NHS
Somerset
Clinical Commissioning Group

**Report to the NHS Somerset Clinical Commissioning Group on 24 September 2020**

| **Title: Somerset Winter Plan 2020 / 21** | **Enclosure I** |
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| | |
|---|---|
| Version Number / Status: | 1.0 |
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| Clinical Lead: | Dr Helen Thomas, Urgent Care Clinical Lead |
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**Summary and Purpose of Paper –**

The Somerset Winter Plan for 2020/21 aims to demonstrate that the Somerset system:

- Reflects a whole system approach to the delivery of services over the forthcoming winter period
- Is building upon the learning from the previous winter plan and the system response to COVID-19 (Covid)
- Understands the demand on all sectors and their dependency on one another
- Has a single escalation system and is explicit about the expectations of each organisation, particularly in periods of heightened escalation
- Will ensure that seasonal or Covid demand will not compromise patient care, experience and service standards
- Has robust policies and procedures in place to ensure that patients remain safe in our health and care services
- Has identified the potential risks and has actions in place to mitigate against them

It is to be noted that the Somerset Winter Plan is currently in draft form and will continue to be adapted locally throughout the winter period.


**Recommendations and next steps**

The Governing body is requested to **Approve** the Somerset Winter plan 2020/21

| **Impact Assessments – key issues identified** | |
|---|---|
| **Equality** | Equality and diversity is at the heart of Somerset Clinical Commissioning Group's work, giving due regard to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited in under the Equality Act 2010) and those who do not share it, in its functions including financial performance. |
| **Quality** | The Somerset Winter Plan aims to improve the quality of service delivery for patients over the winter period. |
| **Privacy** | Share records between providers. |

<table>
<tr><td>Engagement</td><td colspan="4">The Somerset Winter Plan has been developed through the Winter Planning Virtual Group and Urgent Care Operational Group which consists of a wide range of stakeholders who work collaboratively together on the Urgent Care work programmes.</td></tr>
<tr><td>Financial / Resource</td><td colspan="4">Financial and resource implications have been identified as part of the planning process.</td></tr>
<tr><td>Governance or Legal</td><td colspan="4">Not applicable.</td></tr>
<tr><td>Risk Description</td><td colspan="4">Risks and mitigating actions have been identified as part of the planning process.<br><br>The risk rating below relates to the risk of not delivering the 4 hour A&E target. The Governing Body Assurance Framework 3a relates to the strategic risk of people choosing to access urgent and emergency care due to lack of alternative suitable and timely services, or due to lack of awareness of the most appropriate local service.</td></tr>
<tr><td rowspan="2">Risk Rating</td><td>Consequence</td><td>Likelihood</td><td>RAG Rating</td><td>GBAF Ref</td></tr>
<tr><td>3</td><td>3</td><td>3</td><td>3a</td></tr>
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NHS Somerset NHS Foundation Trust

NHS South Western Ambulance Service NHS Foundation Trust

NHS Somerset Clinical Commissioning Group

# Winter Plan 2020/21

## Somerset System

## A&E Delivery Board for System Wide Urgent and Emergency Care

Yeovil Hospital Healthcare

SOMERSET County Council

Meddcare Urgent care service Somerset

# Contents

**Slide No**


2 Version Control

3 Introduction

5 Lessons Learnt From Winter 2019/20

6 Improvements for Winter 2020/21

9 Lessons Learnt From Covid

13 Winter Schemes for 2020/21

39 Demand and Capacity Modelling

50 Winter Capacity

61 Supporting Policies

74 Risk Management

# Version Control

| Version | Date | Comments |
|---|---|---|
| 0.1 | 10 June 2020 | First draft for review by Urgent Care Operational Group |
| 0.2 | 18 June 2020 | First draft for review by System Leaders |
| 0.3 | 3 July 2020 | Second draft for review by Urgent Care Operational Group |
| 0.4 | 28 July 2020 | Second draft discussed with A&E Delivery Board |
| 1.0 | 30 July 2020 | First full version of the winter plan disseminated |
| | | |
| | | |

# Introduction

This system plan sets out the arrangements for winter planning and service delivery for winter 2020/21 by the Somerset A&E Delivery Board for System Wide Urgent and Emergency Care. The plan is structured as below:


The plan has been produced in collaboration with the main stakeholders and is owned by all members of the Somerset A&E Delivery Board.

The winter plan aims to demonstrate that the Somerset system:

- Reflects a whole system approach to the delivery of services over the forthcoming winter period
- Is building upon the learning from the previous winter plan and the system response to COVID-19 (Covid)
- Understands the demand on all sectors and their dependency on one another
- Has a single escalation system and is explicit about the expectations of each organisation, particularly in periods of heightened escalation
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# Introduction

**Approach**

The Somerset Winter Plan will be focusing on a number of different scenarios to model the potential demand and capacity required for this winter. Due to the unprecedented demands placed on our health and care services due to the outbreak of Covid, our planning this year needs to be more robust and take into account these additional factors. Therefore our demand and capacity modelling will review:

- Usual winter activity as seen through the winter of 2019/20
- Model the impact of social distancing measures on bed capacity

**Development of the System Plan**

- The plan is overseen by the Somerset A&E Delivery Board and the Somerset Urgent Care Operational Group contributes to the development of the plan
- Learning from last winter and learning from Covid informs the plan which is in addition to learning from schemes that have been implemented to support admission avoidance and providing additional support and capacity last winter
- A Winter planning workshop also takes place to run through with all system partners an exercise to scenario test the winter plan
- All system partners have provided organisational leads who have been supporting the development of the system plan
- The system plan is also supported by individual organisational plans
- The plan is under constant review and development and identifies the actions that will maintain patient safety and clinical quality over the period of expected surge in demand during winter
- All system partners recognise that the winter period will be challenging with anticipated high demand, pressure on community and hospital capacity, and gaps in local workforce. The system is committed to working together to manage these challenges, learning from our experience of previous winters and Covid

# Lessons Learnt From Winter 2019/20

As a result of Covid, the Winter Debrief session was unable to take place as scheduled in March 2020. Feedback was shared from system partners looking at what went well, what could have been done differently and learning for Winter 2020/21.

It was noted that there had been an increased demand across the urgent care system within health and social care services during the winter period, challenges were faced however the management and impact on the system was managed well.

| What Went Well | What Could Be Improved for 2020/21 |
|---|---|
| Internal and system de-escalation | Homefirst escalation process (pathway 2 and 3 beds) |
| Expansion of the Rapid Response service | Ambulance handovers and batching of ambulances |
| Expansion of Home First capacity | Repatriation challenges |
| Social Workers in A&E Pilot | Package of care availability during school holidays |
| Collaborative System working | Fully established Trusted Assessor Scheme in place |
| Less elective cancellations than previous year | NHS 111 service performance |
| Well managed levels of infection control issues | OPEL triggers |
| SWAST HALO role in place at Musgrove Park Hospital | Admission avoidance schemes and collaborative working with primary care to support prevention of admissions |
| Improved uptake on staff flu vaccinations | Ensure there are sufficient transport services accessible |
| Continued focus on proactive discharge planning in collaboration with system partners | Proactive public engagement to promote alternatives to Emergency Departments |

# Improvements for Winter 2020/21

As a result of numerous changes taking place throughout Covid, the Winter Planning Virtual Group were approached to understand the current position in regards to areas identified for improvement. Comments were shared as below:

| Area Highlighted for Improvement | Work already taken place to improve | Further work required to improve / risks | Status |
|---|---|---|---|
| **Homefirst escalation process (pathway 2 and 3 beds)** | This is now linked to the new discharge guidance and Discharge to Assess model. A Surge Escalation Plan is being developed, to include clear triggers, as part of Operational Governance Group | • Complex care GP to support<br>• Will be considered in demand and capacity modelling<br>• Additional challenges in accessing beds for escalation as a result of some capacity being closed during Covid<br>• Risk – use of community hospitals in escalation | Risk to remain, but on hold pending demand and capacity modelling |
| **Package of care availability during school holiday periods and shortly after (recovery)** | Care packages are not currently an issue during Covid. Improvements have been seen as a result of the Discharge to Assess Model. | • Ensure early secure of care packages<br>• Consideration of shared roles – need to see an increase in D2A | Risk to remain, but on hold pending modelling, and post Covid discussion |
| **Ambulance handovers and batching of ambulances** | HALO role at MPH showed a vast improvement in Handovers. There have been conversations around validation of cat 3 and 4 ambulance disposition within the Clinical Assessment Service which would help reduce batching of ambulances. | • Cat 3 and 4 validation to progress<br>• HALO role to continue and coverage to extend to seven days for the winter period.<br>• Define the HALO role | Ongoing |
| **Repatriation challenges** | Fewer issues seen during Covid. | • Will need to consider swab time in repatriation times<br>• Clear criteria for escalation of repatriation delays.<br>• Learning from what has happened during current closure of Weston | Ongoing |

# Improvements for Winter 2020/21

| Area Highlighted for Improvement | Work already taken place to improve | Further work required to improve / risks | Status |
|---|---|---|---|
| **Fully established Trusted Assessor Scheme in place** | Two Full time Trusted Assessors are now in post (YDH and MPH) | • Need to understand how this service can support RUH and Weston<br>• Need to Maximise the effectiveness of the role:<br>  ○ Need to continue liaison with care homes and expand services<br>  ○ Continued development with hospitals and use in pathways/community hospitals | Ongoing |
| **NHS 111 service performance** | Ongoing conversations with the NHS 111 provider are taking place to review performance | • Continue performance conversations with NHS 111<br>• Reduction in number of abandoned calls. | Ongoing |
| **OPEL triggers** | Pre-covid the triggers were working well. NHS England are compiling an OPEL document to factor in Covid | • NHS England OPEL document to be shared and considered within Somerset Escalation Framework and OPEL Triggers<br>• Reflect social distancing and crowding pathways within Triggers and Escalation Framework | Ongoing |
| **Admission avoidance schemes and collaborative working with primary care to support prevention of admissions** | Work continues and relationships are improving. MDT Complex Care meetings are taking place with input from the Neighbourhood teams.<br>The Larch Scheme has been expanded | • How will this work with new DES and PCN working<br>• Contracts for Primary Care relating to Pathway 2/3 support<br>• Project schemes for consideration by the A&E Delivery Board. Projected numbers of potential impact on hospital beds to be determined | Ongoing |

# Improvements for Winter 2020/21

| Area Highlighted for Improvement | Work already taken place to improve | Further work required to improve / risks | Status |
|---|---|---|---|
| **Ensure there are sufficient transport services accessible** | The service is currently coping however it is recognised that demand is at approximately 65-75%. A Transport Cell is in place looking at options to work in different ways and are also looking at recovery. A national tool has been developed to look at competing pressures on transport.<br>Five 4X4s vehicles have been delivered. Locations are Bridgwater, Yeovil, Frome, Glastonbury and Taunton. Four drivers in each depot have received relevant training in relation to driving in snow/ice conditions and each vehicle has an emergency kit on board, including foil blankets, torch, shovel and de-icer. | • Need assurance from E-Zec that they are able to meet demand<br>• Conflict between OPD and inpatients activity – consider splitting the contract allowing dedicated vehicles for hospital discharge. | Ongoing |
| **Proactive public engagement to promote alternatives to Emergency Departments** | Improvements have been seen during Covid. Patients were following the Public Health messaging and Government advice by seeking help from NHS 111 in the first instance | • Capitalise on the current situation, understand what different options patients have chosen - Patient survey etc<br>• Robust and cohesive communications strategy required to ensure patients are directed appropriately but not deterred from hospital attendance if required. | Ongoing |
| **Complex Care** | Lots of work has been ongoing within the End of Life cell | • How to we share patient Treatment Escalation Plans | Ongoing |
| **OPMH and SRC Capacity** | Additional capacity was provided as a result of covid | • Need to ensure we have adequate provision going into Winter | Ongoing |

# Lessons Learnt From Covid

A number services were changed or implemented in response to Covid. System partners were invited to share updates to understand where positive changes were made that can be taken forward to improve system working.

**South Western Ambulance Service NHS Foundation Trust**

- Support from PTSA colleagues to enable patients to be conveyed earlier in the day, resulting in reduced “batching”
- Support has been offered by Avon and Somerset Fire Service, not yet been utilised but could be explored for additional support over the Winter
- More control over guideline apps used to promote clinical updates
- Invite to Primary Care Network meeting – good value in joining these meetings but advance notice could enable more input from the frequent caller team to support these patients
- Communications circulated to crew to access Consultant Connect at YDH, MPH and RUH
- Moved to a local based model for drugs management – trial if this is beneficial to continue post Covid

**Somerset NHS Foundation Trust**

- Frailty Unit is being tested in MPH to improve assessment time and reduce admissions
- Mental Health Services have been moved closer to the ED front door
- Discharge to Assess method is a significant way forward
- Somerset Primary Link has been developed into the Somerset Hub for Co-ordinating Care, working in collaboration with system partners. Following positive start would like to see this model continuing
- Further expansion of Rapid Response service and collaborative working with Neighbourhoods
- Consultant Connect was recognised as a real positive and there is a need to maximise the service as a whole system

# Lessons Learnt From Covid

**Yeovil District Hospital NHS Foundation Trust**

- Working with specialty partners to Stream from frontdoor which includes Paeds, Ortho and ophthalmology
- ENP carrying out the initial streaming and assessment
- Frailty at front door to avoid admissions
- Physio based in ED to support Minor injury stream
- Zoning of ED and EAU's
- Zoning of all wards being considered with 2m distancing
- Discharge to assess good in theory but need more capacity to ensure same day discharge
- Central bed coordination good concept but :
- Bedded capacity and review of model to be agreed as individual trusts have lost ownership of their discharges and length of stay
- Escalation of bedded pathways to be agreed as not in place when numbers increase or we lose a provision
- Consideration of Hendford Court future to meet demand with new discharge model
- Patient experience and satisfaction feedback is imperative for model going forward – assuming patient choice will be reconsidered
- Virtual clinics very well used and positive feedback from patients and staff
- Consultant Connect working well

**Somerset County Council Public Health**

- Public Health have played a big role in the co-ordination of the pandemic, stepping back from some day to day work
- Public Health will lead the Local Outbreak Management Plan for any future outbreaks of Covid19, including testing, tracking and tracing of contacts.
- Public Health continues its role in flu vaccination programmes and infection control – especially in this context of norovirus and c-difficile.

# Lessons Learnt From Covid

**Meddcare**

- Service model has been changed to support new ways of working for triage and less face to face appointments
- Video consultation has been implemented with some success
- More GPs are willing to work for the service and locum availability has increased – need to work to ensure this is a positive area to work in so that it continues post covid
- Lots of success filling triage shifts
- Want to explore in hours support through 111 for Practices
- Would like to work on revalidation of ambulance dispositions

**Weston General Hospital**

- Substantial piece of work being carried out to look at the footprint of the front door service looking at Same Day Emergency Care and a Geriatric Service
- Looking to utilise BrisDoc who offer a similar service to Somerset Primary Link – discussions are ongoing as to how Somerset feed into this
- Merged with University Hospitals Bristol, working on how this develops

# Lessons Learnt From Covid

**Royal United Hospitals Bath**

- Newly built Rapid Assessment area within ED being used as a red resus area for Covid patients
- Developed a Respiratory Assessment Unit out of the ED, modelling being reviewed to see if this can continue post Covid
- Trauma Assessment Unit (TAU) relocated to the Fracture Clinic in order to continue to see GP expected and walk-in Orthopaedic patients, as well as some ED Minors patients
- Lots of outpatient work is being completed virtually
- Consultant Connect is being utilised across more specialities
- Virtual ward rounds are being piloted
- Socially distance bed space work undertaken in order to meet the 2 metre guidance

**Somerset Clinical Commissioning Group – Work with Primary Care**

- In response to Primary Care SOP established PACs across the county. Have not seen the anticipated large numbers so may need to consolidate PAC sites, ensuring they can be stood back up if required
- Collaborative working with MDT One Team/One Touch approach
- Another piece of work involves looking at how GP practices respond to home visiting, currently being done within practices and PCNs, but exploring a countywide approach as well

# Winter Schemes for 2020/21

During 2019/20, Winter funding was provided by NHS England / Improvement and a number of schemes were identified and implemented through use of this funding to support the Somerset System through the Winter period. As a result of the COVID-19 Pandemic, the schemes were not fully reviewed as a result of the Winter Debrief session being cancelled.

For 2020/21 the A&E Delivery Board agreed the importance of utilising learning from Winter 2019/20 and Covid to factor into the Winter Planning for 2020/21. Project Overview Documents (PODs) were completed for review by the A&E Delivery Board to make recommendations on which schemes should be taken forward.

These PODs included information on benefits, costs and impacts which can be used to support the Demand and Capacity Modelling. These schemes are split into three areas:

- Schemes implemented during Winter 2019/20 to continue
- Schemes implemented for COVID-19
- New Schemes

A total of 29 Project Overview Documents were received from across the system. The schemes have been summarised overleaf and set out the scheme description, main impacts, benefits in implementing the scheme, cost to deliver, risks to delivery, impact rating and strategic fit. The A&E Delivery Board have prioritised the schemes into a heat map matrix which measured against the anticipated impact and the strategic fit of the scheme.

