

Reporting to:	Trust Board, Thursday 30th April 2015
Title	Review of The Trust's Winter Plan 2014/15
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Author(s)	Ian Donnelly, Assistant Chief Operating Officer (Unscheduled Care)
Previously considered by	
Executive Summary	<p>The Operational Resilience and Capacity Plan was phased in from October 2014 and was designed to provide resilience over the winter and ensure that patients received timely access to the quality services that they needed.</p> <p>This paper reviews the impact of the plan and the schemes within it on performance, quality and safety, workforce and finance, and the lessons learnt.</p> <p>It identifies that demand and the number of patients medically fit for transfer exceeded the levels of seen in 2013/14; meaning that there was less capacity available in 2014/15 than in 2013/14.</p> <p>It concludes that despite best efforts the investments received by the local health and social care community did not achieve the aim of ensuring delivery against the constitutional targets of 18 Weeks RTT and 95% Emergency Department 4 hour performance, but without this, performance and impact on quality and safety could have been significantly worse.</p> <p>Recommendations of actions to ensure operational sustainability are included which, when achieved, will give the Trust the ability to manage a surge in demand in the future more effectively.</p>
Strategic Priorities <input checked="" type="checkbox"/> Quality and Safety <input checked="" type="checkbox"/> Healthcare Standards <input checked="" type="checkbox"/> People and Innovation <input checked="" type="checkbox"/> Community and Partnership <input checked="" type="checkbox"/> Financial Strength	Operational Objectives <p>The main focus of the winter plan was to deliver sustainable quality and safety across the site, to support patient flow from the ED within a financial envelope. The main objectives can be best described as follows:</p> <ul style="list-style-type: none"> • Deliver safe sustainable ED departments ensuring staff and patients' feel supported • Deliver improvement in the trust safety target and deliver 95% • Deliver site flow at any time and day of the week • Enhance discharge arrangements to sustain times of increased sustained pressure • Ensure TCIs' are given equal priority as emergency patients' are • Provide additional workforce to deliver safety across all areas • Deliver the winter plan within the financial envelope

Board Assurance Framework (BAF) Risks	<input checked="" type="checkbox"/> If we do not deliver safe care then patients may suffer avoidable harm and poor clinical outcomes and experience <input type="checkbox"/> If we do not implement our falls prevention strategy then patients may suffer serious injury <input type="checkbox"/> Risk to sustainability of clinical services due to potential shortages of key clinical staff <input checked="" type="checkbox"/> If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards <input checked="" type="checkbox"/> If we do not have a clear clinical service vision then we may not deliver the best services to patients <input checked="" type="checkbox"/> If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale and patient outcomes may not improve <input type="checkbox"/> If we are unable to resolve our (historic) shortfall in liquidity and the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	<input checked="" type="checkbox"/> Safe <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Caring <input checked="" type="checkbox"/> Responsive <input checked="" type="checkbox"/> Well led
<input type="checkbox"/> Receive <input type="checkbox"/> Review <input type="checkbox"/> Note <input checked="" type="checkbox"/> Approve	Recommendation The Trust Board is requested to APPROVE the recommendations outlined in the paper.

REVIEW OF THE TRUST'S WINTER PLAN 2014-15

1 BACKGROUND

For the winter of 2014/15 the Trust submitted its Winter Plan as part of the Whole Health and Social Care Community Operational Capacity and Resilience Plan (OCRP) which was presented to the Trust Board in September 2014.

The plan covered both non elective and elective care and described how the whole system would work together collectively to deliver against the constitutional targets of 18 Weeks RTT and 95% Emergency Department 4 hour performance.

The plan was developed using the learning from the 2013/14 plan and benchmarking against core aspects of best practice to inform the allocation of funding. Internal SaTH plans were focused on increasing staff in key areas including nursing, medical staff, therapists and pharmacy. A full financial appraisal is included later in this paper.

2 PLAN SCHEMES 2014/15

With the anticipated increase in demand, SaTH's Winter Plan consisted mainly of increasing staffing across a number of specialities and was used to fund additional staffing in 3 key areas:

- Assessment Units:
 - Emergency Department (ED);
 - Acute Medical Unit (AMU);
 - Surgical Assessment Unit (SAU).
- Flexible bed capacity:
 - Day Surgery Unit (DSU) at RSH and PRH
 - Increasing beds on Ward 32 Short Stay (W32SS), Trauma & Orthopaedics (T&O) and the Clinical Decision Unit (CDU) corridor at RSH;
- Therapy support both sites;
- Pharmacy support.

Funding for increased staffing ensured that we could provide additional junior doctor cover and weekend ward round consultant presence on both sites. Additional nursing staff ensured all flex areas were safely managed to support the maintenance of quality.

