ABMU SEASONAL PRESSURES CAPACITY AND ESCALATION PLAN - 16/17 (20/10/2016)

1. INTRODUCTION

The ABMU Seasonal Pressures Plan builds on the Health Board's existing programme for unscheduled care improvement which includes the following workstreams:

- Implementation of **111** from October 2016
- Continued roll out of **Ambulatory Emergency** Care pathways on all hospital sites, as part of the redesign of both acute medicine and emergency surgery (and linked with external review of medicine at Morriston in September 15.
- Continued focus on tighter **internal standards and processes** to support unscheduled care and escalation on sites and between sites
- Continued implementation and testing of DU recommendations regarding **discharge** at all sites and localities, with care home pathways to be included from November onwards
- Improving **patient flow processes** and capacity on acute sites through additional coordinating and navigator roles (in place from September onwards)
- Continue to consolidate and expand **community health and social care services and models** of care to facilitate timely discharge through Western Bay Programme
- Continue to work with **WAST** on a number of opportunities to develop alternative pathways

A total of £1.25m investment has been made available to support implementation of these plans, as well as the contribution from ICF and primary and community services funding streams.

The purpose of this final version of the seasonal plan is to set out the additional measures that are being put in place for the winter period, over and above the existing work streams. In simple terms it considers:

- Actions to reduce the anticipated peak in demand
- Actions to flex capacity on a short term basis
- Actions to manage escalation
- Actions to manage ongoing risks during this period

2. BACKGROUND

Patterns of service delivery have changed significantly over the last few years as a result of specific service changes between sites, new service developments and staffing challenges. Consequently the Health Board commissioned a demand and capacity review by CAPITA to help quantify the size and nature of any predicted gaps for the winter period.

In summary the outcome of this exercise was as follows:

- The current medical bed pressure being "absorbed" by the system (as evidenced in outliers, 12 hour breaches, pre emptive patients) equated to **64 beds** across the Health Board. This is the baseline gap and is clearly the focus of the current improvement workstreams many of which are targeted at releasing bed days.
- Based on analysis of the last two winters the additional pressure that could be experienced during this period equates to **27 beds** across the Health Board
- Additional growth in 16/17 could equate to an additional **15 beds across the system.**

The total capacity gap of between **91 and 105** beds is fairly evenly split between Morriston, Singleton and Princess of Wales Hospital – each looking to create the equivalent of **at least one ward's worth of capacity** to address the total bed gap as shown on the table below.

Total	Current	Baseline Occupancy avoiding outliers	Scenario 1 2016/17 popn
Core Medical Beds	**786**	**850**	**865**
Winter Medical Beds	**786**	**877**	**892**
Morriston	**Current**	**Baseline**	**Scenario 1**
Core Medical Beds	217	235	239
Winter Medical Beds	217	248	253
Neath Port Talbot	**Current**	**Baseline**	**Scenario 1**
Core Medical Beds	132	132	135
Winter Medical Beds	132	131	134
Princess Of Wales	**Current**	**Baseline**	**Scenario 1**
Core Medical Beds	222	242	247
Winter Medical Beds	222	251	255
Singleton	**Current**	**Baseline**	**Scenario 1**
Core Medical Beds	215	240	245
Winter Medical Beds	215	246	250

There is clearly an important role for communit**y** health and social services in contributing to this gap – and the broad assumption from the modelling was to work on the basis of 25% (ie **between 23 and 26 beds).**

(It is worth noting that whilst modelling provides a helpful guide to inform our plans, it is not an exact science that can predict what will happen in reality.)

3. ACTIONS TO MITIGATE DEMAND

The Health Board is implementing a number of schemes, and is developing new service models which will assist in reducing demand into our acute services over the winter months. These include

