

<b>Reporting to:</b>	<b>Trust Board, 29<sup>th</sup> September 2016</b>
<b>Title</b>	Winter Resilience 2016/17
<b>Sponsoring Director</b>	Debbie Kadum- Chief Operating Officer
<b>Author(s)</b>	Sara Biffen – Deputy Chief Operating Officer
<b>Previously considered by</b>	
<b>Executive Summary</b>	As we approach winter it is necessary to ensure we have enough bed capacity on both hospital sites, to deliver the anticipated level of emergency activity and keep our patients and staff safe. Within the paper are the schemes that were put in place during the winter of 2015/16, together with some alternative options. The Care Groups have identified some internal efficiencies which will be in place to improve patient flow and timely discharge. However these internal actions alone will not create enough capacity. A combination of schemes and enablers is necessary to deliver the anticipated level of activity between 1st November 2016 and 31 <sup>st</sup> March 2017. This paper only identifies the actions that are necessary internally and recognises that we will need the support of our external partners to manage Delayed Transfers of Care (DTOC) and patients who are medically fit for discharge (MFFD)
<b>Strategic Priorities</b>	
1. Quality and Safety	<input checked="" type="checkbox"/> Reduce harm, deliver best clinical outcomes and improve patient experience. <input checked="" type="checkbox"/> Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards <input type="checkbox"/> Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme <input type="checkbox"/> To undertake a review of all current services at specialty level to inform future service and business decisions <input type="checkbox"/> Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme
2. People	<input checked="" type="checkbox"/> Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation	<input checked="" type="checkbox"/> Support service transformation and increased productivity through technology and continuous improvement strategies
4. Community and Partnership	<input type="checkbox"/> Develop the principle of ‘agency’ in our community to support a prevention agenda and improve the health and well-being of the population <input type="checkbox"/> Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies
5. Financial Strength: Sustainable Future	<input type="checkbox"/> Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
<b>Board Assurance Framework (BAF) Risks</b>	<input checked="" type="checkbox"/> If we do not deliver <b>safe care</b> then patients may suffer avoidable harm and poor clinical outcomes and experience <input checked="" type="checkbox"/> If we do not work with our partners to reduce the number of patients on the <b>Delayed Transfer of Care (DTOC)</b> lists, and streamline our internal processes we will not improve our ‘simple’ discharges. <input type="checkbox"/> Risk to <b>sustainability</b> of clinical services due to potential shortages of key clinical staff <input checked="" type="checkbox"/> If we do not achieve safe and efficient <b>patient flow</b> 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 get good levels of <b>staff engagement</b> to get a culture of continuous improvement then staff morale and patient outcomes may not improve <input type="checkbox"/> If we do not have a clear <b>clinical service vision</b> then we may not deliver the best services to patients <input type="checkbox"/> If we are unable to resolve our (historic) shortfall in <b>liquidity</b> and the structural

	<p>imbalance in the Trust's <b>Income &amp; Expenditure</b> position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment</p>
<p><b>Care Quality Commission (CQC) Domains</b></p>	<p><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</p>
<p><input checked="" type="checkbox"/> Receive    <input type="checkbox"/> Review  <input type="checkbox"/> Note        <input checked="" type="checkbox"/> Approve</p>	<p><b>Recommendation</b>  It is recommended that the Winter Schemes from 15/16 should be supported this year as a minimum. In order to protect RTT over the winter period, inpatient beds within surgery would need to be protected. If the beds are not protected then there would be further deterioration in the 92% RTT standard.</p> <p>The Trust Board is asked to consider the contents of this paper, and the financial consequences of the options presented. The Trust Board is asked to <b>AGREE</b> the recommended way forward, and to note a decision on which schemes should be progressed for winter 16/17.</p>

## OPTIONS FOR WINTER RESILIENCE 2016/17



## 1.0 Introduction

This paper sets out the options that have been considered to create additional bed capacity during the winter, to ensure each of the hospital sites is able to maintain flow and keep the emergency departments and our patients safe. Within this paper winter is defined as the period from 1<sup>st</sup> November 2016 until 31<sup>st</sup> March 2017.

An internal winter planning group has been established with representation from all four Care Groups. The aim of the winter planning group was to look at ways we could create additional capacity on both sites and protect RTT activity. This will enable the flow from the Emergency Department [ED] to be maintained and keep the number of long waits within ED to a minimum. We have looked at several options, which we would be able to implement, subject to financial support.

