Shropshire, Telford and Wrekin and Powys A&E Delivery Board

Winter Plan 2018-19

Version	Date	Update
1.1	10/08/2018	First iteration
1.2	18/08/2018	First system updates
1.4	19/08/2018	Demand and Capacity modelling added
1.5	28/08/2018	Post A&E Delivery Group- revised system updates
1.6	29/08/2018	Post meeting with accountable officers
1.7	02/11/2018	Layout and formatting review.
1.8	20/11/2018	Minor accuracy updates and appendices linked

Contents

1. Glossary:

Abbreviation	In Full
A&E	Accident and Emergency
AHP	Allied Health Professional
AMU	Assessment Medical Unit
CAD	Computer-aided Despatch
CCG	Clinical Commissioning Group
CDU	Clinical Decision Unit
CHC	Continuing Healthcare
CQUIN	Commissioning for Quality and Innovation
D2A*	Discharge to Assess* - *see additional information in table below*
DAART	Diagnostics Assessment Access to Rehabilitation Treatment
DH	Department of Health
DToC	Delayed Transfers of Care
DVT	Deep Vein Thrombosis
ECIP	Emergency Care Improvement Programme
ECIST	Emergency Care Improvement Support Team
ED	Emergency Department
EDD	Expected Discharge Date
EL	Elective
EMI	Elderly Mentally Ill
EMS	Escalation Management System
EOC	Emergency Operating Centre
EPRR	Emergency Preparedness Resilience and Response
FFA	Fit for Assessment
FFT	Fit for Transfer
FIT	Frailty Intervention Team
HALO	Hospital Ambulance Liaison Officer
HWB	Health and Wellbeing Boards
KPIs	Key Performance Indicators
LHE	Local Health Economy
LoS	Length of Stay
MADEs	Multi Agency Discharge Events
MDT	Multi-Disciplinary Team
MFFD	Medically Fit for Discharge
MIU	Minor Injury Unit
MOU	Memorandum of Understanding
MPFT	Midlands Partnership Foundation Trust *(formerly SSSFT)*
MSFT	Medically Safe for Transfer
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEL	Non-Elective
NHSE	National Health Service England
NHSI	National Health Service Improvement
NICE	National Institute for Clinical Excellence
OD	Organisational Development

OOH	Out of Hospital
PbR	Payment by Results
PE	Pulmonary Emboli
PHE	Public Health England
PMO	Programme Management Office
PRH	Princess Royal Hospital
RAID	Rapid Assessment Intervention and Discharge
R2G	Red to Green
RCMT	Regional Capacity Management Team
RSH	Royal Shrewsbury Hospital
SAED	System-Wide Accident and Emergency Delivery
SAFER	**S**=Senior Review; **A**=All Patients; **F**=Flow; **E**=Early Discharge; **R**=Review
SaTH	Shrewsbury and Telford Hospitals
SAU	Surgical Assessment Unit
SCHT	Shropshire Community Health Trust
SitRep	Situation Reporting
SSSFT	South Staffordshire and Shropshire Foundation Trust *(now MPFT)*
STP	Sustainability Transformation Partnership
SUS	Secondary Uses Data
T&O	Trauma and Orthopaedic
UCC	Urgent Care Centre
UEC	Urgent and Emergency Care
WDPs	Winter Delivery Priorities
WMAS	West Midlands Ambulance Service
WTE	Whole Time Equivalent

*__Discharge to Assess:__ *Patients are discharged from hospital via 3 pathways for care and rehabilitation support for up to six weeks*	
Pathway 1	To intermediate care and reablement services provided in their own homes
Pathway 2	To residential care within the independent and community sector
Pathway 3	To nursing care within the independent sector

2. Introduction

The Shropshire, Telford and Wrekin urgent care system has faced challenges for a number of years, consistently failing to deliver the 4-hour target.

Winter 2017-18 has been recognised as one of the worst on record for the system, resulting in poor experiences and outcomes for patients.

The system employed an urgent care director in December 2017 and has built on previous improvements to focus on working together to deliver six high impact changes:

- An improvement in ED systems and processes
- Implement SAFER and Red2Green across the system
- Reducing Long Lengths of Stay (Stranded Patient Metric)
- Improve the Frailty pathway across the system
- Develop the integrated discharge pathway
- Develop a demand and capacity plan

The UEC system has acknowledged the need to work on the six high impact changes together and by doing so has developed excellent system-wide operational and leadership behaviours which have resulted in a system ownership of issues and support for achievement.

To date, improvement in the flow out of the hospital has been exceptional with our main Local Authorities placing up to 88% of complex patients within 48 hours, resulting in a reduction in the number of patients who are medically safe for transfer waiting in acute beds. The reduction in the stranded patient metric from 362 to below 250 (aim 180) and in super-stranded patients from 90 to 50 has resulted in us being among the top ten of all systems for the reduction in long lengths of stay.

We have a front door frailty service in Shropshire, to be mirrored in Telford, and the SAFER patient flow bundle and Red2Green are being revitalised through value streams in the acute trust and also in our community hospitals.

As a result of a drive for Home First, many of our Pathway 2 beds in the community are now not being utilised and plans are in place to use them more flexibly this winter to maximise utilisation.

This document builds on the high impact change around the development of a demand and capacity plan which builds the capacity to meet demand all year around. It sets out the Winter Plan (the Plan) for Shropshire, Telford and Wrekin and Powys based populations, and describes how partners in the health and social care economy are planning to ensure that our services can best meet the anticipated emergency demands.

The success of this plan builds on the whole system approach and effective partnership working.

It is crucial that all partners understand their role in supporting and delivering this plan. This year the planning has started earlier and is led through the A&E Delivery Group on behalf of the A&E Delivery Board and more emphasis has been placed on a whole system planning process rather than individual organisations undertaking planning in isolation.

3. Background

It is an expectation of all partners and regulators that an effective plan is constructed and tested for the winter period 2018-19. The Shropshire, Telford and Wrekin and Powys Accident and Emergency Delivery Board (SAED) must be assured that all commissioner and provider plans evidence individual organisational and system wide resilience and congruence.

The Winter Plan (the Plan) has been formed via the employment of best practice and lessons learned from recent winter periods. Delegates from all key stakeholders have been engaged in the formation of the Plan and compliance will be the responsibility of all SAED members, in collaboration with their respective organisation.

We have tested the plan with EMS partners since September 2018 and for the escalation process, we have rewritten action cards as a result. We had planned to implement the EMS+ system in December, but training and testing has resulted in a further development in the system being necessary before we go live, so we are hoping that we start using this process from Mid-December. Until then, our existing escalation management process will continue. We are also testing the action cards with clinicians on the 4th of December to ensure that actions taken in escalation are owned by senior clinicians in the system.

4. Shropshire, Telford and Wrekin and Powys Local Context & Review

The 2018-19 Winter Plan has been developed to ensure the following areas are addressed as a priority. Safety and improved outcomes for patients will be achieved during the winter by: -

- An improvement in ED systems and processes
- Reduction in Ambulance conveyance to the Emergency Department (ED) by crews using the Care Co-ordination Centre pre-conveyance.
- Tangible improvement (up to national average) in the number of patients streamed to primary care by ensuring we have permanent ED streaming staff, streaming to an effective primary care service with appropriately trained staff.
- 98% of non-admitted patients seen within the 4 hour quality standard by ensuring that trained ENPs see patients in a timely manner and refer for any diagnostics necessary in a timely manner.
- The reduction in the number of patients who receive corridor care by using the rapid access to treatment model (Pit-stop), two hourly ED Board rounds, and the use of internal professional standards.
- Reduction in the ambulance handovers exceeding 30 minutes by the use of Hospital Ambulance Liaison Officers (HALOs) and dedicated handover nurses.

- Further embed SAFER and Red2Green across the system
  - Embedding Red2Green (R2G) across acute and community;
  - Embedding the SAFER patient flow bundle across acute and community care

Reduction in long lengths of stay:

- Reduction in all long lengths of stay (aim 180) & extended long lengths of stay (over 20days- aim of<50 to be maintained) in the acute trust; This has previously been described in our system as stranded and super stranded patients.
- Reduce the length of stay in all community beds to the national average.

- Improve the Frailty pathway across the system
  - Implement Frailty front door service at Princess Royal Hospital (PRH)

- Develop the integrated discharge pathway
  - Reduction in the length of time patients are on the Medically Safe for Transfer (MSFT) list;
  - Improvement in numbers of patients discharged before lunch to the national average.
  - Improving the Home First deployment and timeliness of transfer to community services provision including domiciliary care;

- Develop a demand and capacity plan
  - Clear and tangible plans to close anticipated bed deficit (escalation);
  - Implementation of an effective real-time demand and capacity management system.

5. Plan Interdependencies

The Plan has a number of interdependencies and should be read in conjunction with:

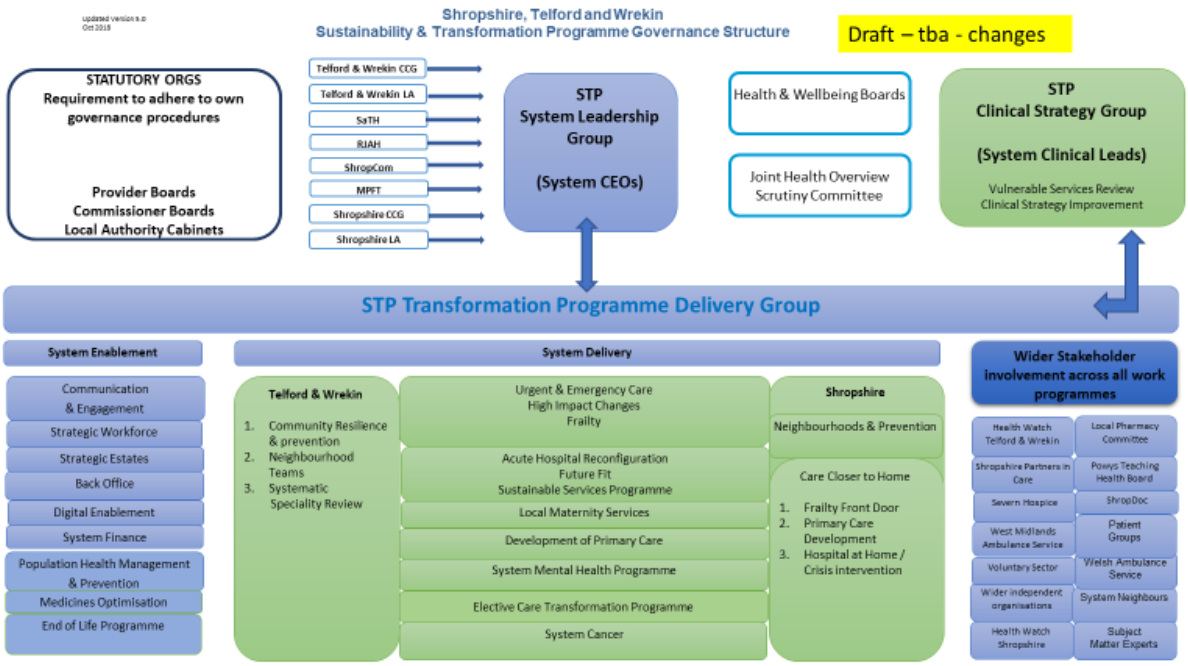
- The Shropshire, Telford and Wrekin and Powys Escalation Plan,
- The Local Heath Resilience Partnership Influenza Plan,
- Powys Integrated Winter Resilience Plan 2018/19
- National adverse weather plans,
- The plans for the six High Impact Changes
- Individual organisational winter plans (e.g. Business continuity, incident response, infection prevention etc.).
- WMAS winter plan

6. Outcomes of the Plan

The Winter Plan is complimentary to the main objectives for achievement in the STP. Our outcome for this plan is to ensure that patients are safe and have improved outcomes over the winter period. Metrics for measurement are detailed throughout the plan.

7. Governance

Winter planning is a sub-work-stream within the STP Urgent and Emergency Care (UEC) Governance structure.



Operationally, planning for winter is enacted through the System-Wide A&E Delivery Group and agreed for recommendation to individual boards through the A&E Delivery Board. The A&E Delivery Board does not have delegated authority to commit individual CCG resources, it can only make recommendations to CCGs and provider boards.

8. Programme Management Office (PMO) & Monitoring

To co-ordinate and monitor the winter period, the CCGs have dedicated an officer, supported by administration, to report on a twice daily basis to the system and to NHSI/E. Support will be provided by the system urgent care director and the STP PMO office.

The system will be using the support functions of the Regional Capacity Management Team (RCMT) Escalation Management System (EMS) to monitor pressure in the system and are revising triggers and actions to support our plan.

9. Winter Plan Key Performance Indicators

The programme has identified a set of key metrics which will enable the success of the winter plan to be monitored. These metrics include:

- % of non-admitted and admitted A&E 4-hour breaches
- Number of patients with a Length of Stay (LoS) >7 days
- Number of patients LoS >21 days
- Bed occupancy rate (acute and community)
- Number of patients on the Medically Fit for Discharge (MFFD) daily list
- Number of patients discharged to Pathway 1 (home with support) within 48 hours of LA receipt of the referral (FFA)
- Number of simple and complex discharges per week

- Delayed Transfers of Care (DTOC) rate (3.5%)

These are set out in the tables below including trigger points for AMBER and RED performance (RAG) rating to enable the system to take early pre-emptive action to avoid deterioration in performance. The triggers for the majority of the metrics are based on a calculation of 1 and 2 standard deviations from the baseline.

