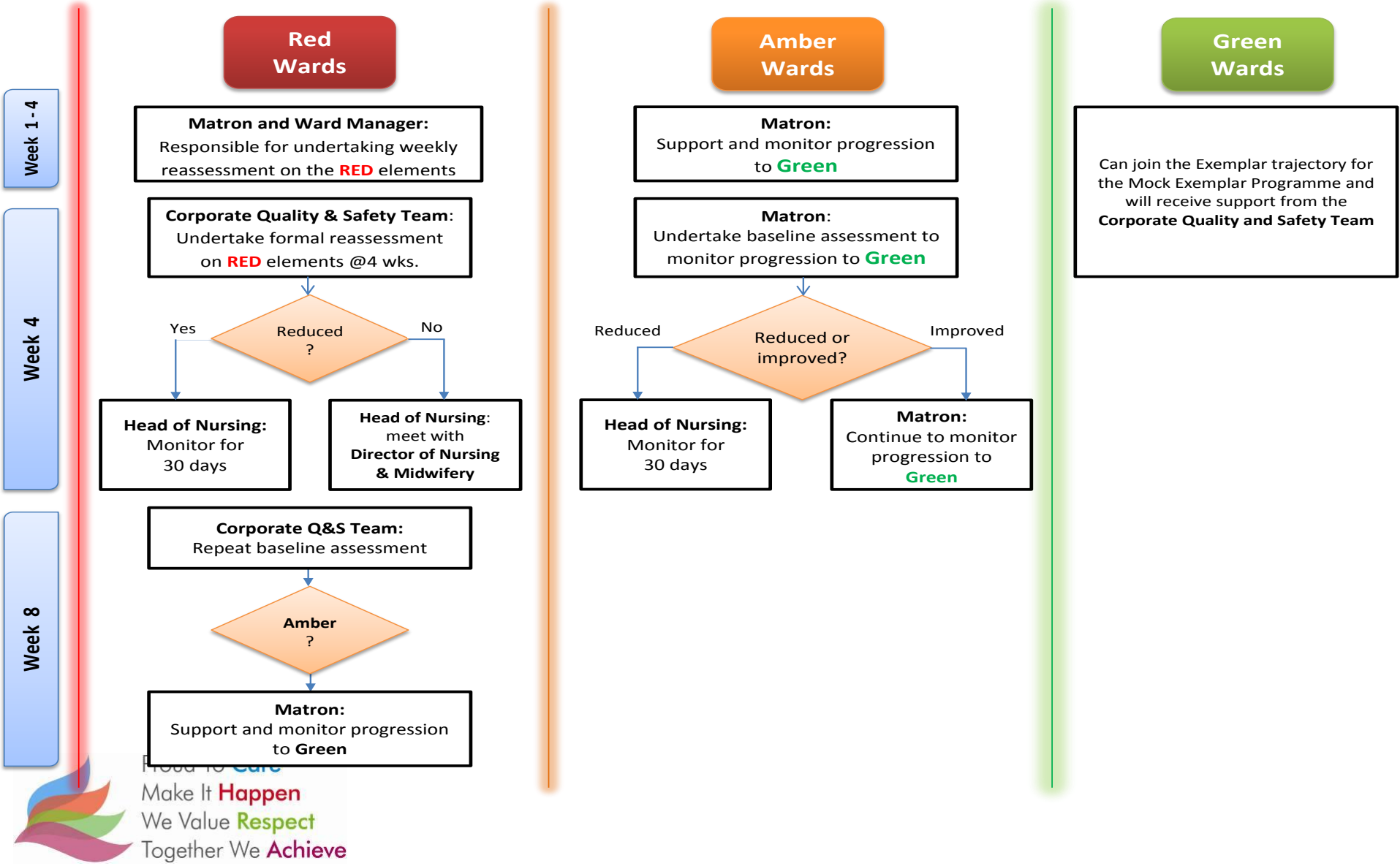
Doctors Sepsis training delivered through:

- Induction
- DEEP Dr sessions
- E-Learning
- On-site Sepsis training – consultant delivered

Section 29 Warning Notice (17/10/18) – Risk to health and safety of service users

CQC Found/Issue	We will /did:	Governance/ Assurance	Exec Lead	Timescale
• Inconsistent recording of nursing documentation WARD 10 and 15 PRH	• Unannounced baseline 'Exemplar' visits to all wards which includes review of all nursing documentation (6 currently completed) • Updated Tissue Viability referral form linked to datix • Self assessment and peer review of documentation daily and weekly • Trust wide roll-out of 'Exemplar' programme continues as commenced in 2017	• Results to Care Group Board meetings, Confirm and Challenge and NMF and in future to Clinical Gov Exec and by exception to Q&S • Escalation to Matron, HoN and Director of Nursing and Midwifery as per SOP	Director of Nursing, Midwifery & Quality	Current Complete December 2018 Ongoing April 2019

Governance of Baseline Exemplar Framework



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Ward 10 and 15 Electronic (RaTE) assessments

2018 - Ward Self-Assessment Results (2 x sets of documentation checked monthly)										
WD10	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Documentation	89.5	100	90	95	90	79.3	90.5	Not completed	100	85
Falls	100	100	100	91.7	100	87.5	100		100	100
Nutrition and Hydration	88.2	94.7	68.4	100	87.5	73.1	70.6		100	81.3
Tissue Viability	92.3	100	76.9	100	92.3	66.7	92.3		100	92.3
WD15	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Documentation	84.2	90	89.3	82.1	93.9	94.7	95	92.9	88.9	94.1
Falls	71.4	100	93.3	100	100	100	100	100	100	87.5
Nutrition and Hydration	91.7	91.7	88.2	80	100	100	100	79.2	75	88.9
Tissue Viability	100	100	100	94.7	100	100	100	94.7	84.6	88.9

- The RaTE electronic tool is undertaken by Ward Managers and reviewed by Matrons and the HoN
- The Baselines Exemplar is undertaken using fresh eyes approach by the Corporate Quality and Safety Team.

