NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

System Surge Plan 2024/25

Integrated Care Board
November 2024

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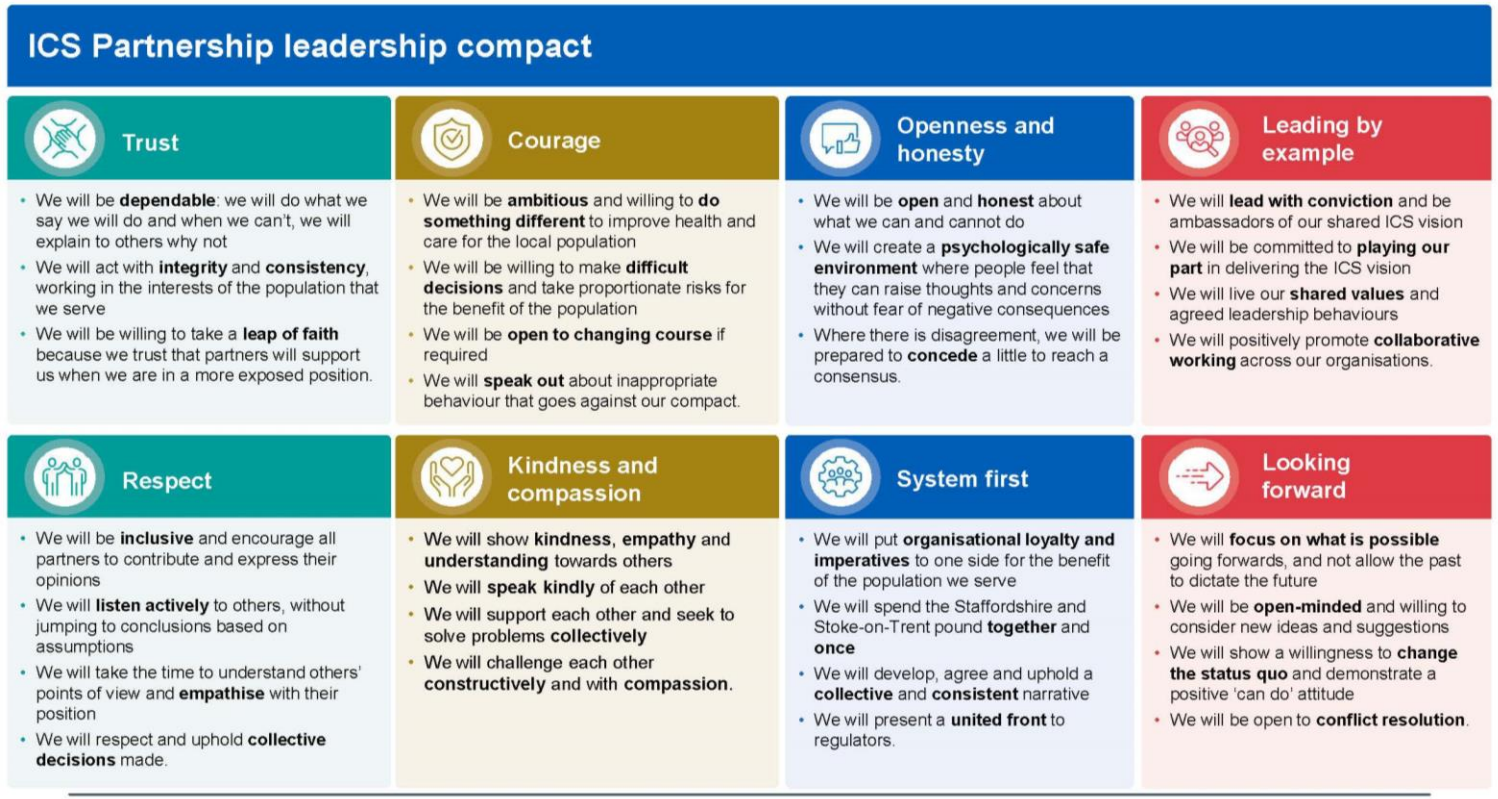
Approach:

The ICS Partnership leadership compact is at the forefront of the UEC Portfolio, it supports the entirety of the governance structure and progressive system development.



2023/24 Lessons learned: Key learning points

What worked well?	What requires improvement?	Key priorities
Winter Planning development & governance processes	Early mobilisation of workforce – role specificity and flexibility	Promote and celebrate success
CRIS – pull from WMAS 999 stack, admissions, conveyance & dispatch avoidance	Recalibrating plans to maximise impact	Linking Surge planning to the System Recovery Programme & Demand Management work
The development of a single System plan, taken to all partner Board meetings	Targeting resource to high impact schemes/initiatives	System-wide sharing of candidates and recruitment
Further development of the System Escalation plan and associative actions	Eradicate the normalisation of sub-standard practice	Engagement with Primary Care. Focus on maximising primary care resources
Industrial Action response – SCC coordination	Staff engagement and communication at times of escalation	Analysis of Critical Incidents and embedding the learning from CIs
Utilisation of wider system partners (i.e. Staffs Fire Service – falls active response)	Learning from Critical Incidents – focus on proactive prevention of CIs	Continued development of System Escalation Plan/approach to Risk
Mutual Aid	Proactive planning for additional funding	Improving engagement and partnership with Local Authorities
Implementation of the Out-Patient Antibiotic Therapies (OPAT) service at RSUH	Adherence to Leadership Compact in times of stress/periods of escalation	Building upon & further embedding the System Leadership Compact
Timely mobilisation of capacity	Utilisation of predictive data and BI to inform Early Warning Signs	Building an improved relationship with WMAS
	Data capture and tracking indicators	Increased utilisation of alternative resources (eg Voluntary Care Sector)

2023/24 Lessons Learned: Actions and outputs

Behaviours & Approach	Escalation & Risk Sharing	Finance & Planning	Embedding Learning
Adherence to the System Leadership Compact & empowerment to speak up	Continued refinement of the System Escalation Plan and Risk sharing	Clear timeframes and costings for known escalation capacity to inform planning	Qualitative assessment of Winter/Surge plan
System Capacity Model refresh to inform early System Surge planning	Assessment of predictive BI/Data to better define Early Warning metrics	Assess candidate sharing and further collaborative recruitment initiatives	Winter Lessons Learned session undertaken, outputs to be shared with partner organisation board meetings
Engagement and advanced work with Primary Care	Assessment of Critical Incident response actions and data to inform future approach	Refresh of the System Bed Model with updated 2023/24 data	Utilising Lessons Learned event outputs to shape system planning
Greater involvement and input from voluntary care and other sectors	Further development of Early Warning metrics and triggers	Prioritisation of resource/spend allocation	Defining outcome measures and metrics to evaluate future plans at the outset
Alignment with System portfolios – i.e. Demand Management		Prioritisation of future plans; doing more of what works and dedicating less resource to what does not	

Priorities

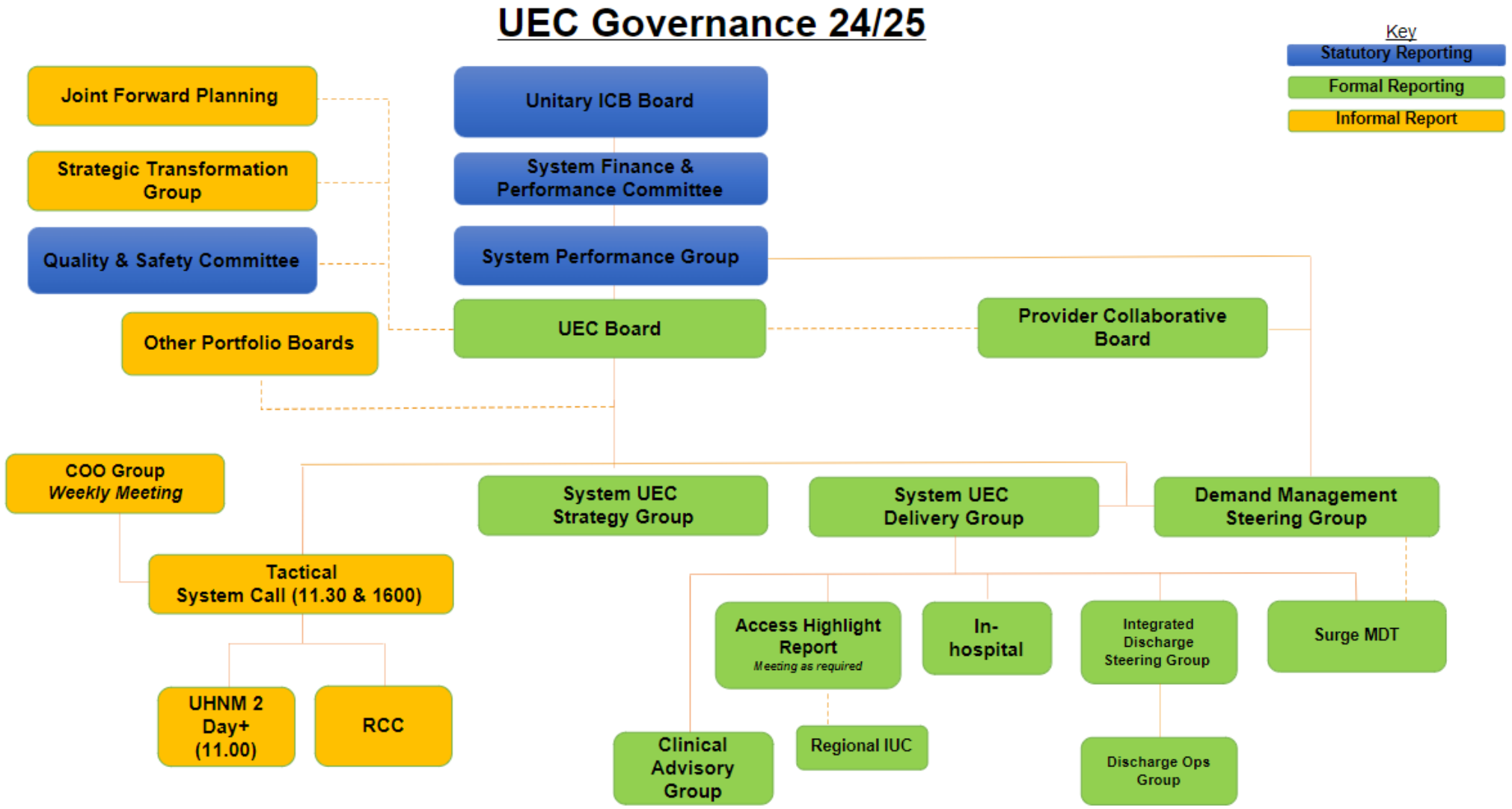
Seven key areas of focus for SSOT Surge Plan:

1. Using our lessons learned to reflect and continue our improvement journey
2. Risk sharing across the system
3. Maintaining patient safety and experience
4. Supporting people to stay well
5. Admission avoidance
6. Focus on reducing duplication with clear priorities
7. Teamwork and compassionate leadership is the culture needed across the ICS to manage the challenges

Maintaining Quality throughout the Winter at UHNM

- Supporting divisions/directorates with themes/trends in reported incidents to inform propionate responses to incidents with system wide actions to support improvements
- Continued support for wards/departments through our internal accreditation processes
- Using our “Harm Free Educator” role to support frontline teams with education and support
- Supporting “Home care is best care” with emphasis on prevent of deconditioning, timely patient review, use of ACAH/Virtual ward capacity and empowering patients to ask “When am I going home?” at ward rounds
- Biannual “Big Bed Clean” – to support a reduction in infections going into the Winter months

Governance structure



Proposed Governance & Sign-off

Meeting	Anticipated Date	Mtg date
System Performance Group	September	25.09.24
UEC Clinical Advisory Group	September	26.09.24
UEC Board	September	26.09.24
System Quality & Safety Committee	October	09.10.24
UHNM Trust Board	October	10.10.24
Clinical Senate	October	10.10.24
ICB People Committee	October	16.10.24
SOTCC Operational Business Meeting	October	29.10.24
EPRR scenario testing	October	TBC
NSCHT Trust Board	October	30.10.24
System Performance Group	October	30.10.24
MPFT Trust Board	October	31.10.24
Finance & Performance Committee	November	05.11.24
SCC Health & Care SLT	November	05.11.24
Staffordshire Health OSC	December	TBC
Stoke-on-Trent Health OSC	December	TBC
ICB Board (ratification)	November	21.11.24

Scope

- This is Staffordshire and Stoke on Trent (SSOT) ICS Surge Plan.
- SSOT ICB are the responsible ICS for UHNM, MPFT & NSCHT.
- Queen's Hospital, Burton (QHB) modelling and mitigations are included to reflect the impacts and implications for SSOT patients. Overall responsibility for UHDB Trust planning is managed via the Derbyshire ICB.
- Given our flow we are linked with RWT colleagues to understand their assumptions, however their acute bed plan is being managed by Black Country ICB. It is recognised that we also have large volumes of flow to Walsall and Dudley which the plan supports.
    - The interdependency of the SSOT community offer is clear and is managed through the UEC System Surge MDT & System Delivery Group, reporting to UEC Board.

