Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	13
Date of Meeting:	6 September 2023		

Title of Report:	Refresh of the RUH winter plan v1
Status:	For approval
Board Sponsor:	Niall Prosser, Interim Chief Operating Officer
Author:	Niall Prosser, Interim Chief Operating Officer
Appendices	Appendix 1: Letter: UEC delivering operational resilience across the NHS this winter Appendix 2: UEC Winter Incentive Guidance Appendix 3: RUH Bed Plan 2023/24 Refresh v1

1. Executive Summary of the Report

In April 2023 the Trust Board agreed the Trusts plan for 2023/24, which included 2023 winter period. However, a number of underlying planning assumptions have changed:

- No longer able to utilise William Budd as a winter ward.
- Q1 saw very low COVID activity, however, the risk remains for additional COVID activity during Q3 and Q4, specifically with a new variant of concern.
- National letter (appendix 1) outlines that there would not be any winter funding available this year, however, there would be access to £150m of national capital funding if any Trust met certain thresholds.
- Non Elective Activity during the first 3 months of 2023/24 is at 107% of the planned activity.
- We have seen a reduction in length of stay, and the current Non Criteria to Reside (NC2R) position is delivering in line with the plan.

The update also refresh's the do nothing scenario, which identified the Trusts bed occupancy would be over 100% during winter. In this scenario the Trust would be required to use the previously used escalation areas (e.g. day surgery unit, cath lab recovery, vascular lab and boarded beds), which has been forecasted to cost £1.7m, and likely lead to a conservative loss of elective income of circa £2m. This scenario would also lead to significant safety concerns with long delays and high volume within ED, and within our community through long ambulance handover delays.

In assessing whether there are further internal improvements the Trust could make to deliver above current plan, there are three elements being considered;

- The RUH patient flow improvement plan has been assessed and reviewed by the regional clinical advisor on urgent care, who highlighted that the improvements the RUH is forecasting, with delivery this year, are "*very impressive and ambitious*", and the improvements seen so far are *"brilliant"*.
- The paper highlights that the Trusts headline length of stay is currently better than the regional average, and further opportunities targeted through the on-going improvement plan.
- The plan for NC2R currently is to have no more than 80 patients waiting. There remain risks within the BSW system being able to deliver improvements beyond this point.

The paper highlighted a number of new mitigations that have been identified and could be, following further governance sign off, implemented to support the RUH bed

occupancy get close to the national target of 92%.

The revised plan also reduces the cost of the winter plan from a previously agreed spend of £2.5m to £2m.

2.	Recommendations (Note, Approve, Discuss)

Discussion and approval on the proposed refreshed Winter plan.

3.	Legal / Regulatory Implications

Failure of a robust winter plan and appropriate mitigations would lead to significant risk of CQC inspections and warning notifications as the hospital would not be providing a safe service, and likely lead to a deterioration within the urgent care and elective care tier allocation (currently in tier 3 – the lowest).

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

The implementation of the refreshed winter plan influences the following BAF scores:

- Risk 1 - Failure to deliver safe, high quality care due to poor compliance with internal and external set standards on quality and safety, with potential risk to patients.
- Risk 2 - Failure to provide safe and quality care to patients attending the hospital in emergency as a result of a mismatch between capacity and demand. This could cause serious risk to patient safety.
- Risk 3 - Failure to reduce elective waiting times through improving elective capacity and productivity. This could lead to poor outcomes and experiences for patients.
- Risk 6 - Failure to deliver a viable financial plan would impact on the Trust's ability to achieve financial recovery and sustainability, and could ultimately affect its ability to provide safe, appropriate and effective care to our patients.

5.	Resources Implications (Financial / staffing)

In April 2023 the Trust Board agreed a winter plan with the cost of £2.5m. This was agreed based on the working assumption that there would be additional winter funding available during 2023/24. The national UEC Recovery Plan letter within appendix 1, notes that there will not be any available funding.

The paper highlights that the do nothing scenario is likely to lead to unplanned expenditure and forecasted loss of income of £3.7m.

The updated plan has therefore rebased the forecasted expenditure for 2023/24, and reduced the figure to £2m.

6.	Equality and Diversity

Failure to deliver a successful winter plan will lead to significantly worsening outcomes for elective patients who are likely to have their elective surgery cancelled at short notice. Evidence highlights the disproportionate effects on patients in lower social economic groups.

