Meeting title:	Trust Board					**Trust Board Paper J**
Date of the meeting:	10 October 2024					
Title:	**2024/25 Winter Plan**					
Report presented by:	Jon Melbourne, Chief Operating Officer					
Report written by:	Jon Melbourne, Chief Operating Officer Sarah Taylor, Deputy Chief Operating Officer					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	x
Where this report has been discussed previously	Trust Leadership Team – 24/09/24					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The UHL Winter Plan provides updates on assurance and actions that are being taken in relation to winter planning and pressures.

Impact assessment
The plan will identify actions being undertaken by each of the Clinical Management Groups to support winter pressures

Acronyms used
Urgent and Emergency Care (UEC), Leicestershire Partnership Trust (LPT) Children and Young People (CYP), Same Day Emergency Care (SDEC) Derbyshire Health Unit (DHU), Emergency Department (ED), Medically Optimised for Discharge (MOFD), Length of Stay (LoS) Clinical Management Groups (CMG's) NHS England (NHSE) To Take Out Medication (TTO's), Urgent Treatment Centre (UTC) General Practice (GP), Multi Agency Discharge Events (MADE) Respiratory syncytial virus (RSV), Personal protective equipment (PPE) Discharge improvement team (DiT), Leicester, Leicestershire, and Rutland (LLR)

1. Purpose of the Report

This document provides an update on the Urgent and Emergency Care (UEC) Recovery Plan which was approved by the Board as part of the 24/25 Operational planning process in May 2024.

The document describes the approach to planning for this winter, an update against the 24/25 Operational Plan for UEC and the scale of the expected deficit in capacity and provides a detailed update on the actions that are being taken in the lead up to, and throughout winter.

2. Recommendation

The Board is asked to:-

- Note the capacity challenges which are being faced and the risk going into the winter period.
- Note the actions that are being taken to mitigate deficit.
- Support the governance process to receive updates via UEC Steering Group, and escalations to the Trust Leadership Team as required.

3. Main Report

This document brings together the key elements of the winter plans submitted by all CMGs in addition to actions to support Infection Prevention, actions during Surge and Escalation, Risk and Governance. This document focuses on UHL actions. A system plan is being developed across all partners and key elements are including in section 3.3.

In May 2024 NHSE wrote to all Trusts setting out the Urgent and Emergency Care recovery plan. This included the 10 High Impact Interventions referenced in Appendix 1. The components of the recovery plan are:

1. Maintain the capacity expansion delivered through 2023/4
2. Increase the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes.
3. Continue to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance, and hospital discharge.

In developing the UEC 24/25 improvement programme the following plans have been developed. The aim of these plans was to support flow across the emergency pathway as well as preparing for winter.

- Flow in, Flow Through & Flow out Improvement
- Leicestershire Partnership Trust (LPT) & UHL Discharge Improvement Plans
- Virtual wards programme
- Childrens and young people plan.
- Intermediate Care programme
- Maintaining clinically ready for discharge for mental health

Key actions include:

- Development of SDEC services and redirection and streaming to DHU UTC's
- Development of Clinical Bed Bureau to provide a single point of contact.
- Development of Pathway1/Pathway 2 capacity in line with monthly demand
- Opening of additional winter capacity above plan in LPT community hospitals (Gracedieu)
- Opening of winter surge capacity for urgent care / treatment
- Improve productivity through reducing LoS, reducing waits for treatment / diagnostics.

Risks exist in the plan, particularly going into the winter period where bed modelling suggests an unmitigated gap of up to 243 based on no growth and 344 based upon 4 – 6% growth levels we are seeing growth greater than this, so the gap is greater. The current plan mitigates 113 beds. We are working through further mitigations but at present there are both physical capacity and financial constraints further detailed breakdown can be found in Appendix 2.

