

Shropshire, Telford and Wrekin Winter Plan 2022/23

DRAFT

Version History

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1 Executive Summary

The winter plan communicates the Shropshire, Telford and Wrekin system approach for winter. The plan has been developed using four key methods for sourcing information and collecting feedback:

- Utilising existing system groups
- Targeted work within the System Demand and Capacity Group to develop bed modelling and other impact information
- Individual discussions with identified people across the system to get specific information for the plan
- Utilising existing business cases and documents for information on interventions

The bed modelling has been undertaken to identify an initial most likely case scenario and a worst case scenario shown in figure one.

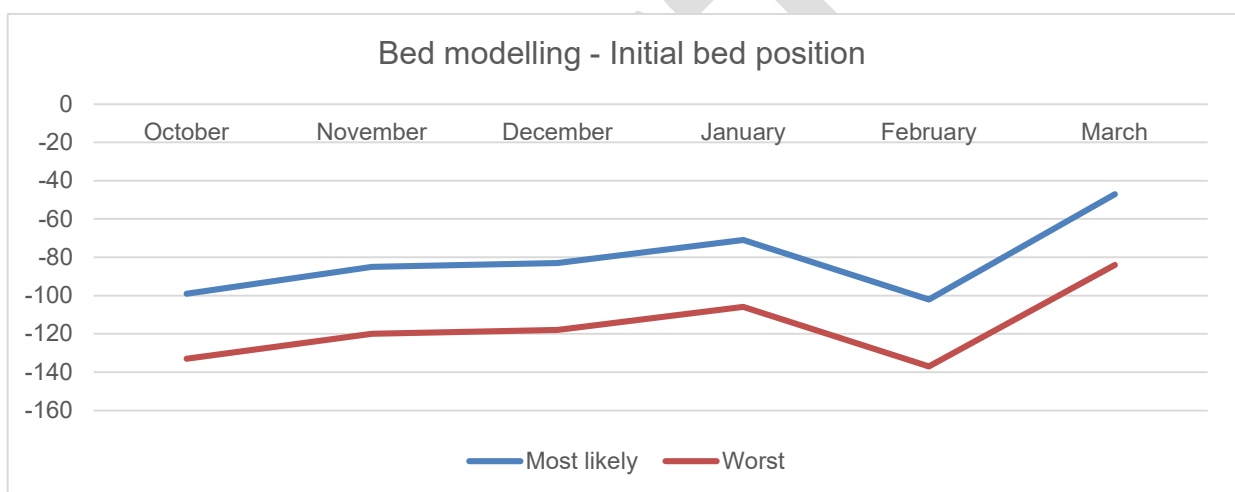


Figure 1: Bed modelling for initial position for most likely and worst case scenario

The modelling shows an average bed gap of 81 in the most likely case scenario and 113 in the worst case scenario.

The interventions and expected impact are outlined in table one.

Table 1: Identified interventions and the expected impact by area

| Area | Intervention | Expected Impact |
|---------------------|---------------------------------|---|
| Primary care | Extended access appointments | 500 hours of extended access appointments per week |
| | Winter funding UEC appointments | 12,927 additional appointments |
| Community | Rapid response expansion | Reduce ED attendances by 6,600 per year Reduce ambulance conveyances by 1,900 per year Reduce non-elective admissions by 2,200 per year |
| | Virtual ward beds | Improve acute bed gap by 38 in October rising to 56 by March |
| | Enhanced therapy support | Reduced length of stay could enable a 20% increase in the number of episodes through reablement beds |
| | Positive Lives Service | Reduce ED activity by 195 |

| Area | Intervention | Expected Impact |
|--------------------|----------------------------|---|
| | | Reduce non-elective activity by 42 Reduce ambulance incidents by 121 |
| Acute | Cohorting capacity | 6 additional spaces in ED |
| | Acute floor | 17 beds in bed model to achieve the initial bed position |
| Social care | Additional reablement beds | Improve acute bed position by 13.5 |

Where the interventions have an impact on the bed model they have been factored in to get to a final predicted bed position for the most likely case scenario and the worst case scenario shown in figure two.

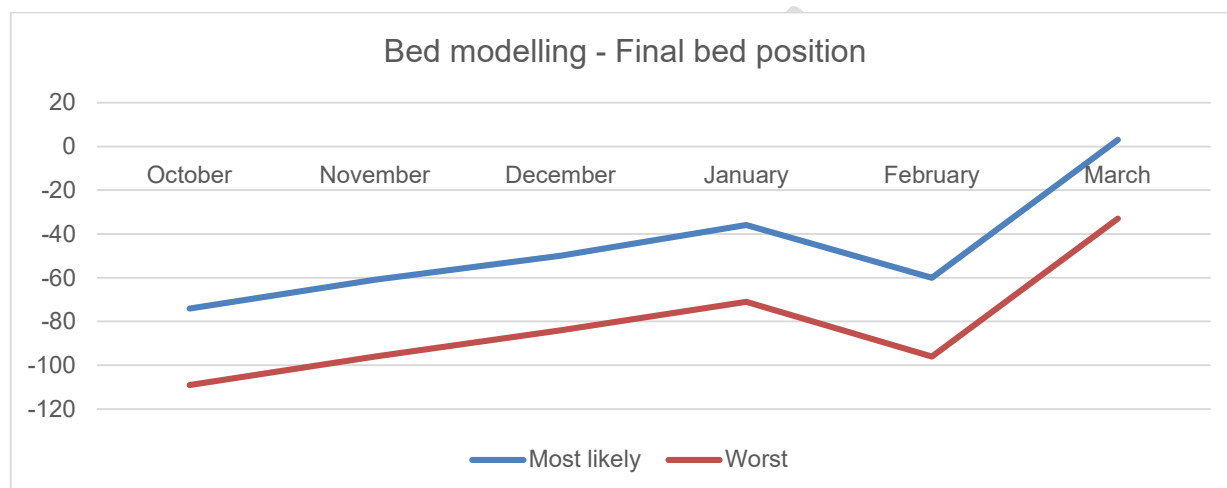


Figure 2: Bed modelling for final position for most likely and worst case scenario

The modelling shows that after the interventions are factored in there is an average bed gap of 46 in the most likely case scenario and 82 in the worst case scenario.

Within the model the bed occupancy rate within the acute trust is set to 92%. One option the system could consider to further bridge the gap is to increase this rate. The impact of this is that flow would be significantly affected and waits within ED would be likely to increase. Some trusts operate well with high bed rates by compensating with more senior workforce, narrowing the gap between beds becoming available and being filled, having timely hospital discharge, more flexible community options, reducing length of stay and delayed transfers of care, and increased use of same day emergency care.

The plan includes summaries of enabling work across the system including:

- Vaccination plans
- Critical care capacity
- Comms and engagement
- Winter surge plans

2 Context

The purpose of the winter plan is to communicate the Shropshire, Telford and Wrekin system approach for winter, the specific pressures that winter presents for our system and how we intend to mitigate them.

Urgent and Emergency Care (UEC) is under significant pressure across the country. Staff have faced one of the busiest summers ever with record numbers of ED attendances, ambulance call outs and another wave of Covid. Despite our best effort staff have not always been able to provide timely access for our patient in the way they would have wanted. The NHS core objectives and actions have been introduced to begin to address these issues:

| Core objective/action | Section of plan |
|---|---|
| Prepare for variants of Covid-19 and respiratory challenges including an integrated Covid and flu vaccination programme. | 5: Vaccination/immunisation |
| Increase capacity outside of acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter | 4.1: Interventions Primary care 4.2: Interventions Community |
| Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999 | |
| Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts | 4.2: Interventions Community 4.3: Interventions Acute |
| Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services. | 4.3: Interventions Acute |
| Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway | 4.2: Interventions Community 4.3: Interventions Acute |
| Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the '100 day challenge'. | 4.3: Interventions Acute |
| Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs. | 4.2: Interventions Community |

The introduction of the new Board Assurance Framework (BAF) gives the system a useful tool to monitor progress against System Capacity Plans, Actions and Good Practice basics and improvement priorities. Alongside the BAF six specific metrics, key to the provision of safe and effective UEC, have been identified.

| Core objective/action | Section of plan |
|---|--|
| 111 call abandonment | |
| Mean 999 call answering times | |
| Category 2 ambulance response times | 4.2: Interventions Community 4.3: Interventions Acute |
| Average hours lost to ambulance handover delays per day | 4.3: Interventions Acute |
| Adult general and acute type 1 bed occupancy (adjusted for void beds) | 4.3: Interventions Acute |
| Percentage of beds occupied by patients who no longer meet the criteria to reside | 4.3: Interventions Acute |

One of the key areas of concern across the system relates to ambulance handover times. The delays in ambulance handovers result from a range of issues across the patient pathway from pre-hospital to discharge back to the correct setting. Evidence shows that full transparency on operational position has a material impact on flow and reducing ambulance handovers and the

development of a new system wide approach to operational management will increase grip within the system. The system Urgent and Emergency Care (UEC) Improvement Programme is our most significant tool in improving ambulance performance, specifically ambulance handover delays. The UEC plan focuses on the set of key actions we believe will have the biggest impact across the UEC pathway and ultimately in improving ambulance performance. In addition, a two phase Ambulance Handover MP summit was held over the summer to focus on briefing MPs on background and specific actions that are being taken under the UEC Programme. The summit noted a number of areas where developments were already having a positive impact on performance including the Single Point of Access, developments in relation to primary care access, increased care home provision and the rollout of the Rapid Response service. The system will continue to focus on delivering the UEC plan. For further details around the UEC Improvement Plan please refer to section 4.3.

