NHS Devon

Winter Planning

October 2024

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Devon System Approach to Winter Planning

- Winter pressures are a predictable event and form part of local partners business as usual planning cycles.
- However, to maximise robustness and effectiveness of individual plans, it is essential that we coordinate actions and ensure that we are collectively focussed on the key issues that drive the additional pressures that we know winter will bring.
- As in previous years we have worked at both a local Plymouth system level and across wider Devon in development of our plans.
- We have built on learning from what worked well last year, and areas we could improve.
- National guidance on winter planning has also been shared, including self-assessment exercises to assess readiness, the output of this has been incorporated into our planning at all levels.
- Clear communication strategy based on preventing infections (e.g. through effective hand and respiratory hygiene) and staying healthy, encouraging seasonal vaccine uptake, particularly amongst those at greatest risk and those experiencing health inequalities, and knowing which service you need, with a focus on helping to keep the elderly or those with long-term health conditions out of hospital.

Plymouth System Winter Approach

- Joint work between ICB and PCC commissioning team to maximise our ‘Homefirst’ approach to discharge matching reablement capacity along with ensuring availability of long-term domiciliary care, and development of placements for individuals with complex/specialist needs (e.g. complex dementia and people living with obesity)
- Clear approach to local escalation protocols to ensure any issues/delays are escalated in a timely way to enable agreement and delivery of short-term tactical actions across partner organisations.
- Delivery of Urgent & Emergency Care focus areas (Urgent Community Response, Virtual Wards, Falls/Frailty/End of Life, Acute Frailty, Same Day Emergency Care, Urgent Treatment Centres)
- Working alongside GP practices and Community Pharmacies to protect core business operations
- Central to local plans is the delivery of the Healthy Lives Partnership (UHP & Livewell) ‘One Plan’ approach to improve access, quality of care and patient experience of the UEC service offer and pathway - this is summarised on the subsequent slides

Seasonal Vaccinations

- Covid and flu vaccinations are now available to people in at-risk groups.
- Eligible groups include people aged over 65 and those in clinical risk groups.
- You can book your jab using the National Booking Service or by calling 119.
- You may also be contacted by your GP practice.
- For the latest NHS information and advice about coronavirus and vaccinations visit the NHS website.
- People between the ages of 75-79 or those who are pregnant are also able to have the new RSV vaccination this winter and should speak to their GP practice or midwife.
- We have seen good early uptake with people attending their GP, pharmacy or vaccination centre.
- Stay Winter Strong, reduce the spread of viruses and reduce demand on our busy GPs and hospitals.

