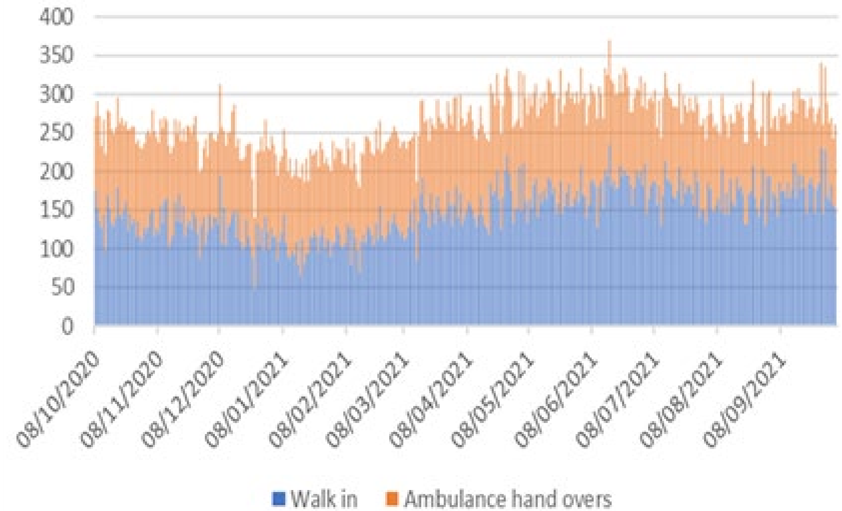
Western Locality Winter Plan 2021/2022

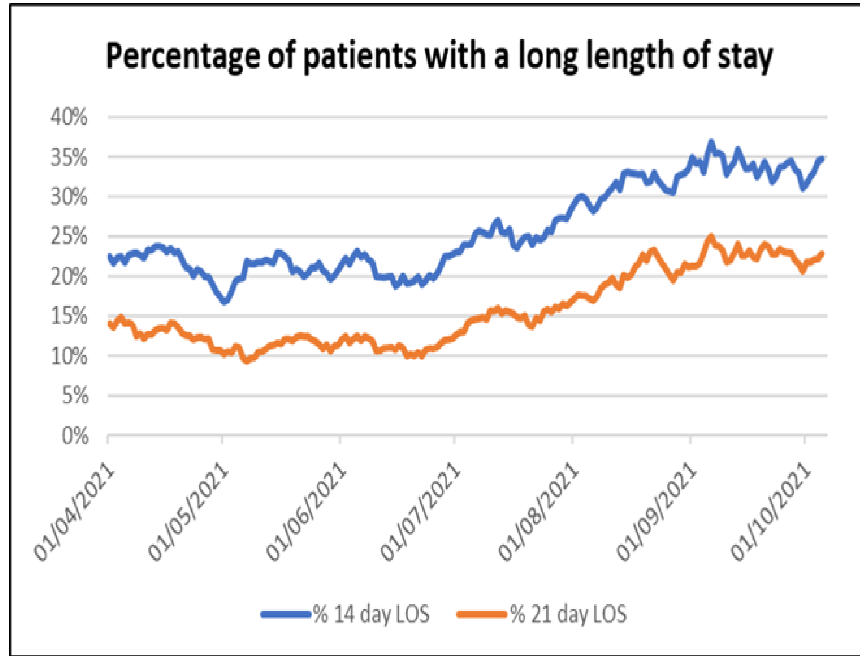
Introduction and Overview

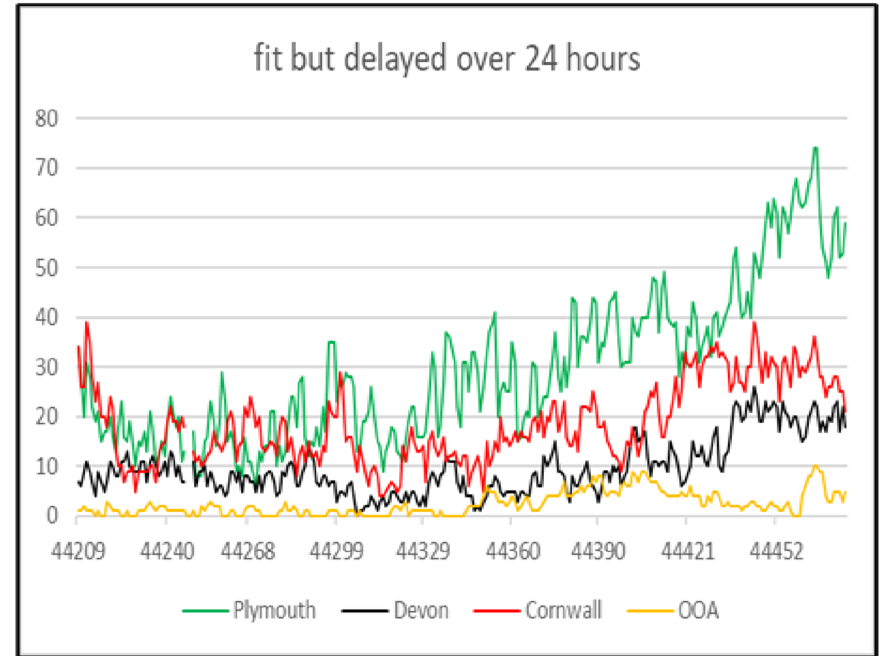
The western system moves towards winter with a number of key challenges. The system is under severe pressure, working at OPEL escalation level 4 for most of the time, resulting in the need for agile commissioning with wider system escalation solutions, including mutual aid and cross provider solutions, with continual challenge to achieve the constitutional standards.