Note: the System Surge Plan is under continual review and detail may be subject to change through the system surge planning MDT and ratified through UEC Board.

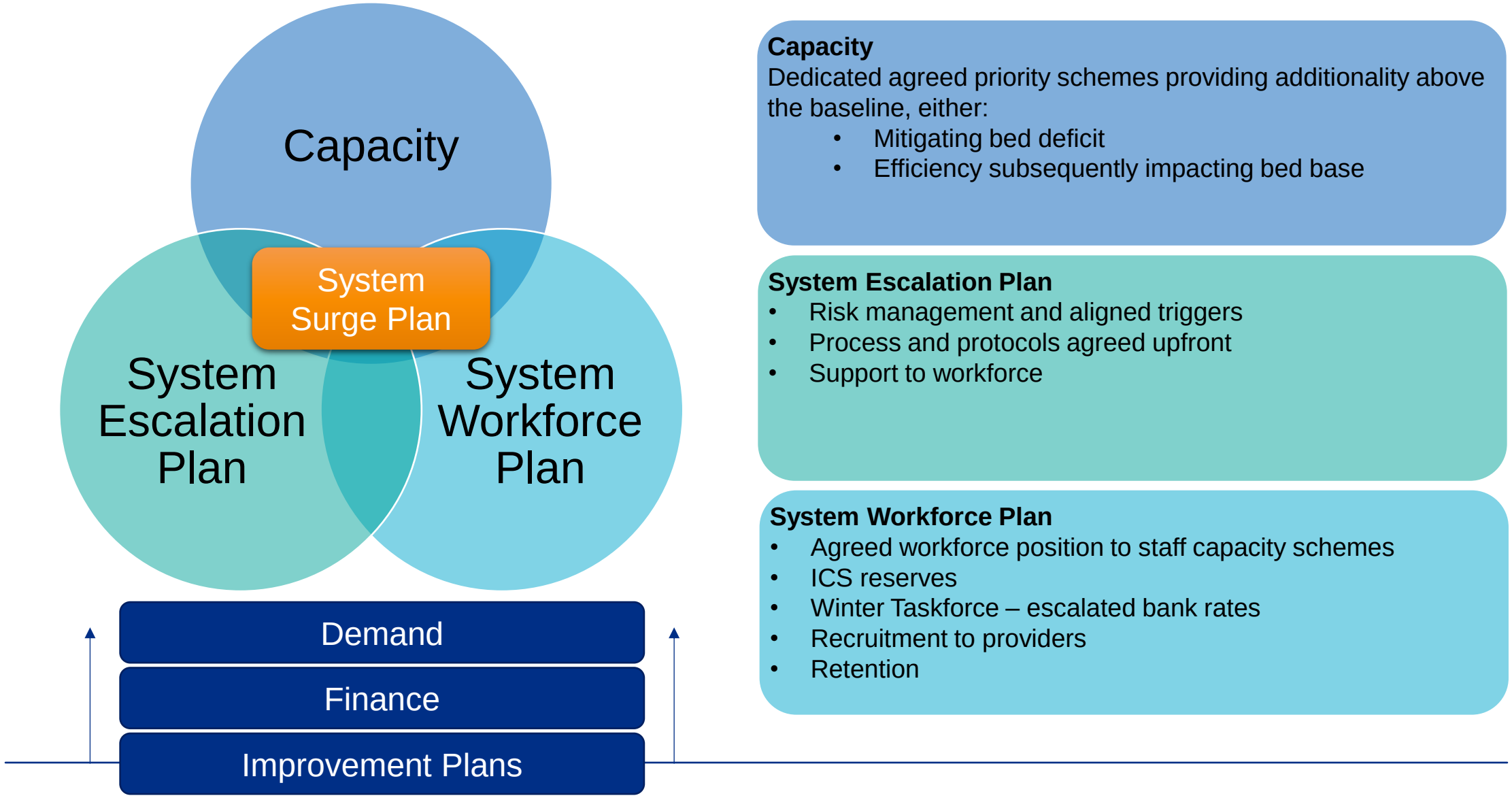
Risk register

Risk Title	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score
UEC Workforce/Staffing	If we fail to improve on the current vacancy rates, or experience increased staff sickness	Then there may be an acute impact upon the system	Resulting in workforce constraints dictating that the system is forced to prioritise urgent services - with a negative impact upon patient flow/patient experience/safety and experience and may lead to negative publicity and increased scrutiny.	**12/08/2024**	Target date extended by 1 month due to delay in review. System Workforce plan in development, in line with System Surge plan development. Full update & refresh due for September deadline	31/03/2025	**25 (5x5)**	**15 (5x3)**	**10 (5x2)**
System Surge Capacity	The system is unable to mobilise sufficient additional surge/winter capacity to offset forecast increased levels of winter UEC activity	The UEC system risks becoming overwhelmed by additional activity and unable to effectively cope with increased demand	Impacts upon patient outcomes, patient safety, patient quality of care, system performance, system resilience and increased regulatory scrutiny	**06/09/2024**	System Surge MDT will hold responsibility for design, implementation and management of System Surge plan. The system capacity model (the system bed model) has been fully refreshed in order to forecast expected levels of excess demand across all system sites. Allowing planning to focus on required capacity, schemes and initiatives to mitigate expected surge. Development of system surge proposals is well underway and a full governance road map has been agreed with presentation to relevant committees and boards anticipated to commence at the end of September. The NHSE winter letter has been delayed and (at the time of writing) is not yet received. The system surge plan will take into account NHSE direction and priorities when received.	30/04/2025	**25 (5x5)**	**20 (5x4)**	**9 (3x3)**

Risk register

Risk Title	If (Cause)	Then (Event)	Resulting in (Effect)	Date of Update	Mitigations and Updates	Target date	Inherent Score	Residual Score	Target Score
D2A Capacity	If the on-going challenges with flow from D2A capacity persist due to in pathway process delays, capacity issues and delays in patients moving onto long term placement both CHC and LA placements..	Then there will be reduced D2A capacity.	Resulting in reduced ability to support flow out of the acute hospital settings and will also impact on winter capacity plan.	**12/08/2024**	12/08/2024 - Review completed, risk remains the same. Current unmet demand is 41 with 17 patients over 4 days. Existing measures remains in place with daily monitoring via system call to ensure plans for timely moves.	31/03/2025	**15 (3x5)**	**15 (3x5)**	**3 (3x1)**
Ambulance Handover Delays	If Continued delays to ambulance handovers are incurred, and sustained or levels increased	Then there will be significant pressures placed onto ED, ambulance crews and the wider UEC system	Resulting in increased instances of patient harm, increased system capacity issues, 'lost' ambulance time & associative issues including financial costs, whereby WMAS are requesting an addition £1.591m from SSOT.	**09/08/2024**	Risk reviewed and remains static. Although there have been some improvements, there are still harms to patients occurring as a delayed responses from Ambulance service and the risk score aligns with the Ambulance Service internal risk register. Improvement plans and trajectory developed by the ICS, with the subsequence actions to support achievement are being monitor through UEC governance..	31/03/2025	**20 (4x5)**	**20 (4x5)**	**4 (4x1)**

System Surge Plan Components



Capacity
Dedicated agreed priority schemes providing additionality above the baseline, either:

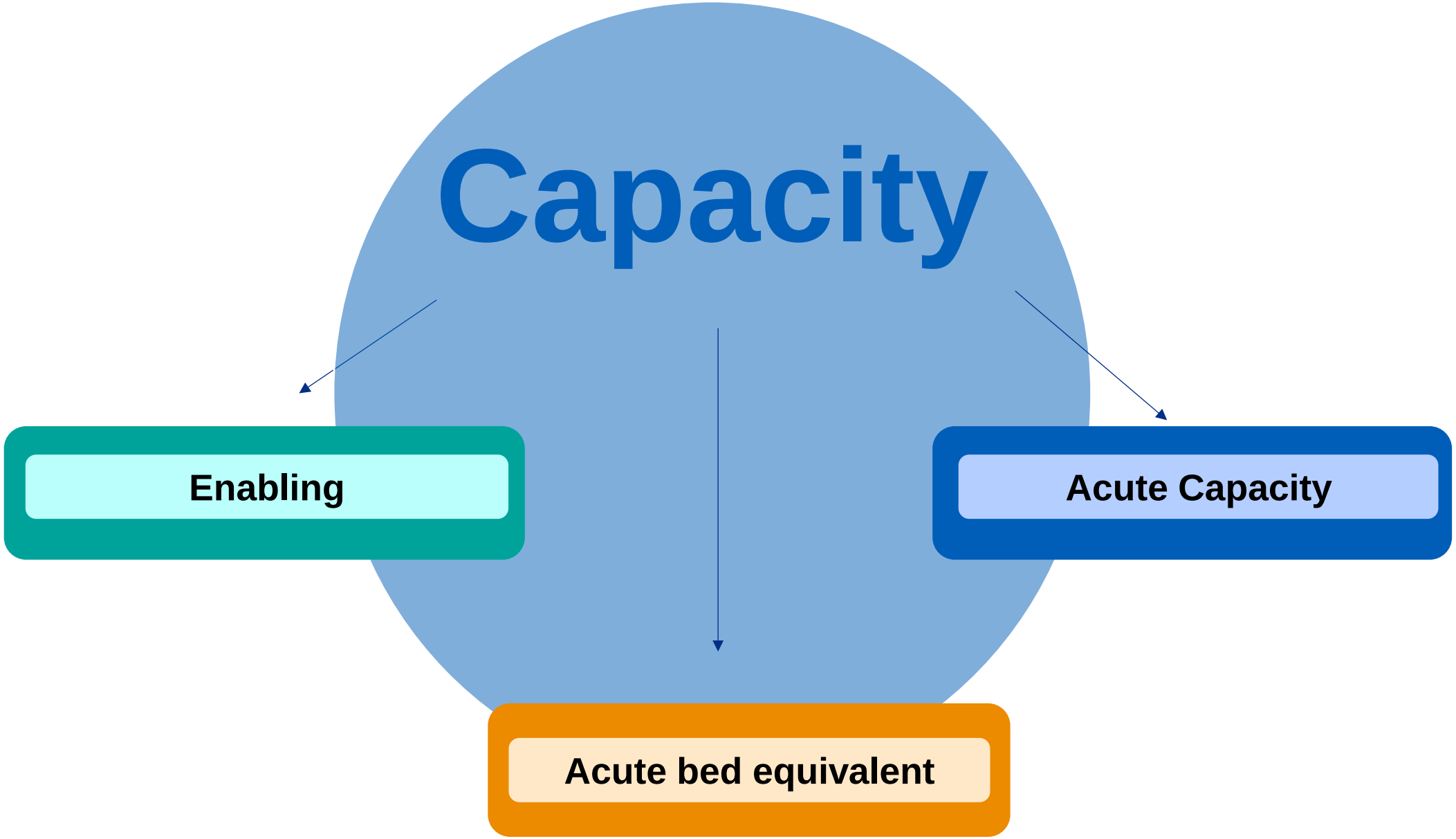
- Mitigating bed deficit
- Efficiency subsequently impacting bed base

System Escalation Plan

- Risk management and aligned triggers
- Process and protocols agreed upfront
- Support to workforce

System Workforce Plan

- Agreed workforce position to staff capacity schemes
- ICS reserves
- Winter Taskforce – escalated bank rates
- Recruitment to providers
- Retention


Capacity
Enabling
Acute Capacity
Acute bed equivalent

Inpatient Capacity Modelling

Underpinning Assumptions

- 92% Bed Occupancy.
- Medically Fit For Discharge (MFFD) at 128 patients in a bed overnight (across RSUH and County).
- An average of 33.5 Decision To Admit patientss is included in the demand for inpatient beds.
- Flu/COVID (Severe Winter Adjustment) at 2017/18 levels – this equates to a pressure of 6/7% per day.
- Annual Growth of 1.8% (as per latest Census/Demographic Data).
- Full protection of Elective activity.
- Full Year modelling undertaken.
- Average Length of Stay (ALoS) of 2.19 days. ALoS for RSUH Medical beds of 1.88 days (based on UHNM actual data).