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UHP One Plan Overview

Restoring high quality access and care to our UEC services

Our Care Model

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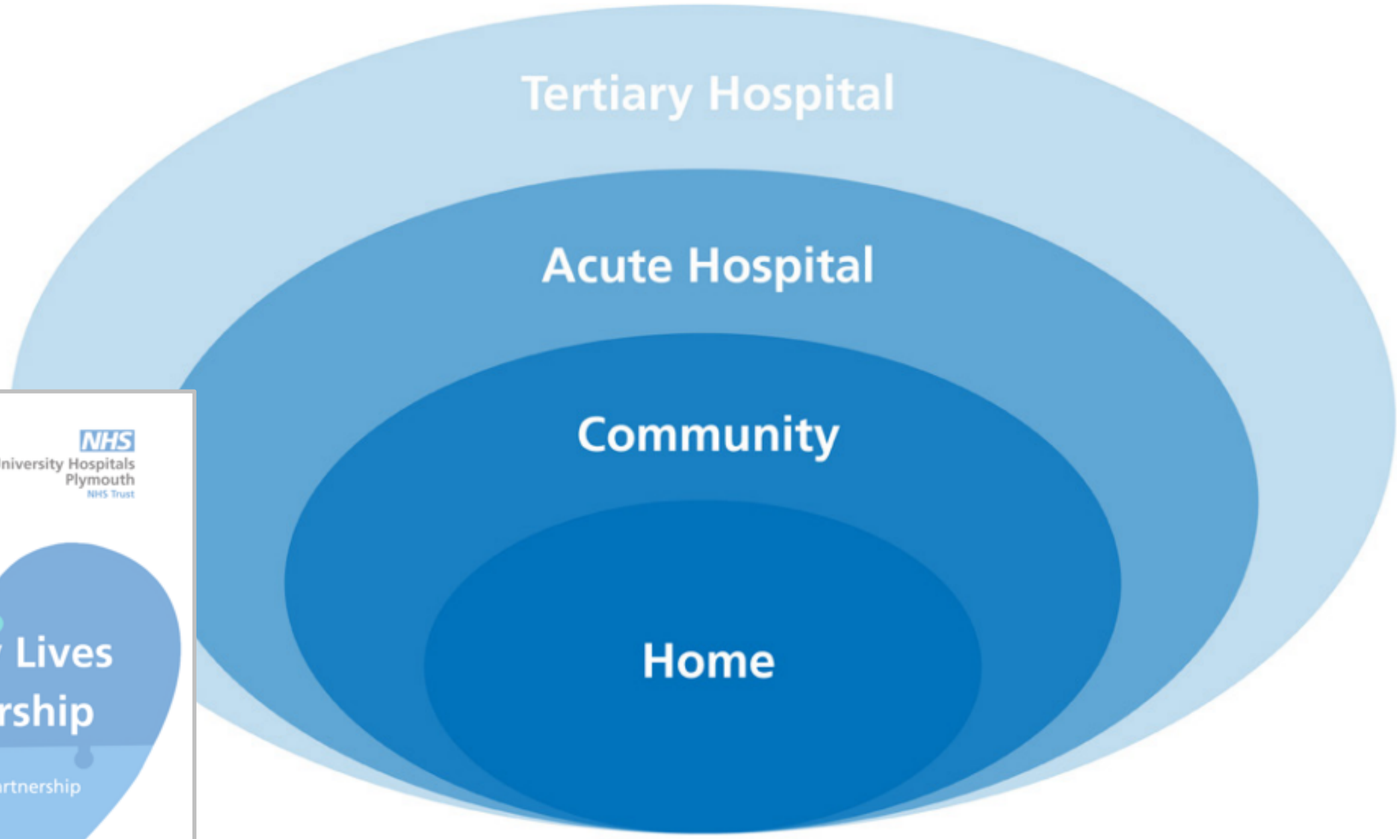
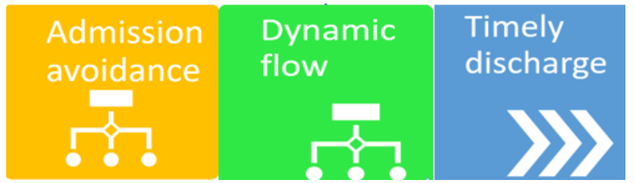
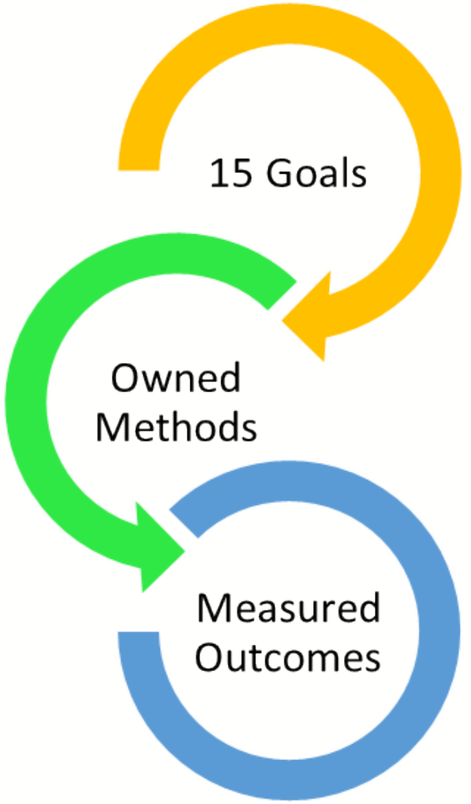


