

<b>Reporting to:</b>	<b>Trust Board, Thursday 1<sup>st</sup> December 2016</b>
<b>Title</b>	Winter Resilience 2016/17
<b>Sponsoring Director</b>	Debbie Kadum - Chief Operating Officer
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<b>Previously considered by</b>	Sustainability Committee 25 <sup>th</sup> October 2016, and Board Development Session 27 <sup>th</sup> October 2016
<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) and a proposal for how this might be achieved is included.
<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</b> (DTOC) 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

	<p>best services to patients</p> <p><input type="checkbox"/> If we are unable to resolve our (historic) shortfall in <b>liquidity</b> and the structural 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</p> <p><input checked="" type="checkbox"/> Effective</p> <p><input checked="" type="checkbox"/> Caring</p> <p><input checked="" type="checkbox"/> Responsive</p> <p><input checked="" type="checkbox"/> Well led</p>
<p><input checked="" type="checkbox"/> Receive    <input type="checkbox"/> Review</p> <p><input type="checkbox"/> Note        <input checked="" type="checkbox"/> Approve</p>	<p><b>Recommendation</b></p> <p>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>SUPPORT</b> the approval of the option recommended by the Sustainability Committee (Option 4).</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). The bed requirement has been calculated assuming that occupancy levels will remain at 98% and medical length of stay is an average of 5.7 days. Activity is based on the 2016/17 planned activity profile from 1<sup>st</sup> November 2016 to 31<sup>st</sup> March 2017. The bed model for each site is available on request.

## 6.0 Winter Funding Available

£1.2M has been assumed to be available from commissioners and must be used to fund schemes which enable SaTH to respond to in-day bed pressures. In addition, £0.5M has been made available to cover lost contribution following a reduced level of orthopaedic activity over the winter period. Therefore the total available funding is £1.7M.

## 7.0 Options

A long list of options has been considered by the Winter Planning Group and includes the following:

- A drop-in ward on both sites – unable to staff;
- Fully implemented discharge to assess model – proceeding as part of the National A&E Improvement Plan led by Shropshire CCG;
- Vanguard unit for elective activity – no units available;
- Use of Copthorne building for supported discharge/step-down beds – unable to staff;
- Purchase 92 step-down beds – does not support the flexibility required to manage in-day pressures nor are the volume of beds available to enable the most effective use of resources.

In support of the Trust's Organisational Strategy, SaTH's internal plan as a minimum must mitigate the following risks:

- On the day surge of emergency patients;
- Boarding on wards and bedding down in the Emergency Department and deterioration in 4 hour performance;
- Cancellation of elective surgery and deterioration in RTT performance;
- Increase in handover delays;
- Financially affordable;
- Increased level of staff unavailability because of sickness.

The shortlisted options considered to be deliverable by 1<sup>st</sup> November 2016 are outlined below.

Option 1	Cost £000	Beds	Bed gap	Consequences & Risks
<b>Bed Gap</b>			<b>-92</b>	
Supported discharge wards, SAU and weekend discharge team	1,015	44	-48	<ul style="list-style-type: none"> <li>• Boarding on all wards (25 patients)</li> <li>• Bedding in ED overnight (up to 20 patients)</li> <li>• Poor patient experience</li> <li>• Privacy and Dignity</li> <li>• Cancellation of elective surgery due to ward moves and escalation ( 70 patients per week) and impact on RTT</li> <li>• Ambulance handover delays exceeding 1 hour (standard is 15 minutes)</li> <li>• Financial risk - loss of contribution</li> </ul>
Improve frailty model	0	6	-42	
<b>Total</b>	<b>1,015</b>	<b>50</b>	<b>-42</b>	

<b>Option 2</b>	Cost £000	Beds	Bed gap	Consequences & Risks
<b>Bed Gap</b>			<b>-92</b>	
Supported discharge wards, SAU and weekend discharge team	1,015	44	-48	<ul style="list-style-type: none"> <li>• Boarding on all wards /bedding in ED (29 patients)</li> <li>• Poor patient experience</li> <li>• Privacy and dignity</li> <li>• Cancellation of elective surgery due to ward moves (35 per week) and impact on RTT</li> <li>• Financial risk - loss of contribution</li> <li>• Ambulance handover delays exceeding 1 hour (standard is 15 minutes).</li> </ul>
Improve frailty model	0	6	-42	
Discharge lounge on RSH site	96	5	-37	
AEC extended hours both sites	100	8	-29	
<b>Total</b>	<b>1,211</b>	<b>73</b>	<b>-29</b>	

