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Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Council of Governors

Being Held on 12th December 2024

Subject	Sheffield Teaching Hospitals (STH) Winter Plan 2024/25
Supporting TEG Member	Michael Harper, Chief Operating Officer
Author	Anna Hescott, Assistant Chief Operating Officer Vicki Leckie, Deputy Chief Operating Officer
Status[1]	N

PURPOSE OF THE REPORT

To brief the Board of Directors on the Winter Plan for 2024/25.

KEY POINTS

Operationally, 2024 has been a challenging year. Teams have focussed on elective recovery and preparation for CONNECT go-live against the backdrop of a challenging summer with high emergency admissions and increased bed occupancy. As a result, preparations for Winter must include plans for managing ongoing operational pressures with a workforce that are increasingly pressured, specific plans to maintain planned care and safe options for further increasing inpatient capacity.

This paper outlines the organisation's proposed plan to prepare for Winter 2024/25 including:

- Plans to manage anticipated bed requirements based on expected seasonal fluctuations
- Plans to maintain the elective recovery programme
- Funded winter schemes; and
- The operational management of flow through the organisation throughout winter.

It describes the context by which the Winter Plan has been drafted and includes the first version of the Winter Plan 2024/25.

The Winter Plan will continue to be developed ahead of, and throughout, Winter. The key next steps are:

29th November	Winter Plan shared with MBB and a discussion on "Delivery through until March"
5th December	STH Winter Plan presented to Sheffield Place UEC Board
12th December	STH Winter Plan presented to Council of Governors

IMPLICATIONS[2]

	Aim of the STHFT Corporate Strategy	✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Create a Sustainable Organisation	
6	Deliver Excellent Research, Education and Innovation	

RECOMMENDATIONS

The Board are asked to receive the current (v2) of the STH Winter Plan 2023/24 and:

- **NOTE** the context of the Winter Plan in terms of:
    1. Supporting key individuals who form the core of the winter response
    2. The risk to other Trust objectives caused by the response to winter
    3. The need for the STH Winter Plan to sit within a wider Place based plan and the need for Partners to step up to describe their winter plans in an equally robust manner.
    4. The risk of costs exceeding allocated winter monies and the additional ones already agreed by TEG.
- **NOTE** the areas that require further development and that updates will be managed through OMG.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	20/11/24	Y
Board of Directors held in Public	26/11/24	Y
Council of Governors	12/12/24	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

Development of the 2024/25 Winter Plan

1. Local Context

In developing the Winter Plan, the following local context is noted:

- As described in the surge paper to TEG on 16th October, operational demand has resulted in significant spend on unfunded surge beds over and above and prior to the intended start of the winter wards on 1st December. This is a significant financial risk to the organisation. Surge beds have been used as follows:

	Summer	10th October	23rd October	Winter Plan	Full Hospital
TAU			32		32
J2 RHH			15		24
Brearley 1 (available 11th November)					28
G2 RHH (available 18th November)				26	26
Firth 1		10	10		10
Huntsman 7	4	4	4	4	4
Huntsman 2		32	32	32	32
Huntsman 4	32	32	32	32	32
TOTAL	36	78	125	94	188

- The impact that acute operational pressures will have on a relatively small number of leaders and clinicians across the organisation. Where these periods are infrequent or expected, those individuals have the resilience to respond, albeit with an impact on their business-as-usual activities. Given current operational pressures and the anticipation of this continuing into the Spring, the impact on these staff has already been noted and TEG are asked to consider how best to support these individuals and further 'spread the load' over the next six months.

- That there are competing, and complementary, asks of senior and operational leaders around activity and financial delivery, workforce support and responding to the pressures of winter. The Winter Plan attempts to identify the opportunities for co-ordinating these individual objectives whilst acknowledging the inevitable conflicts that will arise. A session at MBB in November aims to support Directorates to identify the opportunities for schemes which support winter and maintain activity and financial recovery, whilst supporting teams to deliver.

- The operational pressures of winter will require a system-wide response. Consideration will need to be given to achieve further traction can be achieved with Sheffield Place partners to increase admissions avoidance and support the discharge agenda including reducing the number of inpatients with no criteria to reside.