Introduction



- This is our trust plan for improving access, quality of care and patient experience in our UEC service offer and pathways
- The transformation actions are critical to decompress our ED and reduce and prevent harm as a consequence of overcrowding, also addressing the improvements in quality and safety (section 29a)
- Our plan has three improvement pillars and 4 stages of implementation for resilient, consistent and long-lasting improvement in quality, operational and outcomes to be a high-quality organisation
- Our plan centres upon 15 goals for improvement , with a clear method to achieving the goals and improvements in quality and performance outcomes
- Our plan is clinically led, co-designed and managerially supported
- Our plan has been developed in partnership with our community provider Livewell Southwest
- Seeking a significant move to increasing our community alternatives and supporting care at home



Current State to Future State

Current State

- Worst performing NHS Hospital for ambulance hours lost
- 4 hour standard averaged 54.7% last year
- Section 29a Improvement Notice for our Emergency Department
- Outlier compared to our peers and national averages for higher admissions for frailty, falls, end of life, respiratory, urology, cardiology
- Limited range of alternatives to ED/admission in the community
- Outlier for medicine admissions (37.8%) compared to the median (28.5%)
- ED assessment areas and SDECs too small for the population we serve and to ensure we reduce overcrowding and be more efficient
- ED too small for the activity it now need to provider for on a daily basis, including no collocated UTC
- Lack of integrated front door services with our community provider
- Outlier compared to peers and national average for deaths in an acute bed (palliative care)
- Discharge Delays averaged 12% last year

Future State

- improved performance for ambulance hours lost by March 25 (median England hospitals)
- 4-hour standard to perform at a minimum of 77.9% by March 25
- Section 29a Improvement Notice lifted
- Median range or better for our admissions for frailty, falls, end of life, respiratory, urology, cardiology
- Substantially expanded community alternatives, supported through our community care coordination function, including 125 community Virtual wards beds
- Medical admissions conversion rate in-line with national median
- Rightsized SDEC/ MAU and physician capacity and opening hours reducing admissions by 16 per day
- Collocated UTC open
- Integrated admission avoidance UCR pull team
- Reducing deaths in an acute setting, bringing us in line with peers
- Discharged delays reduced to 5%
- 75% of patients on a complex discharged pathways supported home, reducing further demand for intermediate care bedded capacity

Principles of Our Plan

Enabled By:
- Future Investment
- Capital solutions
- Increased acute medical sessions
- Changes to use of existing capacity and resources

Output:
- Sustained improvements in ambulance waits
- Removal of overcrowding
- Right care, in the right place at the right time

Underpinned by:
Allocative Efficiency
Technical Efficiency
Equity of outcome
Value Propositioning

Put people first
Take ownership
Respect others
Be positive
Listen, learn, improve

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The right care, in the right place, at the right time to meet the needs of the patients and communities we serve

Admission avoidance

Avoiding admission by treating people in the community and as same day emergency care patient reducing the requirement for them to be admitted

- Increasing virtual ward capacity, particularly for the frail elderly
- X-ray car to attend patients with suspected fractures in the community
- Hot clinics for patients to return to
- Direct referral into specialist services e.g. paediatrics, early pregnancy, fractured neck of femur (NOF), urology
- Increase community services particularly for frail patients
- Right sized assessment units

Dynamic flow

Making sure patients get to the right place for their care with the right person

- Right sized Same Day Emergency Care (SDEC) and Medical Assessment Units (MAU)
- Senior decision makers at key points in patient pathways
- Supporting non-operable fracture patients in the community
- Increase alternative ambulatory services
- Increasing community beds for EOL
- Ambulances taking patients direct to SDEC and other areas, e.g. for stroke care and fractured NOF
- Alternative pathways for trauma

