Preparing for winter and surge demand 2020/21

TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent

Introduction

Planning this year will respond to two types of surges (1 October and 30 April):

- Usual winter peaks such as seasonal illness i.e. flu
- Further COVID-19 outbreaks expected.

National priorities also include:

- Restoration and recovery of NHS services by Autumn
- The biggest flu programme in the UK's history
- Roll out of the NHS 111 First programme - support social distancing in urgent care.

Key priorities

- Support patients to remain/be discharged home
- Preventative approach to avoid admission to hospital
- Increase community capacity
- Supporting and protecting residents in care homes
- Real time discharge planning using national guidance (reduce length of stay in hospitals)
- Joined up working across partners to support timely discharge and focus on reablement
- Encourage uptake of the flu vaccine across at risk groups
- Protect NHS, and our workforce, to manage demand safely during COVID-19

Three key areas of planning that form one system plan

Getting ready for winter - working differently to stay safe

- Coronavirus is here for the foreseeable future, meaning we need to **work differently.**
- Need to **step back up essential services**, **plan** for a **second surge**, plan for **winter**

Social distancing (e.g. hospitals)

Green (non-COVID), blue (COVID) and purple (possible) areas

Total Triage

Integrated discharge teams with hospital teams

Crisis response teams in the community

Continuing triage and digital appointments

Meeting demand for inpatient services

Protecting workforce on the frontline

Staff testing: test and trace

Enhanced service for care homes

Outbreak management

Workforce and flexible working

In preparation for winter:
Phase three national restoration and recovery priorities

1. **Accelerating the return of routine services before winter**		2. **Preparation for winter**	3. Doing this in a way… **lessons learned**, keep **beneficial changes,** support **staff**, act on **inequalities** and **prevention**	
Cancer diagnostics and treatment	General practice, community and optometry (eye) restored	Sustaining current NHS staffing, beds and capacity - using independent sector	Support staff to stay safe and healthy	Work collaboratively with local communities
MRI and endoscopy	Increase and expand mental health	Expand NHS 111 First for less complex urgent care	Address inequality for staff	Restore services in inclusive ways
Outpatient attendances and follow up appointments	Learning disabilities/ annual health checks	Flu vaccinations	Flexible working	Targeted prevention programmes (e.g. flu, diabetes)
Clear communications for planned care patients affected by coronavirus	Enhanced support to care homes	Resilient social care services	Grow our workforce	Strengthen leadership to tackle inequality

Restoration and recovery: waiting lists update

- August has reflected the easing of restrictions and returning services
- The number of incomplete pathways are increasing as new referrals are added
- The backlog (> 18 weeks) is decreasing, however the number of patients over 40 weeks is rising
- Performance is improving but the number of long waiters is increasing as urgent patients are being prioritised
- Theatres at UHNM are at 88% of pre-COVID levels and day case/elective performance is at 71%
- Social distancing impact – with 2m rule between beds/cleaning in our theatres and our wards. Clinicians reviewing patients waiting longer than 52 weeks (prioritise clinical need and waiting time)

We would like to thank all our clinicians for their support during COVID-19 - working collaboratively to ensure clinically urgent patients continued to be seen

Assumptions this winter

System

- National ambition return of activity to business as usual levels by October 2020
- Demand growth assumption of 2% across all settings
- Flu demand modelled based on 19/20 experience (no delays vaccine and treatment).

Acute/elective care (booked treatments) assumptions:

- Falls in A&E attendances observed during COVID-19 incident are starting to be reversed
- Meeting activity assumptions and performance standards (e.g. MRI and CT scans)
- Use of independent sector to support capacity - primarily cancer and urgent surgical Removal of beds to support social distancing will impact on capacity. Revised contract with 75% NHS work will impact on R&R recovery

Primary care

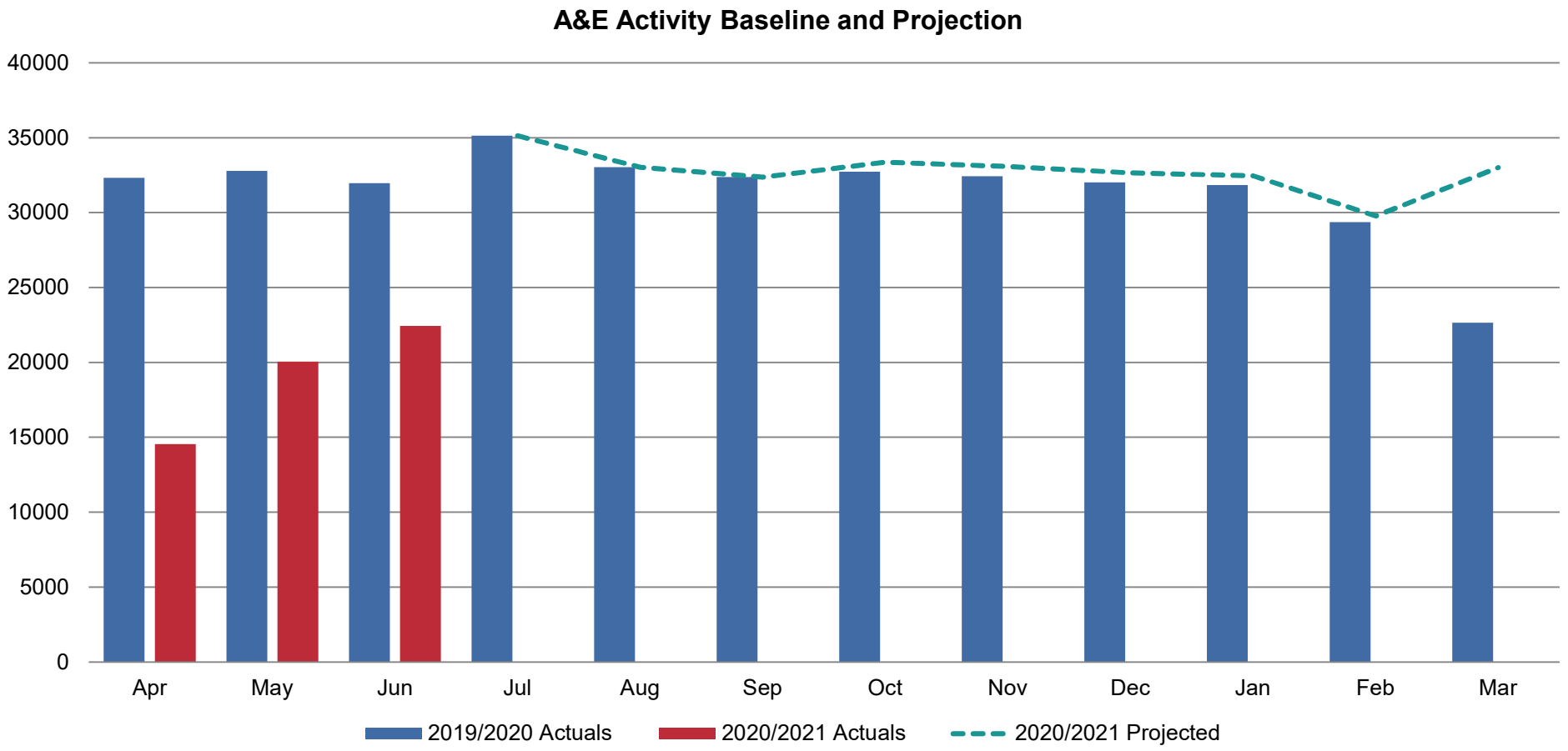
- High level of flu demand
- Demand on hot clinics will rise - patients presenting with virus symptoms (include COVID-19)

COVID–19

- Demand assumptions (based on worst case surge scenario in April 2020)
- Changes in business as usual demands – step up and down services
- Assume non-COVID non-elective (unplanned) activity reduces during surges (assumed equal and opposite impact) if not then elective activity/restoration plans may be impacted
- Workforce sickness

Informed by data: A&E attendances (all)