Improving Discharge Processes

As part of the Discharge to Assess work streams and the development of the site teams we have continued to develop and improve the discharge planning process. This has included increasing the number of pre 13.00 discharges; the development of new paperwork (single referral document), twice daily discharge hub meetings and reviewing our escalation plans. These improvements have supported timely effective discharge ensuring delays are reduced and that we improve pre 13.00 discharge targets. Each ward now has a discharge target and this is reviewed by the site teams with Heads of Capacity and Heads of Nursing deciding what actions are needed to support any ward not delivering the required standards. This will continue throughout this year as we further develop the site teams and the discharge project. During the month of March the following information shows the level of discharge at 13.00.

Discharge @ or before 1300:

- | | |
|-----------------------|---------------|
| • PRH – Weekend – 37% | Weekday – 32% |
| • RSH – Weekend – 43% | Weekday – 33% |

National best practice shows a benchmark of 30-35% of discharges before 13.00.

Reducing the Number of Patients Medically Fit For Transfer (MFFT)

Whilst relying on the community and local authorities to provide sufficient capacity to reduce the number of patients who are Medically Fit to Transfer, SaTH's role is to ensure that these patients are discussed twice daily on each site. This process is led by the Heads of Capacity who provide supportive challenge and ensure that no patients wait needlessly for their next place of care. Aligned to this process is an external escalation of delays to relevant external organisations in order to progress individual cases and also to identify key themes.

The System Resilience Group (SRG) agreed a target of circa 30 patients over 1 day as a maximum on the MFFT list, as directed by NHS England (NHSE) and the Trust Development Authority (TDA) in July 2014. This target has not been achieved.

Bridging the Bed Capacity Gap

Bed modelling had identified an average gap of 66 beds across both sites through the winter period.

It was agreed by the health and social care economy that purchasing additional bed capacity outside of the acute Trust and a main focus on Discharge to Assess (D2A) would be the best use of resources to bridge the 66 (average) bed gap because:

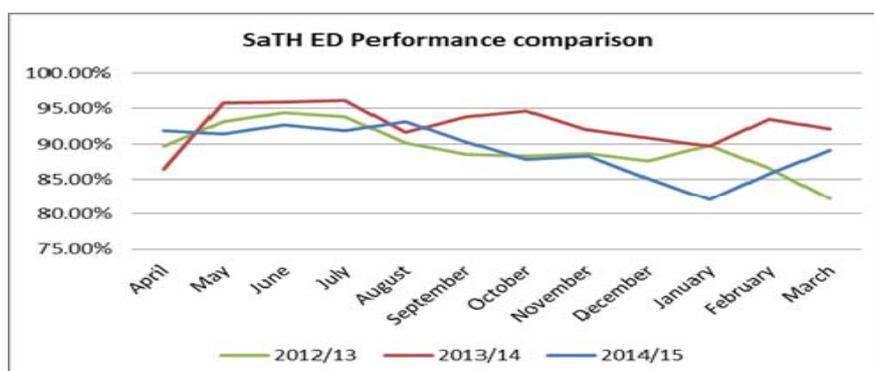
- It was unlikely that the acute Trust would be able to staff another ward given the level of vacancies in nursing staffing at that time;
- Capital costs of a drop-in ward were circa £1M (without staff);
- There was a risk that unless models of care were changing, patients would remain in these additional beds when Medically Fit For Transfer so no additional capacity would be created;
- Purchasing additional capacity from numerous providers spread the risk of alternative providers being unable to staff additional beds;
- It allowed for the development of alternative models of care as part of a longer term strategy e.g. the development of Discharge to Assess;
- It was the right thing to do for patients e.g. only patients needing acute care should be in the hospital setting.

Therefore as part of the system-wide Operational Resilience and Capacity Plan, beds/bed equivalents that would support admission avoidance or earlier discharge should be planned to be purchased and/or additional capacity opened (community hospitals and Robert Jones & Agnes Hunt).

