NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	13 September 2018
Paper number	F3

Winter Plan

For approval:		For assurance:	X	To note:	

Accountable Director	Inese Robotham, Interim Chief Operating Officer		
Presented by	Inese Robotham, Interim Chief Operating Officer	**Author**	Inese Robotham, Interim Chief Operating Officer

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care		Design healthcare around the needs of our patients, with our partners	X	Invest and realise the full potential of our staff to provide compassionate and personalised care	x
Ensure the Trust is financially viable and makes the best use of resources for our patients		Continuously improve our services to secure our reputation as the local provider of choice	X		

Alignment to the Single Oversight Framework					
Leadership and Improvement Capability		Operational Performance	X	Quality of Care	
Finance and use of resources	x	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	**Date**	**Outcome**
Finance and Performance Committee	30/08/2018	Noted
People and Culture Committee	04/09/18	Noted

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	5

Assurance in respect of: process/outcome/other (*please detail*) …….

Significant assurance ☐ *High level of confidence in delivery of existing mechanisms/objectives*	**Moderate assurance** ☐ *General confidence in delivery of existing mechanisms /objectives*	**Limited assurance** ☒ *Some confidence in delivery of existing mechanisms /objectives*	**No assurance** ☐ *No confidence in delivery*

Recommendations	For the Trust Board to: • Note the modelled impact of Winter and capacity requirements • Note the range of mitigating interventions identified to date • Note that further refinement of system wide winter plan is on-going with local health economy partners • Note that a further update will be provided in October.

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Executive Summary

The Trust's Winter Plan 2018/19 is being developed as part of a wider Local Health Economy (LHE) plan to identify capacity and interventions to address anticipated increase in emergency activity.

The Winter Plan for 2018/19 has a significant focus on maximising ambulatory pathways, reducing bed occupancy levels and increasing acute inpatient capacity to meet expected emergency demand.

The impact of the proposed interventions can be tracked through a dynamic demand and capacity model based on midnight bed occupancy rates. The cumulative effect of interventions identified to date is not sufficient for sustainable achievement of bed occupancy of 92% or less.

The interdependencies and joint schemes with Local Health Economy partners will be monitored and managed via the system wide A&E Delivery Board. It has to be noted that the system wide winter plan has not been finalised and there may be further mitigating schemes to be included in the model.

The indicative financial impact of expenditure incurred to date and cost of proposed schemes totals is likely to exceed the £3.5m winter funding included in the Trust's contract. The detail of financial impact is being worked through the Trust's Finance and Performance Committee.

Background

The Trust has a significant underlying deficit of acute inpatient beds, particularly on Worcestershire Royal Hospital (WRH) site. Coupled with a year on year increase in emergency attendances, ambulance conveyances and inpatient admissions this has resulted in both hospital sites operating at bed occupancy levels close to or over 100% and severe overcrowding in emergency departments.

The Trust has had two business cases approved providing early access to £11m of the £29.6m of the Acute Services Review funding; £3m for construction of a link bridge between the main hospital on the WRH site and Aconbury and £8m for refurbishment of the Aconbury East building to provide additional 80 acute inpatient beds. Construction of the link bridge has commenced with an expected completion date of the end of December 2018.

The Winter Plan is based on an assumption that the new Aconbury East wards on WRH site will not potentially come on stream before April 2019 and a range of other mitigating initiatives will be required to address the acute capacity shortfall. It has to be noted that a number of initiatives have already commenced or are planned to commence ahead of October 2018.

Issues and options

1 Capacity and demand modelling

The Trust's Informatics Department has developed a dynamic predictive bed occupancy model to quantify required capacity and to illustrate the impact of planned interventions on both the Trust's bed occupancy rates and associated Emergency Access Standard (EAS) performance.

The model shows that without any additional interventions the average expected bed occupancy for the Trust would be 120% for the Winter period (October –March), with the highest peak of 131% (Appendix 3 of the enclosed Winter Plan document). In order to bring the bed occupancy down to 92% on average an equivalent of 208 inpatient beds would be required.

	Additional beds required (or equivalent admissions avoided) to achieve 92%								
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Average
Total Additional Beds Required	172	192	199	232	230	229	202	209	208

The anticipated impact of planned winter initiatives identified to date is shown in Appendix 4 of the enclosed Winter Plan document. There still remains a month on month capacity deficit ranging from 60 to 95 equivalents of inpatient beds.

2 Impact on Emergency Access Standard (EAS)
Modelling undertaken by NHSI shows a direct link how high levels of bed occupancy have detrimental impact on EAS performance (Appendix 2 of the enclosed Winter Plan document). In view of the underlying shortfall of sufficient capacity to sustain bed occupancy of 92% or below, the expected associated Trust aggregate EAS performance ranges from 73.0% to 75.8%.

It has to be noted that the system wide Local Health Economy plan has not been finalised yet and there may be additional mitigating initiatives to be included in the model. A system wide winter planning forum is scheduled on 11th of September 2018.

3 Main strands of the winter plan with significant positive contribution to lower bed occupancy:

3.1 Additional physical bed capacity (acute or LHE partners):

- Old Evergreen ward (December –March): 28 beds
- Ward 11 Alexandra Hospital (October –March): 6 beds
- Ward 14 re-designation as acute medicine (January –March): 19 beds
- Full utilisation of Worcestershire Step Down Unit – 30 Beds (dates TBC)
- Additional Community Hospital Capacity – 19 beds (dates TBC)

Both costs incurred to date and anticipated costs have been presented to the Finance and Performance Committee. It has to be noted that the Trust has agreed to contribute £73K to the funding of the Worcestershire Step Down Unit as part of a system wide emergency measure to keep the Unit open until end of March 2019.

3.2 Admission avoidance/reduction in bed days:

- Expanded 7 day Frailty service – admission avoidance equivalent to 35 beds
- Patient Flow programme achievement of national ambition of reducing long stays in hospital – reduction in bed days equivalent to 22 beds.

Expansion of the Frailty service was funded as a separate business case and funded as part of the budget setting for 2018/19 therefore no additional costs will be included in financial modelling of the Winter Plan.

Equally the support for Patient Flow Programme has been externally funded through special measures monies and therefore no additional costs will be included as part of the Winter plan.

4 Financial implications

In line with national guidance the additional funding available to CCGs in 2018/19 is to be utilised to enable health systems to fund and plan in a way that improves A&E performance in 2018/19. The CCGs have agreed £3.5m for 2018/19 to support Winter Planning. As part of the winter planning allocation this will support any associated non-recurrent transition costs through additional activity as capacity is increased in-line with the FoAHSW business case. A joint plan will be agreed for this funding which is intended to support additional activity. This will sit outside the main cap/collar contract and be monitored separately.

Utilisation of these monies will require a joint sign-off by both the Trust and the CCGs with the expectation that they will demonstrate:

- How they will complete the implementation of the integrated urgent care strategy; and
- How sufficient capacity will be available to meet planned growth activity through a combination of additional beds and/or operational improvements

The Contract Value and Winter funding will be paid in equal monthly instalments. On a quarterly basis the position over or above the contract value will be established, agreed, invoiced or credit note raised and paid within 30 days of invoice date provided that the overall forecast sits within the cap and collar values in line with the agreed reconciliation process.

The total financial impact of expenditure incurred to date and indicative cost of proposed schemes exceeds the £3.5m winter funding included in the Trust's contract. The detail of financial impact is being worked through the Trust's Finance and Performance Committee.

The key risks to the implementation of this plan are:

- Maintaining support from system wide stakeholders to deliver actions for admission avoidance and timely discharges of medically fit patients.
- The investment of £3.5m identified in the contract is subject to joint agreement with the commissioners
- Financial risk of incurring additional expenditure above the £3.5m.
- Securing sufficient staff numbers to provide adequate levels of acute care in all of the additional capacity areas.