For winter 2022/23 there will still be an impact of Covid-19 including the national requirements to continue to rollout the vaccination programme. In addition, other infections and viruses that were not prevalent during the last few years are expected to experience a resurgence, e.g. influenza, norovirus and pneumonia. As part of the plans to increase protection against respiratory virus's ahead of winter, everyone aged 50 and over as well as those who are clinically at risk will be offered a Covid-19 booster and a flu vaccination this autumn. For further details of the vaccination plans please refer to section 5. Communications plans specifically aimed at reducing the spread of infectious respiratory disease are being implemented across the system. For further details of the communications plans please refer to section 9.

A challenging winter and spring in 21/22 with increased urgent care demand and Infection Control Procedures requiring segregation of Covid positive patients has meant that elective activity has not increased to the levels required to treat backlogs and manage demand. Routine elective care has been vulnerable to cancellation when there has been increased emergency pressures. The system needs to balance the requirements of elective recovery with the pressures winter brings to urgent and emergency care. For further details of the elective recovery please refer to section 8.

3 Bed Modelling

3.1 Most likely case scenario

The bed modelling for the acute trust in figure three has highlighted that the average expected bed gap over the winter period would average 81 beds. The average is taken from October to March in the row shaded yellow.

| | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|--|--------------|--------------|-------------|-------------|-------------|--------------|-------------|
| Beds available | | | | | | | |
| Core Bed Base (Adult) | 699 | 669 | 696 | 696 | 696 | 696 | 696 |
| Paediatrics | 36 | 36 | 36 | 36 | 36 | 36 | 36 |
| Day ward | 25 | 25 | 25 | 25 | 25 | 25 | 25 |
| Unused escalation beds | 6 | | | | | | |
| SITREP position | 766 | 730 | 757 | 757 | 757 | 757 | 757 |
| Acute floor | - 24 | - 24 | 17 | 17 | 17 | 17 | 17 |
| Ward 18 | 17 | 17 | 17 | | | | |
| Critical care (elective) | | 14 | 14 | 14 | 14 | 14 | 14 |
| Winter Beds (ICB funded) | | | 7 | 7 | 9 | 9 | 9 |
| Efficiency savings and discharge actions | 15 | 15 | 15 | 15 | 15 | 15 | 15 |
| Occupancy Target @ 92% | - 57 | - 55 | - 61 | - 60 | - 60 | - 60 | - 60 |
| Beds Available to meet patient demand (exc Covid) | 650 | 636 | 705 | 689 | 691 | 691 | 691 |
| Beds required | | | | | | | |
| Non Elective - Total forecast beds occupied | 701 | 675 | 722 | 714 | 713 | 740 | 681 |
| Additional covid/flu activity | 0 | 20 | 26 | 16 | 18 | 8 | 9 |
| Non Electives (inc additional covid) | 701 | 695 | 748 | 730 | 731 | 748 | 689 |
| Elective Activity Plan* | 42 | 39 | 42 | 42 | 31 | 45 | 49 |
| Average Beds required to deliver forecast activity | 743 | 734 | 789 | 772 | 762 | 793 | 738 |
| Average Shortfall in Beds per Month | - 92 | - 99 | - 85 | - 83 | - 71 | - 102 | - 47 |
| Elective recovery | | | | | | | |
| Elective Q1-2 recovery beds needed | 8 | 8 | 8 | 8 | 6 | 9 | 10 |
| Average beds after elective recovery beds added | - 101 | - 106 | - 93 | - 91 | - 77 | - 111 | - 57 |
| Demand interventions | | | | | | | |
| Reverse Queueing | - | - | - | - | - | - | - |
| Virtual ward | 19 | 28 | 28 | 38 | 38 | 47 | 56 |
| Average beds after impact of demand interventions | - 82 | - 78 | - 65 | - 54 | - 40 | - 64 | - 1 |
| Discharge interventions | | | | | | | |
| Additional Reablement beds (NHSE/I funded £1.212m) | | 4 | 4 | 4 | 4 | 4 | 4 |
| Additional Reablement beds (NHSE/I additional funding TBC) | | | | | | | |
| Average bed impact after discharge interventions | - 82 | - 74 | - 61 | - 50 | - 36 | - 60 | 3 |

Figure 3: Bed modelling for acute trust (Most likely case)¹

The initial part of the modelling includes the impact of the following interventions:

- Acute floor. For further details please refer to section 4.3
- Ward 18
- 14 additional beds created in the space previously used as Critical care at RSH (elective)
- Winter beds ICB funded. For further details please refer to section 4.4
- Efficiency savings and discharge actions. For further details please refer to section 4.3

The second section of the modelling shows the beds that would be required for elective recovery to deliver the operational plan. This is what is required over and above the original plan for the period from Oct-March to recover the planned activity lost in the first half of the year due to a mixture of workforce shortages and emergency pressures. This would deteriorate the bed position by a further 8 to 10 beds over the winter period.

The third section outlines the demand interventions. The reverse queuing intervention that has been funded through the ambulance handover plan improves flow within the emergency department but is not predicted to impact on the bed position. The bed modelling includes a line

¹ Assumptions for bed modelling can be found in appendix two

for this intervention for completeness. The virtual ward intervention will help to bridge the bed gap to the value of 28 beds in October through to 56 beds in March. If the virtual ward intervention meets its higher targets over the winter this will further improve the acute bed position. For further details please refer to section 4.2.

The final section of the model outlines the discharge interventions. An additional 16 reablement beds have been funded through the ambulance handover plan. These additional beds help to bridge the bed gap to the value of 4 beds between October and March. For further details please refer to section 4.4.

Further funding opportunities are currently being explored for additional reablement beds. A line has been included within the bed model so that should these funding opportunities come to fruition the model can be easily updated to accommodate.

Likely case final bed position: Average bed gap of 46

3.2 Worst case scenario

| | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|----------------|----------------|----------------|----------------|----------------|----------------|---------------|
| Beds available | | | | | | | |
| Core Bed Base (Adult) | 699 | 669 | 696 | 696 | 696 | 696 | 696 |
| Paediatrics | 36 | 36 | 36 | 36 | 36 | 36 | 36 |
| Day ward | 25 | 25 | 25 | 25 | 25 | 25 | 25 |
| Unused escalation beds | 6 | | | | | | |
| SITREP position | 766 | 730 | 757 | 757 | 757 | 757 | 757 |
| Acute floor | - 24 - | - 24 - | 17 | 17 | 17 | 17 | 17 |
| Ward 18 | 17 | 17 | 17 | | | | |
| Critical care (elective) | | 14 | 14 | 14 | 14 | 14 | 14 |
| Winter Beds (ICB funded) | | | 7 | 7 | 9 | 9 | 9 |
| Efficiency savings and discharge actions | 15 | 15 | 15 | 15 | 15 | 15 | 15 |
| Occupancy Target @ 92% | - 57 - | - 55 - | - 61 - | - 60 - | - 60 - | - 60 - | - 60 - |
| Beds Available to meet patient demand (exc Covid) | 650 | 636 | 705 | 689 | 691 | 691 | 691 |
| Beds required | | | | | | | |
| Non Elective - Total forecast beds occupied | 701 | 675 | 722 | 714 | 713 | 740 | 681 |
| Additional covid/flu activity | 0 | 25 | 31 | 21 | 23 | 13 | 14 |
| Impact of disease outbreaks and temporary care home closures | | 30 | 31 | 30 | 30 | 31 | 31 |
| Non Electives (inc additional covid) | 701 | 730 | 783 | 764 | 766 | 783 | 726 |
| Elective Activity Plan* | 42 | 39 | 42 | 42 | 31 | 45 | 49 |
| Average Beds required to deliver forecast activity | 743 | 769 | 825 | 807 | 797 | 828 | 775 |
| Average Shortfall in Beds per Month | - 92 - | - 133 - | - 120 - | - 118 - | - 106 - | - 137 - | - 84 - |
| Elective recovery | | | | | | | |
| Elective Q1-2 recovery beds needed | 8 | 8 | 8 | 8 | 6 | 9 | 10 |
| Average beds after elective recovery beds added | - 101 - | - 141 - | - 129 - | - 126 - | - 112 - | - 146 - | - 93 - |
| Demand interventions | | | | | | | |
| Reverse Queueing | - | - | - | - | - | - | - |
| Virtual ward | 19 | 28 | 28 | 38 | 38 | 47 | 56 |
| Average beds after impact of demand interventions | - 82 - | - 113 - | - 100 - | - 88 - | - 75 - | - 100 - | - 37 - |
| Discharge interventions | | | | | | | |
| Additional Reablement beds (NHSE/I funded £1.212m) | | 4 | 4 | 4 | 4 | 4 | 4 |
| Additional Reablement beds (NHSE/I additional funding TBC) | | | | | | | |
| Average bed impact after discharge interventions | - 82 - | - 109 - | - 96 - | - 84 - | - 71 - | - 96 - | - 33 - |