7.	References to previous reports/Next steps
Previous version of the winter plan was presented at April Finance and Performance Committee (FPC), and April Trust board.	

8.	Freedom of Information
Private	

9.	Sustainability
Neutral – whilst schemes included lead to more travel, it is also anticipated that the plan is limiting the need for additional buildings within the RUH site.	

10.	Digital
Neutral	

To:
- ICB:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- NHS acute, community and mental health trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- Primary care networks

cc.
- NHS England regional directors

NHS England
Wellington House
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SE1 8UG

27 July 2023

Dear Colleagues,

Delivering operational resilience across the NHS this winter

This letter sets out our national approach to 2023/24 winter planning, and the key steps we must take together across all parts of the system to meet the challenges ahead.

In January, we published our delivery plan for recovering Urgent and Emergency Care (UEC) services: an ambitious two-year plan to deliver improvements for patients across the integrated Urgent and Emergency Care (iUEC) pathway. This plan, along with the Primary Care Recovery Plan, Elective Recovery Plan and the broader strategic and operational plans and priorities for the NHS, provides a strong basis to prepare for this winter.

The publication of the UEC Recovery Plan followed an incredibly challenging winter – with high rates of infectious disease, industrial action, and capacity constraints due to challenges discharging patients, especially to social and community care. We know these challenges have continued but want to thank you for the work you have done in the face of this to ensure that there have nonetheless been significant improvements in performance. Thanks

to these improvements, we are in a significantly better place compared to last summer. Compared to last June, A&E performance has improved and Category 2 performance is 14 minutes faster.

This progress and the plan we are today setting out for winter preparedness are key steps in helping us achieve our two key ambitions for UEC recovery of:

- 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

To help achieve these ambitions, we have ensured that systems have had clarity over finances well before winter to allow them to plan effectively and further roll-out the measures that we know will improve services for patients. We have invested extensively in this, including:

- £1 billion of dedicated funding to support capacity in urgent and emergency services, building on the £500 million used last winter.
- £250 million worth of capital investment to deliver additional capacity.
- £200 million for ambulance services to increase the number of ambulance hours on the road.
- Together with DHSC, an additional £1.6 billion of discharge funding over 2023/24 and 2024/25, building on the £500 million Adult Social Care Discharge Fund.

While we are making good progress towards achieving our overall ambitions, we want to encourage providers to achieve even better performance over the second half of the year. We will therefore be launching an **incentive scheme** for those providers with a Type 1 A&E department to overachieve on their planned performance in return for receiving a share of a £150 million capital fund in 2024/25. We are asking providers to meet two thresholds to secure a share of this money:

- Achieving an average of 80% A&E 4-hour performance over Q4 of 2023/24.
- Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

We recognise that these are stretching targets but know that many providers will be able to achieve these to help the NHS as a whole make greater headway towards improving care for patients. Providers should already be putting measures in place which will contribute towards reaching these, including a greater focus on the longest times in department, particularly those spending longer than 12-hours, and wider system flow. We will communicate more details on this shortly, including how we will be working with you to improve data quality.

Turning to our wider planning for winter, we are clear that the challenges are not just in ambulance services or emergency departments, and recovery requires all types of providers to work together to provide joined-up care for patients. ICBs will play a vital role in system leadership but the actions we take need to extend across the wider health and care system including mental health services, services for children and young people, community health services, primary care and the voluntary, community and social enterprise (VCSE) sector.

We are therefore setting out four areas of focus for systems to help prepare for winter:

1. Continue to deliver on the UEC Recovery Plan by **ensuring high-impact interventions are in place**

Together with systems, providers, and clinical and operational experts we have identified 10 evidence-based high-impact interventions. These are focused around reducing waiting times for patients and crowding in A&E departments, improving flow and reducing length of stay in hospital settings. Delivering on these will be key to improving resilience in winter. We have recently written to all systems to ask that they assess their maturity against these areas as part of the universal improvement offer for the UEC Recovery Plan. Systems will then receive dedicated support on the four areas they choose to focus their improvement for winter.

More detail on these areas can be found at Appendix A and on the NHS IMPACT website.