Recommendations

For the Trust Board to:

- Note the modelled impact of Winter and capacity requirements
- Note the range of mitigating interventions identified to date
- Note that further refinement of system wide winter plan is on-going with local health economy partners

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• Note that a further update will be provided in October
Appendices • Attachment 1 - Winter Plan • Attachment 2 – NHS Improvement analysis – impact of bed occupancy on emergency department performance • Attachment 3 – Winter 2018/19 – forecast with no additional beds or discharge scenarios • Attachment 4 - Winter 2018/19 predictive model

Worcestershire Acute Hospitals NHS Trust

WAHT Winter Plan 2018/19

Introduction

This paper summarises Worcestershire Acute Hospitals Trust's plans for an integrated approach with the Local Health Economy partners to service delivery across Worcestershire during Winter 2018/19.

The Trust's Winter Plan is built on the following priorities:

1. Front door processes and primary care streaming
2. Creating additional bed capacity and a Discharge Lounge
3. Phasing the elective programme
4. Additional admission avoidance measures
5. Focus on patient flow and effective discharge processes
6. Effective support systems including Flu immunisation programme
7. Planning for peaks of demand
8. Staffing / Workforce Planning
9. Effective System wide escalation and response
10. Severe weather planning
11. Communication

The plan identifies measures that will take place across the trust to improve flow and ensure optimal patient care within the trust; these include both internal and health economy wide initiatives.

Whilst this plan describes the basis of actions throughout winter the trust is committed to a cycle of continuous improvement and will be actively working with the clinical teams to review, evaluate and improve all patient flow processes. Staff are encouraged to explore and suggest improvement ideas which may be incorporated into the plan after its publication.

The Patient Flow Programme will monitor the delivery of key actions required to improve patient flow. This programme commenced in July 2018 and will continue to be delivered in line with the detailed project plan.

The efficacy of this winter plan will be monitored internally through the operational performance route and externally through the Accident & Emergency Delivery Board.

In line with national guidance the additional funding available to CCGs in 2018/19 is to be utilised to enable health systems to fund and plan in a way that improves A&E performance in 2018/19. The CCGs have agreed £3.5m for 2018/19 to support Winter Planning. As part of the winter planning allocation this will support any associated non-recurrent transition costs through additional activity as capacity is increased in-line with the FoAHSW business case. A joint plan will be agreed for this funding which is intended to support additional activity. This will sit outside the main cap/collar contract and be monitored separately. Utilisation of these monies will require a joint sign-off by both the Trust and the CCGs with the expectation that they will demonstrate:

- How they will complete the implementation of the integrated urgent care strategy; and

- How sufficient capacity will be available to meet planned growth activity through a combination of additional beds and/or operational improvements

Demand and Capacity modelling for Winter 2018/19

The Trust's Informatics Department has developed a dynamic predictive bed occupancy model to illustrate impact of planned interventions on both the Trust's bed occupancy rates and associated Emergency Access Standard (EAS) performance.

The model uses the number of inpatients in the hospital overnight and those awaiting a bed as of 01/08/2018 as a starting position for 30/09/2018. To predict the number of beds required as of 01/10/2018, the model adds the number of anticipated admissions based on how many patients were admitted during the corresponding day in Winter 2017/18, and likewise subtracts the number of anticipated discharges based on 2017/18 data.

The occupancy percentages are calculated based on the number of required beds per day forecast using the above methodology, and the average number of core General & Acute beds available per day during Winter 2017/18.

Assumption 1 is that daily admissions and discharges to Worcestershire Royal Hospital and the Alexandra Hospital will remain at the same levels as in Winter 2017/18, thereby assuming the same level of non-elective demand and lengths of stay as in that year, and additionally that a comparable degree of routine elective admissions will be cancelled. Assumption 2 is that the number of beds required on 30/09/2018 will be the same as the data snapshot taken on 01/08/2018, and that there will be no significant increase in inpatient demand in August and September.

The forecast bed occupancy and bed requirements can be adjusted by the addition of scenarios, either to increase the bed stock available (increasing denominator) or by decreasing occupancy by admission avoidance (decreasing numerator). The estimated impact on EAS performance is based on a snapshot of daily EAS performance as of 01/08/2018, and the estimated negative impact on EAS performance of high levels of bed occupancy, based on data modelling provided by NHSI (Appendix 2).

The model shows that in order to achieve average bed occupancy of 92% there is a requirement for additional initiatives equalling to 208 inpatient beds (Appendix 3). Without any interventions the expected average bed occupancy across the Trust would be 120%.

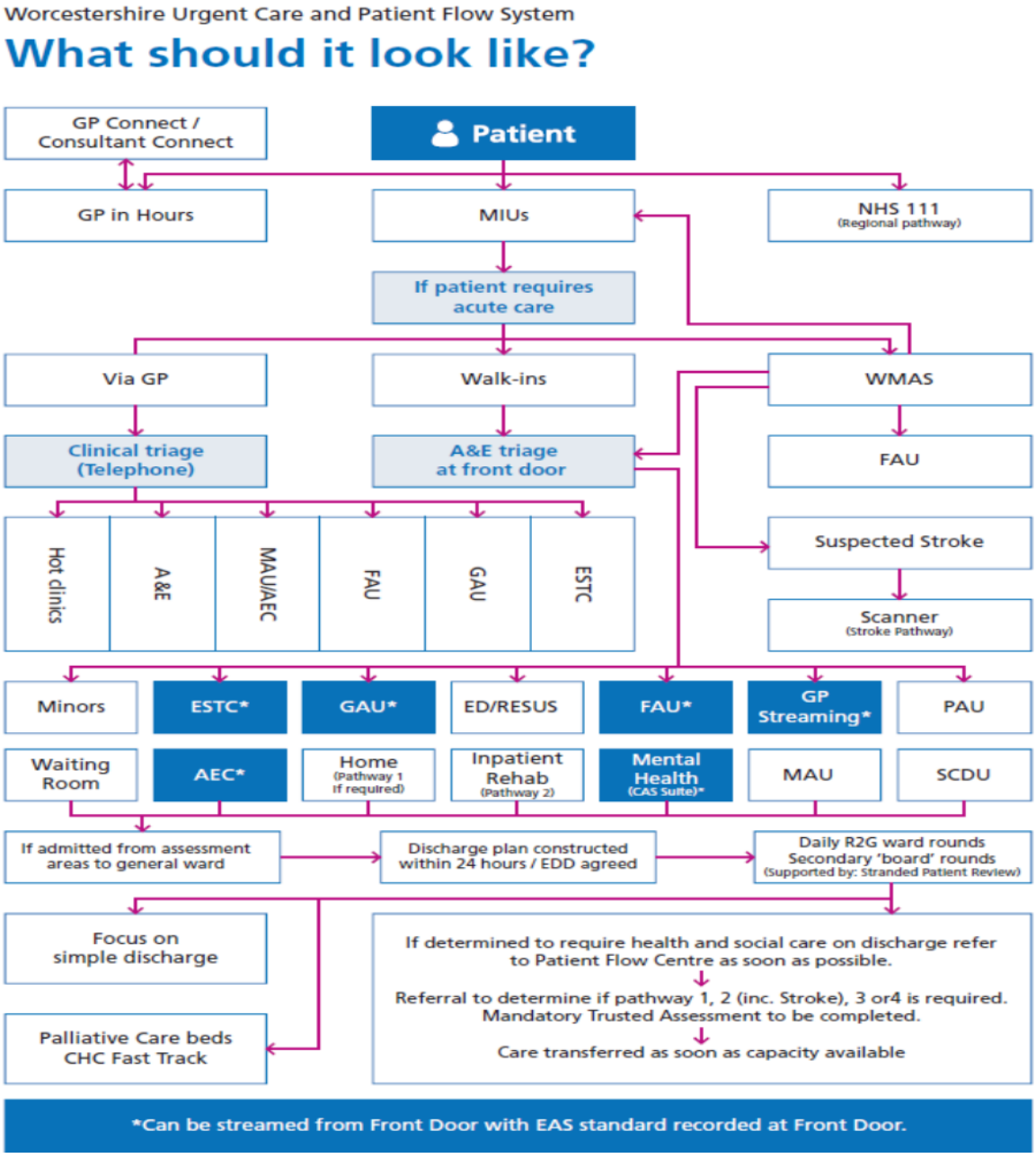
The anticipated impact of planned winter initiatives identified to date is shown in Appendix 4. There still remains a month on month capacity deficit ranging from 60 to 95 equivalents of inpatient beds and the expected associated aggregate EAS performance ranges from 73.0% to 75.8%.