Figure 4: Bed modelling for acute trust (Worst case)

The worst case scenario in figure four shows increased demand for Covid, Flu and other respiratory conditions and a deteriorating position in relation to medically fit for discharge patients should the care market also be affected by infection outbreak related closures and/or staffing shortages. The increases can be seen in the two lines in purple text in figure four.

The impact of this increased demand can be seen in the line shaded yellow where the bed gap from October to March would average 113 compared to 81 in the most likely case.

The impact of the interventions is unchanged from the most likely case.

Worst case final bed position: Average bed gap of 82

4 Interventions/Actions

4.1 Primary Care

Demand in primary care is unprecedented, even though General Practice are providing more appointments than before the pandemic. Over 90% of patient contacts in the NHS are delivered through primary care and therefore primary care expect to see the demands on them increase significantly this winter.

| Pressure point for primary care | How primary care will address |
|--|---|
| Increased winter demand whilst managing the impact of the backlog in elective care | Practices will provide additional appointments through locum, agency and extension of existing staff hours as part of the winter scheme ² . |
| Business continuity – the relatively small nature of practices means that anything that adversely impacts on staff numbers covid and other illnesses and recruitment and retention can severely impact their ability to deliver core services | <ul style="list-style-type: none"> Access to work from home for most staff. Clinical remote appointments are now normal practice. Growing number of ARRS roles and strengthening of clinical team Growing number of locums and other clinical staff on the Lantum online booking platform. Number of initiatives underway to improve GP recruitment and retention Business continuity plans in place and tested throughout 2019-2021 Stronger relationships within PCNs to be able to offer support. |
| Rurality; patients being able to access services | <ul style="list-style-type: none"> Remote triage and appointments via phone and video. Use of remote monitoring digital solutions such as Docabo in Care Homes LA support with cost of living grants |
| Delivery of Flu and Covid vaccinations | Early planning and ordering. Models tested in 2021. |

Primary care has acknowledged that changes are required to ensure access to practices by phone is improved. Redcentric, the telephone system supplier, has been commissioned to undertake a piece of work with the practices to provide enhanced bespoke support to understand the call flows. The output from this work will be recommendations for changes to optimise the

² Subject to approval

functionality of the system to improve patient call experience. Practices that are not currently using the Redcentric system have been offered support to commission an enhanced support package from their own service provider. The feedback on the outcomes of this work is expected in September 2022. The impact of this work is that patients will find it easier to get through to practices on the condition that practices are able to maintain sufficient call handling staff. Recruitment and retention of this staff group remains an ongoing challenge for some practices.

The new enhanced access PCN delivered service is the amalgamation of two current services, PCN extended hours and GPFV extended access into a consolidated single consistent offer. PCNs will provide enhanced service access from 6:30pm to 8pm on weekdays and 9am to 5pm on Saturdays. PCNs will provide 60 minutes of appointments per 1,000 PCN population delivered within the hours stipulated. Appointments will be pre-bookable and same day and will offer a range of appointment types from routine, screening, sexual health, LTC management. There will be a range of options from face to face, telephone and online and telephone booking.

As part of the ICB Winter Plan funding a proposal for additional primary care appointments has been approved. This scheme enables primary care networks (PCNs) to increase planned staffing and activity between October and March depending on the individual PCN demand predictions. This increase in primary care capacity will help to prevent attendance at urgent and emergency care portals over the winter period. The scheme will target the appointments to the areas of greatest need.

Impact: 500 hours of extended access appointments per week and 12,927 winter funding UEC appointments

4.2 Community

The Local Care Programme aims to build on existing good practice and develop more systematic, preventative, integrated interventions that will support the independence and wellbeing of residents in our local communities. The following interventions as part of this programme are expected to have a positive impact on admissions avoidance over winter 2022/23:

- Expansion of rapid response service
- Rollout of virtual ward beds to support admissions avoidance.

Rapid Response Expansion

The Rapid Response Service is a multi-disciplinary team that responds within 2 hours to support people with an urgent need to remain well and recover in their usual place of residence. The model promotes a Home First approach and focuses on early intervention and timely discharge.

Impact of rapid response expansion: Reduce ED attendances by 6,600 per year; Reduce ambulance conveyances by 1,900 per year; Reduce non-elective admissions by 2,200 per year

Virtual Ward Beds

Virtual ward beds are being implemented to support admissions avoidance. The aim of the programme is to have 60 beds by the end of September, 120 beds by the end of December and 180 beds by the end of March. A conservative position has been modelled of 50% of the expected beds to be in place each month. This conservative modelling has been made to account for concerns in relation to the ability to recruit and the clinical engagement. The impact of these beds based on expected length of stay follows a ratio of 1.6 virtual ward beds being equivalent to 1 acute bed.

Impact of virtual wards: Improve acute bed gap by 38 in October rising to 56 by March

As part of the ICB winter funding a scheme was supported for enhanced therapy support for pathway two beds between November and March. The scheme aims to further reduce the length of stay within pathway two beds to 20 days and increase the potential capacity.

Impact of enhanced therapy support: Reduced length of stay could enable a 20% increase in number of episodes through reablement beds

The system has commissioned a Positive Lives service from British Red Cross that goes live 1 October 2022. The service will work proactively with individuals who are over-reliant on emergency services and will take its caseload from data including frequent callers to 111, frequent GP practice visitors, frequent 999 ambulance callers and frequent ED attenders. Through new ways of working the service will provide proactive prevention, coaching, support, counselling, and signposting to other services. This will help reduce some of the demand on emergency services.

Impact of Positive Lives Service: Reduce ED activity by 195; reduce non-elective activity by 42; reduce ambulance incidents by 121

4.3 Acute

The current model of delivery for urgent and emergency care (UEC) is under pressure and is not sustainable. High demand is impacting on responsiveness, risk to patient safety and patient outcomes.



Figure 5: Challenges for UEC in STW

The vision for urgent and emergency care in STW remains that it is focused on continuing to transform our services into an improved, simplified and financially sustainable 24 hour/7-day model; delivering the right care, in the right place, at the right time for all our population. The STW UEC Improvement Plan focuses on three specific workstream areas:

- Pre-hospital
- Hospital Improvement and Flow
- Discharge

The plan has been developed following a review of 21/22 UEC Improvement Plan and incorporating learning from winter 21/22 and the Covid-19 pandemic response. It outlines how the system will work together and across the region to ensure the services meet the needs of the local population.

| Pre-Hospital | Hospital Improvement | Discharge | Linked Programmes |
|---|--|---|---|
| <p>Screening, redirection and reducing Ambulance delays</p> <p>Single Point of Access (SPA) development (alternatives to ambulance conveyance to ED)</p> <p>111 Improvements</p> <p>New direct access pathways</p> <p>Enhanced provision for high intensity users</p> <p>Redesign of Pre-hospital Integrated Urgent Care:</p> <p>Development and commissioning of new model of care</p> | <p>Enhanced capacity and reconfiguration</p> <p>Acute medicine footprint (PRH/RSH), ED refurbishment</p> <p>32 bedded ward, Trauma/Frailty assessment, Vulnerability suite</p> <p>Improving Flow</p> <p>ED redirection/ Acute discharge processes incl failed discharges/patient journey facilitators/integration of therapies</p> <p>Maximise the impact of discharge facilities</p> <p>Direct access pathways</p> <p>Trauma/Frailty & SDEC e-referrals</p> <p>Compliance with new ED standards</p> | <p>Appropriate system discharge provision</p> <p>Develop joint commissioning strategy for P2/P3 community capacity/market development</p> <p>Review of re-ablement care</p> <p>Enhanced integrated discharge team (7 Day working/TOM)/alignment with community services</p> <p>Improving Flow</p> <p>implementation of MADE action plans, DTA model development/criteria led discharge/FFA review, revised pathways</p> | <p>Local care programme</p> <p>Enhanced 2-hour crisis response coverage/A2HA</p> <p>Virtual Ward rollout (COVID/Resp/Frailty/other)</p> <p>Enhanced care in care homes</p> <p>Anticipatory care model development</p> <p>Workforce</p> <p>System demand and capacity modelling</p> <p>Mental health (Adults and CYP)</p> <p>Primary care development</p> <p>Place based integration</p> <p>Digital development</p> |