<b>Option 3</b>	Cost £000	Beds	Bed gap	Consequences & Risks
<b>Bed Gap</b>			<b>-92</b>	
Supported discharge wards, SAU and weekend discharge team	1,015	44	-48	<ul style="list-style-type: none"> <li>• Boarding on wards/bedding in ED</li> <li>• Cancellation of elective surgery due to ward moves (35 per week) and impact on RTT</li> <li>• Financial risk - loss of contribution</li> <li>• Ambulance handover delays exceeding 1 hour (standard is 15 minutes).</li> </ul>
Improve frailty model	0	6	-42	
Discharge lounge on RSH site	96	5	-37	
AEC extended hours both sites	100	8	-29	
Purchase step down beds for DTOC patients	432	21	-8	
<b>Total</b>	<b>1,643</b>	<b>84</b>	<b>-8</b>	

<b>Option 4</b>	Cost £000	Beds	Bed gap	Consequences & Risks
<b>Bed Gap</b>			<b>-92</b>	
Supported discharge wards, SAU and weekend discharge team	1,015	44	-48	<ul style="list-style-type: none"> <li>• Boarding on wards/bedding in ED, but less of a risk</li> <li>• Maintains current RTT performance</li> <li>• Mitigates risk of loss of contribution</li> <li>• Less of a risk of ambulance handover delays exceeding 1 hour (standard is 15 minutes).</li> </ul>
Improve frailty model	0	6	-42	
Discharge lounge on RSH site	96	5	-37	
AEC extended hours both sites	100	8	-29	
Outsource elective activity (35 per week)	500			
<b>Total</b>	<b>1,711</b>	<b>63</b>	<b>-29</b>	

<b>Option 5</b>	<b>Cost £000</b>	<b>Beds</b>	<b>Bed gap</b>	<b>Consequences &amp; Risks</b>
<b>Bed Gap</b>			<b>-92</b>	
Supported discharge wards, SAU and weekend discharge team	1,015	44	-48	<ul style="list-style-type: none"> <li>• Boarding on wards/bedding in ED, but less of a risk</li> <li>• Financial risk - unaffordable</li> <li>• Maintains current RTT performance</li> <li>• Mitigates the risk of loss of contribution</li> <li>• Less of a risk of ambulance handover delays exceeding 1 hour (standard is 15 minutes).</li> </ul>
Improve frailty model	0	6	-42	
Discharge lounge on RSH site	96	5	-37	
AEC extended hours both sites	100	8	-29	
Purchase step down beds for DTOC patients	432	21	-8	
Outsource elective activity (35 per week)	500			
<b>Total</b>	<b>2,143</b>	<b>84</b>	<b>-8</b>	

## 8.0 Spot Purchased Beds

One of the schemes considered by SaTH's Winter Planning Group was the option of purchasing step-down beds from a new care home in Shrewsbury that is due to open mid-November. The cost of these beds is circa £900.00 per week including GP support for each bed but excluding wraparound care. Consideration was given to purchasing more beds than was included in option 5 (21 beds), however after analysing the MFFD list and DTOC's there are insufficient suitable patients for these pathway 2 beds. These beds would only be really suitable for those patients with packages of care in the future. Otherwise there is a risk that these beds will be occupied with patients whose care needs and length of stay is greater than the modelling we have done for winter. Currently the expertise in providing wraparound care exists within both local authorities and Shropshire Community Trust. A key success factor is that these beds within a small number of care homes would need to be located in close proximity to each other to ensure that the support service for these patients i.e. therapy and social work cover, is easily available.