Timely discharge

Getting patients home to their place of residence asap

- Increasing the number of complex patients discharged home with appropriate support
- Community IV antibiotics
- Timely clinical review for outlier patients
- Improved management of frail people to improve rehabilitation/recovery
- Enhanced therapy pathways for the assessment and management of patients

Measures of success:

- 70% 4 hour target
- 70% ambulance handovers <15 mins
- Reduced length of stay
- Delayed discharges
- Better patient experience feedback

Visual Summary Future Model- Additional Services

NB- numbers related to business case references

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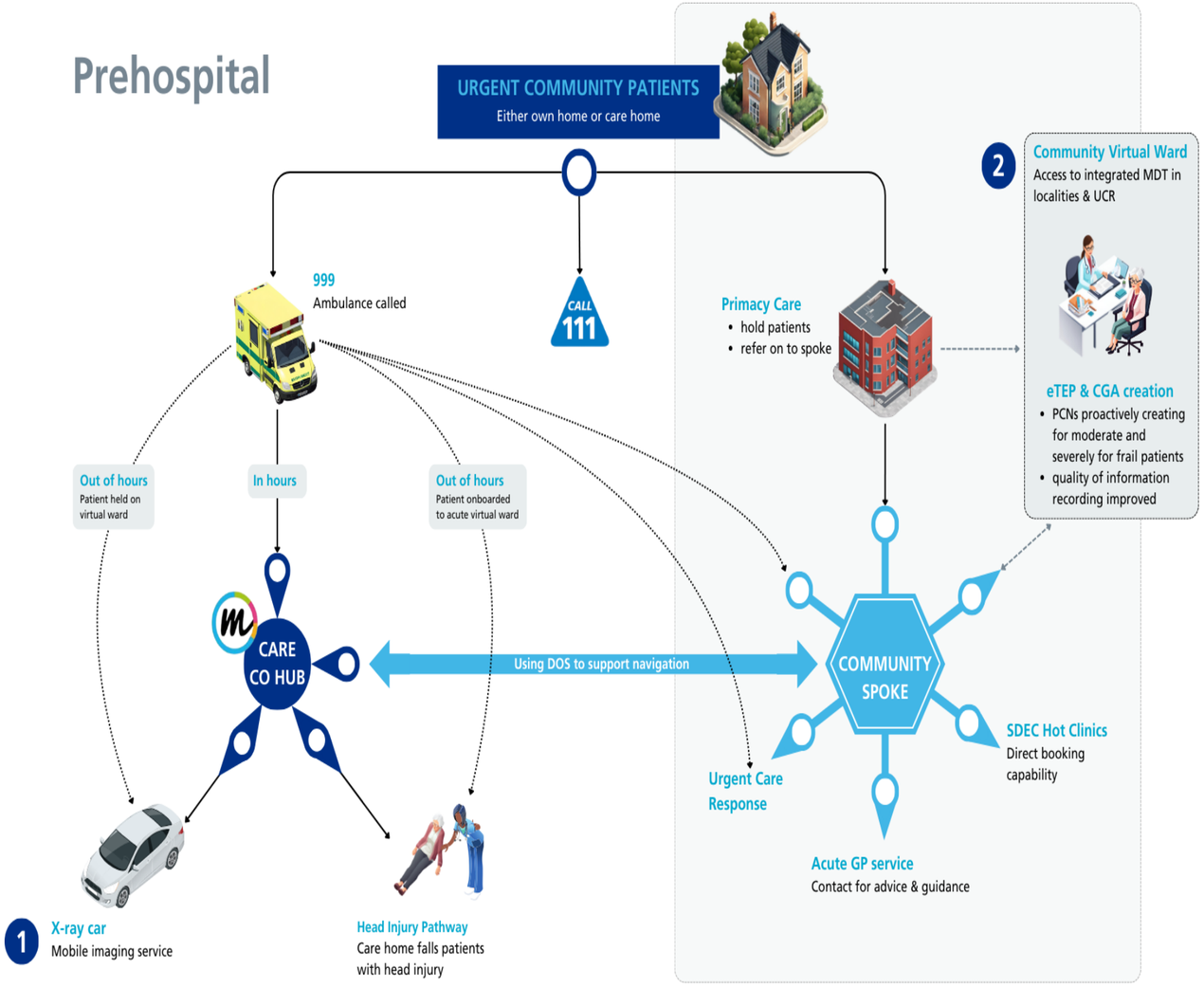