- The development of a comprehensive **flu plan,** building upon lesson learnt from previous years. This year's plan includes training an increased number of flu champions with the aim of achieving increased uptake in inpatients in the adult high risk groups, and in the 2-3 year age group.
- New clinically led **111 service** launched on 4th October, with phased implementation completed by mid October. This service simplifies patient access to urgent care services out of hours, and ensures that patients are assessed and managed by the most appropriate health care professional.
- The provision of 3 **Acute Care teams** in the community providing rapid response and intervention to support patients in their own homes, including care homes. These services are consultant led and operate 7 days within Swansea and NPT with aim of expanding the 5 day service in Bridgend. The recent development on **acute GP outreach service** in Swansea also provides enhanced capacity and expertise within this team
- The development of **Pulmonary Rehabilitation** services across all our community clusters. Staff are currently being recruited and it is expected that this expanded service will be available in the New Year
- The systematic roll out of **Anticipatory Care Planning (ACP**) across our cluster networks to stratify and identify those community based individuals most at risk of admission and developing AC plans to prevent admission to hospital or long term care. The focus of this work over the winter months will be on the provision of plans for patients with respiratory conditions and in the last year of life. Each individual at risk of admission will have an appointed Care Navigator. Influenza vaccination will be proactively targeted to this cohort of individuals.
- **Care Homes Enhanced Service** provides regular GP review to maintain care home placement and prevent patient deterioration which could trigger an admission
- Two new **Care Home Advisors** recruited to proactively work with care home staff to improve capability and clinical skills to better manage care home residents and with the aim of improving care and reducing inappropriate and avoidable admissions from care homes
- The introduction of a new **D&V pathway** between WAST and our community services to prevent un-necessary admissions to hospital.
- Increased **community pharmacy capacity** at weekends and bank holidays for medication dispensing and increased **community dental capacity** for dental emergencies.

The impact and potential benefit of these initiatives has not been built into the capacity and demand scenarios outlined below as they are all in a developmental stage.

4. ACTIONS TO FLEX CAPACITY

Each site has developed proposals to offset the predicted capacity gap through a balance of beds and bed equivalents, based on consideration of local opportunities

to create physical space as well as the feasibility of staffing additional capacity or initiatives in the context of the critical nursing and medical shortages.

4.1 MORRISTON HOSPITAL

Surge Capacity

There is no surplus in patient accommodation on the site. Therefore the main opportunity to flex capacity is through a small capital scheme to convert office accommodation into an **8-10 bedded area**. It is anticipated that this work will be complete by **1 February** at the latest and will deliver wider benefits than just the number of beds per se:

- The new accommodation will house the Theatre Admissions Unit which is currently located adjacent to ED in a much larger facility. This will ensure that the site continues to have the flexibility to admit priority elective patients through the winter, recognising that the vast majority of the surgical work undertaken on the Morriston Hospital site is clinically urgent/complex or cancer related. It does however reduce the size and therefore the flexibility of TAU to support the elective streams.
- The "old" TAU accommodates up to **18 trolleys** and it is proposed that the use of this area is utilised as a Clinical Decision Unit for both medical and surgical streams, to support ED but also to facilitate early senior decision making and faster turnaround of patients. It is anticipated that this will have a beneficial impact on patients waiting 12 hours and in turn this will benefit the 4 hour waits.

So whilst the overall gain to the site is only **8 – 10 beds**, the gain to the emergency pool is approximately **18 beds/trolleys.**

Prior to the completion of the capital scheme the plan is to open the existing TAU at nights and weekends during of December and January (subject to staffing) in order to provide increased flexibility. This provides additional flexibility of up to **8 beds at peak times.**

Clearly a review will need to be undertaken in April 17 to assess what benefits have been delivered as a result of the new Clinical Decision Unit and whether this is something that the Health Board wishes to continue.

The capital costs associated with this will be met from the Health Board's discretionary capital and the additional revenue costs will be met from the Seasonal Pressures Plan provision within the financial plan.

Schemes to provide "bed equivalents"

The Morriston Hospital Unit plan contains a number of additional actions which have the potential to deliver a gain equivalent to **23 beds.** These schemes include the following:

- New D&V pathway with WAST to avoid conveyances

- Non weight bearing pathway to a care home – piloted successfully during summer
- Increased use of discharge lounge for stretcher and sitting patients
- Hot clinics in surgery to reduce admissions
- Speciality hot clinics agreed with Gastroenterology and respiratory medicine and for DVT patients.
- Ongoing improvements to acute medicine and assessment model
- Social work presence in ED
- Continued focus on Frequent attenders
- Use of residential care home capacity to support patients awaiting a package of care start date.

Outflows to other Hospitals

Morriston Hospital also depends on effective flow into other hospitals and is suggesting a clear standard for transfer times that would release **7 beds** currently occupied by patients waiting to go to other hospitals. This already forms part of the weekly performance metrics within the Health Board and will continue to do so. The delivery of these beds is dependent on outflow issues at the other hospitals however.

Responding to Pressures on Respiratory Service

Reconfiguration of the medical wards at Morriston hospital in April 2016 resulted in increased designated bed capacity on this site for respiratory patients. This change has been supported through enhanced medical cover as a result of new consultant appointments which has resulted in a more efficient way of working in this service – ensuring patients are being managed by the appropriate speciality team.