## 9.0 System Winter Plan

The System Winter Plan is going to the A&E Delivery Board on 31<sup>st</sup> October 2016 for approval. Roles and responsibilities of partners within this can broadly be described as:

- SaTH – ensure sufficient flex capacity is available to manage in-day pressures;
- Shropshire Community Trust and Local Authorities – ensure sufficient discharge to assess capacity is available to avoid any increase in delayed transfers of care across the system, including SaTH. Ensure admission avoidance schemes are functioning effectively;
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust – support SaTH through provision of step-down-medical and orthopaedic care;
- Shropshire and Telford & Wrekin CCG's and Powys LHB – ensure sufficient capacity has been commissioned from providers for the winter period.

As part of the System Winter Plan, SaTH requires its partners to offer schemes to bridge the bed gap of 29 beds for the winter period.



This could be provided through a variety of schemes as follows:

- Spot purchase of pathway 2 and 3 beds;
- Increase in number of community beds;
- Increase in the number of packages of care available (pathway 1);
- Deliver on the standards of discharge to assess:
  - Assessments should be done promptly (within 2 hours)
  - Rapid (on the day) access to care and support if it is required
  - Ensuring no DTOC's in discharge to assess beds.

## 10.0 Option Benefits Appraisal

The table below summarises the option benefit appraisal against patient experience and affordability.

Discounted – poor patient experience			Better patient experience		Preferred option and mitigation
Supported Discharge Wards, SAU, Weekend Discharge Team + 44 beds	Supported Discharge Wards, SAU, Weekend Discharge Team + 44 beds	Supported Discharge Wards, SAU, w/e Discharge Team + 44 beds	Supported Discharge Wards, SAU, w/e Discharge Team + 44 beds	Supported Discharge Wards, SAU, w/e Discharge Team + 44 beds	Supported Discharge Wards, SAU, w/e Discharge Team + 44 beds
Improve Frailty model + 6 beds	Improve Frailty model + 6 beds	Improve Frailty model + 6 beds	Improve Frailty model + 6 beds	Improve Frailty model + 6 beds	Improve Frailty model + 6 beds
		Purchase DTOC +21		Purchase DTOC +21	
	Discharge Lounge RSH, extended AEC +13 beds	Discharge Lounge RSH, extended AEC +13 beds	Discharge Lounge RSH, extended AEC +13 beds	Discharge Lounge RSH, extended AEC +13 beds	Discharge Lounge RSH, extended AEC +13 beds
Remaining capacity gap - 42 beds	Remaining capacity gap - 29 beds	Remaining capacity gap - 8 beds	Remaining capacity gap - 29 beds	Remaining capacity gap - 8 beds	29 beds delivered in the Community
Boarding 25 pts Bedding 20 pts	Boarding and Bedding 29 pts	Minimal Boarding and Bedding	Some Boarding and Bedding	Minimal Boarding and Bedding	Minimal Boarding and Bedding
70 Elective cancellations per week	35 Elective cancellations per week	35 Elective cancellations per week	Outsource Elective (35 per week)	Outsource Elective (35 per week)	Outsource Elective (35 per week)
Ambulance handovers exceed 1hr	Ambulance handovers exceed 1hr	Less risk of Ambulance delays	Less risk of Ambulance delays	Less risk of Ambulance delays	Less risk of Ambulance delays
Deterioration in performance	Deterioration in performance	Deterioration in performance	Maintain RTT through outsourcing	Maintain RTT through outsourcing	Maintain RTT through outsourcing
£1.0m	£1.2m	£1.6m	£1.7m	£2.1m	£1.7m
Option 1	Option 2	Option 3	Option 4	Option 5	Option 4
Affordable			Unaffordable		

## 11.0 Recommendation

Option 5 mitigates all of the risks inherent in the winter but is unaffordable, therefore, option 4 which enables SaTH to create flexible capacity to deal with on the day pressures, reduce the risk of boarding and bedding in the Emergency Department; over 1 hour handover delays and reduce the risk of elective operations being cancelled is the recommended option as this also falls within the funding available of £1.7M. This however does not bridge the total bed gap (29 beds) and therefore this should be mitigated by the System Winter Plan.

Sara Biffen  
Deputy Chief Operating Officer, December 2016