Plymouth Approach to Winter 2023

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Introduction

As part of the system planning approach annually, the local NHS is required to undertake winter planning to ensure appropriate system preparedness and actions undertake to provide resilience through the winter period.

To support this process, NHS England published a national approach to 2023/24 winter planning, and the key steps to be taken together across all parts of the system in England to meet the challenges ahead. These are not just in ambulance services or emergency departments - recovery requires all types of providers to work together to provide joined-up care for patients.

There are four main areas of focus:

1. Continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place.
2. Completing operational and surge planning to prepare for different winter scenarios.
3. ICBs should ensure effective system working across all parts of the system, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.
4. Supporting the workforce to deliver over winter, including protecting the public and the health and care workforce against flu and other infectious diseases - the best way being by vaccination. Providers should also ensure they have an established pathway for identifying patients at-risk of COVID-19 and flu in their care, including those who are immunosuppressed.

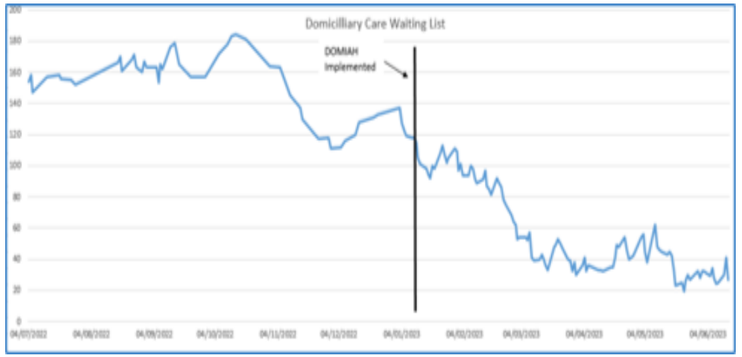
There are a number of initiatives in place to prepare for winter, including the recovery plans developed for UEC, Elective and Primary Care which have been developed as part of the Operational Plan 2023/24

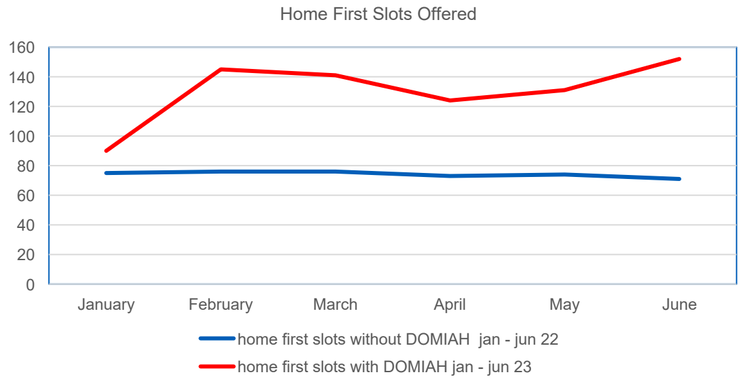
Evaluation of Winter Schemes 2022/23

- In considering our approach to the forthcoming winter, we have undertaken a review of our learning from last winter.
- During the winter period 2022/23 a number of schemes were established covering admission avoidance, ambulance handovers and discharge capacity
- Approach undertaken was driven to respond to real-time pressures and modelled gaps in demand and capacity modelling, but in some cases was constrained by limitations on funding rules (e.g. block bed requirements)
- Schemes built on prior year investments (e.g. Care Hotel), but also evolved to trial different approaches (e.g. bridging service)
- For each of the 2022/23 discharge initiatives a full review of each scheme was completed as part of the project ‘wash-up’. This considered the effect of the scheme and key learning for future years set out in review document.