Currently the model does not include efficiency schemes with marginal impact on bed occupancy, these can be added in as part of operational utilisation of the model.

Further demand and capacity mitigation schemes are being explored with the Health Economy Partners and will be incorporated into the model when confirmed.

Patient Flow System

The diagram below details the expected flow of patients through the Worcestershire Urgent Care system. Over the past 12 months there have been a number of service developments, particularly in ambulatory service provision, which has significantly increased the range of options available to clinical teams when trying to avoid an inpatient admission.



1. Front door processes and primary care streaming

1.1 Enhanced GP Streaming at WRH – Planned delivery date: September 2018

The streaming service aims to make care more efficient and take pressure away from emergency departments by having a primary healthcare professional "stream" patients coming through hospital doors, who can then refer them to primary healthcare or an emergency department.

GP streaming service commenced in December 2017 on the WRH site. This service is currently split into two elements. A daytime service from 10am – 6.30pm which is delivered by the Worcestershire GP Federation. This service is contracted directly by the Acute trust and is set to continue throughout winter 18/19. This is then supplemented from 6.30pm to 10pm by the collocated Out Of Hours GP Service currently contracted by the CCG with Care UK. The Trust and Care UK have been piloting a new streaming model throughout July 2018 which will inform new ways of working to maximise the efficiency and effectiveness of this service throughout the winter months.

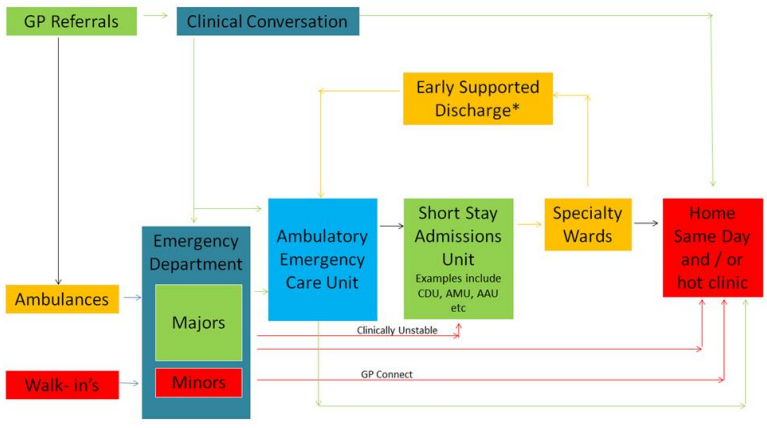
1.2 Ambulatory Care pathways – Planned delivery date: Delivered

Both acute hospital sites have got medical Ambulatory Emergency Care (AEC) services in place. In addition to this, WRH have got an ambulatory service for surgical patients called the Emergency Surgery Treatment Centre (ESTC).

Medical AEC services operate a push and pull model of taking patients directly from ED, and via GP / WMAS referral. The service is aiming to process a minimum of 25 new patients per day (15 at WRH; 10 Alex). In order for the WRH AEC service to accommodate the required number of patients per day, it was expanded in November 2017 to six trolleys and 10 chairs. The initial modelling suggests that by a combination of a push model from ED and a pull model by the Acute Physicians an average of up to 20 patients a day could be diverted from the ED corridor or from a base ward admission pathway to an ambulatory care option.

The ESTC service is seeing a minimum of 6 new patients per day.

Figure 1. Ambulatory Emergency Clinic Pathway



Key: Green flows are highly suitable for AEC, Amber flows may be suitable for AEC, Red flows are generally not suitable for AEC
*Once the core service is fully established AEC can be expanded to provide an 'early supported discharge' stream to inpatient wards

1.3 GP Connect – Planned delivery date: August 2018

The Consultant Connect service has been rolled out across 10 clinical specialties throughout 2018, giving the local GPs direct access to Acute Trust consultants, with an aim of avoiding attendances / admissions.

The Consultant Connect service also has the functionality to work in reverse to allow the Acute consultants direct access to local GPs to discuss patients with the aim of avoiding an admission or expediting a discharge. This is called GP connect.

GP connect is being initially trialled with ED and acute physicians as this has the potential for the most significant benefit in avoiding hospital admissions. Commencement date for the trial was 1st August 2018.

2. Creating additional bed capacity and a discharge Lounge

2.1 Opening Aconbury surge capacity – Planned delivery date: December 2018 (28 acute medical beds)

The old Evergreen ward in the Aconbury East building will be available to open from Mid-December till end of March and has the capacity of 28 acute medical beds following the completion of the link bridge.

This ward will be used as a surge area for acute medical patients under a designated Standard operating procedure.

There is no intention for the ward area to be used to cohort Medically Fit for Discharge patients.

2.2 Surge capacity at the Alexandra Hospital in Redditch – Planned delivery date: January 2019

Six additional medical beds have already been opened on Ward 11 in preparation for Winter 2018/19.

As part of phasing elective activity Surgery division are working up a plan to temporarily re-designate Ward 14 (19 beds) from surgical to medical ward for the duration from 21st of December 2018 to 29th of March 2019.

To enable this change, 6 additional beds will be open on Ward 16 to maintain elective orthopaedic activity during the Winter period.

2.3 Use of escalation areas on WRH site

A number of non-inpatient areas such as Endoscopy, Medical Day Case and Ambulatory Care have been used as inpatient surge areas for a prolonged period of time on WRH site. Whilst continued use is not ideal for provision of inpatient services it is prudent to assume that the use will continue until additional inpatient capacity becomes available. Therefore the cost of staffing these areas throughout the winter has been included in the financial modelling of the Winter Plan.

2.4 Discharge Lounge at WRH – planned delivery date: November 2018

The Trust has commenced the construction of a new discharge lounge facility on the WRH site in July 2018. This will be complete by November 2018 with formal handover currently scheduled for 15th November 2018.

The lounge can be accessed from 8am, the lounge staff will help support moving the patients from the wards. The lounge will have capacity for 3 male and 3 female patients on beds at any one time and another 5 male and 5 female patients on chairs.

3. Delivering the Elective Programme and Maintaining Activity.

3.1 Planned Theatre Maintenance – Scheduled at weekends over winter

Planned Theatre Maintenance on all three sites will take place at weekends over the period of three months (November 2018 to January 2019 inclusive) to minimise the impact on elective and emergency activity. Theatre staff will be deployed flexibly across all three sites to support the phasing of elective surgery on WRH site from the week before Christmas to the end of January 2019.

3.2 Phasing of Elective Activity from the week before Christmas to the end of March 2019

Elective surgical activity undertaken on the WRH site is predominately classified as category one (urgent or cancer surgery). It is essential that this activity is protected, given the potential impact on patient experience and performance against the cancer operational standards. For the period commencing 17th December 2018 to 11th January, the surgical division will reduce its theatre capacity by four lists per week scheduling circa 19 patients per week.

In order to temporarily re-designate Ward 14 as acute medical wards (point 2.2) as mitigation the Surgery Division will be transferring further day case activity from the Alexandra Hospital to Kidderminster Treatment Centre and Evesham Hospital. For a three month period the Division will utilise an additional seven lists (across both sites) per week. The model assumes an additional 21 patients per week; over a 16 week period 294 cases would be undertaken. In addition to this the division is working with SCSD to scope the potential of increasing day case capacity at the Alexandra Hospital (Birch Unit) by extending the working day to 2100hrs (an extra 2 hours per day, Monday – Friday).