Figure 6: STW UEC Priority Transformation Programmes

| UEC Workstream | Benefits |
|--|--|
| Pre-hospital | Increase direct access pathways by 5 by December |
| | Increase cases from WMAS to Single Point of Access (SPA) to 20 per week by September and 30 per week by March |
| | Maintain 95% of cases from WMAS to SPA diverted away from ED |
| Hospital Improvement | Improve ambulance waits of less than 60 minutes to 89% by November and 97% by March |
| | Improve ambulance waits of less than 15 minutes to 33% by October and 40% by March |
| | Improve the number of patients within 12 hours in ED department from 212 per week to 165 per week by November and 66 per week by March |
| | Improve the percentage of patients seen within 15 minutes for initial triage in ED to 50% by November and 95% by April |
| | Improve the mean time in ED for non-admitted patients |
| | Improve the mean time in ED for admitted patients |
| | Consistently achieve 45% admissions via surgical SDEC |
| | Exceed the national target of 30% admissions via medical SDEC |
| | Reduce GP admissions through ED to 50 |
| | |
| Discharge | Improve percentage of discharges before midday to 17% by November and 25% by March |
| | Improve percentage of discharges before 5pm to 65% by November and 75% by March |
| | Increase use of discharge lounge to 50% |
| | Reduce total stranded bed day delays |
| | Reduce delays for optimised medically fit for discharge patients |
| | Reduce cancelled discharge to 1% of daily discharges |
| | Reduce average length of stay on medically fit for discharge list to 2 days |
| | Reduce number of patients stranded for 14 or more days to 2019 level |
| Reduce number of patients stranded for 21 or more days to 2019 level | |
| Linked workstream – primary care | Deliver 60 minutes of extended access per 1,000 population |
| | Reduce emergency admissions for specified ambulatory care sensitive conditions per 1,000 population |
| | Deliver 5 online consultations per 1,000 population |
| | Reduce emergency admissions per 100 care home residents by 10% |
| | Deliver 0.65 community pharmacy consultations per 1,000 population |

Prior to hospital admission

Many of the actions within the UEC plan will be implemented prior to and during the winter period and will support the system to manage demand. To meet local and national priorities the system will:

- Provide better signposting to all urgent care services available, such as walk-in services, pharmacy care and ED
- Work as a network so that care is given at the right time, by the right staff, in the right place with the right equipment
- Ensure the appropriate links between urgent and emergency care transformation and community service transformation, working closely with primary care colleagues and community teams to meet the needs of patients close to their home/where they live to make sure that only people most in need will go to hospital
- Work with the Ambulance Service to manage ambulance demand, handovers and alternative pathways
- Make sure that the system is using technology to help offer the most up to date services and treatments
- Reshape services where necessary to provide the best patient care and experience

Alternatives to hospital admissions interventions that support acute care by offering other options rather than attending ED will be implemented within the system. For further details please refer to section 4.3.

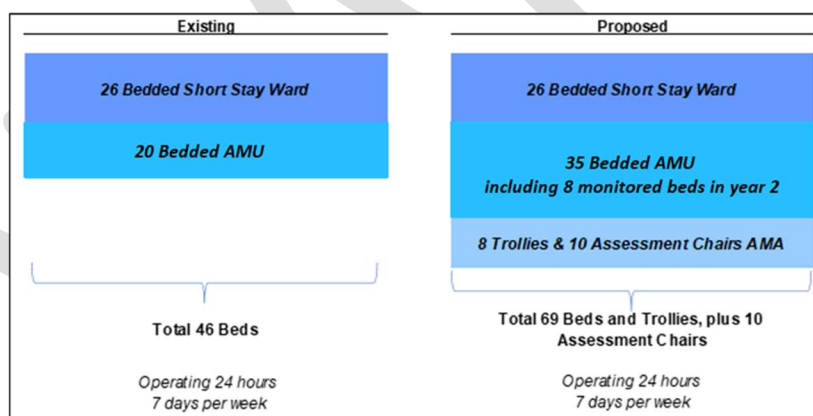
The Ambulance Handover Plan includes the provision of cohorting staff to create additional reverse queuing capacity in SaTH which will help to reduce demand at the front door. The additional SaTH staff for the cohort areas will release ambulance staff from current cohorting arrangements which will reduce/eradicate patients reported as being delayed while they are actual being cared for with the ED environment. The outcome of this investment will be an additional six spaces in ED. The impact of this change will be to improve ambulance handover times.

Impact of additional cohorting capacity: 6 additional spaces in ED

Acute Floor

The system is developing an Acute Floor that creates new pathways and capacity at the front door to support early specialty assessment and direct admission pathways for medicine, orthopaedics and oncology. The proposal creates the following:

- A co-located Acute Medical Assessment area (AMA), a larger Acute Medical Unit (AMU) and a short stay unit
- A co-located trauma and assessment unit and orthopaedic ward
- A co-located oncology assessment area within the oncology ward



Part of the programme will be implemented by the end of December which will have a positive impact on the position over the winter period. These changes will reduce footfall and demand on ED improving performance against UEC measure, reducing ambulance handover delays and improving patient care and experience. This will also improve the working environment for our staff having a positive impact on recruitment and retention.

Impact of acute floor: 17 beds applied within bed model to achieve -81 bed position (most likely case) or -113 (worst case)

Improving flow (including discharge)

As part of the UEC Transformation Programme work has been undertaken to improve patient flow. This work aims to ensure patients are able to move through the hospital in the most efficient way, that supports their care needs and results in care being delivered in the right place, at the

right time, with the most appropriate team. The work has ensured processes are in place for updating systems efficiently and accurately, developed a Standard Operating Procedure for the discharge lounge and improve communications to improve the use of the lounge for all discharges. These changes will all improve the flow within the hospital.

Earlier in the year the ED was reconfigured to ensure the capacity and estates are used to maximum effect and to ensure the most efficient service with the best outcomes for our patients. These changes will help to improve the flow within the hospital over winter when compared to last year.

An ED redirection tool is being introduced to support the audit of attendances that should have been signposted away from ED. This tool is due to go live at the beginning of October as a pilot. The valuable information that will be collected as part of this audit will help the system continuously improve flow throughout the winter period.

The system has developed a Discharge Alliance Plan targeted at improving discharges from acute care. The plan includes the implementation of a number of 100-day challenges for completion by the end of September:

| 100 day challenges | Actions |
|--|---|
| <ul style="list-style-type: none"> Identify patients needing complex discharge support early Ensure multi-disciplinary engagement in early discharge planning Set expected date of discharge within 48 hours Ensuring consistency of process and documentation in ward rounds Streamline operational transfer of care hubs Revise intermediate care strategies to optimise recovery and rehabilitation | <ul style="list-style-type: none"> Developing Trusted Assessors Reigniting End PJ Paralysis work Completion of Therapy Review Encourage patients to take responsibility for their mobilisation Develop criteria led discharge Develop evidence based expected date of discharge Complete IDT review to embed key Discharge to Assess including Home First as a principle Consider case management approach across IDT |

North Bristol Pathway

<Awaiting information about critical care from SaTH (Karen Evans)>

4.4 Social Care

The ICS recognises the need to support the care market and knows the impact upon health if it does not work as a system collectively to support and manage the care market to ensure continued sustainability and high quality provision.

The system needs to have the right resources and work collectively to ensure continued throughput and flow out of the acute and community hospitals and even more importantly preventing the need for admission.

The system will continue to work together to address the workforce issues across the system and with LA's targeting areas of high risk such as the domiciliary care and care home sector.

The ICS will work with Care Providers and in particular care homes to manage safe discharges and support them to manage outbreaks and reduce the risk for hospital admissions.