What went well? Discharge & Flow…

- Robust local escalation processes with engagement from all partners empowered to take tactical actions to support the system
- Adoption of prior year schemes allowed for rapid deployment and learning enabled optimised delivery
- Use of out area workforce so as to avoid destabilising the local social care market and enable rapid delivery
- The ‘DOMIAH Bridging Service’ bought significant additional dom care capacity with a significant impact on waiting lists and reablement capacity
- Some schemes have been incorporated into BAU approaches and pathways throughout the year e.g. Dementia 1:1 and Admiral Nurse offer
- Implementation of increased VCSE provision and review of pathways to maximise utilisation
- MADE Events held across winter with subsequent action plans with engagement across system partners (within Plymouth and Devon/Cornwall)
- Better engagement with out of area commissioners as a result of MADE events and joint work including shared use of Plymouth Care Hotel to support Cornish flow
- The combination of approaches had a demonstrable impact on discharge capacity and flow as is demonstrated in the improvements made in NCTR from mid-January onwards





What went well? Admission Avoidance

- Development of Acute Respiratory Infection Hubs at pace, majority delivered by primary care with additional resource for ED & patient communications
- Continued development of Safe Bus increased activity and providing alternative to ED
- Funding of pharmacist to support SMR's in Care Homes
- High Intensity Users programme – focused Population Health Management approach to communities (e.g. success of work with Marjon's college) and Health Inclusion Pathway Plymouth programme (for people who are homeless or have similarly complex needs)
- Flexed use of Urgent Community Response services to support escalation within discharge and admission avoidance
- ICOPE model supporting completion of CGA's for individuals to identify frailty and offer an enhanced MDT for individuals with moderate & severe frailty – joint approach across primary care and community services for 5 PCN's
- Introduction of District Nursing Specialist Practitioner to support complex case management
- Reintroduction of face to face crises cafes to support people in mental health crises and reduce admissions to acute services
- First Response 24/7 crises line providing advice, support and guidance for people experiencing mental health difficulties

What could have gone better…

- Sustainability and costs of use of external agency staff
- Short notice nature of funding, funding typically non-recurrent, rules around use of funding along with situation with workforce availability limited the options for use
- Remote nature of provider management resource for additional capacity did result in some operational challenges
- Gaps in long term strategic planning led to short term tactical actions with risk of destabilising some areas of system flow and partnership working
- Many of the schemes depended on bed-based offers (i.e. care hotel and block booked care home beds) which worsened the DTA profile and has been demonstrated to lead to poorer outcomes for individuals, increased discharge cost and longer-term dependency on care – this is evidenced in the significant increases seen in long term placements in Plymouth
- Duplication of requests for information from wider system and Region
- Urgent Treatment Centre remained at reduced opening hours and some short notice closures due to demand on service continued to be seen, however, demand shifted to the new hours of operation
- Falls response service was mobilised but anticipated referral levels were not met
- Further focus needed on admission avoidance activity to respond to maximise impact of additional support services mobilised (e.g. Immedicare Care Home Support & High Intensity Users support service)

Approach to winter 23/34

Evaluation of last winter with system partners has informed development of our approach to this winter:

Admission Avoidance

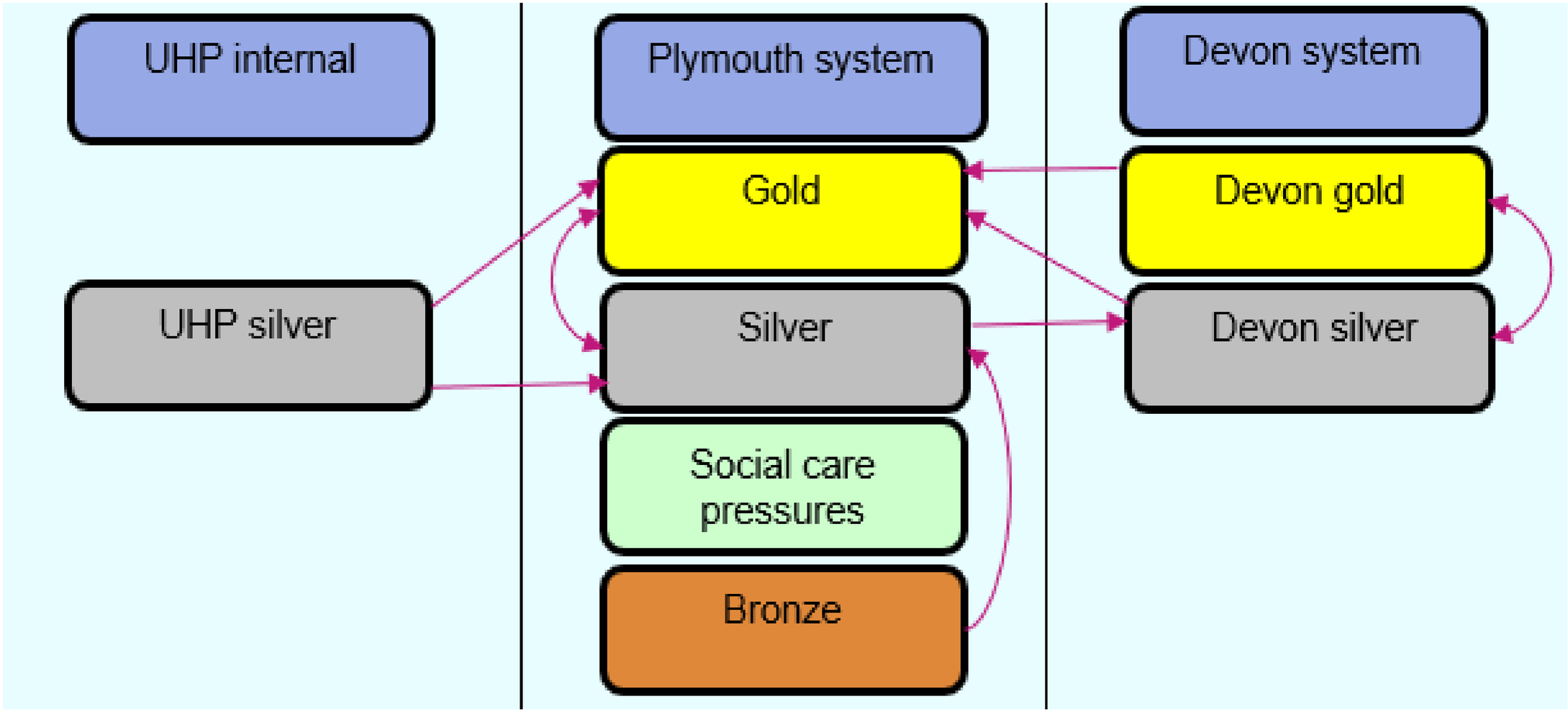
- Review of recurrently funded D&C schemes (community & acute) with reconfiguration/recommissioning of services to maximise impact – including support for Mental Health
- Development of admission avoidance LES with local GP practices
- By Nov 23 all 8 PCNs will be mobilised using iCOPE and Ageing Well MDTs
- Targeted High Impact Change Model to reduce Care Home conveyances to ED – twice weekly review to identify learning and plan actions to respond (e.g. prioritisation of e-TEP)
- Extension of Immedicare service to ensure continuation through winter and support
- GP streaming service – improving rota fill and utilisation
- Cumberland UTC investment to achieve 95% performance and increasing opening hours

Approach to winter 23/34

Hospital Discharge

- Detailed demand and capacity analysis has underpinned our development of our model for Intermediate Care in Plymouth to reshape our offer, deliver sustainability of capacity and improve outcomes for individuals
- This approach has quantified the gap in Pathway 1 capacity and our need to focus additional investment at Homefirst activity to deliver this rebalance
- Our learning from the DOMIAH bridging service demonstrated the positive impact of a flexible service that manages any periods of capacity constraint in the wider social care market
- The Plymouth system is proposing to develop a peripatetic care offer staffed with reablement trained workers that can respond to local need. We are working with partners to finalise this, but envisage a 2 phase approach enabling initial mobilisation by November with agency staff before moving to a more sustained model hosted locally using international recruits
- We are reshaping our bed-based offer to align to best practice and improve P2 outcomes