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| **Somerset NHS Foundation Trust** | | | | | | | | | |
| 1 | MPH discharge & Screening Lounge | To continue to provide a Discharge Lounge Service at Musgrove Park hospital | Yes – Less use of acute beds | Cost savings from reduced DToCs and LOS. Reduction in outliers | Anticipate it will have a 4 beds saving. DTOCs will remain at or below 2.5%. LLOS to keep at or below 56 although as escalation beds are opened this number may fluctuate | £0 275k FYE but included in no. 15 | AMBER: Location of the lounge and staffing | H | H |
| 2 | Mendip Frailty assessment unit | This will provide a 24 hour frailty assessment unit, a 72 hour short stay ward and rapid access clinics | Yes – admission avoidance and less use of acute beds | Reduced presentation to ED, conversion rates to admission, bed days for older (over 75) frail people and increased 0-1 day LOS and use of SDEC and rapid access clinics | Reduction of ED conversion rate to IP for over 75's, reduction in bed days for COOP patients and reduction in presentation of elderly at ED. | £169k FYE | AMBER: Process issues to overcome. Recruitment of therapy staff | M | H |
| 3 | Winter 2019/20 | Open additional 54 beds at MPH to maintain patient safety and quality of care | No | Cancel less elective routine appointments and manage within overall bed base | Reduction in elective cancellations. | £1.9m | GREEN: Unknown impact of COVID-19 demand including social distancing and sufficient staffing to ensure patient safety. | M | L |
| 4 | Same Day Emergency Care | Launch a formal medical Same day Emergency Care Model | Yes – admission avoidance | Allow earlier senior review. Initial increase in operating hours will impact the productivity of the unit providing a reduction in the pressure felt on patient flow during the early afternoon | 2 admissions avoided per day | Cost neutral but may have further costs | GREEN/AMBER: Capacity of the SDEC area and becoming bedded accommodation at times of pressure. | H | H |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 5 | Urgent Care Centre | Create a flexible accommodation space to relocate the Integrated Front Door to within the old AEC footprint at the front of the Trust and create an Urgent Care Centre | Yes – Supports FFMF | Supports the delivery of safe care within the emergency department, reducing the likelihood of overcrowding. Benefit in the delivery against four hour standard, time to treatment and conversion rates to admission. | Improved four hour delivery across ED, in particular the Integrated Front Door area. | Capital costs TBC | AMBER: Initial infrastructure costs to enable the project to go ahead. | L | M |
| 6 | Ward 9- Ambulatory Care Unit (Pilot) | Optimize the capacity for treating patients with haematological cancers whilst enabling to safely practice post COVID | Yes – admission avoidance | A review of outcome data from a number of centres that undertake ambulatory care have seen the LOS reduce from an average of 25 days to 7days. | Previous data collected showed 22 admissions were eligible and had an average LOS of 28 days, 17 of them needed IV antibiotic support for neutropenic sepsis. If these patients had been ambulatory they would have spent an average of 12 days in hospital. 4 admissions did not require any intervention requiring admission so could have saved on average 25 days each. | £12k | AMBER: Increase pressure on haematology beds | M | M |
| 7 | Increase PHDU beds for paediatrics | Temporary additional PHDU facility has been stepped up during Covid-19 pandemic so there is PHDU in both ward settings – for both covid positive and non-covid paediatric patients. | No | Historically, escalation of PHDU beds/cots was to a cubicle on Acorn ward. This will allow appropriate safe clinical care for PHDU level children and enhanced efficiency across the unit. | Number of PHDU level 1 children (compared to baseline and previous winter period); the activity within the Oak PHDU area over the winter period; the number of children transferred/retrieved to PICU. | TBC | AMBER: PHDU level paediatric nurse staffing across two PHDU areas. | L | L |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 8 | Enhance the PAU (Paediatric Assessment Unit) service to 7 day working | A proposal to extend PAU to include weekends over the winter period would align services to 7 day NHS working requirements. | Yes – 7 day services | A 7 day service for PAU over the winter period would result in decreased admissions, decreased length of stay with increased time to senior review and decision making. It would also provide enhanced support for ED teams and referrals, primary care and Consultant Connect. | KPIs for PAU (Jan- Feb 2020 data set) demonstrate that 71% of children are assessed, treated and discharged during weekdays when PAU is open but this falls to 44% over weekends when PAU is not open. 73% of children are assessed and treated within 120 minutes during weekdays falling to 58% at weekends when PAU is not open. | £25k for 4 months | GREEN: No risks identified – this needs confirming | L | H |
| 9 | Rapid Response - Expansion and Capability Enhancement | Extending the scope of the Rapid Response Service offer by equipping the service with additional capacity to support facilitated discharge for frailty unit patients. | Yes – admission avoidance | With a continued 82% achievement rate for avoiding hospital admission, this overall capacity equivalent to 80 acute beds will result in significantly reduced conveyances to the emergency departments located at Taunton, Yeovil, Bath and Weston-Super-Mare. Qualitatively, the avoidance of deconditioning associated with bed-based care will enable some patients to become fully independent once more without the need for ongoing assistive care at home or in bedded facilities. | 10 referrals per day which is equivalent of 40 beds at 85% bed occupancy. Over 80% of patients admitted onto the Rapid Response caseload are not admitted to hospital | £2m FYE | GREEN/AMBER: Failure to recruit the additional staff required and the failure to increase referral levels into the service. | H | H |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| **Yeovil District Hospital NHS Foundation Trust** | | | | | | | | | |
| 10 | Creation of Respiratory Assessment Zone | To create a defined zone for COVID patient care as required by infection prevention and control guidance. | Yes – covid response | It will assist in managing hot and cold patients along with supporting increasing demand and maintaining patient and staff safety as well as privacy and dignity when managing normal winter pressure with the addition of COVID. | To meet infection control requirements for management of new ED arrivals.<br>To reduce in-hospital spread of Coronavirus | £276k | GREEN: Availability of staffing | L | M |
| 11 | Zoning of all areas across the hospital in response to COVID guidance | Requirement to zone areas due to infection control guidance and minimising COVID spread. | Yes – covid response | Quality and patient safety improved from a spread of infection, viral load, appropriate PPE usage point of view. Has enabled split of medical take reducing risk of cross-patient infection. | Maintain low staff sickness of below 5% covid related.<br>Maintain low number of staff to staff/staff to patient transmission of infection<br>Compliance with infection control requirements for COVID19 | £589k | GREEN: Staff sickness may challenge recruitment to roles but currently being filled. | L | M |
| 12 | Increased medical bed capacity including escalation capacity | To create sufficient 37 medical beds to meet likely non-elective demand throughout year including additional winter-ward during winter peak. | No | Increase medical bed base in order to meet rising non-elective demand.<br>Improved safety during winter pressures by reducing outliers and use of escalation spaces. Converts previous medically fit ward beds into medicine beds by providing medical cover which was previously not available. | Reduce crowding in ED awaiting bed allocation<br>Reduce elective cancellations during winter due to lack of beds<br>Reduction in number of medical outliers therefore improving care and reducing LOS | £1.4m PYE<br>£1.6m FYE | GREEN: Financial impact<br>Recruitment challenges both medical and nursing | M | L |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 13 | Increased ED activity | Change in ED staffing to manage issues linked to social distancing within the small department during COVID, staff new ED area opening in October 2020, and ensure safe medical cover out of hours and at weekends. | N | Enables staffing of wider area to meet social distancing requirements of COVID19 that have been particularly challenging in such a small department.<br>Enables staffing of new areas opening in October due to NHSI capital funding.<br>Improves out of hours doctor cover dealing with concerns raised by medical teams over safety. | Compliance with infection control requirements in ED due to COVID 19.<br>Reduce reported incidents and safety concerns out of hours by medical teams due to limited cover.<br>Safe staffing of additional ED areas opened in October. | £850k | AMBER: Ability to recruit medical staff.<br>Ability to recruit nursing staff. | H | L |
| **Somerset County Council** | | | | | | | | | |
| 14 | Expansion of Home First Pathway 1 capacity | Increase capacity to enable better choices of returning home and more people able to go home quicker due to increased availability | Y – less use of acute beds | Availability of P1 slots and care provision<br>Higher % of people returning home<br>Community Hospital bed escalation and winter beds not required | Superseded by the intermediate care redesign so assumption remains as per last year (10 beds impact - capacity not being removed) and therefore no additional saving from this expansion as it will become part of the redesign work going forward | £0<br>£392k FYE<br>Already funded | AMBER: Confirmation of all temporary shared funding required as part of new intermediate care model | H | H |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 15 | Intermediate Care/Home First redesign | To implement a true discharge to assess model, incorporate admission avoidance and EOL and reduce acute and community bed occupancy as a result | Y – less use of acute beds | To introduce an actual D2A service with NO assessments carried out in hospital – this will reduce Medically fit LoS by at least 2 days per person.<br>To keep the Covid element of End of Life coordination in the model going forward.<br>To increase keyworker support and non-hospital bed alternatives (i.e. care home v community hospital). | 46,303 bed days saved in total which is based on the modelling work undertaken of Scenario 1: Continue with existing behaviours with no increased diversion numbers with current delivery and decision making practice, and actual demand distribution seen in May 2020. Assumed diversion numbers remain at constant level and assume 20% overflow demand from reduced acute capacity does not present to intermediate care. Further bed day savings are achieved with alternative scenarios. | £6.7m | AMBER: Workforce (new and realigned).<br>Covid care capacity – staff isolating and patients also needing isolation.<br>Decision making. | H | H |
| 16 | Admission Avoidance ASC A&E Project | To reduce admissions by having social work response within A&E, and associated areas such as frailty unit, who are able to turn people around same day by triaging, signposting and intervention. | Yes – admission avoidance | It will cover associated ED departments such as frailty units.<br>Proposed expansion to include SW cover in SWAST (delayed by Covid).<br>Scheme will impact on admissions, bed state, outcomes for people and reduce requests for long term care either POC or placements. | Admission avoidance – sample numbers in impacts (YDH only) – 65 admissions avoided over 12 weeks (45% of total seen) | £0<br>£244k FYE<br>Funded from BCF | GREEN: Recruiting to Social care positions within A&E.<br>Capacity within Rapid response and D2A. | M | H |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 17 | Trusted Assessor project | To ensure timely transfer of people returning (or new) to a residential or nursing home setting without the need for the home to make their own face to face assessment. | Yes – less use of acute beds | Many delays can be caused by waiting for the individual care home to assess. By placing a Trusted Assessor in each acute hospital (and in future available for pathways and community hospitals) this delay is avoided. In addition it can help with self funders and communication with homes. | In the first four months of the trial at MPH, 103 assessments were carried out, saving at least 101 bed days and 173 hours for care home managers. By having two FTE working for the whole year this would aim to save 1,000 bed days based on the evidence of the MPH work and analysis. This would equate to a 3-5 bed reduction | £0<br>£135k FYE<br>Funded from BCF | GREEN: Staffing fragility based on two full time posts. Covid impacts. | H | H |
| **Meddcare** | | | | | | | | | |
| 18 | IUCS Additional Capacity for winter surge | Additional clinical capacity for IUCS required due to winter demand and upcoming “111 First” marketing campaign. Improved response time for clinical triage and face to face in OOH service. Robust clinical rota for winter period. | Yes – admission avoidance | Positive impact on admission avoidance due to responsiveness of IUCS so people do not deteriorate whilst awaiting treatment or elect to present elsewhere. Early booking of out-of-area agency GPs and clinicians to ensure robustness of IUCS rota.<br>Increase number of triage shifts (including remote triage) for winter weekend periods. | Improvement in CAS call handling times<br>Improvement in clinical triage response times<br>Improvement in face to face OOH response times<br>Increased rota fill compared to previous year<br>Reduced staff absence | £804k PYE | AMBER: Required workforce unavailable. Unmanageable demand due to winter pressure /Covid/Flu/ national marketing campaigns. | M | H |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 19 | Changes to 111 model in Somerset | Strip out elderly/frail cohort from front-end 111 telephony queue and fast track to clinical assessment in CAS. Promote use of 111 "in-hours" to support practices. | Yes – admission avoidance | Right care, right time for elderly/frail cohort with reduced touch points – Reduction in admissions. Switch off percentage of cases for in-hours upstream to allow better use of resources. Improvement in 111 call answering and abandonment rate. | Improvement in attendance figures. | £5k | AMBER: Unmanageable demand due to winter pressure /Covid/Flu/ national marketing campaigns | M | H |
| 20 | IUCS Support for care Homes | Support with confirmed flu outbreaks in care homes (Flu prophylaxis service). Support with confirmed Covid outbreaks in care homes. | Yes – admission avoidance | Ensure other services are not overwhelmed with outbreaks. Support in-hours primary care and ambulance service. 100% response rate for outbreaks. | Reduction in attendance levels. | TBC | AMBER: Unmanageable demand due to winter pressure /Covid/Flu/ national marketing campaigns | L | M |
| **Somerset CCG Joint Proposals** | | | | | | | | | |
| 21 | In-hours Home Visiting Service for Respiratory patients | For patients with respiratory issues, which have prompted a home visit that would usually be undertaken by the patients' own general practice clinician(s). The service would also be for patients with covid or suspected covid symptoms. | Yes – admission avoidance | Should reduce numbers of patients attending hospital, reduce numbers of patients admitted to hospital following conveyance, and reduce overnight hospital stays. Reduction in the number of calls made to 999 and NHS 111 | In an audit from a GP practice that was undertaken in a similar pilot in Wokingham, it had the following outcomes out of a total 599 patient contacts: Hospital attendances avoided: 96; Hospital attendances expedited: 68 (11 with sepsis); 111 calls saved: 177; 999 calls saved: 28; Successful pathway referrals: 58 | £300k PYE | AMBER: Lack of clinical cover availability. Higher than predicted demand. If there is a hybrid approach through PCNs/Devon Doctors, how this can be managed effectively. | L | M |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 22 | 999 (low acuity) and ED Validation within IUC Clinical Assessment Service | Validation of 111 calls reaching a 999 and ED disposition to be moved from Care UK to the CAS to improve validation levels | Yes – admission avoidance | Increase in percentage of 999 and ED initial dispositions that are clinically validated by a non-NHS Pathways clinician from 50% to 100%.<br>Reduction in 999 activity compared to previous years, which in turn will negate/reduce breakglass clause payments, thereby supporting Somerset System's financial position.<br>More appropriate walk-in arrivals at ED following consulting 111. | The following provides an illustrative picture on validations for the period July 2019 – March 2020 inclusive if the proposal (hybrid model with 95% validation with anticipated 60% downgrade) had been in place at that time: 8,373 total low acuity ambulance dispositions requiring clinical validations against a KPI performance at 95%. Based on a 60% downgrade rate 3,606 dispositions would have continued onto 999 referral (compared to the actual figure of 5,749). This equates to a reduction in 999 incidents of 2,143 reflecting a 37% decrease. If this is extrapolated across the full 12 months, this could lead to a reduction in 2,857 low acuity 999 incidents. Impact on the breakglass clause penalty (at £180 per incident) indicates that with 2,143 fewer incidents would have led to a reduction (saving) of £365,740 in the breakglass clause penalty for that 9 month period. If extrapolated to 12 months period then this suggests breakglass clause could have potentially been reduced by £514,260. Breakglass clause penalty actually due for 19/20 was £650,343.<br>The following provides an illustrative picture on validations undertaken for the period July 2019 – March 2020 inclusive if the proposal (hybrid model with 95% validation with anticipated 60% downgrade) had been in place at that time: 5,308 total ED dispositions requiring clinical validations against a KPI performance at 95%. Based on a projected 60% downgrade rate 2,282 dispositions would have continued onto ED (compared to the actual figure of 4,793). This equates to a reduction in ED dispositions of 2,511 reflecting a 52.39% decrease against 'actual' total. If this is extrapolated across the full 12 months, this could have led to a reduction in 3,348 ED dispositions. The average cost for an ED attendance is £100 and this would save £335k. | £814k FYE | AMBER: Minimal delay in transferring validation cases across to IUC CAS.<br>Increase in number of dispositions requiring validation.<br>Adequate IUC CAS clinical shift fill. | H | H |
| 23 | 111 Online – Validation of ED and 999 (lower acuity) dispositions | Validation of 111 online users reaching a 999 and ED disposition | | | | | | | |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 24 | High Intensity Users | A Service Lead who works to support HIU within the community, This one-to-one support identifies the root cause of patient's dependence and de-escalates issues to avoid an unnecessary contact with unscheduled care. | Yes – admission avoidance | Reduction in patient cohort attending at A+E or presenting with issues at the providers and subsequent reduction of inappropriate attendance.<br>Improved outcomes and patient experience through qualitative reporting.<br>Consistency and equity being improved due to having a more co-ordinated offer for HIUs. | Each service lead holds a caseload of 50 patients per wte. A reduction of 40% of A&E and admission costs for 44 patients with >20 A&E attendances would equate to £500k saving. If the service lead capacity were increased to seeing 211 patients with 11-19 attendances then further savings of £1.6m could be saved but this would be offset against a total cost of £500k to deliver the service. | £104 FYE plus £7k set up costs | AMBER:<br>Demanding Role.<br>Information Sharing Agreements and Consent must be in place.<br>Governance to be established. | H | H |
| 25 | Additional mental health crisis provision (mixed model) | Somerset Mind will have a 3 day per week out of hours community front room in each of the four localities, alongside the 24/7 all age mental health crisis line. This proposal looks to expand the operating days/hours of the community front room | Yes – admission avoidance | Decrease in attendances at ED for mental health crisis (evidence from last year's initiative showed that circa 67% of service users would have attended ED had this service not been available).<br>Reduction in attendances at GP practices for mental health needs.<br>Improved patient experience of crisis services with patients being able to utilise the service that best meets their needs in the most appropriate setting of care. | Anticipate seeing a minimum of 50 patients per month based on activity in early 2020, and of these, 33 would have otherwise attended ED (based on service user feedback of those that attended the front room over ED). Over the proposed 6 month operational window, this would potentially prevent 198 attendances worth circa £28,710. In a month, this could improve ED performance by circa 1% against the 95% standard, in addition to any benefit from improved flow in the ED as patients presenting for mental health can require a particularly high level of support and management. | £144k PYE (Dec – May) | AMBER: It is possible this will result in inequitable service provision across localities. Need to take into account the outcomes of the FFMF engagement and consultation work. | M | H |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 26 | Additional support to S136 in the out of hours period | The scheme will provide a dedicated HCA resource for the S136 suite in the out of hours period for the Rydon ward. This will reduce use of the MPH ED as a place of safety | Yes - LTP | Reduce the occasions in which Musgrove Park Hospital is used as a place of safety.<br>Improve patient experience.<br>Reduction in the patient's duration of stay in a S136 suite.<br>There should be limited cost for operationalising the scheme beyond the workforce spend. | Reduction in duration of stay in the S136 suite and reduction in use of ED as a place of safety. | £60k | AMBER: The additional resource will primarily support the Taunton area.<br>Workforce. | M | H |
| 27 | Implementation of the S12 Solutions App | To increase the available local pool of s.12 doctors and allows AMHPs to locate them quickly, thus reducing MHA delays and bureaucracy. This should also lead to faster assessments. | Yes – admission avoidance | Faster assessments should mean a better patient experience and reduced pressure on A & E departments and places of safety. | Faster assessments should mean a better patient experience and reduced pressure on A & E and places of safety. Implementation should also save the CCG an estimated £5,840 per year in admin costs as well as saving/releasing the overall system a further £53,168 per year of doctor's time by streamlining AMHP processes. | £15k | AMBER: Up to date mobile/computing technology to use the app or desktop site, some doctors have older devices that may need to be upgraded.<br>Buy in from clinicians will be key to success. | M | H |