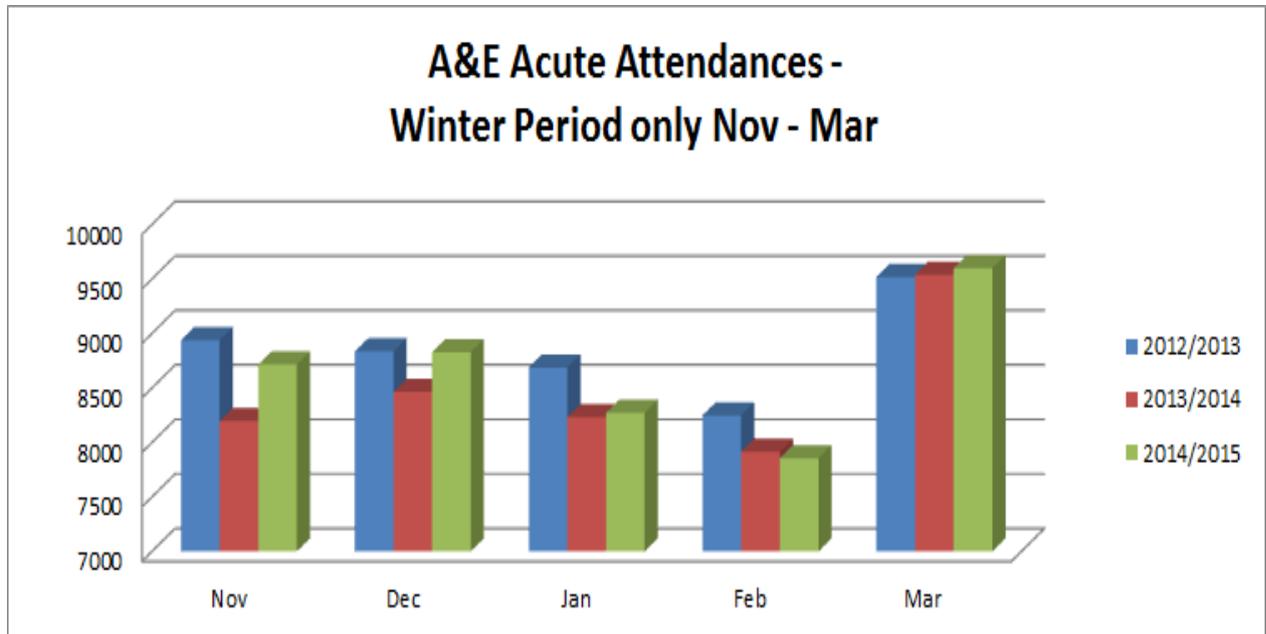
As reported to the Board, each month the MFFT numbers did not reduce over the winter period (and remain above trajectory) and the gap of 66 beds was never bridged; despite commissioners purchasing additional bed capacity. This led to patients being bedded daily in the Emergency Department with long waits for a bed. The Trust cannot function effectively with 10-15% of its acute bed base unavailable and 96% occupancy rates.

3 WHAT WAS THE IMPACT OF THE PLAN?

Regrettably and despite best efforts 4 hour performance deteriorated over the winter. However it must be remembered that the start point going into this winter was lower than in 2013/14. The following graph highlights this as a comparison to 2013/14.



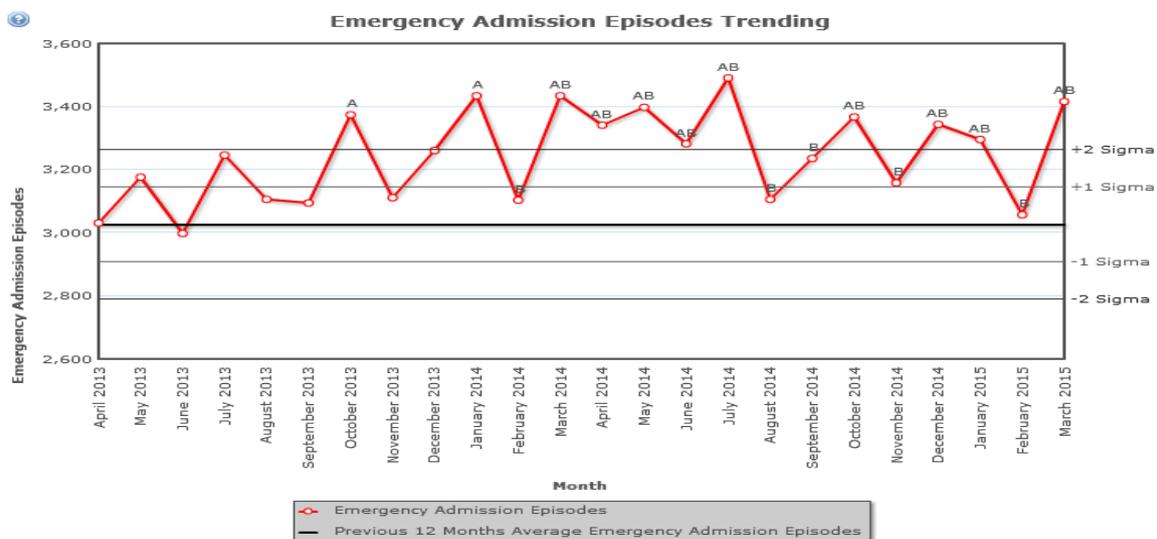
- Attendances during the winter period were 10% above 2013/14 and admissions varied with surges but were 3.5% higher;
- There were an increased number of 8 hour escalations;
- Number of 12 hour breaches – Winter 2014/15 we had 19 compared to none in 2013/14. In 2013/14 high levels of cancellations of TCI's led to failure of the 18 Week admitted performance standard.