How Plymouth Partners will work to ensure safety and performance



Multi agency approach to maintain a de-escalated locality

- Community Approach
  - Development of updated Community Patient Flow and Escalation Management Policy considering the new OPEL Framework to ensure a consistent approach to local and system escalation. This will provide a response to escalation and resilience planning and managing capacity across the system. This will:
    - Contain business as usual actions to maintain flow and resilience
    - Surge plans and tactical actions to use in times of escalation across the system.
    - On a team by team basis to identify specialist services that could be stood down to support those critical to maintaining flow within the system.
  - Implementation and oversight of the escalation policy will be delivered through local escalation processes to support ownership of risk-based decision making
  - This will build on and formalise recent reactive approach to meet escalation demand and enable a more proactive planned approach. (Recent examples of this include refocusing community DTA team into UCR, redirecting community staff into front/back door of acute)
  - A task and finish group including key stakeholders (UHP/LSW/PCC/ICB) has been established to complete this work over the next 3 weeks and will be presented to the Western Unscheduled Care Board on 16th October 2023 for sign off by system partners.

Multi agency approach to maintain a de-escalated locality

- Admissions Avoidance
  - Daily silver calls reviewing admissions avoidance performance with tactical decisions to focus admissions avoidance capacity where required
  - Out of Hospital Cell to enable standardised approach to community integrated teams redistribution of resource and triggers
  - Review of AA services and schemes concluded with targeted investments to increase Falls and HIU services
  - Examples of tactical actions – Care Home call before convey process, increasing availability of urgent primary care response with a model of integrated working which also promotes the production of TEPs in urgent care pathways
  - Increased Acute Respiratory capacity – arrangements being finalised

- Primary Care
  - Responding swiftly to escalations concerning pressure in Primary Care (Devon-wide approach)
  - Further implementation of the Primary Care Sustainability plan including improvements at the interface with acute, community and VCSE and communications and engagement
  - Actioning any opportunities raised through Improvement Week (w/c 25/9/23)

No Criteria to Reside (NCTR) Improvements

- Weekly MADE events throughout winter with senior representation from system partners to:
  - Deliver collaborative working, momentum and improved performance, not only through the event but over the following week, that would provide an improved bed state/occupancy.
  - Review occupancy and capacity plans, both from within the acute trust and in the community, and review social care provision
  - Identify how partner organisations would be able to proactively manage short notice requests for additional capacity/resources
  - To identify issues that require workstreams to improve both processes and communication
- NCTR Working Group established reviewing performance data to identify trends and gaps in capacity. The group are developing key improvement actions to improve the NCTR position and reporting to the Discharge to Assess Improvement Group (joint UHP, Livewell, PCC, ICB group) to provide oversight and assurance
- Development of NCTR waterfall plan to identify key actions/capacity to ensure sustained improvements through winter (aligned to Intermediate Care Plan for Plymouth)