Winter Plan Metrics V6

SHROPSHIRE STP WINTER PLAN 2018-19 TABLE OF KEY PERFORMANCE METRICS	Baseline	Baseline period	Local winter performance target	RAG rating of performance against target		National performance target if different to local
				AMBER	RED	
% Non Admitted Breaches						
SATH	79%	Dec17 - Mar 18	90%	87.3%	83.3%	
PRH	77%	Dec17 - Mar 18	90%	87.3%	83.3%	
RSH	82%	Dec17 - Mar 18	90%	87.3%	83.3%	
% Admitted Breaches						
SATH	29%	Dec17 - Mar 18	30%	24%	21%	
PRH	44%	Dec17 - Mar 18	45%	36%	32%	
RSH	12%	Dec17 - Mar 18	12%	10%	8%	
% Bed Occupancy						
SATH	98%	Oct 17- Mar 18	98%	99.0%	100.0%	
Shropcom	93%	Dec17 - Mar 18	95%	90.3%	88.4%	
Stranded (no. pts >7days LoS)						
SATH	247	Aug 18 - Oct 18	250	260	275	
PRH	122	Aug 18 - Oct 18	117	122	129	
RSH	125	Aug 18 - Oct 18	133	138	146	
Super Stranded (no. pts>21 days Los)						
SATH	58	Aug 18 - Oct 18	50	52	55	
PRH	33	Aug 18 - Oct 18	23	24	26	
RSH	25	Aug 18 - Oct 18	27	28	30	
Discharges before 12 midday (*)						
SATH	13.6%	Dec17 - Mar 18	25%	22.3%	19.8%	
PRH	14.3%	Dec17 - Mar 18	25%	22.3%	19.8%	
RSH	13%	Dec17 - Mar 18	25%	22.3%	19.8%	
PW1 Discharges within 48 hours of receipt of FFA						
Shropshire LA	70%	Dec17 - Mar 18	90%	80.1%	71.1%	
Telford LA	65%	Dec17 - Mar 18	90%	80.1%	71.1%	
DToC						
SATH	3%	Dec17 - Mar 18	2.5%	3.1%	3.8%	
Shropcom	7%	Dec17 - Mar 18	3.5%	4.0%	4.5%	
RJAH	4%	Apr 18 - Aug 18	3.5%	4.0%	4.5%	

Average weekly number of simple discharges (by hospital site)

	SaTH			PRH			RSH		
Baseline	880	Av weekly	Oct 17 - Mar 18	381	Av weekly	Oct 17 - Mar 18	499	Av weekly	Oct 17 - Mar 18
Av Weekly Target	Target	Amber	Red	Target	Amber	Red	Target	Amber	Red
Oct	943	905	867	419	390	365	524	497	476
Nov	917	880	843	396	368	345	521	495	474
Dec	955	917	879	414	385	360	541	514	493
Jan	925	888	851	396	369	345	529	503	481
Feb	891	856	820	383	356	333	508	483	462
Mar	904	867	831	386	359	336	518	492	471

Average weekly number of complex discharges (by commissioner)

Complex Discharges	Weekly Target	Shrops Council				Target	T&W Council				Target	Powys				Target	Other		Target	SaTH Total			
		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement			Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement
Oct	53	45	50	57	61	25	21	24	27	29	11	9	10	12	13	2	3		91	77	85	95	105
Nov	59	50	56	63	68	28	24	27	30	32	15	13	14	16	17	2	3		104	88	97	109	120
Dec	60	51	57	64	69	23	20	22	25	26	11	9	10	12	13	2	3		96	81	89	101	111
Jan	69	59	66	74	79	34	29	32	36	39	12	10	11	13	14	2	3		117	99	109	123	135
Feb	73	62	69	78	84	31	26	29	33	36	11	9	10	12	13	2	3		117	99	109	123	135
Mar	60	51	57	64	69	27	23	26	29	31	11	9	10	12	13	2	3		100	84	93	105	116

Average weekly number of Fact Finding Assessments (FFAs) required to achieve the complex discharge targets above (by commissioner)

FFAs Required	Weekly Target	Shrops Council				Target	T&W Council				Target	Powys				Target	SaTH Total			
		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement
Oct	71	60	67	76	82	33	28	31	35	38	14	12	13	15	16	118	100	112	126	136
Nov	78	66	74	83	90	37	31	35	40	43	20	17	19	21	23	135	115	128	144	155
Dec	79	67	75	85	91	31	26	29	33	36	15	13	14	16	17	125	106	119	134	144
Jan	92	78	87	98	106	45	38	43	48	52	16	14	15	17	18	153	130	145	164	176
Feb	98	83	93	105	113	41	35	39	44	47	14	12	13	15	16	153	130	145	164	176
Mar	80	68	76	86	92	36	31	34	39	41	15	13	14	16	17	131	111	124	140	151

Average daily number of patients on the Medically Fit For Discharge list (by commissioner)

MFFDs	Weekly Target	Shrops Council				Target	T&W Council				Target	Powys				Target	SaTH Total			
		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement		Red Warning	Amber Warning	Amber Achievement	Green Achievement
Oct	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Nov	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Dec	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Jan	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Feb	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85
Mar	42	36	40	45	48	22	19	21	24	25	9	8	9	10	11	74	62	70	79	85

If required, during winter, the baseline and associated trigger points can be recalibrated to reflect improved performance.

A number of these metrics will be monitored nationally on a daily basis by NHS England as part of their winter monitoring arrangements. This data is published weekly, which will enable almost real-time monitoring to take place.

Two additional key metrics will also be monitored. These are: -

- Uptake of the additional capacity for Community IV antibiotics in Shrewsbury, Bridgnorth and Ludlow
- Utilisation of SATH2Home

For those metrics not available on a weekly basis, the system will set up information flows to be able to source as near to real time data as is available.

10. Escalation Planning

The Shropshire, Telford and Wrekin and Powys A&E Delivery Board wholly recognises that the system will experience fluctuations in demand across the winter period and partners have constructed models to forecast demand and plans to support response.

A programme of very senior leadership has been working across the system to facilitate the best possible planning prior to peak periods of demand that includes: appropriate staffing levels and senior level command and control across the system at peak times and in surge.

The Shropshire, Telford and Wrekin and Powys partners have surge and escalation plans which within Shropshire link to the Escalation Management System triggers that allows health system partners to gain situational awareness of capacity pressure. Organisational plans and procedures coordinated across the LHE manage day to day variations in demand as well as the procedures for managing significant surges by having a clear escalation and de-escalation plan based on 4 levels. Winter Escalation Action cards (Appendix 3) set out the pre-agreed key actions each organisation will implement against specific objectives to increase capacity and flow.

With the advent of the new EMS+ product, we have revised all action cards and plan to use the new model to manage our escalation calls. We believe that this will coordinate with the Winter Room process so that they can have real-time updates of our system automatically, reducing the need for extra calls. We are undertaking a programme of training for Our on-call managers and all managers and clinicians involved in escalation calls. We have already developed an agenda template for calls, however the ability to automatically pull reports into the EMS system from site sitreps has still to be developed so the EMS team are working on this before we can test and go-live. In the meantime, our escalation calls continue on a twice daily basis as usual.

10.1 SaTH Emergency Department Plans

SaTH RSH Emergency Department (ED) is a Trauma Unit which supports the regional Trauma Centre service. The Emergency Department, and the PRH Emergency Department will be supported by the emergency floor Rapid Assessment and Treatment model (here called Pit-Stop), which will be improved as part of our high impact changes from October 2018 to expedite flow from the ED into assessment functions.

The two EDs regularly manage a range of attendances per day of 350-420 at seasonal peaks.

The Trust is in surge when ambulance attendances rise to more than 6 (RSH), 8 (PRH) per hour over a 3-hour period and the departments have in excess of 20 major patients.

SaTH are reviewing escalation trigger pathways for Non-Elective attendances arriving at ED in order to get improved pace and response to hourly surge activity into the department together with ‘next day’ risk management and follow on actions for expedited return to Level 1. This will include specialty in reach to support front door ‘Pit-Stop’ (Rapid Assessment and Treatment) and expansion of the ED floor to support flow, for example, the use of head and neck theatres and recovery adjacent to RSH ED and the new front door extension to ED in PRH.

Other hospital flow enablers in place to support contained escalation include:

- Adherence to Internal Professional Standards by receiving specialities, accepting and transferring patients within 30 minutes following referral. We are working with our mental health colleagues to enhance the response rate from Consultant Psychiatrists also.
- Individual tracking using a check, chase and challenge model for patients to ensure timely transfer

11. Surge Plan

As part of business continuity and contingency planning the system has to plan for expected and un-expected surges in demand. Part of the surge plan will focus on the bank holiday periods :

- Christmas
- New Year
- Easter

The system is revising action cards to ensure that risk is shared throughout the system focusing on patient safety.

Escalation calls in periods of escalation, using the EMS system triggers, will continue to be held twice a day through winter with all organisations supporting through senior CCG leadership input, with calls coordinated through SaTH. If the system experiences significant/sustained pressure, issues will be escalated to the senior leaders and regulators.

Providers have included their own specific actions to respond to surge in their winter plans.

12. System On-Call Arrangements

The system has a long-established mechanism for on call across all key partners, which is further complemented by the Escalation Management System (EMS) and Shropshire, Telford and Wrekin and Powys Escalation Plan (Appendix 3). The response element (Action Cards) of the plan is determined by the EMS level and is refreshed bi-annually.

In the event that the system experiences significant/sustained pressure issues, at least twice daily conference calls will be undertaken to identify and respond to the pressures in the system when agreed triggers are reached. During the winter period, we have agreed to have at least two calls at 10.30am and 2pm each day. The calls will be chaired by the system Urgent Care Director or CCG Commissioning Lead or deputy and will eventually use the EMS+ system to both arrange the call and also to record the actions on the call. Each meeting will have an agreed agenda, and partners will all populate the EMS capacity system so that it is visible to all.

The system has an established combination of senior management and executive level on-call rotas which will support the management of escalation.

SaTH will continue to manage flow. Community Trust, RJAH, WMAS, Non-Emergency Patient Transport, Complex Discharge, Social Care and Mental Health Operational Leads are invited to attend to support a single site view of flow and actions required to next Sit Rep.

Each provider has detailed their internal on call arrangements within their plans to ensure there is coverage.

The teleconference template module within EMS is planned to be utilised with effect from 14 December 2018 (if the module is ready and tested), in accordance with the conference call SOP, (in development) to assist with the organisation, reporting and recording of conferences calls relating to escalation.

13. Adverse Weather Plans

All key partners across the health and social care economy have organisation specific adverse weather plans which focus on the maintenance of service delivery and the safety of staff. These plans are fully tested, and the NHS plans are assured via the EPRR Core Standards Assessment Process.

All plans fully reflect the Cold Weather Plan for England, are invoked via the command and control structures and encompass specific communication arrangements. This ensures that a consistent approach is applied across the economy. The Cold Weather Plan for England specifies the levels as:

- Level 0: “Year-round planning” and the Making the Case companion document may be more of relevance to public health professionals, Health and Wellbeing Boards (HWB), local authority chief executives and elected members;
- Level 1: “Winter preparedness and action” and the Making the Case companion document will be of relevance to all professional groups, particularly front-line health and social care professionals;
- Levels: 2-4 “Severe winter weather is forecast through to national emergency” are more reactive in nature and include snow and ice as well as severe cold weather and may be particularly relevant to emergency planners and responders.

Via the EPRR route, partners receive weather warnings from the Meteorological Office and in the event of weather related incident affecting business continuity, a health cell (membership from the Local Health Resilience Partnership) will be established to coordinate the response).

At a local level, plans detail proactive communications (internal and external), staff briefings to ensure services are coordinated, flexible working, mutual aid, the use of the voluntary sector and specialised transport arrangements.

14. Influenza Strategy

The National Influenza Plan is a key prevention item for the winter and sets out a coordinated and evidence-based approach to planning for and responding to the demands across England, taken from the lessons learnt during previous Influenza episodes. It provides the public and

healthcare professionals with an overview of the coordination and the preparation for the Influenza season and signposting to further guidance and information.

The National Influenza Plan encompasses the responsibilities for NHS England, Public Health England, Local Authorities, providers, CCGs, General Practitioners and enacts the National Influenza Vaccination programme.

The Local Flu Plan supports the coordinated and evidence-based approach to planning and responding to the demands of flu across Shropshire, Telford and Wrekin and Powys supported with a Commissioning for Quality and Innovation (CQUIN). A Shropshire, Telford and Wrekin and Powys Influenza Memorandum of Understanding (MOU) is in place to ensure partnership working to support all aspects of the local health economy for example if there was a flu outbreak in a care home they would receive support from Public Health and MPFT with assessment and vaccination.

In 2018-19 the plan aims to ensure that:

- Vaccination is actively offered to 100% of all those eligible groups;
- Vaccination of at least 75% of those aged 65 years and over;
- Vaccination of at least 75% of healthcare workers with direct patient contact;
- Improving uptake for those in clinical risk groups, particularly for those who are at the highest risk of mortality from flu but have the lowest rates of vaccine uptake, such as those with long-term liver and neurological disease, including people with learning disabilities or children, a minimum uptake of 40% has been shown to be achievable in pilots conducted to date. As a minimum uptake levels between 40% and 60% to be attained and uptake levels should be consistent across all localities and sectors of the population;
- Providing direct protection to children by extending the annual flu immunisation programme and also cutting the transmission of flu across the population;
- Monitoring flu activity, severity of the disease, vaccine uptake and impact on the NHS;
- Prescribing of antiviral medicines in primary care for patients in at-risk groups and other eligible patients under NHS regulations and in line with NICE guidance;
- Providing public health information to prevent and protect against flu;
- Managing and implementing the public health response to incidents and outbreaks;
- Ensuring the NHS and PHE are well prepared and has appropriate surge and resilience arrangements in place during the flu season.
- All Shropshire, Telford and Wrekin and Powys providers attained the 75% level in 2017/18 for flu vaccination.

In addition, each provider has reviewed their flu plans and included additional actions within their own organisations plans:

Fig. 6: Additional actions within organisational flu plans

Organisation	Additional Actions
SaTH	• Monthly Flu Steering Group in order to plan, deliver and review flu programme • Embedding of a “check and prompt” process to help protect

	patients with LoS greater than 30 days • SaTH will focus on proactive communications (internal and external), staff briefings to ensure services are coordinated, flexible working, mutual aid, the use of the voluntary sector and specialised transport arrangements.
Shropdoc	• Reviewing option to deliver their own internal flu vaccination clinics
Shropcom	• Will encourage staff to have flu vaccinations with drop-in clinics, communications, increasing number of vaccinators • Work with primary care to vaccinate housebound patients • All in patients and new admissions through winter at community hospitals will be offered vaccination
Shropshire Council	• Communication re precautionary measures and symptoms of flu to care providers and direct payment advisory services
Telford and Wrekin Council	• Target care homes to all residents are offered flu vaccination • Encourage care homes to enable and promote flu vaccinations • Council Staff Flu Immunisation Programme offering free immunisation all Council Staff, in clinics held in a range of venues to maximise uptake. A total of 129 Enablement Workers, provide direct social care, these staff are being offered bespoke workplace clinics. Programme of awareness raising and promotion, including myth busting.
Powys THB and LA	• As per the integrated plan (Appendix 2)
WMAS	• Deliver flu vaccinations at various locations • Train paramedics to administer the vaccination • Aiming 80% uptake by 31st December 2018 • Trust engagement vehicle mobilised to locations not served by paramedics to ensure mobile flu clinics are available.
RJAH	• Delivering flu vaccinations in fixed areas and walkabouts to cover both clinical and non-clinical areas, with additional input from Team Prevent • Programme being advertised in daily bulletins, with Comms team supporting with staff story's • Banners, posters, intranet, with links to videos, and screen-saver messaging • Staff incentives inc vouchers for sandwich & piece of fruit. • Local businesses approached to provide prizes to be drawn each month

15. Outbreak Plans

All provider organisations have robust plans for the prevention and management of outbreaks, predominantly led by Infection Prevention Teams. The plans have been tested, applied to respond to live issues and supported by clinical teams with on-site presence and on call availability.