# Schemes Considered for Winter 2020/21

| No. | Scheme Title | Scheme Description | Strategic Fit | Main impacts | Benefits | Cost to deliver | Risks to delivery | Impact Rating | Strategic Fit Rating |
|---|---|---|---|---|---|---|---|---|---|
| 28 | YDH & MPH A&E Youth Diversion scheme | Young Somerset will implement a young people's wellbeing A&E diversion and de-escalation scheme, where skills of youth workers/practitioners trained in mental health can support and divert young people who are not in need of an immediate acute clinical response. | Yes – admission avoidance | Scheme can release frontline acute staff to concentrate on clinical and medical emergencies. This will be an essential complement to existing urgent/crisis services; introduce young people and families to more appropriate and less stigmatised voluntary and community support. | Capacity to support 100 young people & families per month; avoid attendance, prevent serious disruptive incidences, facilitate quicker discharge and flow through the acute system. | £200k FYE | AMBER: Availability of, recruitment and deployment staff work out of day-time hours on both sites | M | H |
| 29 | Mendip Virtual Diabetes Clinics | To set up virtual diabetes clinics through the mendip practices, bringing specialist patient care closer to home | Yes – admission avoidance | Reduced referrals into secondary care, reduced DNA's and reduced complications in Diabetic patients. Upskilling primary care staff with the support of secondary care colleagues, bringing expertise and knowledge into the local area and spreading that knowledge not only amongst clinicians with a specialist interest but throughout primary care teams. | Evidence from Derby suggests a decrease in unplanned admissions, 50% decrease in total number of bed days for patients with a primary diagnosis of diabetes, and across 29 GP surgeries in Derby City there was a saving of £800k | £21k FYE | AMBER: The future impact of Covid 19 is unknown, we have up until now had relatively low numbers of cases, however if this changed this might make it difficult for staff to attend the clinics | M | H |

**NOTES:**

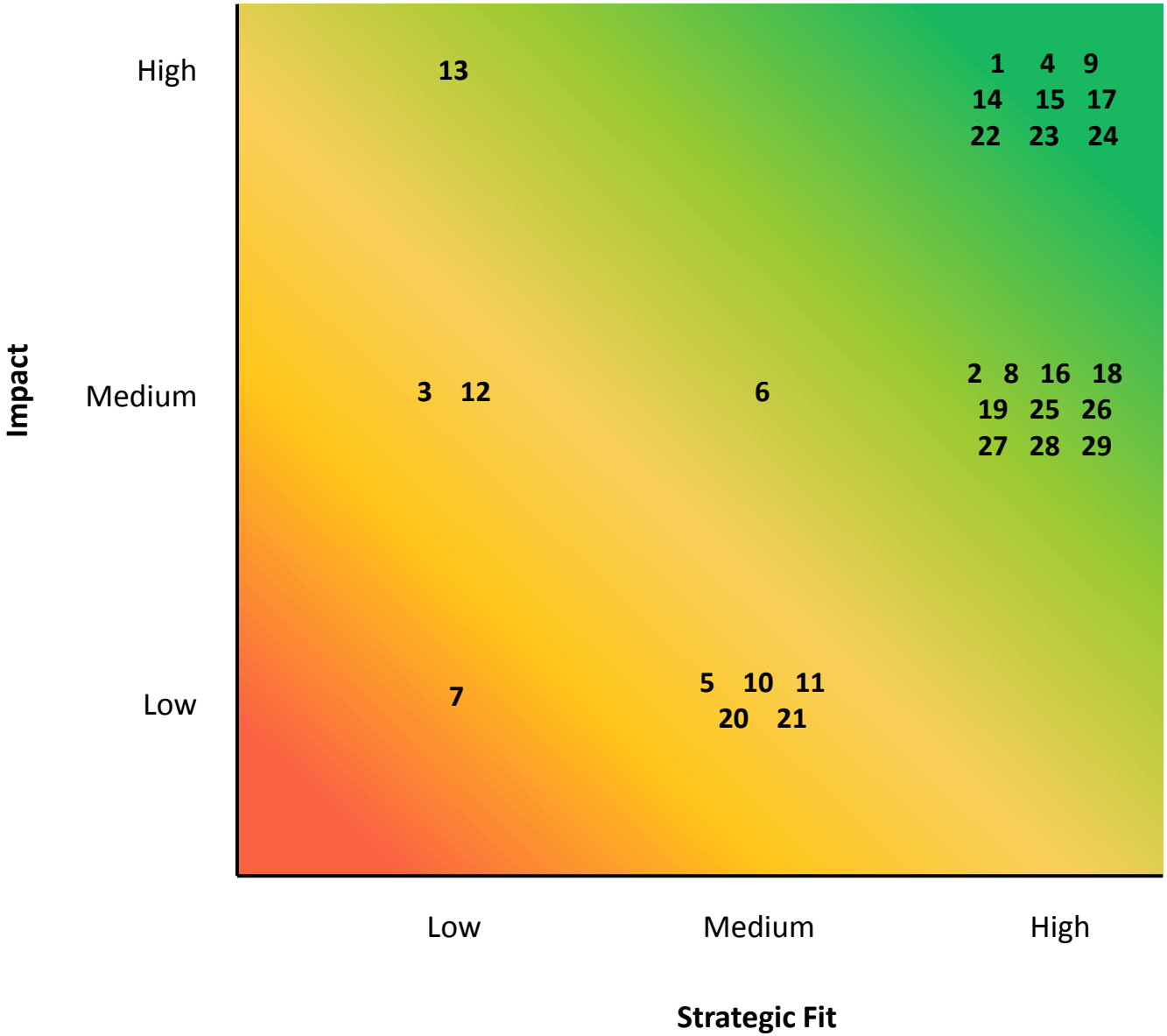
Schemes 1, 14 and 15 have merged and will be one scheme going forwards

Schemes 5, 10 and 13 are linked through management of ED

Schemes 3 and 12 are linked through winter escalation beds

Schemes 22 and 23 have merged and will be one scheme going forwards

# Schemes Considered for Winter 2020/21 Impact and Strategic Fit




| | |
|---|---|
| 1 | MPH Discharge & Screening Lounge |
| 2 | Mendip Frailty assessment unit |
| 3 | Winter 2019/20 |
| 4 | Same Day Emergency Care |
| 5 | Urgent Care Centre |
| 6 | Ward 9- Ambulatory Care Unit (Pilot) |
| 7 | Increase PHDU beds for paediatrics |
| 8 | Enhance the PAU (Paediatric Assessment Unit) service to 7 day working |
| 9 | Rapid Response - Expansion and Capability Enhancement |
| 10 | Zoning of ED to support COVID activity |
| 11 | Zoning of all areas across the hospital in response to COVID guidance |
| 12 | Increased medical bed capacity including escalation capacity |
| 13 | Increased ED activity |
| 14 | Expansion of Home First Pathway 1 capacity |
| 15 | Intermediate Care/Home First redesign |
| 16 | Admission Avoidance ASC A&E Project |
| 17 | Trusted Assessor project |
| 18 | IUCS Additional Capacity for winter surge |
| 19 | Changes to 111 model in Somerset |
| 20 | IUCS Support for care Homes |
| 21 | In-hours Home Visiting Service for Respiratory patients |
| 22 | 999 (low acuity) and ED Validation within IUC Clinical Assessment Service |
| 23 | 111 Online – Validation of ED and 999 (lower acuity) dispositions |
| 24 | High Intensity Users |
| 25 | Additional mental health crisis provision (mixed model) |
| 26 | Additional support to S136 in the out of hours period |
| 27 | Implementation of the S12 Solutions App |
| 28 | YDH & MPH A&E Youth Diversion scheme |
| 29 | Mendip Virtual Diabetes Clinics |

# Prioritisation of Schemes

The 29 schemes received were reviewed by the A&E Delivery Board and prioritised according to the level of impact that the scheme is expected to make and if the scheme is a good strategic fit. The schemes have been categorised as follows:

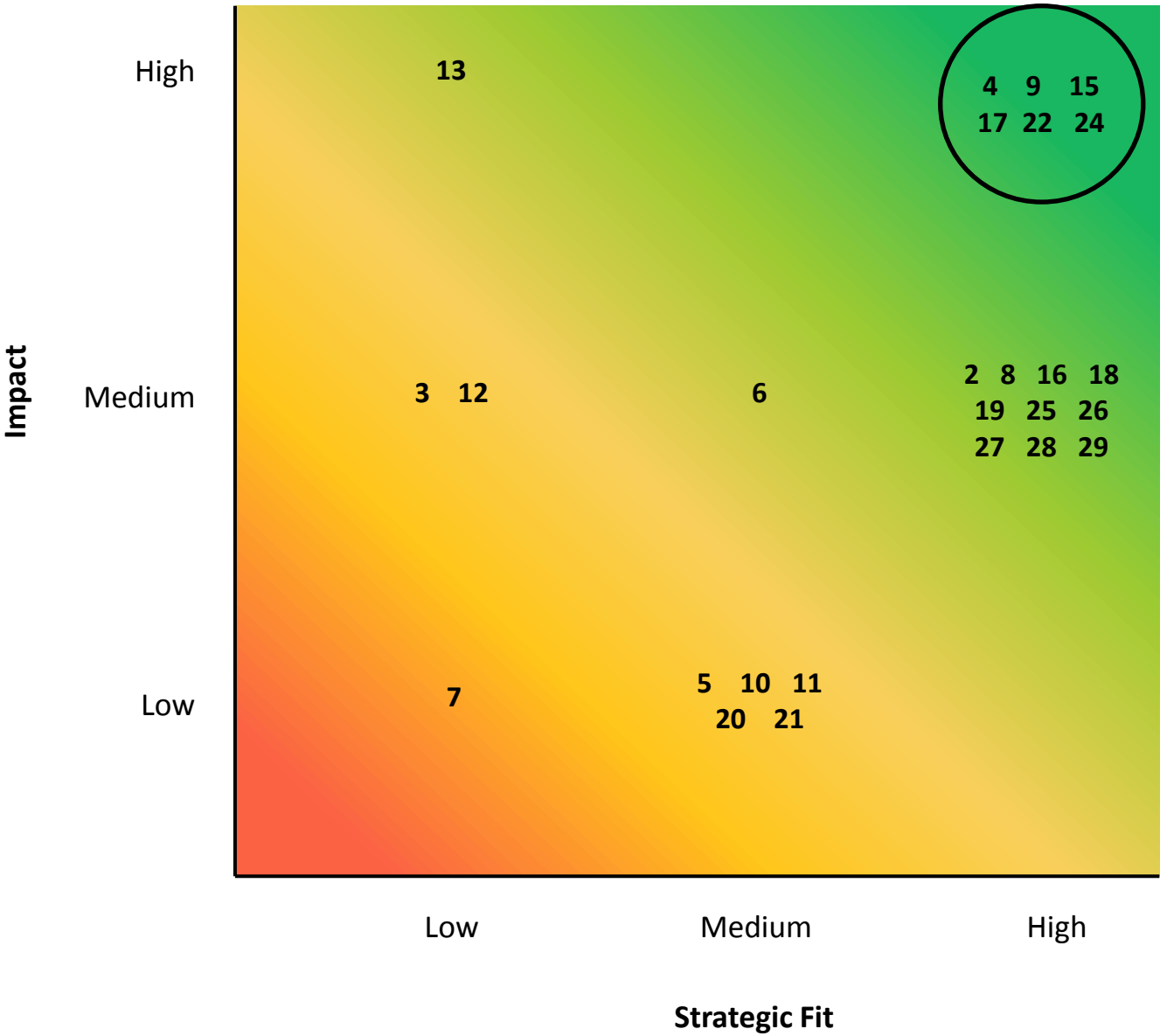
- If the scheme has a high impact and a high strategic fit they are **category 1 – high priority**
- If the scheme has a high impact but a low strategic fit, a medium impact and a medium strategic fit or a medium impact and a high strategic fit they are **category 2 – medium priority**
- If the scheme has a medium impact but a low strategic fit, a low impact and a medium strategic fit or a low impact and a low strategic fit they are **category 3 – lower priority**

As a result of going through the schemes, some of the original schemes have been subsumed into other larger schemes for example the system wide Intermediate scheme now encompasses two of the other schemes originally submitted.

It is also clear that whilst considerable work has been undertaken into providing relevant information on each of the schemes, further work may be required on any prioritised schemes going forward to ensure that the assumptions made on either activity or savings likely to be acquired are correct.

The category of each of the schemes are outlined overleaf.

# Schemes Considered for Winter 2020/21
# Category 1 - High priority




| | |
|---|---|
| **4** | Same Day Emergency Care |
| **9** | Rapid Response - Expansion and Capability Enhancement |
| *The below three schemes have merged:* | |
| **15** | • MPH Discharge & Screening Lounge<br>• Expansion of Home First Pathway 1 capacity<br>• Intermediate Care/Home First redesign |
| **17** | Trusted Assessor project |
| *The below two schemes have merged:* | |
| **22** | • 999 (low acuity) and ED Validation within IUC Clinical Assessment Service<br>• 111 Online – Validation of ED and 999 (lower acuity) dispositions |
| **24** | High Intensity Users |

# Schemes Considered for Winter 20/21
# Category 1 – High Priority

| | |
|---|---|
| **Total cost to deliver schemes** | **£9,625,000** |
| **Assessment of Impact** | Schemes will:<br>• 2 admissions avoided per day are expected with implementing SDEC<br>• Expanding Rapid Response would save 10 referrals per day which is equivalent of 40 beds at 85% bed occupancy. Over 80% of patients admitted onto the Rapid Response caseload are not admitted to hospital<br>• Implementing the Intermediate Care scheme would save 46,303 bed days in total which is based on the modelling work undertaken of scenario 1 which is: current delivery and decision making practice, and actual demand distribution seen in May 2020. Further bed day savings are achieved with alternative scenarios.<br>• Trusted Assessor scheme would aim to save 1,000 bed days based on the evidence of the MPH work and analysis. This would equate to a 3-5 bed reduction<br>• Implementing 999 (low acuity) and ED Validation within IUC Clinical Assessment Service would see:<br>– A reduction in 2,857 low acuity 999 incidents<br>– Financial impact through 999 validation as breakglass clause could potentially be reduced as the penalty for 2019/20 was £650,343 but by implementing validation this would have reduced by £514,260.<br>– A reduction of 3,348 ED dispositions. The average cost for an ED attendance is £100 and this would save £335k<br>– The higher the downgrade rate (above is based on a modest 60% downgrade rate), the higher the savings would be<br>• A HIU service lead holds a caseload of 50 patients per wte and can expect to see a reduction of 40% of A&E and admission costs for 44 patients with >20 A&E attendances. This would equate to £500k saving |

Schemes 1 and 14 are now subsumed within scheme 15 and not included in the total costs or assessment of impact
Scheme 23 is now incorporated into scheme 22

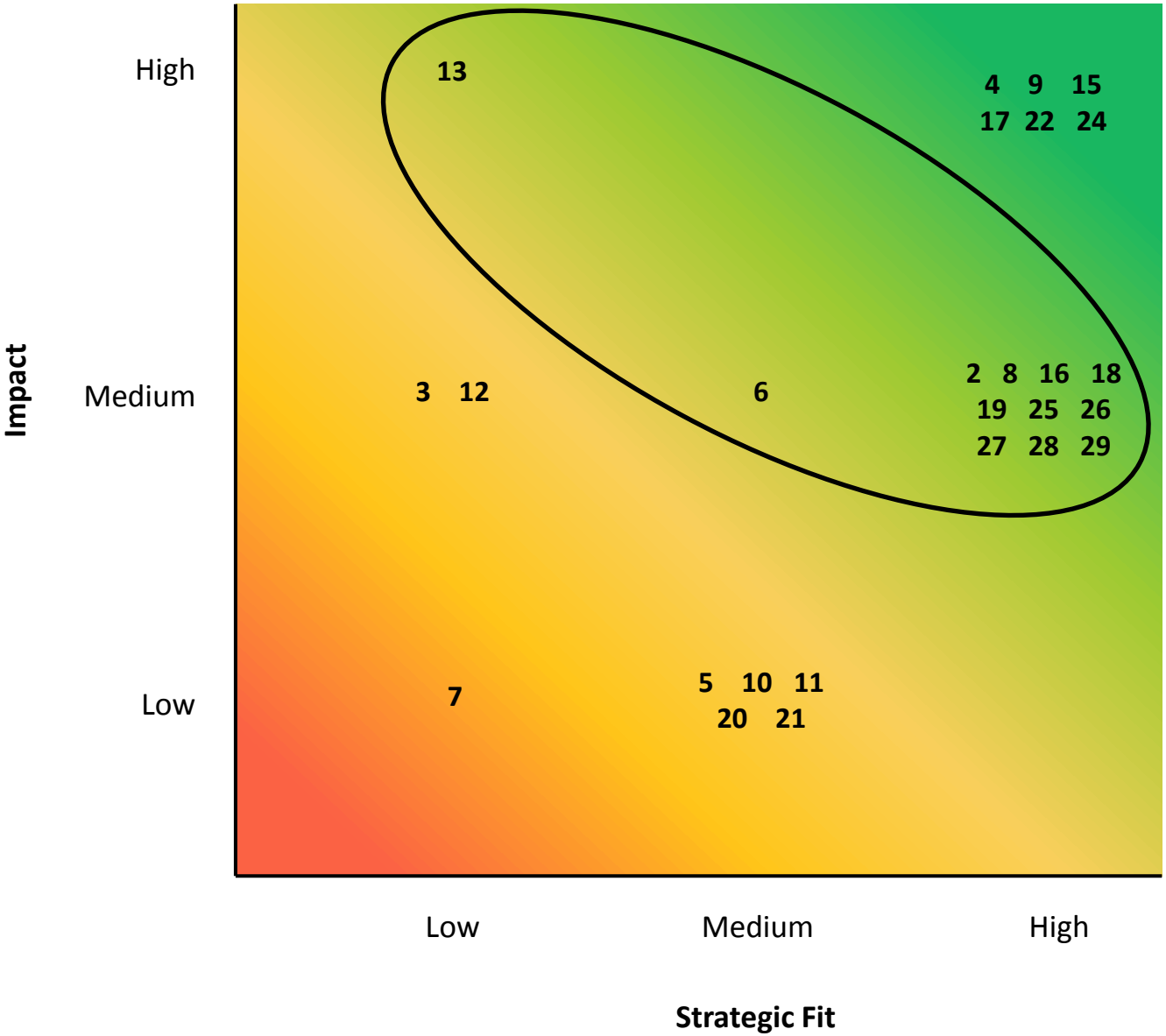
# Schemes Considered for Winter 20/21 Category 1 – High Priority

| No. | Scheme Title | Main impacts | Assessment of Impact | Cost to deliver |
|---|---|---|---|---|
| 1 | MPH discharge & Screening Lounge – now within scheme 15 | Cost savings from reduced DToCs and LOS. Reduction in outliers | Anticipate it will have a 4 beds saving . DTOCs will remain at or below 2.5%. LLOS to keep at or below 56 although as escalation beds are opened this number may fluctuate | £0<br>£275k FYE included in scheme 15 |
| 4 | Same Day Emergency Care | Allow earlier senior review. Initial increase in operating hours will impact the productivity of the unit providing a reduction in the pressure felt on patient flow during the early afternoon | 2 admissions avoided per day | Cost neutral but may have further costs |
| 9 | Rapid Response - Expansion and Capability Enhancement | With a continued 82% achievement rate for avoiding hospital admission, this overall capacity equivalent to 80 acute beds will result in significantly reduced conveyances to the emergency departments located at Taunton, Yeovil, Bath and Weston-Super-Mare. Qualitatively, the avoidance of deconditioning associated with bed-based care will enable some patients to become fully independent once more without the need for ongoing assistive care at home or in bedded facilities. | 10 referrals per day which is equivalent of 40 beds at 85% bed occupancy<br>Over 80% of patients admitted onto the Rapid Response caseload are not admitted to hospital | £2m FYE |
| 14 | Expansion of Home First Pathway 1 capacity – now within scheme 15 | Availability of P1 slots and care provision<br>Higher % of people returning home<br>Community Hospital bed escalation and winter beds not required | Superseded by the intermediate care redesign so assumption remains as per last year (10 beds impact - capacity not being removed) and therefore no additional saving from this expansion as it will become part of the redesign work going forward | £0<br>£392k FYE<br>Already funded and picked up in scheme 15 |
| 15 | Intermediate Care/Home First redesign | To introduce an actual D2A service with NO assessments carried out in hospital – this will reduce Medically fit LoS by at least 2 days per person.<br>To keep the Covid element of End of Life coordination in the model going forward.<br>To increase keyworker support and non-hospital bed alternatives (i.e. care home v community hospital). | 46,303 bed days saved in total which is based on the modelling work undertaken of Scenario 1: Continue with existing behaviours with no increased diversion numbers. Further bed day savings are achieved with alternative scenarios | £6.7m |
| 17 | Trusted Assessor project | Many delays can be caused by waiting for the individual care home to assess. By placing a Trusted Assessor in each acute hospital (and in future available for pathways and community hospitals) this delay is avoided. In addition it can help with self funders and communication with homes. | In the first four months of the trial at MPH, 103 assessments were carried out, saving at least 101 bed days and 173 hours for care home managers. By having two FTE working for the whole year this would aim to save 1,000 bed days based on the evidence of the MPH work and analysis. This would equate to a 3-5 bed reduction | £0<br>£135k FYE<br>Funded from BCF |