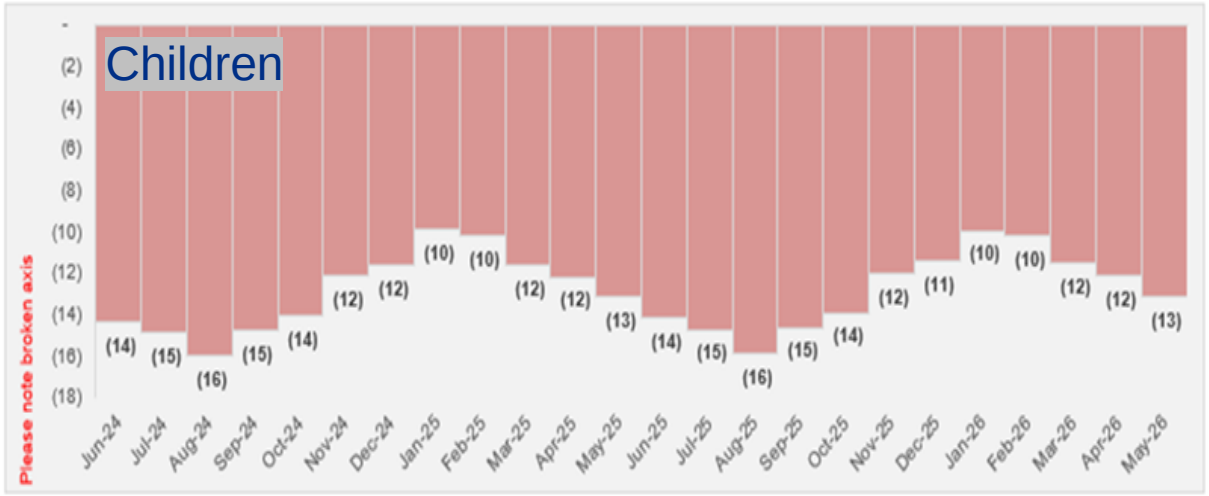
Demand

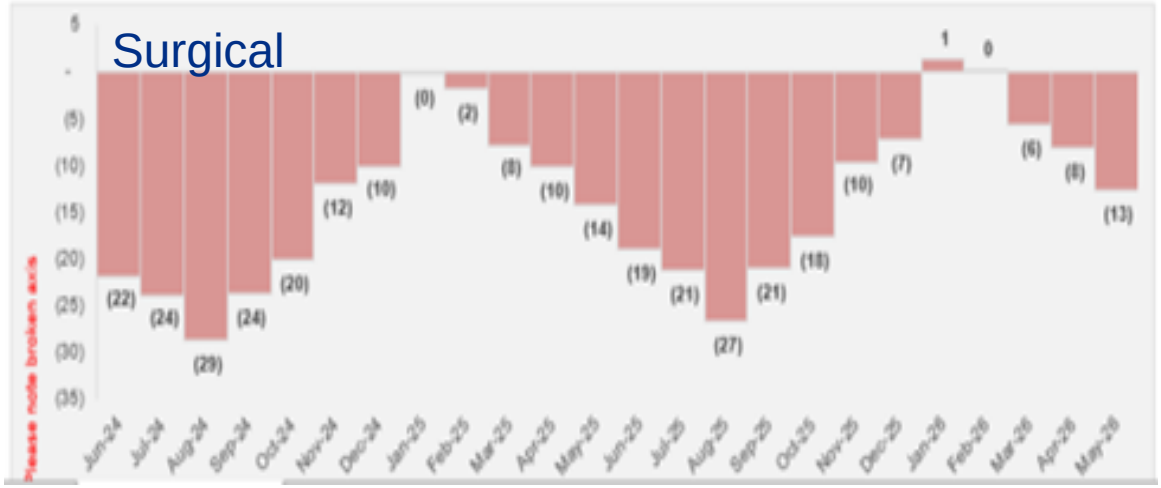
- Demographic modelling indicates that an additional 28 RSUH medical beds this year are required to meet growth (vs. modelling in 23/24)
- The model has been updated with actual UHNM data (to end June 2024) which, given levels of demand experienced last winter, has impacted upon the forecast bed demand.

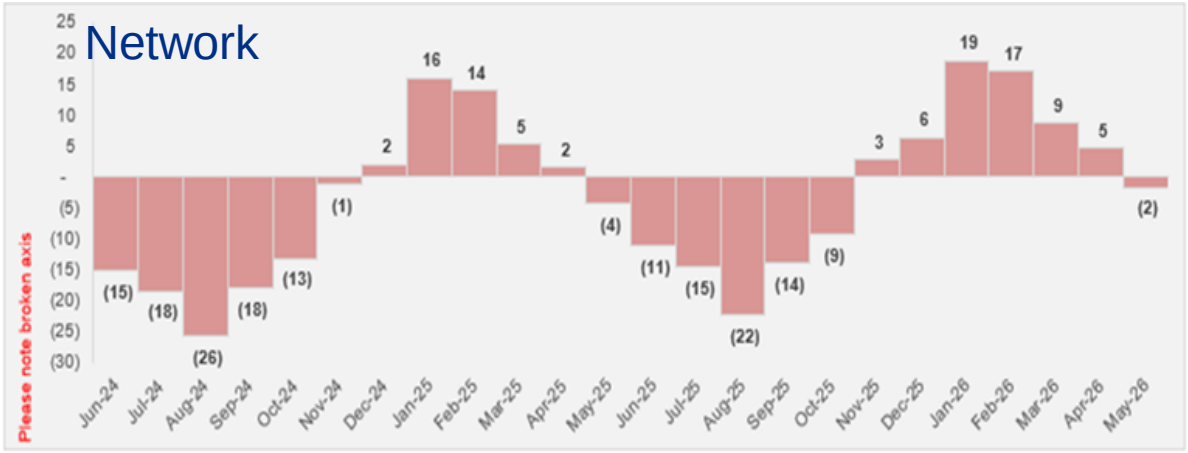
Impact upon Medical Beds at RSUH

- Demand and bed requirements are particularly acute when assessed against the Medicine division at RSUH
- It is recommended that initiatives and mitigations are targeted with this in mind (modelling illustrates Medical bed demand overleaf)
- Excess demand and bed pressures at both County Hospital and Queen's Hospital, Burton have increased this year. Mitigations included within the plan.
- Other divisions (Surgical, Network, Children and ICU) bed pressures are mitigated via internal escalation capacity

Capacity modelling – Children, Surgical, ICU and other

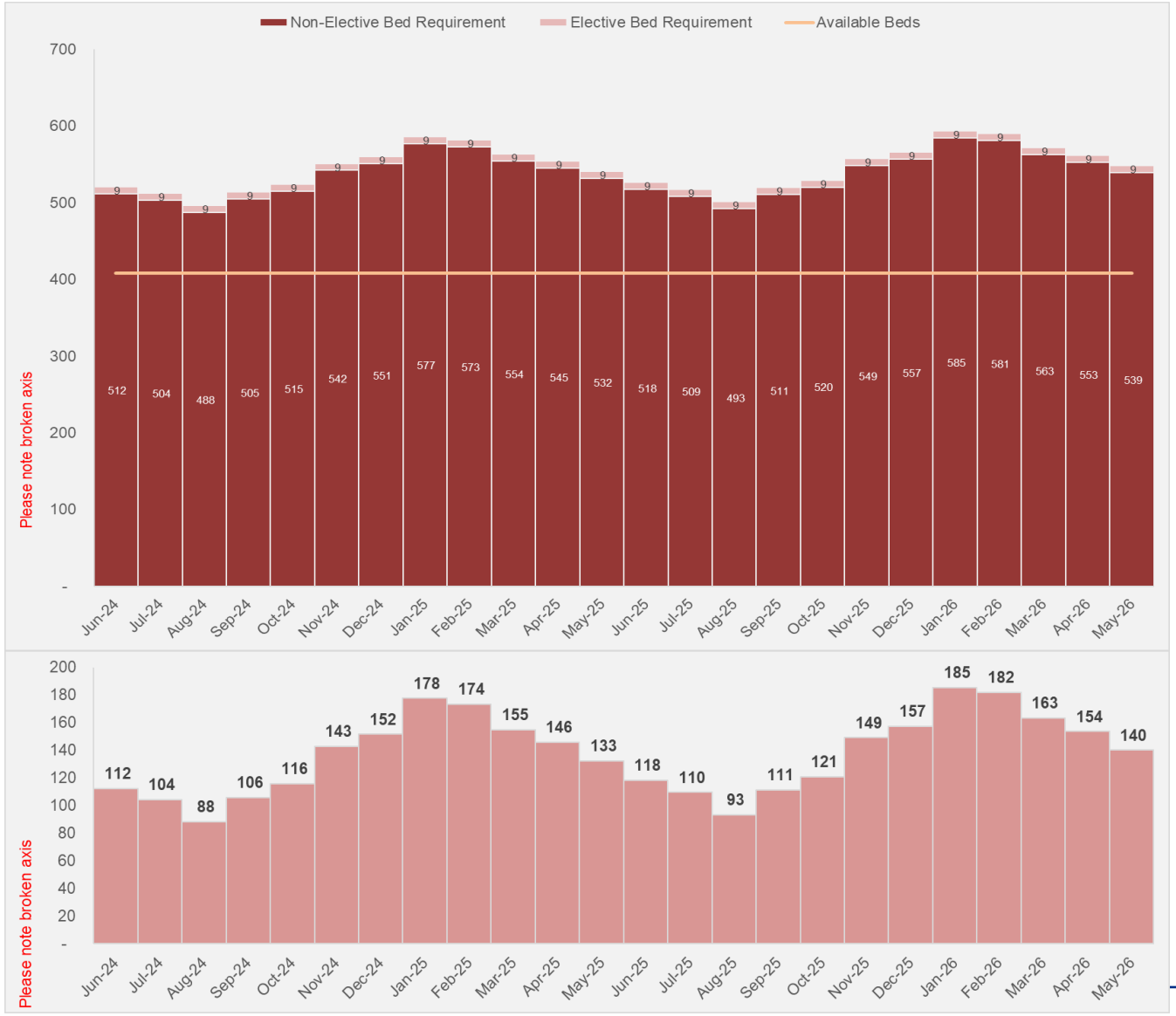






- Modelling forecasts sufficient capacity for both Children's & Surgical divisions
- Network division demand has increased to a higher level and a residual deficit of 16 beds is forecast in Jan-25.
- This is offset to a degree by internal UHNM escalation capacity leaving a residual deficit of 7 Network beds in January.

Bed Modelling – RSUH Medical



- Approach for 24/25 primary focus on mitigation of medicine bed gap at RSUH. The plan will demonstrate that non-medicine beds can be mitigated through internal divisional actions.
- Medical Beds at RSUH represents greatest area of concern and highest forecast bed gap
- Peak Bed Gap is 188 Medical Beds at RSUH Mondays in Jan 2025.
- Infection Prevention Control (IPC) considerations currently estimated at an additional -20 bed pressure.