Morriston hospital will also be providing respiratory hot clinics to support ward discharge and emergency referrals from 1st December. There will be a senior nursing role dedicated to co-ordinating respiratory capacity and access to senior opinion from the beginning of December throughout the winter period.

Responding to Pressures on Critical Care

The Morriston Delivery unit is currently reviewing its critical care escalation plan in the context of the winter pressures experienced in 2016, recent infection control issues in the Burns unit at Morriston hospital, and recently enhanced cardiac surgery critical care capacity. The escalation plan includes the use of theatre recovery when emergency demand exceeds available ITU capacity.

The unit has invested in the development of a 7 day critical care outreach service to support acutely unwell patients on inpatient wards. This service helps to avoid admissions to ITU as well as facilitating earlier discharge.

Other actions include:

- Twice weekly Critical Care Meetings take place involving representatives from each of the 3 critical care areas, where staff are flexibly utilised where

appropriate to support the 3 units. At times of increased pressures daily staffing/capacity meetings take place

- Critical care nursing staff are not allocated annual leave over Xmas/New Year period.
- The Lead Nurse for the Vascular Access Service has been appointed, with further appointment to the Band 6 post progressing. This service whilst early in its development is impacting on earlier discharge of patients.

Reducing Elective Work

The Unit has also considered any opportunities to reduce routine elective work during this period, beyond what has already been included above in relation to the reduced size of TAU. However, the level of routine work on the site is relatively low, and would release a limited number of beds. Consequently the Unit is progressing plans to reconfigure the way in which surgical wards are managed over the winter, with the aim of separating elective and emergency surgical ward capacity. Whilst this will not directly result in increased bed capacity it will improve productivity and flow. The Unit also has a plan to improve joint working with Singleton in relation to transferring suitable elective work during the winter period.

4.2 PRINCESS OF WALES HOSPITAL

Surge Capacity

There is no surplus inpatient accommodation on site. The main opportunities to flex capacity are as follows:

- Cancelling elective work undertaken through Bridgend Clinic from January which will realise 9 beds for NHS activity. This will free up **9 beds** on the main hospital site to improve the emergency bed pool and in particular reduce the impact of trauma outliers on medical wards. This proposal could be activated for 1,2 or 3 months depending on the pattern of demand that emerges. It does however have a detrimental impact on the Health Board's income position.

Schemes to provide "bed equivalents"

The Princess of Wales Hospital Unit plan contains a number of actions aimed at delivering potentially 10 "bed equivalents". These schemes include the following:

- Social work and therapy presence at the front door
- Roll out of SAFER Bundle to next two wards
- Improvements in the assessment process for patients long term care
- Extended 7 day cover of the acute response team
- Enhanced community liaison/ discharge support to facilitate earlier discharge .

There are additional schemes being explored given the shortage of care home capacity in this area, but the likelihood of any short term solutions is very low.

Responding to Respiratory Pressures

The plan to enhance respiratory capacity at this hospital will be to release Consultant capacity within the respiratory specialty to facilitate earlier senior medical review and advice for patients in the Acute Medical Unit. This should improve flow by ensuring appropriate treatment is provided early in admission, allow prioritisation of patients from the front door to the respiratory ward and also provide expert advice on the provision of NIV to ensure only the appropriate patients receive it.

Responding to Critical Care Pressures

Princess of Wales hospital is funded for 4 level 3 beds and 4 level 2 beds, with resources provided to flexibly expand into the 9th bed within the ITU environment , subject to securing additional staffing. The escalation plan includes the use of theatre recovery for the management of critically ill patients at times when emergency demand exceeds funded capacity.

There is also a critical outreach team in place at the Princess of Wales hospital Monday to Friday.

Reducing Elective Work

It is estimated that routine elective work only occupies a maximum of 7 beds on the hospital site at any one time. It is therefore proposed that cancellation of this work will be reviewed throughout the winter period on a day by day basis, as there are often opportunities to flex admissions by creative use of Day Surgery and Short Stay Unit to mitigate against cancellations. The Bridgend Clinic option outlined above already supports streamlining surgical work on the site.

4.3 SINGLETON HOSPITAL

Surge Capacity

The main opportunities to flex capacity at Singleton Hospital involve utilising day rooms and cubicles currently occupied for other purposes between January and March to create an additional **18 beds.** This approach means that the Unit can flex existing staffing up rather than attempting to staff stand-alone areas.