The plan has been developed in collaboration with the four Care Groups within SaTH. The whole system winter plan has not been finalised. It has been challenging to engage with our external partners to create a whole system plan due to the financial pressures within the system.

## 2.0 Background

Typically, around 50% of adult emergency admissions to acute hospitals have lengths of stay of two days or less, and 80% stay less than seven days. The admission rate of the <7 day cohort has no obvious seasonal variation, and therefore does not directly contribute to 'seasonal pressures'. However, the number of these shorter admissions varies randomly by around 25%, which can trigger in-day bed pressures.

Around 15% of adult emergency admissions remain in hospital for between seven and twenty-one days and utilise more than 40% of bed days. This cohort is distinctive in displaying a drop in bed occupancy just before Christmas followed by a considerable increase after Christmas. Easter can display a similar pattern.

Trusts need to have sufficient capacity to manage the random variation inherent in the number of shorter stay admissions. This is achieved by having a bed occupancy rate of no more than 85%. SaTH consistently has bed occupancy of approximately 98%.

Managing the longer stay cohort, many of whom will have complex discharge needs requires considerable focus from clinical teams and multiagency collaboration. The post-Christmas rise in length of stay is not generally due to admissions being 'sicker'. It is due to a relative fall in whole system discharge capacity over the holiday period, leading to hospitals becoming crowded. Regaining equilibrium can take much longer than expected because processes have been destabilised. This means that even when the discharge capacity returns to normal, it may not be able to cope with the increased demand for discharge services. There will therefore be a period before the system re-stabilised.

It is essential that the need to maintain a relentless focus on straightforward as well as complex discharges, and to maintain whole system discharge capacity, is seen as a priority.

Historical patterns of demand and activity at SaTH show that the winter challenge will mean:

- Growing numbers of elderly patients waiting in the Emergency Department with resulting harm such as an increase in mortality, increased length of stay by 1.3 days for a stay of 4-8 hours in the Emergency Department (ED), while a stay in the ED of more than 12 hours increases length of stay by 2.3 days;
- Growing numbers of elderly patients being admitted;
- Growing numbers of people waiting to leave the hospital as measured by delayed transfers of care (DTOC) and medically fit for discharge (MFFD).

### **3.0 Current position**

Resilience through the winter period this year is of concern as escalation areas have been in use throughout the summer period and are still in use. These include:

#### ***RSH***

- Ward 32 Short Stay – 3 beds;
- Clinical Decision Unit corridor – 3 spaces;
- H&N Theatre – 4 spaces;
- AEC – 4 spaces;
- NIV room;
- Day Surgery Unit (not staffed 24/7) only if lists are cancelled.

#### ***PRH***

- Ward 7 – 6 beds;
- AEC - 4 spaces;
- NIV room – 1 space;
- Gynaecology treatment room – 1 space;
- H&N treatment room – 1 space.

### **4.0 Review of winter 2015/16**

In 2015/16, 44 additional medical beds were created (16 on the RSH site and 28 on PRH site), which were used as supported discharge and enabled patients to be transferred to this ward when they were fit for discharge. This worked well on both sites. Unfortunately at times we still had to manage capacity around 12 hour breaches and the patient experience for some patients on the Day Surgery facility at RSH was compromised as well as for those who experienced long waits in the ED. In times of high escalation, the decision to implement the 'Hospital Full' policy was taken which included boarding of patients that exceeded levels in the previous winter. The feedback from staff after last winter indicated that:

- Planning was better than in previous years. However, there was a frustration that the escalation wards were unable to be closed as planned.
- Staff knew where they would be working during the 20 weeks of winter, which improved staff morale
- Day surgery at RSH was not suitable as an inpatient ward for complex elective procedures and would have been best suited to short stay patients.
- Staff were concerned that boarding of patients was becoming the norm.
- Patient experience was compromised.

### **5.0 Planning for 2016/17**

SaTH consistently works above the nationally recommended bed occupancy levels and is currently at 98%, so therefore needs to be able to create some flexible capacity over the winter months. If the activity predictions are correct and length of stay remains unchanged then for the winter period, 1<sup>st</sup> November 2016 to 31<sup>st</sup> March 2017 we will require an additional 92 medical beds.

Each of the options considered within the planning phase have been ratified using the bed modelling tool that we are using for Sustainable Services and the Outline Business Case (OBC). Activity is based on actual discharged spells from November 2015 to March 2016, using current length of stay and occupancy levels. There is no activity growth assumed within this model. Between 2014/15 and 2015/16 there was a growth in non-elective activity of 7.3%.