2. National and regional context

In a letter to providers on Winter and H2 priorities in September 2024, NHSE outlined a number of requirements of Trusts which relate to the winter plan:

- Review general and acute core and escalation bed capacity plans – with board assurance on delivery by the peak winter period
- Review and test full capacity plans which should include ensuring care outside of a normal cubical or ward environment is not normalised; only used in periods of elevated pressure; always escalated to an appropriate member of the executive and at system level; and it is used for the minimum amount of time possible
- Ensure the fundamental standards of care are in place in all settings at all times: particularly in periods of full capacity when patients might be in the wrong place for their care. If caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces
- Ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way

- Ensure plans are in place to maximise patient flow through the hospital, 7 days per week with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility

In addition, there is related work going on across SYICB and Sheffield Place including an updating of the repatriation and ambulance divert policies and discussions around the potential implementation of a maximum 45-minute maximum ambulance handover policy.

3. The aims of the STH Winter Plan

The winter plan aims to reduce admissions, increase discharges and improve organisational flow to respond to the seasonal pressures associated with winter. It aims to respond to the following areas of risk:

- Long waits in A&E/ambulance handover delays
- Responding to the anticipated increased levels of demand for inpatient and emergency services associated with winter alongside pre-existing variation in admissions and discharge over weekend and Bank Holidays
- Managing the complexity of multiple pathways for patients presenting with different respiratory viruses, notably COVID 19 and Influenza across acute and community services
- Supporting and caring for a workforce that is fragile given the ongoing level of operational demand with an increased risk of staff absence
- The continued focus on elective and cancer recovery alongside the increased non-elective workload
- Ongoing challenges outside of hospital impacting upon the number of patients with no criteria to reside
- Adverse weather
- Limitation of the physical estate

As a result, the STH winter 2024/25 plan includes plans to:

- Increase bed capacity, reduce admissions and expedite discharges;
- Maintain the elective recovery programme;
- Maximise the impact of funded winter schemes; and
- Oversight of enhanced operational management of flow and risk across the organisation.

Building on learning from previous winters, this year's plan includes the usual funded Winter Schemes, surge ward plans as well as developments around the Rising Tide and the Full Capacity Protocol, Same Day Emergency Care (SDEC) services, faster flow initiatives and further development of the Care Transfer Hub.

Given the current challenging operational context, the Winter Plan also describes a Full Capacity Protocol as requested by National teams. These would be enacted once the organisation has exceeded Rising Tide Stage 6. The exact plans, and order of implementation, for Stages 7 and 8 would be context specific and dependent on the situation at the time. The Winter Plan therefore describes the range of options potentially available and the structure for assessing and implementing at the time. Silver and Gold Command would be established at these stages. The current draft of the Winter Plan lists outs four categories of actions:

Red Line – TEG have agreed that these actions should not form part of the Winter Plan. They are described in the plan in order to confirm that they should not be used as a response.

Gold Command – TEG have discuss a list of possible actions. Work is underway to further refine these and describe the advantages and disadvantages of using each option. This information will be available such that when Gold is established, there is a level of detail available for Gold to review to make the decisions about actions to be taken. Once discussed at Gold Command, some of these actions may be able to be built into BAU/criteria led decisions.

Silver Command – These include decisions which can be taken out of hours by TEG on-call. A number of them are already used as part of the Trust's operational response. SOPs and criteria for each action will be developed so that staff can enact them in the safest possible way and plans to step out of the actions are clear to teams.

CEO – these actions may be played in, dependent on the situation, throughout the Rising Tide. All require sign off by the CEO 24/7. An SOP for each is being developed such that all the information required by the CEO is available at the point of escalation.

Further work is needed to develop each of these schemes over the next few weeks.

4. Further Development

The Winter Plan has developed over a number of years in order to build on new ideas developed and respond to new risks identified. A number of areas continue to be developed, as described above, and the Winter Plan will have further iterations throughout the winter

Operational Management Group (OMG) has been used throughout September and October 2024 to discuss and approve a number of the operational details described.

5. Summary and Next Steps

Once approved by TEG, the winter plan will be shared in the following forums:

29th November	Winter Plan shared with MBB and a discussion on "Delivery through until March"
5th December	STH Winter Plan presented to Sheffield Place UEC Board
12th December	STH Winter Plan presented to Council of Governors

Updates and changes to the Winter Plan will be managed through OMG.