Schemes to provide “bed equivalents”

The Singleton Hospital plan contains a number of actions aimed at delivering potentially **7** “bed equivalents”. These schemes include the following:

- Redesign of front door to increase coverage of the Acute GP Unit service and provide a more effective assessment unit which could equate to 5 bed equivalents. This may require a period of consultation as it involves changes to the MIU.

- Additional social work capacity
- Additional discharge vehicle support
- Improvements from new patient flow team focusing on choice
- Introduction of acute oncology service in Quarter 4

Responding to pressures on Respiratory Services

The Unit intends to increase the number of hot clinic slots available for respiratory patients within the ambulatory care service, and to increase respiratory CNS presence into the assessment unit to support decision making processes.

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Elective Activity

In terms of elective capacity a plan is being developed to assess what additional work can be accommodated on the surgical ward in Singleton Hospital during the winter to reduce pressure on the Morriston Hospital. This will also include increased utilisation of the day surgery unit at Singleton for patients at Morriston requiring day surgical procedures.

4.4 NPT HOSPITAL

Surge Capacity

There is no identified bed deficit for winter beds in NPT delivery unit albeit current blockages in domiciliary care create queues of patients waiting in other hospitals. . Given the medical cover arrangements on this site the main opportunity to flex capacity is the opening of Ward A on a Sunday afternoon in order to accommodate early transfers in readiness for Monday discharges. This will help offset front door pressures which tend to escalate on a Sunday evening (potential to create capacity for **6 patients**).

Schemes to develop bed equivalents

The Neath Port Talbot Unit is planning a number of other actions to support the management of flow. These include:

- Maximising discharge to CRT, Step Up/Down, Residential/ Nursing capacity prior to the Bank Holiday period;
- Maintaining improved patient flow processes to support discharge over weekends and Bank Holiday to avoid batching and queuing at the acute sites;
- Providing additional Hot Clinic activity in Ambulatory Emergency Care, including some weekend cover
- Supporting enhanced therapy cover at weekends in acute sites to support admission avoidance and expediting discharge;
- Additional physiotherapist and occupational therapist hours to maximise patient discharges prior to the bank holiday period;
- Additional junior doctor cover to maximise flow across the bank holiday.

4.5 PRIMARY AND COMMUNITY SERVICES UNIT

Schemes to Provide bed equivalents

A range of proposals have been developed by the P&CS unit to increase community capacity/ patient flow across the Health Board, tailored to the particular needs and circumstances of each Local Authority Area. It is anticipated that these proposals will be funded through the ICF as they target innovative ways of caring for older people.

The key elements of this plan include the following:

- New enhanced end of life service from October 2016.
- Enhanced reablement capacity
- Extended working of community Discharge Liaison Nurses
- Team to review utilisation of domiciliary care capacity
- Further development of Common Access Points**.**
- Opportunities to flex and expand domiciliary care
- Increased roll out of discharge to assess pathways
- Roll out of non weight bearing pathways, step up and step down schemes
- Strengthened management plans for frequent attenders

Responding to Respiratory Pressures

The Primary and Community Services Plan winter plan targets the next phase of the roll out of the anticipatory care plans at those patients with confirmed respiratory conditions. Each individual at risk of admission will have an appointed Care Navigator. Influenza vaccination will also be proactively targeted at this cohort of individuals.

The unit is proactively working with GP's to secure enhanced cover through the development of GPs with special interest in respiratory care although arrangements may not be confirmed in time to have a significant impact on this winter.

4.6 SUMMARY OF BEDS/BED EQUIVALENTS

	Beds	***Bed Equivalents***	**Total**	**Modelling Deficit based on 16/17 growth**
Morriston Hospital	18	*23*	41	**36**
Princess of Wales Hospital	9	*10*	19	**33**
Singleton Hospital	18	*7*	25	**35**
NPT	6 on Sundays			
Primary and Community	0	*18*	18	
Total	**45** (Plus weekend flex of 6)	***58***	**103**	**104**

5 ACTIONS TO IMPROVE ESCALATION

All acute sites have reviewed their escalation plans, processes and action cards.

Morriston and Princess of Wales hospitals will shortly be confirming their updated LEAPS and handover arrangements with WAST. Site based meetings are taking place by early November to confirm these plans and in particular:

- Options to divert ambulances to alternative pathways
- Early warning systems to initiate divert processes
- Future deployment of HALOs
- Opportunities and risks of additional capacity vehicles.