UHP: Executive Summary

- Plan takes an Integrated approach to winter across UHP and Healthy Lives Partnership
- Sustained demand in 23/24 has required a review and reframe of capacity gap even ahead of modelling for winter.
- This means we have needed to reprofile the baseline for an additional 13% emergency admissions (plan was 2%) and account for higher NC2R at 14% (plan was 7%
- All in the context of an earlier winter illness peak in week 26 (Southern Hemisphere learning) and continued business continuity disruption from industrial action
- Projecting our staff and their health and wellbeing remains a priority and we are aiming for a 75% vaccination uptake
- In the context of above
  - an unmitigated winter position is 150 beds deficit (baseline/worst case)
- Our assessment of the most likely scenario is reducing the **150 bed deficit to 30 by these 5 priority mitigations:**
  - **Additional physical capacity-** We will be opening an additional **35 beds**, 12 at the end of October and 23 at the end of Jan
  - **Additional virtual capacity-** We will maintain 50 additional virtual ward beds but be aiming for >80% occupancy, this increases our capacity by **25 virtual wards beds**
  - **LOS**- We will be **maintaining the LOS improvement** we have made in community and acute beds this has delivered a 1 day reduction in community and a 0.5 day in acute
  - **NC2R**-We will continue our increase to P1 though our 'why not home , why not today programme' however we need the P1 additionally funded capacity, STCC reprofile and the 58 bed dementia capacity all on line for December to bring NC2R down to 7%, this **releases 60 beds**
  - **GP streaming and streaming within UHP-** to support the reducing of the 13% demand we need a resilience GP streaming offer and to decongest ED we are following our further direct ED streaming across the trust across a number of pathways
- **Best case position post mitigations 150-(35-25-60) = 30 bed deficit**

Our plan will focus on four key areas:

1) Leading Well through Winter

- Working together across Health and Social Care
- Create capacity through resilient alternatives to admission and conveyance and step up care
- Tactical Winter Advisory Group (Clinical and Operational Leadership) meeting weekly

2) Workforce Wellbeing

- Winter Vaccination Program
- Wellbeing program to support the health and wellbeing for our people so we look after each other and our patients
- Utilise our workforce to be able to deliver the plans and makes sure we are the place of choice for those seeking work in the NHS
- Continued international recruitment for wider clinical professional groups

3) Creating the Capacity to meet demand

- Additional bed capacity through new winter ward; improved flow through length of stay program and use of virtual wards.
- Maintaining elective capacity
- Making sure that people who come to our ED and Assessment areas are seen quickly by a specialist in a timely way
- Making sure that people are only in hospital when they need to be and ensuring discharges are planned in advance with our partners.

4) Communications

- Supporting our patients and communities to understand when and what services to access and how to self-care
- Preparing our people and communities for the pathways in and through the hospital
- Key campaigns for winter illnesses and or key alternative services

Creating the Capacity to meet demand

Bed model start point

(150 bed deficit)

➢We have re-forecasted the baseline for the operational plan in light of the 13% increase
In emergency admission (compared to a previous 2%) and a 14% NC2R position (compared to a 7%)
this suggests at it peak (week 26) we would be forecasting a **150-bed deficit at UHP**.
➢Protected Elective Capacity will be maintained across Cardiac, Neurosurgery, Orthopaedics, Transplant and Oncology
➢No attendance reduction or admission reduction factored in

Mitigations

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Protecting Elective

- Protect:26 Tertiary Cardiac Beds Clearbrook and 28 Tertiary Neurosurgery Beds
- Protect:24 Orthopaedic Beds (New Build)
- Preserve: Postbridge 23 hour stay unit – prevents cancellations and provides overnight surge capacity
- Stretch: SAU test of change – reduce inpatient beds by 2 to create additional space to stream from ED supported by change to 'Take' and 'Post Take' model with increased Senior Decision Maker capacity
- Review current medical outlier model to mitigate bed gap but preserve protected surgical beds.
- Maximise utilisation of Independent Sector
- Weekend Insourcing

Scenario

30 bed deficit

- Admission avoidance (ICB) and virtual ward stretch (UHP)

4. Communications: Plan on a page

Operational objective(s): Support the delivery of healthcare services during winter 2023/24

Comms objective(s): 1. Influence people to access the most appropriate urgent care services for their needs 2. Encourage uptake of vaccination (staff and public) 3. Demonstrate work to meet patient need and how additional winter funding is being used 4. Recognise the work of staff and impact positively on staff morale 5. Evaluate

Key insight(s): 1. Attendances and use of services 2. Vaccination behaviour 3. Coverage and sentiment