In developing the plans, we are also seeking to address the following:-

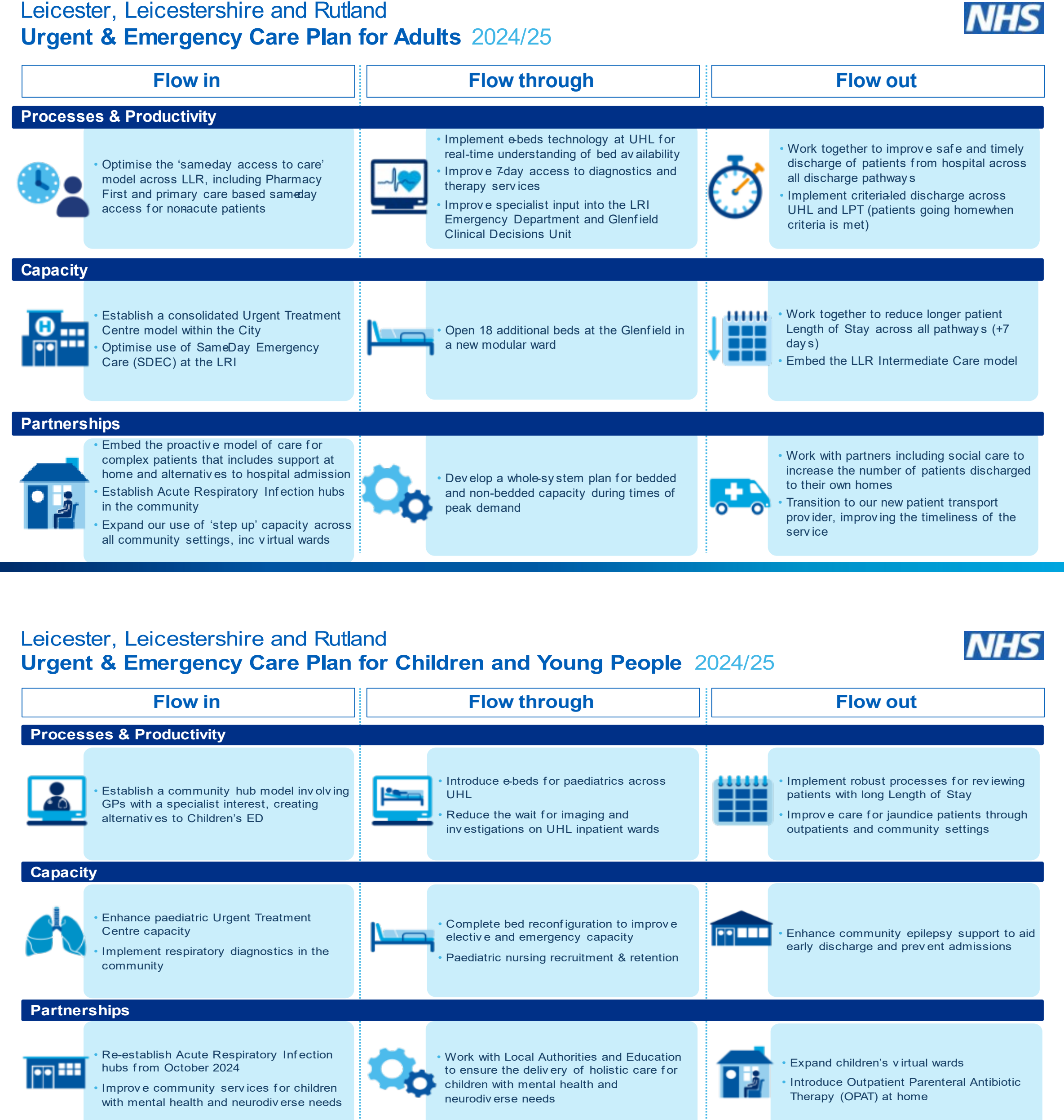
UEC Ambition

- Reducing wait to be seen for ED first assessment, current average is 22mins, target is 15 mins, through focusing resources at front door and streaming and redirection.
- Reducing wait for ED assessment, current average is 99mins, target is 80mins, through reducing waits in ED and utilisation of escalation areas.

- Increase the throughput of SDEC across all areas - target 10% growth based on the last 12 months data show 51,000 units of SDEC activity in the key specialty areas.
- Reducing waits for beds in ED through reducing LoS. June LoS is 3.5 days compared to 4.2 days in June 2023, through reducing internal waits and discharge improvements.
- Reduce 7+, 14+ and 21+ days LoS through discharge improvement plan.
- Reduce MOFD patients who do not leave through escalation of delays and reallocated where patients are not medically fit, this has reduced from 462 in June 2023 to 284 in June 2024

3.1 Internal and System Actions

The following infographics published in April 2024 detail the actions within the UEC plans.