Projected to rise significantly

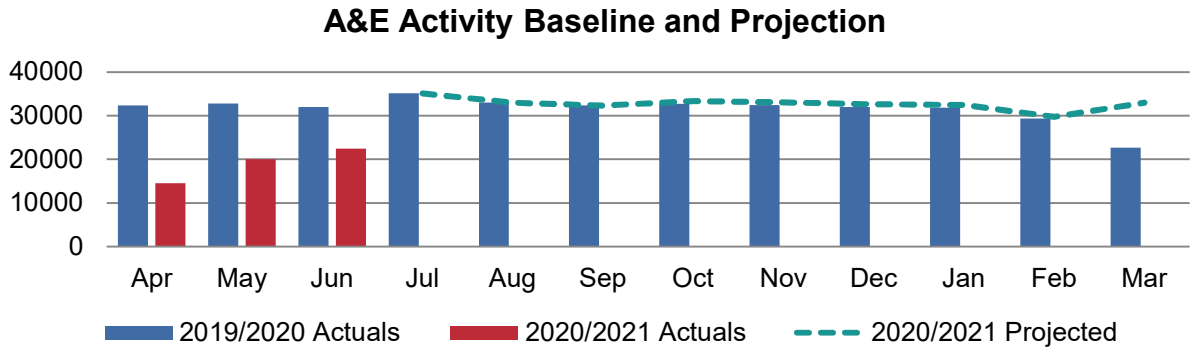


Informed by data

Urgent Care Analysis – A&E Attendances (All)

A&E Attendances

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/2019						31,193	30,644	31,133	31,461	29,198	32,365	
2019/2020 Actuals	32,321	32,787	31,965	35,140	33,028	32,372	32,727	32,432	32,017	31,833	29,357	22,655
2020/2021 Actuals	14,548	20,048	22,432									
2020/2021 Projected				35,140	33,028	32,372	33,382	33,081	32,657	32,470	29,782	33,012



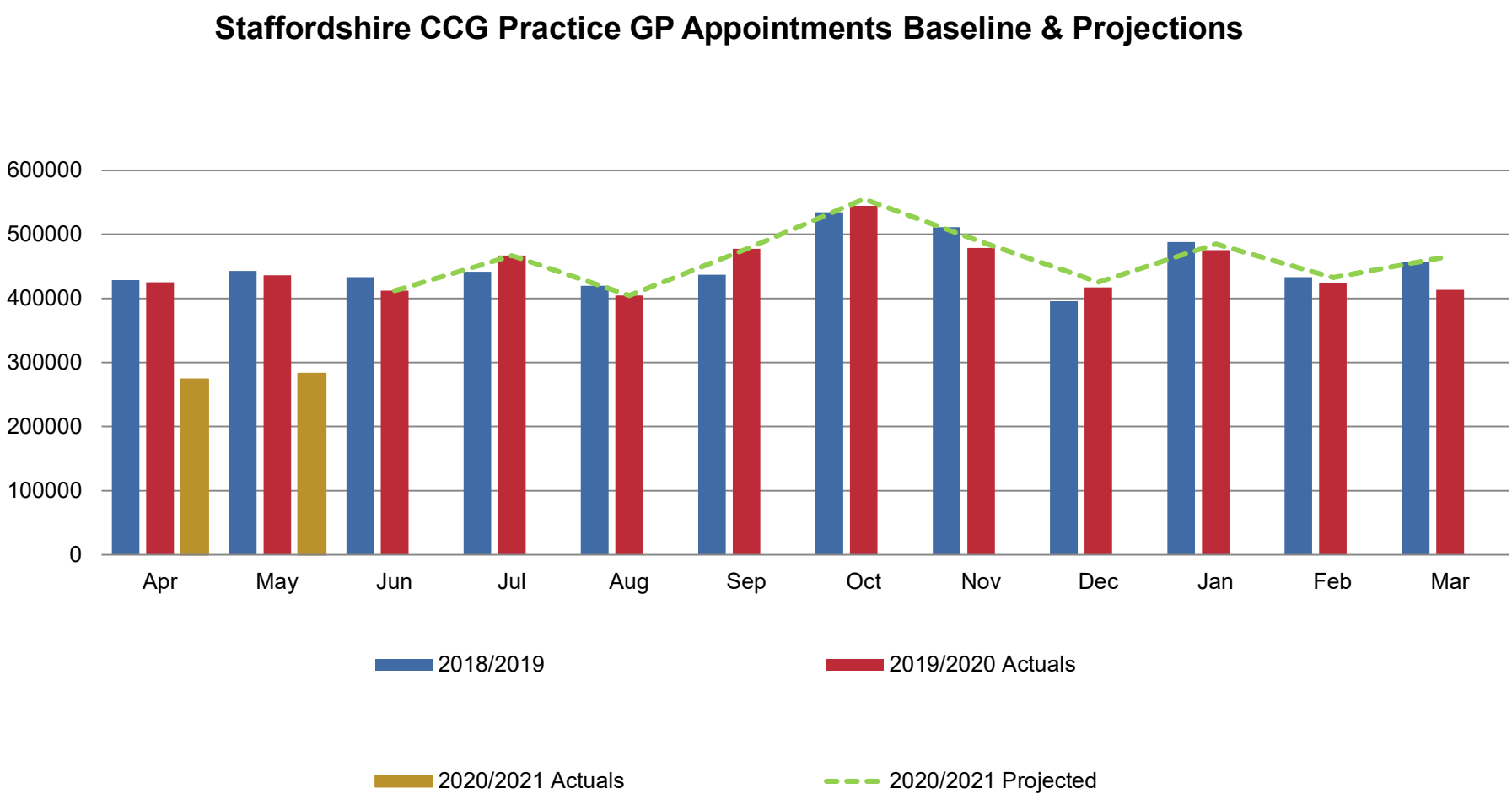
Data Source: SUS AE
Included: All A&E Attendances for all Staffordshire CCGs and the following Providers;
- UHNM
- UHDB (including small element of Derby Acute)
- Royal Wolverhampton

Projection Criteria:
Jul to Sep based on prior year
Oct to Feb based on 2019/20 + 2%
Mar based on 2018/19 + 2% (due to COVID impact in Mar 2020

Sum of commissioned AEActivity(type 1&2)	ReconciliationPoint																		Grand Total
AEReferralSourceDescriptionWithCode	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912	202001	202002	202003	202004	202005	202006	
--: Unknown or not applicable	49	36	53	599	766	391	467	466	418	442	403	414	385	351	283	194	258	318	6,293
00: General medical practitioner	2,107	1,949	2,165	1,965	1,978	1,819	1,914	1,826	1,843	1,980	2,063	1,738	2,027	1,749	1,084	491	832	1,209	30,739
01: Self referral	12,293	11,943	13,202	13,031	12,747	13,119	15,091	14,301	13,977	14,049	13,694	13,568	12,791	12,030	9,486	5,712	8,244	9,277	218,555
02: Local authority social services	11	12	10	4	4	8	2	4	6	6	3	2	3	3	1		4	4	87
03: Emergency services	314	231	265	9	3		11	12	6	9	5	7	9	4	2		7	7	901
06: Police	46	26	51	47	26	45	63	45	35	40	50	52	41	40	49	21	24	35	736
07: Health care provider: same or other	10,602	9,236	10,061	9,922	10,098	9,750	9,467	8,917	9,131	9,820	10,032	10,210	9,736	8,989	7,616	5,854	7,208	7,889	164,538
08: Other	90	81	80	37	48	29	32	30	40	31	28	26	29	23	19	9	8	21	661
92: General dental practitioner	9	8	11	10	12	8	14	8	10	7	5	15	9	9	3	3	4	5	150
04: Work	6	7	4																17
05: Educational establishment	1		2																3
Grand Total	25,528	23,529	25,904	25,624	25,682	25,169	27,061	25,609	25,466	26,384	26,283	26,032	25,030	23,198	18,543	12,284	16,589	18,765	422,680

Informed by data: primary care appointments

Demand for primary care appointments will continue to increase – returning back to pre-COVID levels by Oct