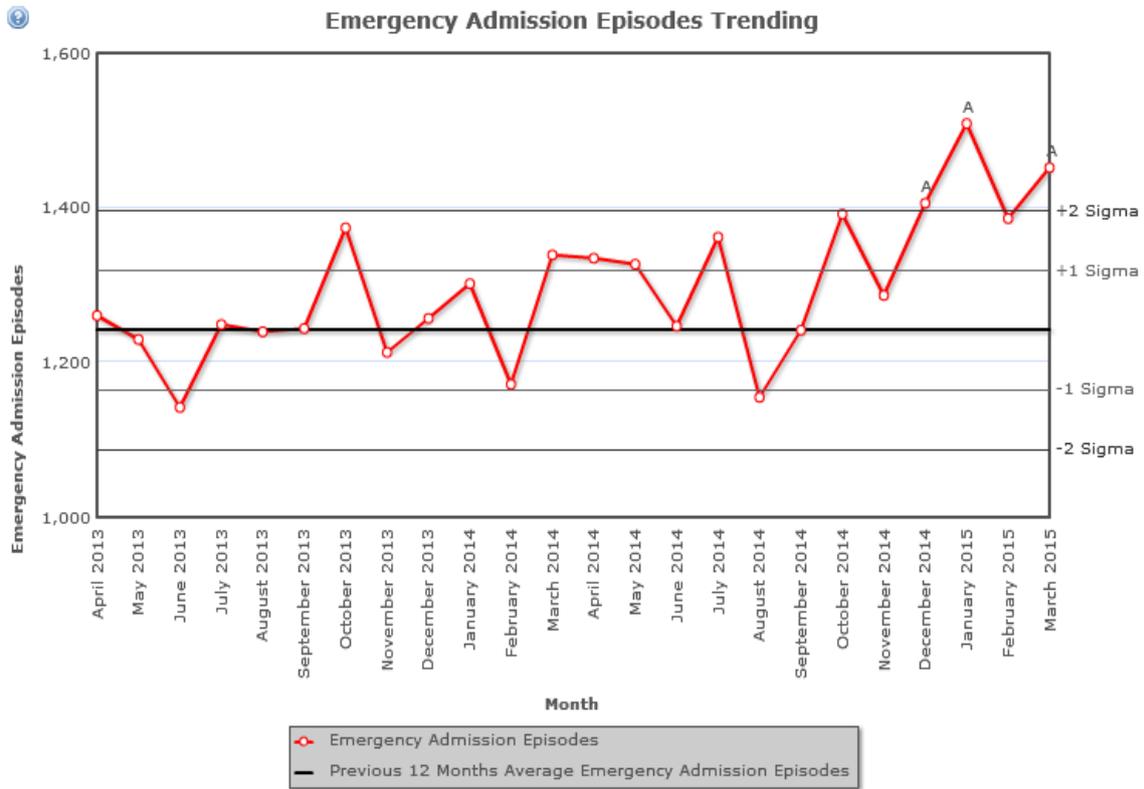
Whole system schemes throughout the year have been aimed at reducing demand.

Emergency admissions have remained above the average for the previous 12 months for all of 2014. There was also a significant increase in emergency admissions to the PRH site from August 2014. Whilst RSH showed a reduction in emergency admissions the rate remained above the average for the previous 12 months. Variation kills flow and over the winter period there were weeks where emergency admissions were 10-13% higher which we are unable to manage when working at 96% plus bed occupancy.

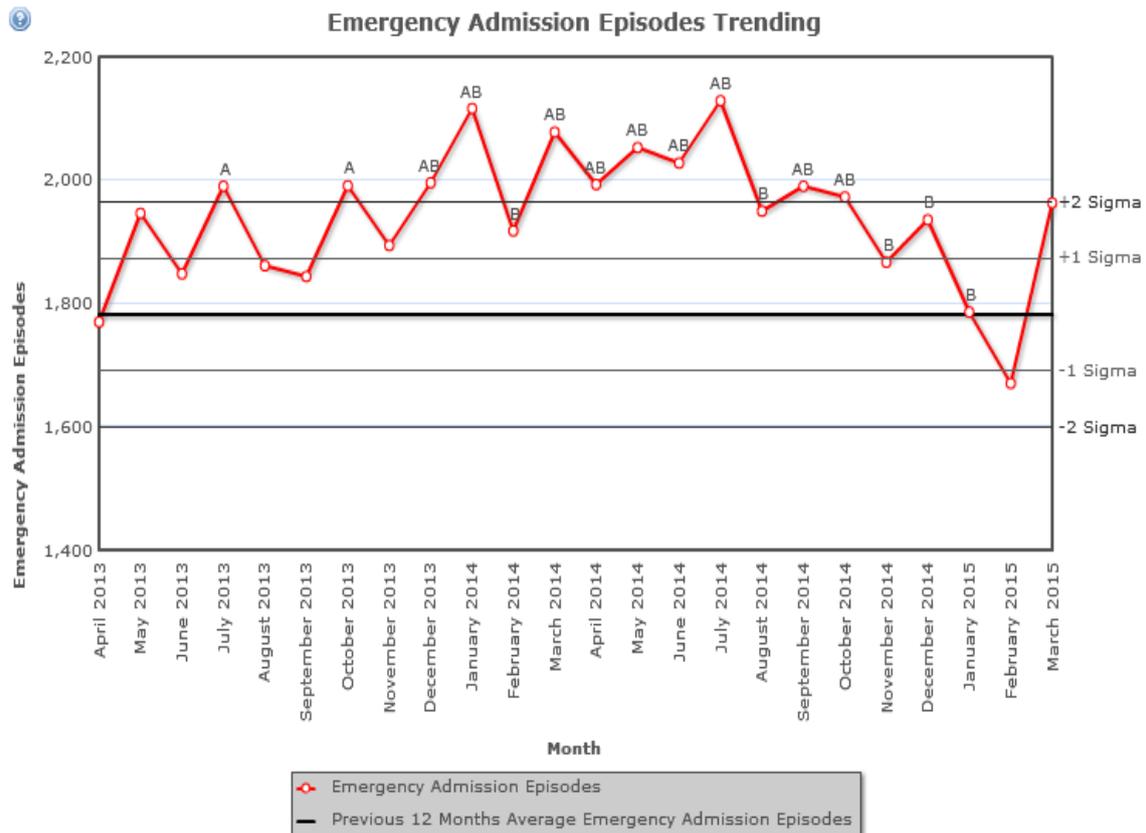
On 31st December 2014 the Trust was on escalation level 4 and was forced to relocate the Paediatric Assessment service from Ward 21 at RSH site so that this could be used for inpatient capacity (14 beds). This was done at risk but essential in order to maintain patient safety and enable the emergency department to function. This ward remained open until 13th March 2015.