The Surgery division is also working with SCSD to secure additional trauma theatre lists to ensure rapid access over a seven day period across both sites (WRH/ALEX) to ensure our patients receive timely access to treatment. This initiative will provide an increase of trauma capacity during the weekend and Bank Holidays.

3.3 Gynaecology Capacity

Emergency Gynaecology Assessment Unit will be operational 24 hours seven days a week. The Unit's capacity has increased from 2 to 4 examination rooms. The 4-6 beds on the antenatal ward will be used as inpatient capacity throughout the winter for screened selective elective gynaecology cases to support elective gynaecology activity. It is planned to reduce gynaecology activity that is not suitable for the antenatal ward between the week before Christmas to the end of January 2019 to coincide with the phasing of the rest of the elective surgery on the WRH site for the aforementioned period of time.

3.4 Additional Paediatric Capacity

The Women's and Children's Division will free up additional capacity in Children's clinic at WRH to provide additional flexible assessment space in times of excessive paediatric emergency activity. The Paediatric clinic will also open 6pm – 10pm Monday – Friday. This will run alongside the Paediatric Assessment Unit (PAU) and will be staffed with a consultant, SHO, nurse and HCA.

Nursing rotas have been reviewed to ensure adequate and dedicated paediatric nurse cover for the assessment pathway. This will assist with the flow of children through ED at what is generally the busiest time of the evening for paediatric attendances

4. Additional Admission Avoidance Measures

4.1 Extended countywide Frailty Model at the Alexandra Hospital, Redditch – Proposed delivery date: First phase - November 2018

A business case to expand the countywide frailty service was approved by TLG in May 2018. This business case gained approval for an extended frailty assessment service to be implemented, providing cover 12 hours per day 7 days per week.

Recruitment is on-going for this development and the plan is to implement an extended service by deploying a resilient and flexible workforce. There has been a subsequent reduction in the number of proposed posts and an acceptance that Advanced Clinical Practitioners (ACPs) can interchange with junior doctors, particularly SHOs whose posts are currently filled by locums. The business case approved the recruitment of ACPs to work interchangeably with junior doctors (SHOs). There is a plan for the service to become ACP led and replace SHOs in the medium to long term. While the service is in its infancy and the ACPs become established SHO cover will still be required. Recruitment of ACPs against the funds approved in the business case is now complete and conditional offers have been issued with anticipated commencement dates in November 2018.

Recruitment to band 5 Registered Nurse posts has been challenging with interview dates being cancelled on several occasions due to no applicants. This is reflective of other wards/departments and not unique to the Frailty Assessment Unit (FAU). Innovative ways to mitigate the vacancies are being explored, such as contacting staff who have applied to other areas and internal transfers from other departments. Whilst recruitment of nursing resource remains a challenge it is not anticipated that this will negatively impact the intended 12 hours per day, 7 day cover.

Extending the Therapists (Physiotherapy and Occupational Therapy) service from 8.30am – 4.30pm Monday to Friday to 12 hours 7 days per week across the Frailty Pathway at AGH is in progress. Recruitment into extra posts funded in the business case is also on-going. In terms of Occupational Therapy the aim is to continue core hours and 5 day service on the wards and commence extended hours once the new staff are recruited and in post in December 2018.

It is anticipated that the fully extended frailty service will be able to provide cover 12 hours per day 7 days per week from January 2019. The service will deliver avoidance of circa 1865 admissions per annum. Based on average LOS of 7 days this equates to a saving of 13052 bed days per annum and is equivalent of 35 inpatient beds.

4.2 COPD In-reach Delivery date: December 2018

A business case to facilitate the best practice tariff for COPD has been approved and the recruitment of 3 WTE specialist nurses/physiotherapists is in progress. This will provide cover at both sites from 9am-5pm Monday to Friday and 9am-5pm on Saturdays on the WRH site.

This additional service will facilitate an earlier discharge of up to 2 patients a week, as they can be reviewed at home next working day.

The specialist team will act as a point of contact for GPs and neighbourhood community teams to discuss patients that could be cared for at home and thus avoid admittance.

4.3 Additional ACS weekend Lists Delivery date: 31.10.2018

There are documented delays for patients admitted over a weekend who need to access ACS lists that are only delivered on weekdays. The cardiology department is running limited extra weekend sessions as required to reduce length of stay for this cohort of patients. A business case is progressing through the Trust's approval process to expand this service for every weekend.

4.4 Heart Failure Pathway initiation. Delivery date: 01.12.18

Heart failure patients requiring I.V. diuretics are currently treated as in-patients. A business case for ambulatory care based model for this cohort of patients has been approved and recruitment has commenced. The cardiology department has identified ring fenced seating areas to deliver treatment in an ambulatory care setting. The model used will follow national best practice and will result in reduction in circa 700 bed days per annum which equates to 2 inpatient beds.

5. Focus on patient flow and effective discharge processes

5.1 Patient Flow Programme – key priorities to support winter

The Patient Flow Programme consists of 5 work streams. These are:

- Front work stream – focused on improving flow in the Emergency Department – as detailed in Section 1
- Middle work stream – centred around No Delays Every Day for all wards
- Back work stream – focused on expediting complex discharges and reducing the numbers of stranded patients
- Frailty work stream – will result in the development of a county wide service focused on avoiding admissions and reducing length of stay – as detailed in Section 2
- Bed Management work stream- will result in new more efficient ways of working for the operational teams

Middle Work stream – Key Deliverables

- Consultant –led MDT board and ward rounds implemented and embedded
- Expected Date of Discharge set and clear clinical plans set for each patient
- Clinical Criteria for Discharge set for each patient
- Recording and monitoring of clinical and non-clinical delays to aid escalation and action on key causes of delay
- Improvement in EDS and TTO's done day prior to discharge
- Establishment of KPI's and measurement of improvement – Knowing How Your Ward is Doing

Back Work stream – Key Deliverables

- Passport for Discharge rolled out to all wards
- Structured long Length of Stay Reviews
- Introduction of the Whippet system

Bed Management Work stream Key Deliverables

- Enable getting patients in the right place first time through 24/7 bed management with clarified roles and responsibilities
- Use of the bed capacity APP
- Review of bed management data and governance

5.2 Herefordshire & Worcestershire Fire Service – Home from Hospital Service - Delivery date: 01/10/2018

A proposal has been scoped with Herefordshire and Worcestershire Fire Service to provide an enhanced home from hospital service to support safe early discharge of patients who may need additional help to settle them back home. This service would help to expedite safe discharges before midday, 7 days per week. Herefordshire

and Worcestershire Fire Service (H&WFS) have agreed to provide a 6 month service free of charge commencing from October 2018 which will enable us to identify the exact requirements of such a service in the future.

6. Effective Support Systems.

6.1 Imaging 24/7 already in place ; ad hoc capacity available for surge management.

6.1.1 WRH

Radiology will be available 24/7 for all clinically urgent patients. Consultant reported CT, USS and MRI will be available 8.30am to 9.00pm Monday to Friday and 9.00am to 5.00pm on Saturdays, Sundays and Bank Holidays with on call arrangements for urgent patients outside these hours. CT appointments will be provided for the same or the next day to support discharge

6.1.2 Alex

Radiology will be available 24/7 for all clinically urgent patients. Consultant reported CT, USS and MRI are available 8.30am to 5.00pm Monday to Friday. Additional capacity via extra sessions will be arranged flexibly for each modality to meet any fluctuations in demand. Bank Holidays will be staffed on a voluntary basis.