This winter it will be more important than ever to work as one system, we will not only have the pressure from both covid and flu; we will also have the additional pressures as a result of the cost of living crisis play out which could enhance the pressure on health and other services taking it to another scale. In order to address this the LA's are working across a number of organisation to support its communities. Across Shropshire a Task Force focusing on the rising cost of living and its social impact locally. The forum provides an opportunity to bring a range of stakeholders together to share their knowledge of the impact and support available for our population and communities. Members include CAB, Age UK, Councillors, SPIC, Shropshire Food Poverty Alliance, Marches Energy Agency, Energize, Qube, Police, Landau, Headteachers, DWP, LEP, ICS, SATH and Shropshire Council (housing, welfare, food insecurity, communications, public health, libraries, economic development, affordable warmth). The Task Force continues to meet monthly to look at gaps and further actions stakeholders can take jointly within Shropshire to support our residents struggling with the cost-of-living increases, with a focus on ensuring that the most vulnerable in our community are supported.

- 1) Review capacity across the system to support people in Shropshire with the cost-of-living crisis. Consider which resources and skills are available. Triage and offer specialist support for those in need.
- 2) Improved information sharing between partners in relation to the cost-of-living crisis to ensure that partner organisations are kept informed of up-to-date information on assistance available so they can cascade to the people they support (e.g., Household support fund, HAF scheme).
- 3) Joint working to create protocols around more common debts.
- 4) Workforce training/Improved signposting information for frontline staff and volunteers to boost their knowledge of support available and increase confidence to hold difficult conversations around the increases in the cost of living.
- 5) Data & Insight. Continue to review what insight is held on groups most likely to be impacted by the cost-of-living crisis. Plan an event to learn what data is available.
- 6) Work with Stakeholders to review the Household Support Fund allocation to date.
- 7) Joint communications on the cost-of-living crisis highlighting help available, including panels on Shropshire Radio. Key messages include: Encouraging householders to contact Marches Energy Agency (MEA) now for help with energy efficiency measures over the summer to help householders get ready for Autumn/Winter & Energy advice. Communications around how to make best use of the £650 government support payment. Promotion of Breathing Space to prevent government support payments being allocated to overdraft/debt repayments/rent arrears.
- 8) Assessment of the impact of the cost-of-living crisis on the workforce, including how it will impact their ability to effectively do their jobs. A key focus on workers on lower incomes, particularly the impact on carers.

Local authorities continue to support the system through prevention for example scoping further use of technology solutions to support discharge and prevent admissions. Social prescribers continue to work with those who need help and support, information and guidance to direct people away from primary care and acute services where appropriate and engage people within their communities to remain healthy and independent.

As part of the ICB winter funding two schemes were supported to provide additional reablement beds across the county to support timely discharge from acute care. The proposal delivers the following additional capacity:

- 28 beds from November to March
- An additional 10 beds from January to March when demand is higher.

The impact of the additional reablement beds has been built into the system demand model in section 3.

The Ambulance Handover Plan includes some additional bed-based interventions commissioned through the local authorities with 16 further reablement beds, capacity

Impact of reablement bed: Improve acute bed position by 13.5

4.5 Mental Health

Midlands Partnership Foundation Trust (MPFT) has been working closely with the third sector to develop non-clinical alternatives to broaden the Crisis Intervention support, which should lead to reduced need for admission and reduce the need for inappropriate out of area placements. As part of improving access to 24/7 support to patients an all-age mental health crisis helpline has been extended since last winter to include professionals supporting children and young people within the access team.

As part of the Dementia Transformation Programme the development of a Dementia Crisis Service is being planned. This will establish and build on the current Hospital Avoidance offer piloted by Midlands Partnership Foundation Trust and provides assessment and treatment of older people with mental health problems. The interventions are focused on maintaining people in their own home/care environments and facilitating early discharge from hospital. The key aim of the service is to reduce ED attendances and support early discharge from acute care.

Since last winter MPFT has appointed Mental Health Practitioners within the Primary Care Networks. These roles are integral to the multi-disciplinary team who will support people presenting with mental health problems to achieve overall wellbeing.

In addition, STW ICS has been allocated a small amount of funding to support children and adults mental health over winter and discussions are currently underway across system partners to agree and develop a range of suitable schemes.

4.6 RJAH

Mutual aid for elective orthopaedic work will be delivered over the winter period through a combination of:

- Work undertaken at RJAH by RJAH workforce
- Work undertaken at RJAH by SaTH workforce
- Additional work commissioned by the independent sector

Sheldon

The Trust's activity plan is based on the 5 beds on Sheldon ward being utilised for elective activity within the Trust as the commissioned capacity for care of the elderly provision is 15 beds. If these beds were repurposed for winter care of the elderly capacity this would create an impact on elective delivery for the Trust and the system which in turn would impact on the elective recovery fund (ERF) delivery.

MCSI

Current pressures with West Midlands for acute Spinal Cord Injury (SCI) beds remain at unprecedented high levels requiring us to work closely with NHSE to ensure patients are being managed safely until they can be admitted to The Midland Centre of Spinal Injuries (MCSI). This bed demand and capacity mismatch results in patients having to wait much longer in MTC's, DGH's (including RSH and PRH) and local hospitals prior to admission to the specialist SCI

centre. MCSI also has bed pressures attributed to re-admissions; primarily urology, pressure ulcer and rehab wait lists.

We propose to ringfence 3 beds Sheldon beds for appropriate MCSI patients and 2 beds for rheumatology elective recovery. The casemix of patients planned these beds impacts on the staffing requirement for the ward. The expenditure budget only allows for staffing for rheumatology / metabolic patients on the ward. If some of the beds were re-purposed for Spinal Cord Injury, funding would be received from NHS England to flex the required staffing levels to support the different casemix on the wards. As the beds are planned to be used for elective Spinal Cord Injury rehab activity re-purposing to MCSI will not impact on the elective delivery plan.

The Networked model of care bid that was successful earlier in 2022, is now being operationalised and will provide and enhanced outreach support across the West Midlands. As the Network Model of Care is intertwined with the current MCSI Surveillance Team, this will positively impact both MTC's and DGH's within the West Midlands

4.7 Remaining Bed Gap

Following the identified interventions there remains a predicted bed gap in our Acute Hospital. In the most likely case scenario the bed position averages -46 beds and in the worst case scenario this averages 82.

To address this the system may need to consider some unpalatable options. Within the bed modelling in section 3 there is an assumption of a bed occupancy rate of 92%. The system may need to consider increasing the bed occupancy up to 100%. The impact of increasing bed occupancy rates is that flow would be significantly affected and waits within ED would be likely to increase. Some trusts do operate well with high bed rates by compensating with more senior workforce, narrowing the gap between beds becoming available and being filled, having timely hospital discharge, more flexible community options, reducing length of stay and delayed transfers of care, and increased use of same day emergency care.

5 Vaccination/Immunisations

Covid-19 Context

As we transition from a period of pandemic emergency response to pandemic recovery, the focus is increasingly on protecting those in society who continue to be more at risk of severe COVID-19 infection. To achieve this, a planned and targeted vaccination programme is considered more appropriate than a reactive vaccination strategy.

The Shropshire, Telford & Wrekin (STW) COVID-19 vaccination programme has been very successful in ensuring good uptake across the system and has regularly been one of the best performing systems both regionally and nationally. Our work amongst our underserved communities and those with health inequalities has been used as an exemplar in regional briefings. The programme has successfully worked with all system partners to achieve this success.

Delivering a sustainable COVID-19 vaccination programme, is an essential mainstay of health prevention. We will make vaccination services accessible to all eligible groups, including those affected by health inequalities by:

- Ensuring there is sufficient capacity across the system to safely deliver a sustainable COVID-19 vaccination programme to the eligible population.

- Ensuring we have a skilled and competent workforce to deliver the programmes safely
- Develop a vaccination offer that provides convenience and ease of access across the system. This will include outreach sessions and focused work that addresses inequalities and harder to reach communities.
- Ensuring that the vaccination offer is consistent utilising a combination of fixed centres and roving/pop-up sites
- Develop contingency plans for periods of surged activity (for example new COVID-19 variant response)
- Develop a coordinated vaccination programme that incorporates co-delivery of other vaccinations when possible and that Makes Every Contact Count (MECC) by incorporating appropriate health advice/screening in line with the NHS Core20PLUS5 approach.

Covid-19 Vaccination Programme

The following groups of people will be eligible for an Autumn Booster according to the current JCVI Guidance (as at September 2022):

- a. residents in a care home for older adults and staff working in care homes for older adults
- b. frontline health and social care workers
- c. all adults aged 50 years and over
- d. persons aged 5 to 49 years in a clinical risk group, as set out in Tables 3 and 4 of the Green Book Chapter 14a
- e. persons aged 5 to 49 years who are household contacts of people with immunosuppression (as defined in Tables 3 and 4 of the Green Book)
- f. persons aged 16 to 49 years who are carers (as defined in Table 3 of the Green Book)

The system continues to offer 1st and 2nd doses to those that have not yet received those doses as part of our 'Evergreen' service.