Current Position – Emergency Dept



Current Position – Length of Stay





Priority Issues

For the system

- Workforce capacity and capability across the whole system but especially community capacity for onward care from hospital
- Ensuring robust plans are in place for potential increases in COVID and respiratory illnesses
- An acute trust with a known capital footprint which historically could not meet demand and is not of a size which can accommodate increasing numbers of people. The capacity is continually at risk of being saturated with small increase in people or ambulances and has been impacted further with social distancing rules although many of these have now been risk assessed and relaxed

Primary care and community

- Supporting the stability, capacity, and resilience of primary care
- Reducing demand for inpatient admission to UHP – which is higher than desirable but is true demand based on triangulated evidence
- Maximising uptake of community alternatives to admission & ED attendance, such as Community Crisis Response and First Response (Mental Health)
- Managing community expectation – availability of primary care/ use of ED / self-help/ impact of longer waiting times
- Care home fragility and domiciliary care capacity, especially if there are further covid peaks.
- Ability to maintain and offer capacity over a seven day period

Hospital front door.

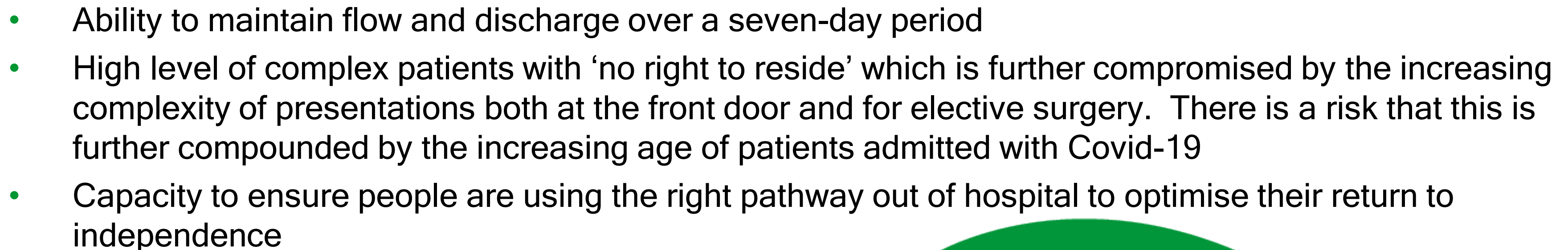
- Handover delays for ambulances
- Social isolation issues in ED and impact on flow
- Admission Avoidance Teams - Patient arrivals who could be treated in other pre hospital services

In hospital issues

- Providing sufficient alternatives to prevent unnecessary admissions e.g. SDEC
- Need to maintain elective capacity as the Tertiary provider in the system to address extensive waiting times created by COVID
- Need to preserve emergency capacity as the Major Trauma Centre (and dealing with associated repatriation)
- Keeping low length of stay and low levels of delay in discharge

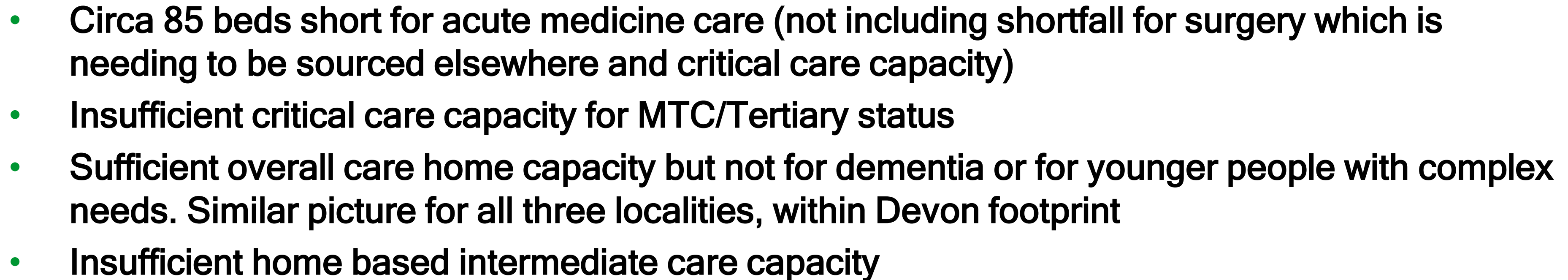
Back door of the hospital

- Ability to maintain flow and discharge over a seven-day period
- High level of complex patients with ‘no right to reside’ which is further compromised by the increasing complexity of presentations both at the front door and for elective surgery. There is a risk that this is further compounded by the increasing age of patients admitted with Covid-19
- Capacity to ensure people are using the right pathway out of hospital to optimise their return to independence



Demand and Capacity

The locality has used a combination of information supplied by CCG Business Intelligence Team, UHP modelling and local H&SC community capacity analysis to identify the challenges for the forthcoming winter.



