2022/23 Winter Planning

5 September 2022

Key Principles for Winter Planning

Winter planning at NUH is underpinned by the following principles:

- Health and care partners across the Integrated Care System (ICS) will work together to offer appropriates services to our population in the right place at the right time
- Appropriate services are available for patients requiring care in the acute setting
- Patient safety is optimised and quality of care is maintained. Patients are not exposed to unnecessary clinical risk (inc. Covid-19)
- The health and wellbeing of staff is maintained
- Any adverse impact on elective activity and associated patient experience, income and performance is minimised. Cancer and clinically urgent activity is preserved
- An agile approach is adopted with plans in place to respond to a potentially rapidly changing environment as a result of the Covid-19 pandemic.

Approach to Winter Planning

1. **Anticipate and assess** issues in maintaining resilient services:
    - Lessons learned from 2021/22
    - Key winter pressure drivers identified – likely epidemiology of winter 22/23
    - Demand modelled
    - Risks identified
2. **Prevent** the likelihood of occurrence and effects of any such issues:
    - Prevent and manage infection inc. vaccination; patient/staff testing
    - Effective patient and staff communications (system approach)
3. **Prepare** by having appropriate mitigating actions, plans and management structures in place:
    - Mitigating actions and flow priorities inc. staff and support service plans; staff well-being
    - NEL surge plans and the extent to which elective activity is protected
    - Specific plans for Christmas and New Year period
4. **Respond and recover** by enacting plans and contingencies as required:
    - Escalation triggers and actions
    - Contingency plans.

2021/22 Winter Reflections

- Covid-19 demand surged pre-Christmas (Omicron wave) peaking in early January (albeit at lower levels than previous year). No national lockdowns. The impact of Covid-19 demand on critical care was significantly lower than the previous Covid-19 winter period
- Pathway segregation remained in place across our hospitals impacting on patient and staff flows between areas
- Staff sickness levels were high in line with high prevalence of Covid-19 in the community; this placed significant pressure on a tired workforce
- Non-elective attendance demand eased a little during Omicron peak; although overall non-elective admissions remained relatively strong
- Significant delays in admitting patients with long 'fit for ward' times and an associated extended mean time in ED
- Medically safe for transfer levels remained high all winter and did not reduce as we entered the Spring/Summer period
- Elective activity was curtailed as bed capacity was required to support non-elective demand. Theatre availability was constrained until late Spring due to staffing pressures.

Key Winter Pressure Drivers

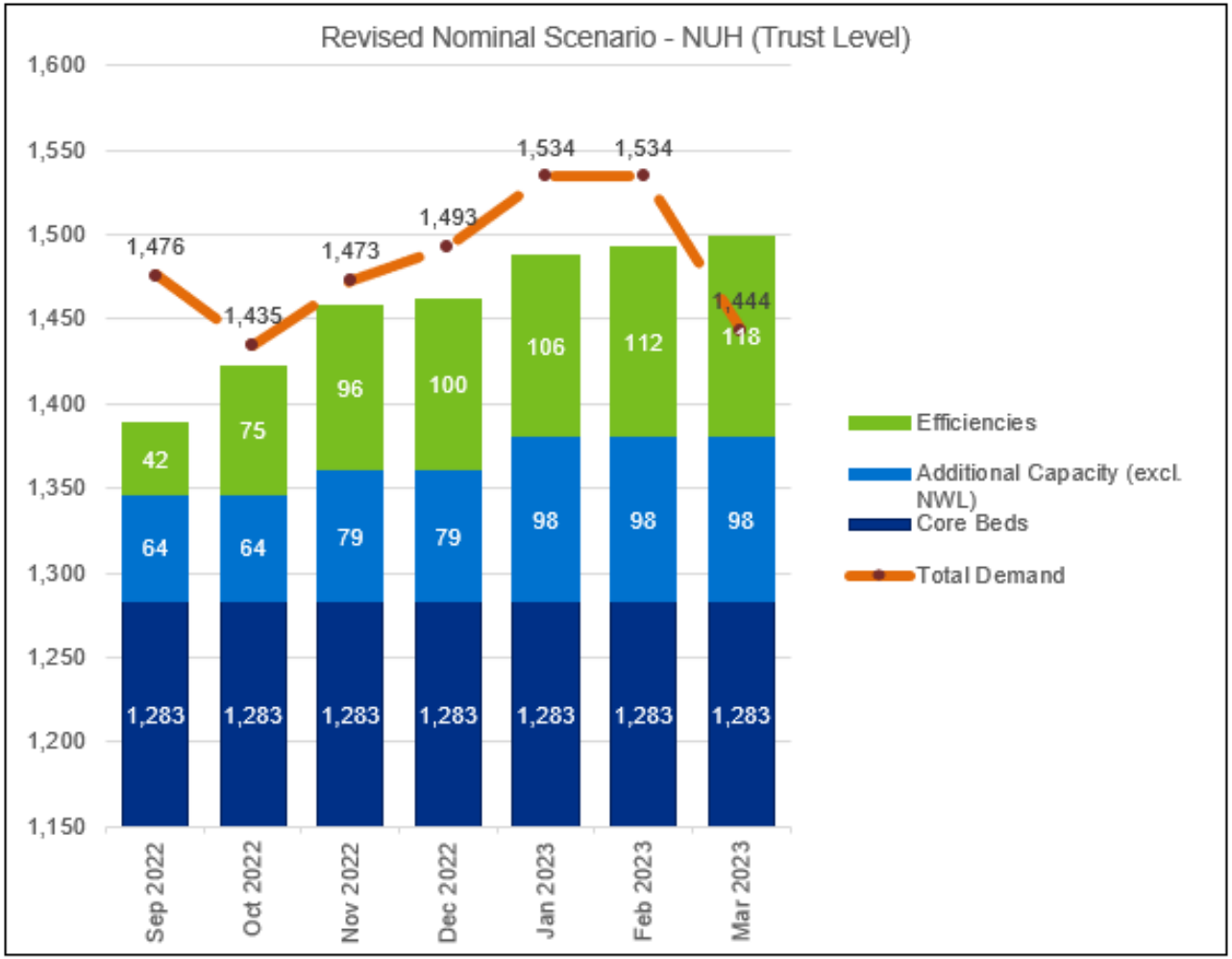
Traditionally, key drivers for our winter pressures relate to:

- Higher acuity
- High prevalence of influenza
- Increase in attendance/admissions in respiratory (inc. RSV) and HCOP
- Increase in beds closed due to infection (norovirus, D&V, CRE etc)
- Increase in number of beds occupied for patients medically safe >24 hours awaiting a P1-3 discharge
- Increased bed occupancy and associated flow challenges out of admission/assessment areas and ED
- Increased competitive locum and agency staffing environment

In the 'living with Covid-19' era there is a degree of uncertainty around what the epidemiology of winter may be like in 22/23. Taking learnings from the Southern Hemisphere.

Adult base ward bed model

- Key focus on the adult general and acute base wards. Scenario-based approach
- Nominal scenario:
  94% NEL demand;
  104% EL;
  85% bed occupancy;
  85th %-tile of demand; and
  MSFT >24 hrs rising from current levels to >200 during Jan/Feb-23
- Chart updated last week to reflect delayed modular ward opening
- System model has additional 14 community beds for Connect Heritage from Oct-22.



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
+/-	-87	-13	-15	-31	-47	-41	55

NUH winter mitigations: In plan

#	Name	Description	Deliverables	Investment required	Timescale	OLT Lead	Proposed Governance
1	Pockets of beds	Open small pockets of beds already accounted for in operational plan year round. Includes: Edward 2 (4 beds); Winifred 2 (4); Harvey 2 (4) and Fleming (6).	Increase bed base by 18	In plan	Aug to Oct-22	Relevant Divisional Nurses	OPG
2	Modular ward	Open modular ward and transfer activity from QMC to City.	Increase bed base by 20	In plan	Jan-23	Neil Ellis	Elective Board
3	Berman 2	Open ward as 'fit for home' unit. Discharge lounge in dayroom area.	Increase bed base 12	No, replacing Newell to deliver equivalent outcomes for investment	End of Oct-22	Lorraine Hourd	Emergency Board
4	NUH Care in the Community	Provider collaborative scheme to provide BD (up to twice daily) packages of care to bridge gap between end of the patients hospital stay and start of social care commissioned package of care.	Reduce P1 discharge delays Impact estimated at 15? beds		Staged from Oct-22	Lorraine Hourd	Emergency Board
5	Homecare reablement service	12-week trial of homecare service provided by a third party.	Reduce P1 discharge delays. Impact estimated at 3 beds	Approved by MB in Aug-22 (£200k)	Sep to Dec-22	Russell Pitchford	Emergency Board
6	Virtual wards	NUH element of the ICS Virtual ward business case.	Reduce LOS. Impact estimated at 13 beds	In plan	Remainder of 22/23	TBC	Emergency Board
7	Microbiology 24/7	Continuation of 21/22 approved case.	Reduce LOS. Impact estimated as 7 beds	In plan	Full year	Amanda Kemp	OPG
8	Paediatric ED opening	Expansion and development of paediatric ED estate.	Reduce LOS / patient turnaround	In plan	Early Oct-22	Russell Pitchford	Emergency Board

Winter mitigations: Further considerations (1/2)