2. **Completing operational and surge planning** to prepare for different winter scenarios

We have already collectively carried out a detailed operational planning round for 2023/24 but we are now asking each system to review their operational plans, including whether the assumptions regarding demand and capacity remain accurate. Although this will cover surge planning for the whole winter, specific plans should be made for the Christmas/New Year/early-January period which we know is often the most challenging time of the entire year.

In addition to this, and recognising the importance of planning for multiple scenarios, we are asking systems to identify how they will mobilise additional capacity across all parts of the NHS should it be required to respond to peaks in demand driven by external factors eg, very high rates of influenza or COVID-19, potential further industrial action.

This planning is essential to ensure winter plans protect and deliver elective and cancer recovery objectives, as well as deliver the primary care access programme, and proactive care for those most at risk of hospital admission (guidance on proactive care will be published shortly).

Next week, we will be issuing each ICB with a template to capture their surge plan and overall winter plan. We will work with those areas that are facing the greatest challenges across the UEC pathway via our tiering programme to support them in completing these returns. If you think you require additional support, please contact england.uec-operations@nhs.net.

All returns should be sent to england.uec-operations@nhs.net by **11 September 2023**.

3. **ICBs should ensure effective system working across all parts of the system**, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.

ICBs will play a vital role in system leadership and co-ordination but it is important that all parts of the system play their role. The NHS England operating framework describes the roles that NHS England, ICBs and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

To help systems plan, we have developed a set of recommended winter roles and responsibilities (**Appendix B**) to ensure clarity on what actions should be undertaken by each part of the system. These will require broad clinical leadership to implement, and systems should be using these to develop their winter planning return, reflecting how these relate to the circumstances within their individual system.

DHSC is also writing to local authorities and the adult social care sector shortly to set out priority actions for improving winter resilience and encouraging cross-system working with the NHS on winter planning.

To assist system working this winter, next week, we will also be publishing an updated specification for System Co-Ordination Centres and an updated Operational Pressures Escalation (OPEL) Framework to ensure we are taking a consistent and co-ordinated approach to managing pressures across all systems.

4. **Supporting our workforce** to deliver over winter

This year colleagues have continued to work incredibly hard in the face of increased demand. We know how much supporting your workforce matters to you, and it is crucial that employers ensure that they take steps to protect and improve the wellbeing of the workforce.

Last winter, we saw flu return at scale. It is vitally important that we protect the public and the health and care workforce against flu and other infectious diseases, and the best way of doing this is to ensure they are vaccinated. Providers should also ensure that they have an

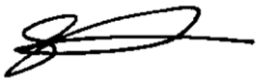
established pathway for identifying patients at-risk of COVID-19 and flu in their care, including those who are immunosuppressed.

Systems and providers should also continue to improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise, as set out in 2023/24 priorities and operational planning guidance and more recently in the NHS Long Term Workforce Plan, and ensure continued supply through maintaining education and training.

We want to thank you and everyone across the NHS for your continued hard work this year, we have again faced some unprecedented challenges but through strong partnership working we have once again risen to these.

The coming months will undoubtably be difficult, but we will continue to support you to ensure that we collectively deliver a high-quality of health service to patients and support our workforce. Thank you again for all your efforts as we work to build a more resilient NHS ahead of winter.

Yours sincerely,



Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Julian Kelly
Chief Financial Officer
NHS England

Appendix A: 10 High-Impact Interventions

Action	
1.	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2.	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3.	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10.	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

NHS England

UEC Winter Incentive – operational measurement guidance

The NHS winter letter published 27 July introduced the incentive scheme for providers with a Type 1 A&E to achieve even better performance over the second half of the year in return for receiving a share of a £150 million capital fund in 2024/25.

Capital money will be allocated to providers achieving the required performance levels.
To be eligible for a share of this fund providers must:

- have a Type 1 A&E department
- achieve an average of 80% all-type A&E 4-hour performance over Q4 of 2023/24
- complete at least 90% of ambulance handovers within 30 minutes from arrival of the ambulance during Q3 and Q4 of 2023/24 (with 95% or more handovers having a valid handover time)
- improve performance in the above areas compared to winter 2022/23.

We expect that these targets will be delivered by:

- increased focus on faster handover of patients and release of ambulances,
- reducing the time patients spend in A&E – with a specific focus on reducing the % that spend more than 12-hours in A&E,
- improving hospital flow, including reducing discharge delays in collaboration with local social and community care providers.