During the Autumn campaign we will use a blend of providers; PCNs, Community Pharmacies, Hospital Hubs and a Vaccination Centre located across the county. Pop-up clinics and roving teams will also be utilised by the programme to ensure we maximise potential to reach our eligible cohorts. Our COVID-19 Vaccination sites will offer both booked and walk-in appointments. We will have a total of 28 static sites delivering COVID-19 Vaccinations to all eligible groups through the Autumn 2022 campaign.

Shropshire Community Trust will deliver the COVID-19 vaccination control clinic for people who have severe allergies and anaphylaxis once a month from the Royal Shrewsbury Hospital (RSH) site. The service will see approximately 10-15 patients per clinic. The team will be looking to move the referral route into this service to the e-referral system to make it more effective.

Seven of our PCN's have signed up to deliver the COVID-19 Vaccination service to their mandated cohorts within the Enhance Service Specification commissioned by NHS England. The mandated cohorts are:

- Care home residents and staff (to be completed within 10 weeks)
- Housebound patients
- Immunosuppressed patients

Our eighth PCN, Shrewsbury, only the 5 rural GP Practices within this PCN will be delivering the COVID-19 Vaccination service to the mandated cohorts. SCHT will be delivering the COVID-19 Vaccination service to the remaining patients who fall within the mandated cohorts. SCHT will

work closely with those Shrewsbury PCN practices to ensure patient lists are shared in line with data protection guidance.

Three PCNs will also be delivering to all eligible groups (Teldoc PCN, South East Shropshire PCN and South West Shropshire PCN). Teldoc PCN are currently available on the National Booking System (NBS), and the other two PCNs are being encouraged to use the NBS for Autumn campaign. This will enable us to articulate simple and consistent public facing communications around how to access autumn boosters.

The Autumn campaign will see the introduction of more Community Pharmacies offering a COVID-19 Vaccination, particularly in those hard-to-reach areas of the county. Following a Community Pharmacy expression of interest exercise managed by NHS England, we were able to pick which new Community Pharmacies we wanted to deliver COVID-19 Vaccinations in our system to add to our capacity. We have asked for an additional 11 Community Pharmacy sites to be commissioned by NHS England to deliver the service to ensure we have enough capacity within our system to deliver the Autumn campaign within timeframes. These sites are currently going through an assurance process with NHS England.

SCHT will deliver the COVID-19 Vaccination service from 3 Hospital Hub sites and 1 Vaccination Centre:

- Royal Shrewsbury Hospital
- Princess Royal Hospital
- Coral House, Shrewsbury
- Robert Jones and Agnes Hunt (RJAH) Vaccination Centre

The priority cohort for the Hospital Hub sites will be Frontline Health and Social Care Staff working in STW.

The weekly available maximum capacity to deliver vaccinations will be 31,152 across the system, with the ability to increase capacity to 40,000 vaccinations per week in a surge situation. The system must prioritise this capacity to ensure that 100% of our care home residents and staff are offered a vaccination within the first 10 weeks of the campaign.

The Autumn campaign is forecast to deliver 210,786 vaccinations by 15th January 2022. This equates to 50% of the STW adult population. Of the forecast activity, 70% is forecast to be delivered by our Community Pharmacies, 16% by our PCNs, and 14% by SCHT. Based on historic data, the programme team are forecasting week commencing the 26th September to be the peak week of activity with an estimated 28,287 vaccinations being administered.

Covid Surge Planning

The Covid-19 Vaccination programme has developed a surge plan to be implemented in the event demand exceeds available capacity. The plan is outlined below:

1.e. COVID-19 Vaccination Campaign Autumn 2022 Surge Plan

Shropshire, Telford & Wrekin (STW) COVID-19 Vaccinations programme has a weekly available maximum capacity to deliver vaccinations will be 31,152 across the system, with the ability to increase capacity to 40,000 vaccinations per week in a surge situation. In discussion with our PCN and CP partners, it is expected that they would need up to a week to ramp capacity up to surge levels.

| Local Authority Engagement | Demand Planning | Capacity Planning | Workforce Plan |
|--|---|---|--|
| <ul style="list-style-type: none"> • Contact made with the director public health team to agree joint planning arrangements • Discussion taken place about local authority support which can be provided – estates, call centre capacity | <ul style="list-style-type: none"> • Unvaccinated population data reviewed • Vaccine equalities tool utilised to understand underserved locations and populations • Geographical areas mapped and scoped for increased existing site activity • New and additional pop-up locations identified in partnership with local communities • Communications plan in place – local media, social media, online content and leaflet drops • Community, faith groups and third sector contacted to agree supportive marketing plan to increase vaccination in underrepresented groups • Requesting councillors and community leaders to increase their visible support of vaccinations and share 'pop-up' plans to raise awareness and stimulate demand | <ul style="list-style-type: none"> • Maximisation of current network capacity (e.g. extending opening hours) • Maximise utilisation – 'sweating' existing assets to ensure maximum capacity from existing sites (e.g. additional clinics/estate capacity at existing sites) • Identifying additional sites either by delivery model type or outreach model e.g. pop-up, buses etc. • Appropriate technology secured to support onsite clinical administration • Local booking service (simply book) in place to handle expected demand • Walk in sites identified • Clinical protocols reviewed for existing and new site operations • Consumables ordered and secured for new sites/pop-ups • Fridges ordered • Cold chain logistics scoped and mapped | <ul style="list-style-type: none"> • A site by site roster / workforce plan detailing shift dates, times and role requirements has been developed – clinical, support and volunteers • The national protocol has been implemented for new and pop-up activity sites to maximise resource allocations • Lead employer contacted to secure locally recruited resources and draw down from national suppliers • Rapid contingency staffing solutions from NHS Professionals and St John Ambulance engaged • Local system mutual aid requested • Site level induction and daily stand ups scoped into daily roster to ensure safety and clinical skill briefings |

The COVID-19 Vaccination Programme team will work closely with system partners to ensure that during periods of surge the system is supported both in the response to COVID-19 Infection and increasing demand for COVID-19 Vaccinations. As a system our aim is to manage our response appropriately while minimising impact on our elective care activity. The system will stand-up the Gold, Silver and Bronze escalation governance structure and procedure. Members of the COVID-19 Vaccination Programme Team will attend system Gold, Silver and Bronze calls.



Improving Lives In Our Communities

Flu Vaccination Programme (included last years section until further information available)

The flu vaccination programme will be starting in September for adults aged over 65 and those identified as at risk. All 51 practices will be offering flu vaccines with 31 practices offering them alongside Covid vaccines. The majority of practices will be offering the flu vaccine at practice level with a small number offering them across the PCN footprint. The latest start date for practices will be week commencing 10 October. There is an aspirational target for over 65s of 75% and for those under 65 who are risk of 65%. The delivery of vaccines will be monitored at a practice level on a weekly basis and will be shared across the PCNs.

6 Critical Care

<Awaiting information about critical care from SaTH and critical care collaborative (Andrena Weston). Expected date: 15 September>

7 Infection Prevention and Control

Winter 22/23 is expected to see higher than average influenza rates, the return of norovirus outbreaks and a further wave of COVID19 with the potential for new variants as the population regains normal social activity. Shropshire Telford and Wrekin have the following measures in place to address this.

- Arrangement with primary care out-of-hours provider to prescribe flu prophylaxis to those meeting the clinical requirements.
- COVID19 Medicines Delivery Unit (CMDU) 7 days a week.
- Care home IPC support including local outbreak management, support and a prompt re-opening review process supported by a SOP.
- ICS wide IPC group to share best practice, standardise approaches to guidance implementation, learn from outbreaks and monitor infection rates.
- Pre-winter review of ventilation in inpatient/residential health and care settings.
- Pre-winter review of learning from outbreaks in NHS providers to inform outbreak management practice.

- ICB engagement in all outbreak meetings across the system.
- Provider local policies and processes to maintain safe respiratory pathways and prevent the spread of infection.

8 Workforce

Workforce plans outlined within the operational plan are expected to improve the workforce position when compared to last winter. Some of the key actions are outlined in table two.