Outbreaks have the potential to significantly preclude system flow and whilst the system does have effective plans and a degree of side room capacity, this remains a significant risk.

All relevant staff are comprehensively trained in infection prevention and in the event of staff sickness having a material effect on a service; a clinical prioritisation process will be applied, supported with mutual aid agreements.

16. Communication

The Winter Communications Campaign on behalf of all CCGs is aligned to the National Stay Well campaign and the STP Communications Plan. The strategy includes:

- Focus on social & digital;
- Pan Shropshire, Telford and Wrekin and Powys coordinated approach including all commissioners and providers;
- Utilising Patient Participation Groups to share information within their local communities.

Providers have organisation-specific communication plans which complement the system-wide plan. All existing communication channels will be used to target the groups most vulnerable over winter to ensure that people who are most at-risk of preventable emergency admission to hospital are aware of and, where possible, are motivated to take actions that may avoid admission this winter.

The campaign will ensure that:

- There is a consistent identity to promote the range of services available to patients/service users (focussing on clinically appropriate alternatives to 999 and ED);
- Patients/service users are made aware that 999 and ED are for life-threatening/serious issues only;
- Patients/service users are made aware that NHS 111 is the most effective service for non-life threatening/serious issues;
- Self-care and prevention is fully promoted.

A communications escalation card has been developed and will be included in the set of escalation cards for the first time this year.

16.1 Cascading Advanced Warnings and Focus on High Risk Groups

In addition, the communication arrangements across the system, partners have specific plans in place to communicate to those patents/service users identified as at a heightened level of risk, due to the winter period. Activities include work with rural communities, high volume users, vulnerable patients/service users, patients/service users with long term conditions and sourcing support from the voluntary sector.

System partners also receive alert information from a number of agencies (e.g. Civil Contingencies Unit, Police, Meteorological Office etc.), which are used to proactively plan and effectively respond via the EPRR arrangements.

17. Demand and Capacity Modelling

17.1 Regional Requirement

Regional Winter Planning 2018/19 Guidance was issued on 22nd March 2018. The key requirements within the guidance included: -

- There will be no additional winter funding in 2018/19
- Winter plans to include phasing profiles to reflect seasonal changes in demand
- Winter plans to demonstrate a system-wide approach that aligns key assumptions between providers and commissioners which are credible in the round.
- Final Winter Plan to be submitted to NHS England by 31st October 2018.
- All plans and schemes in place and operational by end of November 2018 unless phased differently in the plan.in readiness for the start of winter.

As one of the system high impact changes, a system-wide demand and capacity model has been developed, with the planning for winter as an integral part of this model.

17.2 Local System Winter Planning Approach

The Plan has been developed through robust engagement of all key system partners overseen by the A&E Delivery Group. System stakeholders have also attended a NHSE workshop in April and 2 local planning workshops in July.

In parallel, system demand and capacity modelling has been undertaken to determine predicted winter demand and required acute bed capacity to inform the bed bridge calculations.

All Providers were asked to demonstrate an understanding of their demand and capacity over the winter months and provide an organisational winter plan which includes:

- Additionally, and phasing of escalation
- A workforce model to support 7-day working, senior decision making and escalation capacity
- 7-day working
- Christmas, New Year and Easter period
- Options for further surge capacity if required

17.3 Demand Analysis and Bed Bridge Calculation

SaTH experienced significant emergency pressures over the winter period 2017/18. These pressures were fuelled not only by an increasing volume of demand but by the increased acuity of patients, resulting in longer lengths of stay. These factors have been reflected in the activity and winter plan for 2018/19.

SaTH have agreed to a performance improvement trajectory for the 4-hour A&E national standard of 80% by December 2018 and 90% by March 2019. Progression to 95% going forward will be dependent upon sufficient workforce capacity being available and community services and local authorities ensuring continued timely patient transfer/discharge through the

winter. SaTH are drafting a set of internal performance measures designed to support end to end visibility of hospital flow, linked to the three high impact changes they lead on which are: -
1) ED systems and processes,
2) the reduction in the stranded patient metric (reduction in long length of stay patients) and
3) embedding the SAFER patient flow bundle and Red2Green.

Ultimately the analysis of predicted demand over the winter period is to determine the additional number of acute beds that will be required above the current core acute bed stock to meet predicted winter demand (the Bed Bridge).

The Trust's growth figures are based on a detailed bottom-up analysis of local demographics and morbidity, recent experience and known capacity constraints. Detailed demand and capacity analysis has been undertaken to inform this plan through a workstream of the A&E Delivery Group involving all key system stakeholders utilising agreed and validated data sources. Demand analysis has been undertaken at both a SATH and individual acute hospital site level. This is important to ensure that the system is fully sighted on any differentials in demand to ensure that interventions can be appropriately targeted at a hospital site level.

The outcome of this analysis is described in the following sections. The forecast method used is to plot the regression trend through actual weekly SUS data for SaTH catchment activity. Seasonality adjustments by average variances across the last 2 years from regression trend have been applied. This gives flexing of forecast to match the pattern of the last 2 years.

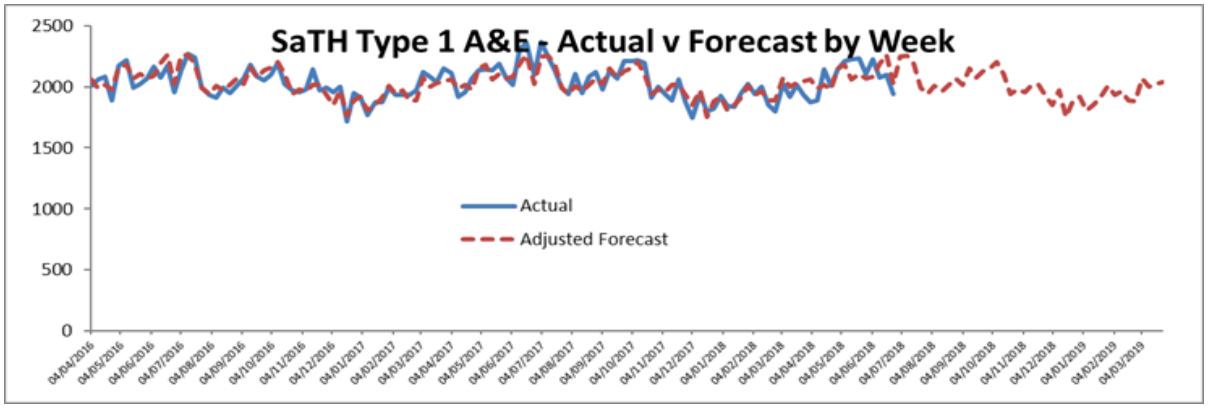
17.4 Demand – Historic Trend and Forecast

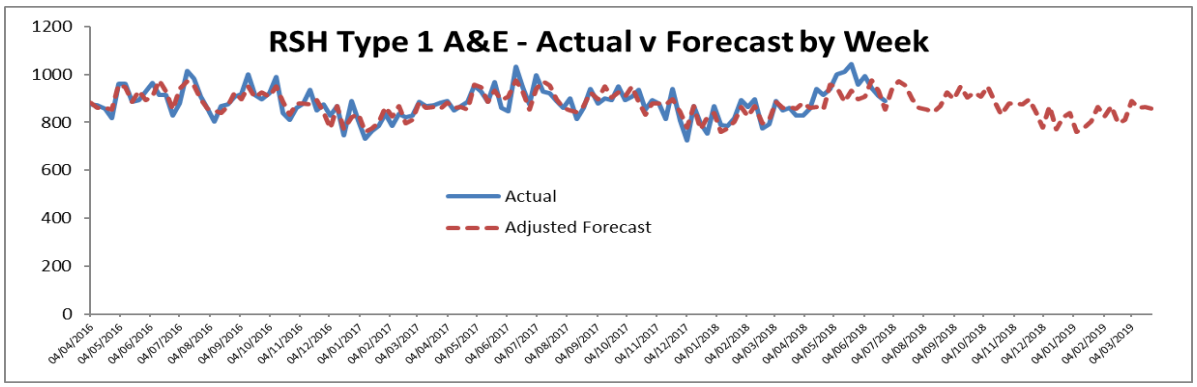
17.4.1 A&E Type 1

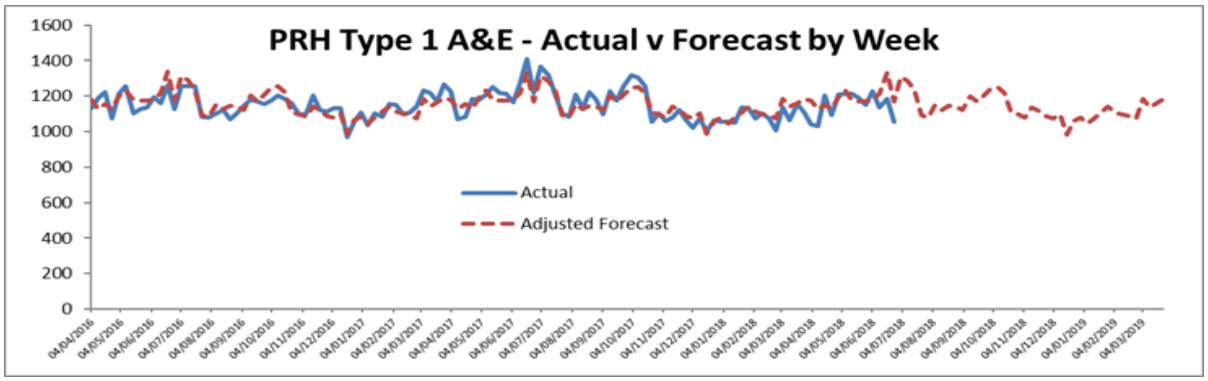
For Type 1 A&E activity the historic trend line is generally a flat trend with summer peak activity and winter troughs. The overall % growth predicted by site is shown in the table below.

SATH	RSH	PRH
1%	0.2%	1.5%

The activity trend lines by site are shown in the graphs below.







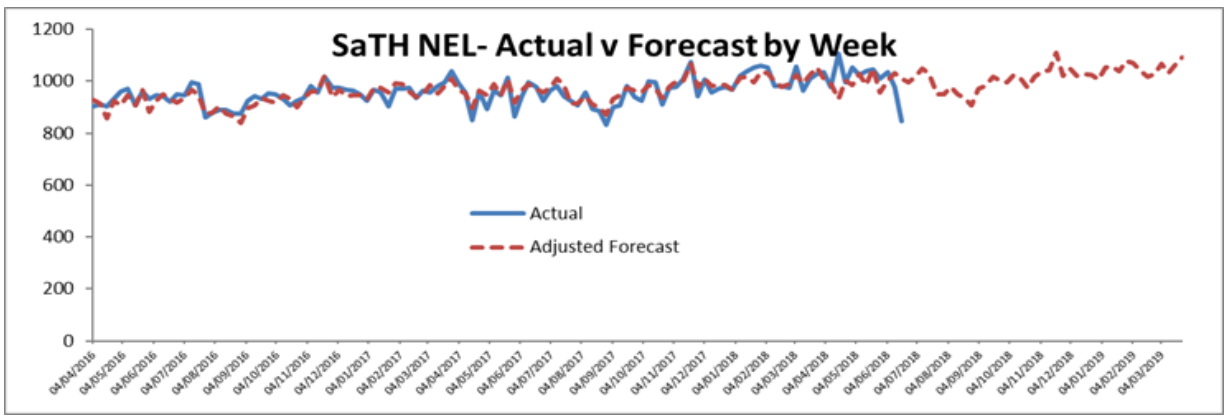
17.4.2 Non-Elective

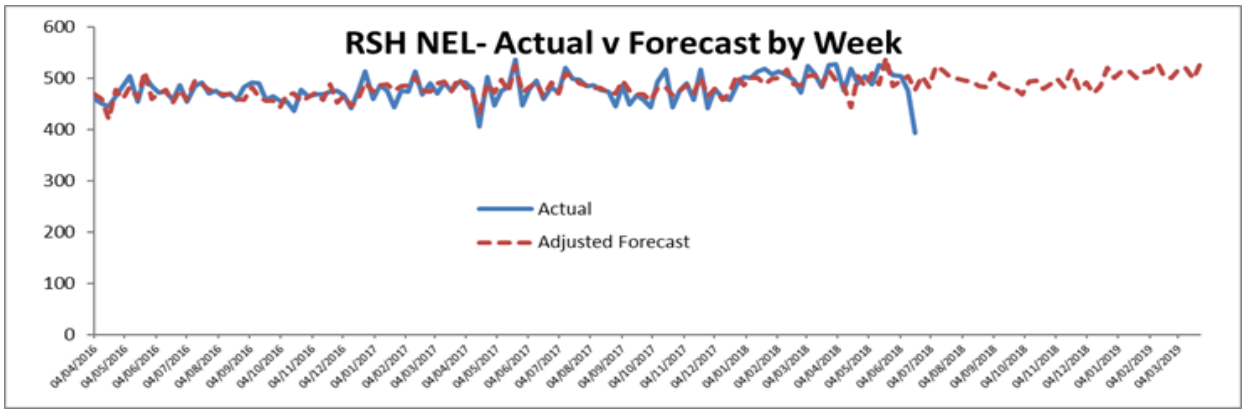
Non-elective activity shows a rising trend line although this growth is more rapid at PRH. Emergency growth is concentrated in the zero-day LOS (Apr – Jun 2017 = 28.4% compared to 33.6% in same period 2018).