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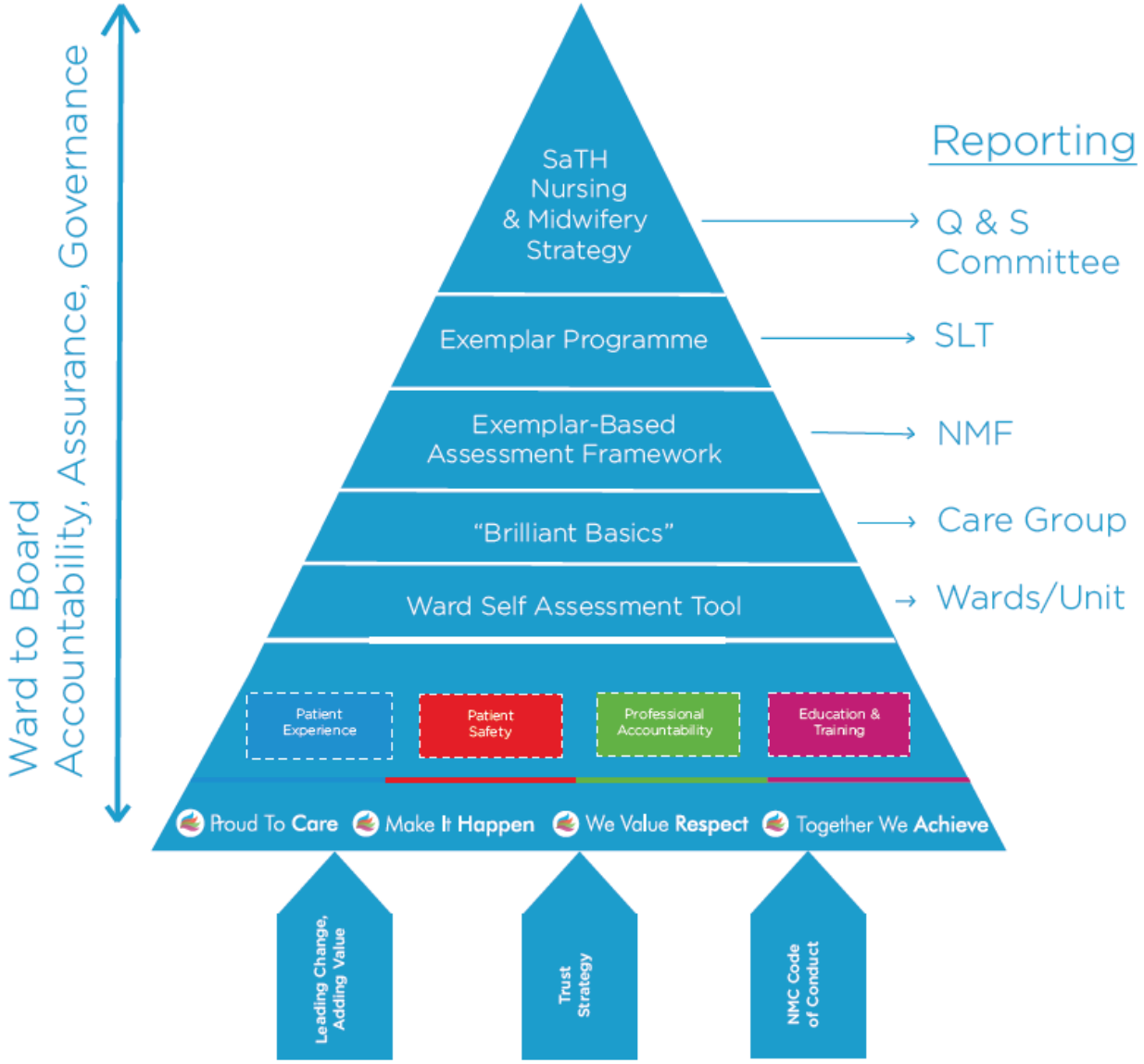
Ward to Board Accountability



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Trust Roll-out of Baseline Exemplar

Commenced pilot roll out of baseline Exemplar in October 2018.

Initially based on review of one random selection of nursing documentation, and now increased to 3 sets of nursing documentation.

Ward	*Last Assessed*	*Next Due*	Environment	IPC	Documentation	Tissue Viability	Falls	Nutrition & Hydration	Leadership	Professional standards	Communication	Care & Compassion	Medicines Management
WD 7	**20.10.18**	**Late Dec**	57%	67%	58%	20%	75%	50%	72%	67%	63%	75%	50%
WD 10	**13.10.18**		73%	78%	75%	80%	88%	88%	72%	88%	100%	83%	86%
WD 23OC	**26.10.18**	**09.01.18**	80%	100%	70%	20%	33%	43%	83%	100%	50%	100%	79%
WD 26	**29.10.18**		94%	89%	91%	100%	100%	62%	70%	100%	100%	100%	71%
Gynae	**07.11.18**		88%	89%	100%	100%	100%	83%	78%	100%	100%	90%	85%

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Section 29 Warning Notice (17/10/18) –
Insufficient Number of competent, skilled and experienced persons within Critical Care

CQC Found/Issue	We Did:	Governance/ Assurance	Exec Lead	Timescale
• Provision of Intensivist cover 24/7 (12 intensivist in post. To split the rota we would need 16 additional 4)	• Recruitment process in place for Consultant Anaesthetist cross site and funding for another 2. • Business case in development	• Theatres, Anaesthetics & Critical Care Risk & Governance Meeting	Workforce Director / Medical Director	March 19
• Dedicated Pharmacist 5/days week	• Actions to progress via internal governance framework			