The bed model for each site is available on request.

In addition to the schemes within the ED improvement plan e.g. SAFER, the Unscheduled Care Group have committed to the following schemes being in place which will reduce the bed gap by 30 beds, leaving a further 62 beds required for winter.

**Table 1: Care Group Winter Schemes**

Scheme	Description	Bed reduction
No patients to be bedded in AEC	This will enable patients to be rapidly assessed and treated and consequently avoid admission to medical beds. Modelling demonstrates this should equate to 17 beds which will not be required.	17
Frailty pathway to be in place	3 additional patients will go through this model each day	13
<b>Total:</b>		<b>30</b>

Detailed below are the options that have been considered by the winter planning group to manage emergency activity and flow over the winter period to further close the gap.

The options are:

- Option 1 Do nothing
- Option 2 'Drop in' ward on RSH site (20-25 beds) for Supported Discharge
- Option 3 Release 16 bedded ward on RSH site from scheduled care
- Option 4 Relocate elective orthopaedic surgery into DSU at PRH
- Option 5 Utilise day surgery capacity at RJAH
- Option 6 Step down beds in Shrewsbury care home provision
- Option 7 Utilise day surgery at RSH

## 6.0 Option Assessment – non financial

The 7 shortlisted options to create additional capacity are set out below.

OPTION	ASSESSMENT	RISK
<b>Option 1 – Do Nothing</b>	<ul style="list-style-type: none"> <li>• No additional bed capacity</li> <li>• There will be long waits for admission within the ED</li> <li>• 12 hour trolley waits</li> <li>• Potential patient harm</li> <li>• Last minute planning to create escalation capacity will result in the use of off framework to deal with the immediacy of the situation</li> <li>• Hospital full policy will be enacted more frequently than at present</li> <li>• Patients will be boarded on wards</li> <li>• Patient experience will be poor in ED and on wards</li> <li>• Staff morale will be affected</li> <li>• Credibility with our staff</li> <li>• RTT performance will decline as</li> </ul>	<ul style="list-style-type: none"> <li>• Agency staff will not be available to staff escalation areas</li> <li>• Ability to set up ward area without suitable planning</li> <li>• Retention of staff may be affected</li> <li>• Failure to deliver RTT</li> <li>• Further reduction in delivery of current ED trajectory</li> <li>• Will not receive STF funding</li> <li>• Increased mortality and overcrowding in ED</li> </ul>

	surgical beds are used for medical outliers	
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OPTION	ASSESSMENT	RISK
<p><b>Option 2</b> – Drop in ward on RSH site for Supported Discharge</p> <p><b>New scheme for 2016/17</b></p>	<ul style="list-style-type: none"> <li>• Drop in wards are used in other health economies</li> <li>• Additional 25 beds available</li> <li>• Protects loss of elective income of circa £1m and failure of RTT incomplete target;</li> <li>• Additional capacity reduces the risk of overcrowding in the ED and resultant harm;</li> <li>• Additional revenue costs covering staffing and rent of ward will be incurred;</li> <li>• Can be placed near the treatment centre on RSH site and connected to the main building</li> <li>• Enabling work to be undertaken to site buildings. Costs to be confirmed.</li> <li>• Lead in time is 8 weeks from delivery</li> <li>• Needs to be considered in conjunction with Options 3 &amp; 7;</li> </ul>	<ul style="list-style-type: none"> <li>• Isolation from the main hospital wards</li> <li>• Recruitment of nursing staff – currently have 50 vacancies within unscheduled care</li> <li>• No additional winter funding identified</li> <li>• Delivery of control total and STF.</li> <li>• Lead in time for opening of ward on RSH site is longer than is predicted</li> <li>• Medical cover for the ward</li> <li>• Relies on external partner to support timely discharge</li> </ul>

OPTION	ASSESSMENT	RISK
<p><b>Option 3</b> Release 16 bedded surgical ward on RSH site for supported discharge ward.</p> <p><b>Scheme in 2015/16</b></p>	<ul style="list-style-type: none"> <li>• Beds are within the ward complex;</li> <li>• Remaining surgical beds would have to be ring fenced;</li> <li>• AEC and frailty pathway need to be in place and reducing admissions;</li> <li>• Admission avoidance schemes must be in place;</li> <li>• Additional staffing costs of £151k (1<sup>st</sup> November to 31<sup>st</sup> March 2017) to open ward;</li> <li>• If surgical beds ring fenced then this just accommodates current medical outliers;</li> <li>• Needs to be considered in conjunction with Options 2 &amp; 7;</li> <li>• Cohorts DTOC patients and facilitates speedier discharge;</li> <li>• Model worked in 2015/16.</li> </ul>	<ul style="list-style-type: none"> <li>• Risk to delivery of RTT for admitted pathway if beds not ring fenced;</li> <li>• Relies on external partners to support timely discharge;</li> <li>• Medical cover for the ward</li> <li>• Recruitment of nursing staff, USC currently have 50 vacancies.</li> <li>• Delivery of control total and STF</li> <li>• Scheduled care will not achieve its financial recovery plan.</li> </ul>