To address this and the increase in activity currently attending ED or being admitted the CMG's have developed specific winter plans covering.

- Activity plans
- Specific CMG actions led by the Head of Operations
- Infection Prevention and Control
- Planned Care requirements.
- Surge and Escalation plan
- Discharge Support and Escalation
- Communication and Engagement plan

The following table details the projected impact of the CMG plans per week.

Beds no of additional (productivity and physical)	OPD no of additional	No of Patients ED attendance avoidance (per week)	No of patients CDU / Admission unit avoidance	No of Patients - admission avoidance	SDEC increase in attendances	LoS impact (TBC)
36	20	70	50	38	25	0.5

This will mean that over the 21 weeks of winter we have plans to:-

- Reduce the bed gap to 94
- Reduce the number of attendances to ED by 1,470 patients.
- Reduce the number of patients admitted by 1,050.
- Reduce the number of patients via ED by 798
- Increase SDEC attendances by 525.
- Reduce LoS across multiple specialities.

These plans are not without risk, particularly the bed gap, which could be significantly more than 94 if mitigation actions in the Trust and system do not fully realise their ambitions. Despite all of this work, this winter will be incredibly challenging and therefore partnership working is integral to mitigating the impact.

3.2 Children and Young People's Plan

In response to previous winters, the paediatric team have developed a robust programme of work, the action include.

- Virtual wards – expand by 6 extra beds.
- Relaunch of Nurse / Criteria Led Discharge
- Additional pharmacy staffing to increase efficiency of TTO's.
- Evening Ward Rounds to prioritise discharges.
- Super stranded patients – review of escalation processes and support to expedite discharges.
- Inpatient / Daycase elective - review of prioritisation process to reduce on the day cancellations during winter surge.
- Create additional urgent slots in general paediatric clinics.
- Additional support to prioritise discharge decision making.
- Review and relaunch of Nervecentre best practice to ensure >95% of patients have a date of discharge identified with TTO's to be completed by the day before.
- Derogation of staffing – in line with Chief Nurse approval process

3.3 System and Partner Actions

The need for a new all-age focused communication strategy for this Winter is key, our communications leads have agreed to action this having joined us at the Winter Workshop – there is a clear need for us as a System to be clear and consistent with our citizens on how they can access the right care at the right time.

We also know that we need to make sure 'Our People' are well communicated with to support this consistent approach of care delivery. There is a need to ensure we have a well-developed and used 'workforce passport' system and this will enable us to respond to changes in demand and risk in service delivery and enable us to flexibly support staffing pressures with the right skills and experience at pace. This will also allow Our People to work in different roles across the System more flexibly, therefore starting to develop a UEC Workforce Strategy.

System actions identified are summarised below. Some of these still require system decision on, and discussions to finalise a decision on those needing resource are being progressed at pace and are expected to be concluded in October 2024:-

Flow in

- **UTC capacity**: Increasing UTC capacity and hours this winter is important. This will require us to ensure we have enough estate capacity at our current sites such as Loughborough. This will require investment and negotiation**.**
- **Direct Access**: The current Direct Access Pilots (Medical SDEC) to be rolled out across the maximum number of SDECs so we reduce the heavy reliance on ED as our one front door.
- **Mental Health Hub direct access**: Direct access from ED to the Mental Health Hub.
- **GP appointments**: Increase in GP appointments that can be directly access via ED and also GP capacity at the front door of ED.
- **Children and Young People respiratory offer.**

Flow through

- **Frailty**: To join up our frailty options including access to senior geriatric expertise therefore reducing LOS and potentially admission.
- **Virtual wards**: Increase virtual ward capacity.
- **Multi Agency Discharge Events**: To continue to consolidate the MADE learning 'quick wins.
- **Transport**: To consider the need for a discharge transit space at the Leicester Royal Infirmary site - to make the most of our transport capacity.