Acronyms

AMRAU – Acute Medical Rapid Assessment Unit.

- A unit where Medical patients transfer directly from the Emergency Department following referral by an Acute Medical Physician and Senior Nurse. GPs can also refer to AMRAU

OPAT – Outpatient Antibiotic Therapies

- The OPAT Team provides a service to allow early discharge of medically stable patients who remain in hospital only because of the need for continued intravenous antibiotics.

FAU – Frailty Assessment Unit

- Unit to assess frail and elderly patients in order to facilitate accelerated discharge.

TDL – Transitional Discharge Lounge

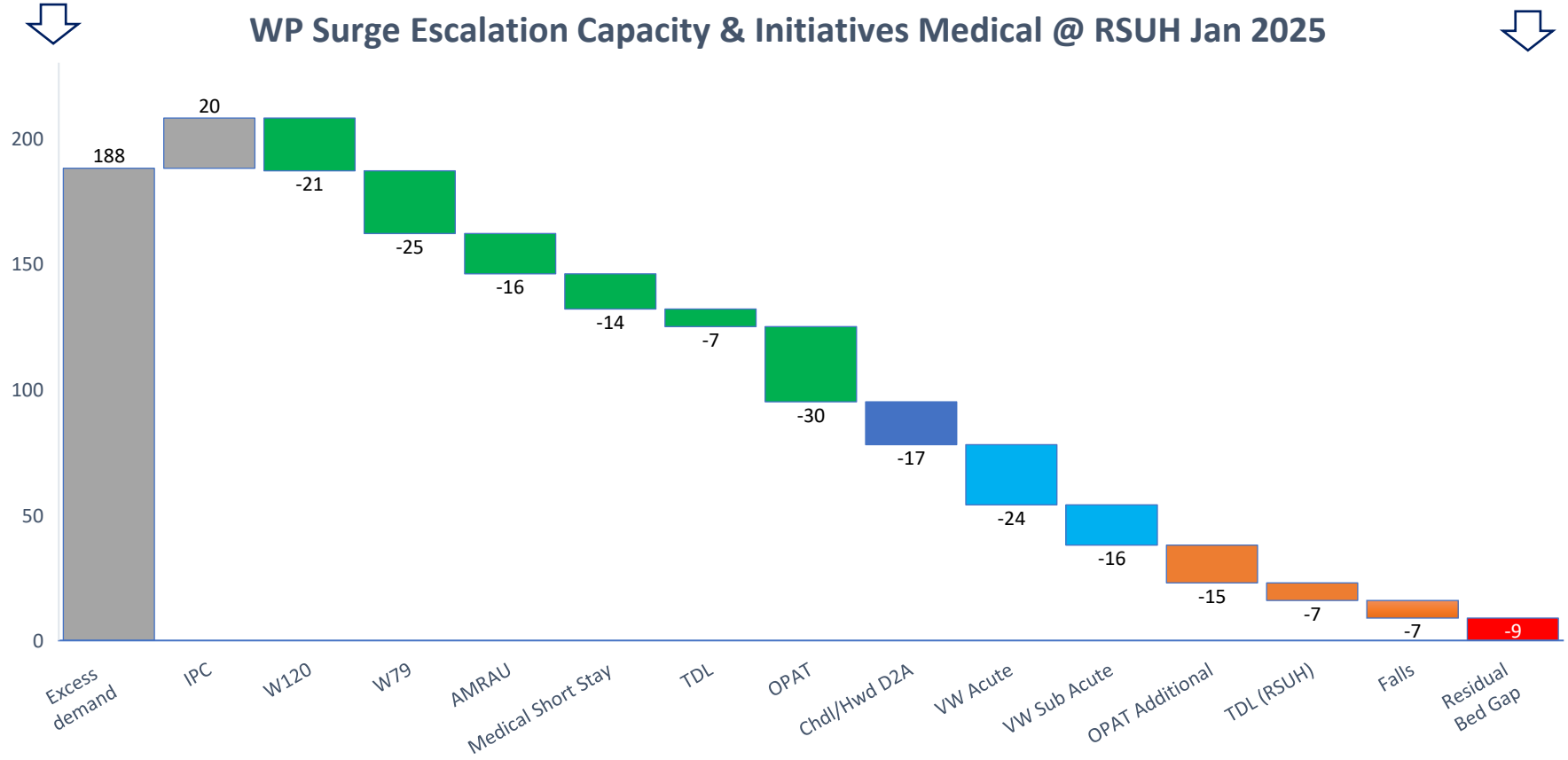
- Unit for patients awaiting discharge. Utilisation frees up acute beds for more seriously ill patients.

ACAH – Acute Care at Home

- The ACAH team oversees the Virtual Wards and other services to provide care for patients at home or in the community.

RSUH Bed Modelling – Residual Gap

Enabling Schemes: Home First Additional Capacity, Primary Care, HALO, NEPTs, Falls Service, Mental Health, CYP, ICC, Public Health initiatives.



Enabling Schemes outlined within Surge Plan

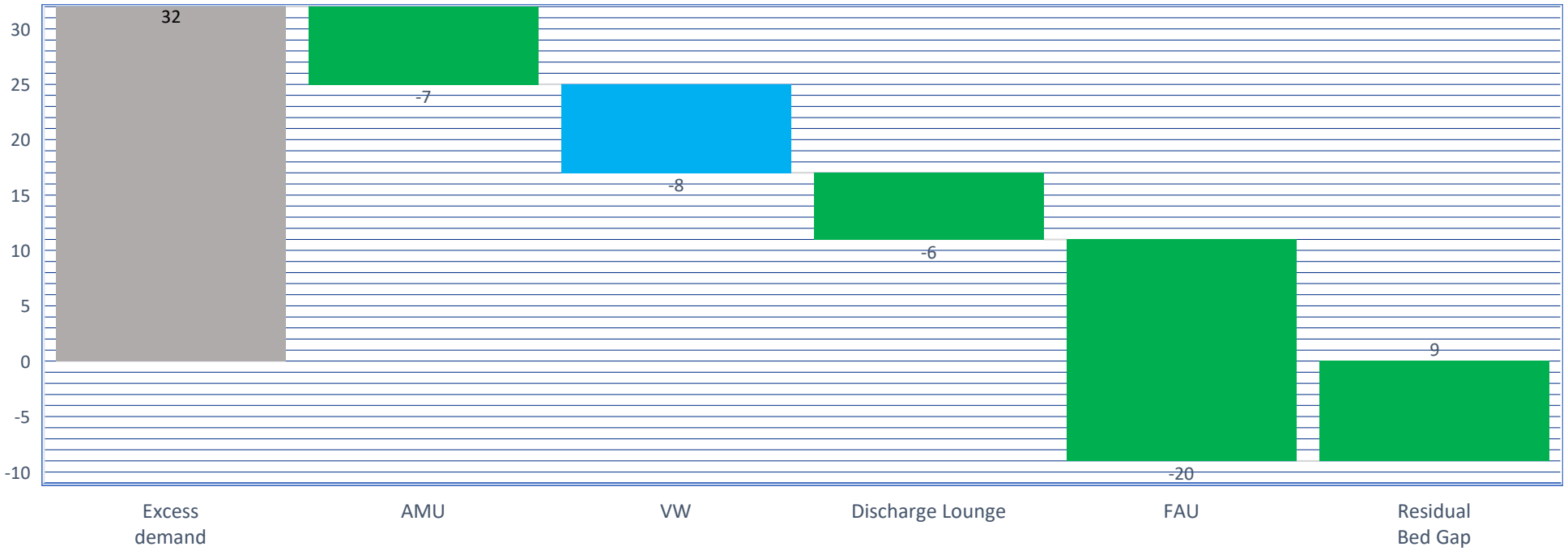
UHNM additional capacity

D2A 2.4:1 ratio
VW - Acute 2.5:1 ratio
VW –Sub Acute 15:1 ratio

- ‘Acute Bed Equivalent’ calculations for community & other supporting schemes represented.
- Additional OPAT and TDL mobilisation underway
- Additional schemes outlined within the plan

County Hospital Bed Modelling – Residual Gap

Enabling Schemes: Home First Additional Capacity, Primary Care, HALO, NEPTs, Falls Service, Mental Health, CYP, ICC, Public Health initiatives.



Enabling Schemes outlined within Surge Plan

UHNM additional capacity

VW - Acute 2.5:1 ratio
VW –Sub Acute 15:1 ratio

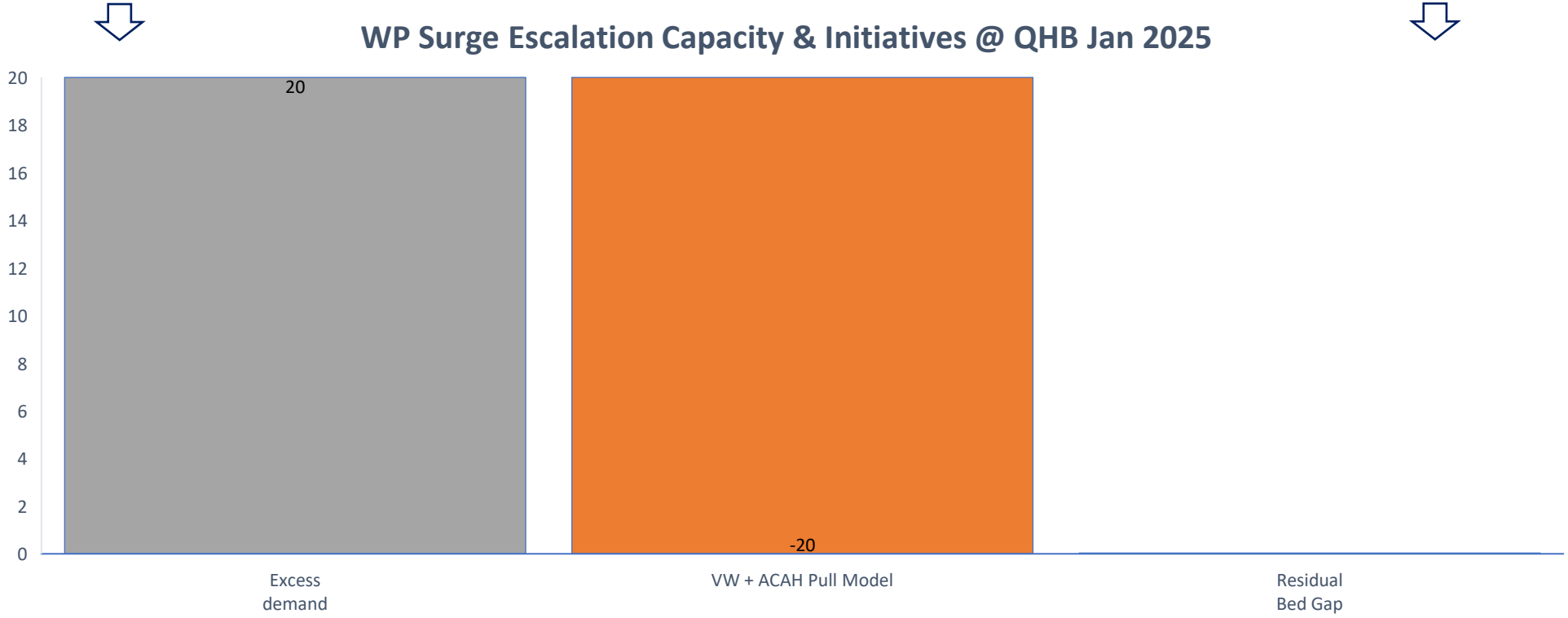
- Residual Bed Gap for Medical Beds at County Hospital = +9 beds.

NOTE

- Illustration is for County beds and demand only

Queens Hospital Burton

Enabling Schemes: Home First Additional Capacity, Primary Care, HALO, NEPTs, Falls Service, Mental Health, CYP, ICC, Public Health initiatives.