• Dedicated Physiotherapists	• Physiotherapy Practitioners pilot project
	  • All trained by end Oct – met
	  • Competency assessment 13/11/18
	  • Impact assessment on the 45 min standard – End Nov.
	  • Business case to be developed by end of Dec
		• Care Group Board
		• Workforce committee
				30/10/18 (Met)
				13/11/18
				
				30/11/18
				
				30/12/18

• Less than 50% of staff with a post registration award in Critical Care	• Succession plan already in place • Critical Care training: • Trajectory - 3RNs currently in training, 5 RNs due to complete and 6RNs to secure a place in 2019. Recruitment continues.			

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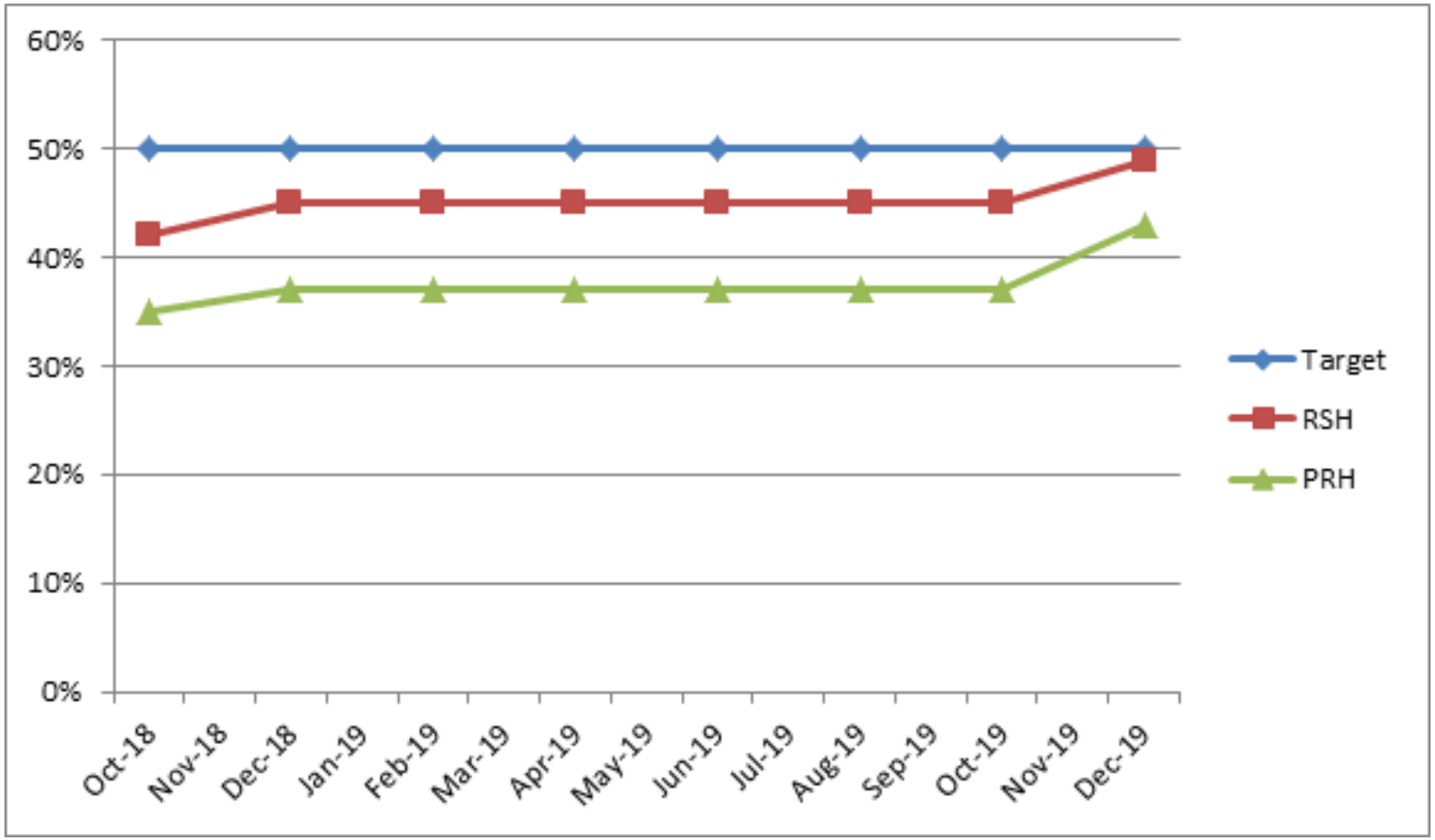
Critical Care Course Trajectory