OPTION	ASSESSMENT	RISK
<p><b>Option 4</b> – Release 28 orthopaedic beds on PRH site for supported discharge ward</p> <p><b>Scheme 2015/16</b></p>	<ul style="list-style-type: none"> <li>Releases 28 beds for supported discharge.</li> <li>Cohorts all DTOCs on one ward to enable flow in other areas.</li> <li>Protects elective activity within orthopaedics; 12 beds on DSU</li> <li>Revenue costs for staffing beds on ward 11 (some staff transfer to DSU).</li> <li>Ensures elective activity continues as escalation of medical patients to DSU will not happen;</li> <li>Model worked in 2015/16 but back up of Vanguard not available this year.</li> <li>Will need to outsource 35 patients per week to RJAH or Nuffield Hospital.</li> </ul>	<ul style="list-style-type: none"> <li>Recruitment of staff for 28 beds.</li> <li>No additional winter funding identified.</li> <li>Delivery of control total and STF.</li> <li>Relies on external partners to support timely discharge.</li> <li>Pharmacy support to DSU.</li> <li>RTT at risk if RJAH or Nuffield cannot support.</li> <li>Cost of outsourcing activity.</li> </ul>

OPTION	ASSESSMENT	RISK
<p><b>Option 5</b> – Utilise Day surgery capacity at RJAH</p> <p><b>New Scheme in 2016/17</b></p>	<ul style="list-style-type: none"> <li>TBC</li> <li>Discussions on-going with RJAH, but further correspondence indicates that the original option would be difficult to implement. An alternative option is being discussed.</li> </ul>	

OPTION	ASSESSMENT	RISK
<p><b>Option 6</b> – Community step down beds (Shrewsbury Care Home provision).</p> <p><b>New Scheme in 2016/17</b></p>	<ul style="list-style-type: none"> <li>New care home opening in Shrewsbury locality</li> <li>Flexible bed base up to 10 in non-acute setting suitable for discharge to assess cohort of patients</li> <li>Option to pre-purchase as required for a set period of time</li> <li>Indicative cost of £1k per week per bed</li> </ul>	<ul style="list-style-type: none"> <li>Capacity of care homes</li> <li>Access to medical/therapy provision for on-going patient support will be required</li> <li>Delays associated with Local Authority on-going provision of care if required could have an impact upon flow through these beds</li> <li>Requires planning as care homes need to 'hold' bed stock as it comes on line in advance of winter</li> <li>Requires additional funding</li> </ul>



		<ul style="list-style-type: none"> <li>• Delivery of control total and STF</li> </ul>
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OPTION	ASSESSMENT	RISK
<p><b>Option 7</b> – Utilise Day Surgery at RSH for short stay Surgery.</p> <p><b>Scheme in 2015/16</b></p>	<ul style="list-style-type: none"> <li>• Implement same model as last year up to 12 bed spaces;</li> <li>• Relies on Endoscopy Unit to support DSU activity</li> <li>• Would need some upgrade to sinks etc;</li> <li>• Additional facilities support e.g. Catering, Pharmacy, Therapies</li> <li>• No additional cost if only 12 beds in use</li> <li>• Needs to be considered in conjunction with options 2 / 3</li> </ul>	<ul style="list-style-type: none"> <li>• The environment is not suitable for inpatients;</li> <li>• No more than 12 beds can be utilised otherwise will impact on elective daycases (mitigation would be to move activity to alternative provider RJAH or Nuffield)</li> <li>• Failure to maintain RTT</li> <li>• Pharmacy support to DSU</li> <li>• Patient experience</li> </ul>

## 7.0 Key Areas of Risk

The key areas of risk associated with this plan relate to the following areas:

- Ability to staff additional capacity;
- Activity is higher than predicted;
- Cold weather and the associated respiratory infections;
- Older people and chronic medical conditions;
- Influenza and the potential for pandemic outbreaks;
- Staff retention and sustainability during long periods of pressure;
- Infection control and our ability to isolate patients;
- Financial pressures within the system;
- Workforce gaps – system wide.
- RTT Delivery

## 8.0 Patient Flow and Discharge Enablers

In addition to the schemes identified within the care group and the options regarding bed provision, there are several schemes that have been identified that will support patient flow, release bed capacity by reducing length of stay, facilitate timely discharge and support delivery of the ED trajectory. In order to implement these schemes, additional resource would be required.