Providers should already be putting measures in place which will contribute towards reaching these. We recognise that these are stretching targets but know that many providers will be able to achieve these to help the NHS as a whole make greater headway towards improving care for patients.

Publication reference: PRN00724

Financial guidance

If the eligibility criteria above are met, providers will be allocated a share of a £150m capital fund.

This capital allocation will form part of the provider operational capital allowance, and providers will be responsible for deciding how this is spent.

A&E data

We will use all types A&E performance from the published Monthly A&E Attendances and Emergency Admissions data to identify those providers with a Type 1 A&E who achieve 80% all-type A&E 4-hour performance over Q4 2023/24. Performance will be assessed at acute Trust footprint level and will therefore include any Type 3 activity mapped to the trust.

Reductions in the percentage of patients spending 12-hours in A&E will be monitored via the 12-hour element of the Supplementary ECDS Analysis publication.

Ambulance handover data

We will use ambulance handover data from the Daily Ambulance Collection to identify those providers with a Type 1 A&E who complete at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

We want to ensure that there is a standardised approach to collecting data and so ambulance services will be required to adopt the following definitions in AQI submissions, the Daily Ambulance Collection and all other handover reporting to ensure a consistent approach nationally.

Cohorting

Cohorting is defined as the handover of patient care to other ambulance service clinical colleagues prior to the formal handover to the hospital. It takes place when ambulance service clinical colleagues at the hospital take over the care of conveyed patients arriving in a different ambulance, to release the arriving crew to attend other incidents.

This will usually be inside the hospital and could be one ambulance crew looking after several patients simultaneously. This type of cohorting is only applicable where patients are transferred between ambulance crews (or sub-contracted ambulance service provision). It **does not** include cohorting by the hospital.

Patients subject to ambulance service cohorting are not considered to have had their care transferred to a hospital and will continue to be recorded as a handover delay until their care has been handed over to the hospital.

Recording handover clock start and clock stop

The Standard NHS Contract https://www.england.nhs.uk/nhs-standard-contract/ technical guidance https://www.england.nhs.uk/nhs-standard-contract/23-24/ provides high-level definitions for how handovers should be recorded. Further clarifications and additional guidance are provided here.

Handover clock start:

Standard Contract definition

When ambulance wheels stop in the patient offloading bay (handbrake applied and 'Red at Hospital' button is pressed on the Mobile Data Terminal [MDT]).

Additional guidance

If an ambulance stops in the queue for the patient offloading bay this also counts as clock start.

Geofence times can also be used for clock start. Where both the 'Red at Hospital' button press and geofence data points are present and valid, the earlier time should be used.

Ambulance services must ensure their geofence trigger matches the ambulance waiting area at the hospital, to avoid incorrect early time triggers.

Handover clock stop:

Standard Contract definition

The time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department.

Additional guidance

Handover times should be agreed and recorded jointly between the ambulance service and hospital at the time of handover.

Where no handover time is recorded jointly, the handover time recorded by the ambulance crew on vehicle systems should be used. Where no handover time is recorded by either provider, this should be reported as missing data. The data on the number of missing handovers will be reported and should be routinely shared with hospital trusts to improve reporting and data quality.

Note that crew clear time **should not** be used as a proxy for the length of handover when a handover time is missing.

Operational (resource) Measures for inclusion in the AQIs will define the clock stop time as:

- Where the patient is clinically handed over to the care of the hospital from the conveying vehicle, or
- Where the patient is transferred to an ambulance cohorting function from the conveying vehicle, the clock stop is the time the conveying crew handover to the ambulance cohort function who take over clinical responsibility of the patient, enabling the conveying crew to leave the hospital.
- Where patients may have transferred to a second vehicle due to shift change, the clock stop is the time the second ambulance crew handover the patient's care to either an ambulance cohort or to the care of the hospital.

Accountability and review

Colleagues in commissioning organisations responsible for ambulance contract management are asked to review the current contracting arrangements around Clock Start and Clock Stop recording and how cohorting is reported to ensure compliance with the national definitions.

Over the coming weeks, the AQI Data Specification will be updated to reflect the definitional collection of ambulance to hospital handover metrics, and we will commence consultation with stakeholders and implementation with ambulance services to ensure that key metrics are included in data submissions.