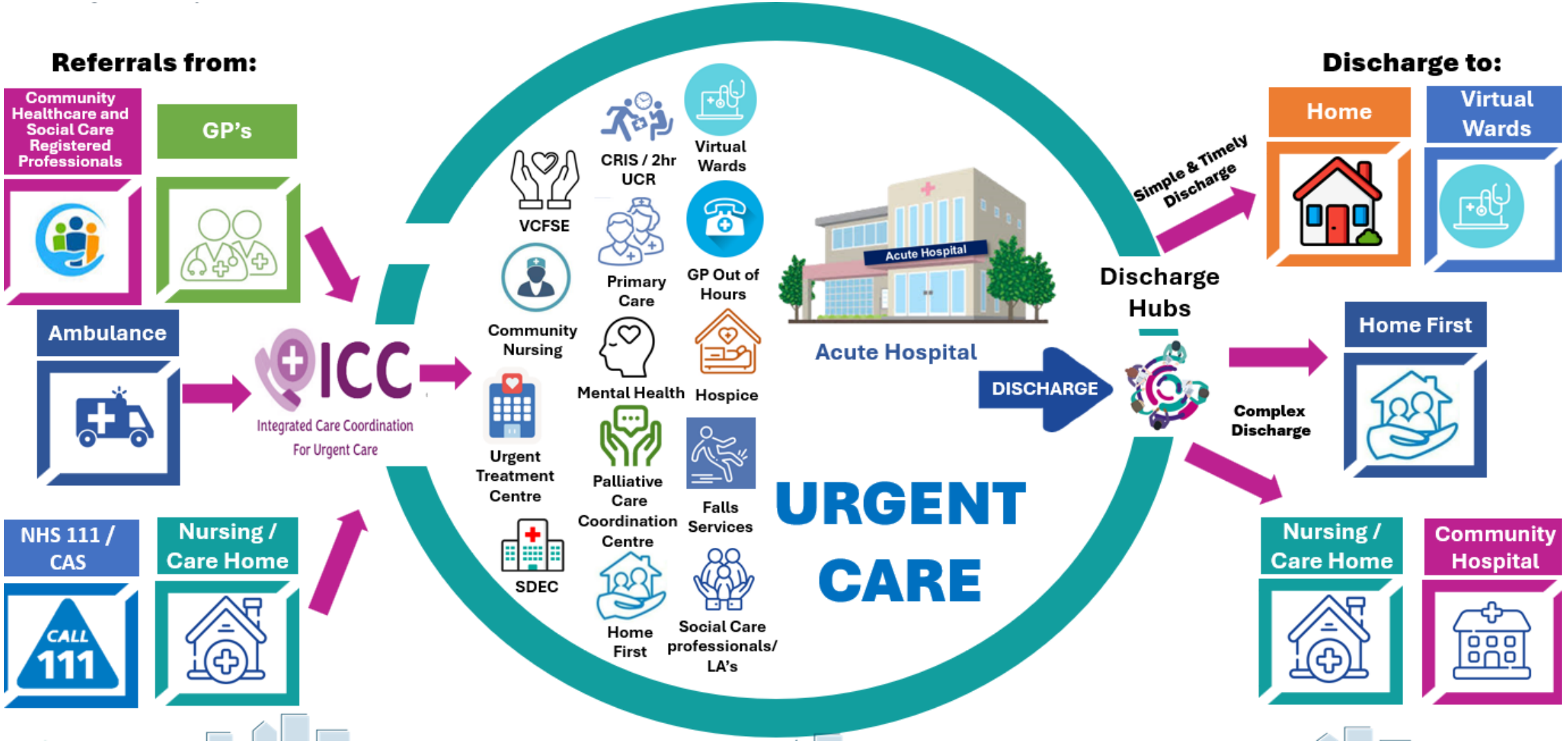


- Full modelling TBC but anticipated excess demand results in residual bed pressure of c20 beds.
- Plan is for this to be mitigated by the impact of the Virtual Wards and the ACAH pull model (to support utilisation of the VW beds).

Additional Capacity Schemes

Title	Summary	Impact	Timescale
Acute Care at Home QHB "Pull Model"	Senior liaison practitioner to 'pull' suitable patients from ED at QHB into Virtual Ward beds. Reducing unnecessary admissions & ED pressure	20 bed impact (alongside VWs) anticipated	October – March
Additional OPAT service	Building upon existing (and well reviewed) service at RSUH to increase capability and caseload of OPAT service.	15 bed impact anticipated	October - March
IDH FEAU "Pull" Model"	Increased discharges via IDH direct from FEAU, without patients admitted into acute beds. Reduced LoS for frail patients	6 bed impact anticipated	November – March
County Hospital Frailty Assessment Unit	Dedicated frailty unit to prioritise admission avoidance & facilitated discharge of elderly/frail patients at County hospital. TOC undertaken, identified significant bed savings	20 bed impact anticipated	November – March
County Hospital Transitional Discharge Lounge	Converting space & staffing at County for additional discharge lounge capacity	6 bed impact anticipated	November – March
RSUH Transitional Discharge Lounge	Converting space & staffing at RSUH for additional discharge lounge capacity	7 bed impact anticipated	November - March
Surgical Same Day Emergency Care (SDEC) Capacity	Implementing dedicated surgical SDEC at RSUH to address excess demand bed pressures during peak of surge demand (as per bed model)	Bed impacts TBC Anticipated to address surgical bed gap	November – March

Integrated Care Coordination (ICC)



Integrated Care Coordination (ICC)

- A single point of access for urgent care for Healthcare professionals (HCPs), a nationally mandated requirement in the UEC Recovery Plan.
- The ICC for Urgent Care is a multidisciplinary team which acts as a single point of access (SPoA) to provide an Integrated Care Coordination (ICC) service for Urgent Care to streamline access to non-ED pathways and reduce the barriers to access the ‘right care, right place, first time’ through a single number.
- The service facilitates access to urgent care services through coordination of physical, social and mental health pathways.
- The aim of the service is to get patients to the right service in the right place at the right time and redirection to services that know them best, not only to manage a current crisis or escalation but also to develop contingency for any future crises and escalations.
- The service makes it easier for health and social care professionals to have an earlier clinical conversation, which will reduce avoidable ambulance dispatch and handover delays.

- The ICC for Urgent Care also collects data on service gaps to inform offers of alternative service to keep more people at home.

Enabling Schemes

Title	Summary	Impact	Timescale
Integrated Care Coordination	Operating costs for delivery of the ICC. A fundamental aspect of system management of UEC and provision of the Single Point of Access for UEC across SSOT.	Single Point of Access for UEC across the system	October - March
Vocare Primary Care 1hr and 2hr disposition support	Primary care 1hr/2hr disposition support via 111. Alleviate in-hours Primary Care demand and provide admission avoidance C1100 hours + volume of activity Creates a 24hr Clinical Advice service	Protection of primary care capacity Admission avoidance Enabling scheme	October – March
Staffordshire Fire & Rescue "Home from hospital" service	Supported discharge for patients discharged from RSUH. Continuation of service from 23/24. Service review showed good outcomes, minimal readmitted patients and facilitated discharges.	Facilitated discharge. Readmission avoidance Enabling scheme	October – March
IDH ED portals Discharge Facilitator (7/7 working)	Expansion of existing and well-functioning discharge facilitator roles to cover weekend working. Increased volume of discharges & alleviation of Monday morning pressures	Improved discharge and patient flow Enabling scheme	October onwards
IDH Outlier Management	7 day cover for management of outlier patients. Staff member to complete transfer of care documentation and discharges as required.	Improved discharge and patient flow Management of outliers Enabling scheme	November - March
IDH Discharge Facilitator 7-day working	7 day cover for IDH discharge facilitator role. Increased capacity from established discharge model and role, to provide weekend cover & alleviate Monday backlog	Improved discharge and patient flow Enabling scheme	November – March
Staffordshire Fire & Rescue Falls service	Falls service operated by SFRS to reduce admissions and responses/conveyances from WMAS Continuation of existing service	Reduced admissions Reduced ambulance involvement	October – March
Mental Health - Approved Mental Health Professional (AMHP) capacity	Increased AMHP capacity at RSUH and QHB EDs to reduce long wait MH patients	Reduced waits for MH patients Improved ED flow	December – February
Operational Development Monies	OD funding ahead of Winter to ensure efficiency of working and further building relationships	Operational development to support winter working.	December

Additional/Enabling Schemes – alternative budgets

Title	Summary	Impact	Timescale
Non-Emergency Patient Transport (NEPTs)	Additional capacity for NEPTs crews during winter period. Provision of patient transport to facilitate improved patient flow and facilitate discharges	Facilitated discharge Improved patient flow Additional patient transport capacity	October – March
Primary Care – Winter MDT hubs	Winter Acute MDT Hubs 1 Hub (+ 3 spokes) in North of SSOT, plus hubs in Stafford, Lichfield, Seisdon, Burntwood, Tamworth and East SSOT (location TBC)	Admission avoidance Greater Prim. Care provision during surge	December – April
Home First Additional Hours	Additional 1000 hours per week for Home First service during Winter months to mitigate patient flow and manage surge in demand	Increased Home First provision to protect discharge capacity	November – March
System Vaccination initiatives	RSV Vaccination programme commenced 1 September. Delivered to older age & maternity cohorts. COVID vaccination programme to commence 3 October – targeted to vulnerable patients & care homes	Increased vaccination uptake	September – December
HRD (High Risk of Delayed Transfer of Care) tool	Risk stratification tool to enable IDH team to proactively identify and track specific cohorts of patients upon arrival at ED. Initial focus on vulnerable patients, inc. rough sleepers and patients of no fixed abode, reinstatements (those patients with existing package of care in place) and patients living alone with a clinical frailty score of 5+	IDH able to support a higher volume of patients to access care and facilitate support from a wider range of services – inc voluntary and charity sectors, virtual wards	November – March

Surge Schemes Summary

Scheme	New / Previously Implemented	Summary
UHNM Escalation Wards (W120, W79, TDL, Discharge Lounge, AMU	Escalation ward capacity utilised in previous surge plans. W120, W79 have remained open year-round	Tangible/physical escalation bed capacity.
Acute Medical Rapid Assessment Unit (AMRAU)	New estate, opened in July 2024. Core capacity moving forward.	Includes Medical Short Stay escalation capacity.
Outpatient Antibiotic Therapy (OPAT)	Pre-existing service. Expanded in 23/24.	Expansion of service delivered in 23/24. Significant impact and tangible delivery of capacity.
Cheadle/Haywood D2A Capacity	Discharge to Assess capacity utilised in previous winters to provide escalation capacity.	Tangible/physical D2A bed capacity.
Virtual Ward (Acute & Sub-Acute)	Year-round Virtual Ward capacity. Bed numbers represented increased capacity (as per plan trajectory).	Established Virtual Ward service.
Frailty Assessment Unit (FAU), County Hospital	New capacity mobilised post Test of Change in Summer 2024.	Streamlined pathway for frail patients to facilitate accelerated discharge.
Acute Care at Home "Pull Model"	New scheme for 2024/25.	Senior liaison practitioner to 'pull' suitable patients from ED at QHB into Virtual Ward beds. Reducing unnecessary admissions & ED pressure.
Integrated Discharge Hub (IDH) initiatives	Expansion of services to cover weekend working.	Three enabling schemes designed to ensure weekend cover for key initiatives designed to facilitate accelerated discharge.
Vocare/Totally Primary Care Dispositions	Existing service, expanded to provide additional resilience to primary care.	Established service from existing provider.
Staffordshire Fire & Rescue Service (SFRS) Home From Hospital & Falls services	Deployed in 2023/24. Continued year-round.	Home From Hospital & Falls services delivered by SFRS from 2023/24. Continuation of well-reviewed services.
Approved Mental Health Professional (AMHP) capacity	Expansion of existing service to provide additional winter/surge capacity & cover.	Increased capacity proposed at acutes across SSOT to provide additional mental health capacity during surge..
Non-Emergency Patient Transport (NEPTs) additional crews	Deployed in previous winters to provide additional NEPTs to facilitate discharge & transfers	Provision delivered previously to support NEPTs across SSOT and out of area acute sites. Operationally integral.