These schemes are outlined below.

### A) Discharge Lounge - RSH

There is a requirement to improve the time of discharge on both sites to enable flow from the emergency department before 10.00am each day. Discharge from hospital requires the coordination of a number of disciplines, which can lead to delays in a patient being

discharged. Patients within acute beds can be delayed whilst awaiting transport, discharge summaries to be written, medication to be dispensed and external care to commence. It is rare that community beds are available to receive transfers from RSH until mid-afternoon. Significant work is required to coordinate a timely discharge and therefore the creation of a discharge lounge on the RSH site would support this process. The objective is to improve patient flow by timely access to inpatient beds, with the aim to reduce trolley waits within the Emergency Department and Acute Medical Unit, improving patient experience, quality and reduced clinical risk.

A space has been identified on the RSH site which would be able to accommodate patients who are being transported on trolleys and also those patients who are fit to sit. However this space is currently occupied by the Therapies team. Alternative accommodation for Therapies has been identified. This would replicate the service delivery model at PRH.

### ***B) Ambulatory Emergency Care (AEC) – Both Sites***

Currently, the AEC unit closes at 5pm. When this happens, patients who are still in the department are transferred to the ED. This has a negative impact upon patient experience and ED performance at this time and often leads to unnecessary admissions as further investigations etc. are required.

With additional resource (5 additional consultant or GP sessions per site each week), this could be avoided by extending the opening hours by 2 hours each day. This will deal with the surge of activity after 5pm. This resource would also be utilised to in reach into ED and AMU to avoid admissions into the main bed pool and support patient flow. After 7pm patients would be redirected to ED.

### ***C) Weekend Discharge Team***

The purpose of this scheme would be to support and enhance weekend discharge provision and planning by ensuring access to senior decision makers. This would contribute to patient flow across the medical bed base over 7 days by increasing discharges.

### ***D) ED Workforce***

Achieving ambulance handover standards and ensuring patient safety becomes challenging during times of peak escalation. The purpose of this scheme is to provide additional nurse staffing to support patients in ED awaiting transfer by implementing a system of reverse queuing from the department as recommended by ECIP. Implementing the scheme would support the delivery of ambulance handover times and the 4 hour standard.

### ***E) Clinical Decision Unit (CDU) - PRH***

Flow within the ED at PRH is compromised by the lack of a Clinical Decision Unit (CDU) which already exists on the RSH site. Each day there are up to 8 patients who would benefit from there being a CDU on site. There may be an opportunity to create a CDU but even if approved is unlikely to be in place before the winter period.

8.1 Whilst these schemes would clearly have a positive impact upon patient flow and support earlier discharge, it is also expected that schemes A-E would address the remaining gap in bedded provision to ensure delivery of the winter plan.

## 9.0 Bed Gap for 2016/17 & Options

Predicted bed gap		-92
AEC efficiency	17	
Frailty pathway	13	
Discharge Lounge @RSH	11	
Ward 11 PRH	28	
16 bedded ward RSH	16	
Step down beds (nursing home)	10	
Drop in Ward	25	
<b>Total Options &amp; Efficiencies</b>		120
Surplus/Deficit		+28

## High Level Financial Appraisal for Options and Support Costs

### Options Costings

Option	Scheme	Revenue Impact £000	Income (loss)/gain £000	Capital Cost
1	Do nothing	1,200	(5,100)	N/A
2	Drop in Ward (25 beds)	1,250		Enabling costs to be confirmed
3	Release 16 beds on RSH site	690		N/A
4	Release 28 beds on PRH site	950		N/A
5	Utilise Day surgery capacity at RJAH	TBC		N/A
6	Community step down beds	200		N/A
7	Utilise 12 day surgery beds at RSH for inpatients	Costs transferred from Vacated 16 bedded ward	N/A	TBC