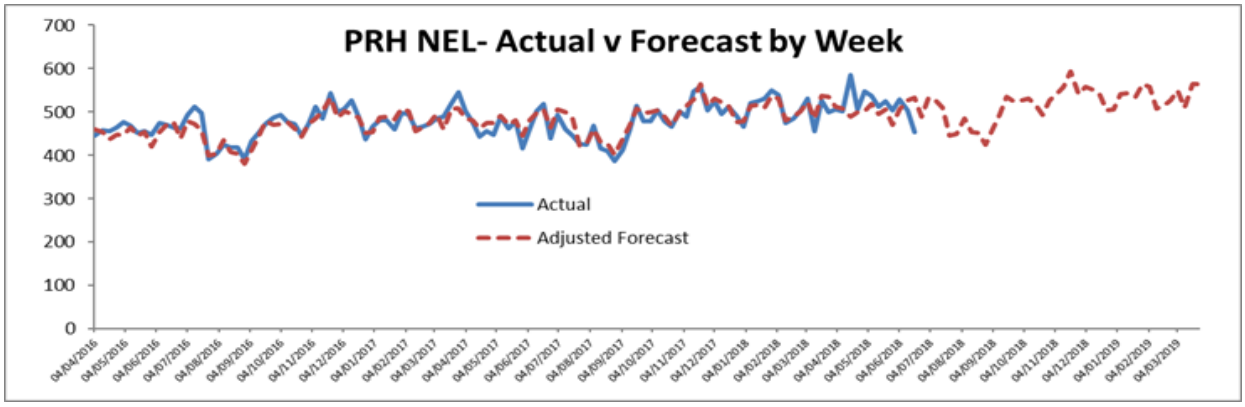
The growth in 0 LOS was higher at PRH (32.6% (2017) to 39.5% (2018). Further analysis confirmed that this growth in activity was attributable to the opening of Clinical Decision Unit (CDU) at PRH and that for RSH the growth (24.3% to 27.3%) had no material impact on required winter bed capacity numbers for that site. Adjustments have been made to the activity calculations to ensure zero LOS is accurately reflected in the bed gap calculations.

SATH	RSH	PRH
2.9%	2.4%	3.4%

The activity trend lines by site are shown in the graphs below.



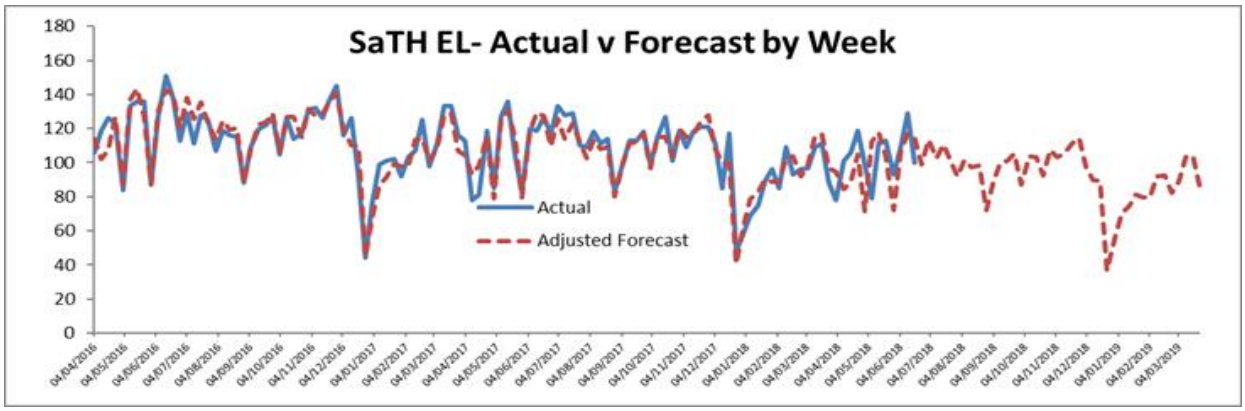


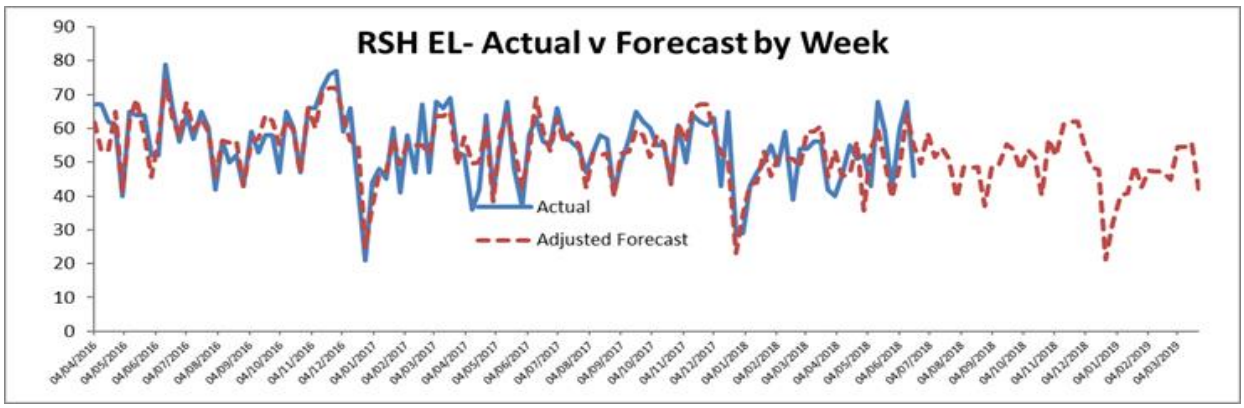


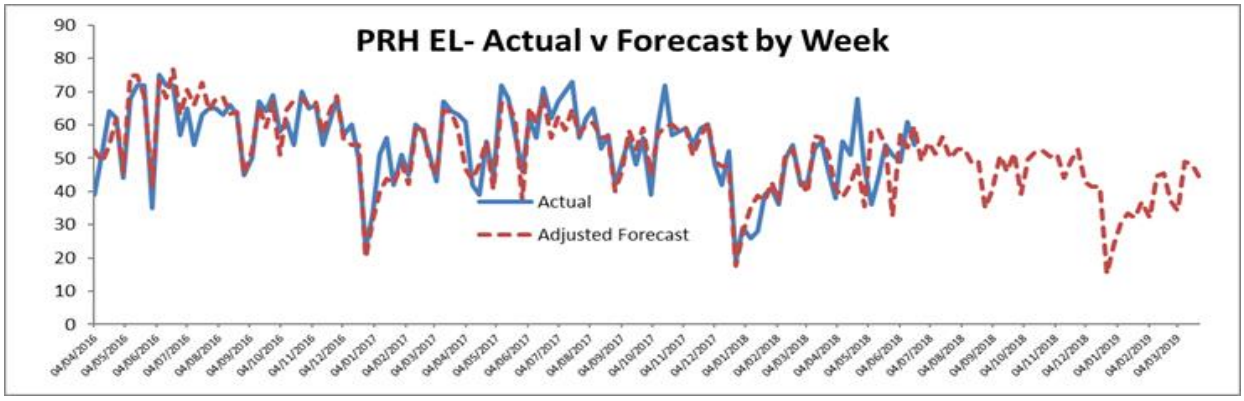
17.4.3 Elective

Analysis of elective activity shows a decreasing trend at both sites.

SATH	RSH	PRH
-7.7%	-6.3%	-9.3%







The tables below provide a more detailed breakdown comparison of the baseline 2017/18 activity and forecast demand in 2018/19 per month. As can be seen from the tables, for SATH, all in-patient activity is projecting a 2% growth. The national prediction of growth is 4% for non-elective. The system has planned for a 5% increase in non-elective activity, a net total inpatient activity increase of 3.9%. This together with the increase in 0-day length of stay in the last 12 months produces an overall 2% increase in the number of beds required as described in section 16.5.

SATH total

	Oct	Nov	Dec	Jan	Feb	Mar	Total	Growth
A&E Type 1								
Baseline 17/18	9,321	8,315	8,091	8,486	7,583	8,735	50,532	
Demand Forecast	9,185	8,477	8,303	8,381	7,670	9,006	51,022	1.0%
Contract	9,020	8,514	8,416	8,646	8,229	9,169	51,994	
Non-Elective								
Baseline 17/18	4,255	4,289	4,330	4,547	3,991	4,487	25,899	
Demand Forecast	5191	4167	5227	4196	4208	4221	27210	5%
Contract (all comm)	4,121	4,247	4,284	4,347	4,095	4,435	25,530	
Original Submission	4,189	4,269	4,491	4,399	4,157	4,589	26,094	
Elective								
Baseline 17/18	497	503	359	343	383	448	2,533	
Demand Forecast	438	465	327	338	346	424	2,338	-7.7%
Contract (all comm)	422	405	368	307	337	380	2,219	
All Inpatient								
Baseline 17/18	4,752	4,791	4,689	4,890	4,374	4,936	28,432	
Demand Forecast	5629	4632	5554	4534	4554	4645	29549	3.9%
Contract (all comm)	4,544	4,652	4,652	4,654	4,432	4,814	27,749	

RSH

	Oct	Nov	Dec	Jan	Feb	Mar	Total	Growth
A&E Type 1								
Baseline 17/18	3,973	3,684	3,480	3,678	3,326	3,794	21,935	
Demand Forecast	3,947	3,739	3,611	3,547	3,300	3,842	21,986	0.2%
Non-Elective								
Baseline 17/18	2,102	2,041	2,088	2,251	1,988	2,259	12,729	
Demand Forecast	2562	2056	2578	2069	2074	2080	13418	5.4%
Elective								
Baseline 17/18	244	254	221	198	201	230	1,349	
Demand Forecast	222	254	181	191	187	229	1,264	-6.3%
All Inpatient								
Baseline 17/18	2,345	2,295	2,310	2,450	2,189	2,489	14,078	
Demand Forecast	2,784	2,310	2,759	2,260	2,261	2,309	14,683	4.3%

PRH

	Oct	Nov	Dec	Jan	Feb	Mar	Total	Growth
A&E Type 1								
Baseline 17/18	5,348	4,632	4,611	4,808	4,257	4,941	28,597	
Demand Forecast	5,238	4,738	4,692	4,835	4,370	5,164	29,036	1.5%
Non-Elective								
Baseline 17/18	2,153	2,248	2,242	2,296	2,003	2,229	13,170	
Demand Forecast	2630	2112	2649	2127	2134	2141	13792	4.7%
Elective								
Baseline 17/18	253	249	138	144	182	218	1,184	
Demand Forecast	216	211	146	147	159	194	1,074	-9.3%
All Inpatient								
Baseline 17/18	2,406	2,496	2,380	2,440	2,185	2,447	14,355	
Demand Forecast	2,846	2,323	2,795	2,274	2,293	2,335	14,866	3.6%

In summary, the predicted growth in activity is shown in the table below.

Predicted % Growth in Demand compared to 17/18 baseline			
	SATH	PRH	RSH
A&E Type1	1.0%	1.5%	0.2%
Non -Elective	5.0%	4.7%	5.4%
Elective	-7.7%	-9.3%	-6.3%
All Inpatient	3.9%	3.6%	4.3%

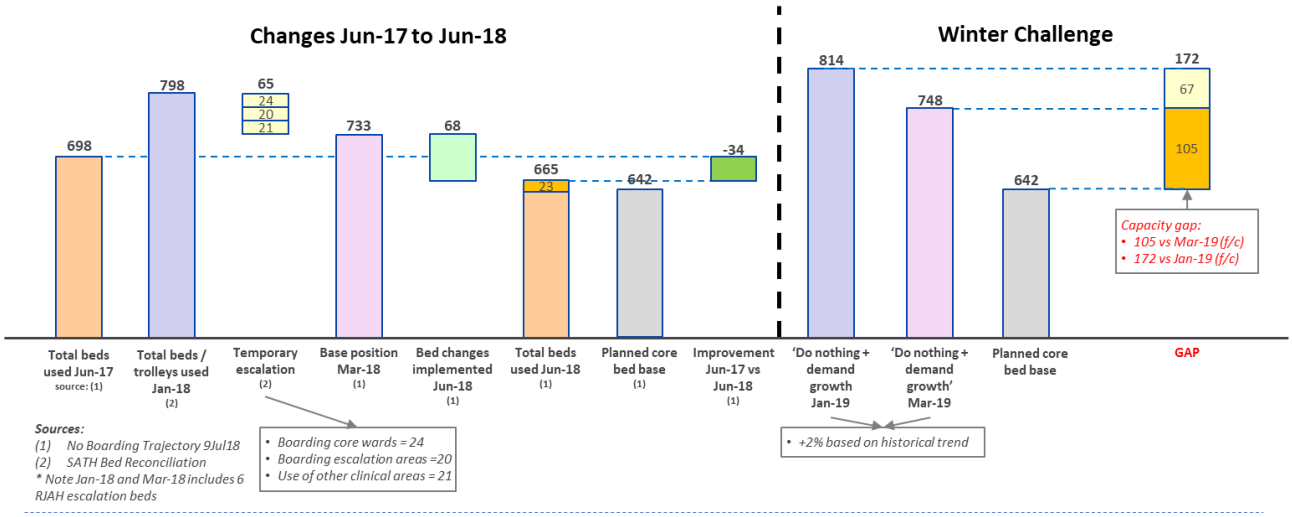
17.5 Capacity – historic capacity used and the 'do nothing' forecast

An analysis of historic bed capacity in use at key points in the year has been undertaken which identifies the trend in bed capacity utilisation, including the peak in January and the start

position this June over and above the acute core bed stock of 642 (this number excludes maternity, paediatrics and critical care). This analysis is shown diagrammatically on the left section of the diagrams below.

17.5.1 SATH Bed Capacity Requirements Winter 2018/19

At the peak of demand in January, SATH reported a total of 798 acute beds in operation, 65 of these beds were escalation expansion into other clinical areas and boarding patients in escalation and ward areas.



In June 2018, the total number of acute beds in use in SATH was 665 which is 23 beds more than the core bed stock level of 642. However, this represents 34 fewer than were in use in the comparable period in 2017. A significant proportion of this bed reduction is attributable to the successful work programme to reduce the number of stranded patients (>7-day LoS) and to reduce the number of patients on the Medically Fit for Discharge list (MFFD).