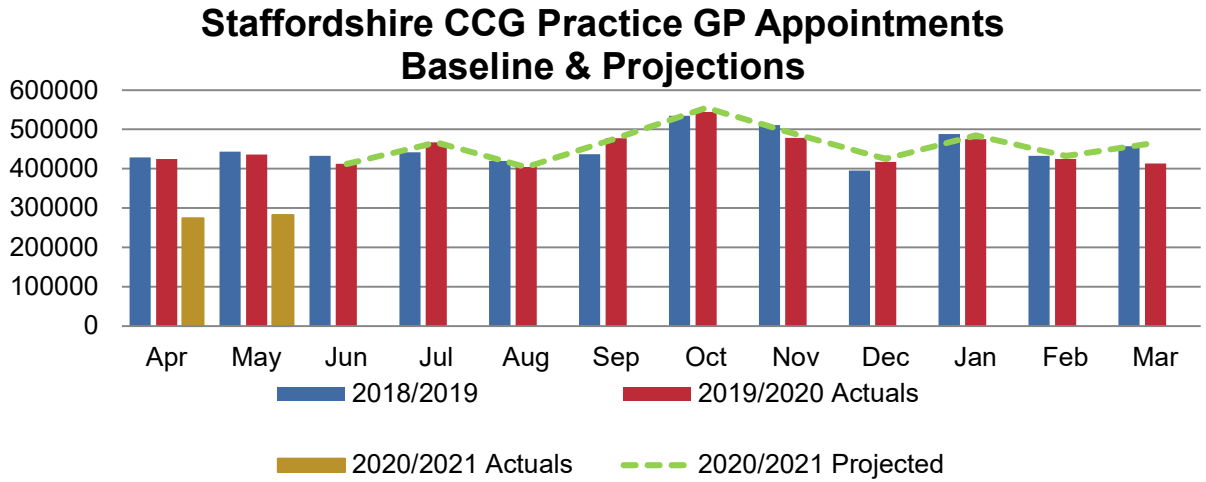
Informed by data

Baseline delivery capacity – Primary Care Appointments

Baseline analysis of primary care appointments (NHS digital)

Primary Care, GP Appointments

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/2019 Actuals	428,650	443,004	433,035	441,595	419,739	436,789	534,214	511,138	395,707	487,924	433,058	457,057
2019/2020 Actuals	424,996	436,012	412,180	466,963	404,638	477,464	544,433	478,703	417,097	475,292	424,408	413,429
2020/2021 Actuals	273,795	282,625										
2020/2021 Projected			412,180	466,963	404,638	477,464	555,322	488,277	425,439	484,798	432,896	466,198



Analysis:

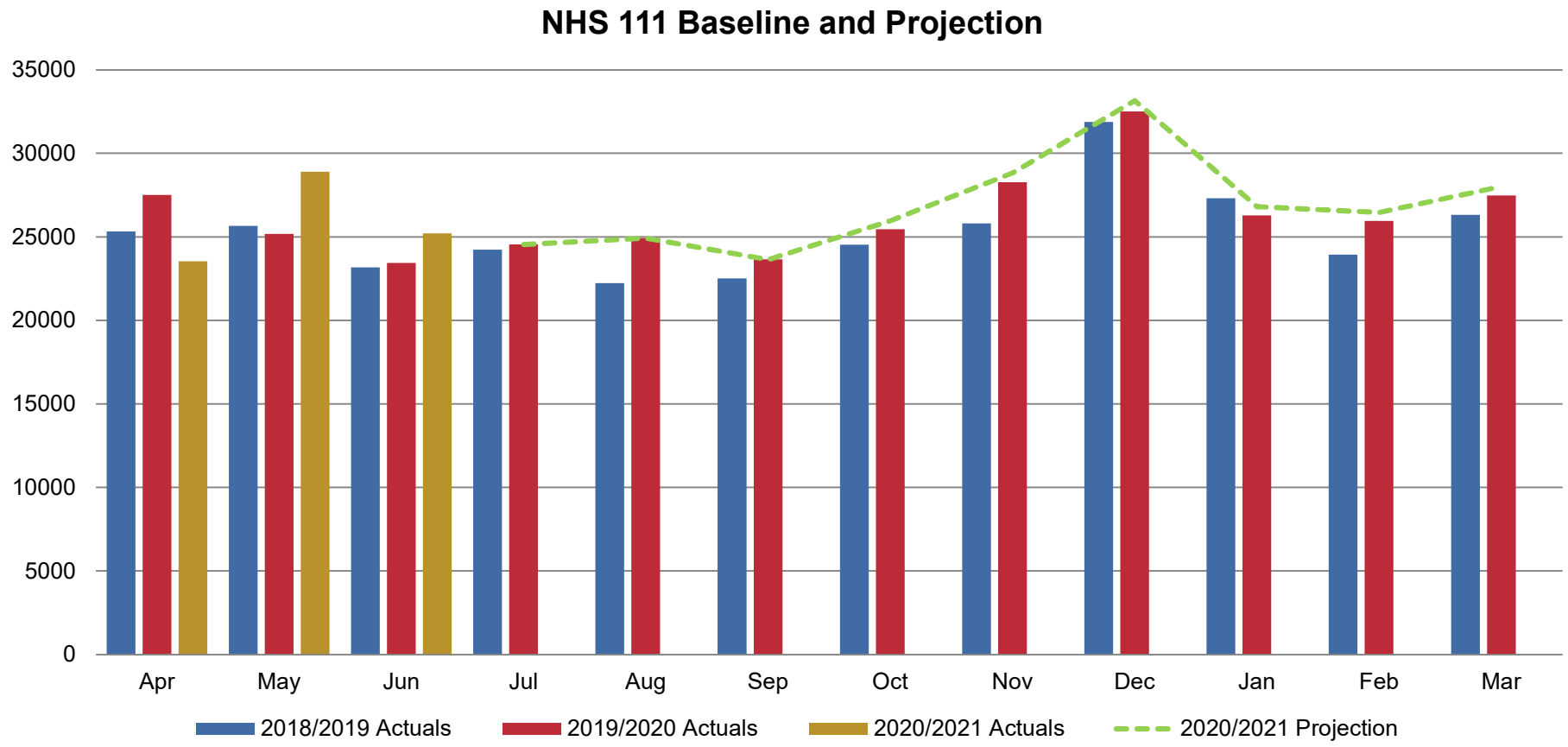
- Some observed seasonal variation in the quantity of appointments provided per month – this would need to be further analysed to understand the variance in the number of working days per month and seasonal holidays.
- NHS digital data is unable to capture a number of initiatives that occur on a seasonal basis including extended access schemes
- Number of changes in the provision of services – COVID-19
- Approx 38% less appointments provided during April and May 2020
- Work on going to understand if this is due to changes in demand or changes in operating processes in primary care.

Surge (winter) Planning assumptions:

- Demand for primary care appointments will continue to increase – returning back to pre-COVID levels by October (safe planning assumption)
- COVID-19 restrictions impact on provision - 20% of activity needs to be delivered differently – this planning gap will need to be mitigated or reflected in increased level of activity in settings including A&E attendances
- Phase 3 planning assumptions include need to return to normal levels of activity for key areas of cancer screening, immunisation and vaccinations.
- Additional demand of flu vaccination programmes
- Need to mitigate capacity deficit within other settings – i.e. acute setting or other urgent care portals
- Phasing of demand analysis indicates additional demand will be seen from January to March

Informed by data: NHS 111 analysis

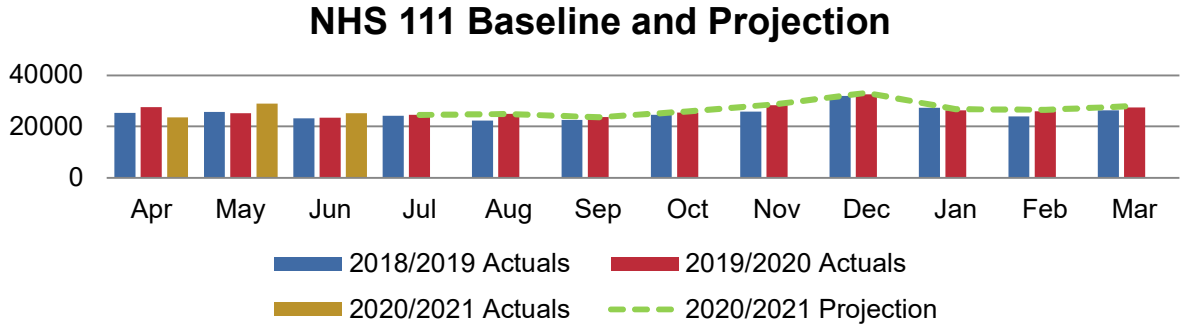
Increased calls during the first wave have not reduced



Informed by data

NHS 111 analysis

NHS 111, Calls Answered													
Year		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
2018/2019 Actuals	25,320	25,663	23,181	24,226	22,238	22,518	24,525	25,802	31,882	27,303	23,933	26,312	
2019/2020 Actuals	27,506	25,178	23,434	24,541	24,920	23,646	25,455	28,273	32,510	26,290	25,955	27,471	
2020/2021 Actuals	23,544	28,905	25,211										
2020/2021 Projection				24,541	24,920	23,646	25,964	28,838	33,160	26,816	26,474	28,020	