6. Recommendations

The Board are asked to receive the current (v2) of the STH Winter Plan 2023/24 and:

- **NOTE** the context of the Winter Plan in terms of:
    1. Supporting key individuals who form the core of the winter response
    2. The risk to other Trust objectives caused by the response to winter
    3. The need for the STH Winter Plan to sit within a wider Place based plan and the need for Partners to step up to describe their winter plans in an equally robust manner.
    4. The risk of costs exceeding allocated winter monies and the additional ones already agreed by TEG.
- **NOTE** the areas that require further development and that updates will be managed through OMG.

The 2024/2025 STH Winter Plan – Version 2

Introduction

The STH Winter Plan this year aims to respond to the following areas of risk:

- Responding to the anticipated increased levels of demand for inpatient and emergency services associated with winter
- Managing the complexity of multiple pathways for patients presenting with different respiratory viruses, notably COVID 19 and Influenza
- Supporting and caring for a workforce that is fragile given the ongoing level of operational demand
- The continued focus on elective recovery alongside the increased non-elective workload
- Ongoing challenges outside of hospital impacting upon the number of patients with no criteria to reside

Maximising flow and winter schemes

Delivery of faster and early flow is essential to ensuring available beds across the Trust are utilised to minimise delays and crowding in A&E resulting in ambulance handover delays. Faster flow initiatives which are already in use at STH are utilisation of the discharge lounge and Anticipatory Flow alongside the work to maximise same day emergency care and the expansion of the care transfer hub. It is essential that throughout winter, directorate teams have operational mechanisms in place to maximise the use of these core ways of working:

Discharge Lounge NGH
The discharge lounge is a key element to improve patient flow through the Northern General Site. There is a continuing programme of work to improve utilisation, including: closer working with partners (YAS, SCCCC, the Care Transfer Hub); trialling taking patients with unverified TTOs; prioritising support for patients identified for Anticipatory Flow. Staff should ensure that discharges direct from the ward are only undertaken if the patient meets one of the agreed exception criteria. This will improve flow and earlier admissions.

Anticipatory Flow
Anticipatory Flow is being used across the GRaDE Care Group (working in partnership with the Patient Flow and AEMP teams) with an increased number of patients moved in the morning from AMU with the intention to trial an additional run in the afternoon. The plan is then to spread learning from this on-going implementation across other Care Groups.

Same Day Emergency Care (SDEC)
STH provides same day emergency care across its medical, surgical, frailty and oncological pathways with a proportion of patients discharged from hospital following an unplanned or non-elective admission on the same day (and every day). Two bespoke SDECs have been developed (so far) at STH – the Medical SDEC and the Frailty SDEC, both with >80% patients having same-day discharge. Work is underway to scope STH services across the 7 SDEC services in the new service specification for SDECs.

Care Transfer Hubs
Care Transfer Hubs (CTHs) are the national best practice operating model for supporting hospital discharge and are being implemented in regions across the country.

The Sheffield Care Transfer Hub has been live since May 2024 as a small-scale test of change. The team of Therapists, Nurses, Social Workers and Administrators now coordinate all supported discharges on seven wards at the Northern General Hospital (Vickers 2, 3,4, Brearley 2,4,5,6) with a planned rollout to include Huntsman 2, 4 and 5 alongside Brearley 7) before Christmas. Some key next steps for the CTH are the introduction of a Discharge Navigator role and a Digital Discharge tool (to enable the sharing of key information for partners in discharge to access the latest information in one place). By the end of March 2025, the plan is that the CTH will support 18 wards across STH.