PRH Site

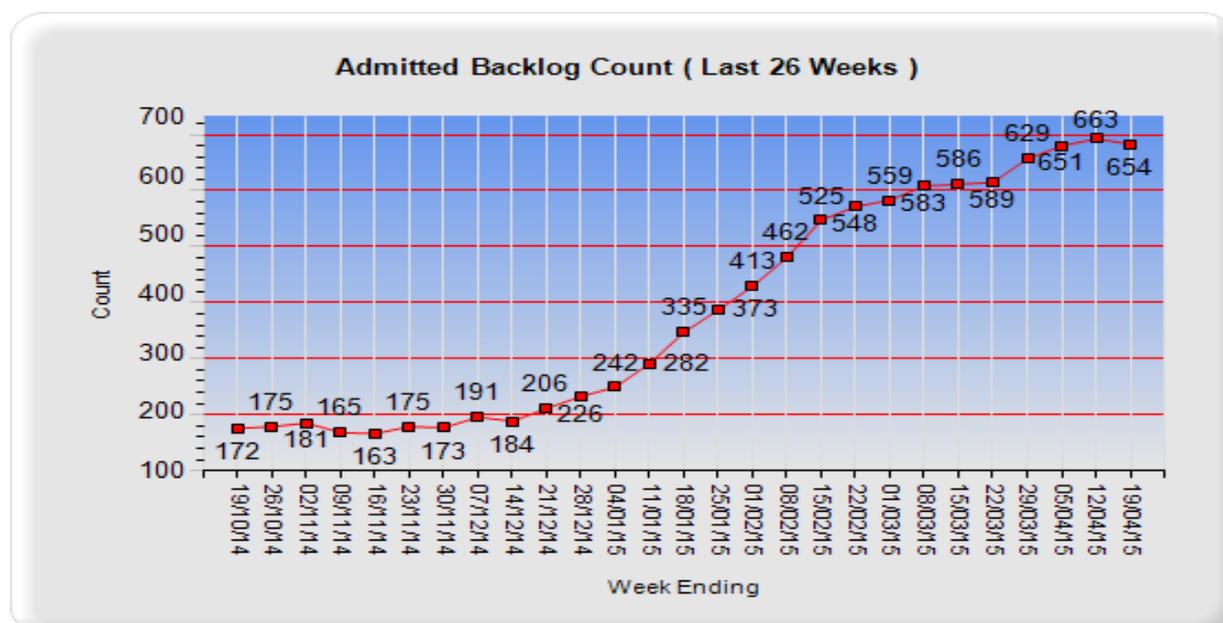


RSH Site



As reported to the Board the acuity of patients at the RSH site increased over the winter period leading to longer lengths of stay and reducing bed availability.

RTT Backlog



The sustained level of emergency admissions led to cancelled operations and an increase in RTT backlog (patients waiting over 18 weeks for treatment).

The admitted backlog increased from 163 in October 2014 to 676 in March 2015.

Ambulance Turnaround

We have made steady improvement over previous winters in achieving handover targets but fell short of 2013/14 figures. However it should be noted that with the severe pressure in both ED's turnaround figures were good with the exception of January; although assessment areas are still struggling to manage this week by week. However we have now reduced the over 1 hour delays by month to single figures on both sites.

The table below shows ambulance handover performance for February & March 2014/15 compared against the same months in 2013/14.