Key metric(s): 1. Use of UTC and MIUs 2. Staff vaccination uptake 3. Google analytics 4. Coverage 5. Online sentiment and wider feedback

Outline plan: Steps being taken to prepare for winter; signposting people to the best service to meet their needs, 'no bed like your own bed' and importance of timely care and discharge, vaccination as a means of staying well, working as part of the wider Devon system

Key audiences: *Staff, public, patients, carers, media*

Who?	What do we want them to know/do?	How will we reach them?	When ?	How will we know this has worked?
Patients and carers	• Know which services are available where and when • Vaccination is available for eligible groups • Patients will be discharged home as soon as they are medically fit	• Health Services Guide delivered to >35,000 homes in Plymouth • Website • Videos • Social media • Online and broadcast media	Oct-Feb	• Increased use of UTC and MIU • Increased use of NHS 111 • Vaccination data
Staff	• Get vaccinated against COVID and Flu • Focus on EDD for every patient to support flow • Recognise the impact they have on patient care through their efforts	• Daily Email • Friday Five • All Staff Briefing • Staff Hub • Staff-only Facebook Group • Staff app • Through Improvement huddles	Oct-Feb	• Staff vaccination uptake • 4 hour target • # of patients in Discharge Lounge by midday • Engagement and sentiment in staff engagement sessions and forums (attendees and themes) and via feedback emails, in Staff Facebook Group, via All-Staff briefing
Media	• Have access to information about our winter preparation and responsive lines to enquiries	• Website and social • Response to media enquiries	Oct-Feb	• Media coverage (extent of and sentiment)

Timeline/critical path: Communications and engagement plan to be finalised by end of October and reviewed regularly, remaining agile throughout winter

Sept: Draft Plan; Start to rollout Staff Vaccination plan → Oct: Begin to roll our wider plan → Ongoing and March: Evaluate and draw through learning

Roles and responsibilities: Operational leads to help Communications Team with explanation of actions for winter, clinical spokespeople needed for media

Appendix – Summary Actions

Increase Capacity Out of Hospital

Alternatives to Admission/Avoidance	Plan	Dates/Capacity	Impact on LoS/Bed Gain
Care Home: Call Before Convey	Pilot of Care Co-ordination hub – call before convey	Mid October	30 patients per week avoided conveyance (based on BNSSG data)
Falls Program	100 day challenge – increase number of >65 patients with non injury falls cared for in community	December	30 patients per week
EOL	100 day challenge – reduce number of EOL patients from care homes conveyance to hospital by 10% EOL specialist nurse support to ED to reduce admission to hospital	December Live	 13 patients avoided admits per month
Discharge P1 Capacity Current gap	Peripetetic Team Development Commissioning of a dedicated bank of HCA workers trained in reablement exercises and deployable into existing services. Areas that the service could be deployed to support include: HomeFirst and Hospital to Home Reablement Pathways Bridging Service offering programme but providing a holding offer until a long-term care package can be secured. Domiciliary Care providers to offer increased resilience during periods of pressure. Front Door Reablement	From November an additional 76 patients per month with additional surge across Dec, Jan and Feb.	Additional Discharge Capacity Created Nov – 76 Dec – 111 Jan – 96 Feb - 91 Mar - 76 Residual gap against D&C modelling to be supported through phasing of community beds to P2
Discharge P2 Capacity	Reviewing commissioned community provision to maximise P2 alignment in line with Intermediate Care Plan – phased realignment of services (STCC, DAU & Community Hospitals)	November	Current Wait 11 days for P2 pathway across 47 patients