## Support Costs

Scheme	Resource required	Revenue Impact £000	Comments	Income Loss/Gain
AEC (at both sites)	<ul style="list-style-type: none"> <li>5 consultant sessions on each site</li> </ul>	100	To support extended day over 5 days	N/A
Discharge Lounge (RSH)	<ul style="list-style-type: none"> <li>Healthcare Assistants</li> <li>Transfer Team</li> </ul>	96	New initiative for 2016/17 to facilitate flow and timely transfer of patients from ED and AMU to specialty wards.	N/A
Weekend Discharge Team (at both sites)	<ul style="list-style-type: none"> <li>Consultant workforce</li> </ul>	53	In place 2015/16 for 20 weeks of winter. 2 sessions every weekend per site This will support further discharges at the weekend. At present this is delivered on a voluntary basis and is not a consistent resource.	N/A
ED Workforce (at both sites)	<ul style="list-style-type: none"> <li>Handover nurse to work with Ambulance service to prevent handover delays.</li> <li>4.48 WTE</li> </ul>	274	Handover nurse was in place over the 20 weeks of winter. This enabled Ambulance crews to be released from the hospital during periods of high demand.	N/A
<b>Total Enabling Costs</b>		<b>523</b>		
Outsourcing activity	Nuffield or RJAH	1,000	This assumes 35 patients per week are transferred to the Nuffield or the RJAH. This will maintain current RTT position for orthopaedics.	N/A
<b>TOTAL COSTS</b>		<b>1,523</b>		

## 10.0 Timescales

Once the preferred option(s) has been decided, to ensure safety and quality of patient care and functionality of the Emergency Department over the winter period, they must be implemented and in place ideally by 1<sup>st</sup> November 2016 and if not then by the end of December 2016.

## 11.0 Recommended Options

At this stage each of the options carries with it a risk of whether we are able to staff the options and the risk of being unable to secure mobile drop in wards. In order to keep patients safe over the winter period a combination of options need to be considered. Therefore the following recommendations are put forward:

### **RSH Site**

- Option 3 is progressed with option 7. This would create a 16 bedded supported discharge ward from 1<sup>st</sup> November; and would cohort DTOCs and MFFD patients in one area. Option 7 is to transfer short stay surgery to DSU (maximum of 12 beds). The cost of this option is £0.69m plus £0.309m for enabling schemes.
- Option 2 is progressed with option 3 and option 7. This would create an additional 41 beds for medicine on the RSH site. The cost of this option is £1.94m plus £0.309m for enabling schemes.

### **PRH Site**

- Option 4 is progressed, which would create 28 additional beds for medicine and transfer elective orthopaedic activity to the Day Surgery Unit (DSU) and outsource to external provider to maintain RTT performance. The cost of this option is £1.95m plus £0.213m for enabling schemes.

## 12.0 Recommended Enabling Schemes

- Discharge consultant /senior decision maker at the weekends to facilitate discharges and also support post take ward rounds;
- Extended working day of Ambulatory Emergency which enables patients to be redirected from the Emergency Department (ED);
- Discharge Lounge on the RSH site, patients will be pulled from each ward at 10am & 11am to create flow and support SAFER 33% of discharges before midday;
- Handover nurse within ED to release ambulance crews and prevent handover delays;
- 35 patients per week to be outsourced to Nuffield or RJ&AH.

## 13.0 Total cost

Site	Proposed Combination of Options and enablers	Combined Costs £000
RSH	Option 3 and 7 and enablers	999
or		
RSH	Option 2,3 and 7 and enablers	2,249
PRH	Option 4, Outsourcing and enablers (maintaining RTT)	2,163
or		
PRH	Option 4, (not maintaining RTT)	1,163

#### **14.0 Winter Funding Available**

£1.2m has been assumed to be available from Commissioners but is in dispute. The total cost of the winter plan exceeds this and is therefore not affordable if we are to deliver the control total for 16/17. The Board therefore needs to discuss the competing risk of not delivering the financial control total and the risk of having insufficient capacity to safely care for patients who present over the winter period and maintain our current RTT position, when considering which options should be progressed.

#### **15.0 Action Required**

It is recommended that the Winter Schemes from 2015/16 should be supported this year as a minimum. In order to protect RTT over the winter period, inpatient beds within surgery would need to be protected and outsourcing of daycase activity in place. If the beds are not protected then there would be further deterioration in the 92% RTT standard. A combination of options would need to be considered if the bed gap over winter is to be realised.

The Trust Board is asked to consider the contents of this paper, and the financial consequences of the options presented. The Trust Board is asked to **AGREE** the recommended way forward, and to note a decision on which schemes should be progressed for winter 2016/17.

*Sara Biffen  
Deputy Chief Operating Officer  
September 2016*