Flow out

- **Capacity**: We have confidence that the intermediate care data driven work shows us that more residential care beds are needed. Therefore, open Gracedieu to bridge this gap (Gracedieu is Community Hospital capacity to bridge the bed gap).
- **Stroke and bariatrics**: Ensure the extra stroke and bariatric capacity is purchased as agreed.
- **Discharge process**: Work with our residential care providers to use trusted assessor and extend transfer cut off times .
- **Discharge capacity**: Ensure continued improvement in pathway 1 and pathway 2 discharge through appropriate capacity outside of hospital.

- **Patient transport**: Improvement in transport provision is required following the implementation of our new transport contract due to the issues being faced as a result**.**

There is risk around these proposal in terms of the financial support required and decision-making process and these are all being worked through over the coming weeks.

3.4 Planned Care

Our aim is to continue and **accelerate our progress to achieve *at least* the national access standards**, by March 2025:

- No 52-week waiters
- 70% of cancer patients treated within 62 days and over 77% achieving the Faster Diagnostic Standard
- 91% of diagnostics within 6 weeks of referral

In doing this we will assume that the elective bed capacity remains in place noting the risk that where clinically appropriate some beds may be used to support winter pressures. We will fully utilise all community elective capacity to maintain daycase, diagnostic and outpatient activity noting the new Community Diagnostic Centre at Hinckley is due to open by the end of January 2025 and the new East Midlands Planned Care Centre opening in December 2024.

4.0 Governance

The delivery of the internal actions will be tracked through the UEC Transformation group on a bi-weekly basis - chaired by the UHL Deputy Chief Operating Officer and includes the Chief Operating Officer, Chief Nurse, Medical Director and wider representation across the CMG's including the Emergency Department Head of Service. This will allow early escalation of emerging risks. Escalation from UEC Transformation group will be directly to the Trust Leadership Team.

External actions will be tracked through the UEC Programme Plan and UEC Delivery Group, with early escalations through to the UEC Partnership Board.

5.0 Infection Prevention

The COVID pandemic highlighted some challenges in the UHL estate which contribute to acquisition of Healthcare Associated Infection. It should be noted that patients with different respiratory viruses cannot be nursed together and require physical separation which means patients with COVID, RSV and Influenza cannot be nursed in the same ward unless there are bays which have both doors and separate shower and toilet facilities within. Also of note, influenza A and B are distinct viruses, so patients infected with these also require nursing separately. Planning includes preparation for Influenza A&B, RSV and Norovirus which will undoubtedly once again be circulating viruses this winter.

The 10 High Impact Interventions are welcome from an IP perspective as some of these seek to reduce the footfall of patients into the acute setting. Wherever possible the use of the Hierarchy of Controls should be employed in the order of the most effectiveness. These include structural and engineering interventions, i.e., physically removing hazards, are the most effective. The Infection Prevention Team will work with Estates & Facilities and operational colleagues to support the employment of these where possible. In the absence of adequate controls, the only option is the use of PPE (face masks), and the organisation should be prepared for the requirement for increased, if not a return to universal mask wearing in specific areas or across the Trust.

In addition to the risk of increased respiratory infections; a programme of estate improvements in Osborne building at the Leicester Royal Infirmary site are underway. A loss of capacity while these works take place has been accounted for the demand and capacity modelling detailed.

Mitigations in place

- '4 panel Cepheid' screening for all patients with respiratory symptoms is in place to ensure immediate appropriate ward placement can be made. 4 panel Cepheid screening identifies COVID, RSV, Flu A&B.
- Improving passive ventilation through increasing window opening to encourage fresh air circulation.
- Increase communications re ongoing risk assessments of respiratory infections across patients and staff, the hierarchy of controls will be considered and may result in a return to universal mask wearing in clinical areas or Trust wide.

6.0 Finance and Approvals

The interventions detailed in this paper were integrated into the UHL planning process in 24/25 and approved via Trust Leadership Team in July 2024, meaning that they are accounted for financially. This paper is not seeking approval for any further schemes.

Any additional schemes that are identified to mitigate new risks will need to be managed through the slippage of other schemes and taken through appropriate approval processes. It should be noted that some of our actions were limited by our financial context and therefore we have prioritised our highest impact interventions.