Mental Health Capacity

Alternatives to Admission/Avoidance	Plan	Dates/Capacity	Impact on LoS/Bed Gain
Ongoing offer for Alternative to ED	Continuation of existing extended hours 1am – 1pm Saturday + Sunday, 5pm – 1am Tuesday, Wed, Fri Expand to 7 nights per week **subject to additional winter funding**	Live 2 week lead time from funding approval	25-30 people per month currently supported Additional 8-12 people per month
Joint Response unit Vehicle	Currently Mon/Wed/Thurs 4pm-midnight. Friday 5pm-1am Expand to cover Tuesday night **subject to winter funding**	Live 2 week lead time from funding approval	40 referrals per month 16 per month additional
FUSE service	Expansion of the Frequent User service to cover all PCNs and provide support in ED to divert people who frequently attend	12 week lead time from funding approval	400 people on caseload ED survey data in FUSE business case
Psychiatric Liaison	3 x daily reviews of ED and Psych Liaison referrals with a new escalation process to respond to patient delays Workforce redesign to increase seniority of staff available within ED	Live November	Improve 1 hour assessment performance toward 905 standard
First Response 111 pathway	National Directive for first response to receive 111 mental health calls	December	Reduce 111 dispositions referring to ED. Currently 15 additional calls per day expected (not all would

Mental Health Capacity

Alternatives to Admission/Avoidance	Plan	Dates/Capacity	Impact on LoS/Bed Gain
Facilitation of Discharges	Funding to support early hospital discharge from MH units and additional social worker capacity This will ensure that people are not delayed due to reasons that can be rectified, such as funding of a stepped down arrangement over night and/or practical support in terms of a discharge. **Subject to winter funding.**	Funding to support immediate discharge needs immediate post funding approval 3 month lead time for social worker	Bed days saved forecast based on 2022/23 experience If this funding is available we will ensure the impact is assessed related to both bed days and financial cost
Local Authority Homeless Recovery Plan	Early conversation taking place with housing providers to identify further provision for MHLDN population Discussion with PCC regarding additional step down capacity to support discharge/intermediate care from MH beds Overseen by Housing Taskforce		
New Seclusion suite at Glenbourne	New facility that reduces the occurrence of the POS being used for seclusion and unavailable for S136/S135	March 24	Circa 2-3 times a month that POS would be unavailable currently.
Homeless Inclusion Partnership Project (HIPP)	This team commenced earlier this year as a partnership between Adelaide Street Surgery and Livewell. It is to ensure that people who are homeless or sleeping rough have a provision of care which will interface with housing providers This team also works with UHP in terms of physical	Currently in place	Reduction in GP caseload and appointments for this group of people Reduction of attendance to ED

Mental Health Capacity

Alternatives to Admission/Avoidance	Plan	Dates/Capacity	Impact on LoS/Bed Gain
Groups in Primary Care Mental Health Team (PCMHT)	Which enables prevention of escalation to both secondary care mental health services and also ED There are a range of both psychological and physical health groups totalling 15 which facilitate a primary care offer for those experiencing a range of mental health presentations	There are 15 groups that are facilitated on a rolling programme between 6-12 weeks. These will continue throughout the winter.	Prevention of escalation to both secondary care mental health services and also ED 20-25 people per group and a significant number would have escalated if this offer wasn't available
Introduction of new roles in community mental health services	We are introducing Mental Health and Wellbeing Practitioners into community services with a second cohort hopefully confirmed by January 2024. These roles will not impact on waiting times (as waiting times are good) but will enable a proactive psychological approach to working with people in what would otherwise be workforce vacancies.	1 cohort of 6x has been appointed and will commence in services by the end of this year. A further 6x are being pursued with HEE to commence Spring 2024.	This impact is in relation to quality and once these posts are in place we will be able to identify the number of people assessed and treated
Bed flow huddles (as standard work)	Bed flow huddles are in place to ensure that all services within the mental health urgent care pathway maintain flow and a clear process in terms of unblocking people who may be in ED, needing an alternative option and/or can be discharged from an acute bed.	Ongoing	We have been able to work in a slightly different way to ensure all beds are used to their maximum capacity and that community services particularly home