Voluntary Care Sector

- The Integrated Care Coordination (ICC) centre facilitates referral to Voluntary Care Sector organisations via utilisation of the Integrated Discharge Hub (IDH) and South Staffordshire Transfer of Care Hub.
- All access is streamlined via the respective hubs to ensure the full breadth of VCSE offers are available to patients and that utilisation is maximised, wherever appropriate.
- The Complex Discharge Tracker records all required and potential VCSE access for patients upon discharge and is fed through the ICC to facilitate access to appropriate offers.
- The Personal Health budgets of all patients are assessed and utilised to ensure access to VCSE offers and services for those patients that could benefit from such services.
- In addition; system leads continue to explore further VCSE opportunities and means of integration into existing pathways to maximise the benefits for SSOT patients.

Indicative Medical Bed Count

Initial winter plan positin	Lead provider	Position	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Bed gap (Inc IP impact)		**-208**	**-124**	**-154**	**-186**	**-208**	**-204**	**-184**	**-154**	**-142**	**-127**
Mitigated by											
W120	UHNM	21	21	21	21	21	21	21	21	21	21
W79	UHNM	25	25	25	25	25	25	25	25	25	25
AMRAU	UHNM	16	16	16	16	16	16	16	16	16	16
Medical Short Stay	UHNM	14		14	14	14	14	14			
TDL	UHNM	7	7	7	7	7	7	7	7	7	7
OPAT	UHNM	30	30	30	30	30	30	30	30	30	30
Cheadle	MPFT	13			13	13	13	13	13	13	
Haywood	MPFT	4			4	4	4	4	4	4	
Virtual Ward (Acute)	ACAH	24	22	22	26	26	26	26	26	26	26
Virtual Ward (Sub Acute)	ACAH	16	12	12	14	14	14	14	14	14	14
OPAT (Additional)	UHNM	15			5	15	15	15			
RSUH TDL	UHNM	7			7	7	7	7			
Falls	UHNM	7				7	7				
Balance		-9	+9	-7	-4	-9	-5	+8	+2	+14	+12

Managing the peak

- The planned interventions described leave an expected peak deficit of -9 across Medicine in RSUH.
- This will be further mitigated by the impact of enabling schemes. Although these schemes are non-quantifiable in terms of acute beds or equivalent, they are essential to maximise admission avoidance.
- The remaining deficit will be managed through a combination of outlying patients, maintaining occupancy in excess of 92%, and the holding of patients with a DTA in the RSUH ED. This will be supplemented by the clinical risk share approach across system partners.
- Should these final actions fail to satisfactorily reduce risk across the System a Business Continuity Incident will be declared and a Command and Control structure established.

Infection Prevention Control

- All system capacity modelling utilises the “Severe Winter adjustment” parameter within the system capacity model.
- This anticipates a 6/7% increase in demand due to increased flu/COVID/RSV related demand and is based upon the pressures experienced during winter 2017/18.
- This represents the most severe winter pressure observed in actual Trust data and is employed to forecast a ‘worst case’ scenario.
- In addition, and to maximise resilience within the planning and forecasts; an additional 20 bed “IPC pressure” is added to forecasts for months Dec-Feb (inclusive).
- Assessment of the UKHSA Winter planning scenarios and the associated toolkit (which forecasts impacts from COVID, Flu, RSV, Norovirus and inclement weather) has been considered and informs the IPC and severe winter forecasts.
- Continual review of UKSHA advice and assessment of activity and trends observed within the system will be integrated to ensure a fluid view and recalibration as required.

De-Escalation

- All system capacity modelling is underpinned by the monthly excess demand trajectory.
- Assessment of the trajectory, and recalibration as required during operational delivery over winter, will inform the system approach to de-escalating capacity and schemes appropriately.
- The weekly System Surge executive report will illustrate progress against plan, both for mobilisation and de-escalation.
- System Surge MDT will hold accountability (alongside COOs and equivalent senior leadership) for ensuring that schemes, initiatives and capacity are de-escalated in a timely manner, with regular reporting (financial and operational) embedded into the monthly reporting cycle.
- A monthly progress report will be produced for F&PC, UEC Board and UEC Delivery Group to ensure oversight and agreement on de-escalation trajectories, with appropriate challenge and scrutiny.

Mental Health

Summary of Key Actions for Winter 2024-25	
Patient flow	**NSCHT** Daily oversight into admissions and discharges with Red – Green implemented across all wards. • Ward rounds / MDTs occur throughout the week. • Bed Management meeting weekly attended by all internal stakeholders and external partners. • Weekly MADE events (Older adults) • A CRFD meeting held every Thursday for patients who are CRFD. • Weekly bed flow meeting held every Friday at 1pm attended by all inpatient areas and Crisis Care service line. • Clear escalation processes in place internally and across the system. • Daily communication with Home Treatment Team (Adult and Older Adults)– admission avoidance, community support. • Escalation action cards in situ from an internal/external perspective • 7 Day Discharge including nurse led discharge **MPFT** • Gatekeeping of all admission via our 24/7 Crisis Home Treatment Teams • Development of early discharge pathways on our acute inpatient Wards • Strengthening of our Crisis alterative pathways • Future Mobilisation Crisis Assessment Centre 2025 on St Georges site Stafford • Review Purpose of admission, care planning and assessment processes through Inpatient Transformation work stream
Social Care & Housing support to facilitate discharge	Designated point of contact in relation to Adult MH inpatients, timely allocation to a social worker & subsequent completion of social care assessments. Stoke local authority working to replicate. Funding has been agreed by NSCHT to March 2025 to fund 2 Social Workers for Stoke patients (both Adult and Older Adult) Stoke LA are leading on the recruitment. Application to resource recurrently will be made to the BCF for 2025/26. All housing and social care needs are discussed weekly and escalated via the ongoing weekly meetings that take place. Hospital In reach Team consisting of social workers and peer recover workers working closely with acute inpatient wards involved and supporting with discharge planning for Service users with Social Care needs both prior to and following discharge from Hospital Dedicated Housing Officer supporting Hospital In reach Team

Mental Health

Summary of Key Actions for Winter 2024-25	
Crisis Team Capacity	**NSCHT**: Efficiencies & service delivery routinely reviewed to ensure demand can be met and a current service review of MHLT will establish additional support requirements to address predicted activity increase during winter. Monitoring of demand & activity in all crisis/front door services occurs daily, key performance monitoring monthly. Senior Leadership Team & Operational Management review internally and across the system. Any future funding sources will be reviewed in line with current capacity/future needs. **MPFT**: Reviewing the Role of Street community triage to enhance CRHT workforce in providing proactive response to mental Health related incidents in the community RCRP Development of joint working pathways with CRHT and Liaison Psychiatry increase capacity. Effective use of Crisis alternative pathways inc safe hands workers/safe Haven , and Crisis House. Improving IMHT response to urgent /unplanned interventions and integration with Liaison to create capacity in CRHT Teams
Reducing attendance of patients with MH needs at ED	'Call before conveyance' initiative in place with calls to NSCHT Crisis Care Centre prior to conveyance to ED in order to reduce the number of patients transported to ED unnecessarily. The MH Crisis Care Team working with the system ICC to further support diversion of patients to the Crisis Care Centre. The MH Ambulance aims to reduce unnecessary conveyances. Ongoing work with WMAS to assess data and utilisation. Strengthening of pathways between CRHT and VCSE's and use of crisis alternative pathways including Crisis House , safe Haven, Safe hands underway to mitigate attendance at ED. Crisis Assessment centre on site at St Georges Hospital scheduled to open early 2025 Close partnership working with Police and Ambulance services. Improving access to mental health services via NHS 111. Ongoing Education with Acute trust staff to enable early recognition of Mental Health needs.

Mental Health

Summary of Key Actions for Winter 2024-25	
Improving timely response to & movement of MH patients from ED to MH services	NSCHT response rates to emergency and urgent referrals from ED and portals remains above target. Once MH services have received the referral they are actioning within 1 hour / 4 hours dependent upon the priority of the referral. MPFT mobilising Core 24 in Queens Hospital Burton. Extended operating hours of liaison at County Hospital in Stafford. Timely response to assessment from Mental Health Liaison Teams in place. Use of Crisis Assessment centre once in operation to facilitate Mental Health Assessments & transfer for patients with Mental Health needs awaiting further Mental Health Intervention from ED. Increased accessibility to digital resources tools and therapies.
Support & management of patients in non-MH beds awaiting admission	Enhanced home Treatment offer via CRHT Teams is in place. Services offers continued support to service users and acute Trust staff in managing patient, regular needs led reviews of risk and care planning Use of Crisis Alternative Pathways is embedded across the system. Close partnership working and engagement with VCSEs There are clear processes including escalations in place to address and limited instances.
Local Crisis lines access via 111 MH option	Full service review undertaken and a new model launched to support anticipated increases in demand via 111 Option 2. Increased staffing in MH Singe Point of Access and social inclusion hub to manage increased demand. Regular review of demand and capacity to ensure delivery of KPIs and service.