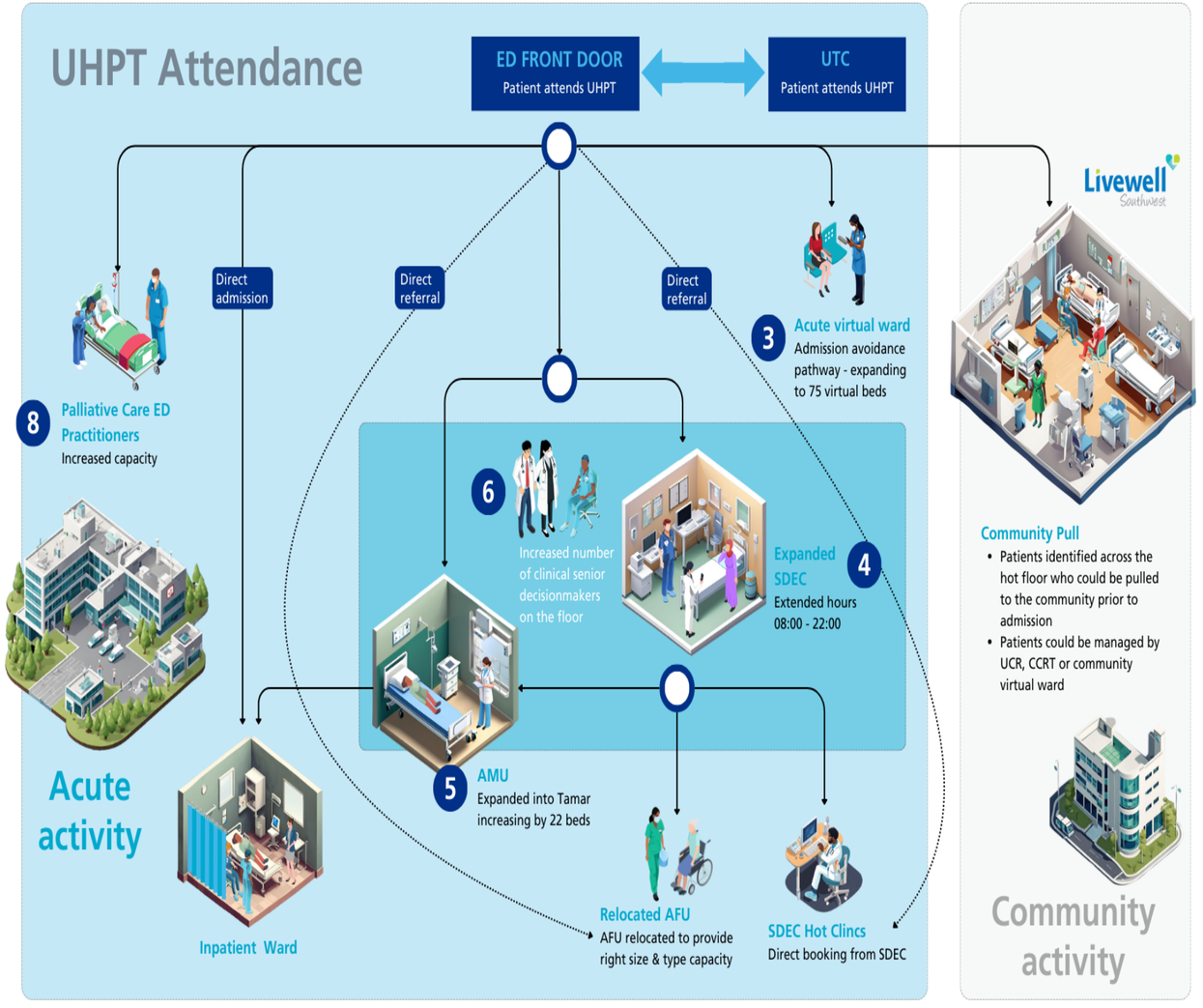

Visual Summary Future Model- Additional Services

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Flow & Discharge

WARD BASED CARE
Discharge preparation

8

EOL Patient Identification Clinicians

St Lukes
Specialist Inpatient & Hospice

NOF Bay

Preferred place of death

Discharge Coordination Hub (DCH)
- Management of complex delays and planning
- Demand and capacity management
- of intermediate care pathways

Delay management / increasing **P1**
Capacity and right-sizing **P2**
capacity based on demand

Home

Mount Gould Dove Unit
Expanding from 4 - 12 beds

Acute activity

Livewell Southwest

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ESD Inreach and Capacity (Stroke)
- Direct pull into ESD community service
- ESD inreach and capacity expansion
- Integrated stroke pathway MDT approach

Livewell Southwest

IV community pull
Identification and pull of appropriate patients to support early discharge into UCR / virtual ward

Community activity

	Overview of One Plan Goals	Business Case Required
	Admission Avoidance	
1	**We will ensure clinical senior decision makers are available in MAU and ED to ensure rapid assessment and development of treatment plans to patients that meets the daily average demand between 0800-2000hrs in MAU and 0800-2200 in ED which will reduce 4hr waits in ED by a further 2.5% in August increasing to 5% from December and time to treatment to an average of 150 minutes and reduce time to transfer to MAU (mean time in department) by 25% by 30th September 2024**	YES BC/oneplan/06 Impacts combined with MAU
2	**We will increase the number of patient treated through streaming to Same Day Emergency Care (SDEC) as opposed to through ED patients by 5% by 31st July 2024 (16 per day), through increased staffing capacity of acute physicians by 5 wte in SDEC, creating new pathways for the top 10 common ambulatory presentations to ED/MAU and increasing direct referral which will improve ED 4hr waits daily by 5%**	YES- SDEC BC/oneplan/04