The forecast of predicted winter bed capacity requirements above the core bed stock is described diagrammatically on the right of the diagrams utilising 2 scenarios: -

1. At Jan Peak - Do Nothing* + 2% growth in bed requirement (resulting from the 5% expected growth in activity quoted above in the predicted growth table in 16.4)

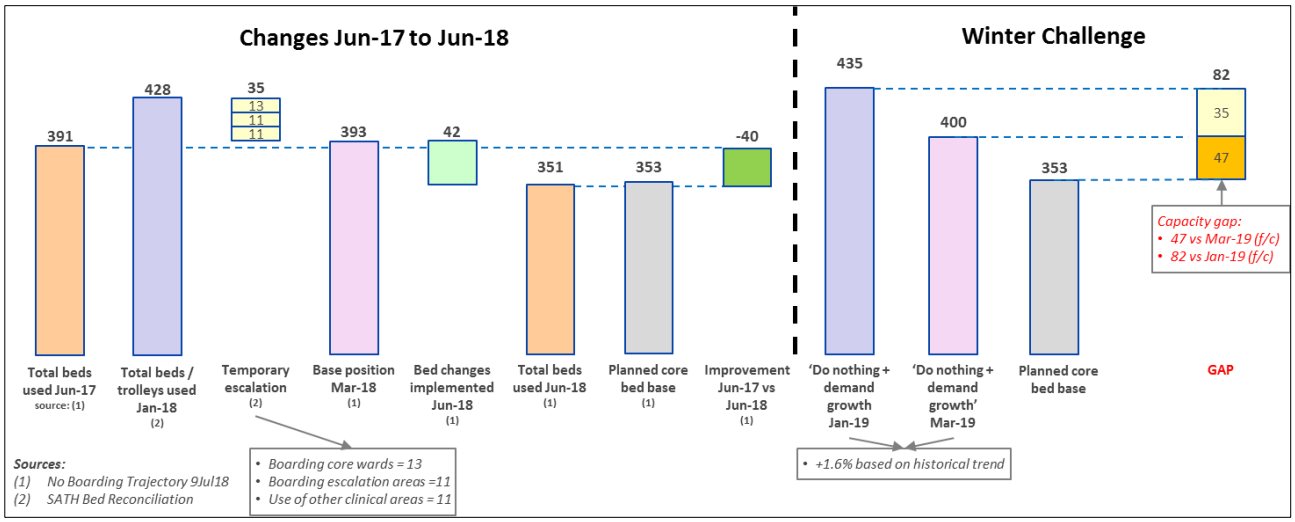
2. At March demand - Do Nothing + 2% growth in bed requirement (resulting from the 5% expected growth in activity quoted above in the predicted growth table in 16.4)

*(*Do nothing means predicted volume of demand recorded in the same period in 2017 with no mitigating interventions)*

For SATH as a whole to meet the predicted peak January demand for acute beds requires an additional 172 beds/mitigation interventions above the 642-core bed stock. To meet the predicted demand in March requires an additional 105 beds/mitigations.

However, as represented in the diagrams below, when analysed at a hospital site level the winter capacity requirements are significantly different. For the most part this is due to the majority of bed reduction benefit from the stranded and FFT programmes being realised at the Royal Shrewsbury Hospital (-40 beds). The Princess Royal Hospital is showing 7 more beds in use this June compared to June 2017.

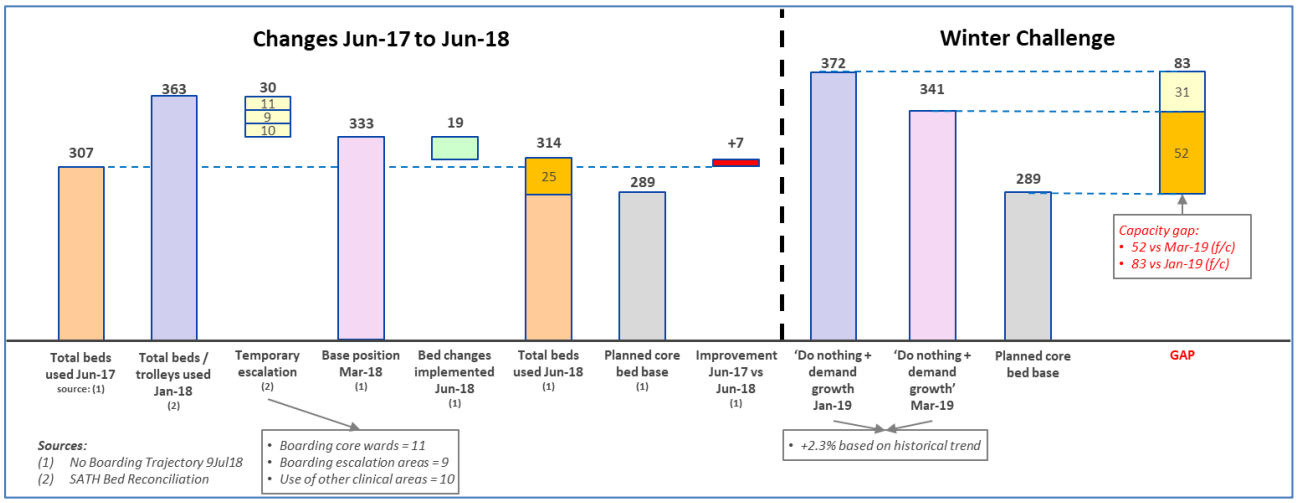
17.5.2 RSH Bed Capacity Requirements Winter 2018/19



The winter 2018/19 bed capacity forecast for RSH shows:

- To meet the January peak of 435 requires an additional 82 beds / mitigations (vs 353 core beds)
- To meet the 'March' demand of 400 requires an additional 47 beds / mitigations (vs 353 core beds)

17.5.3 PRH Bed Capacity Requirements Winter 2018/19



The winter 2018/19 bed capacity forecast for PRH shows:

- To meet the January peak of 382 requires an additional 83 beds / mitigations (vs 289 core beds)
- To meet the 'March' demand of 350 requires an additional 52 beds / mitigations (vs 289 core beds)

17.6 The impact of the PRH ED Closure overnight

At the end of September SATH Board took the decision, due to unsustainable workforce issues and the consequent risks to patient safety, that the PRH ED should be closed temporarily overnight. As a result, the demand and capacity analysis described in the previous section was revised to reflect the impact assumptions on patient flows that the closure is predicted to have.

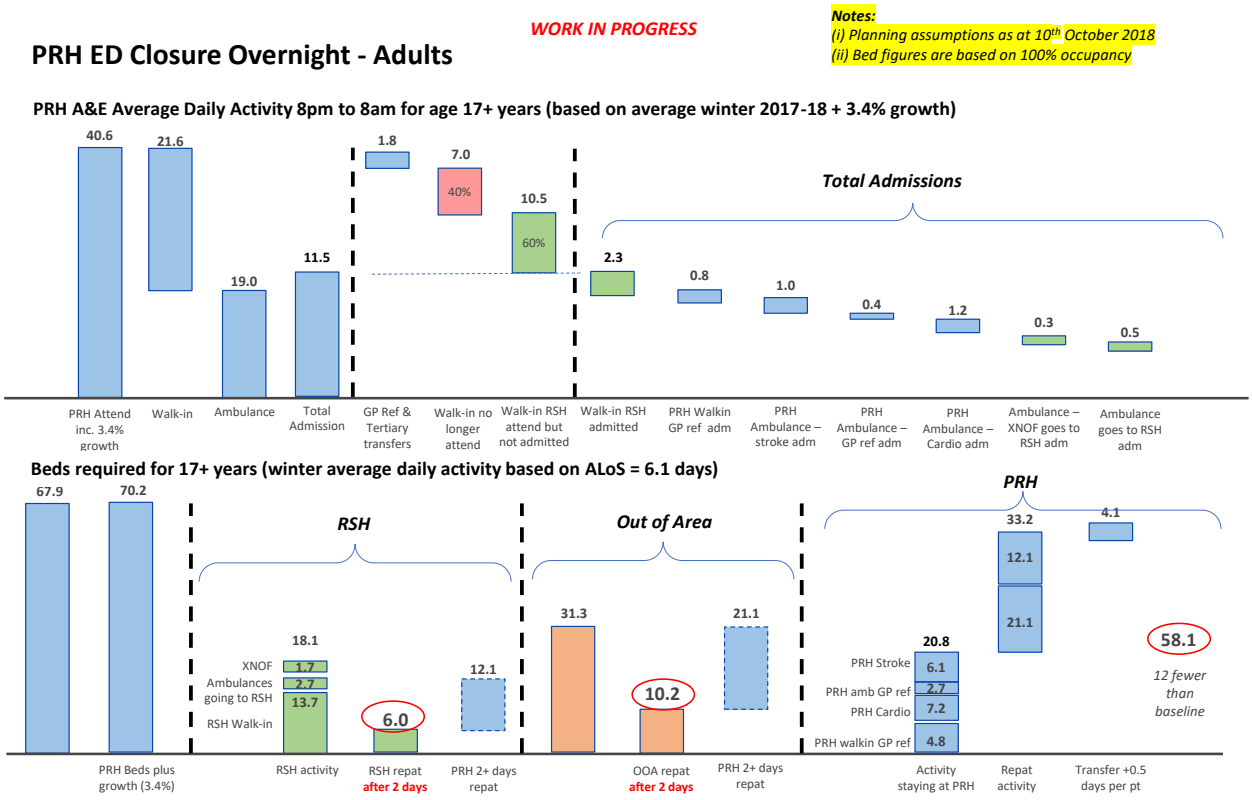
This revised analysis is shown in the diagrams below. The assumptions used in the calculations are: -

For the adult related PRH activity based on the impact experienced with overnight closure elsewhere, the following assumptions have been made:

- An estimated 40% of walk ins will no longer attend
- There are a proportion of admissions (3) that will go to RSH and a number (3) that can still be admitted to PRH overnight based on the agreed clinical pathways.
- The balance will go out of county

This is modelled in the top activity bridge diagram below.

Impact on Adult bed position:



The resulting impact on beds is shown in the bed bridge above. Key points to note are:-

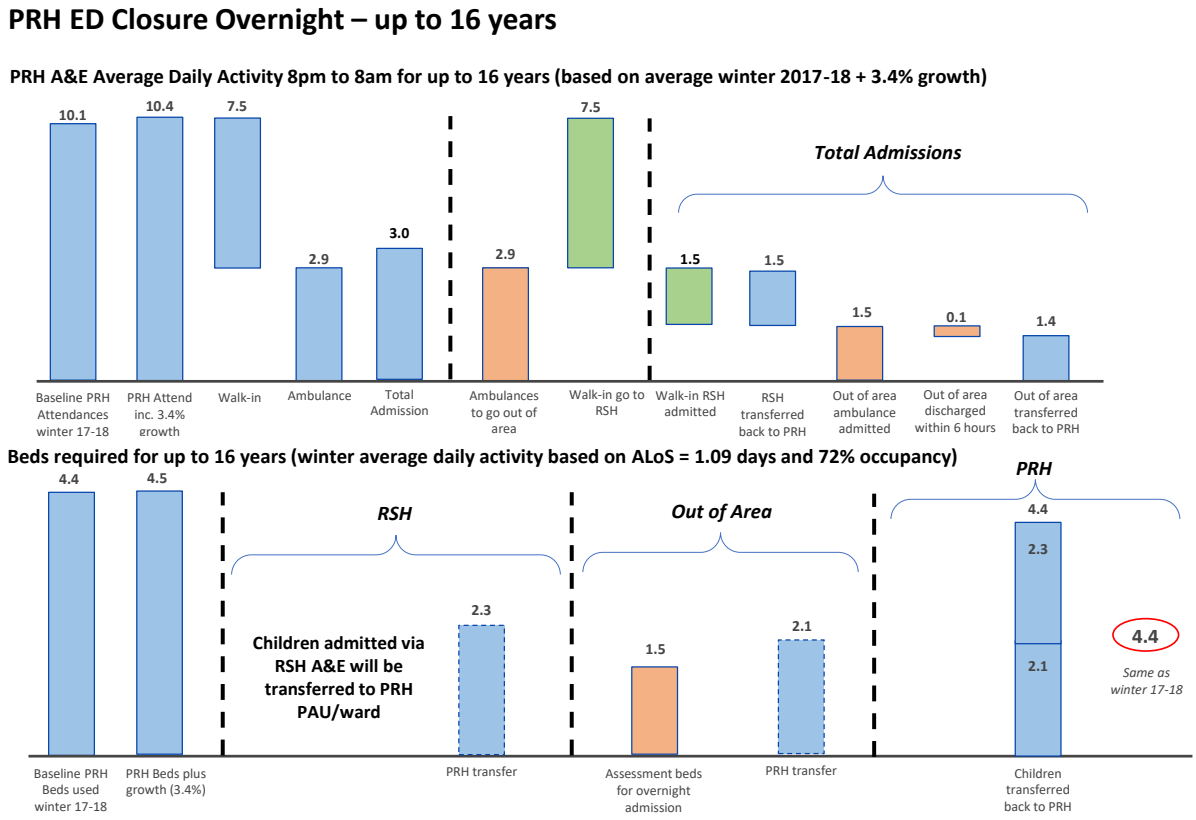
- An additional 18.1 beds are initially required at RSH but post repatriation the net increase is 6 beds. The net impact on out of county providers post repatriation is 10.2 beds.
- The total impact for PRH has been based on the sum of the activity remaining at PRH plus that being repatriated plus an expected increase in LoS of 0.5 days per patient due to the transfer.
- This equated to a total bed requirement of 58 beds which is 12 less than the baseline requirement of 70.2 including growth for 18/19.
- This is based on a planned closure of 8pm. This is currently still under discussion as the Trust has been asked to source additional staff to minimise the hours closed to 10pm – 8am. If this is successful the bed modelling will need to be refreshed for one final iteration.

In summary, this results in a lower demand for beds at PRH of -12, which is the 70.2 original demand minus the new demand of 58.1. The resulting impact for RSH is a net increase in demand of +6 beds. There is also an out of county demand of 10.2 beds.

The planned closure has a specific impact on paediatric demand as the county's Women and Children's services are consolidated on the PRH site. The assumption within the current closure plan is that all this activity will intially need to go out of county and then be repatriated back to PRH. However, the predicted impact on beds is neglible (see diagram below) with only a slight reduction expected due to a small number of children who would be taken out of area but then discharged before repatriation can take place the next day.

Impact on Paediatric Bed Position

WORK IN PROGRESS



In summary, the resulting impact on beds from the paediatric shift is negligible, a new demand of 4.4 beds versus the demand of 4.5 under the original plan where PRH ED remained open.

17.7 Winter Capacity Plan

17.7.1 Overview of the Plan

Planning work to inform the Winter Plan has involved facilitated workshops. Stakeholder partners have also submitted proposals for winter capacity schemes as part of this planning work.

In their winter capacity proposals, partners were asked to submit: -

- details of the scheme

- costs (including whether the cost is to be met from new non-recurrent investment or from existing identified funding streams)
- the anticipated impact on acute beds
- confidence level in successful operational delivery to timescales and ongoing maintenance

All the above information was collated into a long list of approximately 60 schemes. The A&E Delivery Group has undertaken an iterative review process of the long list at its bi-weekly meetings to formulate a shortlist which constitutes the final Winter Capacity Plan.

17.7.2 Summary Winter Capacity Plan Bed Impact

The table below provides a summary position of the capacity that system partners have committed to bring on line to mitigate the anticipated gap throughout the winter period by hospital site. The numbers represent the expected contribution the interventions will make to bridge the predicted bed gap this winter compared with the acute core bed stock of 642 for the peak January period.