6.2 Pathology - 24/7 service already in place ; ad hoc capacity available for surge management.

Normal services are provided on a 24/7 basis for biochemistry and 8am-6 pm and will cover any capacity needs. Microbiology works core hours of 8am -6 pm with on-call cover afterwards. Enhanced cover will be provided in case of an infection outbreak. Flu screens will be completed on a quick turnaround cycles of a maximum of 2 hours from the sample arriving.

Mortuary services provide 7 day cover, there is space for 100 bodies on both sites, and additional capacity is available with the Nutwell Units if required. The department is reviewing the need of renting a portable unit to cover from Christmas to March 2019.

6.3. Extra Therapy Support. In place.

Extra therapy provision is being provided for the frailty unit at the Alex and Ward 11 (the Evergreen model ward at the Alex) and to enhance the support to the front door rapid response team and MAU. 3 additional physiotherapists have been employed to support winter pressures which will also support any additional surge capacity. An additional Band 6 Occupational Therapist will be required when old Evergreen is opened in Aconbury East.

6.4 Pharmacy Provision - Delivery date 31.10.2018

6.4.1 Extended weekend discharge service

Saturdays – extended discharge service until 3.30pm. Sundays – additional discharge service 10.00am – 14.30pm.

Business case for substantive establishment for the extended service to be presented in September 2018.

6.4.2 Enhanced Christmas and New Year fortnight provision

24/12/18: Additional service both sites
26/12/18: Additional service both sites
27/12/18) late discharge service at WRH
29/12/18: Extended service at WRH
30/12/18: Additional service at WRH
31/12/18: late discharge service both sites
01/01/19: Extended service both sites
02/01/19 – 04/01/19: late discharge service at WRH.

6.4.3 Surge area support

Provision of the safe and secure medicines management and nursing support for surge areas:

- Responsive stock list and stock cupboard set-up and forward management
- weekly top-up
- ward-based medicines management pharmacy services including inpatient and discharge medicines supply and daily clinical pharmacist visit to assure safe prescribing and administration (Mondays to Fridays)
- Support for nursing staff on medicines administration including second checking during operating hours.

6.5 Radiotherapy and Chemotherapy - Delivery date: December 2018

SCS Division will review the need to open for the two days over Christmas period to facilitate continuity of patient care.

6.6 Oncology / Haematology - Delivery date: 31. 10. 18

Oncology / Haematology

- Continue to provide daily consultant ward rounds, with weekend ward rounds.
- Submit business case to increase AOS nursing service to 7 day service and from 0800-2000 in the week.
- Further business case to remove side room on silver to create AOS bay, which will enable oncology/Haematology patients to come directly to ward avoiding A&E .
- Increased bed capacity on Laurel 3 which will be available for haematology and oncology admission to support flow, subject to Hereford repatriation patient demand.

Palliative Care

- Continue with on-site nurse led palliative care service at weekends with consultant available via phone.
- Assist medicine directorate in preparing business case for front door palliative care Practitioner following on from last year successful pilot during winter period.

6.7 2018/19 Flu Campaign - Delivery date: plan in place by 30.09.2018

Flu immunisation campaign is led by Deputy Chief Nursing Officer to ensure that the Trust has a plan for an effective flu immunisation programme to commence when vaccines become available.

Similar to previous years the plan will entail:

- Flu hubs at all three sites
- High risk areas on all sites will be targeted pre flu hub launch. (A&E, Paediatrics, Maternity, Chemo suites)
- Occupational health attendance at Trust induction and mandatory training days
- Walk rounds by Occupational Health staff and core flu champions including weekends and evenings
- Ward managers acting as flu champions for their areas to increase uptake
- Trust wide communication programme promoting uptake of immunisation.

7. Planning for peaks in demand

7.1 Rebalancing Outpatient and Inpatient Activity in Consultant Job Plans during times of escalation - Delivery date: 31.10.17

The specialty medicine division is reviewing job plans and rotas to ensure availability of physicians to carry out early ward/board rounds and to increase presence on the wards in times of escalation.

7.2 Increasing On site presence of staff in the flow hub; Delivery date: 31.10.18

Rotas for Clinical Site Manager cover, Bed Manager cover and On Call Manager cover will be reviewed by mid-September to identify where it would make sense to 'double up' during times of peak demand.

7.3 Use of 'Corporate/Off Line' nurses in times of escalation; Delivery date: plan in place by 30.09.2018

A formal rota is being drafted that will identify non ward based nursing staff who could be made available at short notice to support clinical areas. The formal rota will ensure that staff are aware and ready to move at a very short notice.

7.4 Use of Volunteers and non-clinical staff to support clinical areas in times of escalation. Delivery date; plan in place by 30.09.18

Volunteers will be used on the wards to help with non-nursing tasks such as meal delivery, picking up medicines from pharmacy and transporting patients to support areas such as radiology.

8. Staffing / Workforce Planning

The Trust has the following recruitment and retention strategies in place:

- The Trust already has a prospective and on-going recruitment programme in place for medical, nursing and midwifery staff, however, we are maturing the process to support the winter plan.

- Further flexible patterns of working particularly around nights, weekends are being offered to bank staff on block bookings, these staff will assist with filling the main gaps in wards and assist with specialising of patients requiring one to one observation.
- Corporate Nursing Staff and Clinical Nurse Specialists (CNS) will be asked to fill shifts on a regular basis providing it does not impact on service delivery or quality. Support for corporate nursing and CNS roles will be provided to increase confidence in renewing particular clinical competencies during Sept, October and November and also to identify a buddy ward which their clinical skills are best aligned with. The divisions are undertaking a baseline assessment during early September to provide a view for cover arrangements and support.
- External recruitment events are being attended during September and October which includes a stand at the Royal College of Nursing event in Birmingham
- Recruitment open days have been organised for September and October at both the Worcester and Redditch sites
- The Trust has completed the procurement process for the block booking of Tier 1 staff
- The further recruitment of volunteers is underway and a training programme is being developed to support admin staff to assist/volunteer on wards

9. Effective System Escalation Processes & Response

9.1 Internal Escalation Processes Delivery date – in place

Capacity and demand are routinely monitored on a daily basis in the Trust's bed meetings, conducted four times a day and coordinated at Worcestershire Royal Hospital. Physical capacity (beds), staffing levels, external capacity, and the range of operational and site specific issues that impact on patient flow are regularly monitored. At times of increased pressure, leadership in the hub becomes increasingly senior, and a formal command and control structure is implemented across the whole Local Health Economy (LHE).

Figure 2. - EMS.Levels

Escalation Level	Managed In Hours by	Managed Out of Hours by
1 – Normal working	Capacity Manager and Clinical Site Manager	Capacity Manager and Clinical Site Manager
2–Moderate Pressure	Clinical Site Manager and Divisional Representatives	On Call Manager and Clinical Site Manager
3 – Severe Pressure	Director of Nursing for Capacity and Flow with senior divisional representation	On-call Manager supported by On call Director
4 – Extreme Pressure	Chief Operating Officer / Deputy Chief Operating Officer	On Call Director

The escalation levels clearly identify the triggers for escalation. The action cards for managing flow clearly outline the steps needed to manage the documented triggers and the personnel responsible for the actions.
Actions are to be taken in line with the Acute Trust Capacity Management Policy.