# Schemes Considered for Winter 20/21
# Category 1 – High Priority

| No. | Scheme Title | Main impacts | Assessment of Impact | Cost to deliver |
|---|---|---|---|---|
| 22 | 999 (low acuity) and ED Validation within IUC Clinical Assessment Service | Increase in percentage of 999 and ED initial dispositions that are clinically validated by a non-NHS Pathways clinician from 50% to 100%.<br>Reduction in 999 activity compared to previous years, which in turn will negate/reduce breakglass clause payments, thereby supporting Somerset System's financial position.<br>More appropriate walk-in arrivals at ED following consulting 111. | The following provides an illustrative picture on validations for the period July 2019 – March 2020 inclusive if the proposal (hybrid model with 95% validation with anticipated 60% downgrade) had been in place at that time: 8,373 total low acuity ambulance dispositions requiring clinical validations against a KPI performance at 95%. Based on a 60% downgrade rate 3,606 dispositions would have continued onto 999 referral (compared to the actual figure of 5,749). This equates to a reduction in 999 incidents of 2,143 reflecting a 37% decrease. If this is extrapolated across the full 12 months, this could lead to a reduction in 2,857 low acuity 999 incidents. Impact on the breakglass clause penalty (at £180 per incident) indicates that with 2,143 fewer incidents would have led to a reduction (saving) of £365,740 in the breakglass clause penalty for that 9 month period. If extrapolated to 12 months period then this suggests breakglass clause could have potentially been reduced by £514,260. Breakglass clause penalty actually due for 19/20 was £650,343.<br><br>The following provides an illustrative picture on validations undertaken for the period July 2019 – March 2020 inclusive if the proposal (hybrid model with 95% validation with anticipated 60% downgrade) had been in place at that time: 5,308 total ED dispositions requiring clinical validations against a KPI performance at 95%. Based on a projected 60% downgrade rate 2,282 dispositions would have continued onto ED (compared to the actual figure of 4,793). This equates to a reduction in ED dispositions of 2,511 reflecting a 52.39% decrease against 'actual' total. If this is extrapolated across the full 12 months, this could have led to a reduction in 3,348 ED dispositions. The average cost for an ED attendance is £100 and this would save £335k. | £814k FYE |
| 23 | 111 Online – Validation of ED and 999 (lower acuity) dispositions – now within scheme 22 | | | |
| 24 | High Intensity Users | Reduction in patient cohort attending at A+E or presenting with issues at the providers and subsequent reduction of inappropriate attendance.<br>Improved outcomes and patient experience through qualitative reporting.<br>Consistency and equity being improved due to having a more co-ordinated offer for HIUs. | Each service lead holds a caseload of 50 patients per wte. A reduction of 40% of A&E and admission costs for 44 patients with >20 A&E attendances would equate to £500k saving. If the service lead capacity were increased to seeing 211 patients with 11-19 attendances then further savings of £1.6m could be saved but this would be offset against a total cost of £500k to deliver the service. | £104 FYE<br>plus £7k set up costs |

# Schemes Considered for Winter 2020/21
# Category 2 – Medium Priority




| | |
|---|---|
| **2** | Mendip Frailty assessment unit |
| **6** | Ward 9- Ambulatory Care Unit (Pilot) |
| **8** | Enhance the PAU (Paediatric Assessment Unit) service to 7 day working |
| **13** | Increased ED activity |
| **16** | Admission Avoidance ASC A&E Project |
| **18** | IUCS Additional Capacity for winter surge |
| **19** | Changes to 111 model in Somerset |
| **25** | Additional mental health crisis provision (mixed model) |
| **26** | Additional support to S136 in the out of hours period |
| **27** | Implementation of the S12 Solutions App |
| **28** | YDH & MPH A&E Youth Diversion scheme |
| **29** | Mendip Virtual Diabetes Clinics |

# Schemes Considered for Winter 20/21
# Category 2 – Medium Priority

| | |
|---|---|
| **Total cost to deliver schemes** | **£2,300,000** |
| **Assessment of Impact** | Schemes will:<br>• Reduction of ED conversion rate to inpatients for over 75's and reduction in bed days by implementing Mendip frailty assessment unit<br>• Ward 9 ambulatory care unit will reduce length of stay as 4 admissions avoided saving 100 bed days<br>• Increasing the Paediatric Assessment Unit to 7 days per week will result in decreased admissions, decreased length of stay with increased time to senior review and decision making<br>• Provides safe clinical care by increasing ED activity<br>• Admission avoidance by having Social Worker presence in A&E with 65 admissions avoided in 12 weeks<br>• Improvements within the Integrated Urgent Care Service through increased efficiency, better patient experience with less patients admitted<br>• Additional mental health crisis model would potentially prevent 198 attendances worth circa £28,710 plus improving ED performance by circa 1% against the 95% standard and improving flow in ED as patients presenting for mental health require high levels of support and management<br>• Reduction in duration of stay in the S136 suite and reduction in use of ED as a place of safety<br>• Implementing the S12 Solutions App enables faster assessments, a better patient experience and reduced pressure on ED and places of safety. There will be an estimated £5,840 per year in admin costs saved at the CCG as well as saving/releasing the overall system a further £53,168 per year of doctor's time by streamlining AMHP processes<br>• Youth Diversion scheme can support 100 young people & families per month; avoid attendance, prevent serious disruptive incidences, facilitate quicker discharge and flow through the acute system<br>• Reduce referrals into secondary care, reduce DNA's and reduce complications in Diabetic patients by implementing a virtual diabetes clinic in Mendip as evidence elsewhere indicates a 50% decrease in total number of bed days for patients with a primary diagnosis of diabetes |

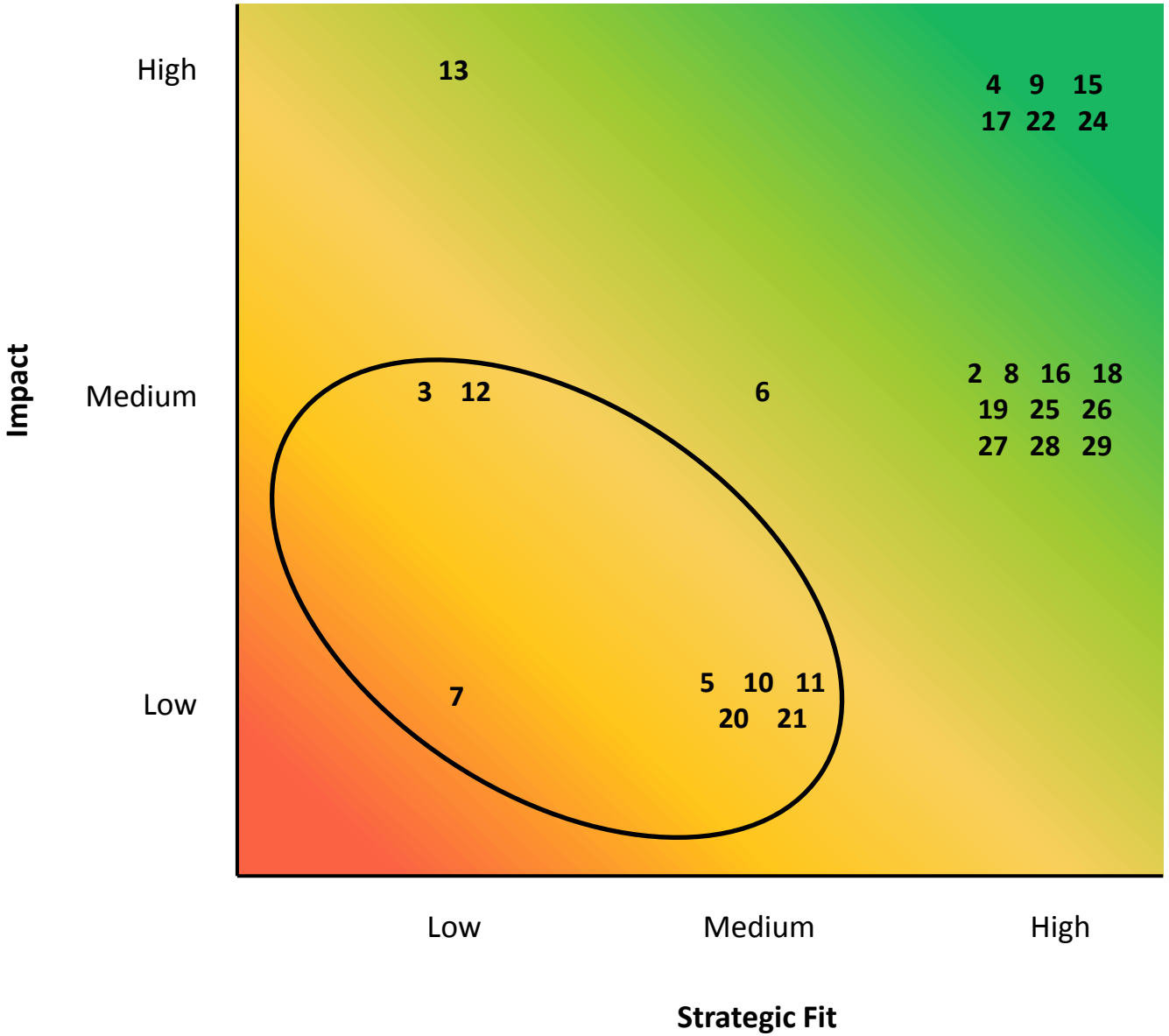
# Schemes Considered for Winter 20/21
# Category 2 – Medium Priority

| No. | Scheme Title | Main impacts | Assessment of Impact | Cost to deliver |
|---|---|---|---|---|
| 2 | Mendip Frailty assessment unit | Reduced presentation to ED, conversion rates to admission, bed days for older (over 75) frail people and increased 0-1 day LOS and use of SDEC and rapid access clinics | Reduction of ED conversion rate to IP for over 75's, reduction in bed days for COOP patients and reduction in presentation of elderly at ED | £169k FYE |
| 6 | Ward 9- Ambulatory Care Unit (Pilot) | A review of outcome data from a number of centres that undertake ambulatory care have seen the LOS reduce from an average of 25 days to 7days. | Previous data collected showed 22 admissions were eligible and had an average LOS of 28 days, 17 of them needed IV antibiotic support for neutropenic sepsis. If these patients had been ambulatory they would have spent an average of 12 days in hospital. 4 admissions did not require any intervention requiring admission so could have saved on average 25 days each | £12k |
| 8 | Enhance the PAU (Paediatric Assessment Unit) service to 7 day working | A 7 day service for PAU over the winter period would result in decreased admissions, decreased length of stay with increased time to senior review and decision making. It would also provide enhanced support for ED teams and referrals, primary care and Consultant Connect. | KPIs for PAU (Jan- Feb 2020 data set) demonstrate that 71% of children are assessed, treated and discharged during weekdays when PAU is open but this falls to 44% over weekends when PAU is not open. 73% of children are assessed and treated within 120 minutes during weekdays falling to 58% at weekends when PAU is not open | £25k for 4 months |
| 13 | Increased ED activity | Enables staffing of wider area to meet social distancing requirements of COVID19 that have been particularly challenging in such a small department.<br>Enables staffing of new areas opening in October due to NHSI capital funding.<br>Improves out of hours doctor cover dealing with concerns raised by medical teams over safety. | Compliance with infection control requirements in ED due to COVID 19.<br>Reduce reported incidents and safety concerns out of hours by medical teams due to limited cover.<br>Safe staffing of additional ED areas opened in October | £850k |
| 16 | Admission Avoidance ASC A&E Project | It will cover associated ED departments such as frailty units.<br>Proposed expansion to include SW cover in SWAST (delayed by Covid).<br>Scheme will impact on admissions, bed state, outcomes for people and reduce requests for long term care either POC or placements. | Admission avoidance – sample numbers in impacts (YDH only) – 65 admissions avoided over 12 weeks (45% of total seen) | £0 as<br>£244k FYE<br>Funded from BCF |
| 18 | IUCS Additional Capacity for winter surge | Positive impact on admission avoidance due to responsiveness of IUCS so people do not deteriorate whilst awaiting treatment or elect to present elsewhere.<br>Early booking of out-of-area agency GPs and clinicians to ensure robustness of IUCS rota.<br>Increase number of triage shifts (including remote triage) for winter weekend periods. | Improvement in CAS call handling times<br>Improvement in clinical triage response times<br>Improvement in face to face OOH response times<br>Increased rota fill compared to previous year<br>Reduced staff absence | £804k PYE |

# Schemes Considered for Winter 20/21 Category 2 – Medium Priority

| No. | Scheme Title | Main impacts | Assessment of Impact | Cost to deliver |
|---|---|---|---|---|
| 19 | Changes to 111 model in Somerset | Right care, right time for elderly/frail cohort with reduced touch points – Reduction in admissions.<br>Switch off percentage of cases for in-hours upstream to allow better use of resources.<br>Improvement in 111 call answering and abandonment rate. | Reduction in admissions | £5k |
| 25 | Additional mental health crisis provision (mixed model) | Decrease in attendances at ED for mental health crisis (evidence from last year's initiative showed that circa 67% of service users would have attended ED had this service not been available).<br>Reduction in attendances at GP practices for mental health needs.<br>Improved patient experience of crisis services with patients being able to utilise the service that best meets their needs in the most appropriate setting of care. | Anticipate seeing a minimum of 50 patients per month based on activity in early 2020, and of these, 33 would have otherwise attended ED (based on service user feedback of those that attended the front room over ED). Over the proposed 6 month operational window, this would potentially prevent 198 attendances worth circa £28,710. In a month, this could improve ED performance by circa 1% against the 95% standard, in addition to any benefit from improved flow in the ED as patients presenting for mental health can require a particularly high level of support and management | £144k PYE (Dec – May) |
| 26 | Additional support to S136 in the out of hours period | Reduce the occasions in which Musgrove Park Hospital is used as a place of safety.<br>Improve patient experience.<br>Reduction in the patient's duration of stay in a S136 suite.<br>There should be limited cost for operationalising the scheme beyond the workforce spend. | Reduction in duration of stay in the S136 suite and reduction in use of ED as a place of safety | £60k |
| 27 | Implementation of the S12 Solutions App | Faster assessments should mean a better patient experience and reduced pressure on A & E departments and places of safety. | Faster assessments should mean a better patient experience and reduced pressure on A & E and places of safety.<br>Implementation should also save the CCG an estimated £5,840 per year in admin costs as well as saving/releasing the overall system a further £53,168 per year of doctor's time by streamlining AMHP processes | £15k |
| 28 | YDH & MPH A&E Youth Diversion scheme | Scheme can release frontline acute staff to concentrate on clinical and medical emergencies.<br>This will be an essential complement to existing urgent/crisis services; introduce young people and families to more appropriate and less stigmatised voluntary and community support. | Capacity to support 100 young people & families per month; avoid attendance, prevent serious disruptive incidences, facilitate quicker discharge and flow through the acute system | £200k FYE |
| 29 | Mendip Virtual Diabetes Clinics | Reduced referrals into secondary care, reduced DNA's and reduced complications in Diabetic patients.<br>Upskilling primary care staff with the support of secondary care colleagues, bringing expertise and knowledge into the local area and spreading that knowledge not only amongst clinicians with a specialist interest but throughout primary care teams. | Evidence from Derby suggests a decrease in unplanned admissions, 50% decrease in total number of bed days for patients with a primary diagnosis of diabetes, and across 29 GP surgeries in Derby City there was a saving of £800k | £21k FYE |

# Schemes Considered for Winter 2020/21
# Category 3 – Lower Priority




| | |
|---|---|
| **3** | Winter 2019/20 |
| **5** | Urgent Care Centre |
| **7** | Increase PHDU beds for paediatrics |
| **10** | Zoning of ED to support COVID activity |
| **11** | Zoning of all areas across the hospital in response to COVID guidance |
| **12** | Increased medical bed capacity including escalation capacity |
| **20** | IUCS Support for care Homes |
| **21** | In-hours Home Visiting Service for Respiratory patients |