3	**We will deliver an increased MAU capacity for medical admissions from 51 to 73 beds by 30th July 2024 which will reduce ED waits > 4hr by 2.5% supported by a new acute medical model which will increase zero-day length of stay by 2.5% reduce conversion to specialty admission and reduce conversation to inpatients wards to the national average of 28.6% and reduce occupied beds from 30th September 2024.**	YES BC/oneplan/05
4	**We will introduce alternatives to attendance and ambulance conveyances or conveyances to ED through use of Care Coordination and use of new/existing pathways for direct transfers to streaming or community alternative services which will reduce ED attendances by 168 per month by March 2025 for the following; EPAU (-75 per month from June) / EOL (-11 in Sep'24 rising to –22 from Oct'24) / Falls (–37 in Sep'24 rising to –71 from Nov'24) .**	YES BC/oneplan/01 BC/oneplan/02 BC/oneplan/03
	Dynamic Flow	
5	**We will deliver a re-sized and realigned bed capacity including the opening of the remaining 23 medical beds on Avon and increasing medical beds by 36 to increase the medical bed base from 557 to 596 for specialities to support medical demand by 30th September 2024 Reducing medical outliers and improve medical length of stay by 0.5 days which will deliver improved bed day usage to an equivalent of 30 beds by 30th September 2024.**	
6	**We will deliver an increased Rapid Assessment and Treatment space to 3 cubicles by the 31st July 2024 that will reduce Time to triage for ambulances from 25 minutes to 15 minutes.**	YES BC/oneplan/06
7	**We will expand our community virtual ward offer for the effective planning, assessment and management of patients whom condition deteriorates and/or can be supported back home from our ED and assessment areas. Wrapping around them our**	YES BC/oneplan/03