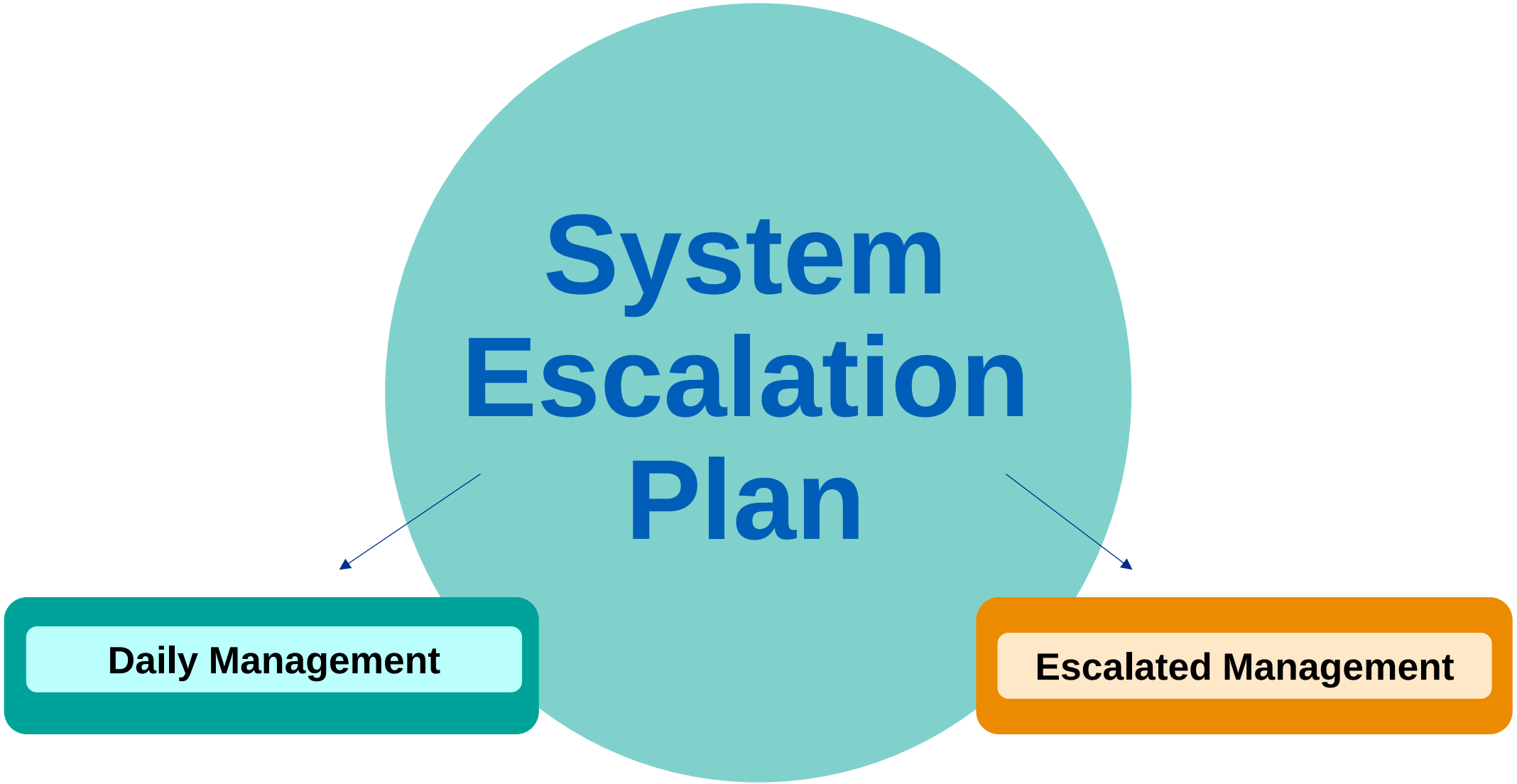
Paediatrics / CYP

- Bed modelling undertaken indicates that paediatric capacity is sufficient to meet expected demand.
- RSV vaccination programme commenced across the system from 1 September.
- Flu vaccination programme for children and pregnant women commenced on 1 September. Delivered primarily in general practice and supported by community pharmacies.
- Core 24 Mental Health provision is in place at both RSUH and QHB 24/7. The Crisis Care Centre, located at Harplands hospital is operational to provide additional CAMHS support.
- The Enhanced Primary Care (EhPC) model at RSUH is in place and well established to stream children who present at ED. Alongside this, the Hospital at Home service offers a community offer for those children that require monitoring rather than hospital-based care.
- Paediatric/CYP considerations have been taken into account within the development of additional ‘enabling’ schemes. These schemes are currently subject to sign-off & final approval.
- The ARI model utilised in 2023/24 (initially implemented to meet RSV and Scarlet Fever outbreaks and associative effects) functioned well and provided much needed capacity – at a point of low acuity and accessible via community means.

Vaccinations

- RSV vaccination programme commenced across the system from 1 September.
- Flu vaccination programme for children and pregnant women commenced on 1 September. Delivered primarily in general practice and supported by community pharmacies.
- Wider adult flu vaccination programme commenced 3 October. Delivered via PCNs.
- COVID-19 vaccination programme commenced 3 October. Delivered by PCNs, Comm. Pharmacies & MPFT targeted vaccination team.
- PCNs to deliver vaccinations to Care Home and housebound populations as priority patient cohort.
- Regular reporting of vaccination delivery and uptake will be included in Surge Executive reporting schedule.

System Escalation Plan



Note: this is continually evolving, updates may be available following paper submission dates.

System Coordination Centre

- SCC 7 days per week 08:00-18:30 – capacity to increase hours at times of escalation.
- Senior clinical leadership in place to support risk mitigation.
- Full 24/7 On Call support
- Collaborative working across the system and region, support from all local partners and excellent working with regional teams.
- Participated in SCC Peer Review, awarded Maturity status with a re-submission for Benchmarkable Maturity (supported by region)

Learning from Critical Incidents & Winter 23/24

- System review of OPEL scoring.
- Single scoring system to inform actions & declaration of CI.
- Proactive planning in advance of known antecedents (i.e. school holidays, increased sickness absence).
- Revised system call actions – linked to Escalation plan.
- Utilising MFFD and Criteria to Reside guidance more robustly.
- Clarity regarding lines of communication and escalation.
- Identification of early indicators and emerging themes (e.g. 111 call abandonment, primary care pressures). Putting infrastructure into place to mitigate.

Further actions to support escalation plan

- Weekends – Discharges – Focus on S&T and rolling dynamic discharges.
- UHNM Level 4 actions review – Reviewing hospital full protocol, risk assessments.
- Testing hospital full protocol for Winter. Annual formal review, quarterly review.
- Business Continuity Planning across the system, - inc. Primary Care, Acute Care at Home.
- Hospital discharge and community support guidance.

SSOT Escalation policy next step

- Task and Finish Group involving all System partners including Local authorities and WMAS to review and develop a refreshed plan.
- Enhancing senior clinical input at provider level during escalation.
- Needs to be led by Operational teams supported by clinicians.
- Review plan against revised OPEL framework.

System Workforce plan

Workforce Planning Approach

- The ICS Health & Care People Team has taken responsibility for coordinating workforce planning and will provide assurance of additional workforce to support Winter Schemes.
- ICS Workforce Leads work in collaboration with NHS Trusts, Local Authority, Social Care, Independent Providers and ICB to understand the workforce required to deliver the surge schemes, explore alternative workforce models and skill mix required, and availability of current workforce to determine any gaps.
- Regular communication and involvement of Partners ensures that plans for workforce scheme activity are monitored and reviewed regularly.
- Providers continue to assess and review their workforce models and additional capacity required for anticipated scenarios and surge.
- Providers are modelling their workforce internally, utilising a range of roles and skills across the schemes, adopting flexible workforce models which respond to demand accordingly. Providers have plans in place to deliver the additional capacity utilising their internal available workforce through skill mix, redeployment and additional hours.

Risks and Mitigation

Risks associated with the supply of workforce in the short and medium term currently include:

- Continued Industrial Action / GP Collective Action
- Low morale among workforce
- Increase in sickness (including peaks in COVID instances)
- Existing vacancies and availability of registered workforce
- Scrutiny around additional bank and agency usage during surge due to financial pressures

Mitigation Includes:

- System wide and local retention programme / People Promise activities including promotion of flexible working and retirement offers, Employee Experience and HWB support targeting highest reasons for sickness absence, career development opportunities, support for new starters and improved on-boarding, 5 high impact actions for nursing & midwifery
- Mutual Aid Support and robust process for mobilisation of workforce across System as required
- Growth of contingent workforce where required via People Hub, including reaching out to private and volunteer sector. Focus on supporting care homes.
- Vaccination programme for front line staff

Workforce Initiatives – Surge 2024/25

ICS People Hub

- Available bank of staff via **People Hub** – workforce sharing agreement in place, particular focus on supporting care homes and discharge
- Growth of System admin pool and launch of Admin Academy in readiness to supply Partners, including GP practices, with appropriately trained staff during surge and without need for agency
- Expansion of **volunteer roles** and launch of Volunteer for Health programme in collaboration with Support Staffordshire and VAST. Working with System Partners to understand need.
- Ensure robust processes in place for workforce requests / mutual aid support via People Hub. Reflected in System Escalation Plan

Recruitment

- Lessons learnt from previous years – timescales, attraction strategies including flexible working
- Collaboration at System level to reduce time and cost – sharing recruitment events and talent
- Scope new posts
- Focus on **'new to care'** so as not to destabilise System
- EDI Lens
- Alignment to Population Health strategies

Provider Banks / Flexible Workforce

- System wide approach to bank rates
- Ensure competitive bank rate as an alternative to agency
- Encourage workforce to pick up additional hours and to work flexibly to meet service needs

Employee Experience/ Retention

- Promotion of System wide and Provider Health & Wellbeing offers
- People Promise Programme and System People Partners
- System wide OD Plan
- Targeted support for Stress, Anxiety, Depression

Next phase : Sept – Oct

- Confirmation of additional workforce requirements and numbers from Providers and Partners
- Confirmation of workforce deficit, following Provider/Partner workforce mobilisation and schemes
- Agree and commence activities to address the deficit / mitigate supply risks
- Agreement on alternative workforce schemes and any escalated bank rates
- Ongoing collaboration with CPOs and Partners to develop and deliver the System plan

APPENDICES

Staffordshire and Stoke-on-Trent Integrated Care System

In Hospital

UHNM Internal Winter Schemes

Division	Area	Description of scheme
Surgery	SAU	12hr ward clerk on SAU 7/7
Surgery	Surgical SDEC	Navigator RN
Surgery	Surgical SDEC	Additional staffing to enable SSDEC service
Surgery	Surgical SDEC	Non elective ambulatory Middle grade doctor resident in SAU/ SSDEC to be part of the wider GS rotation
Medicine	Emergency Medicine	x1 WTE Consultant 09:00 – 17:00, 7 days per week (to support take)
Medicine	Emergency Medicine	x1 WTE Consultant 17:00 – 22:00 7 days per week (to support take)
Medicine	Emergency Medicine	x1 WTE Registrar 21:00 – 09:00 7 days per week
Medicine	Emergency Medicine	x1 WTE SHO 17:00 – 00:00 7 days per week (AEC)
Medicine	Emergency Medicine	x1WTE Tier 5/4 Doctor 8am – 4pm and 4pm – 00:00am (7 days per week) to RAT;DPR
Medicine	Emergency Medicine	Purchase of additional Stryker trolleys.
Medicine	Emergency Medicine	Ambulance (St John) service available 6pm-midnight.
Medicine	Emergency Medicine	Additional portering, 24/7 cover 7 days per week
Medicine	Emergency Medicine	Ad+A4:D22ditional Corridor Nurse Staffing, and bulk liquid oxygen ED
Medicine	Emergency Medicine	Bulk Liquid oxygen A&E Coridoor
Medicine	General Medicine	TDL at RSUH
Medicine	Medical division/ Corp	TDL at County Hospital
Medicine	Specialised Medicine	Recruit Discharge facilitator
Medicine		ACAH Senior Liaison Practitioner: Pull Model
Medicine		IDH FEAU IDH Pull Model
Medicine		IDH - Discharge Facilitation 7/7
Medicine		OPAT
Medicine		IDH - ED Portals 7/7 working
Medicine		FAU @ County
Medicine		IDH Outlier Management

Division	Area	Description of scheme
Networked		SDU medical model
Networked		Heart Centre discharge lounge
Networked		Trauma arrival & departure lounge
Networked		Cardiac flow coordinator
WCCSS	Child Health	Additional ward COW (Consultant of the Week)
WCCSS	Pharmacy	Additional Pharmacy support
WCCSS	Imaging	Inpatient mobile imaging - plain film - Radiographer (RSUH and County)
WCCSS	Imaging	Inpatient mobile imaging - plain film - Imaging Assistant (RSUH and County)
WCCSS	Imaging	Inpatient co-ordinator for IR
WCCSS	Imaging	IR Transfer Nurse - To release ward nurses from transfer for all interventional procedure transfers (CT/IR/US) to improve inpatient flow
WCCSS	Imaging	Imaging Portering - Lyme ED and Hub to support flow (x2 ED, x1 Lyme, x1 Hub)
Corporate	Patient transport servic	UHNM High-dependency Patient Transport Service: *6 days per week (Monday -Saturday) *0 cover on a Sunday *12:00 - 00:00 (11.5hrs per day)
Corporate	Rota coordinator	Medical Staffing - Weekend Rota Co-Ord support
Corporate	Admin	Nurse Bank Support Admin
Corporate	Transfer team	Corporate Transfer Team (2.8 WTE)
Corporate	IPC	covid results and help with outbreak reviews
Corporate	IPC	opportunistic covid, influenza and pneumococcal vaccination to patients
Corporate	Bed Frames	25 bed frames
Corporate	E&F/FM costs relating to all of bove placeholder	
Corporate	Pathology	Additional testing
Corporate	Discharge Facilitators	

Staffordshire and Stoke-on-Trent Integrated Care System

Out of Hospital

Community & Intermediate Care Services

- Additional 18,000 hours of Home First capacity across winter
- 40 Community beds across Cheadle Hospital and Haywood Hospital
- Discharge 2 Assess pathway oversight, grip and assurance (live CDT data system including acute hospital discharge, D2A pathways home and bed and PCCC activity)
- Palliative Care Coordination Centre acts as single point of access for End of Life care requirements from hospital discharge and community step up
- Development and go live of Integrated Care Coordination (ICC) for Urgent Care including broadening of referral pathways for reconnection and redirection to physical heath, mental health and social care pathways
- Review of step-up bed pathway processes including ringfencing of bed capacity to evidence our commitment to providing assessment of care needs closer to home and out of hospital where appropriate