Table 2: Workforce plan actions and the expected impact

| Actions | Impact |
|--|---|
| Ongoing proactive recruitment including international recruitment | To reduce vacancies |
| Use of rotational or shared posts | More attractive offer for potential employees |
| Increased support to international nurses | Improve retention |
| Improved health and wellbeing support to staff | Reduce sickness absence Improve retention |
| Trauma and resilience management (TRiM) pathway. Support to people who have experienced a potentially traumatic event. | Reduce sickness absence Improve retention Improve staff wellbeing |
| Staff psychological wellbeing hub. Support, advice and triage for anyone worried about their mental health | Reduce sickness absence Improve retention Improve staff wellbeing |
| Tools for understanding burnout/stress and building resilience | Reduce sickness absence Improve retention Improve staff wellbeing |
| Tools to support carers and families | Reduce absence Improve staff wellbeing |
| Transition from vaccination workforce to surge/winter workforce | To have access to a workforce that can be deployed across the system during times of surge |
| Embed a sustainable reservist model across the system | To have access to a workforce that can be deployed across the system during times of surge |
| Increased use of apprenticeships | From September increased use of apprenticeships within radiology, orthopaedics and nursing associates |

9 Elective Care and Cancer Elective Recovery

Waiting lists nationally have grown following the Covid-19 pandemic. A challenging winter and spring in 21/22 with increased urgent care demand and Infection Control Procedures requiring segregation of Covid positive patients has meant that elective activity has not yet increased to the levels required to treat current backlogs and manage current demand. Routine elective care has been vulnerable to cancellation when there has been increased emergency pressures with lack of interim bed capacity to support discharge and staff absence to a level that is outside of seasonal norms.

During the winter period our three main hospitals within the system, two acute sites and the specialist orthopaedic hospital, will aim to continue to provide elective surgery to minimise any potential impact on waiting lists. There is recognition that this will be a challenge due to the large bed gap (set out above) that has been identified through the demand and capacity modelling.

The system will continue to use the independent sector capacity both in and out of area (due to the limited capacity within the local system) as well as mutual aid provision through agreement with other NHS providers.

All three providers will also continue to focus on Outpatient transformation with increased focus on virtual appointments and Advice & Guidance to maintain activity levels when capacity is constrained.

Given the likely pressures in the system there will be increased promotion of the “My planned care” app to ensure patients are kept informed of the status of their pathway

The system has identified a number of actions through the operational planning which will contribute to elective care recovery over winter including:

- Fully scoped the use of alternative outpatient and diagnostic capacity including mutual aid and independent sector both in and out of area (due to the limited capacity within the local system).
- Optimising the use of patient-initiated follow-up for patients to release capacity
- Increase in stratified follow ups for cancer patients
- Improving theatre utilisation
- Improving theatre scheduling to align to specialties at risk of cancelling routine patients and to maximise operational hours
- Implement process to backfill patients in terms of short notice cancellations
- Review of operating models and community pathways to implement improvements
- Implementation of teledermatology
- Increased use of virtual consultations
- Optimising the use of advice and guidance by launching new process in advance of winter

The system will continue to implement the System Escalation Policy which on OPEL level 3 and 4 requires a review of elective care activity to ensure there is sufficient capacity to meet the non-elective demand. As part of this review, electives relating to cancer treatment or that are clinically urgent will be prioritised and providers will aim to maximise this activity through existing capacity.

Elective Transformation

The system is undertaking a major transformation programme relating to developing new ways to provide outpatient services. The work is well underway and includes optimised use of advice & guidance, patient initiated follow up discharges, virtual consultations, remote monitoring, nurse-led telephone follow ups and 1 stop clinics all of which, combined, is reducing the number of people requiring face to face appointments in the acute; thereby reducing physical demand in SaTH and RJAH.

An added benefit of this more efficient way of working and providing outpatient service is releasing capacity in the acute hospital. This includes the ability to reutilise clinical space, clinical or admin time that would otherwise be used for face to face appointments.

The system is undertaking a piece of work to review and validate waiting lists with the ambition of reducing follow up waiting lists by 25% by March 2023 which will reduce elective care pressures within the system.

There is a risk to elective care over the winter in that urgent care pressure take priority which results in elective activity getting suspended and clinical and operational colleagues being diverted to support with dealing with these pressures. This may compromise progress of some of the elective care work.

10 Communications and Engagement

The aim of the STW winter comms campaign will be:

- To empower the citizens of Shropshire, Telford and Wrekin to keep well this winter
- Ensure our health and social care system runs as smoothly as possible
- Reducing ambulance handover delays

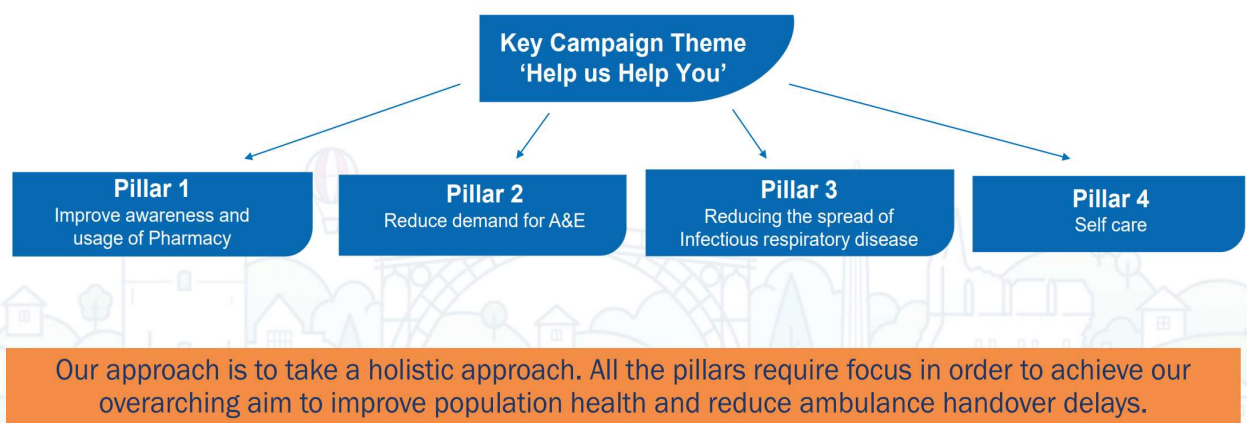


Figure 7: Overarching winter comms campaign and pillars

Pillar 1: Improve awareness and usage of Pharmacists

The system conducted interviews with residents, pharmacists and GPs with the STW system to gain insight on the role and barriers to using pharmacy. The key finding of this were:

- A significant proportion were not aware that the pharmacy offered advice and treatment of minor ailments
- The highest rated benefit of a pharmacist was the fact that no appointment was needed followed by receiving faster answers
- The lowest satisfaction was the ability to talk in private

Drive awareness of the wide range of advice and treatment offered by Pharmacists, whilst, highlighting the speed in which you can be seen.

Pillar 2: Reduce demand for A&E

The attendances at A&E between April and June were analysed to gain insight into behaviours. The key findings were:

- Over half of attendees fell into categories indicating minimal or no investigation or treatment was necessary, with 75-80% of these relating to soft tissue injuries
- These attendances are most likely to happen in the evenings

- These attendances are slightly more prevalent amongst our younger and less affluent populations

Drive awareness of when to use A&E, alternatives to A&E (NHS 111 & MIU) and highlight everyone's part in making our system run well this winter

Pillar 3: Reducing the spread of infectious respiratory disease

As we move into colder months viruses such as flu and Covid are more likely to spread quickly when people are crowded together. Cold weather can also make some health problems worse and even lead to serious complications, especially for those aged 65 and over. This can put additional pressure on our hospitals. We can reduce the spread of respiratory disease by:

- Keeping vaccinations and boosters up to date (Flu and Covid)
- Hygiene: Hand washing
- Staying home when ill
- Masks (in some settings)

Drive awareness and need of minimising the spread of respiratory disease this winter and actions they can take to minimise the risk

Pillar 4: Self care and maximising your wellbeing

We can raise awareness of important self-care techniques that will help people and their families to stay well and help ease pressures on local health services:

- Simple steps include eating well, taking daily vitamins and staying active
- Wrapping up warm whilst you're out and about this winter
- Stocking up on self-care essentials (OTC medicines, at pharmacies and supermarkets, help relieve many common symptoms of illness)
- Look after yourself, your loved ones, and your neighbours, and get the right care in the right place

Drive awareness of how to keep yourself, your family, and neighbours healthy this winter by doing all you can to stay healthier

Comms Strategy

| | |
|-----------------------------|---|
| Paid social media | <ul style="list-style-type: none"> • Hyper target and localise to creatively reach audiences who fit our key segments • Unlimited adverts running at once |
| Youtube | <ul style="list-style-type: none"> • Key channel to drive awareness • Build short form video content |
| Programmatic Display | <ul style="list-style-type: none"> • Ads on news and entertainment sites showing only to people likely to be ready to change behaviours |
| Radio | <ul style="list-style-type: none"> • Split into traditional and Instream to ensure multiple demographics targetted |
| PR | <ul style="list-style-type: none"> • Use close links with local media to amplify the campaign and focus on good news stories |
| Digital toolkit | <ul style="list-style-type: none"> • Pull together a digital toolkit containing campaign assets for partners to share |
| Maildrop | <ul style="list-style-type: none"> • Targetted maildrops around the local hospitals and areas of low cost hospital attendance • Posters and leaflets distributed by partners to target hard to reach groups |
| Loading page content | <ul style="list-style-type: none"> • Launch a campaign page on the NHS Shropshire, Telford and Wrekin website |

11 Risk Analysis

The system has identified a number of risks to the delivery of the winter plan and these are outlined in table three.