Year on Year Comparison of Ambulance Handover Turnaround					
<i>Ambulance Handovers not completed within 30 mins</i>					
	Nov	Dec	Jan	Feb	Mar
Target	0	0	0	0	0
2013/14	8	21	10	4	19
2014/15	36	48	62	51	25
YoY Variance	28	27	52	47	6
YoY % Increase	77.78%	56.25%	83.87%	92.16%	24.00%
<i>Ambulance Handovers not completed within 60 mins</i>					
	Nov	Dec	Jan	Feb	Mar
Target	0	0	0	0	0
2013/14	0	4	1	0	4
2014/15	4	10	16	3	5
YoY Variance	4	6	15	3	1
YoY % Increase	100.00%	60.00%	93.75%	100.00%	20.00%

There was a 10% increase in ambulance conveyances to PRH over the winter period and there has been a change in the peak times of arrival from 12.00 – 13.00 to 18.00 – 20.00 with Tuesdays now seeing the highest number of arrivals than any other day of the week.

4 WORKFORCE

We have seen an increase in sickness absence over the winter period both long term and short term. There has been an increase in staff recording stress related illness as a reason for absence over the previous 6 months.

Care Group	Number of staff citing stress related illness as reason for absence October 2014- March 2015
Estates and facilities	16
Womens & Childrens	24
Support services	18
Unscheduled care	64
Scheduled care	76
Corporate	10
Total	208

We continue to work with managers to support staff and have recently improved access to our occupational health and staff counselling service. The health and wellbeing of our staff is a priority within Our People Strategy and we continue to deliver interventions to both directly support staff and also to help managers in their ability to support their staff.

Over the winter period ward managers and matron's in particular report low morale amongst ward staff describing staff as tired, with all high level escalation areas, including staff from clinical support staff expressing concerns about the demands put upon them. We have also seen an increase in narrative feedback from staff exiting the organisation who have chosen to leave the NHS altogether citing pressures at work over the last 6 months as the main reason for leaving.

Pressures have also impact upon the ability to send staff on training opportunities including statutory training, ward managers have reduced their time spent on management duties (impacting on sickness absence, performance management and appraisals etc.). The increase in temporary staff has impacted upon team working and morale, whilst the effects are not immediate the recent successful recruitment drives should help to improve morale within the clinical areas.

5 FINANCIAL APPRAISAL

The Health and Social Care Economy received £5.4M funding for the Operational Resilience and Capacity Plan.

Outlined below is a breakdown of where the funding allocated to SaTH was spent including planned spend against actual.

Winter Resilience 2014/15 Financial Summary

	Total Income Received £,000	Actual Costs Incurred £,000	Variance £,000
Tranche 1			
Escalation of capacity 7 day working	1,187,000	1,817,000	(630,000)
A&E/AMU Resilience	207,000	246,000	(39,000)
Additional Pharmacy Capacity	84,000	84,000	0
Single Referral Process/Trusted Assessor Project	46,000	46,000	0
Tranche 2			
Ambulatory Care Development	760,000	773,000	(13,000)
Total	2,284,000	2,966,000	(682,000)
Escalation costs incurred but within funding source			
Ward 21	0	403,000	(403,000)
Total	2,284,000	3,369,000	(1,085,000)

Summarised staffing and cost breakdown by scheme

	SaTH Escalation to capacity 7 day working		A&E/AMU Resilience		Additional Pharmacy Capacity		Single Referral Process/Trusted Assessor Project		Ambulatory Care Development		Ward 21		Total	
	WTE	£,000	WTE	£,000	WTE	£,000	WTE	£,000	WTE	£,000	WTE	£,000	WTE	£,000
Consultant	1	62							2	373			3	435
Medical Staffing	2	63	7	210					5	120			14	393
Nursing	57	1,382	2	36					10	179	25	376	94	1,973
Other Clinical	9	180			2	84	1	16	1	34			13	314
Non-Clinical	2	19					2	30	1	41			5	90
Total Pay	71	1,706	9	246	2	84	3	46	19	747	25	376	129	3,205
Non-Pay		111								26		27	0	164
Total	73	1,817	9	246	2	84	5	46	20	773	25	403	134	3,369
Timeline (approx.)	Oct-Mar		Oct-Mar		Oct-Mar		Oct-Mar		Dec-Mar		Jan-Mar			

6 QUALITY & SAFETY IMPACT

This winter patient experience has been compromised and on occasion severely compromised with patients waiting excessive lengths of time in the Emergency Department for beds.

This resulted in 19 x 12 hour breaches occurring between 29th December 2014 and 2nd February 2015 compared to none in 2013/14.

Some deterioration in the quality metrics (falls and pressure ulcers) over this period were seen raising concerns that the increased demand was compromising the quality of care patients were receiving due to patients not being in the right speciality bed, with inadequate staffing levels.

The number of operations cancelled increased as the winter period progressed leading ultimately to the failure of the RTT admitted target in February 2015. In total there were 799 cancelled operations due to no beds for the period December 2014 to March 2015 inclusive.