7.0 Risks

The overall UEC risk that there is insufficient capacity to meet the Urgent and Emergency Care demand in UHL remains rated at a 20.

There are several risks in the delivery of the plan which are described in Appendix 3;

- There is a risk that capacity may not be delivered on time.
- There is a risk that out-of-hospital schemes are not delivered on time or have the impact.
- There is a risk that there is a lack of availability of workforce.
- Assumptions in the demand and capacity plan are not all realised.
- Transport due to new providers inability to match capacity with the demand.

8.0 Escalation / Surge

The Whole Hospital Response is based on an end state escalation when there is failure to deliver sufficient patient flow to meet demand. There will be times when the ED is deemed to be at full capacity and the Trust has more patients than it can potentially safely care for. This is usually demonstrated by long waits in ED for specialty or Assessment Unit beds. The Whole Hospital Response will be activated when the trust is operating at its highest escalation levels where demand significantly outweighs capacity and actions taken at OPEL Level 4 have failed to improve service pressures.

The policy requires a wider and faster range of UHL and partner activities to be enacted to rectify the situation as the Trust services can no longer be maintained within routine service arrangements, and it requires special procedures not previously employed.

The below sequence must be adhered to:

1. All empty beds must be used by outlying base wards.
2. Rapid Flow and Boarding has taken place across appropriate areas.
3. Cancel non-cancer/non-urgent elective inpatient surgery & consider cancelling outpatient clinics (only where it can free up medical & nursing staff to support inpatient care)
4. Opening additional capacity - *opening additional capacity will be agreed in UHL Tactical Bed Meetings by the Chief Operating Officer/Chief Nurse/Medical Director and/or the Director on-call (out of hours).*
5. Cancel urgent electives (not cancer)

The UEC plan includes strengthening processes around bed management therefore during Autumn and Winter we will be:-

Embedding new areas of e-beds to include

- Bed Reservations to ensure moves within 1hr 30 mins.
- Daily review of closed beds to ensure timely action to open.
- Use of updated bed board to identify empty beds and opportunities earlier in the day.
- Ensuring all patients are in the right place (ensuring inter speciality moves are timely)

Embedding the daily review of discharge lists and long stay reviews for escalation internally and to system partners.

Clinical Decision Unit processes have also been reviewed and they will ensure that the tactical and Manager of the day teams attend the huddles in the unit. Discussion with clinical colleagues to ensure they understand the overview of the trust position (ensuring better representation on tactical command and at 07:30-8am, 13:00-13:30, 17:00-17:30) along with the ability for the teams to see patients waiting Cath labs procedures/investigations etc.

8.0 Discharge Support

A daily rhythm has been established which includes the following:-

- Complex discharge list – track and ensure timely discharge of patients.
- Home today is updated on nerve centre.
- Discharge status reports provided on tactical meetings.
- Liaise with LPT colleagues and transport to ensure optimisation of concurrent flow.
- Review the discharge flows to ensure the ‘home today – maybe’ fields are being updated to improve discharge flow throughout the day.
- Daily point of contact with colleagues on discharge queries.
- Review Criteria to reside completion and feedback to Manager of the day to resolve queries.

Escalation

Discharge Improvement Team (DiT)	Capacity & Flow
• Discharge Experts – point of escalation for discharge constraints. • Leaders in trust wide and system wide discharge improvement. • Complete trust wide discharge reporting and external responses. • Provide trust wide discharge training.	• Daily tracking of the complex discharge list. • Daily tracking of completion of Nervecentre and support to CMGs to ensure completion. • Check, challenge and support on status of discharge delays liaising with (DiT) if expert knowledge and support is needed. • Daily liaison with external partners to raise requests and escalations.

• CMGs	• Leadership
• Daily board rounds and processes to identify, progress and discharge patients within their areas. • Daily updates of Nerve centre (e.g. RDS, Home today, Criteria2Reside). • Regular reviews of long length of stay and planning for complex patient discharge. • Escalations to Senior Operational Manager or DiT as required.	• Dawn Angliss, Kate Hepton & Sue Bendelow – Overall. • Gill Staton – Discharge Improvement. • Chelsey Evans – Capacity & Flow. • HoN & Matrons – CMGs.