Data Source: NHS 111 MDS
Included: Staffordshire NHS 111 Service

Projection Criteria:
Jul to Sep based on prior year
Oct to Mar based on 2019/20 + 2%

Surge (Winter) Planning assumptions:

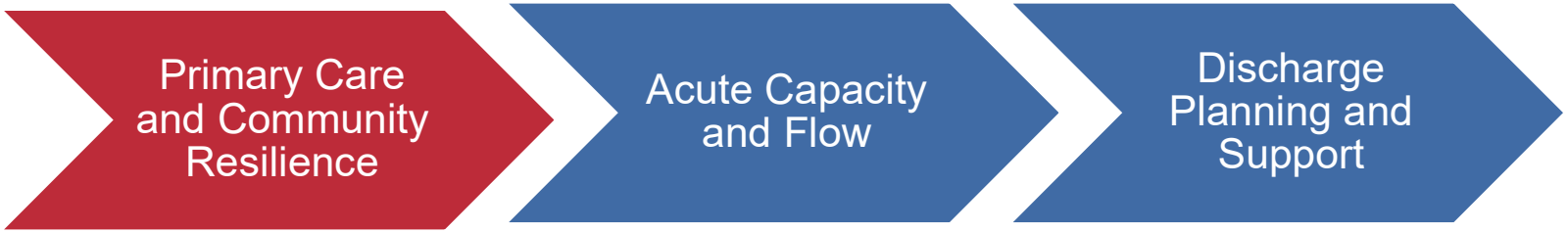
Non COVID-19 demand

- Phasing to follow same trajectory as previous years
- 2% growth in calls based on system demand growth analysis

COVID-19 demand

- Increased calls during the first wave have not reduced
- Additional demand greater than baselines due to COVID demand and clinical model/use of NHS 111 and NHS 119 approx. 4,000 additional appointments per month over a baseline of 2019/20 (worst case Scenario)
- Links to new programme initiatives – NHS 111 First – UTC and Same Day Emergency Centres – will provide potential mitigation in activity to A&E services

Areas of focus



Additional primary care capacity provided through:

- In hours capacity – virtual and face to face (if funding is made available)
- Increase in hot (COVID-19) clinic capacity over winter months.

Community Rapid Intervention Service (CRIS)

- Support patients within their own home without need to access acute care
- Care home management and visiting to be retained as part of the North service
- Continued levels of CRIS in the North
- Implement in South East and South West

Areas of focus

Primary Care and Community Resilience → **Acute Capacity and Flow** → **Discharge Planning and Support**

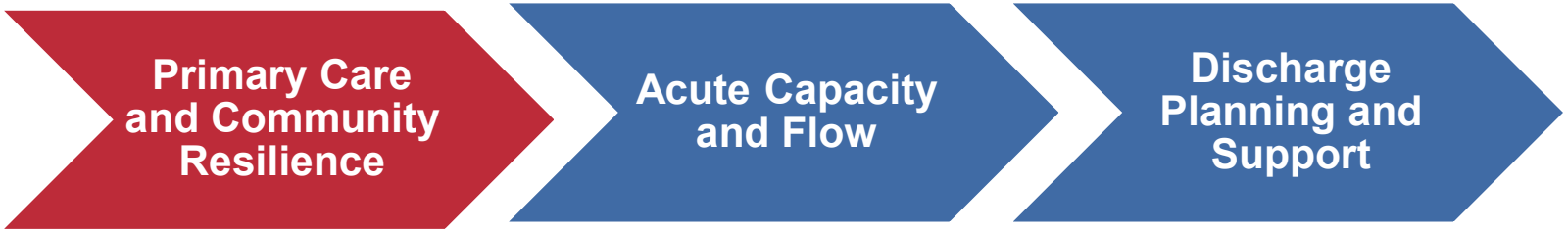
Flu delivery

- Largest ever flu programme in the UK
- New cohorts of patients agreed nationally
- At risk patients to be prioritised in September/October
- STP will be prioritising care home patients, those in clinical at risk group, shielded/housebound, vulnerable groups
- Capacity and demand modelling undertaken
- Bank of immunisers and admin staff for practices that need extra workforce
- Bulk ordering of PPE on behalf of all practices
- Plans to increase workforce vaccinations, particularly care home and frontline staff
- Communication and Engagement plan developed
- Focused approach on communities and practices with high deprivation and BAME populations to promote uptake.

Flu vaccine extended to:

- Household contacts of NHS shielding patients
- Year 7 pupils
- Care workers - direct payments/personal health budgets
- 50-64 year olds in November and December (provided sufficient vaccine) (around >140k extra patients)

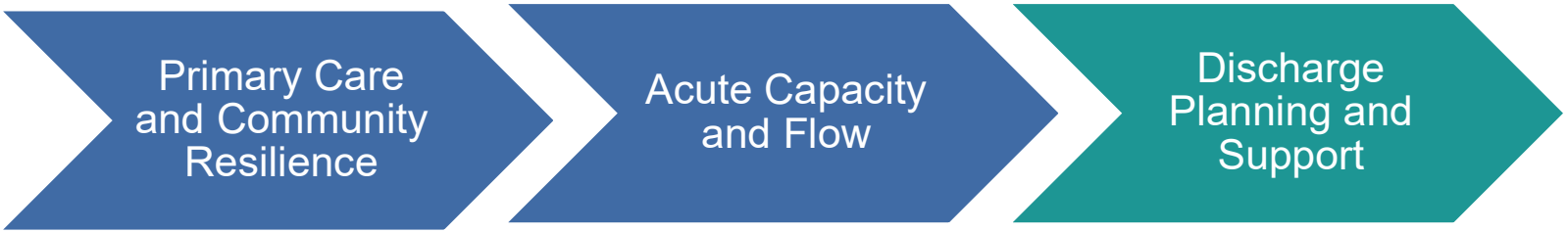
Areas of focus



NHS 111 First

- **National priority** for all systems in preparation for Winter
- Continue to encourage patients to **phone NHS 111** as the first point of contact for urgent care needs
- Ensure the safety of staff and patients (**social distancing**), minimise unnecessary waits in waiting areas
- National ambition to reduce walk-in attendances for unheralded patients (no clinical touchpoint before attending) to use NHS 111 for **signposting/direct booking**
- NHS 111 will use the local Directory of Services
- **Clinicians** are developing **pathways** to support patients to be directed to the right place
- Working with NHS 111 to help plan for additional demand **(increased investment)**
- Where A&E is the right place - intention is for NHS 111 to book into timeslots (gradually phased in during Autumn/Winter)
- **No one will be turned away from A&E** – though eventually they may wait longer than people with booked appointments (or be encouraged to phone NHS 111) if clinically safe
- **Staff** will be trained to give messages to patients who do go to A&E without phoning 111
- A **communications plan** is being developed to promote NHS 111
- Recruitment is underway to support increased demand

Areas of focus



- Patients at Risk of Increased **Length of Stay in Hospital** (PARIS) - early identification of co-morbid or complex social situations. Case management approach through system-wide multidisciplinary teams and clinical escalation
- Maintaining low levels of complex **Medically Fit for Discharge** (MFFD)
- **Additional Home First** (pathway 1) Community Capacity for Winter
- Wraparound support services to maximise flow – additional capacity, including additional therapy, social care, mental health input and night sitting services including the voluntary sector
- Early supportive discharge
- Additional discharge to access (D2A) capacity on ward 4 at Harplands Hospital
- Meeting the physical health needs of older aged adults with mental health needs
- Continued delivery of nationally mandated Discharge Policy & Operating Procedures

Mental health

- Recognition that mental health will be essential this winter both for people: existing, COVID-19 rehab and for new patients (lockdown)
- Proactive support to focus on physical health for people with mental health needs
- Employing a locum GP or nurse for 6 months to work across Outreach, Care Home Liaison and Older People's Wards at Combined Trust.
- Working alongside the Consultant Psychiatrist with a focus on better meeting physical health needs to support flow and early discharge

NHS is here for you

- 24/7 urgent NHS mental health service providing telephone support, advice and triage
- If you live in North Staffordshire or Stoke-on-Trent: 0300 123 0907
- If you live in South Staffordshire: 0808 196 3002
- (the 0808 phone number is free from any phone)