Figure 3 EMS Escalation Triggers

	Level 1 - Planned Operational Working		Level 2 - Moderate Pressure
	Acute		**Acute**
1	No current risk of a patient waiting more than 4 hours to be seen in ED	1	Risk of one or more patients waiting more than 4 hours in ED within the next hour.
2	Transfer of Ambulance patient care is shorter than 15 minutes.	2	Transfer of Ambulance patient care is between 15 and 30 minutes.
3	Expected admission capacity greater than or equal to expected admission demand for the next 24 hours.	3	There is an expected admission capacity deficit of less than 10% of expected demand for the next 24 hours.
4	Elective work proceding as planned.	4	Up to 10% of elective and urgent inpatient work cancelled on the day.
5	Patients subject to a decision to admit not at risk of 8 hour trolley waits.	5	Risk of one or more patients subject to a decision to admit at risk of waiting 8 hours on a trolley in the next 2 hours.
6	Medical outliers form less than 0.5% of total inpatient population.	6	Medical outliers form between 0.5% and 1% of total inpatient population.
7	Cubicles in A&E are less than 80% occupied.	7	Cubicles in A&E are 80% -100% occupied.
8	More than 1 resuscitation bay available for immediate use.	8	Only 1 resuscitation bay available for immediate use.
9	Beds in Assessment Areas are less than 90% occupied.	9	Beds in Assessment Areas are 90%-99% occupied.
10	Planned additional bed capacity on standby.	10	Planned additional bed capacity open and less than 80% occupied.
11	No loss of admission bed capacity due to infection control measures.	11	Partial or whole ward closed to admission or discharge due to infection control measures.
12	Critical care capacity less than 80% occupied.	12	Critical care capacity is 80%-100% occupied.
13	Gender specific beds available as planned.	13	Patient moves required, expected within 1hr.
14	DTOC cases form less than 1% of the inpatient total.	14	DTOC cases form between 1% and 3% of the inpatient total.
	Community Providers		**Community Providers**
	Community Beds		**Community Beds**
	(Minimum of two triggers applicable)		(Minimum of two triggers applicable)
1	Community bed availability is > 5%	1	Community bed availability is < 5%
2	No operational issues	2	Discharges are planned for today
3	Planned admissions > 5%	3	Planned admissions < 5%
	Urgent Care Centres/Minor Injury Unit/ Walk In Centre		**Urgent Care Centres/Minor Injury Unit/ Walk In Centre**
1	100% of patients are treated and discharged with in 2 hrs	1	98% of patients are treated and discharged between 2 to 3 hrs
	Community Services		**Community Services**
1	Able to deliver desirable routine, essential and critical services within the next 6 hours	1	Able to deliver routine, essential and critical services within the next 6 hours
	WMAS		**WMAS**
	(Normal working - all triggers apply)		*(3 out of 4 triggers apply)*
1	Red response for cluster is > 75%	1	Red response for cluster is < 75% for the cluster
2	No out of time referrals for the cluster	2	RRV's are waiting > 15 minutes for back up in the cluster
3	WMAS reporting REAP level 1 or 2 WMAS reporting REAP level 1 or 2	3	5 or less out of time referrals in the cluster
		4	Hospital Turn round issues have been escalated to Senior Management level within the Cluster
		5	WMAS reporting REAP level 2 or 3
	OOH		**OOH**
1	Call volume within forecast	1	Call volume 20% above forecast
		2	Staff redeployed to meet demand
	Hospital Social Care Services		**Hospital Social Care Services**
	(Minimum of two triggers applicable)		*(Minimum of two triggers applicable)*
1	Normal staffing levels available	1	<70% of normal staffing levels available
2	Normal amount of referrals received eg. Section 2 referrals	2	>10% increase of the normal amount or referrals eg. Section 2 referrals
3	<10% above the normal amount are unable to progress	3	>10% above the normal amount are unable to progress
4	Normal team caseload levels	4	10% above normal team caseload levels10% above normal team caseload levels
5	All cases have been assessed within 24hrs of an active Section 5 referral	5	>5% of cases which have not been assessed within 24 hrs of the active Section 5 referral (not due to external factors)

	Level 3 - Severe Pressure		Level 4 - Extreme Pressure
	Acute		**Acute**
1	One or more patients waiting more than 4 hours a decision is unlikely to be made for the next hour.	1	One or more patients waiting more than 4 hours and a decision is unlikely to be made for the next 4 hours.
2	Transfer of Ambulance patient care is between 31 and 60 minutes.	2	Transfer of Ambulance patient care is longer than 60 minutes.
3	There is an expected capacity deficit of between 10% and 20% of expected demand for the next 24 hours.	3	There is an expected capacity deficit of more than 20% of expected demand for the next 24 hours.
4	10% to 90% elective and urgent inpatient work cancelled for the next 24 hours.	4	More than 90% elective work including oncology patients cancelled for the next 24 hours.
5	One or more patients subject to a decision to admit now waiting longer than 8 hours on a trolley.	5	One or more patients subject to a decision to admit now waiting longer than 8 hours on a trolley and at risk of waiting longer than 12 hours.
6	Medical outliers form between 1% and 3% of total inpatient population.	6	Medical outliers form more than 3% of total inpatient population.
7	All Cubicles in A&E are full and patients are waiting in planned overflow areas.	7	All Cubicles in A&E are full and patients are expected to wait in unplanned overflow areas.
8	No formal resuscitation bay available in A&E for the next 30 minutes.	8	No formal resuscitation bay available in A&E for next hour.
9	No Assessment area beds for up to 3 hours minimum.	9	No Assessment area beds for more than 3 hours.
10	Planned additional bed capacity open and more than 80% occupied.	10	All planned additional bed capacity open and full; unplanned capacity in use.
11	More than one ward closed to admissions or discharge due to infection control measures with local restrivtions on visiting.	11	More than one ward closed to admissions or discharge and whole Hospital closed to visitors due to infection control measures.
12	All formal critical care capacity occupied and planned overflow areas in use.	12	All formal critical care capacity occupied and planned overflow areas in use. Potential transfers identified but unresolved.
13	Patient moves required, expected within 4hrs.	13	Patients waiting for appropriate gender beds; non-planned or available.
14	DTOC cases form between 3% and 5% of the inpatient total.	14	DTOC cases form more than 5% of the inpatient total.
	Community Providers		**Community Providers**
	Community Beds		**Community Beds**
	(Triggers 1 to 3 are mandatory)		(Triggers 1,2 & 3 are mandatory)
1	No community bed capacity	1	No community bed capacity
2	Anticipated discharges by next day	2	All additional capacity is open
3	Planned admissions by next day	3	No anticipated discharges within 48 hours
		4	Emergency direct admission being refused (Optional trigger)
	Urgent Care Centres/Minor Injury Unit/ Walk In Centre		**Urgent Care Centres/Minor Injury Unit/ Walk In Centre**
1	95% of patients are treated and discharged between 3 to 4 hrs	1	Time taken to treat and discharge any patients is > 4 hrs
	Community Services		**Community Services**
1	Able to only deliver essential and critical services within the next 6 hours	1	Able to only deliver critical services within the next 6 hours
	WMAS		**WMAS**
	(4 out of 5 triggers apply)		*(2 out of 3 triggers apply)*
1	Red response < 65% for the cluster	1	Red response is < 60% for the cluster
2	RRV's waiting >30 minutes for back up on the cluster	2	Empty status plan for the cluster
3	6 or more out of time referrals in the cluster	3	WMAS reporting REAP level 4 or 5
4	Hospital Turn round times escalated to Director/SHA level within the Cluster		
5	WMAS reporting REAP level 3 or 4		
	OOH		**OOH**
	1. Call volume 20-50% above forecast	1	Call volume > 50% above forecast
	2. Extra resource deployed to meet demand	2	Able to only deliver urgent care
	Hospital Social Care Services		**Hospital Social Care Services**
	(Minimum of two triggers applicable)		*(Minimum of two triggers applicable)*
1	<60% of normal staffing levels available	1	<50% of normal staffing levels available
2	>20% increase of the normal amount of referrals eg. Section 2 referrals	2	>40% increase of the mormal amount of referrals eg. Section 2 referrals
3	>20% above the normal amount are unable to progress	3	>40% above the normal amount are unable to progress
4	20% above normal team caseload levels	4	40% above normal team caseload levels
5	>10% of cases which have not been assessed within 24 hrs of the active Section 5 referral (not due to external factors)	5	>15% of cases which have not been assessed within 24 hrs of the active Section 5 referral (not due to external factors)

9.2 External Escalation Processes - Delivery date: plan in place by 30.09.2018

The Trust's winter plan will be integrated into a system wide winter resilience plan. The system wide Winter Plan is scheduled to be signed off by A&E Delivery Board on 28th of August 2018 with subsequent submission to NHSE early September 2018.