#	Name	Description	Deliverables	Investment required	Timescale	OLT Lead	Proposed Governance
9	Re-locate and expand Gastro bed base	Transfer Gastroenterology beds into South block and expand into a second (Hepatology) ward with associated specialty bed base adjustments.	Productive use of capacity and improved pull from B3	Not significant	TBC – workforce change required. Aim pre-winter	**Surgery** and medicine	Emergency Board
10	HCOP reconfiguration	Reconfigure HCOP (to support Gastro scheme above) including in-reach into Surgical wards. And further potential and opportunities supporting bed access.	Reduce LOS. Impact estimated xx beds			Surgery and **Medicine**	Emergency Board
11	HCOP de-medicalisation	De-medicalisation of some HCOP wards and increased HCOP in-reach into other areas	Improved use of medical resource	No.	Oct/Nov-22	Medicine	Emergency Board
12	C24 move	Reconfigure major trauma and Emergency General Surgery capacity. Develop C24 as a short-stay emergency surgery ward.	Enabler for scheme 13	Not in the short-term. Investment required to expand major trauma	TBC	**Surgery**	Emergency Board
13	Emergency theatre lists	Create optimal number of emergency theatre lists over winter.	Reduce LOS. Impact estimated xx beds	No. Opportunity cost	Oct-22	Surgery and **Clinical Support**	Elective Board
14	Extension of 7 day MDT	Invest in additional resource to deliver LOS improvements inc. senior decision makers, pharmacy and therapies. Would need to be focussed on high impact areas.	Reduce LOS. Impact estimated xx beds	Yes	Staged from late 2022	Medicine (primary lead)	Emergency Board
15	IPC weekend services	IPC support to minimise capacity loss through due to IPC issues, risks and concerns	Reduce closed beds due to infection	Yes – 2x B8A's, 4x B6's. Investment case in draft.	ASAP	TBC	OPG

Winter mitigations: Further considerations (2/2)

#	Name	Description	Deliverables	Investment required	Timescale	OLT Lead	Proposed Governance
16	POC testing	The recommendation is that we implement the 4-plex cepheid test (Covid-19, fluA, fluB, RSV) in ED, SRU and RAU	Reduce closed beds due to infection	Yes. Investment case in draft	Depends on scale	CAS	OPG
17	Virtual ward expansion	Going beyond the deliverables detailed in the ICS business case.	Reduce LOS.	TBC	TBC	TBC	Emergency Board
18	Rehab	Post critical care rehabilitation across medicine and surgery (predominantly medicine?). Initial idea at this stage.	TBC	TBC	TBC	Medicine & Clinical Support	TBC
19	Maximising daycase	Increase the volume of daycase activity. Would link to 7-day services as we would need to invest in weekend resource.	TBC	Yes	TBC	Ambulatory Care	Elective Board
20	Criteria-led discharge	Increase number of specialties where criteria-led discharge is implemented	Reduce LOS. Impact estimated xx beds	TBC	TBC	Divisional Directors and Nurses	Emergency Board
21	Culture and risk appetite – clinical	Pros and cons; review underway following Critical Incident. Would need to consider how we support staff.	Reduced LOS.	No	Staged – cultural change will take time	Divisional Directors	Emergency Board
22	Non-clinical work reduction and risk	Output of further discussions post cold debrief as discussed in Management Board.	TBC	TBC	TBC	TBC	TBC
23	Respiratory winter planning	Mitigate additional complications around respiratory surge options	TBC	TBC	TBC	Medicine	TBC
24	Urgent treatment centre potential	On-site escalation urgent care model	TBC	TBC	TBC	Medicine	TBC
25	7-day site ops	7-day senior site ops cover based at QMC	TBC	Yes	TBC	Duane Mclean	Emergency Board

Risks

IF

- **Physical space** is insufficient to meet demand.
- Unable to provide sufficient **medical and nursing staff** to meet demand
- Unable to maintain a **resilient workforce**
- Insufficient **equipmen**t to meet demand
- Insufficient number of **hospital beds** to meet demand
- Insufficient **system capacity** to maintain system flow and the timely transfer of medically safe patients
- Experience a **influenza pandemic** or significant norovirus or CRE outbreaks
- Experience any significant issues with the **fabric of our buildings** or other infrastructure (e.g. ICT)

THEN

We may not deliver resilient services

RESULTING IN

- Adverse impact on **patient safety and harm**
- **Inability to deliver appropriate services** to our patients (particularly on elective pathways)
- Adversely impact on our **reputation** causing undesirable media coverage and a loss in confidence from the population we serve
- **Reduced staff morale, resilience and retention**
- Lack of compliance with national standards causing **undesirable regulatory action**
- Additional **costs and financial pressures**.

Arguably some of these risks are issues…

Next steps

1. Gather more information about vaccination programme
2. Further liaison with Communications teams re. system and internal approach
3. Agree approach to staff and patient testing (investment required)
4. Deliver mitigations in plan and agree if schemes for further consideration are all going to be progressed
5. Capture any additional Divisional capacity, process and staffing actions planned to support flow over winter
6. Agree non-elective surge plan and extent to which elective capacity is protected
7. Develop the formal Winter Plan word document (in draft)
8. Specific focus on Xmas and New Year plans in November (when staffing rotas are clearer) using similar format to previous years.