# Schemes Considered for Winter 20/21
# Category 3 – Lower Priority

| | |
|---|---|
| **Total cost to deliver schemes** | **£4,465,000** |
| **Assessment of Impact** | Schemes will:<br>• Reduce elective cancellations<br>• Improve 4 hour delivery across ED<br>• Reduce medical outliers and LOS<br>• Avoid hospital admissions<br>• Provides safe clinical care |

| No. | Scheme Title | Main impacts | Assessment of Impact | Cost to deliver |
|---|---|---|---|---|
| 3 | Winter 2019/20 | Cancel less elective routine appointments and manage within overall bed base | Reduction in elective cancellations | £1.9m |
| 5 | Urgent Care Centre | Supports the delivery of safe care within the emergency department, reducing the likelihood of overcrowding. Benefit in the delivery against four hour standard, time to treatment and conversion rates to admission. | Improved four hour delivery across ED, in particular the Integrated Front Door area | Capital costs TBC |
| 7 | Increase PHDU beds for paediatrics | Historically, escalation of PHDU beds/cots was to a cubicle on Acorn ward. This will allow appropriate safe clinical care for PHDU level children and enhanced efficiency across the unit. | Number of PHDU level 1 children (compared to baseline and previous winter period); the activity within the Oak PHDU area over the winter period; the number of children transferred/retrieved to PICU | TBC |
| 10 | Creation of Respiratory Assessment Zone | It will assist in managing hot and cold patients along with supporting increasing demand and maintaining patient and staff safety as well as privacy and dignity when managing normal winter pressure with the addition of COVID. | To meet infection control requirements for management of new ED arrivals.<br>To reduce in-hospital spread of Coronavirus | £276k |

# Schemes Considered for Winter 20/21
# Category 3 – Lower Priority

| No. | Scheme Title | Main impacts | Assessment of Impact | Cost to deliver |
|---|---|---|---|---|
| 11 | Zoning of all areas across the hospital in response to COVID guidance | Quality and patient safety improved from a spread of infection, viral load, appropriate PPE usage point of view. Has enabled split of medical take reducing risk of cross-patient infection. | Maintain low staff sickness of below 5% covid related.<br>Maintain low number of staff to staff/staff to patient transmission of infection<br>Compliance with infection control requirements for COVID19 | £589k |
| 12 | Increased medical bed capacity including escalation capacity | Increase medical bed base in order to meet rising non-elective demand.<br>Improved safety during winter pressures by reducing outliers and use of escalation spaces. Converts previous medically fit ward beds into medicine beds by providing medical cover which was previously not available. | Reduce crowding in ED awaiting bed allocation<br>Reduce elective cancellations during winter due to lack of beds<br>Reduction in number of medical outliers therefore improving care and reducing LOS | £1.4m PYE<br>£1.6m FYE |
| 20 | IUCS Support for care Homes | Ensure other services are not overwhelmed with outbreaks.<br>Support in-hours primary care and ambulance service.<br>100% response rate for outbreaks. | Reduction in attendance levels | TBC |
| 21 | In-hours Home Visiting Service for Respiratory patients | Should reduce numbers of patients attending hospital, reduce numbers of patients admitted to hospital following conveyance, and reduce overnight hospital stays.<br>Reduction in the number of calls made to 999 and NHS 111 | In an audit from a GP practice that was undertaken in a similar pilot in Wokingham, it had the following outcomes out of a total 599 patient contacts:<br>Hospital attendances avoided: 96; Hospital attendances expedited: 68 (11 with sepsis); 111 calls saved: 177; 999 calls saved: 28; Successful pathway referrals: 58 | £300k PYE |

# Demand and Capacity Modelling

Due to the uncertainty surrounding Covid the A&E Delivery Board took the decision to look at 4 scenarios within the Demand and Capacity Model.

**Demand returning to 100% with Capacity at 100% and Demand returning to 80% with Capacity at 80%**

Demand returning to 100% with Capacity at 100% or Demand returning to 80% with Capacity at 80%, would lead to bed shortfalls in line with last year a maximum 91 at Musgrove Park Hospital and of 98 at Yeovil District Hospital. *(Slides 42&43 / 46&47)*

**Demand returning to 100% with Capacity at 80%**

As would be expected the least desirable scenario would be Demand returning to 100% with Capacity at 80%. This would lead to bed shortfalls from July, peaking at 201 beds at Musgrove Park Hospital in January and 157 beds at Yeovil District Hospital in February. *(Slides 44 / 48)*

**Demand returning to 80% with Capacity at 100%**

With respect to bed requirement the best scenario would be Demand returning to 80% with Capacity at 100% would lead to a bed shortfall of 0 at Musgrove Park Hospital and 20 at Yeovil District Hospital.*(Slides 45 / 49)*

Demand has been continually monitored and an updated demand curve has indicated that it is unlikely to cap at 80%. The model has therefore been updated to gradually return to100% predicted demand levels with updated bed capacity to reflect social distancing measures.

The updated model indicates bed shortfalls from June, peaking at 118 beds at Musgrove Park Hospital in January and 154 beds at Yeovil District Hospital in February. *(Slides 40 / 41)*

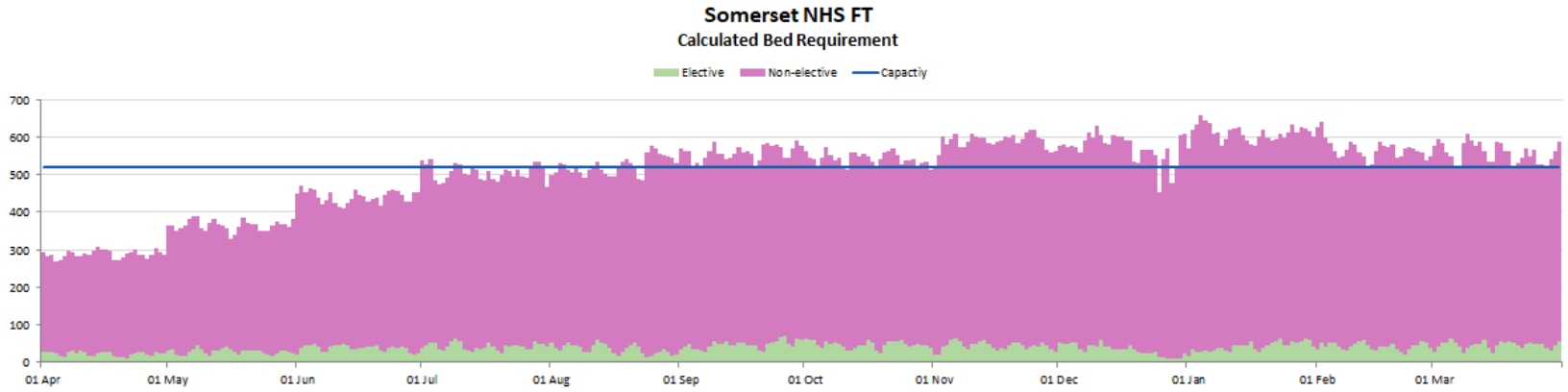
# Musgrove Park Hospital

**Updated Model June 2020**

## Inputs & Assumptions

| | |
|---|---|
| *Underlying Growth* | 2% |

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 67% | 78% | 93% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| *Capacity* | 522 | 522 | 522 | 522 | 522 | 522 | 522 | 522 | 522 | 522 | 522 | 522 |




| | April | May | June | July | August | Septembe | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (100%) | 308 | 389 | 472 | 542 | 577 | 590 | 575 | 620 | 630 | 658 | 640 | 608 |
| Days where bed requirement exceeds core bed base (100%) | 0 | 0 | 0 | 8 | 17 | 29 | 27 | 29 | 28 | 31 | 28 | 29 |

92%

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 303 | 388 | 462 | 536 | 565 | 586 | 567 | 616 | 610 | 640 | 616 | 593 |
| Bed Shortfall (95%) | 0 | 0 | 0 | 14 | 43 | 64 | 45 | 94 | 88 | 118 | 94 | 71 |

*Number of beds needed to achieve occupancy level 95% of the time

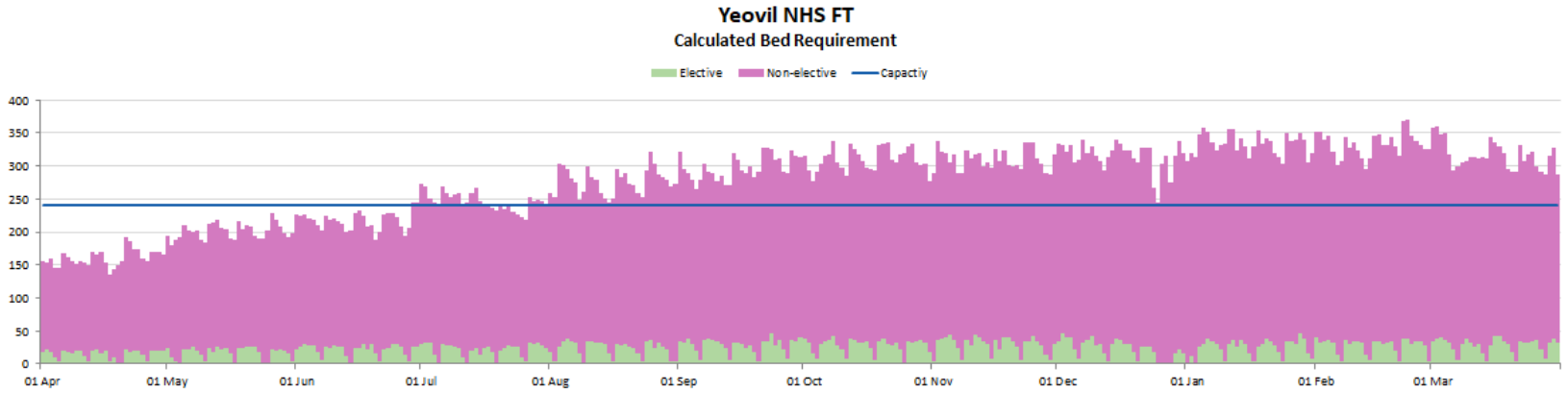
# Yeovil District Hospital

**Updated Model June 2020**

## Inputs & Assumptions

| | |
|---|---|
| *Underlying Growth* | 2% |

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 54% | 70% | 74% | 86% | 96% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| *Capacity* | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 | 240 |




| | April | May | June | July | August | Septembe | October | Novembe | Decembe | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated max bed requirement | 208 | 248 | 266 | 296 | 349 | 356 | 367 | 367 | 370 | 389 | 402 | 392 |
| Days where bed requirement exceeds core bed base | 0 | 1 | 13 | 30 | 31 | 30 | 31 | 30 | 31 | 31 | 28 | 31 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 197 | 237 | 260 | 293 | 329 | 355 | 365 | 365 | 368 | 387 | 394 | 385 |
| Bed Shortfall (95%) | 0 | 0 | 20 | 53 | 89 | 115 | 125 | 125 | 128 | 147 | 154 | 145 |

**92%**

*Number of beds needed to achieve occupancy level 100% of the time

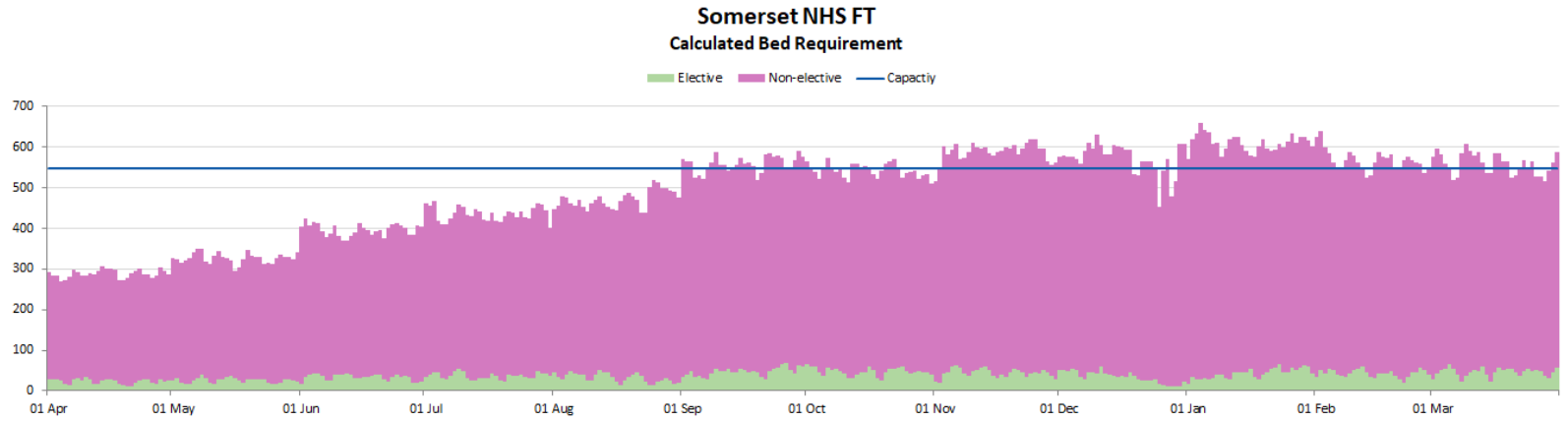
*Number of beds needed to achieve occupancy level 95% of the time

# Musgrove Park Hospital

## Recovery to 100% demand.
## Capacity = 100%

| | |
|---|---|
| *Underlying Growth* | 2% |

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 60% | 70% | 80% | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| *Capacity* | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 |




| | April | May | June | July | August | September | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (100%) | 308 | 348 | 424 | 466 | 520 | 590 | 575 | 620 | 630 | 658 | 640 | 608 |
| Days where bed requirement exceeds core bed base (100%) | 0 | 0 | 0 | 0 | 0 | 20 | 10 | 29 | 25 | 31 | 21 | 19 |

| 92% |
|---|

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 303 | 347 | 415 | 461 | 509 | 586 | 567 | 616 | 610 | 640 | 616 | 593 |
| Bed Shortfall (95%) | 0 | 0 | 0 | 0 | 0 | 37 | 18 | 67 | 61 | 91 | 67 | 44 |

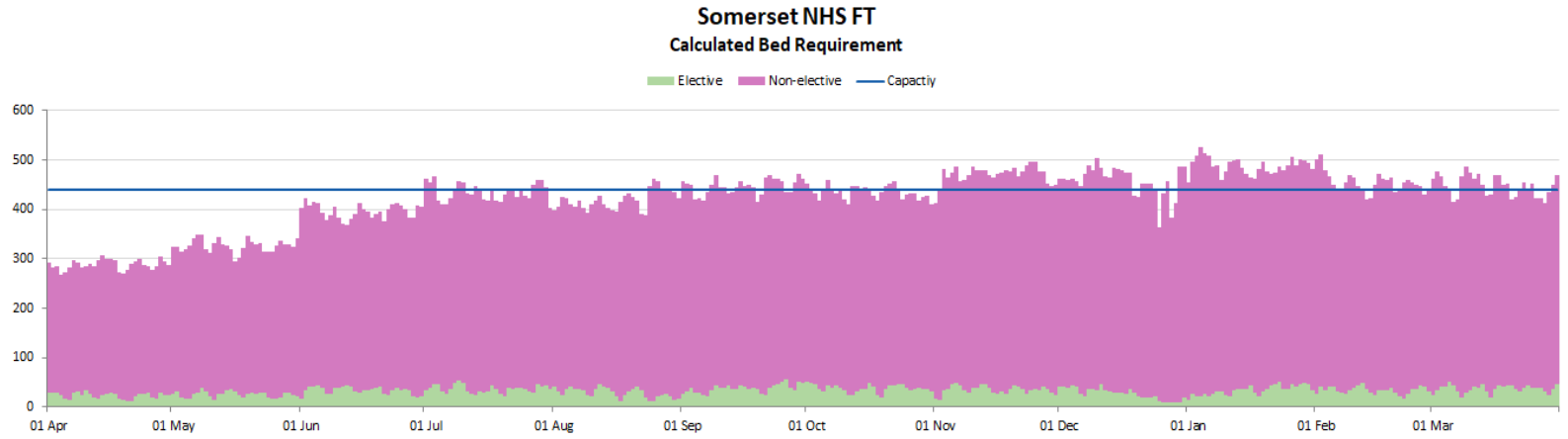
*Number of beds needed to achieve occupancy level 95% of the time

# Musgrove Park Hospital

## Recovery to 80% demand.
## Capacity = 80%

| | |
|---|---|
| *Underlying Growth* | 2% |

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 60% | 70% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |
| *Capacity* | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 |




| | April | May | June | July | August | September | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (100%) | 308 | 348 | 424 | 466 | 462 | 472 | 460 | 496 | 504 | 527 | 512 | 486 |
| Days where bed requirement exceeds core bed base (100%) | 0 | 0 | 0 | 13 | 5 | 20 | 10 | 29 | 25 | 31 | 21 | 19 |

92%

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 303 | 347 | 415 | 461 | 452 | 469 | 454 | 493 | 488 | 512 | 493 | 475 |
| Bed Shortfall (95%) | 0 | 0 | 0 | 22 | 13 | 30 | 15 | 54 | 49 | 73 | 54 | 36 |

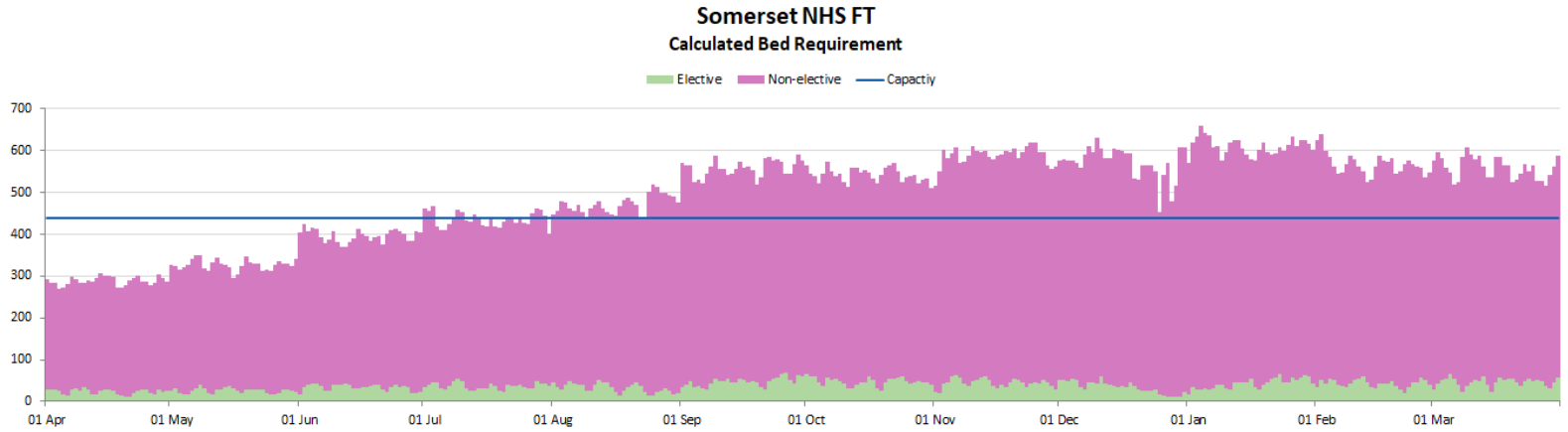
*Number of beds needed to achieve occupancy level 95% of the time