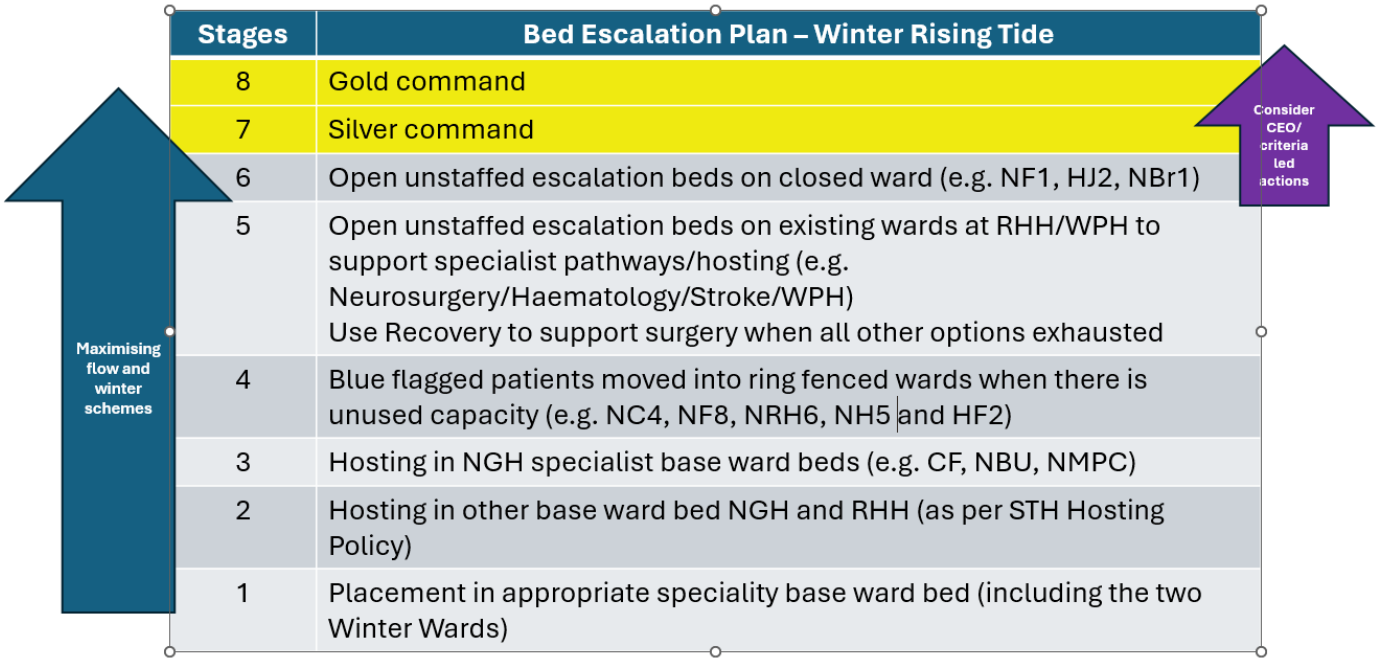
Winter Schemes

Alongside these year-round activities, £3.73m of non-recurrent schemes have been approved to support the Trust's response to the pressures of winter. The full list of schemes is included in Appendix A.

The STH Rising Tide

The STH Rising Tide is an operational framework which outlines a hierarchy of actions which create capacity and flow within the organisation. To maximise utilisation of staffed capacity (reducing the need for surge capacity) and minimise the cancellation of elective activity, the rising tide model has been updated for winter 2024/25.

The model identifies the operational stages that would be enacted as operational flow becomes more challenged, enabling the best use of available beds across the organisation. The model brings together the local agreements and SOPs and plans for additional surge and escalation wards as required.



Stages	Bed Escalation Plan – Winter Rising Tide
8	Gold command
7	Silver command
6	Open unstaffed escalation beds on closed ward (e.g. NF1, HJ2, NBr1)
5	Open unstaffed escalation beds on existing wards at RHH/WPH to support specialist pathways/hosting (e.g. Neurosurgery/Haematology/Stroke/WPH) Use Recovery to support surgery when all other options exhausted
4	Blue flagged patients moved into ring fenced wards when there is unused capacity (e.g. NC4, NF8, NRH6, NH5 and HF2)
3	Hosting in NGH specialist base ward beds (e.g. CF, NBU, NMPC)
2	Hosting in other base ward bed NGH and RHH (as per STH Hosting Policy)
1	Placement in appropriate speciality base ward bed (including the two Winter Wards)

Stages 1-5 of the Rising Tide: Maximising use of capacity alongside speciality pathways and elective care

The early stages of the rising tide aim to maximise the use of staffed areas and place patients in the best available spaces for their needs, while balancing the needs to maintain and protect specialty and elective pathways. Historically, elective capacity has been utilised at times of winter surge; converting from elective to non-elective capacity. However, the majority of inpatient elective capacity is already contained within the following areas:

- Firth 8
- Chesterman 4
- Robert Hadfield 6 – ringfenced bay and side rooms for elective MSK patients
- Sheffield Elective Orthopaedic Centre (SEOC) – ringfenced for MSK patients
- F2 RHH

As part of the Rising Tide stages 2-5, SOPs are in place for patient placement outside of the appropriate speciality base ward bed and for when non-elective patients can be placed into protected elective capacity. Fully repurposing any of the elective areas for non-elective capacity would result in the cancellation of elective activity and therefore impact on Priority Two elective cases or long waiting patients and the related recovery trajectories. This decision sits at CEO and/or Gold level. Where the cancellation of elective activity is required due to a lack of inpatient beds, a 'surgical commander' (drawn from the

CMO office or a senior surgeon) should prioritise which cases must proceed, and which procedures can be replanned.