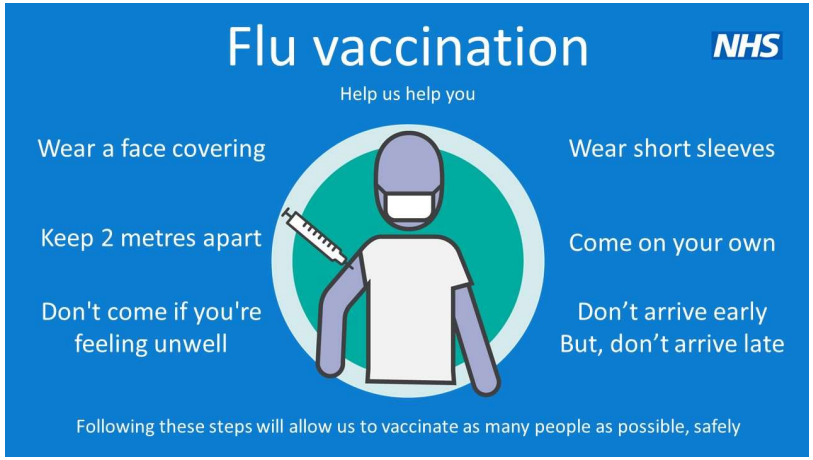
Planning for COVID-19 surges (a challenging winter)

- Developing resilient plans based surge demand scenario (April 2020)
- Detailed bed modelling undertaken – to maximise use of beds and theatres
- Includes:
  - The loss of beds for social distancing
  - Learning from the first wave - understand what services to start and stop
  - New ways of working – COVID-19 free zones (green) and COVID-19 positive (blue) zone beds and side rooms to support containment, ED cubicles with doors
  - Continued routine treatment for long term waiters in the first surge
  - Increased infection, prevention and control and PPE requirements- tracked daily with extended pathology testing shifts for expedited swab results 24/7
  - **Ready to respond - additional capacity**
- Seeking to increase adult critical care beds, to respond to demand - regional aspiration for 106 extra beds across West Midlands – detailed modelling underway and seeking capital funding
- Dashboard to track capacity and inform any additional sub-acute capacity that needs to be mobilised
- Access to Nightingale hospitals (should they be needed)

Communications and engagement

All health and care partners will be working towards the following aims:

- Implement and amplify **national campaigns** - consistent messages to help people use the right services for their needs
- Increase take up of the **flu vaccine** across priority groups (especially pregnant women, people with long-term conditions and staff)
- **Promote Call 111 First** to help staff and patients stay safe, and access the right services for their needs
- **Build public confidence -** it is safe to use services
- Support escalation with **proactive information** sharing with public and stakeholders



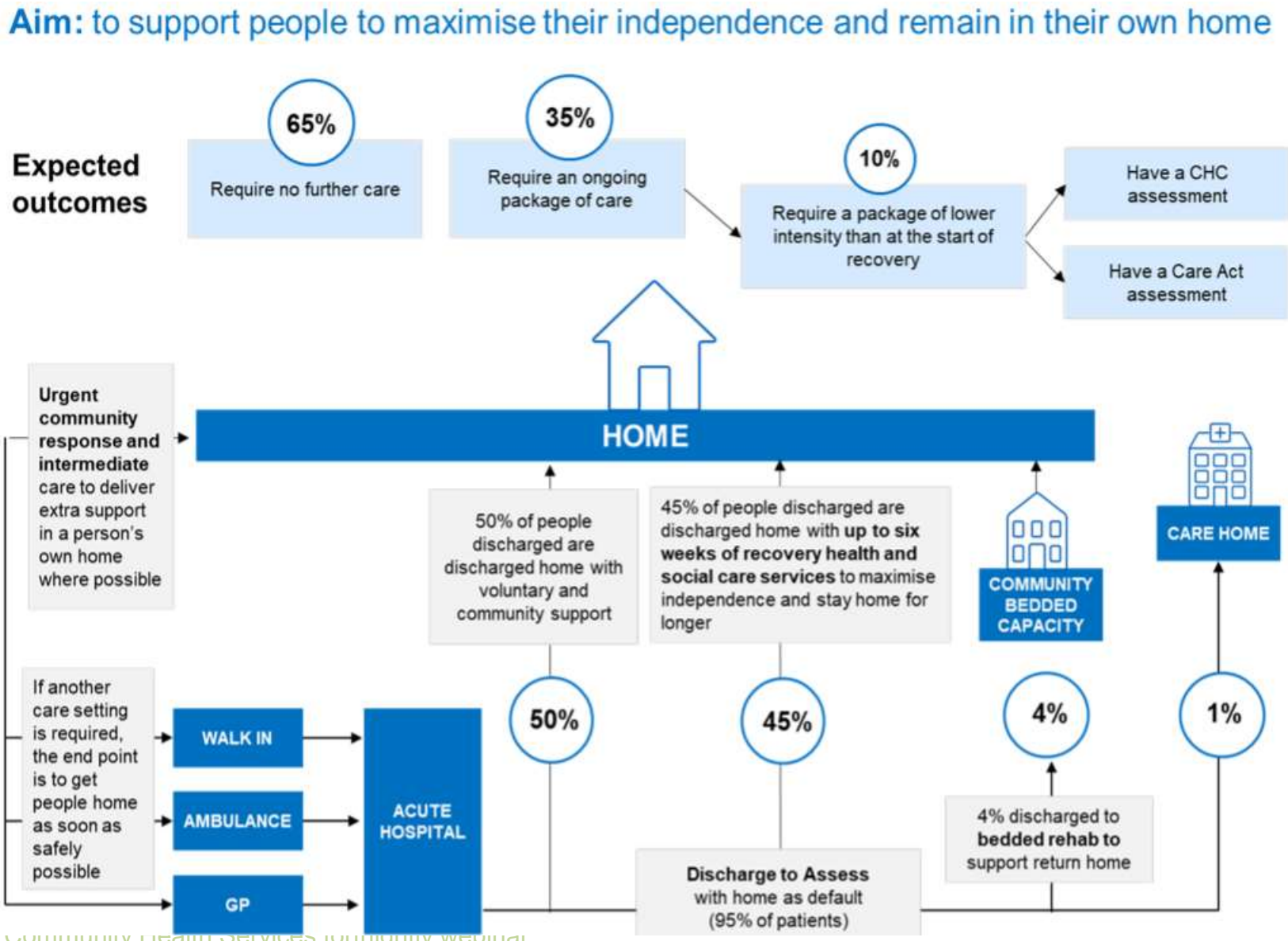
Risks and mitigations

Risk	Mitigation
Primary care – workforce, COVID-19 reduction in activity, patients not access services = unmet need	Hot clinics mobilised Communications to build public confidence
NHS 111 increased demand/ workforce availability/ national timeframes	Additional investment/recruitment
Flu vaccine – social distancing impacts delivery, PPE, workforce	Flu plan in place. Bulk PPE order and central process
Multiple services/pressures could lead to fragmentated approach leading to increase in Length of Stay	PARIS multi-agency processes System working
Increase in demand for medically fit for discharge	System working
Financial risks without additional funding	System working and escalation to regional team
Acute bed gap	Sub-acute beds Home First