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Section 29 Warning Notice (17/10/18) –
Insufficient Number of competent, skilled and experienced persons within the Emergency Department

CQC Found/Issue	We Did:	Governance/ Assurance	Exec Lead	Timescale

• Requirement of RSCNs- 6WTE already in place
 	
• **Requirement for 10 WTE Consultants
• **Middle grade Doctors High agency usage (both Drs and nursing) and ED nurse staffing and no formal risk assessment or staffing tool.
	• Paediatric Simulations – held 25/10/18 @RSH (with further planned monthly) – attended by:
	  • Consultant
	  • Jnr Drs (ED and on-call)
	  • Resuscitation Officers
	  • Anaesthetist
	  • ED Nursing staff
	• All nursing staff receive PILS training on a rolling programme.
	• All band 6 and senior band 5 are EPLS and ALS trained:
	  • PRH x 12
	  • RSH x 19
	
	• Derby programme: training our own doctors through to consultant level
	• 7 wte substantive Consultants by March 2019
	• Aim to achieve another 5 appointments.
	• CESR placement and fellowship roles to address gaps in rota (currently filled by agency).
		• Daily Safety Huddle
		• Weekly Safety call
		• 7 day prospective nursing roster view
		• NHSI workforce call bi weekly
		• Weekly ED Workforce Steering Group
		• Weekly ED Recruitment (Medical Staffing) Meeting
		• Workforce Committee
			Workforce Director	March 19

ED Medical Staffing – current vs projection

**

Consultants (both sites)	Current	Feb-19
	4	6.5

	Current (WTE)		Dec (WTE)		Variance (WTE)	
	PRH	RSH	PRH	RSH	PRH	RSH
Middle Grade	5	6	5	4	0	-2

PRH	1 x long term leave
	2 x day shift only
RSH	1 x long term sick
	2 x day shift only + 2 trainees in numbers who work days only currently
	Interviews taken place this week with 4 offers made

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CQC Found/Issue	We will /Did:	Governance/ Assurance	Exec Lead	Timescale
• EOLC 7/7 service delivery	• Independent external review of service delivery model	• Steering group monthly meetings to review progress. • Workforce Committee • Clinical Gov Exec and by exception to Q&S • Review at Steering group	Director of Nursing, Midwifery & Quality	Feb 2019
• Central list of patients receiving palliative care.	• This data is already captured on SEMA		Director of Nursing, Midwifery & Quality	Dec 2019
• Location of syringe Pumps	• New loan form on palliative care web • Meeting with EBME to discuss tracking already in place – resolved	• Audit of loan forms to review compliance		Jan 2019
• Completion of EoLC care plan	• Pilot on 3 wards complete - full roll out to Trust	• Attendance at drop in workshops • Audit of new EOLC planned for 1st April 2019	Director of Nursing, Midwifery & Quality	Apr 19
• Medicine- dirty utility in renal unit	• Planned refurbishment – 12th November 2018 - resolved	• Care Group Board • IPCC • Q&S by exception	Finance Director	15th November 2018
• Lack of education and training of staff of MHA and MCA	• Work collaboratively with MPFT to meet the requirements of MHA - proposal received	• Workforce committee	Director of Nursing, Midwifery & Quality	March 2019