As we continue to progress through to implementation and publication of defined hospital handover metrics, systems should continue to monitor and review local handover data.

Royal United Hospitals Bath
NHS Foundation Trust

RUH Winter Plan Refresh 2023/24

Niall Prosser, Interim Chief Operating Officer

Version 3

The RUH, where you matter

Executive Summary

1. Trust Board agreed a bed plan for the year in April 23 which included the plan for 23/24 winter period. These slides build on the previously agreed plan.
    1. Previously agreed bed bridge identifying change in number of beds over previous years (development of day case unit, IPC works and opening mini PY).
    2. Included mitigations for 23/24, such as use of William Budd ward as a winter escalation ward
    3. Agreed plan cost £2.5m which was assumed to be offset against additional nationally available winter funding
2. A number of the key assumptions have changed since April that require Trust Board to agree a new approach for 23/24
    1. Access to William Budd is no longer achievable due to delays in Dyson Cancer Centre build
    2. Plan included using escalation beds (boarded beds, B36) as core beds to support the plan. These have been removed
    3. NHSE have now confirmed that there will be no winter funding available to support Trusts during 23/24 winter.
    4. There is an incentive opportunity of additional capacity if we meet certain thresholds
3. If the Trust withdraws the winter schemes previously agreed or doesn't identify new schemes the Trust is forecasting bed occupancy of over 105%. This will require utilisation unplanned escalation areas.
    1. Forecasting identifies this will cost an estimated minimum of £3.7m in additional costs or lost income.
    2. Significant clinical risk and patient safety concerns for ED, front door services and patients in our community
4. Trust has identified an updated winter plan, which needs renewed Trust Boards support
    1. Builds on the success the Trust has had recently, identifies new mitigations to support reduced bed occupancy to just below 95%. Individual schemes need further work and executive sign off
    2. Requires investment of £2.1m to deliver

Changes since April agreed plan

- Delays in access to the winter escalation ward

- Q1 of 23/24 has not seen significant COVID activity. Potential for this to return during Q3 or Q4. impact modelled at 25 beds. – New Variant 2.86 is causing great concern and the modelling of 25 beds may be too low.

- Recognition that boarded beds significantly impact on flow. Removed from plan as core bed base. Will only be utilised to support spikes in bed demand and limited in use.

- National letter (attached) outlines lack of winter funding available – but access to £150m capital funding if performance targets met.
    - 90% of ambulances offloaded within 30 minutes within Q3 and Q4 – RUH currently at 65% but averaging 36 minutes to offload
    - 80% 4 hour performance within Q4 – the RUH currently at 66.5% for Month 5
- Wiltshire Health and Care have requested that the RUH takes on the management of Chippenham and Trowbridge MIUs – impact currently being assessed, with further paper back to FPC/ Board

If we do nothing

Without the planned mitigations it is forecast that the Trust will have a bed occupancy above 100%. It is anticipated that this will lead too;

- Unplanned use of escalation areas such as day surgery suite, cath lab recovery, vascular lab and boarded beds

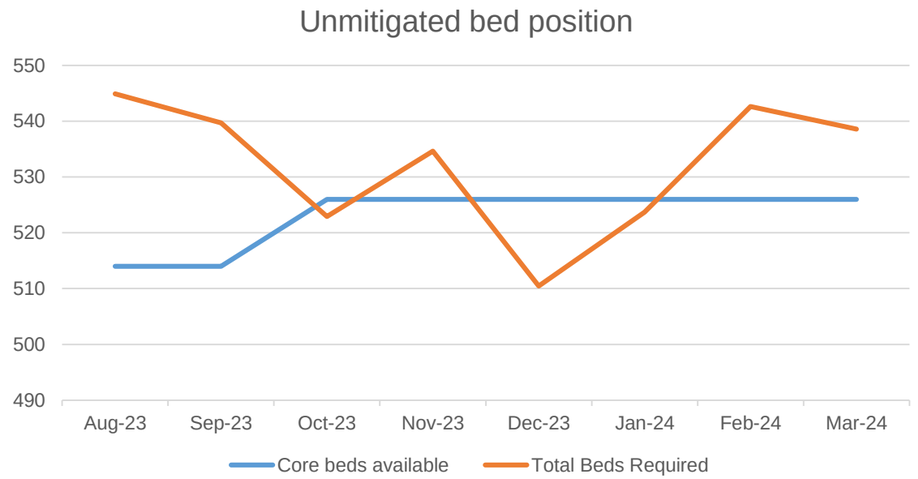
- Use of these areas will require unfunded agency nurses to support – calculated cost of £1.7m (November to March running of escalation)