Within ABMU the agreed Health Board wide pre-emptive or “boarding protocol” is a key part of our escalation process to create capacity in the Emergency department. This protocol results in additional patients being moved to wards/ discharge rooms over and above their established bed capacity, following a risk assessment process, and supports the early release of ambulance crews.

Other arrangements in place to improve escalation this year include:

- Director of the Day model to ensure maximum escalation of any issues impeding flow;
- Development of agreed inter professional standards (eg specialty response to ED)
- Additional patient flow navigators and coordinators at front doors to ensure pre emptive action is taken to escalating pressures

- Ability to convene additional multi agency conference calls in addition to the planned twice daily conference call arrangements already in place.
- Twice daily escalation calls with CRT and Local Authority – discussing patient level plans;
- Weekly detailed Highlight Meeting of complex patients (with LA and CRT partners;
- Daily executive led escalation of patients with other Health Boards where repatriation exceeds 48 hours.
- Invoking surgical clinical cabinet which is a daily review meeting to support and match planned surgery and available capacity at Morriston and Singleton hospitals
- Strengthened bed management/system wide capacity awareness including community care availability.

6. ACTIONS TO ADDRESS KEY RISKS

There are two main risks that will affect the delivery of the above plan.

Staffing

The impact of current shortages cannot be overstated. We currently have 332 nursing vacancies and 113 medical vacancies. In addition to the ongoing focus on recruitment, retention and rostering, the main opportunity available to the Health Board is to encourage its own staff to offer more shifts to the bank. We are currently developing initiatives to improve supply of internal bank staff. A number of different options are being modelled with an aim of agreeing this in early November.

LA capacity/commissioned capacity

There are already significant risks in the system associated with shortfalls in capacity – be it social work capacity at hospital sites, care homes, or domiciliary care. We have agreed with LA partners to undertake a joint capacity modelling exercise for community services, but the timing of this will not inform any specific actions for the seasonal pressures plan – it will however inform the development of the IMTP. In the meantime a targeted review of domicilary care capacity is being undertaken using ICF funding.

Measures to address the risk in 16/17 include the following

- Joint agreement to use non recurrent ICF to support schemes that help make best use of existing capacity – this includes preventative work, extended support from the third sector, further development of the “What Matters to Me” model in the community including non weight bearing pathways, step up and step down options, review of traditional models for allocating domiciliary care capacity.
- Development of seasonal pressures plan through Western Bay Community Services Board with full involvement of partners.

- Escalation of risks as necessary to the Western Bay Leadership Group and / or individual Chief Executives.

7. COSTS

Each of the Service Delivery Units received an allocation of investment to support the Unscheduled Care Improvement Programme at the start of the year amounting to just over £1.1m.

In addition an allocation was also held centrally towards the "winter plan" equating to approximately £500k. This will cover the basic costs of the winter plan but will not cover the costs of making all the additional capacity options outlined above available for the full duration of Q4. Other than the Morriston bed capacity options the other schemes would only be affordable for a 1 month period. Given the unscheduled care pressures facing the Health Board, together with the other access targets, it would be desirable to fund the capacity options on all sites for the full 3 months – particularly as the last two winters have seen spikes in demand in different months. This would roughly double the cost associated with the winter plan. As this is in excess of the current financial plan and in view of the Health Board's financial challenges it is anticipated that these discussions will be finalised as part of the current targeted intervention process in the near future.

It should be noted that any financial risk to the Health Board is linked closely to the feasibility of recruitment to these schemes.

The costs identified exclude the schemes identified by the Primary and Community Services Unit, as these schemes will be supported through ICF funding where appropriate.

8. PERFORMANCE

The effectiveness of this plan will be monitored through a number of system wide indicators, both in terms of in year trends and comparison with last year:

- Impact on unscheduled care performance standards – 4 hour, 12 hour, 1 hour, ambulance response times
- Cancellations of operations due to beds
- Critical care utilisation and DToC's
- Medical outliers
- Use of pre emptive policy
- Transfer times between hospitals
- DToCs and discharge fit numbers

9. CONCLUSION

A detailed level of planning has been undertaken to give the Health Board the best possible chance of mitigating the impact of seasonal pressures – not just on unscheduled care but on the wider system.

The components of the plan have a high degree of ownership from the Service Delivery Units and align with the broader actions of the Health Board's Unscheduled Care Improvement Programme.

Effective risk identification and risk management will remain essential however as there are a number of factors that could affect the success of the plan.

This plan will therefore continue to evolve and adjust as the winter approaches.

Alex Howells

Chief Operating Officer

20 October 2017