In addition, the protocol for the direct fractured neck of femur pathway requires that a male and female bed within Huntsman 5 are ringfenced for direct admission of these patients to the ward. This improves the pathway for this cohort and whilst this will reduce this ward's ability to care for hosted patients and reduce the available bed stock by 2, it will free up beds in other areas of the organisation for hosting or patient placement if required.

There is also a proposal being reviewed by SYRS and Surgical Services colleagues regarding the proposal to return Chesterman 3 and Chesterman 4 to primarily hosting cardiothoracic and cardiology patients respectively. Once mutually agreed, this will be included within the plans to protect elective capacity.

Stage 6 of the Rising Ride: Increasing capacity beyond staffed areas

The Winter Plan facilitates the opening of two staffed and funded (through winter monies) wards for winter from 1st December. This is in addition to Huntsman 4 (the 'summer surge' ward) and acknowledged, by TEG, that these may need to open (at additional cost) before the planned/funded dates.

In addition, ward capacity is available on Firth 1, Brearley 1 and J2. No staffing is identified for any of these areas. Whilst staffing patients in a ward facility is preferable to a non-ward or non-clinical area, opening beds without the appropriate staffing can have a significant impact on patient experience, outcomes and length of stay. Every effort should be made to ensure all surge areas have appropriate support from the full multi-disciplinary team.

Outside the winter plan described in the table above, only J2 and Brearley 1 would be available for any required ward decants required over the winter period (for unplanned IPC or estates purposes).

<u>Firth 1</u>
Is often used as a step-wise increase in beds given its size (10 beds). It can be used for medical and surgical patients.

<u>J2</u>
Work is required to identify a medical team and pathway to RHH if this is opened.

<u>Brearley 1</u>
Work is required to identify a medical team and operating model for this ward if opened above current surge capacity.

Stages 7 and 8 of the Rising Tide: Organisational Command and Control

The day-to-day operational oversight of the organisations is run via the Operational Support Room (OSR) 8am-5pm Monday to Friday, led by the Clinical Operations team. Outside of these hours oversight rests with the First on Call Senior Manager. Currently there is a daily operational huddle at midday with a further huddle at 3pm if required. These huddles are chaired by the Patient Flow Matron with support from the Senior COO lead during the week and escalations made to FOC as needed during the weekend/bank holidays.

Operational Senior Leads of the Day for each of the key directorates report into the OSR. A daily rhythm exists to ensure:

- Data is used to predict daily admissions and discharges 48hours in advance
- Oversight of the live bed position, ambulance delays, empty beds and PDDs
- Early transfer from admissions units, allocation of domestics and portering and maximising use of the discharge lounge
- Decisions, and follow-up actions, are clear at each Operational Huddle
- Collaboration with the System Co-ordination Centre (SCC)

Silver Command will be established to provide additional oversight of the operational position where the organisation is in a challenged operational position for a period of time. The current trigger is to establish Silver Command when the organisation has been on OPEL level 4 for 72hours (enacting stage 7 of the Rising Tide (once all unstaffed escalation beds are open, prior to cancellation of non-urgent elective activity to release IP beds)).

The role of Silver is to identify risks across the organisation and respond in a way which reduces the overall level of risk held by the organisation. It will be used to cascade information, monitor risk and make and enact decisions. Silver Command will be chaired by the Chief Operating Officer (or deputy) in hours and First on-call out of hours. It will meet with Bronze Commands as a collective, but also work in the background to co-ordinate the Winter response in collaboration with the established operational oversight of the organisation. Silver Planners may be established which will be a small cohort of senior leaders to review risks on a dynamic basis and set direction for the organisation through Bronze Commands.

The establishment of Silver Command will result in the Trust considering its options under the **Full Capacity Protocol**. The exact plans, and order of implementation, for Stages 7 and 8 would be context specific and dependent on the situation at the time. The Winter Plan therefore describes the range of options potentially available and the structure for assessing and implementing at the time.