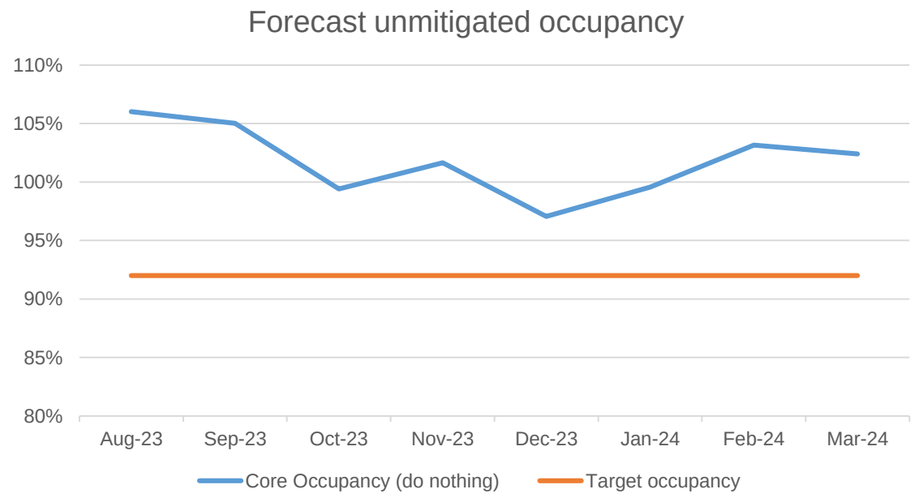
- Cancellation of elective activity due to failure to be able ring fence days surgery suite/ mini PY – lost elective income of £2m (loss of £400k per month from November to March).

- Significant delays in ambulance handovers due to lack of flow

- Significant safety concerns within ED and in the community as patients wait for ward beds to become available

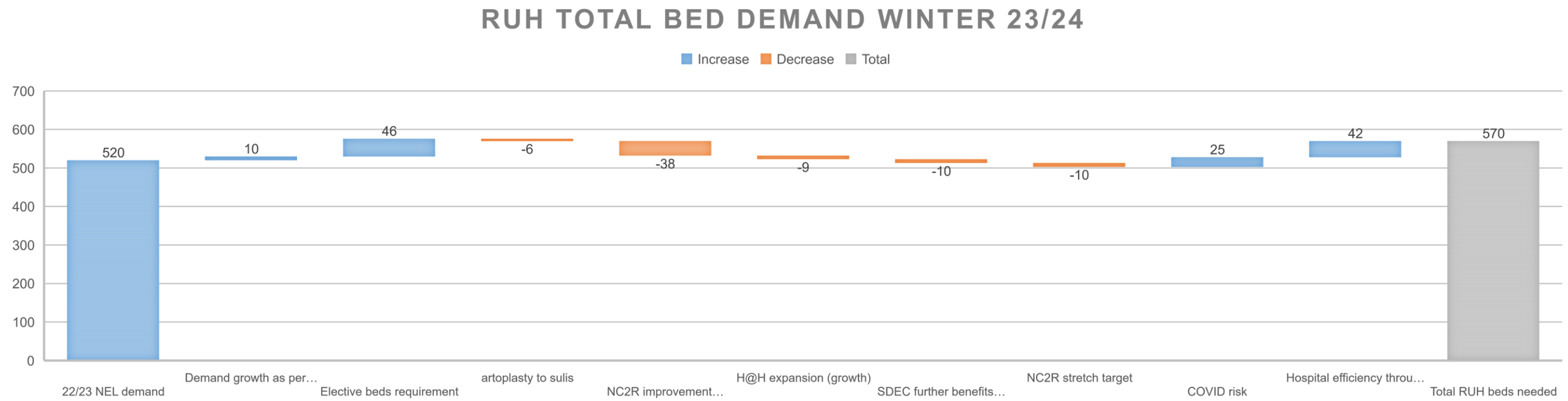
- Challenging working environment for staff leading to working experiences and associated impact