9.0 Communication and Engagement

The Leicester, Leicestershire, and Rutland (LLR) communications and engagement community has co-designed a plan for Winter 2024/25 to ensure consistent messaging and collaboration among partners in health and urgent care. The plan is aimed at maintaining public confidence in health services, supporting colleagues with information and recognition, and fostering strong collaboration across the LLR system. UHL plays a key role in supporting delivery of the broader system plan alongside UHL specific actions.

Objectives

1. **Public Confidence**: Maintain public trust in health services by providing clear messaging, promoting alternatives to emergency department (ED) visits, and ensuring appropriate use of NHS services.
2. **Colleague Support**: Ensure that internal communication keeps healthcare staff informed, safe, and supported.
3. **Partnership and Collaboration**: Foster increased collaboration among partners by sharing updates and promoting new initiatives across the system.

Messaging

In alignment with the LLR Winter Operational Plan, messaging will emphasise the following key areas:

1. **Prevention**: Promote actions that keep people healthy at home, including vaccinations (RSV, flu, Covid), repeat prescriptions, long-term condition management, and cold weather advice.
2. **Flow In**: Encourage the appropriate use of services, from self-care options to the use of NHS 111, pharmacies, urgent care, mental health services, and the NHS app.

3. **Flow Through and Out**: Provide clear guidance on referral pathways, discharge procedures, and patient transport to enhance system-wide effectiveness.

For colleagues across LLR, communications will focus on supporting staff well-being through vaccinations, health, and wellbeing initiatives, and by ensuring clarity about local services. Efforts will include:

- Acknowledgment of colleague contributions in executive messaging
- Timely updates on operational performance
- Cross-partner messages emphasising the collaborative system approach to Winter.

Key audiences

Externally, targeted messaging will focus on the following groups:

- Inner-city residents, especially those in higher deprivation areas.
- Parents and carers of young children, particularly with respiratory concerns.
- Those facing health inequalities and difficulties accessing services.
- Stakeholders, including MPs, councillors, community leaders, and the media.

Channels and activities

LLR partners will use a mix of communication platforms, including social media, websites, newsletters, and community networks. Depending on available budget, targeted social media advertising and a door-to-door campaign promoting alternatives to ED visits may also be pursued. For colleague communications, partners will use their established internal channels.

UHL-specific actions

UHL will amplify system-wide messages and undertake activities such as:

- Media briefings to highlight the challenges and Winter actions across our services, showcasing the efforts and commitment of colleagues.
- Public-facing messaging on appropriate service use, especially with a focus on new ED triage processes.
- Internal campaigns focused on #SaferUHL - colleague well-being, infection prevention, safety (Phase 2 of the Kindness Campaign) along with operational updates and alerts, making best use of our newly launched intranet.

These examples are not exhaustive, and more detail is available in the full plans, which are designed to remain flexible, allowing for adjustments based on emerging issues and opportunities throughout Winter.

10.0 Conclusion

UHL defined its UEC plan for 24/25 – as well as its planned care and CYP plans - early this year, including sharing these plans with colleagues in April 2024. This has allowed us to become more proactive in our planning for Winter 2024/25. Our winter plan wholly aligns with this plan.

Yet the demand and capacity challenges which we face as a Trust are significant and we will continue to work on initiatives to reduce the risk this challenge presents. This risk presents in various ways, including patient care, patient experience, access and financial pressures.

UHL has a clear plan and robust governance and escalation in place for winter 24/25, whilst we also acknowledge that there remains risk going into this winter given the challenges in capacity on both our elective and UEC pathways which still exist.

Board is asked to:

- Note the capacity challenges and risks which are being faced.
- Note the actions that are being taken to mitigate deficit.
- Support the governance process to receive updates via UEC Transformation Group, and escalations to the Trust Leadership Team as required.

Appendix 1: 10 High Impact Interventions

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, e.g., 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.

Appendix 2: Bed Gap

The following tables describe the bed gap at a trust level, these scenarios assume 0% growth. The overall bed gap in January 2025 is minus -243.

			Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
	0% Growth (NEL & Emergency) 24/25 Elective & Day Case at plan	Beds Required	1756	1803	1777	1693	1687	1744	1804	1827	1778	1850	1800	1786
		Beds Available	1727	1727	1727	1727	1727	1727	1727	1727	1727	1727	1727	1727
		Gap	-29	-76	-50	34	40	-17	-77	-100	-51	-123	-73	-59
Additional requirements	Avg. no of patients waiting in ED for beds at 08:00		53	58	52	42	46	57	66	66	60	84	70	67
	Reduce to 30		23	28	22	12	16	27	36	36	30	54	40	37
	Avg. no of patients waiting in CDU for beds at 08:00		37	36	28	27	27	41	40	39	49	57	38	39
	Reduce to 25		12	11	3	2	2	16	15	14	24	32	13	14
	Patients waiting in GPAU		14	14	14	14	14	14	14	14	14	14	14	14
	Patients in escalation beds (Rapid Flow & Boarding)		10	10	10	10	10	10	15	20	20	20	20	20
	Total additional		59	63	49	38	42	67	80	84	88	120	87	85
Unmitigated gap	Best case		-87	-139	-99	-4	-2	-84	-156	-183	-139	-243	-160	-143

Post mitigations detailed below the bed gap reduces to -130

			Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Mitigations 75%	Acute - capacity		41	41	41	41	41	41	41	41	61	61	61	61
	Acute - productivity		2	2	2	6	6	6	6	23	30	30	30	30
	Non Acute - PTCDA		3	3	3	3	3	3	3	3	3	3	3	3
	Non Acute - virtual wards		0	3	3	9	9	9	12	12	12	12	12	12
	Non Acute - Productivity		8	8	8	8	8	8	8	8	8	8	8	8
	Total mitigations		54	57	57	66	66	66	69	86	113	113	113	113

24/25 Winter Beds – Previous Schemes that were opened in 23/24, have closed or are due to close in Q1-2, with plans to open for this Winter.

CMG	Scheme	Implementation Date	Net impact
RRCV	Ward 16 GH open 4 beds during winter	Jan 25	4
LPT	Open Gracedieu for winter	Sept 24	20
RRCV	Ward 34 GH use during winter	Jan 25	8
ESM	Ward 20: CHUGGS to Medicine	April 24	19
LRI wards post CRO	Ward 15 / AMU South	Oct 24	16

Appendix 3: Risk

Risk	Description	Impact
There is a risk that capacity may not be delivered on time	Due to delays such as suppliers, planning or other competing demands, the additional capacity planned as part of the mitigations may be delayed	**Access** – bed bridge capacity will not be delivered as per the plan, and this will impact on occupancy levels and performance output for patients. **Quality** – patients may still see longer waits for admission in some periods. **Financial** – if the acute hospital is in surge and requires additional actions that have not been planned for, there may be a need to spend additional revenue that has not been budgeted for
There is a risk that out-of-hospital schemes are not delivered on time or have the impact	Due to delays outside of the direct influence of UHL, additional capacity and demand management schemes may be delayed	**Access** – bed bridge capacity will not be delivered as per the plan, and this will impact on occupancy levels and performance output for patients. **Quality** – patients may still see longer waits for admission in some periods. **Financial** – if the acute hospital is in surge and requires additional actions that have not been planned for, there may be a need to spend additional revenue that has not been budgeted for
There is a risk that there is a lack of availability of workforce	Workforce supply for the additional capacity is a significant risk, with reliance on bank and agency. Increased sickness levels due to increased respiratory illnesses and other sickness	**Workforce** – increased sickness levels due to reduction in staff morale and moral injury due to exhaustion
Assumptions in the demand and capacity plan are not all realised	If demand exudes the assumptions, or more capacity closes due to a lack of workforce available of IP restrictions then access to emergency care will be further restricted	**Access** – longer waiting times for patients. **Quality** – patients may still see longer waits for admission in some periods
Transport	Ability for Transport provider EMED to deal with daily demand	**Access** – longer waiting times for patients. **Quality** – Re-beds meaning patients do not go home on the day they are able to