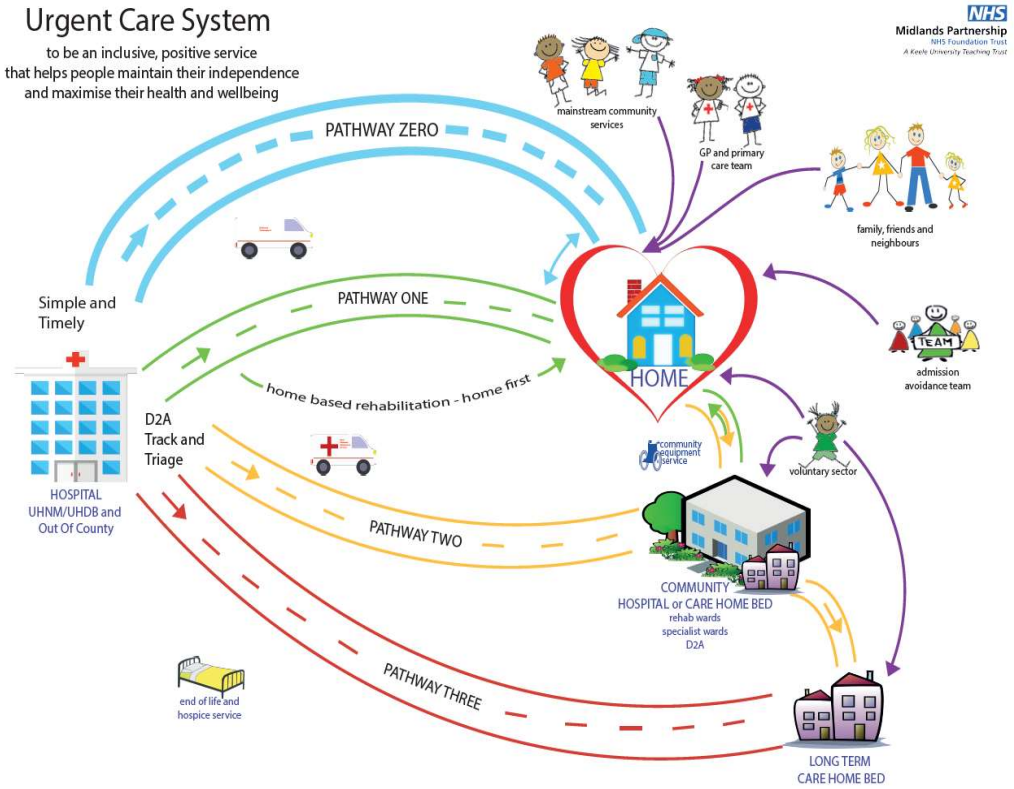
Next steps

- System plan to be submitted to NHS England/Improvement 21 September
- Providers sharing plans through Governance routes
- Systems and processes to monitor and respond to demand

National Discharge Service: Policy & Operating Model



Discharge Pathways – System Success



	National Policy & Operating Procedure	UHNM Footprint	UHDB & Out of County (proportion of D2A discharges only)
Pathway 0	50%	84%	Data not yet available
Pathway 1	45%	10%	63%
Pathway 2	4%	4%	26%
Pathway 3	1%	1%	5%
Palliative (Fast Track) Home or Bed	Included in above numbers	1%	6%

Proportion of Patients Discharges to each Pathway 1/4/2020 – 03/09/2020

Outcomes from Hospital Discharge Pathway:

- 94% of patients return to their previous place of residence
- 4% transferred to rehabilitation bed
- 1% transferred for assessment for long term care
- 1% discharged with fast track palliative care (of which 55% go home, 45% transferred to 24 hour care)

Outcomes from Home First (Pathway 1)

- 80% of people (currently) leave Home First without needing immediate ongoing support

Key to our success has been a whole system approach with all partners working collectively to support the changes needed to achieve the best outcomes for our patients and residents

Questions and answers

TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent

University Hospitals Derby and Burton NHS Foundation Trust (UHDB)

TOGETHER WE'RE BETTER
Transforming health and care for Staffordshire & Stoke-on-Trent

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Healthy Staffordshire Select Committee

UHDB winter planning

Contents

Bed Modelling

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

The bed modelling indicates that if…

- The Trust operates at 92% bed occupancy (providing some headroom to be able to manage the variation in patient flow),
- Estates schemes are delivered as planned
- Elective wards are protected on both acute sites
- NEL demand returns to normal + 4% growth
- Future Covid-19 demand remains modest
- 100% of LOS improvements are sustained

Then:

- RDH site has a deficit of 1.5 wards at the peak of winter in January. This will push bed occupancy up to around 98%.
- QHB site has a deficit of 1 ward at the peak of winter in January. This will push bed occupancy up to around 99%.

Bed Modelling (QHB)

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Occupancy Rate	92%
Covid - Reaction Period	4 weeks - R0 1.2

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medicine & Cancer Burton: Surplus/ Deficit	67	92	83	65	12	14	10	4	-4	-34	-8	-1
T&O Burton: Surplus/ Deficit	44	41	33	32	13	19	20	16	18	17	18	19
Surgery Burton: Surplus/ Deficit	29	18	15	6	-5	-8	-8	-13	-10	-11	-10	-9
Burton Covid Demand	0	0	0	0	-10	-10	-6	-3	-3	-2	-1	-1
Burton Total	139	152	131	103	10	15	16	3	2	-30	-1	8
Bed Gap in Wards	***7.2***	***7.9***	***6.8***	***5.3***	***0.5***	***0.8***	***0.8***	***0.2***	***0.1***	***-1.6***	***-0.1***	***0.4***

Assumes surgery and orthopaedic elective beds are ring-fenced:

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medicine & Cancer Burton: Surplus/ Deficit	67	92	83	65	12	14	10	4	-4	-34	-8	-1
T&O Burton: Surplus/ Deficit	16	14	7	0	-1	-2	-1	-5	-3	-5	-3	-2
Surgery Burton: Surplus/ Deficit	16	5	3	-9	-10	-11	-10	-16	-13	-15	-13	-11
Burton Covid Demand	0	0	0	0	-10	-10	-6	-3	-3	-2	-1	-1
Burton Total	99	111	93	56	-9	-9	-7	-20	-23	-56	-25	-15
Bed Gap in Wards	***5.1***	***5.8***	***4.8***	***2.9***	***-0.5***	***-0.5***	***-0.4***	***-1.0***	***-1.2***	***-2.9***	***-1.3***	***-0.8***

Second wave preparation

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University Hospitals of Derby and Burton
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Planning for a potential 2nd wave of COVID-19 continues and with the implementation of a 2nd wave planning group has broadened to include mitigation plans for the organisation past that of reviewing existing surge and capacity escalation plans activated in the 1st wave of the pandemic.

- A number of 2nd wave scenarios have been modelled to Identify the potential patient demand at its peak.
- The size of this peak is likely to be dictated by the National and Local response to an increase in cases and any delay in which lockdown measures are re-introduced. *(5 scenarios modelled - Intervention = 'Immediate, 2,3,4,6 weeks')*

Areas of focus.

1. Seasonal Flu and COVID-19 Vaccination Programmes.
2. Workforce contingency plans.
3. Impact of a local lockdown/workforce/patient access/staff travel/VWRAs.
4. Rapid Patient Testing, Testing processes and capacity.
5. Infection prevention measures, Isolation rooms/Ready rooms in Emergency pathway areas.
6. PPE provision and Fit Testing.
7. National/Local Incident updates and sharing of Intelligence

Next steps.

1. Modelling a 2nd wave of COVID-19 and seasonal demand to establish the impact on the organisation.
2. 'Lessons learned' exercise commencing with Business Unit leads to explore how learning from the 1st wave response and service changes made would influence their planning response to a 2nd wave of COVID-19.
3. Discussions with Business units will also explore whether there could be options to continue to provide some services should a 2nd pandemic wave occur to support ongoing R&R plans.
4. Workforce Contingency are currently undertaking lessons learned exercises of their own
5. Ongoing development of points 1-7 above.

Locking in Transformation

NHS
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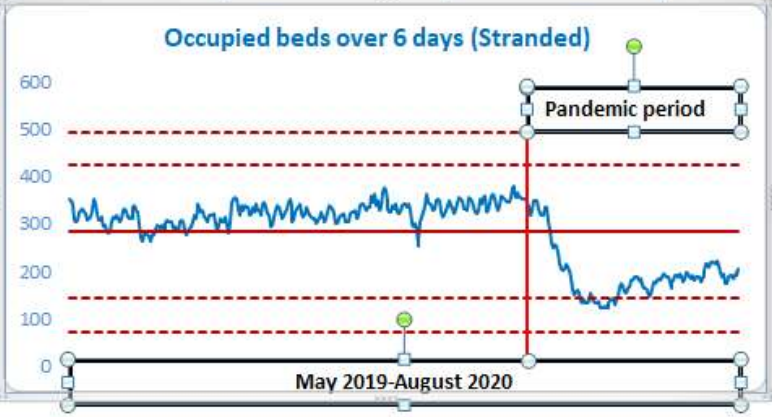
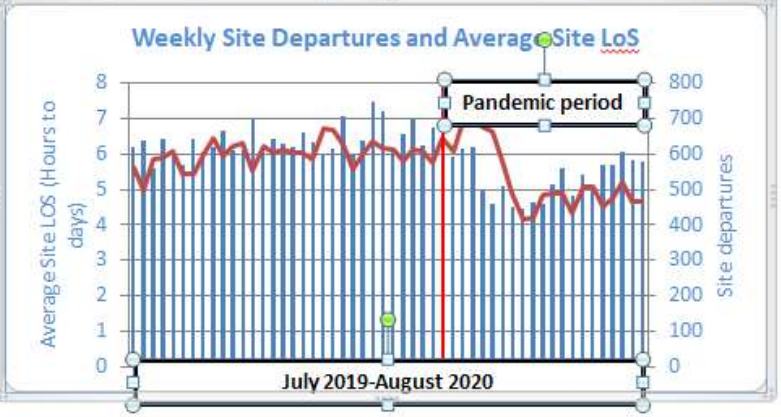
- Improvement Team is working with divisional and corporate teams to capture, assess and lock in beneficial changes - example below – being supported by detailed analysis.