Staffordshire and Stoke-on-Trent Integrated Care System

Local Authorities

Stoke-on-Trent City Council

City of Stoke-on-Trent

- AMPH support across the surge period will be flexible to meet the demands of Mental Health Act assessments in both inpatient and outpatient settings.
- There will be daily escalation of appropriate delays to manage unmet demand with focus on pressure areas as identified with the system with Senior manager oversight
- As required interim beds may be utilised on a case-by-case basis during this time if demand and capacity enforced the need within health settings to support flow. For example housing needs, major adaptations
- Ability to flex social work resource from Localities to areas of pressures in hospital pathways if required. This can be virtual or onsite. Additionality in regard to assessment staff has been retained to support surge pressures – this equates to 5 full time assessment staff
- Focus on additional community domiciliary care capacity to reduce potential for unmet need if required which supports flow in the HomeFirst service (14/10/24 POLR declared at 28 hours)
- Use of alternative pathway 0 services where possible to mitigate homecare delays eg vol sector, community lounges
- Focus on reinstatement and retainers for care packages to support efficient discharge pathways home where care is identified on admission
- 7-day Broker support in place.
- Front of House team in place and working to provide strength's based approach to new adult social care referrals to include enablement, conversion rate reducing into full assessment and care needs dependency – impact on wellbeing and intended consequence of lesser use of urgent care services
- Beds – pressure area in regard to band 1 and 2 residential beds – focus on pathway 1 where possible and full utilisation of available Marrow beds
- Working with Primary Care to better support Care Homes to reduce the number of admissions into the hospital from care homes
- We are able to map our predicted demand picture for this surge period and also predicted outcomes for assessment in order to plan capacity measures

Staffordshire County Council

- Social care staff deployed into integrated discharge arrangements via S75 with MPFT
- SCC's in-house Independence at Home service, and (in the south of the county) reablement service through its wholly owned company Nexxus) will continue to be utilized to keep POLR at or close to zero hours
- Regular market management actions to support sufficient home care capacity, including tracking of and contingency planning for international recruitment risks
- AMPH support across the surge period will be flexible to meet the demands of Mental Health Act assessments in both inpatient and outpatient settings.
- Trigger levels established to ensure appropriate levels of senior oversight for sourcing of permanent care home beds through Council brokerage service
- There will be daily escalation of appropriate delays to manage unmet demand to appropriate level of senior management
- Ability to flex brokerage resource within team to prioritize urgent care (alongside P1 community cases) where neceesary
- Support for reinstatement through contract management where required
- Ability to escalate requests for support for AMPH and learning disability social work services required, via the urgent care representatives and links

Staffordshire and Stoke-on-Trent Integrated Care System

Mental Health

North Staffordshire Combined Healthcare

- Winter Plan approved by Trust Board on 10th October, following previous approval by SLT and Quality Committee.
- Surge and Escalation plans updated and form part of both organisation and overall system plan
- Modelling demonstrates sufficient bed capacity to meet local demand over the winter period
- Increased staffing into Crisis Care Centre to meet expected increases in demand associated with NHS 111 Option 2
- Virtual Discharge hub enhanced and focus on delayed discharges, with dedicated senior leadership and investment into 2WTE social workers in relation to Stoke on Trent LA to support flow and reduce patients who are Clinically Ready for Discharge (robust process and resourcing already in place for Staffordshire LA)
- Bid to BCF for Approved Mental Health Practitioner capacity (for future years) and some funding allocated within ICB Winter Funding (this winter)
- Plans agreed for COVID, influenza, mpox and norovirus in acute and community settings
- Primary Care extended access arrangements in place for our directly managed GP settings

Midlands Partnership Foundation Trust

- Benchmarking data suggests for lengths of stay and out of area placements are upper quartile performance – Oct 2024 RMHOG data pack – achieving less then 60 days for LoS (Adult Acute), less than 90 days for LoS (Older Adults) and 0 Inappropriate OAP
- New Crisis Assessment Centre scheduled to open in Feb
- Increased staffing recruited to support demand associated with NHS 111 Option 2 and commenced winter campaign for Comms.
- Implementation of the 10 high impact actions for discharge in line with national guidance
- Discharge pathway fully recruited to all vacant posts, recruitment of older adults/dementia social worker using SDF funding to support patient flow. The average number of patients delayed discharge against CFFD criteria is 2 per week, we expect position to improve following recruitment of additional social worker.
- Redesign of crisis café, safe hands, and crisis house to integrate with clinical services and support high-acuity patients. This aims to reduce demand on clinical services and maximize the use of these alternatives while offering patient choice and also supporting diverting activity from ED's.
- Plans agreed for COVID and influenza in acute and community settings

Staffordshire and Stoke-on-Trent Integrated Care System

Primary Care

Primary Care Winter – Services/Schemes

- **Multi-Disciplinary Primary Care Acute Urgent Access Hubs – additional same/next day appointments during surge period (activity to be confirmed)**

Creating capacity in General Practice to free up GP time to focus on frail elderly, people with complex needs and long-term conditions

- **Additional support commissioned locally over and above Care Home DES requirements**

Including face to face ward rounds and advanced End of Life care planning

- **Facilitation of Admission Avoidance Scheme (FAA) (North practices only)**

To support frail patients by assessing their individual needs with delivery and support to access safe and effective services to improve outcomes and reduce avoidable hospital attendance or admission.

- **Thresholds included in local QIF Plus that stretch national QOF Requirements**

Areas of focus include management of LTCs e.g. Children's Asthma, COPD and Heath Failure and Improvement of blood pressure in people with Hypertension, Stroke and Chronic Heart Disease

- **Expansion of Keep Warm Keep Well Scheme into Primary Care**

To prevent readmissions of vulnerable patients whose health conditions are at risk of being exacerbated by living in a cold and damp home.

- **Promotion of Staffordshire County Council Quick Fix Fund to General Practice**

To provide a timely solution to those scenarios that 'fall between the gaps' of current service provision.

Primary Care Winter – Vaccinations

- Winter vaccination campaign opened on 1st September with flu vaccines being offered to children and pregnant women. From 3rd October, flu and COVID vaccines will be offered to wider cohorts of people.
- Vaccination continues to help protect against severe illness, hospitalisations and deaths arising from COVID-19. Care Home and Housebound patients will be the priority for the beginning of the programme with co-administration of Flu and COVID-19 Vaccinations where possible.
- RSV Vaccination Programme commenced on 1st September 2024 for older adults and pregnant women. Vaccine Health Inequalities Group continues to meet and work to develop meaningful solutions to improve Vaccination Uptake across SSOT.
- The ICB has been working with Local Authorities, MPFT and Voluntary Sector organisations deliver targeted MMR Vaccination Clinics.
- QIF Plus scheme also includes indicator to focus on increasing PPV given anytime for those aged 65 and over.

GP Collective Action

- System MDT in place to provide updates on CA to system partners. Space for partners to escalate any concerns and to feed in any impact that CA is having on their organisations, with risks reviewed and mitigating actions put in place.
- Local dashboard has also been developed to support with monitoring impact of CA which includes GP appointment data, ED attendances and referrals activity across all providers.
- Primary and Secondary Care Interface meetings in place to discuss CA impact and actions.
- Fortnightly meeting in place between ICB and LMC which includes providers and is an opportunity to discuss action being taken / potential future action and agreeing next steps and communication.

Staffordshire and Stoke-on-Trent Integrated Care System

Communications

Staffordshire and Stoke-on-Trent Integrated Care System

Supporting operational resilience in urgent & emergency care ahead of winter – a summary of the communications strategy

2024-2025

Background

- Earlier this year, NHS England published the NHS England » Urgent and emergency care recovery plan year 2: building on learning from 2023/24, underpinned by ongoing extensive programmes of work to deliver improvements across urgent and emergency care ahead of winter.
- This plan, along with the NHS's Primary Care: update and actions for 2024/25 plans and the broader strategic and operational plans and priorities for the NHS, provide clear priorities for preparing for the winter period.
- In our system, the continuing focus for UEC performance is:
  - 76% of patients being admitted, transferred, or discharged within four hours by March 2025, with further improvement in 2025/26.
  - Ambulance response times for Category 2 incidents to 30 minutes on average over 2024/25.
- Winter planning will consist of the following products:
  - High-impact priority interventions that we know lead to a safe and effective service to patients. All systems will be asked to deliver these.
  - Clear roles and responsibilities for each part of the system so that both shared and individual organisational accountability is clear.
  - Returns from systems on system-level resilience and surge planning, to avoid systems becoming overwhelmed at times of peak demand and a narrative return against key lines of enquiry.

Key messages for winter

- In light of the findings of the Darzi report, which outlines that priority focus, care and funding is hospital-based, rather than outside these settings, NHS Staffordshire and Stoke-on-Trent ICB will campaign on:
- **Home Care is Best Care** – any unnecessary hospital admissions, or stays which are longer than necessary, can have a negative impact on patient recovery. This can often cause serious harm and impact negatively on health and wellbeing (deconditioning), so benefits of being in the hospital must outweigh the risks.
- **Pharmacy First** – launched 31 January 2024, Pharmacy First adds to existing consultation services and enables community pharmacies to complete episodes of care for seven common conditions following defined clinical pathways.
- **Vaccination Campaigns** – childhood immunisation, flu and covid vaccination programmes are being promoted to keep our communities safe and well.
- **Self-care** – NHS 111, to direct people to the right place for them, as quickly as possible, pharmacy, dental care, eye care, mental health, keeping warm, keeping active are all within scope for self-care messaging.
- **Falls** – working with partners including Midlands Partnership NHS Foundation Trust, we will continue to raise awareness and educate families around preventing falls for the elderly and / or vulnerable.

Objectives

1. Reduce the number of people presenting to our urgent and emergency care services with:
   - conditions that could have been prevented,
   - symptoms that could have been alleviated through self-care or
   - by being seen and treated by a community service closer to the place they call home.

1. Promote key national campaigns and public health messages of:
   - staying well,
   - keeping healthy and
   - using NHS111 online, via the app or calling.

2. We will continually revise our plan and look to build on strengths and successes of previous campaigns. We will utilise previous toolkits around conditions such as norovirus and RSV and prevention campaigns such as COVID, Flu and falls.

3. We will respond to the data, developing targeted campaigns to raise awareness or address known challenges across the system.

Localise national campaign materials

- We will adapt national campaign materials for local audiences, to build on the current TV, radio and outdoor advertising and recognition.
- We will work with partners to amplify key messages locally, utilising existing channels, digital and non-digital, and community relationships.
- We will develop social media campaigns (toolkit issued to all members of the Staffordshire and Stoke-on-Trent ICS)
- We will develop partnership media releases

NHS England Campaigns 24/25

- **‘We Are the NHS’ UCAS Clearing:** To increase the number of suitable applications to nursing and allied health professional (AHP) degree courses via UCAS clearing for the 2024 academic year, supporting the objectives in the NHS Long Term Workforce Plan.
- **Pharmacy:** To support the NHS Primary Care Access Recovery Plan commitment to deliver a national campaign to increase the use of community pharmacy services for the seven common conditions and reduce pressure on General Practice services.
- **Act FAST: Stroke:** To increase earlier diagnosis and treatment of stroke by encouraging people to act more quickly on symptoms, supporting the NHS Long Term Plan ambition "to reduce the number of deaths from strokes”.
- **NHS 111:** To reduce pressure on Urgent & Emergency Care Services by increasing use of the NHS 111 service by people with urgent medical needs, so that they can be directed to the right NHS service, supporting objectives in the NHS Long Term Plan and Operational Guidance.

P A U S E – during periods of high demand

Problem

- Is there a theme in attendances? What are the patient presentations that could be diverted?

Audience

- To help us target our communications and ensure our graphics resonate, who is attending? Age, gender, ethnicity…?

Understanding the audience

- What will influence their decision to go somewhere else? What do you know about why they came?

Symptoms and self-care

- Use NHS.uk to describe symptoms and self-care

Exacerbations and escalation

- What to look for and where to go if it gets worse