	PRH	RSH	By When
Bed Gap			
Bed bridge gap at peak winter demand	-83	-82	Jan/Feb 2019
Bed impact of temporary closure of PRH ED overnight (+ve means reduction in beds needed)	12	-6	5th December 2018
Bed gap	-71	-88	
SATH Mitigations – Low Risk			
MFFD maintained at c70/Stranded patient improvement	24	43	1st October 2018
Extended operating hours in MAU/SAU	3	3	TBA
Phase 1 - Planned escalation bed capacity (Wards 21 and 8)	14	16	Phased from 1.10.18 as necessary, fully operational by 1.12.18
Phase 2 – Planned escalation bed capacity (Ward 19)		30	24th December 2018
Total low risk mitigation bed capacity	41	92	
Net bed gap	-30	4	
Additional system mitigations – Low Risk			
Improved utilisation of community hospital beds	10		1.10.18 criteria flexed. Discussions ongoing with acute about speciality cover allowing further sub-acute admissions
Additional LA D2A beds	7	5	1st October 2018
Expansion of SATH2Home capacity	8	2	TBA
Total additional system mitigations bed capacity	25	7	
Net bed gap	-5	11	
Additional system mitigations – High Risk			
Improved weekend discharges	5	5	Requires detailed delivery plan
Reduction in Powys LA delays	1	1	Requires agreement from Powys
Total	6	6	
Final position (+ve = surplus) net bed gap	1	17	
If required, short term time limited SATH surge contingency bed capacity			
Planned time limited contingency escalation beds	24		PRH DSU eg February for 3-4 weeks

Additional system mitigations to support the maintenance/improvement in acute flow (no direct bed capacity impact)			
Community IV antibiotics			1.10.18
Discharge lounge on both sites			
Frailty Front Door/Admission Avoidance services			RSH in place. PRH tbc
T&W Care Home MDT			Operational
Carers in a Car			Operational
x8 Shrewsbury Pathway 2 care home beds			Operational
x4 Pathway 3 Dementia beds (Redwoods)			1.11.18
Additional social work and brokerage capacity			To support weekend discharge
Rapid Response / WMAS Car scheme in Telford			Operational since 5th Nov – impact to be quantified

Assumptions applied to this plan are:

- There is no variation in the calculated bed gap throughout the winter period;
- Maintenance of the reduction in long lengths of stay at 250 (over 7 days) including 50 (over 20 days).

A more detailed description of the planned mitigations/interventions which support the Winter Capacity Plan is set out in the following section.

As previously indicated, unscheduled care demand in the Winter Plan is profiled above 17/18 activity. If the service is unable to return to seasonally expected unscheduled care activity levels, further compensatory provision will need to be made to the capacity modelling for winter.

This will be kept under review by the system wide stakeholders.

17.8 Acute Bed Gap Mitigating Interventions Winter 2018/19

17.8.1 Admission Avoidance

Frailty Front Door RSH

The integrated acute and community Frailty Intervention Team (FIT) was introduced in A&E at RSH last winter. The team have continued an on-going process of developing, embedding and improving working relationships and pathways to optimise the team's ability to support same day discharge from ED wherever possible for frail older patients. The introduction of this team has been a significant contributory factor in the ED conversion rate to admission for >75s being 6% lower between April – June 2018 than the same period last year. The improvement cycle will continue, and the team is exploring opportunities to work in partnership with the ambulance service to identify appropriate patients for direct access to the caseload by the ambulance crews to reduce demand on ED this winter.

Frailty Front Door at PRH is planned, but the commissioners and providers feel that the staffing situation going into winter will inhibit the development of this service until the next financial year. They are, however, committed to the development as soon as staffing levels allow, and are also providing admission avoidance schemes to try to prevent patients being conveyed and admitted.

Improving streaming at the front door:

The permanent provision of a streaming function at both PRH and RSH remains variable due to both staffing and confirmation of permanent funding. SaTH, with the CCGs, continue to focus on

an interim and permanent solution to ensure the service is provided during winter, as well as planned for FY 19/20

Carers in a Car

In Telford and Wrekin, Integrated Discharge Teams (IDT) highlight night needs e.g. toileting and wound/ pressure area care as a rationale for Pathway 2. The provision being commissioned will enable night time support as an alternative to Pathway 2. This will be an adjunct to domiciliary care calls where identified.

Shropshire Council have a new service to meet the needs of service users at night called “Two carers in a car.” This project came from the question, “Do all the people going into residential care or having night sit services actually need that level of care?”

The Council found that sometimes where 24-hour residential care, or a full night’s domiciliary care support had been commissioned, only short periods of assistance were actually needed through the night due to occasional falls, anxiety, or emergency support being required in the night once or twice. In addition, night time packages and residential care can take a long time to source so a solution was required to support people to come out of hospital more quickly and in some cases to prevent them from going in.

The Council have created a unique service that can support people to stay at home longer, support better hospital discharges, support people in their choices based on their confidence, comfort and dignity, making sure people are safe. They have commissioned 5 contracts which deliver a service which operates a 7 night a week service and provides two carers 10 pm – 7am on a block contract – each contract covers a specific area as follows:

Oswestry and surrounding area (Approximately 5-mile radius)
Market Drayton and surrounding area (Approximately 5-mile radius)
Bridgnorth and surrounding area (Approximately 5-mile radius)
Ludlow and surrounding area (Approximately 5-mile radius)
Shrewsbury and surrounding area (Approximately 5-mile radius)

Referrals come from the social work and EDT teams, but they can also come in from hospitals, A&E, Out of Hours Doctors, district nurses, GP’s, alarm call centre etc. The carer team are able to take referrals directly via smart phone during the night and during the days calls are picked up by their office. Carers can therefore allocate their own work and make judgements about what is needed.

The service started in Shrewsbury in July 2017 for a pilot which was so successful it has been expanded to the 5 market towns in the table above.

Telford & Wrekin Care Home MDT

The Care Home MDT is embedded within the Telford & Wrekin Rapid Response team to deliver admission avoidance and preventative interventions. They are focusing on the top six high admitting care homes in Telford and Wrekin initially. Rapid Response team take calls from the targeted care homes, rather than the homes dialling 999 initially. The dedicated Care Home MDT provide additional support after identifying training and development needs; focusing on prevention and proactive working, specific to the needs of the home and residents.

The Team are rolling out “Emergency Passports” for the residents in the six targeted homes; already successfully used by WMAS in the Walsall area, delivering a reduction in conveyances to hospital. They are also working with SaTH and the Dementia Team to develop the nationally

recommended “Red Bag Scheme” in care homes. In addition, falls prevention awareness “I-Stumble” protocol has been implemented in the six homes by the team, which is a tool aimed at care homes for use in assessing falls and includes guidance for staff on what to do during and after a fall, including when it is appropriate to call 999.

Shropshire CCG and LA are working in partnership to implement the ‘Emergency Passport’ and ‘Red Bag Scheme’ this winter in a targeted number of care homes.

Use of Community Hospitals for Step Up

Historically, 80% of community hospital admissions are from planned acute hospital discharges. The average utilisation of available community hospital beds during winter 2017/18 was 89.7%. ShropCom has committed to promote the use of community hospital beds for the avoidance of acute admission as a ‘step up’ approach, in circumstances where a ‘Home First’ approach is not appropriate. It is anticipated that 5 beds across all sites would be available for admission avoidance to maintain occupancy at 95%. Planned actions to facilitate this are;

- Introduction of the Clinical Capacity Manager from October 2018
- Flexibility of Community Hospital admission criteria
- Improved access to community hospital beds for admission avoidance

The key performance metrics will be used by the A&E Delivery Board to monitor performance.

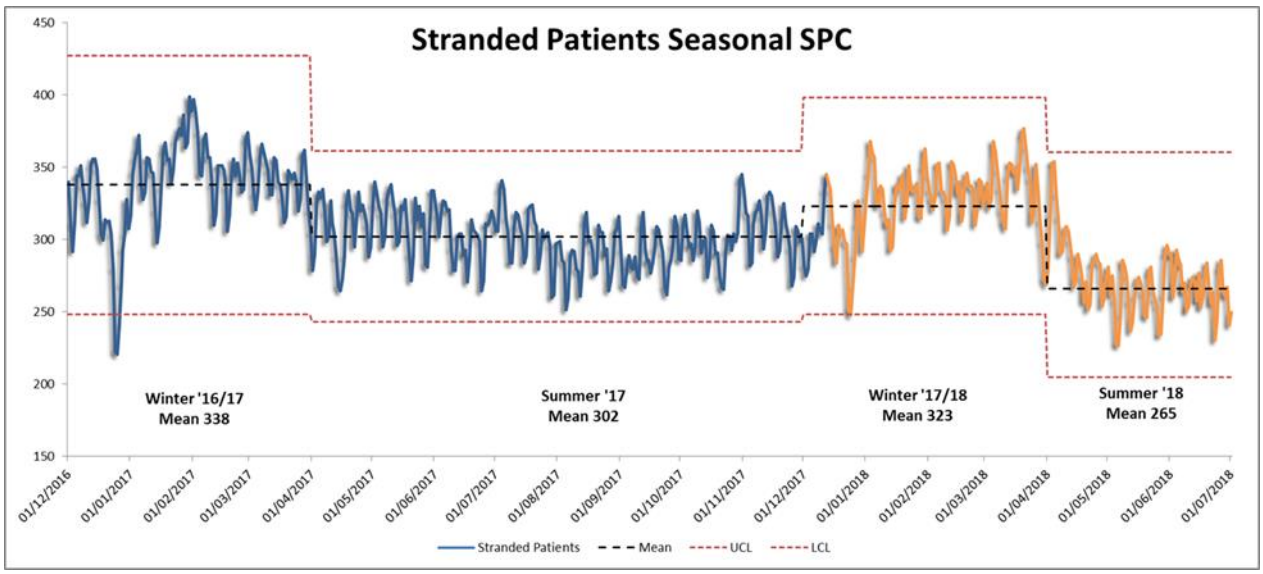
17.8.2 Improving/Maintaining Acute Hospital Flow

A number of key initiatives are planned to support internal acute flow this winter. Many are funded as part of the winter funding initiatives, however there are some schemes that require funding over and above the CCG Winter funding given. These are marked in this plan and will be subject to further negotiation with commissioners/NHSI/NHSE.

The Trust are planning to achieve 90% A&E performance by March 2019 by redesigning flow through majors to allow greater in-reach, which will be dependent on maintaining sufficient capacity at SaTH and in community services to ensure flow. The A&E internal plan includes:

- Review of A&E 4-hour breaches and reasons with a view of targeting specific pathways;
- Review Emergency Department floor template to maximise flow for admitted pathways;
- Speciality doctors ingress into A&E to ensure greater in-reach from bed-based specialities;
- Plan to achieve 95% target in both minors and paediatrics at SaTH by the end of December 2018 to achieve the overall target, this will then be sustained (Rapid Improvement Week with ECIST national programme leads-10th December 2018);
- The Trust have decided that this winter plan will be their winter plan for 18/19

A key factor in delivering the winter capacity plan is maintaining the improvement in the number of long length of stay patients (>7-day LoS) through delivery of the ‘Stranded Patient trajectory’. The graph below shows the step change in performance which has been achieved in summer 2018 delivering a 25% reduction in bed days associated with long stay patients which equates to the equivalent reduction of 22 acute medical beds (RSH) plus 14 acute medical beds (PRH site).



- Orange indicates when SaTH began looking at the stranded patient metric (patients over 7 days in hospital).
- It shows that the work prevented the worst of the winter spike
- It shows sharp improvement out of the worst of winter
- Summer 2017 Mean (302) vs Summer 2018 mean (265) = 37 improvement

Sustaining the improvement made with long stay patients will be achieved through continuation of the daily Check, Chase, Challenge process and the weekly Long Stay Patient escalation review meetings. The CCGs, Councils and ShropCom are working closely to support the Trust. ECIST are helping the system to refine all relevant processes and checking against all the advice in the "Reducing Long Stays in Hospital" guidance.

SaTH have defined 'super stranded' patients as those in a bed for more than 21 days. The following actions will be taken by the Trust:

- Daily board rounds;
- Weekly MDTs in escalation beds;
- Daily Check, Chase and Challenge meetings;
- Executive-led weekly review of long stay patients;
- Daily conference calls across community and bed-based services;
- Planned MADEs across services commencing at the end of November and early January and an enhancement of the daily Check, Chase and Challenge to incorporate Long Stay Wednesday as advised by the National Long Stay Toolkit.

SaTH have set themselves an internal aim of a reduction in long stay patients (above 6 nights) of 180 (from 362 in January 2017) they are at an average of 250 in August 2018. Further actions are now focussing on targeting PRH and medical engagement. The stranded metric reduction high impact change has the executive leadership of SaTH's Medical Director.

The provision of a Discharge Lounge on both sites will support pre-midday discharge.

The extension of the operating hours in the assessment areas of AMU and SAU will support increased same day discharge which is predicted to translate into the equivalent contribution of 3 additional acute beds on each acute site.

SaTH and ShropCom therapies are undertaking a review as part of the NHSI improvement cohort with Allied Health Professionals (AHPs) to strengthen the current provision. There are currently different models in place across services in relation to therapies. To ensure effective flow and improved outcomes for patients, the current vacancies in the services will be filled as soon as possible.

Projects are being undertaken as part of the NHSI AHP Collaborative involving a partnership between SaTH and ShropCom therapy services. This nationally led project is aimed at reducing length of stay across patient pathways. The first pathway to be reviewed by SaTH and SCHT therapists is trauma & orthopaedics from ward 22 T&O at RSH to Whitchurch Hospital. The aim is, through integrated working, LoS will be reduced by 1 day at RSH and 1 day at Whitchurch over the next 3 months. Following this, further pathways will be reviewed from a therapy integration perspective including stroke, neuro-rehab and frailty. The intended outcome of this work is seamless goal planning and transfer of care across organisations to avoid duplication so maximising the opportunities for patients to receive the therapy interventions they require in the right environment to meet their needs.

Currently, community based IV therapy is not robustly available within Shropshire / Telford and therefore, to increase the amount of IV antibiotic therapy delivered within the community as an alternative to acute based care, the system has adopted a phased approach, commencing October 2018. Phase 1 will be a pilot for an initial 12 months as part of the Winter Plan consisting of a 'Chair based' IV Antibiotic therapy for bronchiectasis, cellulitis, diabetic foot and urinary tract infection (UTI) – using existing community staff resources within Bridgnorth, Ludlow and Shrewsbury DAART/MIU (for mobile patients). Referrals to this service are monitored on a daily basis via the escalation calls to ensure it is fully utilised.

New twilight shifts will be added in ambulatory care in RSH and PRH. The Ambulatory clinics will remain open until 11pm which will enable patients to be treated and discharged, thus preventing an admission.