# Musgrove Park Hospital

## Recovery to 100% demand.
## Capacity = 80%

| | |
|---|---|
| *Underlying Growth* | 2% |

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 60% | 70% | 80% | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| *Capacity* | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 | 439 |




| | April | May | June | July | August | September | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (100%) | 308 | 348 | 424 | 466 | 520 | 590 | 575 | 620 | 630 | 658 | 640 | 608 |
| Days where bed requirement exceeds core bed base (100%) | 0 | 0 | 0 | 13 | 29 | 30 | 31 | 30 | 31 | 31 | 28 | 31 |

92%

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 303 | 347 | 415 | 461 | 509 | 586 | 567 | 616 | 610 | 640 | 616 | 593 |
| Bed Shortfall (95%) | 0 | 0 | 0 | 22 | 70 | 147 | 128 | 177 | 171 | 201 | 177 | 154 |

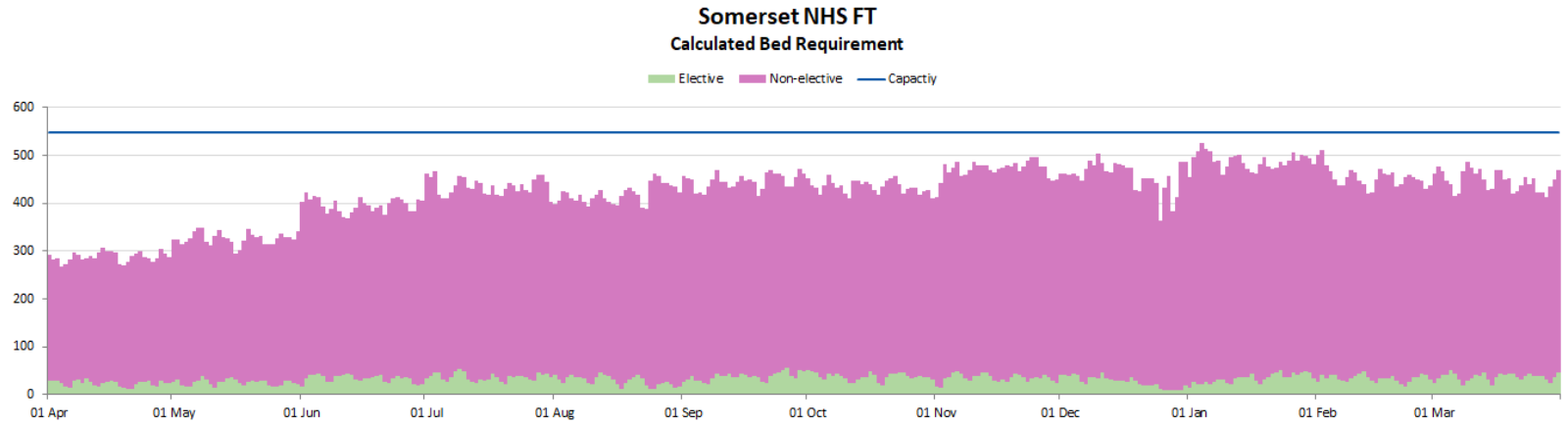
*Number of beds needed to achieve occupancy level 95% of the time

# Musgrove Park Hospital

## Recovery to 80% demand.
## Capacity = 100%

| | |
|---|---|
| *Underlying Growth* | 2% |

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 60% | 70% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |
| *Capacity* | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 | 549 |




| | April | May | June | July | August | September | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (100%) | 308 | 348 | 424 | 466 | 462 | 472 | 460 | 496 | 504 | 527 | 512 | 486 |
| Days where bed requirement exceeds core bed base (100%) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

92%

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 303 | 347 | 415 | 461 | 452 | 469 | 454 | 493 | 488 | 512 | 493 | 475 |
| Bed Shortfall (95%) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

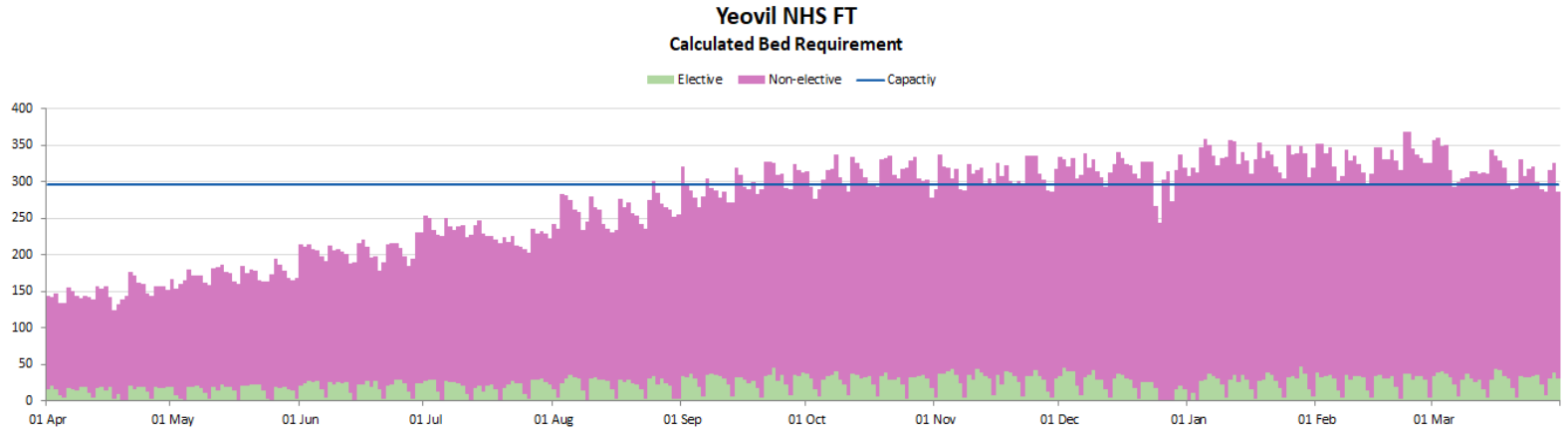
*Number of beds needed to achieve occupancy level 95% of the time

# Yeovil District Hospital

## Recovery to 100% demand.
## Capacity = 100%

| *Underlying Growth* | 2% |
|---|---|

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 60% | 70% | 80% | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| *Capacity* | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 |




| | April | May | June | July | August | September | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated max bed requirement | 192 | 212 | 252 | 276 | 327 | 356 | 367 | 367 | 370 | 389 | 402 | 392 |
| Days where bed requirement exceeds core bed base | 0 | 0 | 0 | 0 | 8 | 27 | 31 | 30 | 29 | 31 | 28 | 31 |

| 92% |
|---|

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 182 | 203 | 246 | 272 | 309 | 355 | 365 | 365 | 368 | 387 | 394 | 385 |
| Bed Shortfall (95%) | 0 | 0 | 0 | 0 | 13 | 59 | 69 | 69 | 72 | 91 | 98 | 89 |

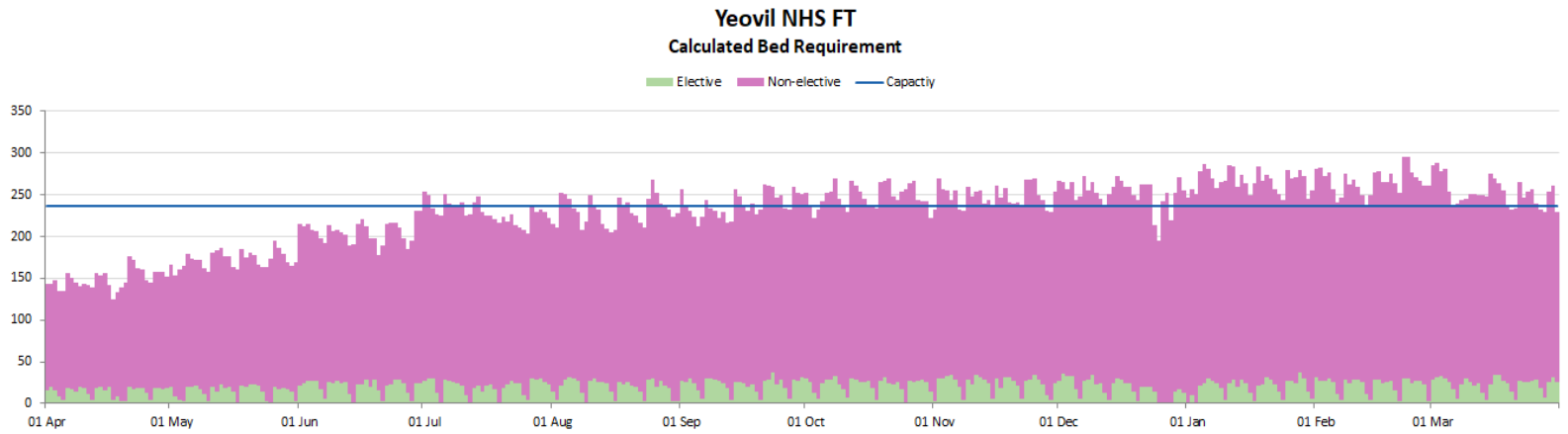
*Number of beds needed to achieve occupancy level 95% of the time

# Yeovil District Hospital

## Recovery to 80% demand.
## Capacity = 80%

| *Underlying Growth* | 2% |
|---|---|

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 60% | 70% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |
| *Capacity* | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 |




| | April | May | June | July | August | September | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated max bed requirement | 192 | 212 | 252 | 276 | 291 | 285 | 293 | 293 | 296 | 311 | 321 | 313 |
| Days where bed requirement exceeds core bed base | 0 | 0 | 3 | 25 | 21 | 27 | 31 | 30 | 29 | 31 | 28 | 31 |

92%

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 182 | 203 | 246 | 272 | 275 | 284 | 292 | 292 | 295 | 310 | 316 | 308 |
| Bed Shortfall (95%) | 0 | 0 | 9 | 35 | 38 | 47 | 55 | 55 | 58 | 73 | 79 | 71 |

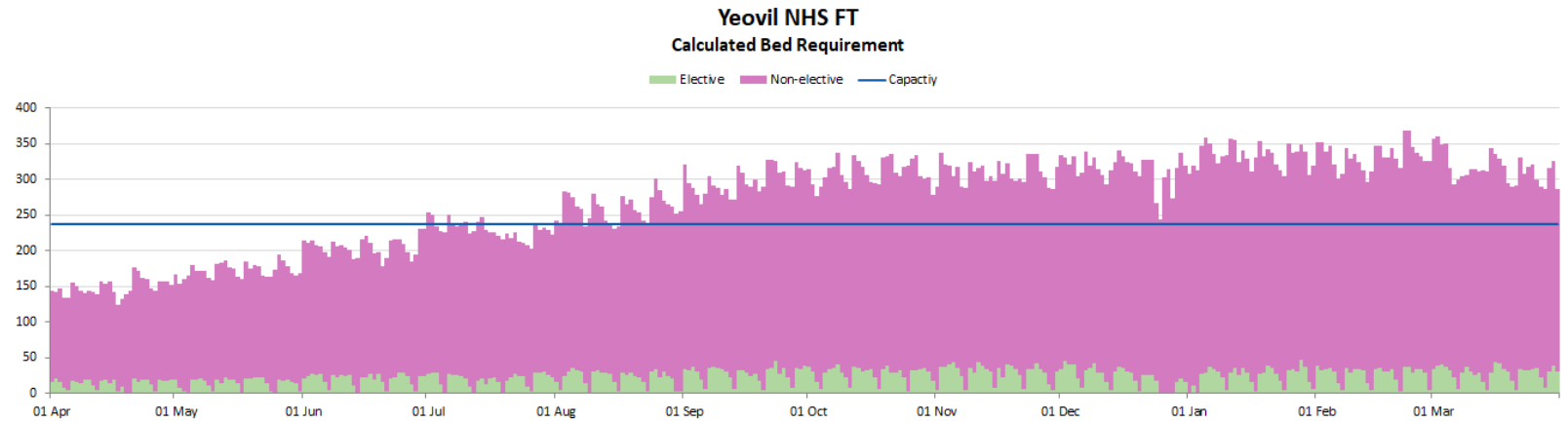
*Number of beds needed to achieve occupancy level 95% of the time

# Yeovil District Hospital

## Recovery to 100% demand.
## Capacity = 80%

| *Underlying Growth* | 2% |
|---|---|

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 60% | 70% | 80% | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| *Capacity* | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 | 237 |




| | April | May | June | July | August | September | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated max bed requirement | 192 | 212 | 252 | 276 | 327 | 356 | 367 | 367 | 370 | 389 | 402 | 392 |
| Days where bed requirement exceeds core bed base | 0 | 0 | 3 | 25 | 31 | 30 | 31 | 30 | 31 | 31 | 28 | 31 |

| 92% |
|---|

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 182 | 203 | 246 | 272 | 309 | 355 | 365 | 365 | 368 | 387 | 394 | 385 |
| Bed Shortfall (95%) | 0 | 0 | 9 | 35 | 72 | 118 | 128 | 128 | 131 | 150 | 157 | 148 |

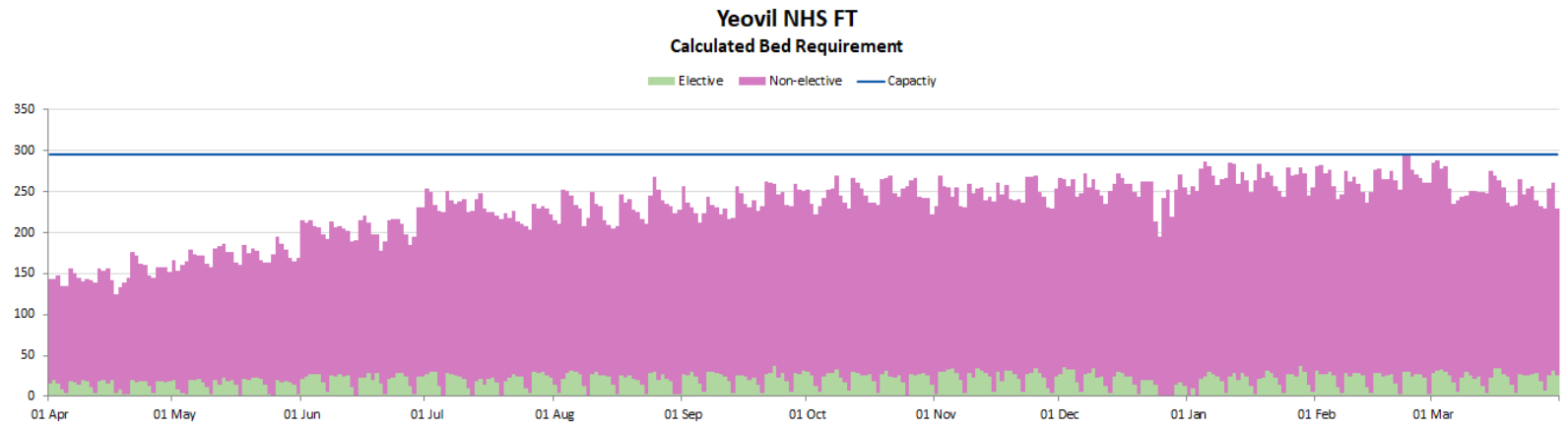
*Number of beds needed to achieve occupancy level 95% of the time

# Yeovil District Hospital

## Recovery to 80% demand.
## Capacity = 100%

| *Underlying Growth* | 2% |
|---|---|

| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Demand (Adjusted for COVID)* | 50% | 60% | 70% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |
| *Capacity* | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 | 296 |




| | April | May | June | July | August | September | October | November | December | Janurary | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated max bed requirement | 192 | 212 | 252 | 276 | 291 | 285 | 293 | 293 | 296 | 311 | 321 | 313 |
| Days where bed requirement exceeds core bed base | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 10 | 10 | 5 |

| 92% |
|---|

*Number of beds needed to achieve occupancy level 100% of the time

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Calculated bed requirement (95%) | 182 | 203 | 246 | 272 | 275 | 284 | 292 | 292 | 295 | 310 | 316 | 308 |
| Bed Shortfall (95%) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 | 20 | 12 |

*Number of beds needed to achieve occupancy level 95% of the time

# Winter Capacity

Each organisation is enhancing their Winter capacity. Plans to cover the winter period for 2020/21 are being discussed and put in place to help manage surge, escalation and maintain flow throughout the System, these are discussed during Winter Planning teleconferences scheduled twice a month from June 2020 . Outline plans for each organisation are summarised on slides 50 - 60.