Gold Command will be established (enacting stage 8 of the Rising Tide) when it is evident that the recovery time objectives set by Silver Command cannot be met (e.g. extended requirement to use TAU risking urgent elective activity). Gold will be chaired by the Chief Executive or deputy. Silver Command will escalate risks that it cannot mitigate. At this stage, City partners will be asked to establish their own Command and Control structures and STH Gold will link into, on behalf of STH, the Place winter response.

Further work is ongoing to refine and develop schemes within the Full Capacity Protocol (FCP). The red lines are described in the Plan but are not to be enacted as part of the response. Silver and Gold will manage the organisation wide risks associated with enacting the FCP, based upon the following framework:

Red lines (excluded from the FCP)	• Set higher criteria for admission for all emergency patients • Set lower criteria for discharge • Close/divert tertiary pathways • Bedding down of non-ward spaces (e.g. UAU, SDEC, discharge lounge) • Bedding down of assessment areas (e.g. AMU pitstop, SAC A bay, SFU chairs) • Close renal for planned care and use for general emergency patients
Gold – stage 8 of the Rising tide	These are a series of options that include decisions to alter established patient pathways AND/OR that potentially increase risk in specific clinical areas in order to reduce the overall organisational risk AND/OR include decisions outside of usual working practices
Silver/on call teams out of hours – stage 7 of the Rising Tide	• Identify medical model and pathway to Osborn for patients who don't fit criteria to create more general emergency beds • Encourage patients who are MFFD to wait at home • Specialty in-reach into A&E to support Dr wait • In collaboration with triumvirates, agree to use non-clinical DCCs and SPAs to be used to support flow • Cancel outpatient activity to free up clinical teams if needed to ensure morning review of inpatients • Extension of operating hours in existing spaces - e.g. UAU, SDEC, Discharge lounge • Temporary escalation of existing spaces overnight (e.g. AMU pitstop, SAC A bay, SFU chairs) • Prioritise A&C staff for ward clerk duties • Community matrons in-reach to support discharge • Cancel outpatient activity to release AHPs to support inpatient care

In addition, a number of actions may be required at any point on the Rising Tide that require CEO approval before enacting. These are:

CEO approval	Accept patients may wait over 12-hour for admission Allow mixed sex breaches (e.g. in recovery/RSU) A&E non-MTC divert TAU admission spaces converted to emergency beds impacting on DC and IP elective admissions Cancel elective surgical lists to create emergency theatre capacity Cancelling elective care in advance to accommodate emergency patients

System Co-ordination Centre (SCC) and National Operating Pressure Escalation Level (OPEL) framework and National Reporting

The organisation provides updates to South Yorkshire Integrated Care Board (ICB) and subsequently the Regional NHS England team via the System Co-ordination Centre (SCC). The SCC is a central co-ordination service for providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible.

An update to the national Operational Pressures Escalation Levels (OPEL) framework is expected imminently, including a new community OPEL scoring alongside the existing acute OPEL. The framework uses core parameters to define the OPEL assessment, which are updated digitally to provide a real-time assessment of the OPEL escalation level, reported through the SCC.

Local escalation polices will be updated to reflect the updated national OPEL action cards. As part of their role, SCCs will be responsible for the co-ordination of an integrated system response using the OPEL Framework alongside constituent ICS providers and ICB policies. The YAS/SYICB Joint Escalation Action Plan (JEAP) will also be updated in line with the updated OPEL actions.

Updates will be required 7 days a week to the SCC and 8am-5pm. Monday to Friday this will be completed by the Clinical Operations team, and at a weekend, supported by the Patient Flow Matron with escalations into First On Call as needed.

From 1st November 2024, NHS England recommenced 7 day a week reporting for the Urgent and Emergency Care performance and exception reporting. In hours this is completed by the Clinical Operations Team and out of hours this is completed by the First on Call Senior Manager.

The **Sheffield Place winter plan** outlines the system plan aimed at improving the 4hr standard, reducing category 2 ambulance response times and reducing the number of patients with no criteria to reside. There is also a Rising Tide response being developed for the City in line with updated OPEL guidance. This will be pursued through the Urgent and Emergency Care Board. If Gold is established there will be an expectation that Place partners are in a similar state of escalation and are following pre-prepared plans to reduce the overall risk in the health and social care system.