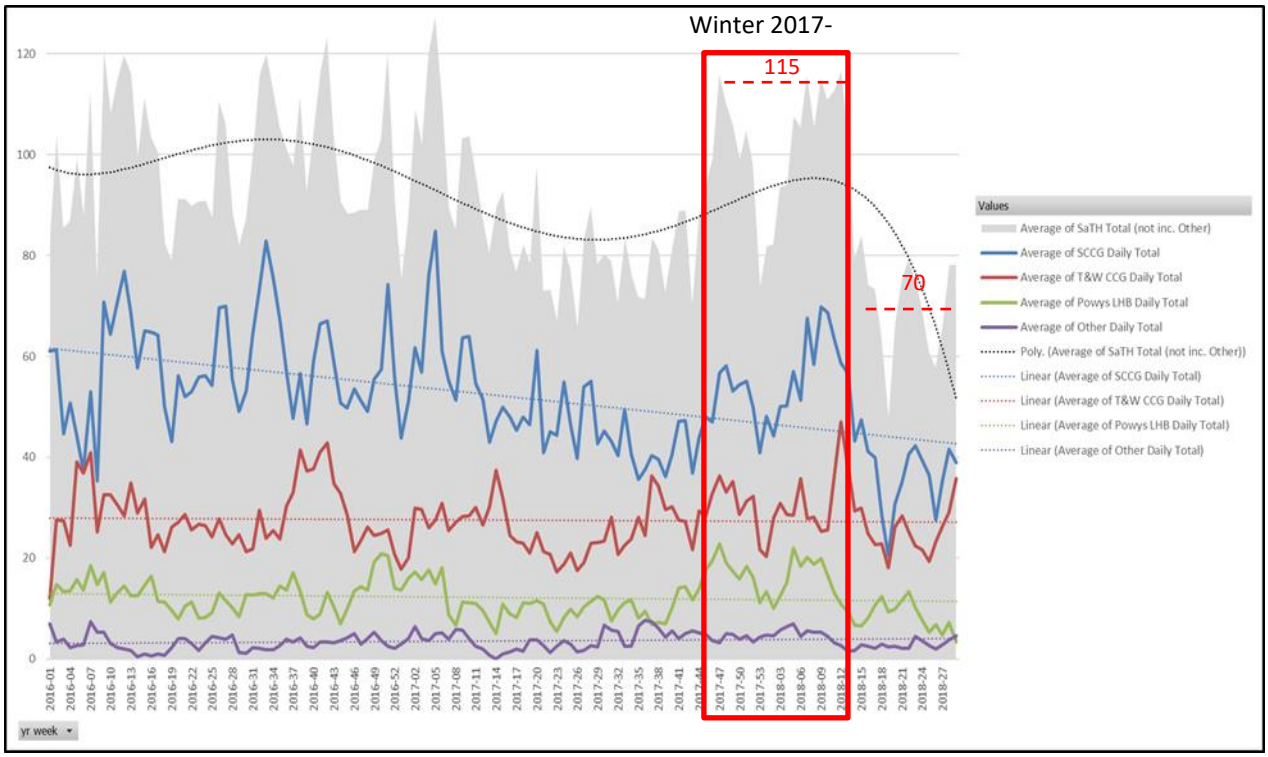
Other System-wide Acute Flow Enablers in place to support escalation between October 2018 and April 2019 are:

- Three high impact changes: Improvement in ED systems and processes, embedding SAFER patient flow bundle and Red2Green across acute and community
- Review of NCEPOD capacity – improve NEL surgery access and reduce LoS, ring fence elective capacity;
- SaTH & WMAS: Tactical Admission Avoidance through non-conveyance
- System-wide Choice policy application – refresh to include Patient Welcome Cards
- Value Stream Mapping respiratory and cardiology pathways: multi stakeholder teams. High Intensity user admission avoidance with out of hospital pathway

The key performance metrics will be used by the A&E Delivery Group to monitor performance of this section.

17.8.3 Managing Complex Discharges – to avoid growth in the 'Medically Fit for Discharge (MFFD)' List

The graph below shows the significant reduction in the number of patients who are reported daily as being on SATH's Medically Fit for Discharge (MFFD) list. Last winter the number of patients on the list peaked in October and March at 115. The number reported on the MFFD list in the first quarter of 2018/19 has reduced to, and is being maintained at, c70.



Key planned interventions which will contribute to maintaining the MFFD at c70 patients per day are: -

- Increasing NHS commissioned community rehabilitation bed capacity in Shrewsbury (compared to the same period last year)
- Increasing LA commissioned discharge to assess bed capacity (compared to the same period last year) in both LA areas.
- Increasing bed occupancy rates in Shropshire Community Health NHS Trust community hospital beds through optimisation of usage against the current eligibility criteria and agreed flex criteria
- Reducing the length of stay in NHS commissioned independent sector and Robert Jones and Agnes Hunt rehabilitation beds.
- Increasing the EMI discharge to assess bed capacity through the use of spare capacity in the Redwoods Dementia Unit and general nursing discharge to assess independent sector beds to EMI. Additional nursing home beds will be purchased to support dementia flow as temporary placements when permanent care becomes restricted.
- Releasing domiciliary capacity to support increased acute discharges to Pathway 1 (home with support)
- Additional social worker capacity at the weekends
- Addressing the supply of home care in the hardest to serve areas of the county;
- Ensure sufficient brokerage capacity to manage increases in discharge numbers.

The key performance metric will be used by the A&E Delivery Board to monitor performance of this section.

17.9 Additional Acute Hospital Beds

Phase 1 – 1st October 2018

Up to 16 escalation beds will be opened at RSH and up to 14 escalation beds at PRH with a fully dedicated Multi-Disciplinary Team (MDT) available, including Social Worker support, to ensure continuity of care and flow.

Multi-Agency Discharge Events (MADE) will be undertaken at the end of November (24th and 25th) and in early January 2019 and the daily Check, Chase and Challenge will be enhanced to include 'Long Stay Wednesday' as recommended by ECIST and the National Long Stay Toolkit.

At times of escalation senior presence will support the ward to ensure flow is maintained to free up capacity. Clear escalation processes will be in place to ensure patients who become delayed are expedited.

There will be a concentration from the system on weekend discharges. Our actions are:

External system

- Increased community therapy and nursing input to support discharge home at the weekend.
- Integrated discharge hub to run at the weekend
- Additional social work capacity being funded from additional national winter monies
- Work with the Fire Service to explore transport for patients' options and checking of safety for patients on discharge.

SATH

- Discharge liaison nurse capacity at the weekend
- Pharmacy cover for discharge at the weekend
- Therapy-cover at the weekend
- Additional substantive consultant ward round at the weekend.

Phase 2 - 24th December 2018

Opening Ward 19 RSH - 30 beds

Weekly Multi-Agency Discharge Events will be undertaken throughout January 2019 and the daily Check, Chase and Challenge will be enhanced to include 'Long Stay Wednesday' as recommended by ECIST and the National Long Stay Toolkit.

The key performance metrics will be used by the A&E Delivery Board to monitor performance.

17.10 RJAH - Acute Hand Trauma

Hand trauma provision will be provided by the Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, following a pathway agreed by SaTH and the CCG's. Expected numbers are, however, small; predicted 2 per day.

17.11 Mental Health – MPFT

As part of the capacity and demand review, the mental health review from the liaison nurses within 1 hour in the ED was seen as appropriate for need. The review on the wards within 24 hours was also appropriate for need. There were two areas that required review:

1. Assessment and Care of the young person- particularly for Powys young people

To rectify this, the mental health team have conducted a rapid improvement event to establish a clear pathway between the young people's crisis team and the RAID assessment team, establishing a clear pathway to specialist opinion 24/7. Outcomes will be reported to the A&E Delivery Group as part of the 30/60/90-day review process.

2. Complex discharge of patients with confusion and dementia

To rectify this, Shropshire LA will vary the current discharge to assess contract and will continue to spot purchase nursing dementia beds as required.

Shropshire LA are discharging more complex patients back to their home with confusion and dementia. This has been supported by schemes like 2 carers in a car, in reach support from the dementia home treatment team, carer's advice and support in reaching into the acute trusts and targeted reablement support has resulted in an increased number of individuals at home 91 days following discharge.

Telford and Wrekin will continue to work closely with the RAID team and have 2 block purchased specialist EMI Nursing beds available for Complex confusion and dementia Discharges on Pathway 2. For those on Pathway 3 they will spot purchase residential or Nursing EMI beds. There is a specialist Mental Health Social worker within the team who links closely with the West Midlands Partnership Team.

Support for all people and their carers leaving hospital including those with dementia and confusion has been established. There is a link carer's supporter who works with those with complex needs, their family and carers. The Assistive technology team is based in the Team and there are individual packages available to support with discharge. British Red Cross provides Discharge Support for an extended period on discharge.

17.12 West Midlands Ambulance Service (WMAS) Capacity

WMAS have a robust winter delivery plan that details all the actions that will be taken to ensure a safe and robust service over the winter and festive periods. WMAS have provided detail of their expected demand within their plan (Appendix 1). Typically, there is 4.5% increase year and year with a 10% growth in December and January. The Trust has developed a strategic plan with early investment for robust plans in place to ensure that during winter there is the maximum number of staff available and they can meet the demand expected.

WMAS has a strong Command and Control structure to ensure resource is managed effectively. An additional Duty Senior Commander will be based in headquarters as it has been proven in the previous two years that it is beneficial to have extra senior leadership on site.

WMAS will meet this additional demand through recruitment of more staff, ensuring timely replacement of vehicles to enable a temporary increase in the fleet for the busiest months, increased call takers and Vehicle Preparation Operatives.

17.13 Powys

Powys Local Authority are experiencing delays in discharging complex patients within 48 hours of being MFFD. All commissioners are required to seek alternatives to a delayed placement if this results in the patient being MFFD over 48 hours in an acute bed. For Powys LA, the system is seeking an agreement that Shropshire Council will place patients over 48 hours in Shropshire beds and that Powys will reimburse the cost to Shropshire Council. This will commence as soon as agreement can be reached with Powys LA.

For Powys LHTB, when patients are over 48 hours MFFD, permission will be sought for an alternative placement for example into a Shropshire Community Hospital bed where available.

Powys' Winter Plan (Appendix 2) sets out how Powys will deliver the 5 winter delivery priorities (WDPs) set out by Welsh Government:

WDP 1: **Optimising clinical engagement and partnerships** to deliver timely and high-quality access to services

WDP 2: Explicit focus on **better management of demand in the community**

WDP 3: **Enhanced operational grip and clinically focussed hospital management** to mitigate peaks in pressure and manage risk effectively

WDP 4: **Focus on the significant opportunities to enable people to return home (or as close to home as possible) when ready from a hospital bed**

WDP 5: Wherever possible, people should be supported to return from acute hospital sites to their home for assessment (**implementing a discharge to assess model)**

The Powys Integrated Winter Preparedness and Resilience plan has been developed jointly by partner organisations to respond to the assessed risks associated with winter. They are based upon a structured review of 2017/18 and learning from previous winters. The plans are described to mitigate risks and are expected to provide adequate assurance that all reasonable actions are being taken in preparation, recognising there are constraints on each of the partner organisations and not all eventualities can be accounted for.

17.14 111 (Care UK) Capacity

We are awaiting final version of the plan from Rachael Ellis the Regional Commissioner

17.15 Shropshire Doctors on Call (Shropdoc) Capacity

Shropdoc will continue to monitor demand and performance weekly, combining this with system partners to identify and/ or predict any upsurge in demand as quickly as possible. They use the prevalence of respiratory illness as an indicative clinical marker for expected increased activity.

Where increases in demand are identified they have the ability to put on additional GP resource at weekends, the 'Shropshire Relief car' which can undertake home visits, community hospital visits and base visits depending on where the demand is greatest.

17.16 Primary Care Capacity

Extended Access will be in place from 1st September 2018 and this will result in the following:

- Shropshire CCG – 600 x 15-minute appointments per week across an extended day;
- Telford and Wrekin CCG – 500 x 15-minute appointments across an extended day per week.

Shropshire

This will improve access for the population by providing time slots across evenings and weekends. It should be noted that these appointments are intended for routine, pre-bookable (non-urgent) clinical appointments and will have limited impact on urgent care resilience.

In addition, however, the CCG has approved funding for additional same day urgent appointments and expressions of interest from practices are currently being obtained. The likely start date for this additional primary care capacity is 1st December.

Telford and Wrekin

There is no national funding this year for winter pressure for practices – T&W executive/PCCC have approved the spend at £2.24 per patient.

Practices are submitting their plans at neighbourhood level to encourage closer collaborative working – plans will be based on previous successful winter pressure campaigns and plans. T&W primary care clinical lead has also suggested some win-win approaches which should also make significant impact on the wider system:

The CCG is suggesting a model structure that they think could be delivered, and that would be focused on addressing some of the areas of need/structural weaknesses in existing urgent care structures, as well as helping to develop neighbourhood working

That structure for each neighbourhood could include some or all of: -

1) Additional afternoon urgent care clinic 3pm -7pm, available to 111 plus

2) Additional morning urgent care clinic 8am -10am, available to 111

3) Neighbourhood-based afternoon home visiting service

4) Neighbourhood based early in season flu vaccination of the housebound

5) Enhanced influenza vaccination targets

T&W priority is the enhanced urgent care access for patients contacting services later in the day, as they already see a peak of demand in ED late afternoon that extends in to the evening, that we need to address. The morning appointments would allow appropriate diversion of patients away from ED overnight when the streaming service is not available.

Practices and neighbourhoods are invited to adopt parts or all of the model structure, or to submit alternatives if they cannot deliver the model, or feel they have a better proposal. Any alternative proposals would clearly have to deliver equivalent benefit.

17.17 Falck Capacity (Patient Transport)

Shropshire FALCK Capacity is detailed within (Appendix 8)

17.18 HALO

The safety of patients when they enter the Emergency Department is currently enhanced by the presence of specific handover nurses at both ED's. There is a HALO at RSH ED (an additional will be provided at PRH subject to final sign-off of winter funding schemes), who provides a West Midlands Ambulance Officer on-site presence providing the Strategic Operations Commander within West Midlands Ambulance Service Emergency Operations Centre local intelligence regarding capacity (current and anticipated), operational issues identified across the

healthcare care system that could affect optimisation of ensuring flow out of the ED resulting in ambulance handover delays. The HALO will attend site safety meeting and monitor the CAD and EPR for appropriateness of conveyance to hospital, challenge as require conveyances that could potentially be referred to other providers other than ED, these may be community-based services or directly to speciality within the Acute.