7 PARTNERSHIP WORKING

The implementation of ‘Year round ‘pressures planning’” was introduced as a concept during last winter and ensured there were economy-wide escalation plans and procedures that responded to predictable events such as winter and supported enhanced communication processes, thus retaining strong links with our local economy.

7.1 The importance of clarity of communication was never more important than at times of extreme pressure and support when sites were at escalation Level 3 (defined as severe pressure) or above. Weekly health and local economy senior management meetings were held. We were requested as a Trust to attend or participate in meetings and/or conference calls; with the following information provided, and reviewed:

- **Trust Development Authority (TDA) Updates** – This was a standard Excel spreadsheet covering all performance information and including breaches reasons. A narrative was also provided as to why performance was poor and actions to address.
- **Discharge Hub** – The twice daily discharge hub on each site provided support to Local Authorities and Community. Escalation of themes for delays to discharges was provided to the Senior Managers Winter Planning Meeting held on a weekly basis. This subsequently became the Programme Management Office (PMO).
- **PMO** – Attended by the Chief Operating Officer and or the Assistant Chief Operating Officer. The Unscheduled Care Group provided a confirm and challenge of all winter schemes and ensured that where needed the escalation of themes from the discharge hub was discussed with deliverable actions.
- **Telephone Conference Calls** - A telephone conference was held twice daily which involved stakeholders from the Trust, the Clinical Commissioning Groups, the Community Trust, Robert Jones & Agnes Hunt, the Area Team, the Local Authorities and Powys Local Health Board. If during the day de-escalation did not materialise a further escalation conference call took place at Executive level at approximately 18.00. Daily calls were held at weekends and are continuing.
- **Fortnightly CEO/Accountable Officer Urgent Care Recovery Meetings.**
- **Monthly Urgent Care Working Group Meetings.**
- **Monthly System Resilience Group Meetings.**

7.2 Key System-wide Schemes

Two system-wide schemes were key to the delivery of the objectives of the Operational Resilience and Capacity Plan:

7.2.1 Integrated Care Services (ICS)

As part of the Health and Social Care Economy Plan, Integrated Care Services (ICS) was set up for patients across all of Shropshire and was mirrored by Telford and Wrekin enablement scheme. The ICS team will be fully recruited to in June. Analysis is being undertaken to ascertain whether this will be sufficient to deliver the service to the number of patients requiring it.

7.2.2 The Discharge to Assess Model

The CCG also launched a Discharge to assess project as a prototype approach and focussed on two wards at each site in SaTH.

The Project defines the primary purpose of discharge to assess as being : all decisions about long term care and support needs are made outside an acute setting so that every patient has the best opportunity to maximise their rehabilitation and enablement potential and return home from their in-patient hospital stay (home being their normal place of residence).

This prototype will continue until June 2015 when a full business case will be presented to the System Resilience Group regarding full rollout of the service.

8 LESSONS LEARNT FROM WINTER 2014/15

- i. Internal plans were focused on ensuring safe staffing levels for escalation capacity and the emergency departments and escalation areas to manage an increase in demand. As the Trust had been using its escalation areas throughout the summer there was no ability to open any more acute beds. On the wards this was delivered in the main but through the use of agency staff which had a negative impact on the income and expenditure position. The recruitment trajectory will mean that there will be more substantive staff in post going into the winter of 2015/16, thereby reducing the reliance on temporary staff for escalation areas.
- ii. More patients were discharged at weekends with the additional ward rounds which were put in place with excellent pre 13.00 discharge rates.
- iii. Therapy services have undertaken an audit of the impact of twilight and weekend working over the winter and can demonstrate a direct correlation between their interventions and increased discharges at a weekend. This pilot over the winter will inform a business case to develop 7 day working.
- iv. The Trust cannot be in the position of going into next winter with a bed capacity gap, when it has no ability to create any capacity itself to manage a surge/increase in demand. This gap, which exists all year round, increases in the winter period. The prime focus this financial year for the System Resilience Group must be on implementing schemes which mitigate this risk for the acute Trust.
- v. The Trust entered the winter period with less capacity than the year before and with increased demand and higher acuity of patients than in 2013/14. This winter was challenging for the whole of the NHS. Transformational change is needed through the System Resilience Group to avoid the need for the heroic efforts staff made this year to keep patients safe.

9 NEXT STEPS

Discussions are already underway internally and with our local health economy in preparation for winter 2015/2016. However for nearly 12 months now the Trust has been delivering non elective demand through escalation capacity so there is no ability to deal with a sustained surge in demand, e.g. winter.

Crucially there needs to be whole system capacity and demand modelling supported by earlier predictive forecasting of demand. This will be led by the System Programme Manager.

As a Health and Social Economy the discussions have been centred around ensuring that surge planning for winter is a whole year event and not just for winter. Under discussion as part of the UCWG and the PMO each area has a number of plans, labelled as Urgent Care recovery, but delivery will support the future flow through SaTH back to the primary care.