Appendix A

Green/Blue Schemes

No	RAG	CG	Scheme name	£'k
1	Pre	CCA	Provision of non-nursing staffing for GSM winter ward (Medics)	278.8
2	Pre	Various	IM3s	233
3	Pre	GRaDE	Respiratory consultant	112.3
4	Pre	COO	Patient Flow - Band 6's x2	43
5	Pre	CCA	Hadfield - Junior Doctors	37
6	Pre	Labs	Influenza Point of Care	176.5
7	Pre	COO	Flu vaccine	109
8	Pre	COO	Admin staff for staff vaccinations	41
9	Pre	COO	Flu staff costs of dispensing	39
10	Pre	COO	Ambulances (365 and night transfer)	125
11	Pre	Various	24/25 M1 winter costs	313
Subtotal - pre-commitments				**£1,508**
12		Facilities	Bed Turnaround Team	88.4
13		Facilities	Rapid Cleaning Team (Nights)	47.8
14		AEMP	Appointment of 3 WTE F3 Drs	70.9
15		AEMP	Increased Junior Doctor Locums for A&E	63.8
16		AEMP	Additional Acute Medicine Consultant Physician Shifts at Weekends (above recurrent approved recruitment costs)	27.0
17		AEMP	A&E Point of Care Testing – COVID-19 and FLU - Additional Clinical Support Workers (CSWs) or Registered Nurses (RNs) (given CSW recruitment challenges)	33.8
18		AEMP	Evening and weekend enhanced Pharmacy services. Increased support within the central pharmacy services to process prescriptions and orders and facilitate access to medicines and prioritised TTOs. Additional ward-based pharmacists and MMTs for admission wards at weekends	126.0
19		AEMP	Enhanced Care Pharmacist Monday to Friday (current roles)	73.1
20		AEMP	Enhanced Pharmacy support for weekend discharges at NGH- 1 roving pharmacist at weekends and bank holidays to liaise with the central department and the discharging team(s) at NGH	13.8
21		GRaDE	Additional PTWR support for GRaDE at a weekend	27.7
22		Labs	Point of Care Testing Staffing	14.9
23		Labs	Microbiology/Virology Staffing	38.8
24		COO	Central winter transfer team	53.8
Subtotal – non ward schemes(to be allocated)				**£679**
25		Facilities	Domestics for winter wards	135.4
26		AEMP	Ward clinical pharmacy support - 2 additional wards	37.6
27		CCA	Acute Therapy Services requirements per additional ward	60.8
28		CCA	Dietetics requirements per additional ward	3.6
29		CCA	Speech & Language Therapy requirements per additional ward	17.9
30		CCA	AHP Package per additional ward (SaLT, OT, PT, dietetics)	82.1
31		SS	HOOH for 2 additional wards	31.6
32		CCA	GSM Winter Ward - Nursing Costs (26 beds)	564
33		GRaDE	GRaDE Winter Ward - Nursing Costs (32 beds)	607
Subtotal – ward schemes (to be allocated)				**£1,540**

Total	**£3,727**

Amber Schemes

34		Facilities	AMU Turnaround Team (Nights)	74
35		AEMP	STH HALO (Hospital Ambulance Liaison Officer) - Cum - Ambulance Streaming Sister	44.6
36		AEMP	A&E and AMU Flow Coordinators	89.1
37		GRaDE	TTO DRs	13.4
Total amber:				**£221.1**

Red Schemes

38		CCA	Provision of Respiratory Physiotherapy Service to AMU	35.84
39		AEMP	Additional Clinical Support Workers (CSWs) or Registered Nurses (RNs) (given CSW recruitment challenges) AND Orderlies for A&E and AMU - Transfer Team **Replaced by Central Winter Transfer scheme**	53.84
40		GRaDE	Matron cover to provide senior leadership and governance oversight, and promote excellent patient flow practice.	37.9
41		GRaDE	Anticipatory flow and Discharge Band 6	36.0
42		MiMP	MIMP Portering until 00:00	43.8
43		MiMP	Additional radiographer for IP/ED x-ray	49.6
44		MiMP	Additional hot reporting for ED	6.7
45		MiMP	Additional Reporting Capacity	23.4
46		MiMP	Additional Ultrasound Capacity	206.0
Total red:				**£493.1**