Table 3: Risk summary

| Risk Description | Mitigating actions |
|--|--|
| The winter schemes implemented could address unmet need which would meant that the expected impact was not achieved | Work with project leads to identify key measures and milestones for monitoring. Closely monitor winter schemes to identify if they are addressing the expected cohorts. |
| The system may not be able to change the established behaviours of its workforce | Use the clinical leadership within the system to drive change Comms and engagement with key stakeholders to ensure workforce is informed and involved |
| The system may not be able to change the established behaviours of patients and the general population | Comms and engagement with our population. For further details please refer to section 9. |
| The system may not be able to recruit to the required posts which could affect the ability to deliver the expected changes | Implement workforce plan in relation to recruitment. For further details please refer to section 7. |

| Risk Description | Mitigating actions |
|--|--|
| The system may have to rely on agency staffing which will be more costly than planned | Implement workforce plan. Ongoing monitoring of use of agency staffing. For further details please refer to section 7. |
| The system may destabilise another area with its recruitment to additional posts by creating an internal market | Implement workforce plan in relation to recruitment. For further details please refer to section 7. |
| The system may not be able to manage competing priorities e.g. additional Covid-19 waves | Regular monitoring of demand and review of plans |
| The inconsistency in relation to 7 day working across the system may affect the ability to manage out of hours discharge | Regular monitoring of impact at weekends. Planning discharges early to mitigate impact of weekend discharges |
| The large expected bed gap may not be able to be bridged | Interventions detailed throughout the winter plan. For further details please refer to section 4. |
| The system may not be able to effectively manage walk in demand for urgent and emergency care | Managing demand through interventions identified. Ongoing monitoring of walk-in demand for urgent and emergency care. For further details please refer to section 4. |
| The system may not be able to effectively manage admitted demand for urgent and emergency care | Managing demand through interventions identified. Ongoing monitoring of ambulance and prebooked demand. For further details please refer to section 4. |
| The impact of infections, e.g. Covid-19 or influenza, may be underestimated which could destabilise the system | Modelling of impact and projections to be monitored for early warning. |
| The impact of unexpected severe seasonal weather on the system ability to deliver services | Business continuity plans |
| The system may not be able to effectively deal with the conflict between dealing with system recovery and the winter demand | Ongoing monitoring of elective recovery and winter demand. For further details of interventions relating to elective recovery please refer to section 8. |
| The system may not be able to identify the capacity for EMI to meet the demand | Quantified as part of demand and capacity modelling |
| The system may not be able to manage the specific workforce constraints within theatres and radiology | Plans in place to manage specific workforce constraints within theatres and radiology |
| The impact of the market issues relating to domiciliary care may restrict flow out of hospital or reduce the number of patients able to be discharged home | Ongoing monitoring of market for early identification. For further details please refer to section 4.4 |
| The impact of market issues relating to community bed based care may restrict flow out of hospital | Ongoing monitoring of market for early identification. For further details please refer to section 4.4 |
| Capacity in people team to develop plans | Work with System Planning and Performance Group to identify resource requirements in relation to planning |
| Independent sector capacity is not at sufficient scale to mitigate gap in NHS capacity | Ongoing monitoring of independent sector capacity. Maximise use of available independent sector capacity. Explore mutual aid arrangements. |

A full risk register with mitigating actions will be developed to coincide with the move into the implementation stage which will be owned by the System Planning and Performance Group.

12 Surge Plan

<Awaiting update following surge planning meeting held 9 Sept>

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Appendix one: Engagement activities

| Engagement | Impact |
|--|---|
| Winter planning workshop held in June with representation from health and social care | Launched process for winter proposals. Identified areas of focus for winter planning. Information from breakout sessions fed into demand and capacity work and winter plan. |
| Non-elective demand and capacity group with representation from health and social care | Demand and capacity information used to frame winter plan. Identification of assumptions and known interventions |
| Head of Planning and Systems Operation (SCHT) | Covid vaccination information for winter plan |
| Director of Communications and Engagement (ICB) | Communications winter planning summary for the winter plan |
| Head of Elective Care and Transformation (ICB) | Elective care section of the winter plan |
| Associate Director of Primary Care (ICB) | Primary care section of the winter plan |
| Director for Local Care Programme (SCHT) | Local Care Programme impact for winter plan |
| Assistant Director of Joint Commissioning (Shropshire Council) and Place Based Strategic Commissioning Procurement Lead (Telford and Wrekin Council) | Social care section for winter plan |
| Service Delivery Manager: Hospital and Engagement (Telford and Wrekin Council) | Discharge Alliance Plan for inclusion in the acute interventions section of the winter plan |
| Centre Manager, Patient Access, Theatres, Anaesthetics and Critical Care (SaTH) | Critical care section of the winter plan |
| Head of Mental Health and Transformation (ICB) Head of Operations (MPFT) | Mental health section of the winter plan |
| Surge Planning Meeting with RJAH, SaTH, SCHT and ShropDoc | Surge plan section of the winter plan |
| Interim Deputy Chief Operating Officer (SaTH) | Finalising acute bed modelling used to frame winter plan |
| Operational leads | Feedback requested – none received |

Updates provided to the following groups at various points between June and September:

- Chief Executive Group
- Urgent and Emergency Care Board/Group
- Systems Planning Group

Where documents have been submitted to UEC group and other relevant forums these have been used to develop the plan e.g. acute floor business case.

Appendix two: Assumptions for bed modelling

The assumptions that apply to both scenarios for the bed modelling are outlined below:

- Demand is forecast based on the historic trend of non-elective discharges and bed days from January 2019, excluding the period March 2020 to April 2021. This uses a linear regression model where the algorithm takes the impact of underlying changes in LOS, MFFD patients and admissions and accounts for seasonality. The training data for the model extends to July 2022 to take into account the significant changes that have occurred in bed days utilisation over the last few months and ensure these are captured in the forecast. Total bed day usage and discharges are forecast separately and these can be used to calculate the change in length of stay, however this is not a specific input into the model itself.
- Covid – These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Flu - These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Norovirus - These are included in the baseline forecast as drivers of historic activity over winter and throughout the year. Additional demand is included from October to January, to allow for a disproportionately high winter season
- Length of stay (LOS) – The change in LOS is calculated from the forecasted change in bed days and discharges. This 22% higher than the 19/20 position on average, with higher LOS in the winter months. As this calculated from other fields, it is not possible to revise the model by changing the increase in LOS alone.
- MFFD – MFFD patients are included in the training data, starting from the current high baseline of around 145. These will increase over winter with the seasonal increase in bed days seen in previous years but are not a separate part of the model that can be altered. Therefore, the additional impact of the 38 extra winter pressure funded reablement beds (calculated from the acute discharge demand & capacity model) is already accounted for within this model.
- Elective demand – this is taken from the operation plan for 2022/23
- Capacity – Bed base changes year on year based on improvement and developments. The acute floor development through the autumn means that there are significant ward changes through this period.
- Virtual ward – A conservative position has been modelled of 50% of the expected beds to be in place each month. This conservative modelling has been made to account for concerns in relation to the ability to recruit and the clinical engagement. The impact of these beds based on expected length of stay follows a ratio of 1.6 virtual ward beds being equivalent to 1 acute bed.
- Winter beds ICB funded and reablement beds – The impact of these beds follows a ratio of 4 reablement beds to 1 acute bed due to differences in expected length of stay.

The additional assumptions that apply to worst case scenario for the bed modelling are outlined below:

- Covid - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line
- Flu - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line

- Norovirus - Additional impact is also factored in around the closure of care homes on LOS, see "impact of disease outbreak" line
- Impact of disease outbreaks and temporary care home closures - Worst case assumption that disease outbreaks will affect discharge pathways and increase LOS of P1 and P3 patients by 50% from their 22-23 position. Use this to calculate an additional bed day utilisation for these patients and therefore beds needed

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