**Somerset NHS Foundation Trust**

- The continuation of a dedicated winter ward with the provision of 22 beds under normal circumstances or 14 beds if social distancing is applied.
- A three phased critical care escalation plan with a maximum of 49 beds available
- Admission avoidance schemes totaling a maximum bed saving of 50 beds
- Risk assessed and patient experience impact assessed escalation beds – maximum 31 beds
- An 7 day additional winter ambulance commencing mid November

**Modelled bed requirements including escalation beds and with social distancing applied**

| | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Modelled patient requirements (demand)** | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
| Core beds (capacity) | 557 | 557 | 557 | 557 | 557 | 557 | 557 | 557 | 557 | 557 | 557 | 557 |
| Occupancy 92% | 525 | 526 | 542 | 538 | 559 | 555 | 575 | 558 | 568 | 611 | 597 | 545 |
| Surfeit/Deficit | 12 | -12 | -29 | -25 | -46 | -42 | -52 | -45 | -55 | -66 | -60 | 1 |
| Occupancy 95% | 508 | 509 | 525 | 521 | 541 | 538 | 557 | 540 | 551 | 592 | 578 | 527 |
| Surfeit/Deficit | -57 | -56 | -12 | -8 | -28 | -25 | -44 | -27 | -38 | -79 | -65 | -14 |

# Winter Capacity

**Somerset NHS Foundation Trust** *(continued)*

**Community:**

- Extra capacity is generated by putting teams into escalation – this process puts routine work on hold to adopt plans to in reach into the acute and community hospitals to expedite discharges
- Robust Flu Immunisation Programme in place
- Rapid Response service in place countywide supporting Acute Trusts as well as Primary Care
- Robust on call arrangements  in place
- Neighbourhood managers supporting the Somerset System
- Integrated teams working across the 7 day period
- Intensive Dementia support Service now county wide
- Minor Injury Service operating 7 days per week
- Review at times of escalation mandatory training
- Somerset Hub For Coordinating Care (Incorporating D2A, Rapid Response, SPL, Bed Request Hub and EOL CCC)

**Staffing**

- Close management of the rotas and vacancy situation is in place and will continue to ensure early identification of potential pressures.
- Forward planning for staffing supported by block booking of bank and agency staff
- Integrated Discharge Service 7 day service in-place.
- Comprehensive flu vaccination programme commencing October 2020.
- 7 day therapy service
- Additional ward round - weekend

# Winter Capacity

**Yeovil District Hospital NHS Foundation Trust**

- AEC expansion to manage ED flow and increased pathways to stream away from front door
- Elective capacity with  no winter stand down due to covid backlog
- Maintain cancer and urgent operating that cannot be accommodated off site throughout the whole year
- Reduced core bed stock due to zoning – with clear escalation as per growth and activity slide
- Staffing etc to manage zoned areas throughout all workforce
- Review of all outpatient activity before and during covid – virtual activity to continue
- Increased capacity for discharge model to maintain low MFFD numbers

**Bed Position and Growth**

| | Medical | Elective (not inc. any add. activity) | Total av. bed occ | % of winter bed base | Unquantified growth? Figures based on last year | COVID Risk? Estimates |
|---|---|---|---|---|---|---|
| 92% Occupancy average | 251 | 17 | 268 | 85% | | Max of 24 Beds (5.7%); average of 3.3% of Winter Bed Base - all within Medical Emergency |
| 85% Occupancy average | 272 | 19 | 291 | 92% | | |
| 92% Occ inc. Demand Growth | 253 | 17 | 270 | 86% | 0.9% for Em 1+LoS and 1.8% for Elective IP | |
| 85% Occ inc. Demand Growth | 274 | 19 | 293 | 93% | 0.9% for Em 1+LoS and 1.8% for Elective IP | |
| 92% Occ inc. Demand Growth | 177 | 6 | 183 | 58% | 0.9% for Em 1+LoS and 1.8% for Elective IP | EL IP Winter usually  4.5% of Beds if assumption of @ COVID occupancy of 3.3% in Winter Beds, expect reduction to 35% of expected EL Ips |
| 85% Occ inc. Demand Growth | 192 | 6 | 198 | 63% | 0.9% for Em 1+LoS and 1.8% for Elective IP | Expected COVID Occupancy @3.3% of Available Winter Beds, COVID outbreak/lockdown disproportionately reduced all EM IP by over 30% |

# Winter Capacity

**Somerset County Council**

- Adult Social Care is planning demand support measures with the health and care system as a whole. Care and reablement resources will as such be diverted to the system intermediate care solution which will seek to provide a significant uplift in alternatives to admission and in the number of people able to be discharged home with the right support to recover independence and prevent readmission. Capacity planning will dictate the required number of care home beds required to support this.
- Adult Social Care plans to continue with its current way of sourcing long term care (requires SCC standing order permission post covid) in order to maintain a timely transition from intermediate care to long term care if required. This has the objective of keeping unmet need to a minimum as has been achieved during the emergency covid scenario.
- 7 day working will be supported alongside additional resource to Frailty units and A&E departments to support timely patient flow
- Adult Social Care Health Interface Service team workforce capacity below, this is not just acute based but reflective of various locations of person demand according to the Intermediate Care model:

| Date | MPH and associated CHs and pathways | YDH and associated CHs and pathways | WGH and associated CHs and pathways | RUH and associated CHs and pathways | Total |
|---|---|---|---|---|---|
| 21/12/2020 | 14 | 12 | 9 | 9 | 44 |
| 22/12/2020 | 14 | 12 | 9 | 9 | 44 |
| 23/12/2020 | 14 | 12 | 9 | 9 | 44 |
| 24/12/2020 | 12 | 10 | 7 | 7 | 36 |
| 25/12/2020 | EDT | EDT | EDT | EDT | |
| 26/12/2020 | 2 | 2 | 1 | 1 | 6 |
| 27/12/2020 | 2 | 2 | 1 | 1 | 6 |
| 28/12/2020 | 14 | 12 | 9 | 9 | 44 |
| 29/12/2020 | 14 | 12 | 9 | 9 | 44 |
| 30/12/2020 | 14 | 12 | 9 | 9 | 44 |
| 31/01/2020 | 12 | 10 | 7 | 7 | 36 |
| 01/01/2021 | 2 | 2 | 1 | 1 | 6 |
| 02/01/2021 | 2 | 2 | 1 | 1 | 6 |
| 03/01/2021 | 4 | 4 | 2 | 2 | 12 |

# Winter Capacity

**Primary Care**

- 65 practices in Somerset ran by 53 provider organisations
- There are workforce pressures in the primary care general practice workforce with regards to the numbers of GPs and practice nurses currently working.
- Capacity to see patients face to face will be reduced this winter due to IPC requirements and the need to use PPE
- Potential for capacity to be increased by continuing with total triage models, utilising telephone triage and online consultations. These can take longer than a traditional face to face appointment but the problem is usually fully resolved.
- Opportunity for cross practice working and/or cover. We have seen this as part of the COVID-19 response and this may be transferable to other areas of primary care demand.
- There has been a commitment to collect primary care data to identify trends and increases in activity. The aim is to roll out an improved capacity tracker from October 2020.
- All practices have robust escalation plans to step up PAC sites should COVID-19 demand increase including an increase in other respiratory cases.

**Meddcare**

- Continue to work on demand and supply for Out of Hours Primary Care during the summer and will apply the necessary uplift to provide the required capacity during the winter period
- Peak days (Christmas Day, Boxing Day, New Year's Day) will have additional staffing to take account of the Bank Holidays (and associated weekends will also be subject to enhanced staffing)
- Additional capacity will be put in around known peaks in demand around the holiday period and winter months. This will include additional clinical and non-clinical staff resource including ANPs and other non-GP clinicians to support the delivery model. As there is no additional funding savings in summer months are required in order to support the winter rota.
- CPCS Community Pharmacist Consultation Service , commenced October 2019, will continue throughout winter period.

# Winter Capacity

**NHS 111**

- Meddcare has a suite of EPRR and Business Continuity documents that set out how the business is to respond in times of operational pressure caused by service operation. This includes the impact of bad weather, utilities failure, IT failure, and loss of a site. There are appropriate response documents in place for each of the events, with action cards to be followed by those in the operation and the Meddcare escalation protocol. These processes cover the actions of the CAS, Treatment Centres and Mobile Resources. The Business Continuity document sets out the priority that key resources will be allocated in the case of system failure, and ultimately how the service can run without access to its computer systems. These are subject to annual review by NHS England; the latest compliance rating is Significantly Compliant
- In the event of Care UK, on behalf of Meddcare, being unable to provide a 111 service, this will be escalated to the Care UK national estate and then to national contingency in discussion with NHS England. We have reviewed the Care UK Business Continuity and EPRR policies and can provide assurance that these are robust.
- The arrangements that are currently in place for 111 Online will be maintained as per the current business as usual processes. Due to the NHSE/I national campaign we are expecting an increase of circa 10% in demand, this is not yet quantified but taken from we what know of demand for this year added to predictive outbreaks . We have not yet received full data and therefore please note this is estimated.
- Care UK provides the NHS 111 service within Somerset. This is delivered from the Bristol call centre. During periods of high demand Care UK has the option of using their wider estate to support delivery.
- The Care UK service is stress tested at a national level and submits weekly updates for both staffing and forecasted demand levels to NHSE/I. The mechanisms in place for streaming and call backs have been profiled and tested robustly.

# Winter Capacity

**Think 111 First – Somerset**

Somerset is establishing workstreams to focus on implementation of Think 111 First ahead of winter. This will be clinically led and have a number of enabling workstreams that sit beneath it to support the process. The governance of the Think 111 First programme is on the following page.

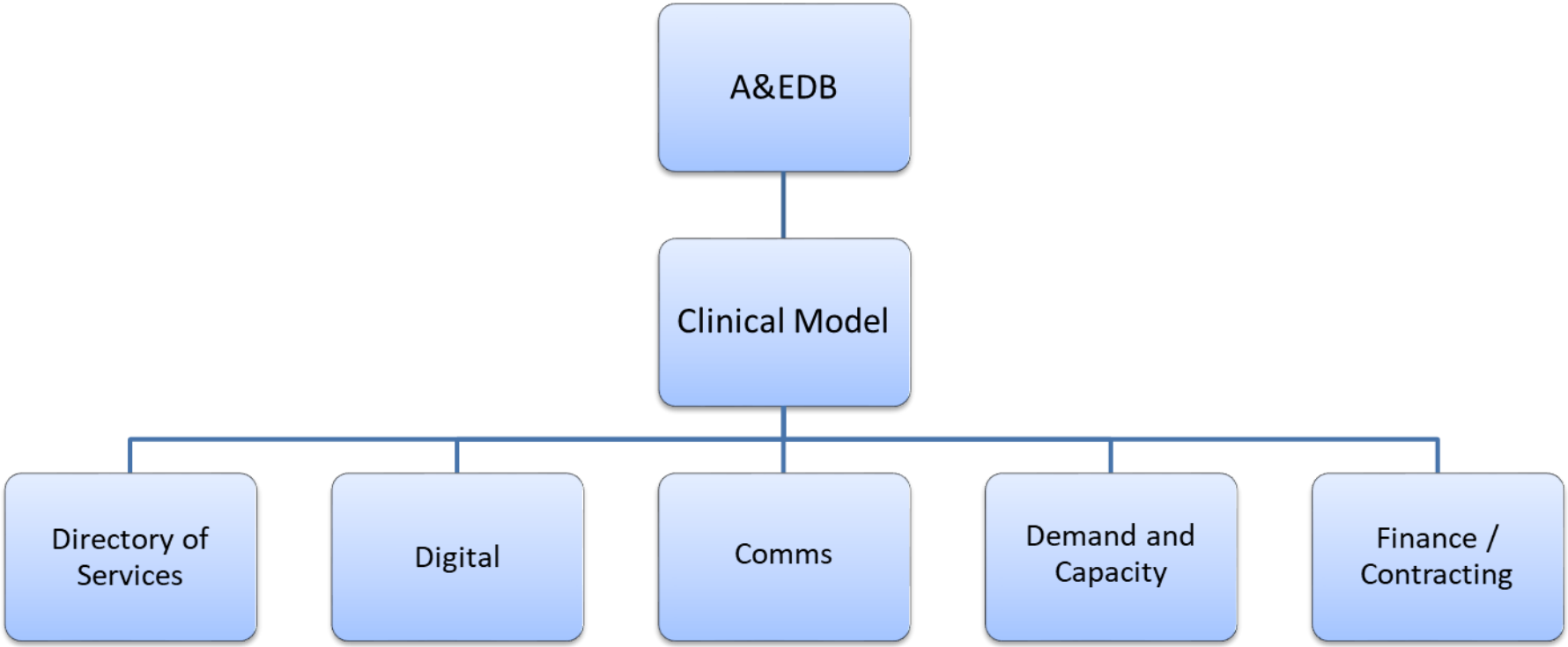
The principles of Think 111 First will be to:

- Ensure our Emergency Departments do not become over-crowded and patients receive a sub-optimal service in and out of hospital through the impact of Covid-19 and demand returns to previous levels
- The nationally led campaign of Think 111 first aims to ensure a more robust 111 service is in place to support patients and direct them into the right service for their needs. Within Somerset it is planned to optimise the use of the Clinical Assessment Service to ensure patients can be clinically triaged and assessed
- To ensure attended services are as safe an environment as we can make them, for all staff and patients, we need to control numbers and make better use of available resources.
- Principally this is enabling a system of direct booking rather than walk in's and online consultations rather than face to face to enable controlled flow and better use of resources.

The programme is just beginning to mobilise and the phasing of the programme will be included in future versions of the winter plan. At present the aim is to implement the programme in mid October to thoroughly test out the plans prior to the peak months of winter and the national deadline for implementation of December 2020.

# Winter Capacity

**Think 111 First – Governance Structure**



# Winter Capacity

**South Western Ambulance Service NHS Foundation Trust**

- Regional and county level demand modelling based on previous years activity levels, predicted upturn and in year contracted levels.
- COVID 19 surge planning assumptions to include future peak period modelling as part of the SWASFT Surge Plan
- Organisational Escalation planning to include REAP (OPEL) actions at levels 1-4
- Workforce & Recruitment planning to include staff turnover rates and increase in workforce numbers as part of Commissioner Investment plans for 2019/20/21
- Workforce abstraction planning to support daily/weekly Operational and Clinical Hub resourcing levels to include use of overtime and incentive payments.
- Workforce abstraction planning to support increased capacity over festive period with 50% reduction in normal leave abstractions.
- Deployment of additional resources including agency, volunteers and key partners at peak times or during periods of escalation.
- 24/7 Command structure in place at an Operational, Tactical and Strategic level. To support this there will be an option to open a SWASFT Incident Command Centre and County Coordination Centre (Somerset) supported by other key functions and Commanders
- Vehicle (fleet) capacity to support future investment plans with emphasis on increasing conveying vehicles

# Winter Capacity

**E-Zec**

- Comprehensive review of historic E-zec activity & winter discharge support activity to map resourcing against demand
- Daily OPEL reporting to key stakeholders (inclusive of a demand management tool)
- Trialling a dedicated discharge vehicle at both Musgrove Park Hospital & Yeovil District Hospital in preparation of winter
- Ongoing recruitment in place to remain above establishment levels
- Limiting annual leave allowances throughout winter periods amongst road staff / management to ensure services aren't impacted

**Royal United Hospitals Bath**

- Staffing rotas continue to be reviewed and monitored on a daily basis to ensure an optimum cover.
- Nurse Staffing Authorising process 7 days per week to support nurse staff allocation.
- On-call rotas in place which include directors, managers and matrons. Management support is available to deal with service issues and effective communications are maintained.
- Clinical Site Team Meetings 3 times per day. Escalation plans in place to manage patient flow, capacity and demand.
- Daily OPEL reporting to key stakeholders, via SHREWD or Site Reports.
- Therapies provide a 7-day service.
- GIM Consultant on site 08:00 – 20:00 7 days per week.
- Radiology working 7 days per week and ED Radiology covered 24/7.
- Continuous focus on discharge remains a priority for the Trust.
- Discharge Hub in place 7 days per week.
- Integrated Discharge Service (IDS) in place 7 days per week.
- Full utilisation of non-emergency patient transport, which is provided by FAST.
- Virtual clinics / appointments to continue in order to reduce the footfall on site.

# Winter Capacity

**Weston General Hospital**

- OPEL triggers to be re-defined to recognise addition pressures cause by Covid-19
- Non elective Covid admission pathway identified and Hospital Zoned
- Elective SOP pending approval
- New discharge lounge now open
- Medical day facility now complete and operational
- TRU reconfigured to support Covid theatre recovery
- Day case theatre and full unit designated green pathway for elective care
- PUSHDr virtual GP available in ED
- Mortuary refurbished
- Now using full UHBW weekly theatre restoration group to prioritise elective programme across all sites
- Use of Theatres and Endoscopy suites at independent sector provider sites (Nuffield and Spire(Endo))
- Use of UHBW weekly out patient group to authorise and prioritised Outpatient activity across all sites
- Introduction of Attend anywhere and extended use of telephone appointments to reduce level of Face to Face activity in out patient department.
- Current social distancing rules have required the removal of 43 inpatient beds from usual stock. Current routine availability now 222.
- Purchase of mobile unit to support ultrasound capacity
- Use of independent sector (spire) for additional imaging capacity

# Supporting Policies

Ahead of the Winter Period, there are four key areas that have been highlighted as a potential concern; Transport, Severe Weather, Flu and Infection Prevention and Control. Slides 59 – 63 outline the work that is being undertaken to support the system around these key areas.

**Transport**

The following work has been undertaken by Transporting Somerset / Somerset County Council Cars and Fleet ahead of the Winter Period to support patient transport:

- Review of historic activity & winter discharge support activity to map resourcing against demand
- Daily RAG scoring of capacity vs demand
- Close working with taxi providers to expand number of available vehicles with bulkheads or minibuses to support social distancing
- Flexible working of staff to support sub-contracting arrangements (as required) for E-zec
- Leasing of fleet of ambulances in place to support standing down of volunteer drivers (through Covid-19)
- Limiting annual leave allowances throughout winter periods amongst booking teams and ambulance fleet crew
- Winter resilience - Five 4X4s vehicles have been delivered. Locations are Bridgwater, Yeovil, Frome, Glastonbury and Taunton. Four drivers in each depot have received relevant training in relation to driving in snow/ice conditions and each vehicle has an emergency kit on board, including foil blankets, torch, shovel and de-icer.

# Supporting Policies

**Severe Weather Procedures**

Commissioners and provider organisations receive severe weather warnings, weather alerts and forecasts from the Met Office. This information is also cascaded to organisations on the operational escalation calls to ensure that the required actions are undertaken.

The Cold Weather Plan for England was published in October 2018 by Public Health England and remains the most current guidance. Organisations have each reviewed their plans to ensure that they align with the national guidance and action cards are utilised depending on the alert level that is in place. NHS England formally launch the cold weather alert period at the end of October and issue any updated guidance.

There is a Local Health Resilience Partnership (LHRP) Severe Weather Plan in place which incorporates all the elements of heatwave, flooding, and cold weather. This plan is periodically reviewed to ensure it reflects the latest guidance and incorporates any learning from recent incidents including snow. The LHRP and Somerset work programme includes severe weather and the LHRP participates in the Avon and Somerset Local Resilience Forum Severe Weather Group which includes all Category 1 responders.

Organisations in Somerset have confirmed that they have their own severe weather plans in place as part of their winter resilience planning, to deal with adverse weather conditions. The aim of these procedures is to maintain safe staffing levels to manage any increase of trauma patients presenting through the Emergency Department or Minor Injury Units.

The Somerset Emergency Planning Group has worked together to develop a 4x4 transport protocol which set out how the co-ordination of and access to the 4x4 resource during extreme weather conditions would be managed in Somerset. The protocol is reviewed each year to ensure it aligns to the LRF and organisational plans.

# Supporting Policies

**Severe Weather Procedures** *(continued)*

The Standard Operating Procedure for Somerset Health Partners for Requests for 4x4 Transport during Severe Weather has been collectively drawn up by the members of the 4x4 Task and Finish Group. The aim of the document is to co-ordinate access to 4x4 transport support for providers and commissioners of NHS care when their local business continuity arrangements have been exhausted and their ability to deliver critical front-line services is impaired. This aim will be achieved by fulfilling the following objectives:

- act as a liaison point with the ASLRF which will identify specific transport resources which could be used by commissioners and providers of NHS funded care
- Somerset CCG to act as single point of contact and co-ordinating hub for health partners in Somerset
- outline review arrangements (including feedback and debriefing), following a period of high activity levels or feedback by any party.