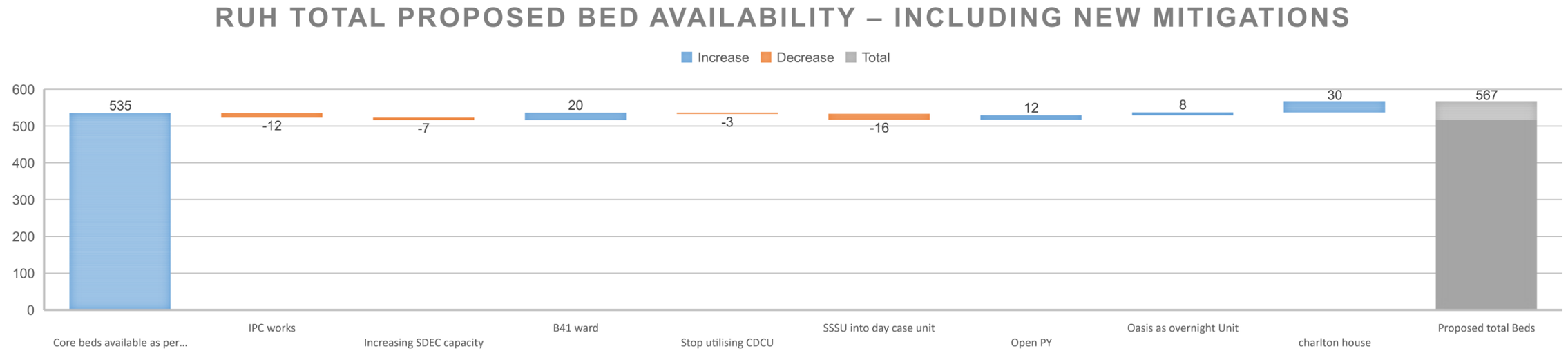




Note – December position impacted by Christmas period

Refreshed demand and capacity waterfall

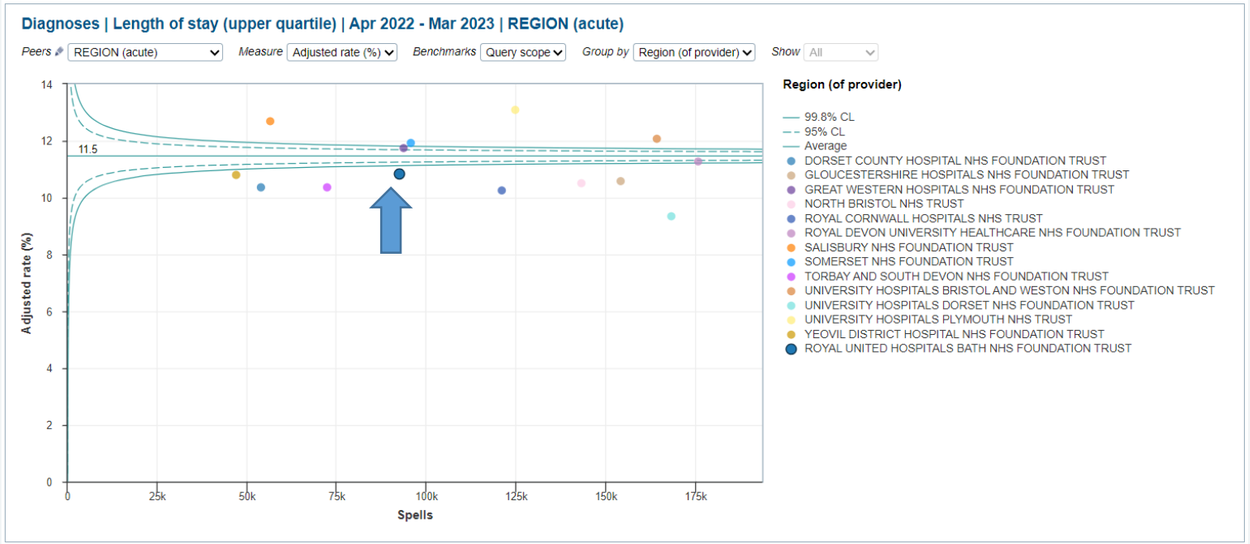




Can we go further/ faster

Feedback from the regional clinical advisor, Stevan Bruijns, on Urgent Care bundle implementation for NHSE southwest;

- "*This is a very impressive and ambitious plan. I'd be quite keen to have your permission to share with other providers as an example of good operational practice?"*
- *"Just reviewed Bath's UEC dataset. What a brilliant job you guys are doing"*
- *"Occupancy continues to drop. %NCTR still fairly high in region, but also showing a downward trend. Non elective LOS remains low compared to region. 0-day remains static, but 14-day and 21-day trending in the right direction."*
- *"Summary: Occupancy improvement is quite remarkable and suggests a consistent effort"*



We have an ambitious plan already which is focused on reducing admissions (SDEC, new ways of working) and reducing internal delays.