The HALO will endorse and actively promote the use of alternative providers other than EDs across Shropshire and the Care Co-ordination Centre escalating to the West Mercia Directory of Services Lead any issues with access that may need resolution, participate in retrospectively reviewing same day conveyed discharges for trends and potential deficits in service provision other than ED's. Monitoring the CAD and subsequent escalation to the capacity teams within the Acute to advise of potential surges in ambulance conveyances will be undertaken whilst the HALO is on duty so mitigating actions can be taken to minimise any potential ambulance handover delays by creating sufficient flow out of the ED or supporting with additional clinical staff.

A key role of the HALO is to optimise ambulance resource availability once the clinical handover has been undertaken and the patient is on an ED trolley. The HALO will undertake actions as required to ensure ambulance resource is available in a timely manner without any un-necessary delays and escalate any issues internally within WMAS. The HALO role is not designed to accept handover from the ambulance crews unless the ED is operating to extremis levels. In the event of extremis, the HALO where appropriate will cohort patients escalating any clinical concerns to the ED staff and identify such patients to the hospital desk by requesting a cohort call sign is assigned the WMAS incident number.

18. Workforce Planning

18.1 SaTH Workforce Planning

Recruitment remains challenging around medical, therapy and nursing posts given the competition from other NHS organisations and private providers. The Trust continues to work with the external recruitment provider to expedite the selection process for those successful applicants going through the employment checks process.

Rolling adverts are being utilised to aid a speedier recruitment and selection process, and recruiting managers are requested to review/interview candidates as and when applications are made rather than waiting for specific closing dates and pre-scheduled interview programmes.

The Trust will be visiting a number of Job Fairs at Universities over the coming months in order to seek to attract newly qualified nursing staff to work at the Trust.

The Trust will also look to increase the availability of flexible workers through an internal recruitment campaign whilst being mindful of the European Working Time Directive and the health and well-being of staff already employed in a full-time role within the Trust.

The Trust will be tapping in to the national nursing recruitment campaign launched on the 4th July 2018 to celebrate the 70th Birthday of the NHS and using the Careers social media accounts and the expertise of the Trust's Communication Team to point candidates towards the employment opportunities within the Trust.

In addition to the above, opportunities for employment within the Trust are being promoted through leisure centres radio across the County, and we are looking to use the information screens in doctor's surgeries to enable us to target the areas with most need.

The learning and development programme is being reviewed and revised, including the time allocated for shadowing in some areas where this is appearing to be lengthier, to ensure that the workers are available at the earliest opportunity, whilst having the correct skills to undertake their duties safely.

Retention has been identified as an issue within the workforce one of the main reasons cited is the shift patterns, these are being re-visited by the E-Rostering Team, operational managers to see if there is a more efficient and effective roster that can be implemented that better supports the work life balance of the workers and therefore aids retention of their skills, whilst recognising the needs of the service.

Information is collated on a weekly basis and vacancies monitored through the STP Programme Board, a specific Workforce Workstream, reporting in to the STP Programme Board to support the recruitment, development and retention of this workforce and more closely monitor progress towards a full establishment.

From October 2018 a new structure of weekend working for discharge doctors will commence. The weekend discharge team is being scoped with a senior medical lead, physiotherapists, occupational therapists and pharmacists to prevent delays for those patients who are medically fit for discharge.

The discharge team will be reviewing patients to ensure decision for discharge has been determined and all the actions required to enable the patient to be discharged will be put in place. Additional rotas will be in place to manage the additional escalation wards across both acute sites.

The importance of EDD setting and the use of clinical criteria for discharge cannot be underestimated in the achievement of success for this team.

18.2 ShropCom Workforce Planning

Recruitment remains challenging for nursing posts given the rural nature of Shropshire and competition from other NHS organisations and private providers. The Trust continues to work with the external recruitment provider to expedite the selection process for those successful applicants going through the employment checks process. The areas judged most vulnerable to staff shortages and additional pressures are Community Hospital Inpatient wards, Minor Injuries Units and Stoke Heath Prison.

To provide a secure and flexible workforce the trust is;

- Increasing the numbers of available staff and give these, and other services, a greater degree of resilience, Shropshire Community Health is undertaking targeted recruitment campaigns and a general drive to increase the size and availability of its internal staff bank.
- Has revised the staffing model for Community Hospitals in recognition of the long-standing vacancy rates for qualified nurses in Inpatient Wards, and now features a

higher proportion of Healthcare Assistants. Recruitment to the new model is under way and overall vacancies have reduced.

- Recruitment of Apprentice Assistant Practitioners and developing plans for future cohorts of Nursing Associates.

18.3 MPFT Workforce Planning

To provide 7 days working for services over winter will require a change in service provision. Before any consultation commences the Joint Staff Partnership need to be notified, this is too late for July and there is no JSP in August, so a separate meeting has been convened. There is also a need to complete a comprehensive Equality Impact Assessment on the staff groups affected.

Below was a timescale based upon a start date of 1st October for 7 days working. SaTH have now confirmed that this will go live on the 1st of December as the consultation period for staff was extended to the 26th of November.

This will be for AHP and Social Work roles:

Date	Activity
w/c 23th July 2018	Commence consultation with affected staff and Trade Unions
27th August 2018	Close consultation on proposed seven days working.
w/c 27th August 2018	Consider representations and queries. Response to the Consultation and issue any changes.
30th August 2018	Issue letters advising changes to contract
1st October 2018	Seven day working pattern commences
1st of December	Revised start date based on consultation

Recruitment remains challenging around the Home First service and nursing posts given the competition from other NHS organisations and private providers. The Trust continues to work with the external recruitment provider to expedite the selection process for those successful applicants going through the employment checks process. Rolling adverts are being utilised to aid a speedier recruitment and selection process, recruiting managers are requested to review/interview candidates as and when applications are made rather than waiting for specific closing dates and pre-scheduled interview programmes.

The Trust will be visiting a number of Job Fairs at Universities over the coming months in order to seek to attract newly qualified nursing staff to work at the Trust. The service does not currently utilise bank staff in the Home First workforce and options around this are being explored within the Care Groups. The pool of flexible workers, both qualified and unqualified registered at the former SSSFT Trust will increase the availability of workers to the service going forwards to cover any sickness absence, this is not something that has previously been available.

The Trust will also look to increase the availability of flexible workers through an internal recruitment campaign whilst being mindful of the working time directive and the health and wellbeing of staff already employed in a full-time role within the Trust. An advert for flexible Health Care Support workers is currently live on NHS Jobs and there are plans to expand the number of adverts across all professional groups in order to address agency spend.

The Trust will be tapping in to the national nursing recruitment campaign launched on the 4th July to celebrate the 70th Birthday of the NHS and using the Careers social media accounts and the expertise of the Trust's Communication Team to point candidates towards the employment opportunities within the Trust. In addition to the above opportunities for employment within the Home First service are being promoted through leisure centres radio across the County, and we

are looking to use the information screens in doctors' surgeries, that will enable us to target the areas with most need.

The learning and development programme is being reviewed and revised, including the time allocated for shadowing in some areas where this is appearing to be lengthier, to ensure that the workers are available at the earliest opportunity, whilst having the correct skills to undertake their duties safely. We are in discussions with an NHSI approved care agency and exploring opportunities for them to be able to provide domiciliary workers to the Trust under a master vend arrangement, these discussions are also part of a wider remit to expand the existing master vend arrangement for all clinical roles across the new Trust ensuring we engage workers at the most competitive rates wherever possible.

Retention has been identified as an issue within the Home First workforce one of the main reasons cited is the shift patterns, these are being re-visited by the E-Rostering Team, together with Meridian and operational managers to see if there is a more efficient and effective roster that can be implemented that better supports the work life balance of the workers and therefore aids retention of their skills whilst recognising the needs of the service. Exit data and Listening-Into Action data will be examined over the next few months, to establish any other areas of dissatisfaction, and an OD plan developed based on the results.

The contract with the outsourced recruitment provider SBS ends in October, moving the recruitment and selection process to an in-house service will give greater control and flexibility over the recruitment process and allow for team resources to be flexed to meet demands in recruitment to posts.

Information is collated on a weekly basis and vacancies monitored through the Programme Board, a specific workforce workstream, reporting in to the Programme Board is being established to support the recruitment, development and retention of this workforce and more closely monitor progress towards a full establishment.

Key risks & mitigation to delivery

Risk	**Mitigation**
Market forces impact on Recruitment	Identifying high risk areas where demand could outreach capacity, alternative solutions are being identified and internal actions are currently being explored to reduce the risk.
Inability to flow patients through Home First	Additional recruitment, working with partners to monitor and report the situation, daily escalation via CCGs
Retention issues with AHPs and Social Care staff as it may be that staff leave rather than accept 7 days working. The therapy services are already identified as "hard to recruit" posts.	Good communication and consultation with staff could reduce the risk.
Moving to a 7-day working pattern without further investment in staffing levels would clearly not in itself improve capacity	additional funding would be required to increase staffing
Market forces impact on availability of temporary staff	Identifying high risk clinical areas where demand could outreach capacity, which could impact on safer staffing levels, alternative solutions are

	being identified and internal actions are currently being explored to reduce the risk

Mental Health Liaison operates 24/7 at RSH for adults and older people, and at PRH from 8am to 8pm, with a core hours service for children and young people under the age of 16.

18.4 Shropshire Council Workforce Planning

Shropshire Council will monitor the on-going demand and are committed to being flexible to meet the requirements of this and continue to explore the viability of seven day working across assessment capacity and supporting teams.

The Commissioning staff will communicate with providers over the coming weeks to ensure that a full list is formulated of providers who will work seven days and what the working patterns will be over winter.

This will be shared with Social Work colleagues to improve speed of placements and keep referrals targeted to then aid egress from hospital for residents or users of domiciliary care. This list will be modified throughout winter and we will also monitor referral rates at weekend and over the bank holidays to not only ensure that we know where referrals can effectively made, but also in order to shape our response to seven days working internally.

Shropshire Council will be able to see the availability of staff over Christmas and New Year, and any existing capacity on rotas will be able to be utilised.

18.5 Telford and Wrekin Council Workforce Planning

While the Council will promote seven-day assessments and discharges across all care homes with which it contracts, due to the nature of many providers and the balance of supply and demand, the winter plan is not premised on achieving equal flow into all care homes on each day of the week.

The Trusted Assessor model is focused on those care homes that are most frequently used to support hospital discharge (due to their capacity, price and other elements of market position).

Similarly, in terms of seven-day access into home care, the contractual requirements to support restarts of packages can be triggered seven days a week. For new referrals, the Council's approach is to prioritise flow seven days a week into its key strategic home care partners.

Our Social Care and Brokerage Teams will continue to work closely, alongside all key partners to ensure availability over the Christmas and New Year periods.

18.6 WMAS Workforce Planning

WMAS have no vacancies (including paramedics). They have a low utilisation of bank staff and the lowest level of sickness in the country. The Trust is completing early recruitment of new staff to ensure training is complete and they are operational for the festive period.

To maximise capacity there will be no non-urgent/non-mission critical meeting in headquarters between December 14th and January 9th.

All officers must book on duty with the EOC so that they are able to respond to incidents with the closest vehicle, all managers with a blue lighted care will make themselves available throughout winter. The Trust has agreed key dates where all operationally qualified managers make themselves available:

- December 2018 – 14, 15, 16, 17, 21, 22, 23, 24, 26, 27, 28, 31,
- January 2019 – 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15

18.7 Shropdoc Workforce Planning

Shropdoc are currently recruiting for all clinical and operational roles in line with their winter staffing requirements. The training programme will be completed in autumn to ensure all staff are available to work frontline across the winter period.

19. Closure of Winter Capacity

Similarly, to the phasing of the opening of the escalation beds moving into the winter period, a similar exercise is required to decant those same beds post-Easter. This will ensure these beds do not become part of standard usage and are available again as escalation beds as part of winter planning in 2019/20, if required.

A system approach will be used to ensure that bed closures do not negatively impact upon any system partner.

19.1 Risks to the Shropshire, Telford & Wrekin and Powys Winter Plan

The plan takes into account the review from previous year's winter planning and where possible has mitigated aginst the key identified risks.

The following are key risks identified across the health economy. There are plans being executed to mitigate the risks going into winter:

- Workforce availablity (including sickness increase);
- Activity exceeding planned capacity;
- Unprecedented impact from Flu;
- Higher levels of infection resulting in closed wards
- Unexpected domicilary agency closures
- Adverse Weather

20. Finance

The financial model to support the implementation of the Winter Plan is built on a number of funding streams, as follows:-

a) CCG winter money funding of £2.9m
b) Allocation of iBCF monies
c) Additional tariff income from additional bed capacity in SATH
d) Existing resources

In developing the Winter Plan, system stakeholders submitted winter capacity scheme proposals which described the scheme, source of funding (new or existing), impact on acute beds and confidence level in operational delivery.

These proposals were consolidated into a long list of approximately 60 schemes. This long list was reviewed by the A&E Delivery Group at meetings in July/August to form a shortlist.
SATH are receiving £2.3m of the £2.9m CCG winter money to fund their winter capacity schemes as set out in the table in section 16.7.2. This funding also includes ambulance handover nurses on both sites. The remaining £600k was pre-committed following approval from the System A&E Delivery Board.

21. Appendix Listing (enclosures):

All in location /NHSE-templates/UEC/Shared Documents/WinterPlan18-19 Appendices

Appendix 1	WMAS Plan	WMAS WINTER PLAN Version 3.0 2018.pdf	Appendix 1-WMAS-WINTER PLAN V3.0 2018.pdf
Appendix 2	Powys Plan	Powys Integrated Winter Resilience Plan 2018 / 2019 DRAFT	Appendix 2 -POWYS INTEGRATED WINTER RESILIENCE PLAN 2018.docx
Appendix 3	The Shropshire, Telford and Wrekin and Powys Escalation Action cards	Further updating currently in progress from workshop on 17/9/18 & clinical risk workshop to test amended cards 04/12/18	Appendix3-Draft-Winter Escalation Action Cards
Appendix 4	T&W Primary Care Plans	ShropCom Winter 2018 2019 escalation plan DRAFT	Appendix 4-Shropcom Winter 2018 2019 escalation plan DRAFT.docx
	SaTH winter plan	SaTH have decided that the system winter plan is their plan	
Appendix 6	MPFT winter plan	MPFT Winter Plan Draft V4.1	MPFT Winter plan Draft V4.1
Appendix 7	Shortlist of Winter Capacity Financial Schemes	Shortlist of Capacity Schemes	Appendix 7-Shortlist of Winter Capacity Schemes-29Aug18
Appendix 8	FALCK Shropshire		FALCK_SHROP-WINTER_PRESENTATION_2018-19.pdf