Draft system partner plans include following additional capacity:

Social Care

30 Discharge to Assess beds located at the Worcestershire Step Down Unit, Redhill Nursing Home. This unit was not fully operational until the end of March 2018 and had limited capacity during the summer of 2018 therefore there has been limited benefit to date. This unit is now fully operational and should provide an additional 30 beds of capacity to take patients from the Acute Trust and reduce the number of delayed / stranded patients.

Health & Care Trust

3 additional beds at Tenbury Community Hospital for patients in the west of the county, plus 17 beds on William Astley Ward at Evesham. These will be fully staffed by the H&CT which will make them accessible in the same way as any other community rehab beds.

This will provide an additional 20 beds in total to support the transfer of patients from the Acute trust throughout winter 2018/19.

10. Severe Weather Planning

All Divisional Directors of Operations are responsible for ensuring they have plans in place for each area of their divisions and directorates to continue to deliver services during periods of reduced staffing (e.g. inability to recruit/retain staff; increased demand on services; industrial action; flooding; winter weather).

In preparing for winter, divisions will remind staff that they are contracted to attend work and they should anticipate delays, potential road closures and potential closure of education establishments and that they should make suitable and alternative arrangements to attend work during periods of disruption.

The Trust's corporate response plans for service continuation during times of adverse weather conditions can be found on the Trust's Intranet on the Major Incident Response Plans page. In the event of adverse weather conditions impacting on the Trust's ability to provide normal levels of business, a Command, Control and Coordination structure will be invoked as detailed in the plans. The EPRR Manager is available out of hours for advice and support. It is the responsibility of the COO/DCOO (during office hours) and the On-Call Director (out of hours) to link in with Local Health Economy Partners, NHS England and the Local Resilience Forum for additional support if required.

11. Communication Plans

11.1 Winter Communications Plan - Delivery date: plan in place by 30.09.2017

To manage and reduce the impact of winter pressures the Trust will be working very closely with the CCGs and other local health economy partners to ensure that there is a consistent and clear message being communicated to the population of Worcestershire.

In addition, the Trust will run its own winter communications plan concerned specifically with the pressures experienced at the Trust aligned to the trigger points for escalating communications.

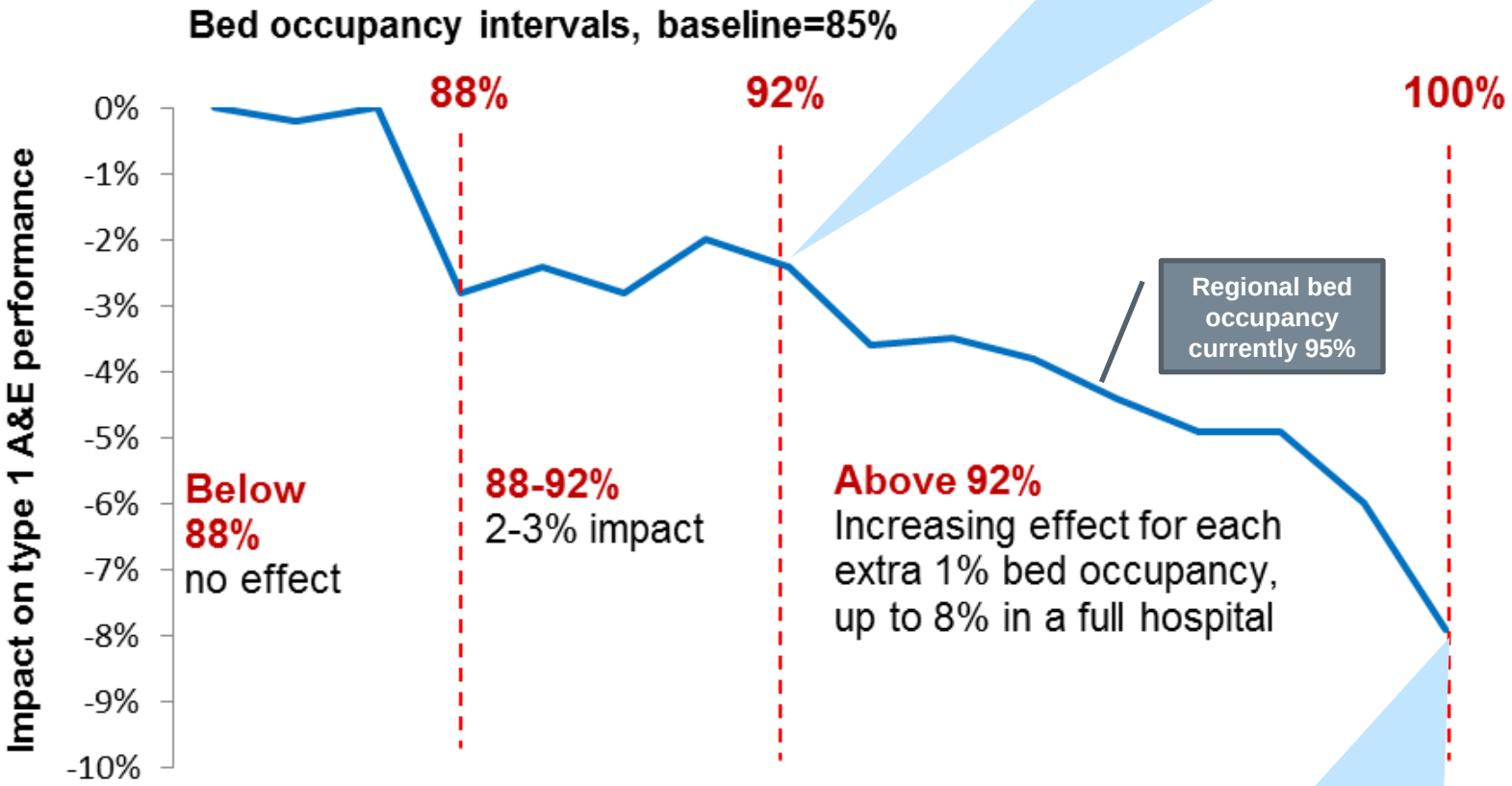
12. Evaluation

12. 1 Hold the date - Delivery date: April 2019 – Lessons Learnt Event

The Trust will undertake a joint evaluation with system partners of the effectiveness of the system wide Winter Plan and actions taken over the winter during Quarter 1 2019/20.

NHSI Analysis – Impact of Bed Occupancy on ED performance

Analysis of last two winters – shows strong correlation between bed occupancy & A&E – tipping point is 92% bed occupancy when effect on ED performance accelerates



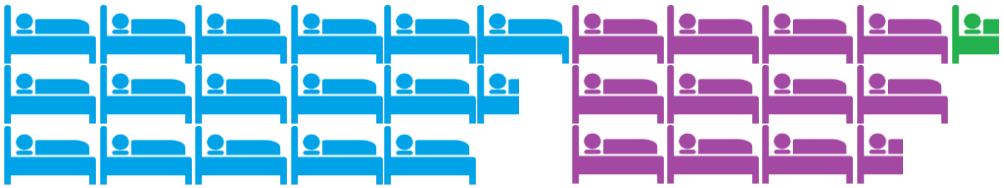
Importance on the need to reduce Super Stranded Patients:

- Super Stranded Patients (>21days) have significant impact on both bed occupancy & bed flexibility
- Super stranded patients – despite making up just 4% of patients they can account for 40% of total bed days for a hospital

Hospitals with 100% bed occupancy – have 8% worse A&E performance than other hospitals with the same characteristics but bed occupancy of 85%

Winter 2018/19 - Forecast with No Additional Beds or Discharge Scenarios

Maximum Forecast Core Bed Stock (Based on 2017/18)

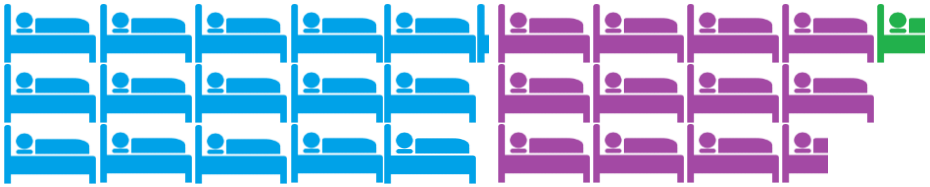


Total Beds
711

Worcestershire Royal Hospital	411 beds
Alexandra Hospital	288 beds
Kidderminster Hospital and Treatment Centre	12 beds

Each bed icon represents 25 core beds.