We have limited scope for improvement on LOS but continued opportunity to further reduce NC2R (current plan reduces to 80).

Potential to further improve how we operationally run the hospital on a day to day basis to support improved flow eg discharges earlier in the day.

National Letter (within the appendix) highlights 10 high impact interventions.

- First 3 (SDEC, Frailty, improve flow and length of stay) relate to acute services and are already a corner stone of our internal plans
- Remaining 7 relate to community services. These are already in place (Virtual Wards, Urgent Community Response, single point of access) or built into the systems plan for delivering the planned reduction in NC2R (community bed productivity, care transfer hubs, intermediate demand and capacity) or reduce demand (acute respiratory infection hubs) are being developed at the moment.

Refresh financial overview of the mitigations

		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	In year total
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Adjustments to bed base	SSSU to be completely daycase	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(30.0)	(360.0)
	SDEC - acute medicine and frailty				11.0	11.0	16.5	16.5	27.5	27.5	33.0	33.0	33.0	208.9
	PY as a medicine ward													0.0
	Savings from closures/changes	**(30.0)**	**(30.0)**	**(30.0)**	**(19.0)**	**(19.0)**	**(13.5)**	**(13.5)**	**(2.5)**	**(2.5)**	**2.98**	**2.98**	**2.98**	(151.1)
Mitigations	Oasis / merged dicharge lounge							38.5	38.5	38.5	38.5	38.5	38.5	230.7
	Additional escalation as required (B41) and B36 in	99.9	145.8	90.4	101.7	101.7	101.7	101.7	101.7	101.7	101.7	101.7	101.7	1,251.3
	Site team review							0.0	12.0	18.0	23.8	23.8	23.8	101.3
	Medical team for medicine							0.0	25.0	25.0	25.0	25.0	25.0	125.0
	Weekend discharge team							0.0	0.0	0.0	0.0	0.0	0.0	0.0
	New ways of delivering CAHMs demand								12.0	12.0	12.0	12.0	12.0	60.0
	Charlton House								95.0	95.0	95.0	95.0	95.0	475.0
	Hot clinics in resp and cardiology							0.0	2.0	2.0	2.0	2.0	2.0	10.0
	Total Mitigations	**99.9**	**145.8**	**90.4**	**101.7**	**101.7**	**101.7**	**140.1**	**286.1**	**292.1**	**297.9**	**297.9**	**297.9**	2,253.3
	Total cost	**70**	**116**	**60**	**83**	**83**	**88**	**127**	**284**	**290**	**301**	**301**	**301**	2,102.3

Trust Board agreed a plan at a cost of £2.5m to support the annual bed plan, including winter. The refreshed plan reduces this cost by £0.4m.

A number of the schemes being identified are high risk (Red or Amber) of delivery, with the higher confidence schemes being focused on temporarily ensuring sufficient beds are available.

Conclusion

1. Significant risk to the RUH if we don’t do anything differently this winter including;
    1. Significant long waits for our patients within ambulance, in the community and within ED
    2. Reduction in elective income matching 22/23 levels of circa £2m
    3. Unplanned bed escalation will be required to support position. In 22/23 this was £1.7m

2. Mitigated NC2R position still means that, best case scenario, the RUH will be looking after between 55-80 NC2R patients at anyone time. System cant go further.

3. Regional team have assessed our plans and highlighted the strength in our delivery and ambition already built in

4. Have reduced the cost of the plan from £2.5m to £2.1m

5. New mitigations to be converted into operating plans to be signed off by relevant exec team to ensure meets EQIA

Ask of Board

1. Does the Board support the direction of travel for the refreshed Winter plan for 23/24?

2. Appetite for risk if system do not support funding for winter plan?