Exercise Glacier was in January 2019 to test the Somerset transport command, control and communication arrangements during a severe weather incident and the SOP was further tested by a live event of severe snow on 30 January 2019. On that occasion a decision had been taken during the LRF Operational Link teleconference to maintain a watching brief and not to stand up the LRF Transport Cell at this stage, so the CCG On-call Director agreed that requests for 4x4 support should be co-ordinated by the CCG Somerset Transport Cell, directly with Wessex 4x4. The LRF Logistics Cell protocol was revised and tested by the LRF and partners in December 2019 and is a resource that can be activated to support with the response to severe weather incidents. The Somerset SOP will be further refined and reviewed by the Somerset Emergency Planning Group to take account of the current Covid-19 restrictions and then exercised again in October 2020.

The Somerset Health Partners periodically issue communications to raise awareness for 4x4 drivers to come forward and volunteer to support organisations either through Wessex 4x4 or locally. The aim is to both build resources within the voluntary sector and provide a local pool which can be verified in advance and contacted as spontaneous volunteers in the event of a severe weather episode.

# Supporting Policies

**Flu**

We are reviewing the Somerset System Response to the upcoming flu season we have established a Tactical Flu Group from which there are 3 task and finish groups looking at the following areas:

- **Flu Communications** - Agree a system approach to identity and target messages for difficult to reach audiences with the aspiration to increase flu uptake across the system especially in at risk groups.

- **Community / Pharmacy** - How can we work differently and what alternative solutions can be offered to provide vaccinations at scale, aiming to deliver final draft plan by the end of July.

- **Flu Finance** - Outline the blockers and challenges around finance payments associated with setting up new and bespoke flu vaccination offers, and developing some myth busting guidance.

We are conscious that the upcoming flu season will be significantly different to previous flu seasons due to COVID and the Social Distancing and subsequently we are aiming to establish better guidance on how to run a flu clinic and suggestions as to what can be done at scale.

The CCG are reviewing their internal Flu Campaign and ensuring that this is commissioned appropriately for the revised staffing model.

# Supporting Policies

**Infection, Prevention and Control (IPC)**

The CCG IPC Team will maintain the current COVID-19 management functions during winter 2020/21. The IPC cell will remain operational 7 days a week for support and advice to Primary and Secondary Care. There is a SOP for the functioning of the IPC Cell. Initial support for Care Homes will be through the LARCH Team who have access to the IPC Team for specialist advice as needed. The IPC Team will work in collaboration with Somerset Public Health Team in COVID-19 outbreak management in line with recently agreed system outbreak protocols. The IPC Team will ensure that outbreaks of COVID-19 in Hospitals and in Primary Care are notified and managed in line with national guidance. Training for Care Homes on COVID-19 prevention and management is being rolled out. This training includes standard infection prevention and control precautions and the information on isolation and outbreak management will assist Care Homes in managing outbreaks of other infections such as Influenza and Norovirus. The IPC Team is also providing specialist advice to other CCG cells including Primary Care, PPE and Care Homes.

The IPC Team will continue to provide system wide information on outbreaks to provider organisations. The Team works with Somerset Public Health Team to prevent and manage outbreaks of Norovirus across the system. This is done through public information and education. The following programmes of work are aimed at reducing healthcare associated infection and minimizing the impact of delayed discharges and increased admissions:

- Clostridium difficile
- MRSA and MSSA bacteraemia
- E. coli bacteraemia

The IPC Team is currently reviewing its structure with a view to ensuring greater resilience of the team.

# Supporting Policies

Contained in the following slides are short summaries of the policies in place that will support each organisation throughout the Winter Period. A copy of these policies are available upon request.

**Somerset NHS Foundation Trust**

- **Seasonal flu Plan** –comprehensive plan outlining the response and containment phases. It is expected that any seasonal flu outbreak will be at least complicated or superseded by concurrent infections of COVID-19. As in previous years the Trust will have a comprehensive flu vaccination programme which will commence with the first vaccinations at the beginning of October 2020 with a target of 80% uptake.
- **Severe weather Plan** –plan linked to the Met Office warning system with command, control and co-ordination processes fully detailed.
- **Communicable Diseases Plan** - provides staff with information for the appropriate care of patients with a communicable disease. Detailed procedures of control, as set out in published best practice and in compliance with national legislation are cited.
- **Escalation Plan** - incorporates the escalation status setting, bed capacity and emergency department trigger points, and associated escalation action plans. This plan enables the Trust to deal effectively with fluctuations in demand and capacity so that it can manage associated clinical risk within acceptable limits.
- **Business Continuity Plan** - provides a framework for the Trust to respond to any crisis, whether foreseen or unforeseen. The plan consists of the arrangements, procedures and documents for reference in the event of a major incident or serious interruption to the Trust's business.
- **Winter Plan** - sets out the arrangements for planning for the winter period for 2020/21 whilst giving consideration to the ongoing and potentially increasing impacts of the coronavirus outbreak. Focussed on three key elements; admission prevention at the front door; resilience under increased pressure; delivering a full D2A model.
- **Critical Care Escalation Plan** - ensures that the Trust is in a position to respond to those patients requiring Level 2 or Level 3 critical care by increasing the overall critical care capacity of the Trust during an outbreak

# Supporting Policies

**Yeovil District Hospital NHS Foundation Trust**

- **Pandemic Illness Plan** in place to reflect learning from Covid-19. The plan clearly sets out lines of action and responsibility relating to the Organisational response to pandemic illness and the associated effects on staff and services. Used as a outline for Covid-19 response with good effect.
- **Annual Flu Vaccination campaign** will be in place from October to February. To be lead by DDIPC and infection control team this year. Aim for at least 80% of staff to be vaccinated. Link to wider system approach already in place.
- **Severe Weather Plan** in place with good system links. A planned exercise will take place to test this with particular reference to severe winter weather.
- **Trustwide Business Continuity Planning** reviewed during Summer 2020. Clear BC plans for key areas that recognises key risks that include loss of staff, disruption to transport networks etc.

**Somerset County Council**

- SCC Public Health Team are Deputy Chairing the Somerset System Flu group to drive the flu agenda across the Somerset system. A an organisation, we will also by leading the SCC flu group to ensure that we have an effective flu vaccination programme to vaccinate frontline health and social care staff.
- Somerset County Council Civil Contingencies Unit will continue to plan for and help the response to severe weather.
- Somerset County Council Public Health will lead on Test and Trace for Covid19, and will lead any necessary response to local outbreaks.
- Adult Social Care and the Care Sector Board will drive and monitor the use of infection control grant funding, with a particular focus on protecting staff and preventing staff spread across multiple settings of care.

# Supporting Policies

**Primary Care**

- All practices have robust IPC policies in place following national guidance to ensure that patients needing to be seen on site can be seen safely and staff are kept safe.
- All practices have business continuity plans in place. This is a contractual and CQC requirement and should cover all areas where there is a risk to the delivery of services including adverse weather conditions, staff sickness, disease outbreaks, loss of premises etc.
- These have been reviewed following the COVID-19 outbreak and have been thoroughly tried & tested including the use of innovative digital solutions.

**Meddcare (Integrated Urgent Care incorporating NHS 111)**

- **Business Continuity Plan** in place to support ongoing provision of company as result of major event. The plan informs of stakeholder providers and contact details.
- **Emergency Preparedness, Resilience and Response Policy** to define roles and responsibilities with subsequent actions to be taken in response to emergency/pandemic situation.
- **OPEL escalation** (OOH) to define what measures are to be taken and by whom as a result of increased in demand for service.
- **Pandemic Flu Plan** sets out lines of action and responsibility relating to the Organisational response to pandemic illness and the associated effects on staff and services and support to system partners.

CARE UK's business continuity and EPRR plans reviewed in December 2019, these are planned for testing the Autumn 2020 ahead of Winter 20/21.

# Supporting Policies

**South Western Ambulance Service NHS Foundation Trust**

**Flu Plan 20-21**

This plan currently in development will look at local and regional best practice from 2019-20 to deliver the organisational and national immunisation targets for season flu across the SW region in 2020-21. This will be coordinated centrally and delivered at a local county level with the County Commander responsible for the plan and the overall vaccinate rate compliance. The regional and national targets for vaccination are still to be confirmed however the NHSE/I target is 90%.

**Winter Plan 2020/21**

The Winter Plan supported by the Severe Weather Plan provides a framework for the management of 'Winter Pressures' and in the event of a significant weather event such as flooding or snow. This policy links to the Business Continuity, Command and Escalation Policies to protect the SWASFT 5 and the maintenance of core businesses during any 'severe weather' or 'rising tide' event. The Winter Plan also covers the agreed processes for delayed handover escalation and actions at each acute (ED) across the region.

**Infection, Prevention & Control Policy**

The Trust is committed to creating robust systems of infection prevention and control, based on a comprehensive infection prevent and control policy. This policy is a live document and is subject to constant review based upon identified risks. Continual infection control audit allows areas of good practice to be promoted, whilst systematically identifying areas where improvements are necessary. The infection control work is underpinned by robust and comprehensive infection prevention and control processes and procedures. An annual infection prevention and control programme is developed for each financial year to set a programme of work for that year.

# Supporting Policies

**South Western Ambulance Service NHS Foundation Trust** *(continued)*

**Escalation Plan**

Ambulance Trust Providers are committed to providing the highest level of patient care to the public including times when it is experiencing capacity pressures and periods of high demand. This Escalation Plan provides a consistent and coordinated approach to the management of the Trust during times of pressure including excess demand and supports capacity management across the emergency and urgent care divisions.

Four levels of escalation will be utilised within REAP (Resource Escalation Action Plan) which aids ambulance services to integrate into the wider NHS surge or escalation framework and OPEL levels. These levels will be used to determine what actions are necessary to protect the core services and supply the best possible level of service with the resources available. REAP will be reported nationally as well as being utilised within the Trust dynamically each day to guide escalation planning.

REAP is designed to ‘be informed’ by any disruptive challenges and ‘to inform’ internally and to the wider NHS, and other partner agencies, of the pressures facing the organisation. The considerations and actions contained within ‘the REAP’ are designed to assist in protecting staff, patients and the organisation and should be viewed as a guidance in challenging situations.

The REAP should be used dynamically and the appropriate actions considered either by just one county or trust wide depending on the situation. Actions within one county may not affect the overall REAP level but allow for appropriate actions to be taken within the Trust to prevent further escalation.

# Supporting Policies

**South Western Ambulance Service NHS Foundation Trust** *(continued)*

**Business Continuity Strategy**

Business Continuity Management (BCM) is a statutory requirement for the Trust to deliver in an effective and robust manner. The short-term objective of a Business Continuity Management System is to ensure that during disruption at least the 'priority' services may continue with minimal impact and patient care is maintained. The longer-term objective of a Business Continuity Management System is to ensure that the Trust can resume normal services as quickly as possible in the aftermath of any disruptive challenge or emergency situation.

**Business Continuity Plan**

The SWASFT Business Continuity Management Programme provides the framework within which the Trust can comply with the Business Continuity requirements of our patients and stakeholders by aligning the Business Continuity Management Programme with ISO22301:2012. Business Continuity Management has been established to ensure the Trust can continue to deliver a minimum level of service to our patients and stakeholders in the event of any disruption. This plan will be activated in response to an incident causing significant disruption to normal service delivery, particularly the delivery of priority activities.

**Command Policy**

This policy aims to ensure that SWASFT has an integrated approach to command and the management of incidents and core Trust activity. It is designed to ensure that all levels of commander are trained to the same level and understand and discharge their responsibilities consistently. It also aims to provide a shared perspective amongst commanders to help deliver the best possible response to any particular emergency / incident and to improve the best possible outcome for the patient's involved. Each of the command grades (Strategic, Tactical, and Operational) are trained in line with the National Occupational Standards, NHS England EPRR Core Standards for Command and Control, the Joint Emergency Services Interoperability Principles and the criteria described in the national ambulance command and control guidance.

# Supporting Policies

**E-Zec**

- Severe Weather Plan Procedure & Business Continuity Plans (including 4x4 provision, snow shovels / snow socks, grit etc)
- Flu vaccination programme for all front line staff
- IPC policy remains the same throughout winter pressures

**Royal United Hospitals Bath**

- RUH Winter Plan
- Incident Response Plan (EPRR)
- Severe Weather Procedures
- Pandemic Influenza Policy
- IPC Arrangements & Strategy
- Flu Cohort SOP
- OPEL Escalation Triggers and Escalation Policy
- Business Continuity Plans (Trust-wide and departmental)
- Full Hospital Protocol and Internal Significant Escalation

# Supporting Policies

**Weston General Hospital**

- **Pandemic Influenza Plan –** comprehensive plan outlining the response and containment phases. It is expected that any seasonal flu outbreak will be at least complicated or superseded by concurrent infections of COVID-19. As in previous years the Trust will have a comprehensive flu vaccination programme which will commence with the first vaccinations at the beginning of the autumn 2020.
- **Severe weather Plan** –plan linked to the Met Office warning system with command, control and co-ordination processes fully detailed.
- **Communicable Disease Response Plan** - provides staff with information for the appropriate care of patients with a communicable disease. Detailed procedures of control, as set out in published best practice and in compliance with national legislation are cited.
- **Escalation Plan** - incorporates the escalation status setting linked to OPEL, bed capacity and trigger points, and associated escalation action plans. This plan enables the Trust to deal effectively with fluctuations in demand and capacity so that it can manage associated clinical risk within acceptable limits.
- **Business Continuity Plan** - provides a framework for the Trust to respond to any crisis, whether foreseen or unforeseen. The plan consists of the arrangements, procedures and documents for reference in the event of a major incident or serious interruption to the Trust's business.

# Risk Management

In terms of the Demand and Capacity Modelling that has been undertaken incorporating the proposed Winter Schemes, risks have been considered in relation to the unmitigated and mitigated scenarios which are outlined on the following two slides.

The risks of the unmitigated scenario:

| Risk | Examples | Likelihood | Consequence | Score |
|---|---|---|---|---|
| Safety | Crowding<br>Ambulance response times<br>Cancellation of urgent surgery | 5 | 5 | 25 |
| Patient experience (performance) | Long waits<br>Sub-optimal environment of care | 5 | 4 | 20 |
| Workforce | Colleague harm<br>Morale/engagement<br>Higher vacancies | 5 | 5 | 25 |
| Financial | Short term reactive expenditure – not anticipated in forecast plan<br>High costs | 5 | 5 | 25 |
| Regulatory | Concern about grip and control in system | 4 | 4 | 16 |
| Strategic | Forced into delaying key strategic changes going into 2021/22 | 4 | 5 | 20 |

# Risk Management

The risks of the mitigated scenario:

| Risk | Examples | Likelihood | Consequence | Raw Score | New score |
|---|---|---|---|---|---|
| Safety | Crowding<br>Ambulance response times<br>Cancellation of urgent surgery | 5 | 5 | 25 | 3X5 = 15 |
| Patient experience (performance) | Long waits<br>Sub-optimal environment of care | 5 | 4 | 20 | 3X4 = 12 |
| Workforce | Colleague harm<br>Morale/engagement<br>Higher vacancies | 5 | 5 | 25 | 3X5 = 15 |
| Financial | Short term reactive expenditure – not anticipated in forecast plan<br>High costs | 5 | 5 | 25 | 3X 5 = 15 |
| Regulatory | Concern about grip and control in system | 4 | 4 | 16 | 2 X 4 = 8 |
| Strategic | Forced into delaying key strategic changes going into 2021/22 | 4 | 5 | 20 | 2 X 5 = 10 |

In addition there is a risk that this winter brings covid second wave, flu and other high demand. This would enhance the raw risks and increase the importance of mitigation.

# Risk Management

The following risks and issues have been detected regarding plans being put in place for winter and execution of the plan. Mitigating actions have been identified along with the level of risk.

| Risk / Issue | Mitigation | RAG Rating |
|---|---|---|
| **Transport**<br>Ensuring there is enough capacity across the county as this may be restricted due to Covid | • Workshop session taking place with Urgent Care Operational Group on 5 August 2020 to identify gaps and concerns<br>• Work with the transport cell to identify alternative solutions | Amber |
| **Bed Capacity**<br>Concerns over bed capacity if demand is greater than capacity especially if there are further waves of Covid or flu outbreaks / D&V etc | • Alternative solutions to bed based admission are being prioritised through A&EDB to only ensure people who need a bed are in hospital<br>• Escalation capacity is being considered for winter in case there is a high demand for beds | Red |
| **Funding for Winter Schemes**<br>Winter schemes to mitigate demand have been identified but there may be no funding available to put in place before winter | • A process to prioritise winter schemes is already underway within the A&EDB<br>• The prioritised schemes have been presented to the ICS Executive<br>• DoFs are mandated to develop a mechanism for system decision making to support those proposals which are time critical | Red |

# Risk Management

The following risks and issues have been detected regarding plans being put in place for winter and execution of the plan. Mitigating actions have been identified along with the level of risk.

| Risk / Issue | Mitigation | RAG Rating |
|---|---|---|
| **Deliverability of Winter Schemes**<br>Winter schemes do not deliver the anticipated results so there is increased demand in urgent and emergency care services | • Schemes have been through a prioritisation process through the A&EDB<br>• Schemes that are allocated funding will be thoroughly monitored to ensure they are delivering the required results and providing the necessary mitigations | Amber |
| **Staffing**<br>The system does not have enough staffing in place for this winter and will need to consider the impact of track and trace | • Each organisation to produce a robust workforce plan<br>• Workshop session taking place with Urgent Care Operational Group on 5 August 2020 to identify gaps and potential mitigations | Red |
| **Discharge to Assess and Care Package provision**<br>The system does not have enough capacity for D2A and packages of care this winter | • Alternative solutions were put in place for Covid and these could be stood up again if required<br>• Strategic Programme Board in place which will have oversight and can step up provision if needed | Red |

# Risk Management

The following risks and issues have been detected regarding plans being put in place for winter and execution of the plan. Mitigating actions have been identified along with the level of risk.

| Risk / Issue | Mitigation | RAG Rating |
|---|---|---|
| **Critical Care Capacity**<br>Concerns over whether there will be enough critical care capacity if there is a further wave of Covid or flu | • Critical care bed demand and capacity modelling being produced<br>• Potential use of Nightingale Hospital in Bristol | Amber |
| **Use of Voluntary Sector**<br>Capacity of the voluntary sector and how they can support the system | • Review voluntary sector contribution and identify gaps<br>• Identify funding opportunities for the voluntary sector within Somerset or how they can contribute to existing contracts in place | Amber |
| **Implications of Brexit**<br>Will there be issues with planning for Brexit such as staffing, medications etc that will impact on winter | • EPRR leads to plan for mitigations<br>• Regular updates from EPRR leads at Urgent Care Operational Group | Amber |