The System Objectives are:

- To consistently achieve the 95% A&E operational standard;
- To deliver services that support care closer to home and prevent unnecessary admissions;
- To ensure individuals are informed about and engaged in their care and treatment;
- To design and deliver services that enable simpler navigation for both patients and clinicians;
- To deliver services that ensure individuals receive care and treatment in the appropriate care setting across 7 days;
- To proactively manage and flex service capacity to meet surges in demand.

Delivered Through:

- Implementation of Urgent Care Centres co-located with Emergency Departments;
- Development and implementation of a greater range of ambulatory care pathways;
- Expansion of integrated health and social care to prevent unnecessary admissions and facilitate early rapid discharge for those requiring acute care;
- Partnership working across organisations to facilitate timely transfer and enhance individuals experience of this transfer of care;
- Enhanced clinical input, training and education to Care Homes to better support individuals at risk of avoidable admissions;
- Continued emphasis on improving discharge processes from all hospital beds and the use of community beds for admission avoidance;
- Collective modelling, planning and agreement of additional capacity requirements.

Internally within the Trust there is an improvement plan focusing on ensuring that internal processes are as streamlined and effective as they can be to ensure that there are no delays in patient care.

Fundamentally the learning over the past 12 months is that the shape of the Urgent Care System in Shropshire, Telford & Wrekin and Powys needs to change and the plans outlined above are aimed at achieving the right shape but will require transformational change.

Whilst this is looking forwards a short term plan is needed to bridge the bed capacity gap and plans are in an early stage to achieve this on the RSH site.

10 OPERATIONAL RESILIENCE AND CAPACITY PLANNING 2015/16

Notification has been received that NHS England through its oversight of CCG's will ensure that no resilience schemes funded during winter 2014/15 are withdrawn unless there is clear evidence that they have been ineffective or that better alternatives are now in place. A whole system review of the effectiveness of the 2014/15 scheme is due.

Providers and Commissioners will be expected to reach agreement on funding plans in 2015/16 from the use of baseline of allocation and the marginal tariff rate reinvestment plans. Monitor, NHS TDA and NHS England in their assurance role of plans for 2015/16 will want to assure that the overall operational resilience plan is achievable, affordable and delivers on performance.

As a minimum, the plans will be expected to deliver the following eight 'High Impact Interventions'.

1.	No patient should have to attend A&E as a walk-in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hour's services.
2.	Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GP's should be considered.
3.	The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.
4.	SRG's should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
5.	Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management of falls without conveyance to hospital where appropriate.
6.	Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

7.	Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
8.	Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharges. SRG's will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

The responsibility for addressing these rests with the System Resilience Group (SRG) and should be included in the final operational plan. Submission for CCG's for 15th May 2015 for subsequent implementation.

The Board will note the immediate challenge to delivery for the high impact interventions 6 and 7.

Intervention 6: Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

Rapid Assessment and Treat can only be delivered by Senior Doctors in the Emergency Department and the Board is well cited on the gaps in senior doctor cover within the Trust.

Intervention 7 : Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

This will be tested when the 'Breaking the Cycle' initiative takes place during the first week of June 2015. Consultant presence in every specialty 7 days a week may facilitate a discharge but not if it is a complex discharge which cannot be initiated due to the lack of availability of Community and Local Authority services 7 days a week also.

Intervention 8 : Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharges. SRG's will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

The Trust Board will be pleased to note that the stretch target of 2.5% for delayed transfers of care (DTOC) has been set.

11 CONCLUSION

This paper has given an overview of the response taken with regard to the peak in emergency pressures that historically occur during the last quarter of the financial year, known as winter and the impact of the Operational Resilience and Capacity Plan.

SaTH promotes a learning culture, and the experience of 2014/2015 has again proven difficult with reactive management responding daily to increased demand, but more managed and controlled than in previous years.

A paradigm gear shift is now essential to develop the processes necessary to respond in the new financial year to reduce bed occupancy to circa 90% and deliver sustainable flow.

Despite best efforts the investment which the local health and social care economy received to ensure delivery against the constitutional target of 18 Weeks RTT and 4 hour performance, this was not achieved.

It is not possible to say what the position would have been without the additional investment but could be reasonably assumed that the impact on quality and safety and performance would have been significantly worse.

12 RECOMMENDATIONS

The Trust Board is requested to **APPROVE** the following recommendations:

- 1) Quarterly updates as part of the Integrated Performance Report on the progress against the internal improvement plan;
- 2) The Board to receive quarterly updates on the progress of the local health and social care community projects aimed at reducing demand and the number of patients on the Medically Fit to Transfer list;
- 3) To use the lessons learnt from winter 2014/15 to inform both our own internal plan and the whole health and social care economy resilience plan for winter 2015/16 in support of all year-round operational resilience planning;
- 4) The development of a more robust plan to protect elective capacity over the winter 2015/16.