	Overview of One Plan Goals	Business Case Required
	Dynamic Flow	
8	We will scope and expand a community intravenous therapies and infusions service that meets the demand and capacity of 20 patients a day by 30th September 2024 to reduce 10 in-patient beds per day.	
9	We will deliver improved pathways for Fractured Neck of Femur (NOF) and Non admitted fractures (NAF) avoid 3 admissions per day and admit 2 direct from ambulance 30th June 2024 and reduce occupied bed days by 20 and reduce length of stay by 2 days.	
10	We will deliver an improved ambulatory and diagnostic surgical pathways to SAU which reduces the time to decision to admit and reduce admission by 5 patients per week by 31st December 2024	
	Timely Discharge	
11	We will deliver a reliable and consistent standard ward processes using SHOP principles by the 30th September 2024 that will improve discharges by midday to 25%	
12	We will establish an integrated discharge co-oridnation hub (TOC) for the rapid and effective discharge of patients from hospital beds across UHP for pathways 2 and 3, and supporting a single point of access for pathway 1. It will reduce time of delay for discharge from 52 hours to 24 hours would generate a further 1,172 bed days per year By the 31st July 2024.	
13	We will ensure early supported discharge services have appropriate capacity to support discharge at point the patient is medically fit for stroke pathway patients and deliver a delay of no more 24 hours for referral reducing length of stay by an average of 14 days and support 60% of patients in 24/25, releasing 12 outlier beds by September 2024	YES BC/oneplan/07
14	We will increase the number of patients who are supported to die in their preferred place of death by 1,262 per year, reducing the number of deaths in the acute site by 642 per year. Working with specialist end of life partners to, introduce care professionals (registered and unregistered staff) who will actively identify, facilitate transfer of care and holistically support carers and patients to an alternative location of care (Mount Gould end of life beds, in first phase and bridging for community packages), increasing from 4 to 12 beds by September 2024	YES BC/oneplan/08
15	We will champion that home is best and increase the number of people we are supporting home with or without support following an acute or community stay. Resulting in moving from 42% of patients on complex discharge pathways home with support to 75% within 24 hours of being ready for onward care at home by September 2024.	

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Quality and Safety impact

Implementation of the one plan is expected to have measurable impacts on the quality and safety of care provided across the Trust. Through improved quality and safety risks, as well as addressing variation, the one plan has patient centred quality improvement at its core and is expected to make sustained impact on patient and staff experience.

Reduced crowding and waits, timely assessment, avoided admissions appropriate flow and timely discharge will:

- Improve experiences of care
- Reduce crowding
- Eliminate board
- Reduce risk of hospital acquired infections attributable to crowding
- Reduce variation
- Enhance privacy and dignity
- Support our most vulnerable and their colliding needs