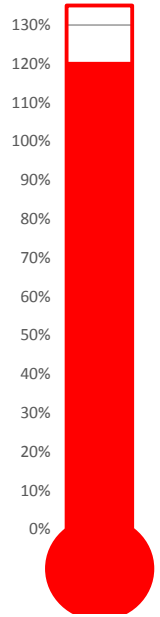
Minimum Forecast Core Bed Stock (Based on 2017/18)



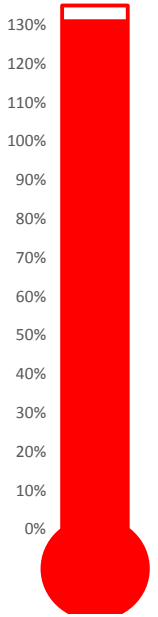
Total Beds
678

Worcestershire Royal Hospital	379 beds
Alexandra Hospital	287 beds
Kidderminster Hospital and Treatment Centre	12 beds

Each bed icon represents 25 core beds.



Average Overnight Occupancy
120%

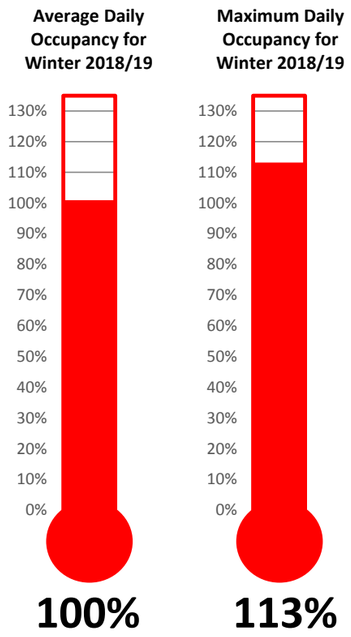


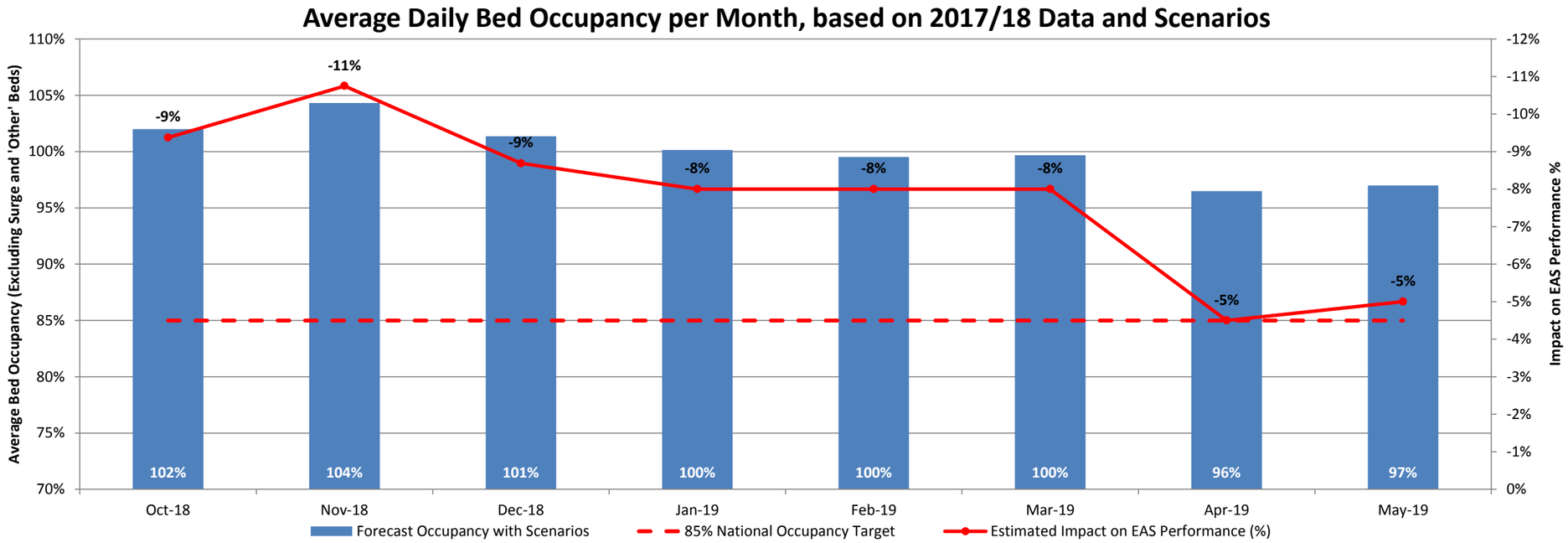
Maximum Overnight Occupancy
131%

*Excludes non-G&A beds and 'surge' beds

Additional Beds Required (or Equivalent Admissions Avoided) to Achieve 92%								
Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Average
172	192	199	232	230	229	202	209	208

Winter 2018/19 Predictive Model





Forecast										
Category		**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Period Aggregate**
Baseline Forecast Occupancy	Average	115%	117%	118%	123%	122%	123%	119%	120%	**120%**
Forecast Occupancy with Scenarios	Average	102%	104%	101%	100%	100%	100%	96%	97%	**100%**
	Minimum	94%	97%	87%	94%	92%	91%	89%	93%	**87%**
	Maximum	110%	113%	110%	109%	106%	108%	104%	102%	**113%**
Estimated Impact on EAS Performance (%)		-9%	-11%	-9%	-8%	-8%	-8%	-5%	-5%	**-8%**
Estimated EAS Performanced (%) **Excluding** Kidderminster and Health and Care MIUs*	*65.48%*	61.1%	59.7%	61.8%	62.5%	62.5%	62.5%	66.0%	65.5%	**62.5%**
Estimated EAS Performanced (%) **Including** Kidderminster and Health and Care MIUs*	*78.79%*	74.4%	73.0%	75.1%	75.8%	75.8%	75.8%	79.3%	78.8%	**75.8%**

**Based on performance as shown for 01/08/2018*

Scenarios (Figures show Scenario Impact per day)										
Scenario Name	**Active**	**Type**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**
Aconbury Beds from October 2018	Yes	Bed			28	28	28	28		
Aconbury Beds from March 2019	Yes	Bed							46	46
Phasing of Elective Surgery (Ward 14 Alex)	Yes	Occupancy				-19	-19	-19		
Frailty Admission Avoidance	Yes	Occupancy	-35	-35	-35	-35	-35	-35	-35	-35
Reduction in Super Stranded patients	Yes	Occupancy				-22	-22	-22	-22	-22
Transfer Medically Fit Patients into Community	Yes	Occupancy	-49	-49	-49	-49	-49	-49	-49	-49
6 Additional Substantive Beds on Alex Ward 11	Yes	Bed	6	6	6	6	6	6	6	6
Average Additional "Stretch Target" Beds Still Needed to Achieve 92%		Bed	75	95	74	62	60	60	35	42
Additional Beds or Equivalent Provided by Scenarios Selected			**90**	**90**	**118**	**159**	**159**	**159**	**158**	**158**