Summary

- Circa 85 beds short for acute medicine care (not including shortfall for surgery which is needing to be sourced elsewhere and critical care capacity)
- Insufficient critical care capacity for MTC/Tertiary status
- Sufficient overall care home capacity but not for dementia or for younger people with complex needs. Similar picture for all three localities, within Devon footprint
- Insufficient home based intermediate care capacity

Planned Increase In Capacity - Beds

Additional capacity	Oct	Nov	Dec	Jan	Feb	Mar	Notes and risks
Woodland villa beds	12	12	12	12	12	12	Must be kept full, virtual ward oversight
Care Hotel Plymouth	12	32	32	32	32	32	Must be kept full, virtual ward oversight
Woolwell					10	10	CQC and staffing
W&PCV centre				12	24	24	Staffing and capital development reliant
South Hams Super surge beds	3	3	6	6	6	6	Staffing dependent
Cornwall Patient Hotel in Newquay		6	6	6	6	6	Commences 8.11.2021 (35% of 20 beds Plymouth facing)
Bodmin and Cornwall Cares – short stay blocked beds		x	x	x	x	x	Date for commencement to be confirmed
Total 'true' additional beds	**27**	**53**	**56**	**62**	**90**	**90**	
Impact of prevented admissions		x	x	x	x	x	TBC
Impact of reduced delays 5% target		25	25	25	25	25	Based on august data.
Total efficiency improvement		**25**	**25**	**25**	**25**	**25**	

Demand and Capacity – Home Care

Additional capacity	Oct	Nov	Dec	Jan	Feb	Mar	Notes and risks
Plymouth - additional hours per week							
25wte additional staff being recruited by Livewell.		60	100	140	180	210	Recruitment dependent (figures based on oct/nov).
Additional IAH plan for increasing capacity		50	100	150	200	250	Ongoing recruitment increasing numbers, but also need to address attrition
Layering process \ as per DCC to maximise staff time.							Challenge that recruits from each other rather than new capacity.
Additional end of life specialist support							Link with D2A project and CHC, expecting incremental increases.
GSW for care hotel Abicare		70	70	70	70	70	Employed under hotel.
GSW for short placements from stroke ward.							
GSW increase in existing services.							
SHWD additional hours per week (except PA is cases)							
Overtime/agency capacity - hours of care		200	200	200	200	200	Deploy through STS
Review for sufficiency project	5	10	15	20	25	30	
Training and guidance for providers reducing double-handed care	TBC						
Increase use of shared lives home from hospital for P1 and P2							Shared lives host resource development required
Increase use of Personal Assistant market	2	2	2	2	2	2	Package per week
Kernow							
Cap removed from Dynamic purchasing (post STEPs)	TBC						
£1200 grant	5-10						On going

Winter Challenges

- Elective restoration and recovery
- Primary care resilience
- Bank Holidays
- Communications
- Mental health
- Infection control

Risks

Risk	Mitigation	RAG rating
Additional effort and capacity introduced to community urgent care gets left unused.	• Virtual ward set up • Change in bed bureau model • Daily oversight of utility using proactive calling to homes/hotel.	
Insufficient primary care capacity leads to greater use of ED	• Actions to increase wrap around care for primary care and practical options. • Local and Devon wide communications about use of primary care and other options	
High conveyance levels lead to high handover delays.	• Active support by SWASFT of alternatives • Refining the use of the call stack interventions. • Dynamic conveyancing model pursued.	
Insufficient workforce for all home care leads to delays in discharge.	• Purchase of alternative holding capacity • Recruitment initiatives • EOL right size work • Enhanced triage pilot.	
Continued COVID prevalence reduces access to care homes and acute beds	• Dynamic risk assessment approach to closing and re-opening facilities for admissions. • Support from QAIT and IPC teams • Support from care home liaison service. • Access to testing and rapid results.	
Over prescription continues and exhausts capacity	• Enhanced triage pilot. • Redesign of bed bureau with improved communication and oversight of requests. • Additional social work on site to ensure patient choice at centre of decisions making.	
Flow over weekend weak and impacts on rest of week workload.	• Review of escalation process with particular attention paid to presence of decision makers at the weekend. • Review plans for operational services over seven days, including discharge team. • Reintroduction the hospital discharge lead • Agreement of the role of the winter director • Seven-day ward round and review process • Seven-day access to community provision • Additional trauma lists at weekends (to prevent wait for Monday). • Additional diagnostics in place – USS and CT already actioned. • AAU opening seven days per week although nurse led on Sunday pending recruitment.	
Overuse of bed capacity – need to maintain 92% occupancy to enable restoration of elective care	• Demand initiatives to be successful. • Reduction in delayed discharges and length of stay for all people. • Increased use of SDEC and frailty services.	
Continued COVID prevalence impacts on ward and staffing capacity.	• Dynamic review of IPC processes and regulations. • Application of national covid testing and isolation rules.	