Summary of the Demand and Capacity Impact of One Plan- 75% success rate

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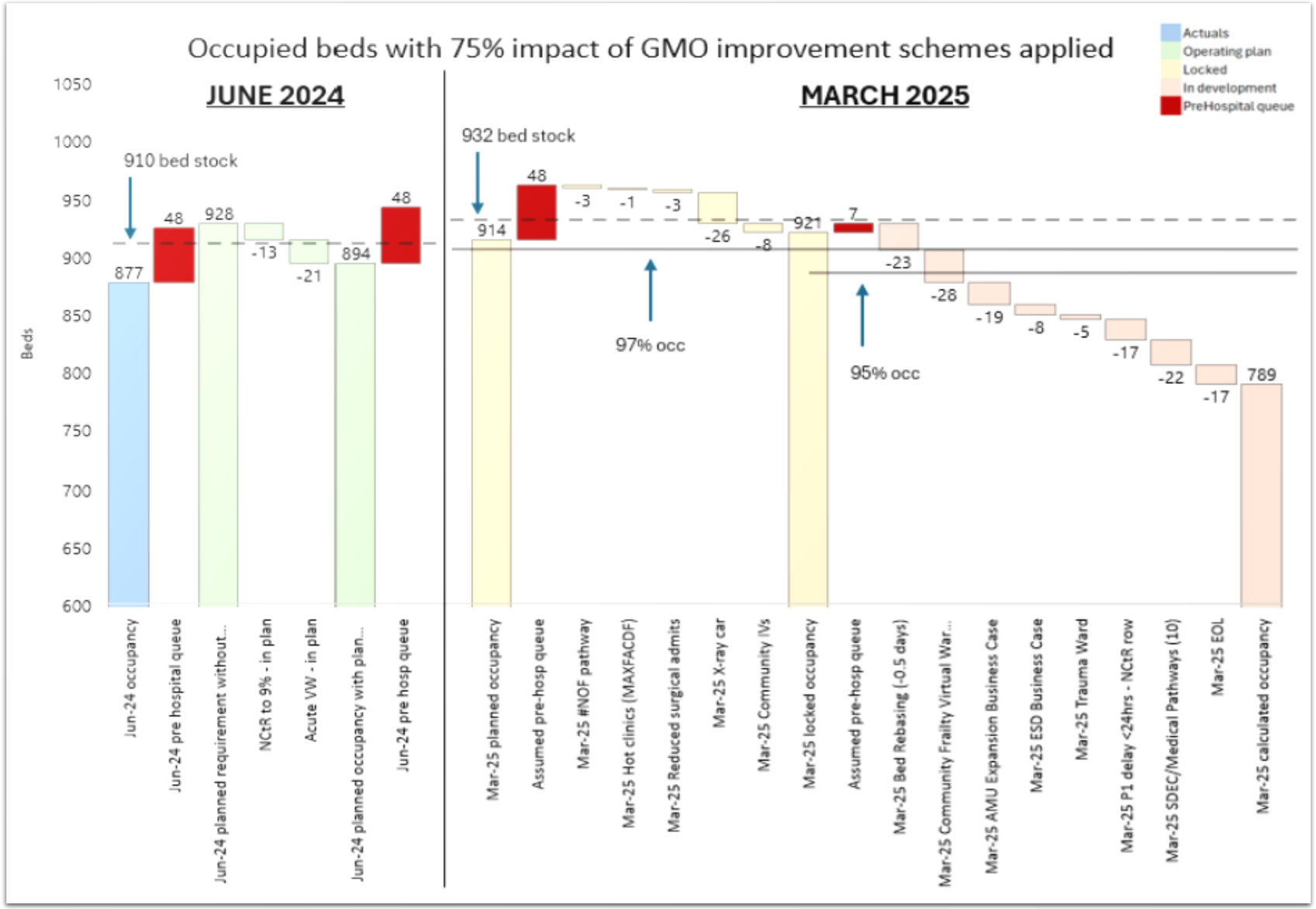

Assumptions

75% success rate of all improvement schemes

Demand doesn't increase

NCtR remains at 9%

Pre hospital queue cleared as priority

Next Steps

We will develop over Qtr2/3 options for this liberated capacity to support current year and future years patient needs

We are also reviewing impact on community beds

Governance

- One plan PMO and PMO room
- PID and weekly highlight report owned by SROs
- Programme Governance in place for all schemes
- Weekly CEO led portfolio board reviewing progress, dealing with escalations and course correction, collaborative working across LSW/UHP with care groups
- Quarterly deep dive report to trust board
- Monthly IPR to trust board
- ICB assurance through locality meeting and SIAG
- Ongoing Engagement to shape design and awareness of new services with care home steering group, LMC, PCNs, coroner, SWAST, care co-ordination, and UHP and LSW operational teams