Urgent Care Pathway

Pathway Element	Unwell Patient in Community	ED	Assessment Units	Ward Transfer	Treatment & Ward	Discharge
Problem to solve	High volume of covid symptomatic patients.	Unwell patients reluctant to attend ED.	Increased covid admissions/reduced non-covid admissions.	Increased covid transfers/reduced non-covid transfers.	High volume of patients requiring critical care.	Unable to discharge patients quickly enough to create capacity to meet demand.
Transformation applied	Increased use of 111/GP triage services to assess need for ED attendance.	ED separated into Red/Green/Blue zones for rapid assessment and turnaround.	Separation into red/green pathways for direct admission/cohorting of ?covid patients.	Wards designated red/green, allowing for rapid transfer/cohorting of ?covid patients.	Critical care capacity increased and escalation plans in place on wards for patients requiring critical care.	Discharge Assessment Units introduced with focus on management of discharge specific tasks. LoS reduced as a result.
Retain Transformation?	Yes.	For duration of pandemic (until vaccine)?	For duration of pandemic (until vaccine)?	Yes.	Yes.	Yes.
Action required	'Think 111 First' action plan.	Maintain efficient streaming and ED turnaround.	Maintain principles of rapid assessment/transfer.	Maintain rapid transfer model.	Escalation plans in place in case of future need to flex up.	Embed model and establish division of responsibilities between wards, DAUs and external partners.





Urgent & Emergency Care

Key assumptions	• NEL Activity is at 100% of FY 19/20 Winter • ED footprint to expand at RDH site in September 2020 • Second wave COVID-19 demand equates to 28 inpatients at RDH and 3 inpatients at QHB at the peak. Forecast assumes no downturn in NEL activity as seen in wave 1. • Workforce - base case assumes current sickness levels continue	• Bed occupancy at 92% • Bed model assumes the Trust will sustain 50% of the LoS improvement gain at the height of covid-19
Risks	• Trusts' current COVID-19 assumption in our likely scenario plan are lower than the regional assumption best case scenario • The additional ward capacity that fails to be realised will be equivalent to around 4% increase in occupancy	• Plan to protect surgery and orthopaedic elective beds limits urgent care capacity potentially increasing occupancy • Current modelling suggests a peak shortfall of c. 30 beds • Surgery NEL is also in deficit in all scenarios c.13 beds at the peak
Mitigation	• Further improvement on LOS - Trust replicates the LOS improvement seen in COVID-19 outbreak which would further reduce the bed deficit from c3 wards to c1 -1.5 wards over winter.	• Increasing occupancy in medicine and cancer to 95% would reduce the deficit by 1 ward • Re-launch of professional standards in ED to ensure flow through the sites

Outpatients – News, Follow ups and Procedures

Key assumptions	• Outpatient forecasts assume significant volume of outpatients delivered virtually (40% of FU in surgery)	• For cancer services; forecasts is to meet demand in full • Several services planned relocation to LRCH from RDH site
Risks	• Specialty level modelling remains a work in progress but is challenged by sufficient data and modelling capability • Triangulation with diagnostic capacity incomplete but in progress • There is an anecdotal view that virtual appointments take longer than face 2 face and thus impact on throughput.	• Forecast and residual gap is based on Phase 3 target and thus further work is required to understand overall impact to backlog in line with plan and waiting list size and profile at year end. • Decision on future permanent location of the DAU could result in a reduction in OP estate • Services planning capacity assumptions on existing estate footprints which may change specialty forecast if a shared estate solution is adopted
Mitigation	• Further work is in progress to identify upside forecast and confirm which additional activity could be done taking into account factors such as: virtual appointments, PIFU. Advice and guidance etc.	

Planned Care – Elective Inpatients and Daycase

Key assumptions	• No significant COVID-19 spike resulting in cancellation of electives • Referrals increasing to 80% by March 2021 (100% for urgents) • NEL activity returns to pre-COVID-19 levels from September 2020 • Beds modelled at 92% bed occupancy at both RDH and QHB sites • Elective capacity is protected throughout Winter period • No evening or weekend initiative lists assumed in current forecast	• Sessions at IS will continue until March 2021 • Case mix has shifted towards electives due to clinical prioritisation and availability of particular theatres • Case mix changes means activity forecast does reflect the extent to which our theatre capacity is increasing i.e. theatre sessions to be restored to 83% but only equates to c.50% of activity
Risks	• Current forecast will see 52 week waits increase significantly • Extent to which we can protect elective beds over winter • Inability to re-instigate WLIs (or equivalent) – also affects delivery of Private Patient activity • Ability of shielded staff to the workplace, limiting recovery of theatre lists • Sickness and vacancies remain high (7 – 12%)	• Unable to maximise Barlborough capacity due to case mix, patient choice and lower acuity threshold • Non-green lists remain a pressure on resources • Continued use of additional staff used in theatre • Reduced throughput requiring additional lists needed for emergency and trauma
Mitigation	• Theatre throughput increased • Shielding staff being supported to return to the workplace lists	• Additional utilisation of independent sector partners • Emergency staffing ratios • WLI lists

Diagnostics – CT, MRI, Ultrasound and Endoscopy

Key assumptions	• Gastro Day case/Endoscopy Diagnostic assumed at M4 for RDH, plus additional capacity coming at Sir Robert Peel late 2020 • Additional capacity available from mobile MRI from October 2020	• Continued access to Nuffield for imaging • Returning to % targets set out in phase 3 letter in most modalities.
Risks	• Plain film X-Ray is challenging linked into other clinic and theatre restoration plans • No confirmed timescale for the 4 air scrubbers from NHSI/E for endoscopy theatre.	• Pressures exist particularly in ultrasound and nuclear medicine which will remain a challenge. Confidence level low in achieving the phase 3 letter targets in both of these modalities • Compromised diagnostic Nuffield capacity in Q4
Mitigation	• Trust has invested in own mobile MRI unit. (No net increase until Q3 2021/22) • To recruit Clinical Fellows and a Nurse Endoscopist to provide operational capacity. Business case approved at FIG on 21 July 2020	• Workforce - Successful international recruitment from Portugal

University Hospitals North Midlands NHS Trust (UHNM)

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Transforming health and care for Staffordshire & Stoke-on-Trent

UHNM comments

- Planning for a second COVID-19 surge whilst delivering R&R with hospital zoning to create carve out areas for expedited elective and non elective flow, whilst acknowledging 46 beds out reduction for 2M social distancing and 75% cap on Independent Sector contract
- Investment in extended pathology resources for expedited turnaround of COVID-19 swabs to support decision making/pull from ED for NEL flow part of key enablers to winter plan
- Other NEL enablers include: Portal Capacity enhancement: Emergency Access Unit for our Haematology and Oncology patients, Priority Decision Unit adjacent to ED (10 assessment beds) to support Specialised flow plus SAU bed flex, all supporting SDEC delivery and access standards improvement.

Plans to increase capacity on the Royal Stoke University Hospital (RSUH) site include:

- Investment case to support a Paediatric Modular Build to enable isolation pathways for any acute COVID-19/flu presentations in the Emergency Department.
- Investment case to support the creation of additional Critical Care Capacity (2-10 beds on the RSUH site)
- Investment case to support the creation of an additional 28 bed ward within the RSUH footprint by remodelling the existing estate
- The purchase of PODS to convert our identified COVID-19/flu wards to support IPC isolation capacity
- We have reconfigured our medicine portal and acute ward capacity into a single zone to support improved pull and flow of patients from the Emergency Department

Plans for winter at County Hospital, Stafford include:

- Additional 25 bed escalation capacity plus AAU unit flex (7 beds) with COVID-19 positive patient moved to RSUH so County can be used for step downs and elective protected beds

UHNM comments

Plans for winter with our System Partners include:

- Working with our community partners to support integrated discharge planning and refreshing our approach to health and social care systems – building upon the hospital discharge service developed during the COVID-19 response, incorporate learning from this phase, and ensure discharge to assess processes are fully embedded for all people aged 18+
- UHNM internal Length of Stay Initiatives commenced to reduce stranded/super stranded LOS and Home for Lunch initiatives with Wards and the Discharge Lounge Teams
- We are working with our system partners to support diversion of appropriate pathways to Haywood Walk in Centre and to establish a subacute unit to support medically fit patients who are awaiting placements in order to free up our assessment and acute beds.

Winter slide for SRM

- Surge planning group convened since July 20, chaired by Simon Whitehouse and all partners engaged including NHSE/I
- Modelling and scenarios developed by the system analytical cell and signed off by all partners – final version to be signed off on 10th Sept 2020
- Focus is on urgent care needs and challenges for population of Staffordshire and Stoke-on-Trent so includes UHDB and RWT.
- UHNM bed deficit focus of system planning around urgent care/winter/covid surge
- NHSE/I Urgent Care escalation meeting arranged for 15th September 2020
- Plans in place

System Governance focusing on 3 work streams:

1. primary and community resilience,
2. acute 'in hospital' flow, and
3. community and discharge flows.

Focus of all 3 workstreams-

- Mitigate the bed gap for UHNM as detailed in the table opposite (v2.6b is the scenario modelled prior to any winter enablers)
- Actual capacity (beds) and enablers (MFFD level reductions) will be used mitigate bed gap pending funding and scoping of physical and workforce capacity
- **UHNM:**
- expedited winter workforce enabler approvals in July 20 so recruitment under way with +20 medical staff recruited into 6 month contracts.
- Investment bids to support additional critical care/ acute ward/ED and Portal capacity. Confirmation of ED Paeds investment 28/8.
- Urgent Care Programme enablers include: ED pathway review and handover delay focus, Ambulatory/SDEC enablers, Divisional action plans to pull from ED, Ward Enablers and Stranded and super stranded improvement trajectories coordinated via Integrated Discharge Lead, Director of Operations and System Discharge Leads.
- **SYSTEM:**
- Maintain MFFD at consistent low levels (akin to Covid surge scenario)
- Reduce LoS in all community based beds against agreed KPIS
- Planned opening of sub acute community beds against surge triggers
- NHS 111 First Board established but concerns around delivery
- Ambulance conveyance rates Flu vaccine programme board well established and Neil Carr providing CEO oversight
- Care Home and Nursing Home focus – building on strong work delivered during initial COVID19 response

Chart showing system modelling - all providers

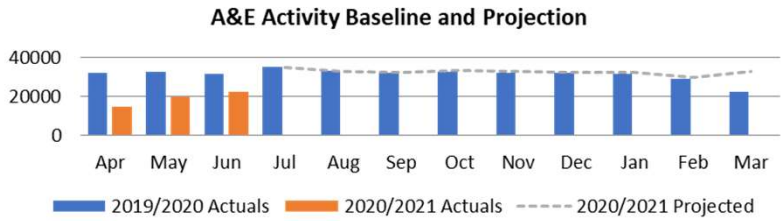

Table detailing UHNM (V 2.6b) Bed demand and Bed Gap for adult beds

Bed Base	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Core Bed Base (excluding Maternity, Paediatric or Critical Care Beds)	1,186	1,186	1,186	1,186	1,186	1,186	1,186
RSUH	999	999	999	999	999	999	999
County	187	187	187	187	187	187	187
Demand	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**
Anticipated Bed Demand (Based on 92% bed occupancy)	1,332	1,358	1,398	1,426	1,395	1,395	1,363
Royal Stoke	1,148	1,171	1,199	1,217	1,190	1,190	1,167
County	184	187	199	209	205	205	196
Core Bed Gap	146	172	212	240	209	209	177

Risks

- Commissioning plans for larger capital schemes with risk of covid surge
- Revenue consequence of additional services
- Availability of flu vaccine and clarity on phases
- Staffing availability – balancing restoration and recovery with winter demand
- Staff resilience and moral and capacity
- NHS 111 First delivery

Waiting lists

- August has reflected the easing of restrictions and returning services. The number of incomplete pathways are increasing as new referrals are added, the backlog (> 18 weeks) has decreased in total, however the number of patients over 40 weeks is rising. The latest number is 4392, a rise of 658 from July.
- Performance is improving but the number of long waiters is increasing as urgent patients are being treated out of date due to their deteriorating condition for some specialties.
- The admitted patients (those with a decision to admit for treatment) has shown a decrease, whilst the non-admitted numbers have increased.
- The number of clock stops is rising as patients are seen and treated.
- Day Case and Elective Performance circa 75% compared to in year plan.

- Current position as a Trust based on an assessment of the 19/20 average weekly activity compared to current

	Daycase	Elective	Total
Surgical	41%	52%	43%
Specialised	47%	72%	58%
Medical	66%	109%	67%
WCCS	86%	77%	85%

Recovery plans for Admitted

Theatre Cell reporting 88% of pre-covid theatre capacity now restored including IS.

• Independent Sector Contract offer from 1st September – 30th November 75% NHS and 25% private which will impact on Trust Trajectories (this equates to 24 sessions down to 20 for the Nuffield but slight increase of 14 to 15.5 for Rowley (on account of them having less private work currently).Outsourcing options also in train to cover off the gap.

• R&R trajectories for Day Case and In patient activity have been drafted and need to be aligned to the 12 week plan.

• The rate limiting factors will be workforce and job plan alignment to be able to swap out activity that supports the clinical prioritisation intentions although it has been noted that clinicians have been so accommodating during covid in working collaboratively to ensure clinically urgent patients are seen and it is in this spirit that the plan is being put together.

• September IS capacity has already been booked in so adjustments will be made in future weeks around capacity to retain or drop.

• R&R trajectories being reworked in response to the Phase III letter.

Urgent Case volumes may exceed current theatre and bed capacity and activity for surgery and specialised has increased (seasonal affect). Theatre capacity enabled and bed plans under review but workforce case mix to manage elective and non elective remains challenging.

• Acute and IS capacity plans to be aligned to 12 week plan and Phase II bed zoning model.

• Workforce and surgeon job plans will be the rate limiting factors.

• PPE being kept under daily review but revised zoning of theatres will support improved flow.

• Perfect week enablers planned for 07/9 to support harnessing of all recent new ways of working and SOPs to support.

Day Case and Elective Performance circa 62% compared to in year plan.

Non Admitted and Long Waiters

• Divisions to review 52 ww pathways split by elective and non elective and to book patients against length of wait and clinical priority.

• Trust is participating in the NHSI Home Swabbing Pilot (Pillar 2) with first service live 24/8. Medicine are leading the way with the work in support of this.

- MS Teams training to all booking teams for assurance of retaining activity and ensuring only clinicians delivering the treatments make decisions about patient cancellations.
- Surgery to progress 12 week theatre prioritisation plan against coded waiting list. Clinical forum to debate principles for socialising at TEC.
- Head of Elective (interim) to prepare action plan in response to PTL Audit of Waiting List to share at next meeting.
- Cancer 2ww front door vetting and triage model to continue with Cancer Manager leading plan and sharing at next meeting.
- Teams to review 52 ww file circulated and advise on booking priorities for non admitted patients and review admitted patients and document outcomes and return to corporate validation team.
- Home Testing for Covid19 pilot to be tracked for benefits as this will form a support function for any second surge to ensure continuation of electives.
- Phase 3 trajectories now revised and submitted to NHSEI 28/8.
- In sourcing options with 2 companies to continue to manage cancer wait times and support improvements in 52ww clearance.
- PTL external diagnostic of in patient waiting list completed. Interim Head of Elective working on action plan against recommendations with Divisions and the Corporate DQ and Validation Teams.

Midlands Partnership NHS Foundation Trust

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- An integrated Trust providing adult social care on behalf of Staffordshire County Council, mental health services in South Staffordshire and out of hospital healthcare in Staffordshire and Stoke-on-Trent
- Committed to working as a system and support this plan; we have no plan of our own
- Delivering much of the community element within the plan and this presentation

NHS
Midlands Partnership
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A Keele University Teaching Trust

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